SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES
ADMINISTRATION (SAMHSA)

Advisory Committee for Women's Services

9:10 a.m.

Tuesday, August 25, 2009

Palmer House Hotel
17 East Monroe Street
Chicago, Illinois 60603

P R O C E E D I N G S

MS. NEVINE GAHED: Good morning, everyone. Hello. I'm Nevine Gahed. I'm the designated Federal official for the SAMHSA Advisory Committee for Women's Services. And having a quorum, we can begin the meeting.

Ms. Enomoto?

MS. KANA ENOMOTO: Good morning. Thank you, everyone, for making the journey to Chicago, and thank you to Chicago for hosting us. We are excited to be here.

We have a wonderful agenda set up for us today, and I'm really pleased to be able to report out some of the fruits of the committee's work are really coming to bear in a number of the gray areas. And so, we'll be giving you updates on that, and then we just have an all-star cast of presenters.

I want to thank -- before we get into the meat of things. I want to do some introductions and also some thanks. Debbie Crump and Nevine Gahed from SAMHSA, I'm sure all of you have been in contact with, have just been amazing and a seamless, wonderful,

hard-working team to get the meeting together.

[Applause.]

MS. KANA ENOMOTO: Nevine actually wrote that “thank Debbie Crump for so ably handling the technology portion of our meeting today.”

MS. NEVINE GAHED: And Debbie says not so fast.

[Laughter.]

MS. KANA ENOMOTO: Debbie said, “Thank me at the end of the meeting.”

So we do have a new and different way of handling our technology. We’re doing this remotely to SAMHSA, remotely from our headquarters. And so, we’ve done a Web -- we’re also doing this as a Web conference. And so, I’ll let -- we will explain some of that a little bit later.

I want to thank our -- also just to introduce to the members and to the audience some of the staff who are working here today. We have Irene Goldstein, who is an old friend. But she is our writer for the meeting. We have Don Lewis [inaudible], who is doing our sound and AV and will

let us know if we're to move our mikes closer.

MR. ED HIRONIMUS: I can't hear anything.

MS. KANA ENOMOTO: Okay. And --

FEMALE VOICE: Is that loud?

[Laughter.]

MS. KANA ENOMOTO: Already I'm being critiqued. Okay.

MS. NEVINE GAHED: It's Ed Hironimus, actually.

MS. KANA ENOMOTO: Okay. Oh, Ed Hironimus is our Verizon person. It takes a village to make an ACWS meeting happen.

We also have Mr. Marvin Oltman, who is doing our transcription. So, for our members, he may be coming to us as we are cautious about use of acronyms and abbreviations, and I'm pretty sure he will come to you if he needs additional clarification on things, as will other folks.

Is it okay to do a roll call? Okay. So we're going to do our roll call. And today's added feature, we're going to ask our audience and the folks online to introduce ourselves, just so that everyone

can be aware of who's listening and who's in on the conversation.

MS. NEVINE GAHED: Okay, Operator?

OPERATOR: Do you want the roll call, ma'am?

MS. NEVINE GAHED: Do we want to start with the --

OPERATOR: We're not able to hear you very well on the audio. I apologize.

MS. NEVINE GAHED: Yes. We're going to be starting with a roll call of the people at the meeting here, and then we will open it up to those who are online.

OPERATOR: Okay. I'll be standing by.

MS. KANA ENOMOTO: Thank you. This way.

DR. STEPHANIE COVINGTON: Stephanie Covington.

DR. ROGER FALLOT: Roger Fallot.

MS. AMANDA MANBECK: Amanda Manbeck.

MS. SUSAN AYERS: Susan Ayers.

MS. GAIL HUTCHINGS: Gail Hutchings.

DR. JEAN LAU CHIN: Jean Chin.

MS. NEVINE GAHED: Nevine Gahed.

MS. KANA ENOMOTO: Kana Enomoto.

MS. PEGGY POWERS: I'm Peggy Powers.

MS. KANA ENOMOTO: And if you just want to say your affiliation and where you're from.

MS. PEGGY POWERS: I work for the Illinois Alcoholism and Drug Dependence Association, but I'm here representing SAAS.

MS. ALICE GEIS: I'm Alice Geis. I'm an advanced practice nurse with Trilogy, working on an integrated health program.

MR. FREDERICK QUINN: Frederick Quinn, representing the Illinois Department of Human Services, Division of Mental Health, Juvenile Forensics Trauma Team.

MS. TERRI MARIANO: Terri Mariano. I'm also with IDHS, and I am on the same trauma team.

MS. SUSAN AUMAN: I'm Susan Auman, as well on the IDHS trauma team.

MS. SHIRLEY HELM: Shirley Helm. Thesholds Psychiatric Rehabilitation Centers in Chicago.

MS. ERICA ABU-GHALLOUS: Erica Abu-Ghallous with the Region V Office of Women's Health.

MS. LESLEY CRAIG: Lesley Craig with the Region V Office of Women's Health.

MS. LISA GOODALE: Lisa Goodale with Depression and Bipolar Support Alliance.

MS. SHARON AMATETTI: Sharon Amatetti with SAMHSA Center for Substance Abuse Treatment.

MS. LINDA WHITE-YOUNG: Linda White-Young with SAMHSA Center for Substance Abuse Treatment.

MS. NEVINE GAHED: All right, Operator?

OPERATOR: On the audio portion, Toian Vaughn, your line is open.

MS. TOIAN VAUGHN: Toian Vaughn, SAMHSA.

OPERATOR: Thank you. And Debra Warner, your line is open.

MS. DEBRA WARNER: Hi. This is Debra Warner.

OPERATOR: And Nevine, that is all on the audio portion at this time.

MS. NEVINE GAHED: Oh, okay. Thank you, Operator.

MS. KANA ENOMOTO: Just as a reminder, members of the public who are on the phone are going

to be on mute for the rest of the meeting until 3:00 p.m., when we open the floor to public comment.

And for those of you who are on the phone, if you wish to speak, please let the operator know ahead of time. You'll have 2 to 3 minutes to make your comments, and that will run from 3:00 p.m. to 3:15 p.m.

We will also have the capacity for people from the public to join us remotely at the listening session at the National Association for Community Health Centers meeting, where we are reconvening at 4:45 p.m. for a 1.5-hour listening session on women and trauma taking place at the Chicago Hilton.

The toll-free number and that conference link will remain the same. So we're going to transport our technology over a few blocks to the other hotel. And for those who are joining via Net conference, a shared folder of all the presentations is available for download.

I just wanted to acknowledge that Jacki McKinney is not able to join us for this meeting in Chicago, and Renata Henry will be -- Renata and Britt

will both be joining us a little bit later. But they are en route.

MS. NEVINE GAHED: Yes. What we're going to do is basically put all the files on the screen. People who are actually remote can see all the presentations, and we are going to be going by order. So, as a matter of fact, even though the presenters are here, we are basically going to be running the slides for them. So it will be an easier way of managing --

MR. ED HIRONIMUS: Operator?

OPERATOR: I'm standing by.

MS. NEVINE GAHED: All right. Can we put Ed on -- Ed, I'm sorry. We're going to put you on mute at this point. Thank you.

And the same thing is going to happen also in the afternoon. So if you need any of the presentations, we do actually have CDs on the table for any of the members of the public who would like to have them. If you are missing anything, there is also my card. Please let me know, and I will send them to you.

MS. KANA ENOMOTO: All right. So, on to our update. We at SAMHSA continued nose to the grindstone, very much going ahead full throttle in waiting for the announcement on the nomination for a new administrator. Lots of rumors are flying, but still nothing official from the White House. Debbie has the official job of checking the White House Web site twice a day. But we are anticipating an excellent nominee and are looking forward to the days ahead where SAMHSA will have its official political leadership.

But in the meantime, Dr. Rick Broderick, our acting administrator, is doing a fantastic job of keeping us steady and also engaging in a dialogue around health reform, as well as the American Recovery and Reinvestment Act work that's going on and the stimulus funding coming to the department, not so much to SAMHSA.

At our last meeting, we had a conversation on health reform and some panel presentations in May. And we outlined to you the core principles on health reform, which Gail Hutchings really did yeoman's work

in helping SAMHSA put together. I think we had scanned, I don't know, 100-plus organizations and members of the public who provided to SAMHSA their thoughts around what needed to be included in any really meaningful health reform bill.

We had nine principles at that time.

MS. NEVINE GAHED: We had nine? I believe we had 10.

MS. KANA ENOMOTO: No, we had 10, and we are down to 9. And so, under A-5 in your packages, you have the revised version after we had had our conversations with you and had our conversations with stakeholders. Principle 2, we now include in that legislation universal coverage of health insurance should be one with full parity. So universal coverage is not -- is not enough, but we need to ensure that parity is part of that.

And we added a new Principle 3 that links improved health with the need for fiscal sustainability, and the term "behavioral healthcare" throughout our document was replaced with "substance use and mental health conditions" as a way to

distinguish ourselves from other forms of behavioral health and as well as the ability to clearly identify the conditions that we're talking about.

And that's illustrated in Principles 4, 8, and 9. And really, I think the remarkable thing that happened as a result of this is Dr. Broderick wanted to ensure that there was a more consistent voice being heard around health reform and the inclusion of substance use conditions and mental health conditions in that dialogue.

And so, we've convened some of our leading advocates on the Hill to tell politicians about these principles and to get their consensus in terms of can we all -- it won't help us if we're all going forward with each our own agendas and 20 different messages. If someone's saying, well, just get parity in there, and then we're fine. The risk of kind of people going to the lowest common denominator and then feeling like they can check off the box of mental health and addictions.

So we convened our -- the group, we are fondly calling it the "architects group" because we

felt like these were really going to be the architects of the action on the Hill. They are the ones who are speaking loudest to our representatives and to our senators, and they all came together around the principles. They embraced them, and they agreed that they should be a floor, that we cannot ask for less than this.

And as organizations will ask perhaps for different things, but we could all be in agreement that these principles are really ones that should be included in everyone's ask. And that was quite an accomplishment. I think a number of them noted that they hadn't done something like that since parity, and parity was really many, many, many years in the making of that advocacy effort. But around health reform, we were more united more rapidly.

So I think that's been a very good process for us. We've been staying in touch with them on a pretty regular basis. Of course, we are not in the conversations on the Hill, but they are letting us know what they see happening and the trends emerging and implications for SAMHSA or providing information,

as is helpful regarding implications for cost or coverage or otherwise, or we have data or analysis that could be helpful to them.

So it's been a very nice, symbiotic relationship and really helped to form a dialogue. And we shall see the outcomes. I mean, we're hopeful that our understanding is that, say, in the first tri-committee bill, there were a number of places where either SAMHSA was left out or mental health and addictions were left out, and in fact, when some of our legal organizations met with folks, they were very open to amendments. And so, they did accomplish several important amendments in the draft legislation on the House side. And so, we'll see where it ultimately comes out.

But it's good news that when it's brought up that, "You've left out SAMHSA, you've included HRSA, CDC, and NIH, and ARC, but you need to include SAMHSA," that people have said, "Yes, we will include SAMHSA. That was an oversight." Or if you said, "You've articulated these conditions. You also need to articulate mental illnesses and addictions," that

people have been open to doing that.

So there is good progress on that front, and we continue to stay abreast, and we will keep you updated.

Update on the budget. You have our budget highlights in your folder under A-5(a). The President's budget was available in the spring. We talked about that in May. The SAMHSA request, the President's request for SAMHSA was $3.525 billion, or $3.5 billion. For us, it was an increase of $59 million, or 1.7 percent of our FY 2009 level.

Now when you have House and Senate language, and in the House appropriations, it looks like SAMHSA's budget is total of $3.551 billion, and that is an increase of $84.5 million, or 2.4 percent over our 2009 operating level, and $25 million over the President's budget.

So, in addition to some center-specific funding increases, including the block grant, the Substance Abuse and Prevention Treatment Block Grant, it does include funding for congressional projects. About $10 million worth of earmarks are included in

that House number.

On the Senate side, we have an even bigger increase of $94.9 million proposed. It's $3.561 billion total. That would be a 2.7 percent increase for SAMHSA over 2009, and about $36 million, or 1 percent greater than the President's request. The set-aside there is a proposal for $40 million additional to the Substance Abuse and Prevention Treatment Block Grant.

But some good news for us on both sides. We actually have -- I think within the department, they did an analysis of the percentage increases on the House and Senate side, and SAMHSA is coming out, I think, number two for across the department. So we're not seeing huge jumps for any of the operating divisions, but of the jumps, we're doing quite well on the plus side.

We have some grant --

OPERATOR: Nevine, this is the operator [inaudible]. We are having a lot of difficulty hearing you on the audio portion.

MS. NEVINE GAHED: Thank you.

MS. KANA ENOMOTO: Do I need to speak here?

MS. NEVINE GAHED: Yes.

FEMALE VOICE: Kana, are you staying on the budget, or are you moving to something else?

MS. KANA ENOMOTO: I'm moving to something else. Are there any questions about the budget?

FEMALE VOICE: Do you know -- first, it's nice to have the increase, of course, on PRNS -- and I'm trying to be acronym conscious. So the Programs of Regional or National Significance under CMHS on the House mark, do you know what that $12 million is for? Is that where the earmarks will be? And there is another $2 million there, and I'm just wondering what program that might be for. Any idea?

MS. KANA ENOMOTO: Well, I think that's primary care and behavioral health.

FEMALE VOICE: Okay. Okay. So there might be a new cohort of grantees over there. Okay. Great. Thank you.

MS. KANA ENOMOTO: I think there has also been conversation about a grant to help communities in response to -- I think we're calling it fostering

resilience in times of economic recovery. But it's addressing the challenges that -- it will be a pilot program to address challenges of people who are dealing with economic hardship.

FEMALE VOICE: A grant program?

MS. KANA ENOMOTO: A grant program.

FEMALE VOICE: And I know I should know this, so can you remind me what NASPER is under CSAT?

MS. KANA ENOMOTO: It's the, I think, prescription medication registry?

FEMALE VOICE: Thank you very much.

MS. KANA ENOMOTO: Which we had been delegated by the Secretary, but no funds. And so, now there are finally funds --

FEMALE VOICE: Nice.

MS. KANA ENOMOTO: -- and that's worked out.

FEMALE VOICE: Thank you.

MS. KANA ENOMOTO: Let's see. Continued support for children's mental health and for homelessness. And obviously, very strong support for drug courts and Screening, Brief Intervention, Referral to Treatment within CSAT. [Inaudible.]

Are there questions about the budget?

[No response.]

MS. KANA ENOMOTO: No? Okay, great.

I want to give updates on programs and activities, and I did actually clear it with folks beforehand. But Linda and Sharon, did you want to give quick updates on the trauma-informed systems guidebook and on the Core Competencies Project?

MS. SHARON AMATETTI: Sure.

MS. KANA ENOMOTO: Okay, Sharon? So Sharon Amatetti will give a brief update on the Core Competencies for Working with Women and Girls?

MS. SHARON AMATETTI: Right. Do I need to turn this on?

MS. KANA ENOMOTO: It’s on.

MS. SHARON AMATETTI: Well, you’re familiar with the project as we discussed it at our last council meeting. So you know the direction we were going in. The core competencies first draft, or recent draft anyway, has been sent out to all the experts that participated in our advisory panel, and we have received all the comments back from those

people and are now incorporating them.

And so, there will be another draft that will go out to a broader review now that we have the feedback from the participants who actually helped us draft the core competencies. So it will go out to the State women's treatment coordinators for review, as well as some additional people who expressed interest in looking at the product.

MS. KANA ENOMOTO: Will we be able to send it out to this committee for review?

MS. SHARON AMATETTI: Yes.

MS. KANA ENOMOTO: Okay.

MS. SHARON AMATETTI: And some committee members overlap and that they are also part of the expert panel.

And the other thing I just would like to briefly say is that we also planning the Women's Treatment Conference again for next year. It's going to be here in Chicago. So we had that established at the end of July, and I hope everyone will come back to Chicago again next year for that.

MS. KANA ENOMOTO: Great. Thank you,

Sharon.

And Linda White-Young will provide a brief update on our trauma-informed systems guidebook.

MS. LINDA WHITE-YOUNG: Yes. Good morning.

We are making progress. We held our first meeting last month with the panel, who actually gave us quite a bit of feedback. We are hoping that the draft will be ready within about another month, and we will be disseminating the draft back to the panel.

And we hope that the final document will be completed within about 2 months, and we will be submitting it to this committee for review.

MS. KANA ENOMOTO: Great. And really, the trauma-informed systems conversation was fabulous. We have formed sort of a steering committee, and Roger was a part of that -- Maxine Harris, Renata. Stephanie is an honorary member and was not able to attend. Sandy Bloom, Norma Finkelstein, Lisa Najavits -- real sort of very big names in trauma, a wonderful group of people. And we hope to use them as a steering committee for us as we move forward with the trauma agenda.

So the trauma-informed systems guidebook will really be a starting piece of this, but not the ending piece. But we do understand that many State and local administrators need something like this to help them understand how to navigate. It's not just implementing trauma-informed care in a service site, but how to help whole systems work with one another to promote the whole approach of the trauma informed.

And so, that will be one piece of it, but I think we're hoping to have a trauma summit and continue the dialogue and really raise it so that we're bringing in Federal partners, as well as State and local partners, to understand what SAMHSA needs to do to move this ball down the field and really bring it to scale.

So we have a very nice group formed, and I think we will be able to continue to consult. We will lead the way in terms of really bringing trauma into the mainstream. I think it's growing. The time is right. There is a lot of energy behind it, and so now we just really need to get our strategy together to make it a national agenda item.

So we're very pleased at that, and I'm very thankful to the ACWS for providing the momentum behind it.

Linda, also you have a PPW grantee meeting. Do you want to give a quick update on it?

MS. LINDA WHITE-YOUNG: Yes. In June, we had our annual Pregnant and Postpartum Women grantee meeting, and that meeting focused on rebranding our services to accommodate the changing times. And we had about 170 or 200 people at that meeting.

And as a result of that meeting, we have developed learning labs. There were a lot of topics, a lot more information they wanted. So we are now working with the grantees to develop these learning labs, and each month, we're actually having a speaker, having listening sessions. And so, we will give updates.

MS. KANA ENOMOTO: Great.

OPERATOR: Nevine, this is the operator once again. We're not able to hear a thing.

MS. NEVINE GAHED: Thank you.

MS. KANA ENOMOTO: Okay. I'm speaking as

loudly as I can.

Okay. You have in your -- on your disks, right, the White House report? The White House Council on Women asked the Department of Health and Human Services, as well as all the other Federal departments, for updates on their activities related to women and girls.

SAMHSA responded to the department around a gamut of services related to whole women's economic, social, and health experiences. They specifically asked about work-life balance, interventions in the workplace as well as in the field, and potential collaborations that we could do with other agencies to improve the quality of women and girls' lives.

So we sent members a copy of that report. It includes overarching recommendations, and I'll just share some of the overarching recommendations that SAMHSA put forward to the White House Council. And they were to provide the necessary policy and service mechanisms that advance the mental health and the prevention and treatment of substance abuse for women and girls, their families, and their communities. We

noted that this is essential on reducing legal, social, and other related healthcare costs as envisioned in healthcare reform.

To continue to promote the raw concepts of prevention and wellness, including the prevention of addictions and mental illnesses through awareness, education, and environmental behavioral change.

To maintain the work of community mental health and substance abuse treatment providers who have special expertise in gender-appropriate care and who are family centered.

To pursue gender-based evaluation and accountability of public health programs that impact women and girls, to identify service gaps, develop best practices, and support comparative effectiveness research.

To continue efforts to develop operational standards for trauma-informed healthcare and core competencies of individuals who work with women and girls in the fields of substance use and mental health.

To strengthen the evidence base on gender-

specific health services and programs for women of color in order to reduce health disparities, improve patient safety, and ensure quality care.

And to encourage collaboration across HHS and other departments around the vital need to overcome stigma and eliminate barriers to treatment for mental and substance use disorders.

So we're grateful to the staff at SAMHSA, who worked very, very quickly to pull this together, as well as a listing of SAMHSA's accomplishments and our current work in this area.

Then on July 29th --

MS. GAIL HUTCHINGS: Kana? Excuse me.

MS. KANA ENOMOTO: Yes?

MS. GAIL HUTCHINGS: Can we stay on this topic for a second?

MS. KANA ENOMOTO: Sure.

MS. GAIL HUTCHINGS: I'm wondering, protocol wise, could the committee request a meeting or a teleconference call with the council? I think it might be nice to try to personally emphasize some of our recommendations and expectations from them. And

otherwise, I'm afraid we're going to end up in a long pile or large pile of recommendations that they've been provided with and that we won't get any air time.

MS. KANA ENOMOTO: Right. I think we could easily request a meeting with our representatives to the council. The representative to the council is the Secretary, and she's being staffed by Dr. Jones and OWH, as well as Dora Hughes and one of our White House fellows.

So that's probably -- it would be challenging to request a briefing of the actual council, much easier to request a briefing of the folks that are staffing the Secretary. Although I will say that after we sent forward the SAMHSA submission, we did get quite a few questions, and there was a great deal of interest in the work that we're doing, the fact that we have an ACWS and the focus on trauma.

So I'm happy to try to pursue more, further conversation with them if that would be of interest to the committee. Or we could see what we could set up, and then we'll float it and see.

MS. GAIL HUTCHINGS: I guess I leave it to my colleagues to comment. Personally, I think it's a very well-done list. So, congratulations. I just -- again, anything that would prevent it from getting buried and try to continue to elevate a conversation as well as expectations -- I want to emphasize the expectations -- I think is a good use of our time. And with our role to be hopefully of potential benefit to SAMHSA, as well as women and girls.

MS. KANA ENOMOTO: Right. No, I think that is a good suggestion.

MS. SUSAN AYERS: I love the one on to maintain the work of the community mental health and substance abuse treatment providers that are in the community, actually, on family-centered care because, honestly, with the economy having done what it's done and doing what it continues to do, the service delivery system in the day-to-day, door-to-door, "what's going on with your neighbor" has really gotten decimated. And it's not a pretty picture.

And the only reason I'm here still with [inaudible] is because there's been a lawsuit in

Massachusetts, and so they have to fund kid services. And other than that, the adult system has been creamed. I mean, it's just -- it's quite extraordinary. And there are people in developmental disabilities and living in their homes, their subsidies are gone. And people are dying.

And I think it's really important to get that message out there because in the real world, where everybody is every single day face-to-face in families' homes, it is very, very difficult.

MS. KANA ENOMOTO: Okay. I think we can see what kind of briefing or conversation we could set up, and we'll see if there is interest on the committee's part to do that. To the degree we can help our representatives better understand what we're talking about and the import of our recommendations, I think the stronger advocates they'll be.

MS. GAIL HUTCHINGS: That's precisely where I'm coming from. And I mean, these generally are phenomenal recommendation to make sure it's trauma-informed care and more evidence-based practices around that. But if you don't know the prevalence of trauma

in the first place in behavioral populations, and you don't know people have been harmed from not having trauma-informed care, you can't embrace the need, much less the overall recommendation in any kind of sensible way. In a mass of --

MS. KANA ENOMOTO: Right. I mean, there are recommendations on screenings for --

MS. GAIL HUTCHINGS: Exactly. Exactly.

MS. KANA ENOMOTO: -- breast cancer and heart disease and everything else that the other HHS operating divisions have in their bailiwick. So, right. I'm sure there is -- these fabulous recommendations are joining a sea of other fabulous recommendations. So as a strategy to help our recommendations come at length, I think a conversation would be great.

So, duly noted. Done.

[Laughter.]

MS. KANA ENOMOTO: Magic wand. Well, speaking of our magic wand or my magic wand that I so fondly call Nevine --

[Laughter.]

MS. KANA ENOMOTO: The conversation with the institutes, which was, you know, from more rain to the reality on the Internet. Nevine very deftly brought to life a suggestion from the last meeting to get a briefing from NIMH, NIDA, and NIAAA on the -- and Renata is a former council member at one of the institutes. They did get very nice presentations on sort of state-of-the-art, up-and-coming data research program from the three different institutes focusing on women and girls. I think they were excellent. The institutes were very enthusiastic in their response.

I mean, we sent the invitation email, and within 5, 10, 20 minutes, we got our answers and commitments to send senior people to do those presentations. And I guess the feedback -- I guess I would like to ask for the members for feedback. I sort of had to get off the phone after the presentations, but I was wondering if you all had thoughts? Also, if you have feedback about the technology, that we did it as a Webinar, for those who weren't aware.

DR. STEPHANIE COVINGTON: I thought it was

very useful, and I was amazed by the technology. I was a little hesitant to have to do anything that's new, other than read my email. And so, I just want to say that it worked, I thought, very well, considering all the potential glitches that could have been.

And I also was dubious about being on anything that long, always to me is "oh, my word." So I think it was remarkable. Thank you.

I thought the presentations were, in terms of -- I thought it was very beneficial, and I thought the presentations were mixed in terms of content and in terms of the presenter's actual knowledge about women's services. I would say that part was -- what shall I say?

MS. KANA ENOMOTO: Variable?

DR. STEPHANIE COVINGTON: Variable. Thank you. That's a politically good term, variable.

MS. KANA ENOMOTO: All right.

MS. GAIL HUTCHINGS: I, too, thought it was a tremendous opportunity. I thought it was well done. I also -- the word "variable" popped in my head also. I thought there were some -- you know, I think not

only was I grateful that they did it and were so responsive, but I think if you could continue a sort of formal relationship with them and then start it being more of a dialogue exchange, both in an educational, cross-pollination way, as much as an expectation setting again of they know that sooner or later they're going to have to come back to us -- and what their portfolio is for women, et cetera.

I thought it was a wonderful opportunity. I learned a lot during it, and I appreciate that. So nicely done.

MS. KANA ENOMOTO: I think it's also something that SAMHSA might consider for our National Advisory Council to do more broadly a cross-cutting conversation about the services research and starting to have that dialogue on a more regular basis as well. That would probably be very fruitful because we just haven't had it.

So, once again, the ACWS leads the way in helping SAMHSA think through some of these thorny issues. But, yes, I think it was a good conversation, and it really was illuminating for us in terms of the

variable understanding at the institutes on these issues, as well as just a very different culture. A very different culture.

We were asking some questions where they're like, "Yes, no, we don't do it that way. We don't ask questions that way." And probably not going to.

So it clarified what the role of SAMHSA is. It clarified what the role of the institutes is and how we each approach our work. So some good opportunity for further bridging. So let's think through how we can continue that dialogue. I don't know that in 6 months or a year, they're going to have that much data.

MS. GAIL HUTCHINGS: Well, I have an idea for the interim, those 6 months, which is, of course, their datasets are very impressive and the emerging research that we all like. And SAMHSA has impressive datasets, as we all know, as well. So to have OAS focus with us on that household survey, as well as maybe DAWN and DASIS, some of the other datasets -- I'm sorry for the alphabet soup. But it would be a nice interim step to say, okay, we've gone from

research. Let's go to the services side and see what's coming out of some of these in empirical ways that I think we all could benefit from, too.

And similarly, not only hearing what the data is, but what data may not be there in some of the SAMHSA datasets as well would be nice to, as a committee, be able to weigh in and say we'd really like to know this disaggregated by X, Y, and Z? So just the idea of bringing change.

MS. KANA ENOMOTO: And the new listed data will be released in early September as part of the Recovery Month activities, and we understand there is a new measure on serious mental illness, which we have not had in the National Survey on Drug Use and Health in the past. We did have serious psychological disturbance issues --

MS. GAIL HUTCHINGS: Distress.

MS. KANA ENOMOTO: Distress, which is slightly different. The SMI variable will be interesting. It's a much smaller group of people. So how we present and understand that data will be important. It will be in our pre-briefing on the new

NSDUH results.

They did ask about whether or not there is a measure of trauma, and they do not yet have that. But they are working towards it, and their conversation is in play. So that we can better understand the relationship -- through our own data, we can better understand the relationship between trauma and mental illnesses, addictions, and chronic disease because there are a number of chronic disease and health concern measures in the NSDUH as well, as well as service and motivation and other factors.

MS. GAIL HUTCHINGS: So will we be consulting with the committee about developing the trauma measures? I'm a little worried that if it's done -- not that there aren't plenty of other experts besides us. But if it's not done with some -- help me get the right word now -- informed input. Is that fair?

MS. KANA ENOMOTO: Right.

DR. STEPHANIE COVINGTON: Well, I think it's back to an earlier issue I was thinking about with the presentations and about the research. The big issue

is, I think, how do you get -- we always want to talk about how do you take the research and get it into the field in terms of practice? But also how does the field inform research? And do we have this -- and I think you're asking about can the field help inform how some of these measures are developed and what's useful to the field?

I mean, some research may be excellent research, but it's totally useless if you're providing services. And wouldn't it be better to have our research be useful?

MS. KANA ENOMOTO: Well, with respect to the National Survey on Drug Use and Health, adding the SMI measures, it was a multi-stage process. It began with the convening of folks like Ron Kessler, Howard Goldman, and others, and I imagine that as we move toward -- it also cost millions of dollars. To add one of these things, each of the fields has to -- before they'll risk changing trend lines on the NSDUH. It's a considerable process.

So CMHS has been having that conversation. So they will certainly be involved, and I think now

that we have our trauma steering committee, there may be a role for that group to play as we move forward to the NSDUH. But I think it's -- it's not like it's going to be in the next go-around. But it's that there is the awareness of the need and a willingness to do that work, which I think is the big hump that we are over. So now it's a matter of doing all of that work, which is another considerable hump.

But in past years, it was like trauma, why would we measure trauma? This is drug use and health. And now there is, yes, we'll need to add trauma, and we're just figuring how to best do that.

DR. ROGER FALLOT: I'd just like to pick up back where we were with the meeting with the institutes in general. The thing that was striking to me about it was the cultural contrast between the institutes -- and I'm framing this as positively as I possibly can -- the differences that were [inaudible] and the kinds of questions they asked, the methods they used to answer those questions, and the results that they expect out of those methods in general.

And I want to reiterate what Stephanie just

said about the importance of having the service to science part of this equation be reopened and reiterated again and again because we know a lot about the obstacles that there are in getting science into the field and into practice. We need to take equally seriously the difficulties in having the science folks listening to the practitioners and the service folks because that's an equally damaging gap, I think.

MS. KANA ENOMOTO: Duly noted. I know many of the recent conversations folks have been having with the Hill, the Hill has been asking us for services research findings, and we're saying, "Well, we don't do services research. We don't have those findings."

Or, "Give us a list of evidence-based interventions, and do they have NIDA's stamp of approval?" NIDA says, "We don't stamp things with our approval. That's not how we work."

And so, the gap in the area of sort of applied services research or policy-driven services research is becoming increasingly apparent because there is a push for comparative effectiveness. Folks

that are in policy positions are having a newfound appreciation for the value of research data, but they want the research data to answer their policy questions. And hence, they are asking them and finding that there is not such a good matching up of the research and the policy questions.

So it's sparking -- certainly, it's sparking a fresh dialogue. So I guess these things go in a cycle.

MS. GAIL HUTCHINGS: Or not.

MS. KANA ENOMOTO: Or not.

[Laughter.]

MS. SUSAN AYERS: Actually, I wanted to ask so what would be the next steps? I mean, how do you get this focused in terms of as your cycle moves through, where -- how will the dialogue be created? And where are they going to get those answers to inform -- have the data inform the policy?

DR. JEAN LAU CHIN: Wouldn't that be clear we could take a role in that? Because I think this issue is obviously not a new issue. It's been one that's been going on. So that I think the shift is

that there is the awareness and there is some policy that expects that to happen, but implementation and monitoring doesn't occur.

And so, that I think it could be useful to have specific indicators, measures, or something as way of questioning and asking for the kind of data and response that would drive the institutes to provide more of the answers so they'd look at it. Because I think it's left that the policy now -- of its importance, but it's not being [inaudible].

MS. KANA ENOMOTO: Right. I think it's an important conversation. So perhaps we can set aside time on our next agenda or have another, more in-depth call on kind of the services research question and what the next steps are.

MS. GAIL HUTCHINGS: Because what you're hinting at is there might be a role for asking the Assistant Secretary's Office on Planning and Evaluation of the department. It's seems it's somewhat of a natural role leadership wise to me for them to play of trying to get the research agencies and the services agencies together in this case

[inaudible]. Not to put you on the spot.

Maybe there's an ASPE person that can be engaged on substantive conversation. I want to make it easy.

MS. KANA ENOMOTO: Right. I think there is definitely room for that conversation, and where SAMHSA's role is in this I'm not sure. But certainly it has been tossed around. To whom -- are the institutes accountable? Certainly the field has been asking for this. It hasn't happened in 10 years. Is it ever going to happen? And if it's not going to happen, where should it go?

But again, it's probably not a conversation for today. And we're running a little late, late.

[Laughter.]

MS. GAIL HUTCHINGS: Subtle.

FEMALE VOICE: She just said a little late.

[Laughter.]

MS. KANA ENOMOTO: But if you want to give our members a chance to give updates on sort of where they've been, what they've been doing, what's kind of burning and churning at the top of your mind. So we

could do that, and I'll start with Jean.

DR. JEAN LAU CHIN: I don't know what's new. Let me pass and let others --

MS. GAIL HUTCHINGS: As you can see, I'm recovering from this broken ankle. So I haven't been around very much, and I've been watching some of the action in Louisiana. For those of you who don't know, they're taking their mental health office and their substance abuse office, and the governor just signed legislation that creates an Office of Behavioral Health, which is an interesting development.

They're also starting to pay some attention about their Medicaid and the paucity of Medicaid funds, mental health services down there. Many of you are aware that particularly on the children's side, we need services in that State. It's a deplorable situation. So I'm doing some work down there and looking forward to trying to see some systems elevation.

Really was honored to work on healthcare reform and the principles, lots of engaging conversations. I learned a lot from that process.

Kristen King was the technical writer that I worked with. I want to acknowledge publicly again her tremendous work on that. It was really a great process for me to be able to learn and grow from. So I really am grateful again for it.

I've been invited to England this fall and work with Leicestershire Trust, the biggest mental health trust in England in trying to focus on consumer rights and inclusion celebration. They've made some big strides over there in trying to bring some conversation about health reform. They're pretty interested with what we're mucking around with here and what the fight's all about. So I'm already picturing the cartoon in the slide deck should be pretty interesting, I think. There's no shortage of those.

And then I just think there are some wonderful developments. Without dropping any hints, I'm really looking forward to the announcement from SAMHSA that particularly with the primary care, we have our health integration grants will look like, who will get those, and I think that's such a topic -- I

could easily see devoting the entire rest of my career on that topic if I was smart enough to do that, and I'm not. So I will keep moving.

And I continue to be grateful to be in this role. I really am honored by it. So, thank you.

MS. KANA ENOMOTO: Susan?

MS. SUSAN AYERS: Well, sometimes I feel like I shouldn't really be negative at all in terms of coming from Massachusetts because I know we are blessed with a wealth of resources compared to what's going on in the rest of the world. Having said that, you know, you just want to see things continue to progress and have a fair amount of sensibility in public policy.

I have to say I think from our point of view, we're pretty worried about what is going to happen with the national healthcare scene. What about a public option? The forces that are out there are pretty powerful, and it feels a little discouraging sometimes or worrisome to say, "Oh, we'll get something and then we'll fix it."

But it feels like our systems that are made

up of fixes just get layer after layer after layer of complexity. So, but being a pathological optimistic, we kind of move on.

And in my specific case, I really sort have built and run a child and family agency for 21 years at the Guidance Center, and we actually are making a major corporate move September 1st. We're going to become a division of a much larger community-based organization that operates a little farther west of us in Massachusetts.

So that it will certainly ensure our viability. We'll continue to operate as the Guidance Center in the Cambridge and Somerville areas and be able to bring a lot more heft to the table, better adult services and substance abuse services, more integration, and hopefully, be able to hold together our community system, which is really getting splintered apart by -- well, by just forces of the economy and the service delivery care system that we have.

So we're excited about this, and it's been really, really interesting to see what this Rosie D.

remedy, which is what it's being called, the sort of redesign of our community system. Actually, to look a lot like what we've been doing at the Guidance Center for years, only now we're going to have to be billing it in 15-minute increments, which is a little scary. But we're having parent partners and case management and good treatment all being integrated and managed locally, which is, again, very exciting.

So not only will this policy change mean there will be sort of more Guidance Center-type places around, but it also will give us -- the merge is going to give us an opportunity to replicate our model in lots of different places in Massachusetts. So we're excited.

MS. KANA ENOMOTO: Thank you.

Amanda?

MS. AMANDA MANBECK: Well, it's been a really interesting few months working in the different Native communities across the country. White Bison just recently finished completing a 6,000-mile journey across the United States visiting 23 present and former boarding schools.

You know that I was on the panel for the tribal trauma-informed care back I think it was in February or somewhere around there. And I think what I found was really interesting is the lack of cultural competence not only with the Government, but also within the tribal system itself.

So I really do believe in this trauma-informed care. However, I do believe that it needs to be much bigger than that. I do believe that there needs to be some gender-specific issues brought up, as well as culturally the different facets of trauma.

On the journey, there is a big -- I guess there is starting to be a big inspection of what intergenerational trauma is. And I think that it's been very misleading how simple the explanation of that has become. And I think that now tribal leaders are starting to take a look at the long-term implications that this is something that is never ending unless we do something, that this will continue to destroy our communities and continue, unfortunately, to destroy our culture. This is something that happened 500 years ago, 400 years ago,

300 years ago, two decades ago, yesterday.

I think that the difficult part is when you look at a community, there are statistics that 80 percent of the Native population has suffered from sexual abuse. And that's very difficult because then you start looking at these people go home. They have children. And emotionally, the damaging effects of that reach every part of the community.

And I think that a lot of counselors and the different behavioral health, I think they've got the best intentions, but they are not necessarily well equipped to handle that. This is a new discussion that's been taking place. So nobody kind of really knows what to do with it.

So I'm really excited to be on this committee, and I'm really excited that SAMHSA is starting to look at that. That is very important. SAMHSA funds quite a few tribal programs, and for them to be taking a look at this will only better the situation, as well as the Office of Justice. But that's a totally different matter.

So I think that with regard to the Native

community, substance abuse, we understand that. Everybody understands that there is a problem. But that is only a cost. That is not the underlying root of the problem. Trauma is the problem, and I think that people are starting to understand that and to see the significance in looking at the trauma that has affected not only the individuals, but the families and the community and the tribal nation as a whole.

So I'm really excited. I apologize that I was unable to attend the last meeting. But I had some health concerns and some health issues. But I'm really grateful to be here today and thank you.

MS. KANA ENOMOTO: Roger?

DR. ROGER FALLOT: Those of you who know a bit about what I bring to this table, in addition to a hoarse and lower voice than most of you --

[Laughter.]

DR. ROGER FALLOT: It's that I got interested in working especially with women around trauma issues, and the importance of trauma-informed approaches to care is something that has been part of my work for now over a decade. Personally, we've just

wrapped up a couple of NIH studies, which is an interesting set of -- has raised some interesting issues for us in terms of the research we've been doing on trauma, the specific services of the Trauma Recovery and Empowerment Model groups for women and the men's version of that group.

We're very much looking forward to seeing the data analysis from those studies and being able to find out whether or not these interventions are able to demonstrate the sort of effectiveness in real-world settings that we're talking about needing to be able to demonstrate.

In terms of trauma-informed care, my work has taken me around the country actually. And interestingly, in terms of what Amanda is saying, one of the SAMHSA programs that's funded in the Native communities has to do with integrating behavioral health and primary care, and I went to Alaska for the first time to consult with a group of grantees around the issue of trauma in settings that are primary healthcare-oriented settings, which was a fascinating experience and really clarified for me the

extensiveness and the pervasive impact not only of current, but historical trauma in the Native communities.

The next thing that I did since our last meeting was to attend the trauma-informed services guidebook meeting that Linda referred to, which was also very interesting in precisely these ways -- in looking at systems of care and the larger systems that are involved and their needs in identifying the importance of trauma and trauma-informed services approaches.

Interestingly, I think, and perhaps most interestingly to me currently, is something that grew out of that meeting or that got consolidated in an important way, which is an emphasis on values-based approaches as a complement to evidence-based practices. That is that the same sort of emphasis needs to be given to recovery orientations, to trauma-informed care, to gender responsiveness, and to cultural competence as values-based approaches that provide the context for any effective evidence-based practice to be put into implementation that’s going to

be meaningful.

The opportunity to do that may start in Connecticut before too long because there are some places there that are interested in incorporating all four of those, which have been started at different times in the State. And the idea that they may be able to integrate those in a meaningful way is something that has recently emerged, and we're talking about.

So I'm very excited about the possibility of articulating more clearly the importance of these values-based approaches and also to be involved in developing some of the ideas more fully.

MS. KANA ENOMOTO: Thank you.

Stephanie?

DR. STEPHANIE COVINGTON: Let's see, like Roger, I've been doing this for a long time. And I'm actually looking forward to the possibility that we'll be working together in Connecticut.

I had started a number of years ago working with them on the gender-responsive piece, which really was focused on substance abuse. Roger has been

working with them on trial reform, and he's gotten focused in mental health. And now we're in the beginning discussion of how do we put these things together?

I've been thinking about cutting back and had actually said multiple times that I wasn't going to write any more program material. But I changed my mind about a month ago, and I'm very excited about a new project.

A lot of you know I spend a lot of time with girls and women in jails and prisons, and I just agreed to write a curriculum for women who commit violent aggressive offenses. And I was approached by this and said no multiple times. "This is not my level of expertise. No, I'm not writing anything else." And then two things happened.

One, I was in a correctional facility in the State that had asked me to write this, and a woman came up to me and said, "I hear you're going to write something to help us." And I said, "No, no. Information goes fast, but that's misinformation." And she got teary and she said, "I killed my best

friend of 19 years. Can you help me?" Well, that was heavy, to say the least.

And then I heard there was program material for the men in that State, and when the men went through the curriculum, it allowed them to go before the parole board and often get their sentences reduced. But since the women didn't have that material -- and that infuriated me. So I said, yes, I'd write this.

[Laughter.]

DR. STEPHANIE COVINGTON: And I've actually become really excited about the prospect. It will be the last piece of program material I write for sure, but it's the -- what can I say? It's so multifaceted, and the challenges of thinking about when I've been writing focus groups with women who have been involved in these situations, how do you work with a group of women who -- we often don't think of women being violent, number one. Number two, so many of them have had violence in their own lives in terms of the being the subject of the violence.

How do you help people -- we live in a

violent world. How do you help people, how any of us living in a violent world live a peaceful life? And so, anyway, that's what I'm immersed in, and I said yes, even though I had said no. So we never know what we're going to do, right? Sometimes we get touched in ways that move us in our work. So that's what I'm into at the moment.

MS. KANA ENOMOTO: Thank you.

DR. JEAN LAU CHIN: I'm going to take my turn now. We'll shift a little from the trauma side, although it's certainly important. But we have been involved with the -- there has been a practice summit by the American Psychological Association recently. And the participation in that was looking at where practice and services need to go in the 21st century basically.

And I think the several key issues that came out of that is the innovation of health and mental health towards a primary care system and its link with behavior health, the emphasis on health technology, and the issue of global and diverse, working within those contexts. And the importance of those in terms

of being more transformational toward how we train -- not just how we serve, but how we train psychologists to be able to practice in this new environment.

And I think that has been dramatic in terms of the national efforts that we're working on. Not only in the service delivery system, but within the training institutions towards training for those areas. So that's the major area that we've been doing.

MS. KANA ENOMOTO: Well, thank you, everybody, for your updates.

I'm feeling -- and I know this is probably wrong. But I'm very validated at our selection of committee members because each of you is doing such important things, and each of you is making such an indelible mark on the field and with respect to women's services and kids' services and health reform and service provision in general and actual level that I'm sure members of the public can appreciate what a great committee we have and how important the work you're doing is. So I thank you for your updates.

Now for an order of business, I skipped the

staff. Nevine won't let us skip it altogether. I'd ask our members for consideration of the minutes of the May 11th and 12th ACWS meeting. I'd like to ask for a motion for formal consideration and approval of the minutes for the May 11th and 12th meeting.

MS. NEVINE GAHED: That's fine.

MS. KANA ENOMOTO: The minutes were sent to each of you in advance of this meeting. They were certified in accordance with the Federal Advisory Committees Act regulations. Members have been given the opportunity to review and comment on the draft minutes. You also received a copy of the certified minutes.

If you have any changes or additions, they will be added in this meeting's minutes. Does any member have changes or additions to the last meeting's minutes?

[No response.]

MS. KANA ENOMOTO: If no, may I have a motion to approve the minutes?

DR. JEAN LAU CHIN: So moved.

MS. KANA ENOMOTO: Jean Lau Chin moves to

approve the minutes. May I have a second?

DR. ROGER FALLOT: Second.

MS. KANA ENOMOTO: Roger Fallot has moved to second the motion. The minutes are approved.

Thank you very much.

So, at this time, I'd like to give everybody the chance for a 15-minute break. We will convene promptly at 10:30 a.m. because we have -- our panelists are arriving, and we are very excited to have the next session.

[Break.]

MS. NEVINE GAHED: We're back. Thank you so much.

MS. KANA ENOMOTO: All right. Well, thank you, everyone, for joining us again for our Integrated Services for Women and Girls -- A Community Health Perspective. We have a really wonderful panel today. And one of the advantages of being here in Chicago is we get to hear from some of the local folks who are doing just incredible work and setting the tone for the nation, but doing it here in the hustling, bustling metropolis of Chicago.

We're aware of the important role of community health centers. As we know, we're here in partnership with the National Association of Community Health Centers. We'll have an opportunity to talk to folks from there for us over lunch.

But right now, we have Donna Thompson, who is the CEO of ACCESS, the largest community health center in the country. We have Falguni Amin, who is representing Asian Human Services, a leading ethnic-specific health service community health center and provider of behavioral health services in Chicago. And Terry McInnis, who is joining us from GlaxoSmithKline.

For those of you who know Ron Manderscheid, I asked Dr. Manderscheid please recommend a speaker on the medical home model because I think as we're talking about integration, we need to talk about medical homes and apropos of healthcare. Within seconds, Ron emailed me back and said Terry McInnis is the one -- Dr. McInnis is the one you need to hear from. And so, that is a resounding endorsement. And so, we're very pleased to have Dr. McInnis as well.

Our first speaker will be Ms. Thompson, chief executive officer of ACCESS Community Health Network. Ms. Thompson has been on the frontline of patient care delivery for over 20 years and right now is CEO of ACCESS. She demonstrates an incredible commitment to patient care and the health of the entire community.

We were very fortunate yesterday to do a visit at the Haymarket Center, where ACCESS is providing onsite healthcare to the clients of that primarily substance abuse treatment facility, including community healthcare for pregnant, prenatal, and post natal care for pregnant and postpartum women and children. And through her work at ACCESS, Ms. Thompson has demonstrated how a focused commitment to high-quality community healthcare can save lives, revitalize communities, and preserve the possibility of a healthy life for hundreds of thousands of patients of all ages and backgrounds.

Ms. Thompson has led ACCESS to become the largest FQHC, Federally Qualified Health Center, organization in the country. So that’s really saying

something because those are some big organizations, and of those, this is the biggest. They offer more than 20 specialty care services and serve more than 215,000 patients annually, 70,000 of whom are uninsured, and they have 52 health center locations across the Greater Chicago area. So very large, very impressive organization.

And with that, I would cede the floor to Ms. Thompson.

MS. DONNA THOMPSON: Well, thank you very much for a very kind introduction. I'm so happy to be here to really take you on a short journey of ACCESS. And again, thanks for the advisory council for having me today.

First of all, we are pleased to say at ACCESS that we are the healthcare home to over 215,000 unduplicated patients. We cover about 1,700 square miles, city and suburbs.

And a little history -- we started out really being inner-city health centers, mostly surrounding public housing. And when much of the public housing started to come down in Chicago, our

majority consumer board really directed us to follow that trajectory, which ended up many people being located in the suburbs. And for many people in the suburban market, trying to find a medical access for many is just invisible. Medicaid, many times, is treated like you're uninsured.

So, a big highlight -- 64 percent of our patients are women, women with children. As you said before, about 70,000 of the 215,000 patients are uninsured. But we know, especially in this economy, many people are on and off of benefits. And we really want to be what I call that anchor in the community for everyone in the community to have access to affordable care, quality care.

And so, as we look at many of our healthcare challenges, it's really about how do you continue that commitment? We are FQHC. So that means that we see all patients regardless of their payer mix. And that also includes commercial patients because I think it's important for our patients to understand that when you do get insurance, we still want you to continue your healthcare home with ACCESS.

But more importantly, being an FQHC has allowed us to have an enhanced Medicaid rate with our Federal grant that then allows us to see those that are uninsured. If you would look, though, that based on our Federal grant and our enhanced Medicaid rate proportionately, we do have a high rate of those that are uninsured that the grant really doesn't cover.

At ACCESS, I think one of our hallmarks is that when we go into communities, it's really based on the uniqueness of the community. It's not based on a cookie-cutter model. And so, for some of our health centers, we might open at 7:30 in the morning and close at 10:00 at night because of the community needs. Throughout our providers, which is a mix of physicians, nurse practitioners, physician assistants, they speak over 34 different languages and many dialects.

Our anchor is a continuum of care model. We really strongly believe that as a primary healthcare home, it is our responsibility to hold our hand or provide those services that reaches optimum wellness for our patients, meaning I don't like to see patients

that have to take two buses and a train to get to another healthcare entity who is willing to see them.

What does that mean? A lot of times I have fights with hospital CEOs, but I keep coming in their face because, again, when I look at so many patients who are many times faced with do I get primary care? Do I get secondary and tertiary care? Or the fear of going into debt -- that really pushes people away from healthcare rather than pulls them to it.

Our physician and staff, we've got close to over 900 employees at ACCESS, and we've really aligned them around quality. And their compensation, whether it's a medical assistant or a receptionist, is pretty much aligned with quality, customer service, looking at our productivity, but also looking at how well they align to the needs of the community.

Teaching and research, it's our infrastructure, and we've really invested in research. And research based on questions that the community wants to have answered rather than researchers kind of coming in, what I call taking advantage many times of the community, and leaving not only with the

information in their back pocket, but also many times leaving with resources that they had invested during the research and then they would leave.

One of the things I'm happy to say is that being a CEO of this company, I have the patients hold me accountable. And so, I'm available as a resource, but also a face to be held accountable for any type of research or resources that we put within the community.

How we've also grown, though, is back through our co-locations. And I'm proud to say Haymarket being one of them, but also the Illinois Eye Institute, where we found out 75,000 people would come in annually to the Illinois Eye Institute, mostly low income, and many didn't realize that their eye issues were related to neglect of primary healthcare.

And so, as we built upon the growth of ACCESS, it's been really through partnerships. And that's not always easy -- you can just leave it right there. I'll catch up. But it's also one where we've been able to maximize not only resources, but as our focus has been around primary healthcare, we've

partnered with those agencies at other niches to really build upon and maximize the services of the patients.

We're also -- school of health is a big area that we've focused on. We've just entered I think our fifth community-based healthcare relationship with schools, and also we're happy to say that we're going to a youth center, which is on the south side of Chicago, which has like the drill team, has a lot of youth in the community that goes there for other services. And we're able to build on mental health services and to offer for many of those young people.

We're Joint Commission accredited, meaning that our quality standards are in parallel to many hospitals and other agencies, and we've been recognized by the United Way for our quality, as well as with Blue Cross Blue Shield for achieving eight out of nine quality stars for their members.

Now how the SAMHSA investments helped ACCESS is really around three programs -- our Center for Substance Abuse Prevention, our CSAT or our Center for -- the CSAT grant, which is focused on the SBIRT grant

and targeted capacity expansion, and CMS, in which we've had more investment of mental health into our health centers.

A little bit about Chicago. If you notice the chart, in Chicago, 37 percent of Chicagoans are African American, with 79 percent of females having the HIV cases. If you comparatively to white and Hispanics, you see that African Americans really have a dramatic disparity when it comes to HIV cases, and that's where we have had focused attention through our grants.

If you also look at the next slide in which we talk about the HIV transmission for African-American women, you see that 79 percent of those cases are through heterosexual contact. And so, again, when we look at the needs of the women in Chicago, we have really focused these grants on the African-American women population.

I'm going to talk a little bit about some of our grants and some of the highlights. One that we've really been engaged with is our Women Returning Home. And in Year 1, we were able to enroll 300 women, and

100 women were retained in primary care. The interesting part about this particular grant is how we've done the in-reach into the Illinois Department of Corrections, how we've also reached out into the Sheriff's Furlough Program.

And one of the things when I've attended some of the meetings with the women as part of the Sheriff's Furlough Program, and this is how women are really locked up for the majority of the day, but then they're let out. But because they are not in jail, so to speak, for 24 hours, they're not eligible for services through the Cook County Jail. And so, again, when we hosted the women at our health center, the first thing we did was to get them engaged and get them to select a provider, their own provider, and get them enrolled into healthcare.

And so, again, when we look at where we see gaps in our health system and in our ability to get women connected, this is just what I call one kernel of information that many people don't even know about, but it's so important to get women where they're at and to start what I call the journey of getting them

engaged in healthcare.

Our SISTAS Connect program, which is a CDC-based curriculum in which we have remarkable results in getting women through our curriculum, getting them engaged by having not only peer support and facilitators of the program, but then once they are no longer part of the program, we keep support groups ongoing in our health centers.

Just a little example, we had a 32-year-old recently who had been in and out of jail so much that the judge said, you know what, if I see you again, I might as well put you on a plane because between the time that I sentence you and that you get incarcerated and out, you seem to -- just this revolving door.

We got the client engaged and willing to join the SISTAS program, and so when we went in front of the judge and told the judge that we wanted to get this individual engaged in the program, the judge said, okay, we'll give it one more shot. Out of this, this young woman has not only gotten involved in the program and graduated, she is now gainfully employed, and she also is a resource of the support group.

She's an alumni.

And so, again, when we talk about these programs, it's not something on paper. But I always say if you see it, you can believe it. And there is nothing like alumni who are willing to help navigate other women and share their story.

Our SBIRT program is really targeting residency training programs, primary care residency training programs. We've got one program that is located in our health center on the west side, and then the other programs that we're engaged in, these are all trainings where we are working with the residents through the case managers and through a model that is around team training to get them to understand how to identify those high-risk individuals and how to shape their practice so that it's a natural piece rather than something that they struggle with once they get out and graduate.

And I think for many providers over the years -- and I'm a nurse by background -- sometimes their biggest challenge is how to have that conversation, how to really pick up. I know recently

we had one of our providers who now swears to the program. But he said, “You know, Donna, not long ago, I would have thought I could eyeball someone and say who was at risk.” And he said, “Until I had a woman who was a senior, and I just couldn’t figure out how come I couldn’t get her blood pressure down. And then finally, I took a risk assessment tool, had her fill it out, and I found out that she was a cocaine addict.” And he said, “She was a grandmother. I would have never pegged her.”

So we talk sometimes about intergenerational, about who are the people that we need to make sure we educate. It’s really about how do we train our healthcare experts and those that are leading the teams in making sure that they have the skills necessary to start leading those conversations and, more importantly, to be comfortable having those conversations.

And so, when we talk about more trauma-informed program designs, when we talk about who we have our outreach to, it’s not waiting for someone to walk into our health center doors, it’s really going

beyond the health center doors and going to where the women and girls are. And so, as we talk about our curriculum, it's about taking it and making sure that it's based in the community, making sure that if we go into correctional facilities, that's where we're introduced.

And the one thing is that we also serve as ombudsmen, meaning that when someone comes and is no longer incarcerated, that we're there at the front door to really greet them and bring them into the health center. And I think that's the value of community-based care, and working with providers and teams who embrace a population that might have suffered with addictions.

As we know when we talk about how have we applied our learnings, this is a very highly mobile population, many times isolated from their communities and also from trusted relationships. For us, many times, we are the one relationship that we say you can trust. And I think for many of our women who have gone through this program, being able to have someone, either through a peer support or someone who is a

facilitator, a case manager who might have walked the same road, is valuable in making sure that it is trusted relationship.

But I think it's also important that our case managers, our peer counselors are fully integrated in the health centers. And so, again, really addressing any stigmas that health center staff might have.

But also I think a large part, it starts with myself as the CEO saying that this is a population we're going to embrace. I do go into the jails. I do talk with women, and I do bring other programs in there. So, again, when we talk about a holistic approach, it is about how you get patients early on engaged into their healthcare needs.

It's also about leveraging our FQHC, whether it's through the 340B program, being able to get medications. It's also about our ability to co-locate and be nimble enough that we can change and modify our programs, depending on the needs of the clients.

And so, in closing, I think as a community-based organization in which 51 percent of our

consumers -- and I've got some of my board members here, if they want to raise their hand. It's about them being engaged and saying that this is a population we will serve. It's also a population that we will not be blind from, but we will embrace and totally integrate within our own health system.

So, thank you.

[Applause.]

MS. KANA ENOMOTO: Do our members have any questions or comments?

MS. SUSAN AYERS: I'd be interested in kind of your family-centered approach. Are you able to sort of track families and see siblings and moms or whoever -- grandmas?

MS. DONNA THOMPSON: Absolutely. Absolutely. And that's a great question. I like the vision of maybe grandma and mom coming in with two or three kids into the waiting room. And you find out grandma has high blood pressure; mom, there might be some issues; a teenager, there might be some depression. It's about really making sure that that whole family is connected.

One of the things that I'm really excited about is that we're looking at the architecture of our health centers. I believe that when you create through architecture a design that really welcomes families -- at one of our health centers, we have what we call a comfort room. And it's soft hues of color. It's comfy chairs. But again, why do you always have to do something in an exam room?

And so, part of what we're pushing back is how do you get people excited about healthcare? It's also how do you keep in someone's hand that vital information? So when we talk about healthcare vaults, how do you have it? Because many families are mobile. If they live on the west side of Chicago, spend their weekends on the south side of Chicago, how does the mom or the caretaker have information at hand so that they can take it to another ACCESS site or another site where the provider might need their information?

So, again, we're very much about family-centered care, about not only how that is put together from our perspective, but from the family's perspective. And I think, again, a big piece is that

we have open access models. So, again, we're trying to really make sure that we easily address many of the barriers that people have when they are trying to stay attached to healthcare.

DR. JEAN LAU CHIN: How do you integrate the mental health services with the primary care?

MS. DONNA THOMPSON: That is a great question. We have invested not only in case managers, but also in LCSW, licensed clinical social workers, psychologists, and psychiatrists.

Because of our size, we don't have an LCSW or a psychiatrist at every site. So what we've done is to create regional approaches to care. For many of our patients, that means that if it's a high-volume site, you might see an LCSW or a psychiatrist there, but then they also are hub sites for other clinics within that area to come there and get their needs met.

We deliver close to 4,000 babies a year. And so, part of what we're also doing is looking at our support for moms, how we're going to address depression, but more, on how we're going to also get

that peer-to-peer and community support. So we've started a patient centering program, where cohorts of moms are coming together.

In the old days, everybody would just come to the OB and just gestate until it was my turn to get seen by the doctor. Now we're getting women engaged in taking each other's blood pressures, weighing themselves, having a nurse there, having that psychosocial support there, and again creating that bridge where they can take control of their health, but also to start addressing in a very friendly manner, not in an exam room, but really in a very comfortable manner, in a conference room that has soft colors and healthy snacks, how to start addressing in bringing down the barriers.

We know that for many issues, people are numbing themselves with drugs because they really can't talk about the pain they're feeling, and sometimes culturally they feel alienated.

MS. KANA ENOMOTO: Gail?

MS. GAIL HUTCHINGS: First, of course, I'm so grateful for you being here, and really, this is a

long overdue conversation.

MS. DONNA THOMPSON: Yes.

MS. GAIL HUTCHINGS: I think that you have so many board members with you is probably a testament to a whole bunch of things I'm not even realizing. But it's a really a powerful statement, I think, of continuity and support, and the success is clear. I'm going to have to come back and have lunch with all of you guys because I have a million questions --

[Laughter.]

MS. GAIL HUTCHINGS: I guess I'll just start with two, hopefully, basic ones. One is does every single person who comes in your door at whatever venue you offer, and an impressive number at that, get screened for mental health and addictions issues? Every single person that comes in?

MS. DONNA THOMPSON: One of the things that we're creating, we're investing in our Epic software. And what we're creating through that software is the ability that every single patient not only is screened, but that we have that data. Right now, I can clearly say all of our pregnant women, they all

get screened, and I think what we want to be able to do is figure out ways where we can have patients more self-select and start that screening.

Now we're already talking about how can you use the investment in information technology so that by the time the provider knocks on the door and they have the chart, they've already screened out what the patient has said, maybe what the social worker has said, but more importantly, to start discussions more around that plan.

And again, we're looking at information technology as a way of that investment to really make sure that that is consistent.

MS. GAIL HUTCHINGS: So can you give us just a brief picture -- of course, we're interested in mental health and addictions overall. Many of us are particularly interested in the term serious mental illness and people that fit those categories as well as serious addictions issues.

What kind of people with behavioral health issues do you see? And what are some of the -- do you see women with schizophrenia? Do you see they have a

bipolar disorder? Do you see adolescents with PTSD?

MS. DONNA THOMPSON: Absolutely. We do. And I think -- and I think this is the part about a community health center that is unique. Many times, the staff -- and I'll start with the receptionist -- they know the community, and they know the patients.

And so, there have been times that someone who's had a diagnosis of schizophrenia, gotten off their meds, they might appear to be disrupting in the waiting room. And sometimes, another organization might say, well, they need to go. Because of community health centers, and I think not only the investment in the community but the longevity of understanding their patients, usually the staff will say we'll just make sure that this patient gets routed right into the exam room, in with the provider.

One of the things that I think is important is that we're nimble enough that we're able to take people throughout the spectrum. And I think, again, where we're really going to have to really sharpen is how to do it in many times when we might not have all the information and many times, if you look in the

State of Illinois, where many mental health centers and substance abuse treatment centers have had to power back because the State cut their funds.

We had a co-located center right in the heart of one of the harshest communities on the west side of Chicago that had to close down -- it's been a co-located portion of our health center -- because they lost their funding. And so, I think the reality is as more and more at the State level that they're cutting back, we're going to see more people off their medications, people who had historically been managed well to just really be out there, trying to find a home and have their needs met.

And so, I think, again, it's at the Federal level what might be happening. But if it's not in synch or understanding the gaps that are created at the State level, there will be even a broader disconnect, and you'll have more people who might have been compliant and really managed well to all of a sudden just really be out and wandering.

Did I answer your question?

MS. GAIL HUTCHINGS: Yes, you did.

DR. ROGER FALLOT: Let me reiterate Gail's admiration for what you've accomplished. The question I have is about the peer intervention, especially around the roles they're involved in and the sort of training they receive, the sort of support they get on an ongoing basis, and how you pay for those services?

MS. DONNA THOMPSON: They get a stipend, and it's interesting, I was just also working with our community advisory committee for our HIV patients. And it's interesting that I had three of our clients who said -- and again, we want to help people figure out how to get through the system and answer questions, and what they were describing was navigation. And so, this was kind of a grassroots "this is what I think is needed."

What we're also seeing is that as many times, as our clients have gotten healthier, and they want to give back. And so, when I look and I talk to the staff, and I said, "Well, what do you see, though, right now is the biggest void for many clients?" And they're like, "Housing."

And so, for many, it's hard to get to that

wellness if, once they're no longer incarcerated, they burn bridges. How do you stabilize them so that they can reach optimum wellness? And so, again, housing is going to continue to be a major issue unless we address that with the clients that are affected.

MS. KANA ENOMOTO: Speaking of optimum wellness, I wonder the degree to which ACCESS is looking at average childhood experiences and their relationship to healthless behaviors as well as chronic disease?

MS. DONNA THOMPSON: Absolutely. Well, within ACCESS, we have enough pediatric patients to fill Soldier's Field. So that's about, whatever, a good Bears game, which is 70,000. And a couple of things. Obesity is a big area that we're focusing in on. Childhood depression is another big piece. And someone was talking about intergenerational trauma, and one of the things that we're looking at is the impact if our women aren't healthy, then the impact when they have their babies and also as they're raising their children.

And so, I think, again, when we talk about

assessment and you were asking about assessing all of our patients, I think we have opportunity to really have what I call assessments on all of our patients and then ongoing as they go through life challenges.

I think the other piece is I always look at what are the tipping points. We know that violence in Chicago is huge. In the summertime, it's not unusual for me to see some of our patients sitting in our health centers for two reasons, either cooling stations or it's safe.

You can walk in sometimes any waiting area, and sometimes what might appear as someone might be waiting to see a provider, it's not that. It's, "I felt safe here." And so, I think, again, what community health centers represent is far more than being attached to the provider. But then how do we then start addressing and engaging around what I call a very toxic society in which many of our children are living in and not feeling safe?

And on a beautiful day like this, the idea of going outside and riding bicycles is just unheard of. And so, when we talk about the obesity issue,

what we've also got to tackle is toxic neighborhoods. And so, if mom thinks I'm only safe if I'm in there with the Nintendo and she doesn't feel comfortable letting me go out to the parks or ride my bike, then how do we? And so much of this is connected.

And I think it's our goal as leaders to make sure that not only are we addressing the housing issue, but the safety issue and also issues around food deserts -- you know, healthy, affordable access to food and nutritional support.

MS. KANA ENOMOTO: Any other questions? All right. Well, thank you very much, Donna.

[Applause.]

MS. KANA ENOMOTO: Next, we have Ms. Falguni Amin, who is the operations manager at Asian Human Services Family Health Center. She serves as the mental health program coordinator as well as the chronic disease program coordinator. So we're very grateful to have her here today.

She's been working on the HRSA Health Disparities Collaborative for Asian Human Services, and she provides language-specific and culturally

appropriate mental health counseling and case management. She's been at Asian Human Services since she came out of graduate school and engages the center's clients in the development of their treatment and rehabilitation plans, received a master's in education in community counseling from Loyola University.

So, thank you, Ms. Amin.

MS. FALGUNI AMIN: Thank you. That was a nice introduction.

Asian Human Services, we've been in existence since 1976, and we provide quality, compassionate human and social services to mainly refugee and immigrant community. And when we talk about that particular community, the challenges are totally different. It starts from language. It starts from at the airport. You land, and you don't know where to go. So it starts from that level, and I can speak to it that we've been having workers who provide support and a lot of navigation, as Donna mentioned.

So we've been in existence since '76, and

the health center, actually, we started the AHS Family Health Center in 2004, and it is a Federally Qualified Health Center. And Donna mentioned a little bit about what Federally Qualified Health Centers are. So I'm not going to go into that.

The clients we serve, we have a very diverse clientele. Forty-eight percent of them are Asians, 24 percent Latino, 9 percent African American, and 13 percent Caucasian. Sixty-two percent of our clientele are women, and as you see, a majority are uninsured and they fall below poverty levels.

At the AHS Family Health Center, we are a baby of ACCESS, I would say. We have one site. We are at Edgewater. Actually, it's Edgewater's largest part, and currently, we serve 15,000 unduplicated patients. And as you see on the slide, we have -- my main focus is going to be on integration of family health and behavioral health, but I also want to give you a little bit of what we do at a health center.

We have served about 938 women last year through our Illinois breast and cervical cancer program. We run an opening door school, which is a

monthly group for our women, and it's free. We invite speakers, and they are kind enough to provide stress reduction and dealing with anxiety, depression, those kind of groups for women.

As you see, the depression collaborative, the part of the collaborative, it's run by HRSA and Bureau of Primary Healthcare. And I'll explain what it is about in the coming slides, but we've been part of the collaborative since 2004, and that's our main work around integration comes from the collaborative.

And we also have All Kids enrollment and WIC enrollment services. So we serve about 1,300 families every year in that program.

And while we talk about medical home, I want to say that especially for the low-income community, as soon as the women are pregnant, they are approved for our Medicaid presumptive eligibility so they can see our OB/GYN physicians. And we have pediatrician, and they get their prenatal education, breastfeeding education, all of that. And then we enroll them for insurance, which is Medicaid. So it's like a one-stop shop for the family, basically.

As far as services, we do provide mental health services. I am a licensed therapist there, and we have interns. As you know, there is a lot of turmoil going on in the mental health area as far as the funding. So it's an ongoing challenge, but we do have interns who are -- and then we have licensed social workers. We have licensed substance abuse, CDP workers. And but our main focus as far as mental health itself is the Asian community, and it's the largest pan-Asian mental health service-oriented organization in the Midwest, I would say.

We have a community health program where we kind of want to target the Asian community and increase their awareness about health, and so a lot of education outreach to the Asian community. We have a Passages Charter School, which is pre-K through sixth grade, and we also have pro bono legal services especially mainly for Asian community.

A little bit about Health Disparities Collaborative. It's funded by Health Resources and Services Administration, and it's initiated by Bureau of Primary Healthcare. And the main purpose is to

integrate behavioral health and primary care, and it's a team approach.

So just to tell you a little bit about what we do at our site, as soon as a patient walks in for the first time, they're screened for depression and anxiety. And all patients are screened, and then they're referred -- well, if the therapist is onsite, then they would be invited in the room with the physician, and they are introduced. And so, they are linked because there is a lot of stigma around mental health in the Asian community. Also in the Hispanic community, I would say.

So the healthcare worker is pulled in the exam room, and that kind of reduces that time gap that they go home and they never come back to get services. So all of them are screened and for substance abuse as well, and we refer them to the neighboring rehab community counseling centers of Chicago. We work a lot with Trilogy as far as integrating mental health and behavioral health.

And the whole focus is a team approach and where there is the primary care physician, the

psychiatrist, the caseworker, the mental health worker, and the patient. And a lot of case management comes on the part of the mental health worker and, in itself, is therapeutic for the patient.

So as far as the collaboratives, our first disease we did was depression, and I am really fascinated by the chronic care model as to how comprehensive it is in the roles of the community, the health systems, as well as the patient. So that's the model that we try to incorporate as far as integration.

The goals of the collaboratives are to reduce health disparities, improve accessibility to services, develop expertise and leadership, and it's a continuous learning and improvement model. As far as other programs and services, like I said, we have community health department, and they have been in existence for 15 years. And outreach and education, health fairs. We serve about 5,000 clients annually at our community health department.

We have a Banyan Tree program, which is an HIV prevention program, and a lot of our immigrant

African refugee community in that program. Women's Health Initiative, development for disabilities, chronic disease prevention, and needs assessment are some of the community health initiatives. And our mental health program, we recently collaborated with the Asian-American Substance Abuse Initiative, which, as a part of which Donna talked about SBIRT, we just incorporated that in our primary care facilities.

Domestic violence services is a big one, especially with the immigrant Asian women, and we have counselors who speak over 24 languages, Asian languages. And so, that's a great program, mental health program.

And we have a psychosocial rehabilitation program, and this is for chronically mentally ill clients who are mainly Asian. And we have about 50 clients who come every day, and the program is from 9:00 a.m. to 3:00 p.m. every day, and we have different psychoeducation groups and the focus being the recovery model. These days, the workers help them kind of navigate more hands on, take them to grocery store, access the system. Simple things like getting

a CTA pass sometimes is challenging for them. So that kind of psychoeducation and how to adjust to the community happens in the rehabilitation program.

And then some of the other programs are adult literacy, where we have computer classes, ESL classes for immigrants, employment program, where there is job readiness trainings, and how to go to career fairs and how to interview and those kind of skills are taught to the mainly immigrant population.

As far as barriers, we all know language, culture. A lot of them don't have Social Security numbers. They're dependents. So a lot of advocacy on behalf of those. Transportation, limited job skills, not aware of the services available. We have a disabilities program. So we try to address as many barriers as we can.

And as far as strategies on how we deal with these barriers is learning a lot about the culture. We have staff that comes from that culture. So it kind of helps to develop that rapport. Respect for everyone, assess their needs, and be sensitive and be humble and kind of putting yourself in their shoe is

something that we really strive for.

Thank you.

[Applause.]

MS. KANA ENOMOTO: Thank you, Falguni.

Do we have any questions on this from our group?

I have a question regarding -- again, conveying back to trauma and also integrating mental health and addictions into the primary care services. So it sounds like you have kind of a linkage model where the physicians are doing the screening, and then, on that slide, they're bringing in somebody. Are they also looking at trauma histories? I know that and a lot of these -- sort of refugee by definition and in their populations --

MS. FALGUNI AMIN: Yes, definitely. And we, like I said, we have the community health program mainly deals with the refugee and immigrant population, and they have their trauma -- they have done a lot of work in trauma, and they have done a needs assessment around the refugee community. So we see a lot of PTSD, honestly. And so, most of our work

is around domestic violence and PTSD.

DR. JEAN LAU CHIN: Are the medical workers part of the initial screening team, or are they referral based?

MS. FALGUNI AMIN: Well, it depends. Yes, it depends how the patient walks in. If they are referred, if they already have a worker attached, then, yes, they are a part of this community. But we have patients who are just seen -- they are first coming to see our primary care physician. So our nurses are trained to do the screening.

And so, the nurses do the screening in their triage and social history when they first see the patient, and then they get to the medical worker.

MS. KANA ENOMOTO: Are there other questions? I guess this is for both Donna and Falguni. But what has the reception been of your primary care professionals with the nurses and the physicians in terms of asking them to do the mental health and addiction screenings and trauma screenings? Have they been -- has it been a challenge to get them to change their practice, or have they been pretty

welcoming of that?

MS. DONNA THOMPSON: One of the -- and I think it's how we've organized ourselves. Each health center is co-led by a provider and administrator, and then we have regional administrators, which are providers and administrators. One of the things that we really promote is to identify those gaps.

What we've found out for a lot of providers and for reasons that they didn't ask, they said, "If I ask, I need to do something. And if I don't have any place to refer, then we're just standing there looking at each other." No provider likes to open up and then tell a patient, "I don't know what to do."

When we started really putting in programs and implementing those resources and at the same time teaching our providers, a lot of things started to happen. We created a [inaudible] orphan program, which is led by 8 or 10 of our providers in which they work with patients addicted to heroin that's within our own community health center. So, again, that's an example of providers really meeting and really taking what I call full charge of those issues.

MS. FALGUNI AMIN: For us, I mean, it was challenging in the beginning, but we have a medical director who is a part of our team in integrating this behavioral health and primary care, and he is very passionate about the integration, and I think he does most of the provider representation. But we had to train our staff. It took a lot of training and a lot of education and kind of really getting them to buy into the purpose of this integration.

And I think as it kicked in, they saw how the integration was going really well, and I think then they were willing to do the screening.

FEMALE VOICE: Do either of you have a mental detox program? Do you run detox?

MS. DONNA THOMPSON: We are co-located with the Haymarket Center who does detox. We also have relationships, though, with other entities. You know, one of the things that sometimes in the addictions community, you'll name a place and either clients will say, "No, I've burned my bridges" or "I don't want to go there." And so, what we're learning or have learned is that we've got a lot of different

relationships, but to first ask the client if they're willing to partner with them on how they will take that journey.

MS. KANA ENOMOTO: Thank you very much again, Falguni.

[Applause.]

MS. KANA ENOMOTO: And so, now we have our third presenter. I think this leads very nicely into kind of the practice on the ground and what's happening locally here, and the conversation on the medical home model at large.

We have Dr. McInnis, who is an M.D./M.P.H. medical director of health policy and advocacy at GlaxoSmithKline. She has over 20 years of senior executive and clinical experience in a number of different areas, including employer, military, and hospital practice health management segments.

She's presented nationally on the concepts of benefit design strategies and solutions to rising healthcare costs -- this is a hot issue, obviously -- and is actively involved in health policy and advocacy at the State and Federal Government levels in emerging

payment systems. So she's very busy these days. We're very lucky to have her.

She's a graduate of Erskine College and received her M.D. from Wake Forest Medical School, was designated an NIH student clinical scholar and serves on the board of trustees at the Thornwell Home for Children.

So, thank you, Dr. McInnis.

DR. TERRY MCINNIS: Thank you.

Well, I think what you've already heard is sort of the medical home in action. So I think my job here is going to be much easier by being last in this panel, and I'm just -- I'm grateful to have the opportunity to hear exactly how it's working out on the ground. And I spend a lot of my time actually doing that, going from State to State and place to place and learning what's happening.

So another hat I wear and one of the reasons Ron probably recommended me for this is I've been very active with a group called the Patient-Centered Primary Care Collaborative. How many in this room, just by curiosity, have heard of the PCPCC?

[Show of hands.]

DR. TERRY MCINNIS: A few, not that many. Well, let me tell you about it.

The PCPCC started, it was actually organized as a group in 2006. It started with several employers, led mostly by IBM, who came to the large primary care organizations -- namely, American Academy of Family Practice, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association, which represent most of the primary care physician providers in the country -- and said, look, we as payers, as employers, don't like what we're paying for. This episodic, splintered care that we're paying for is not addressing the fact that 75 percent of our costs are now chronic conditions.

And so, in the U.S., we see that we have a broken model of payment, and our primary care system has really been decimated. So that was the beginnings of this collaborative.

Well, they realized they needed all the stakeholders at the table. So they got the primary care docs. They came up with the collaborative

principles. Next, they approached the large insurers. They approached the Aetnas, the Cignas, the Uniteds, and Blue Cross Blue Shield, and seven of the major carriers in the U.S. in the beginning. And basically said, look, we don't like what we're paying for. We don't like what we're getting, and we need you at the table to also help change it since most of the reimbursement is done through the carriers.

So that group came onboard. And then, obviously, we needed consumers. So consumer groups came onboard. AARP was on the advisory board from the beginning. We have a whole list of consumer groups that have been involved. And so, we really ended up -- we've got governmental groups. ARC comes onboard. CMS has been actively involved with the group. And now over 550 groups have signed on.

So what this collaborative, again, is about is they believe that we really do need to, first and foremost, begin to coordinate care and reinvigorate the whole issue of primary care in a team-based approach. And if we don't do that, it really doesn't matter what we do about insurance because, as

Massachusetts has taught us, even when you have an insured population, they have no place to go.

And I think the FQHCs have really understood this issue and are actually one of the -- I think if you look around the country, they have some of the most organized advanced medical homes out there, and they're really leading the way. And I think HRSA has done a lot to really enable that.

And I had a wonderful conversation, just to digress a little bit, with Dr. Kay Felix-Aaron, who is the chief medical officer for HRSA and is sort of in charge of quality initiatives from the medical standpoint, and she fully embraces this and has been onboard with it. So, anyway, what I'd like to say is all of the major stakeholders that we need -- patients, providers, Government, employers -- everybody is there. Insurers are there.

And what that has enabled this group to do is really push for the agenda in terms of the national scene and also at the State level for healthcare reform. So what you see is in each of the pieces of healthcare reform legislation now, including you see

what President Obama has said, have really endorsed this. This is not a Democratic issue. It's not a Democrat issue. It's not a Republican issue. We have bipartisan support, and we have presidential support.

So it's one of the few things I think everybody is agreeing on. And we just don't hear much opposition to. So I just kind of -- I think President Obama said it well. He said, "I support the concept of a patient-centered medical home, and as part of my healthcare plan, I will encourage and provide appropriate payment for providers who implement the medical home model, including physician-directed, interdisciplinary teams, care management and care coordination programs, quality assurance, health IT systems, which collectively will help to improve care."

So going forward from that, I've provided a lot of information in this talk. I'm not going to read through all of this, but I'll just give you a little bit of a sense. This is sort of the medical home care side, the right side. I'm not going to go into today's care. But I'm just going to say it

really is about being patient centered. It's about coordinating care. It's being about access when a patient needs access. It's about proactive planning instead of just reacting to acute visits.

And it goes into some of the conversations we've heard around the table here, like are you actively screening for mental health issues? Are you actively screening for substance abuse? Are the patients getting immunizations? Are they getting the prenatal care?

So it really is not just about chronic disease managements like the Wagner model. It goes a little bit further and says we're talking about proactive planned care, and it very much is a team approach. I'm going to skip through some of the evidence of quality improvement and the evidence of cost reduction slides for the sake of time.

I will say that the Commonwealth Fund has done a lot of research on what happens with disparities of care in this model. I've included one slide on that that looks at racial and ethnic differences. Basically, those begin to evaporate in

this model. And I think the FQHCs will probably be one of the first ones to tell you when you begin to focus on the patient, when you're making sure their needs are met, when you're making sure they have their reminders and the care plan in place and that they're not falling through cracks, then you see a lot of the disparities begin to disappear.

And that's what the Commonwealth Fund has found, and I have some references if you would like to see all of their slides. That's the one that I just pulled out that basically sees the disparities go away.

Now I'll focus a little bit more on the topic today is why we need to integrate behavioral health? And just to let you know, there are four major centers currently with the Patient-Centered Primary Care Collaborative. And I co-chair the Center for Public Payer Implementation, and that's why I probably do more for PCPCC these days than I do for GlaxoSmithKline, but don't tell them that.

[Laughter.]

DR. TERRY MCINNIS: So what we're really

seeing is through the four centers, we're able to then focus on certain issues. Within my center, for example, right now, we've broadened it. We're looking at the role of it happens to be medication management in the medical home, and then we have another task force that is involved looking at behavioral health in the medical home.

And that behavioral health task force, we took a break during August, but it had been meeting biweekly as a group, and it will start meeting again in September. So any of you all who are interested in being part of those calls and really influencing what that integration needs to look like, please do so. The whole purpose of that has really been the fact that -- I'm going to skip over to slide 12. But I just wanted to read this. I think it's best when we hear it from the ground.

This comes from Dr. Jim Barr out of New Jersey. He says, "Thanks for your efforts toward integrating behavioral and mental health into the patient-centered medical home model. My personal belief is that we will fail unless this issue is

addressed. The duration and quality of the physician-patient relationship within the PCMH can drive real changes to occur in the lifestyles and physical health status of our patients, but without mental health, all will be lost."

So I think that sums it up. We have another good from a patient perspective who really benefited from integrated care, said, "The staff at Marillac Clinic actually cared about what I had to say. They were there to help when I needed it, not just medical help, but counseling, and the medications needed to get well. Marillac helped me learn how to care for myself. I understood how to accept myself from the kindness in their eyes."

So we really are talking about team-based approach, and Donna and I had the opportunity to -- how long ago was it, a month or so -- to participate in a Carter Center group for 2 days. It was dealing with two issues. It was how we integrate preventive and wellness care into the medical home, and how do we integrate behavioral health into the medical home?

And so, it was a robust 2-day thing where I

learned a lot being a part of that, and I think I learned a lot from Donna and others. And really heard how it's happening in the Federally Qualified Health Clinics around the country, but also in some of the larger integrated systems, like David Grossman we heard from at the Group Health Cooperative of Puget Sound. We heard how it's happening in Minnesota and other places.

Just to sort of give you a sense of how big this is, this isn't small. This has gotten large. There are 46 States now that have identified activity around medical homes. Actually, the slide says 22, but I know that Minnesota has a big health home initiative, too, now, and they weren't on the slide. Twenty-three have what we call multi-stakeholder demonstrations or actually State-wide initiatives.

And when I say multi-stakeholders is what we've found is many States started this in Medicaid and through FQHCs, and what we know we need -- and that's part of what my center does for public payer implementation -- is to make sure we're not just integrating Medicaid, but we want State employees, we

want Medicare, we want commercial wise. Because when a physician sees patients, they don't really see them as, okay, you're Medicaid. You're Medicare. You're Aetna. You're Blue Cross Blue Shield. I'm going to practice medicine as a physician uniformly with all my patients.

So to ask them to really transform their practices into medical homes that integrate with this broad-based team approach, we really have to change the reimbursement model. We have to make sure the IT systems are robust enough and our other ways of conversing are robust enough. Our networks are robust enough and that we're actually measuring outcomes. We're not just holding up our hands and saying, "We're doing it. Pay me more." We're actually getting this coordinated care and getting the outcomes that we need.

So if you look at the current legislation, and your crystal balls are as good as mine on this, what we do have is there is medical home coordinated care language in all the bills. And so, we think we've got a very good chance of this -- having some

sort of passage around this. And Medicare has a demonstration project that will involve 8 States, 400,000 patients. We've actually asked that Medicare expand this. There is actually -- one part of the legislation I think is actually part of the House bill asks that the Secretary have the authority to expand that if, indeed, they see the medical home model as being a viable model.

So, again, I think there's a lot of momentum here, and behavioral health has been identified as front and center as it being part of that absolutely needed team.

So I'll stop there and be glad to take any questions. And thanks for the opportunity.

[Applause.]

MS. KANA ENOMOTO: Questions? I'd like to welcome Britt Rios-Ellis to the table and to our meeting this morning. And do I have questions from the committee members? Gail?

MS. GAIL HUTCHINGS: You know, I think -- speaking of crystal balls, mine is back from the cleaners. So I guess I will try it. I think when,

and I don't think it's an "if," I think this integrated care and medical home model will become a foundational element in our healthcare system, and I think the unknowns are clear, especially with legislation coming. But from what we do know -- again, using my trusty crystal ball -- I think, overall, mental health will come out okay. Probably better than where we are now, hopefully more [inaudible].

It's addictions that I think under the current financing mechanism, and I particularly point out the lack of Medicaid reimbursement for addictions, that we are in trouble for. I had dinner last night with Dr. Lorrie Jones, the mental health commissioner of Illinois. She remarked about a $40 million health hit to the community side, what happens. Donna, we just heard from you about the direct impact of that being one of the co-located partnerships you had closing.

That's clear. And we really need to get a strategy together about medical home model and addictions, and with that, comorbidity and, in this

case, I mean substance use disorders as well, but I think that's where we're headed for difficulty. And in the nonserious mental illness, to the extent that whether Medicaid will pay for that or not.

And of course, I say this with humility around all the people who are not eligible for Medicaid. We think that everybody with a mental health issue gets through that door. We know that's not the case either by any means.

But for those that do get in, it is a significant portion of the financing picture, and we're in big trouble today around addictions treatment care, and we're headed, I think -- I'd love to hear your perspective. But I fear for worse -- for a moment, I'll put aside quality and evidence-based practices, and I'll talk about purely financing issues, and I'm really afraid for that. I'd love your perspective.

DR. TERRY MCINNIS: Well, I share some of your same concerns, to be honest. And one of the things that -- and I've been more on the employer side of financing. Before I came to GSK, I was corporate

medical director for Michelin of North America. Before that, I was a healthcare manager for GE and had North and South Carolina. So I kind of came from that perspective.

And one of the ways I met Ron way back was we were actually at the National Business Group on Health and put together the employers -- you've probably seen that. We put together what employer-sponsored mental health services should look like, and obviously, we included that we thought that addictions should be covered.

So I think there's a lot of momentum from either the employer side and what they think should be covered. But I do think you're right. It's an uphill battle. I'm not sure I have the answers behind that. But I think, obviously, when we're talking about care, if we don't get our delivery system, a primary care delivery system and focus on that right, then I don't think it matters what else we do.

And I think substance abuse is a big part of that. So I agree, but I don't have the answer to that.

MS. GAIL HUTCHINGS: I just -- with that, I share your focus on the employer side, but what happens when benefits run out, people end up in the public sector system, where there isn't really I think a tangible evidence of support for addictions. So it's compounded, of course, in the public sector more around poverty rates in the first place, people with addictions issues or if they were fortunate enough to have employment, loss of employment, exhausted benefits, where are they? Where are we? Terrible.

DR. TERRY MCINNIS: And I think you're exactly right. I mean, I wasn't implying that we just --

MS. GAIL HUTCHINGS: No, no.

DR. TERRY MCINNIS: But from my background, I've been more on the employer because if you have an individual who is employed and has these issues, and you just have limited EAP and you really don't have the services to take care of some of those bigger issues, then they do. They lose their jobs, and they end up going down that spiral.

So I think it's really incumbent that

employers really have robust systems to keep people from -- get them more on the early part of that curve when they're still in jobs and give them the help they need to try to tackle those addictions and keep them working. So, yes, I agree.

MS. SUSAN AYERS: I wondered about, this is not one of those 5,000-feet questions. This is like very [inaudible] answer. Physicians practices and what not, in terms of how do they fit into this medical home kind of model, just in day-to-day life? You know, when I think about the public option, here I have an 85-year-old mom, and I was able to sort of relax when she got a wonderful primary care physician.

I mean, that PCP is the person we all trust. She's unusual in terms of she extends herself. She thinks my mom is like her grandma, or however you want to think about it. And it's a really extraordinary relationship. And I worry about her because of her -- kind of independent, she's been an independent primary care physician. She has networks. She's respected in the community, large suburban community.

But sort of where do these individual

practitioners and then smaller physicians groups sort of fit in this? I just don't know.

DR. TERRY MCINNIS: Well, I think it's a great question, and that's been a big focus because if you look at what's happened to primary care, and that's including look at nurse practitioners, too. If we look at all primary care providers, we don't have enough. And if you look at physicians in particular right now, there have been such a gap in reimbursement in terms of the cognitive services.

It's just like I said this system, the current system that we have in the U.S. reimburses for acute episodic care. Not to sit down and have a conversation with somebody, not to email, not to coordinate care or find out what the specialist did. There is really no reimbursement for that for anybody. And so, but if you --

As a matter of fact, I was listening to the radio the other day, and a primary care doctor put it well. I don't know if she meant to, but she said, "I saw nine patients this morning." I think she was an internist. She said, "My last patient had an ingrown

toenail." She said, "I removed the ingrown toenail, and I made more for that procedure than I did seeing the other eight patients."

And it goes to the point that we are losing the primary care docs because if I were a young -- and I'm not a primary. I'm actually a preventive medicine specialist. But if I were going through medical school now, it's like, okay, I'm going to work this many hours, and this is my -- I can barely make it in a practice now as a primary care doc. Or I can be a specialist, and I can make this. It's a no-brainer, to be honest, and that's what's happened in our system just because of how we're reimbursed.

So you're right. I fear for that. Now the second part of your question, though, was how do they organize the medical homes? And if you look at North Carolina, I think they have one of the most robust systems that we've seen. And what they've done is they've taken the doctors that are out there kind of in the onesies and twosies practices, or they might be nurse practitioners or physicians, and what they've done is they've looked at those areas. Eastern North

Carolina is very different from Raleigh or Charlotte like where I'm from.

But they have said what are the resources we have there? And so, Community Care of North Carolina is a not-for-profit that they set up, and they actually hire part-time paid medical directors from each of those catchment areas. They give them case managers, care coordinators. They coordinate the mental health services. They have a network of pharmacists.

So what they do is if I'm a practice, let's say I'm out there single practice, like you mentioned, by myself. I can't afford to have -- to pay for a care coordinator. I can't afford to pay for a case manager or pay for a mental health provider in my clinic. That just won't work.

But if I've got a system that will allow me to integrate with those people and can help me. So there might be a care coordinator for five different small practices. That's how they do it in North Carolina, and that's how they've been extremely successful. It's shared resources.

MS. KANA ENOMOTO: What about -- we had talked earlier in our recommendations around mental health necessities for the Women's Advisory Council at the White House. One of the recommendations that Susan said she liked was about preserving the safety net, the specialty care safety net of mental health and addictions to providers.

Where do -- for many of our folks who have sort of chronic, recurring issues, and part of why they have this disparity in terms of a 25-year shorter life expectancy is that they have very serious chronic health problems, but the provider that they see most often is a mental health provider or an addictions treatment provider, and they weren't getting that core needed medical care.

But I'm not sure that the answer is to say that their medical home is somewhere outside of the specialty treatment provider that they've been working with for many years. So how does the PCPCC look at placing medical homes within specialty mental health and addictions treatment?

DR. TERRY MCINNIS: I think it's how you

define “medical home.” And the basis is when you look at the medical home, kind of the prime area where that place is, whether it’s a nurse practitioner or physician or whatever. It’s kind of being able to look at the whole realm of services. So everything from making sure you’re getting your immunizations to where you go for when I’ve got the flu, when I’ve got -- when I need my physical exam, when I need everything, but also realizing that you’re not the place for the specialty care.

So then, if you’ve got an individual like you mentioned that has maybe severe mental disorders that sort of they really need specialty care a lot more than they need to see the primary care, is you would still -- the way it’s envisioned here is they would have the medical home. They would still see that specialist for most of their care, but then they’re not going to be -- their diabetes and their hypertension and the things that are also shortening their life by 25 years are taken care of and coordinated.

So that’s the thought is it doesn’t mean

that -- instead of move the foci of where your needs are, they could say the same thing for like end-stage renal patients. Well, end-stage renal patients still have other needs, too.

So the thought is that the medical home is able to coordinate that, even if the patient is not there because they need to physically be there a lot of the time. Does that make sense?

MS. KANA ENOMOTO: Well, I guess --

DR. TERRY MCINNIS: It's coordinating all the needs.

MS. KANA ENOMOTO: Right, and I guess my question is whether, for example, my dialysis center could be where my medical home really is? You sort of set up a primary care shop. If I have ESRD and I'm going there 3 days a week, then that makes the most sense for me to get screened for other things, for me to get my flu shot there rather than having a medical home that's coordinated elsewhere, even if it's virtually elsewhere.

Or similarly, if I have group or services at the mental health center 3 or 4 days a week, does it

make sense for me to get my immunizations there? That we have medical homes that are centered in specialty care as well to coordinate, to do that coordination for that treatment, that high need sort of chronic treatment population.

DR. TERRY MCINNIS: And really, the PCPCC, the whole kind of thing is it's not saying any specialist could probably do this, but you have to do it. In other words, you have to be willing to make sure all those needs are met. That the Pap smears are getting done, the mammograms are getting done. If you've got prostate issues, they're getting handled.

So most of what we hear from specialists is that once you say, okay, but these are the criteria for really making sure this patient's total care is being taken care of, most don't want to do that. And that's what we hear.

But I think as long as that's happening, that's fine. I mean, if they can do that and if you're big enough and you want to have those services there, and you're making sure all that occurs, that's fine.

I think the big issue is a place, a kind of this is the person like you're talking about your grandmother that goes to that person is not going to be able to take care of all of her needs, but she's coordinating. If she's a real medical home, she's coordinating for all of those needs and making sure that they're being met and communicated. That's the point of it.

MS. DONNA THOMPSON: You know, I think one of the things I always say is who is the one that's really going to stem the blister, that's really going to be accountable and responsible for the care of the patient? And I know that within ACCESS, that's why we've been successful with co-locating because we've brought really our niche of focus on the primary care needs of the patient into like Haymarket Center or into Schwab at the Anixter, which was adults with disabilities. Where we could keep a focus on a specific population, but orchestrate all the needs.

And I think the big piece, too, is the communication, the ability, though, that whether you co-locate or you're in separate places, who's going to

really make sure at the end that they have the information that's needed for that patient in all aspects of the care?

MS. KANA ENOMOTO: Falguni?

MS. FALGUNI AMIN: One of the things that made me think about mental health, you mentioned about loss of funding and loss of employment. And lately, the last one we've had patients walk in with a letter that, "We'll be no longer able to fund you for your mental health needs, and these are your 30-day medications." And they come, and we have had influx of those at our health center, and how do we deal with those?

How do we deal with those who lost their jobs, and now they're doing new sliding fees. And so, what we've been doing is really training our primary care physicians to provide some of the mental health kind of services and to understand depression and to understand anxiety and to understand ADD and to kind of have [inaudible] treatment guidelines for these.

So our psychiatrists are really available to consult for these kind of illnesses while the primary

care can treat depression, or they can treat anxiety or ADD or ADHD, adjustment disorder, those kind of things. And the psychiatrists, where we have them for a limited time because of funding, they can be more available on a consult basis, and they can treat more of the chronic, like schizophrenia or bipolar or those kind of things.

So we've been trying to do that.

MS. GAIL HUTCHINGS: I just want to -- I think you've asked the key question of probably the next 5 years or decade of behavioral health and primary care integration, and I think it bears quite a bit of conversation down the road of I think from a fields kind of it will either go well and you realize things are changing and let's get with it. Or it will be the clash of the titans in a way.

I think that will be geographically relevant. I think it will be discipline specific. I think it's going to literally make or break the kinds of care and the kinds of welcoming or unwelcoming environments that particularly people with behavioral health disorders and particularly those with trauma

histories are going to see.

Because I don't know if we know really enough about one another field wise to have the kind of foundational respect that we need, and that we see these boundaries in all sorts of ways, especially the values-based areas that Roger mentioned earlier, too. And to the extent that we could focus on this and get out front with, and this is another opportunity to appreciate SAMHSA's opportunity to be a convener and to hold forums and to be able to bring out toolkits and things of that nature.

DR. TERRY MCINNIS: I did see a survey. Don't ask me where. I can't give you the reference for it. But this came out probably about 6 months ago. It was one of the primary care surveys of what were the needs for primary care doctors. And their biggest need says really a lack of behavioral health services. They can't find behavioral health people out there to refer their patients to.

And I think, again -- I'll put on my old employer payer hat -- you get what you pay for, and we haven't appropriately reimbursed behavioral health.

And I think that's what's happened with primary care. So I think that's part of the issue. It's not that primary care doesn't want it. It's just that you can't find it.

And when I was at Michelin, I had the same issues with some of my patients. I couldn't get them in to see a psychiatrist, even suicidal bipolar one time. I mean, it was a real issue in terms of being able to access the services.

MS. GAIL HUTCHINGS: At the same time, if we had some community health center directors here, they're so worried that you, the big huge organization are going to steal their staff, that you, as little as you have, can pay more, would get reimbursed at higher rates for sometimes the same service. You certainly pay a lot less for meds.

And so, without these kinds of relationships that you've done so well setting up, memorandums of understanding or co-location or what have you, we're going to dismantle a pretty shaky system in the first place without any smart ways to ensure that these bridges are there. And I don't want to get into even

workforce development and training issues.

[Laughter.]

MS. DONNA THOMPSON: I think sometimes it's not all the money.

MS. GAIL HUTCHINGS: Yes. Yes.

MS. DONNA THOMPSON: And I know within ACCESS, as we've grown, we've really taken the lay of the land in the community to really see what make sense. If there is something next door right down the street, why would you replicate it?

And I think, again, it really talks from a community perspective and really seeing what the assessment -- doing the assessment and seeing what the needs are. I think the big downfall, though, is the lack of State funding when mental health was slashed at the State of Illinois level. And so, you had patients lined up at your door saying, "Now what do I do?"

MS. GAIL HUTCHINGS: Right.

MS. DONNA THOMPSON: And so, you know that you either try and be nimble and try and figure something out. Or at the end of the day, you are the

medical home. I think that's where we talk about the medical home, it's kind of the good, the bad, and the ugly. And so, you've got to be able to how you're going to shape that to be responsive to the client's needs.

When everything is there and in place, it's great. When all of a sudden there is a big gap, that gaping hole, how do you still try and preserve?

And I think, again, what you guys are doing, you just what can we do? We train and we equipped our primary care providers. We're going to utilize the psychiatrists for those hard to manage clients. They'll be able to consult. And I think that that's many times what we're faced doing, but not always the best way to really address long-term needs of the community.

DR. JEAN LAU CHIN: We really ought to be allies. As you can see, I'm just sitting here with all my little parallels going because I also work a lot in the child welfare system, and the question of who's in charge? I mean, really, who is it? Is it the child welfare worker, or is it the person from the

Department of Mental Health?

I mean, everybody has got a piece of the action when it comes to these families. Just like you've got a primary care physician, or what about the neurologist or how about his person? So it's this -- it is. It's time for the collaboration. We've got so much specialization, and it's sort of losing charge and how are we going to communicate about these things?

MS. KANA ENOMOTO: Well, I think, Donna, you used the word "nimble" a number of times, and I do think that adaptability really is going to be the leadership quality that's called upon most in the coming years with health reform and our changing systems and changing finances and changing economic climate. That on the health side, on the mental health, substance abuse side, we're all going to have to adapt and be nimble to what challenges arise.

I want to thank Dr. McInnis especially for the last presentation, but all three of our panelists for a very robust discussion.

[Applause.]

MS. KANA ENOMOTO: We're now going to adjourn for lunch, and we'll be reconvening at 1:30 p.m.

Thank you very much.

[Break.]

MS. KANA ENOMOTO: All right. Well, thank you very much. We apologize for the slight delay, but we appreciate everyone's patience. And I know you would be patient because we have such a great panel set up for this afternoon, and everyone will be well rewarded.

We're grateful to our speakers today. We have Carole Warshaw, Janelle Prueter, and Linda Teplin, each of whom is very well regarded in her field and across the field of women's services in their area of specialty. So we're going to start today with Dr. Warshaw, and then we'll go to Dr. Teplin, and then we'll have Ms. Prueter.

And we have -- again, we'll be able to take advantage of being in Chicago and having the national experts, but who are locally located. I think it's going to be very insightful. Where we heard earlier

from ACCESS healthcare and Asian Human Services, as well as Terry McInnis from GlaxoSmithKline, who talked to us about the medical home, and that's I think one end of the continuum. And now we're going to a different part of the continuum. We're looking at kind of justice-involved women, as well as the men involved in domestic violence. These are really key issues for us on the committee.

First, we'll start with Dr. Warshaw, who is executive director for the Domestic Violence and Mental Health Policy Initiative at the National Center on Domestic Violence, Trauma, and Mental Health. She actually chaired the committee that wrote the AMA Guidelines on Domestic Violence and coauthored the Family Violence Prevention Fund manual for improving the healthcare response to domestic violence.

So, again, continuing that theme on how to integrate our issues or the issues of trauma and mental health and addictions in primary healthcare, as well as she coauthored the AMA's Guidelines on the Mental Health Effects of Family Violence. Dr. Warshaw has provided consultation to a number of Federal

agencies and national advisory boards. She's served as a reviewer for peer review journals and speaks about domestic violence, trauma, health and mental health both nationally and internationally and has published numerous articles on these issues.

She is currently an adjunct faculty member in the Department of Psychiatry at the University of Illinois, and we're very fortunate to have her here today. Thank you, Dr. Warshaw.

DR. CAROLE WARSHAW: What do we do about time? Do we still have 20 minutes or half an hour, or how are we?

MS. KANA ENOMOTO: I think we're doing it 20 plus 10.

DR. CAROLE WARSHAW: Okay. I just wanted to talk a little bit about our national center, which is funded by the Department of Health and Human Services, the Administration on Children, Youth, and Family, Family Violence Prevention and Services Program.

And we started as a local project in 1999, and now as the national center since 2005, and our goal is to really develop the comprehensive,

accessible, and culturally relevant responses to the range of common related issues faced by domestic violence survivors and their children and to ensure that survivors who are experiencing both domestic violence and psychiatric disabilities have access to the full range of services that they want and need.

And also promoting advocacy that is survivor defined and rooted in principles of social justice. And that is really important to us because there is a lot of work on trauma-informed services, which would be more clinically oriented, and a lot of the advocacy work, where there had been rifts historically, are because they are social justice focused. And obviously, those issues are very much linked, both at the impact and at the prevention end.

And so, that is part of our mission is to keep those in focus and to figure out ways to both develop services that keep that in mind and also when we are thinking about prevention, a way to develop those issues. And I will talk about some of the ways -- part of what I will do is talk about a kind of framework that reaches those perspectives and, at the

end, talk about some of the projects that we been doing to try to integrate services and how those have evolved over time as we try something and it works or doesn't work, and then we try something else.

And then, again, obviously eradicating the social and psychological conditions that contribute to interpersonal abuse and violence across the lifespan. Again, when we don't look at the sociopolitical roots of violence, then we don't end up ending the interpersonal level, and we don't look at the individual developmental levels, and we keep creating the same social and institutional form. So, again, that is one of the things about kind of merging the advocacy and clinical perspective is having that broader social perspective.

So, again, I know you are coming from a lot of different places with expertise in a lot of areas. So I don't know what is going to be redundant. When we started doing this work, it was clear that people were aware that domestic violence could have serious mental health consequences. But on the mental health side, clinicians weren't always aware about how

abusers use mental health issues to control their partners.

So that we heard lots of stories from abusers forcing them to take overdoses and then having them committed and then threatening to take their kids because she was incompetent. Particularly in the Asian women's shelter Apna Ghar in Chicago, that would happen, particularly when a woman didn't speak English and couldn't speak for herself.

We also heard stories of abusers having a psychiatrist report to the husband. One case from New York where a woman said -- she finally got herself to a domestic violence shelter, and her husband got the psychiatrist to go to the judge and write an injunction saying that she had bipolar disorder, and when her lithium level dropped, she became delusional and thought her husband was abusing her.

So there are lots and lots of stories that people hear. So those are the things that abusers do to literally drive their partners crazy. They force them to stay up at night for many days in a row, control their medication, not giving medication, all

those things that we don't think about. We don't think about when someone comes into a psych ER, and you ask for collateral information from a family member. Who is that person who is providing the information?

One of the things we did with a project we did with the Chicago Department of Public Health -- that was a partnership with three domestic violence programs and three community mental health centers that were trying to become centers of excellence -- was just changing the intake at the health department, and when you ask, "Are you a danger to yourself or someone else?" Maybe not in that language, adding one question, "Are you in danger from another person?"

It made a big difference just in how people thought about things, and because it costs so much money to change one question, they weren't able to change the next question, which is, "What is stay in contact information for you?"

So just it is always keeping in mind that kind of safety lens when we're having the added issue of ongoing danger or force of control from the

partner. Thinking about when we share information or confidentiality issues. When someone is in another system, that there are different protections. That their rules may be different than what information is protected under domestic violence programs.

So the people who are experts in confidentiality in domestic violence even recommend having informed consent to talk to the lawyer in a program because the lawyers have to report if a crime is about to be committed, but they don't have to report about child abuse, whereas a clinician might have different requirements. So that people know how that information is being used or misused by other systems.

Another issue that has come up is as people have become aware of the effects of witnessing or exposure to domestic violence on children, a lot of overzealous judges are taking kids away from their mothers who are very good parents. That then creates a whole other level of problems. So we think a lot in the DV field about unintended consequences and how is information going to be used.

Once people, for example, started screening for domestic violence in healthcare settings, there were a number of insurers who dropped women from their policies, saying they have a pre-existing condition, they are being abused. For life insurance, if they were at risk, then they were protecting you by canceling the life insurance so he doesn't kill you to get the money.

So, again, each time there has to be damage control. And so, as we move forward in our learning, we try to rethink and advance. One of the things we know from the child trauma field, that supporting the parenting capacity of any attachment to the non-abusive parent is what is most helpful to kids who are experiencing abuse and violence exposure.

The other issue that I know you are all aware of -- two other things on this slide. One is that stigma is a major factor in making it possible for abusers to use mental health issues against their partner. If people -- if that wasn't there, then they wouldn't be able to get away with it in the same way, to say, you know, "You are not a good parent. You are

not going to be able to keep the kids."

One of the things we learned -- I learned actually very recently in July in developing a training for judges is that judges think that if you have a psychiatric diagnosis, you are not a fit parent, and they will want to take kids away from a mother who is a perfectly good mother. So, again, a lot of education needs to happen in the courts, and abusers certainly use those issues against their partners.

And the other issue that we talk about a lot, and I am sure you are all aware of, is how abuse and trauma play a significant role in the development and exacerbation of mental health disorders, all this stuff about the ACE study. And it really helps people reframe how they think about abuse and violence and also helps undo some of the stigma associated with mental illness. So that has become -- talking about some of the neuroscience has been very useful both in the advocacy arena and in the mental health arena in creating that bridge.

Next slide.

And again, I mentioned that taking on the legal system becomes very important when we are talking about trauma-informed services, that trauma affects survivors' responses to law enforcement. There was one legal case that I did for a woman whose criminal case -- she had been severely abused and tortured by her husband -- was thrown out of court because she didn't -- misremembered one detail of the time when something happened. She was able to win her civil case.

So, again, educating the courts and the judges about the effects of trauma, about testimony, about how someone appears in court. Lots of people that I work with won't open the letter from their lawyer because it is a trigger, and it reminds them not only of what happened, but of all the really difficult, complicated decisions they have to make. And yet the prosecutor may view them is not complying with their case, and so they won't get the support.

So, again, thinking about all the ways that this can play out in other systems. And again, as we start to think about this, some of the pushback from

the advocacy field in doing this work, when we would talk about being trauma informed, people would think we meant trauma defined, that everything is seen through a clinical lens. As opposed to it's one critical layer that affects all of our lives and not the same that defines everything. So, again, it's that not everyone needs psychiatric treatment. It is how we're affected and how do we change the conditions that create violence?

These are some of the issues that survivors of domestic violence face, and this is sort of how our thinking evolved. First, when we started in 1999, we spent a year just talking separately with survivors, DV advocates and programs, and community mental health providers in Chicago, and at first, people were just looking at the mental health effects of domestic violence. People weren't talking about PTSD or trauma yet. It was depression. And they said, "Well, of course, she is depressed. She is being abused."

And what people would say is someone comes into the shelter, and they would feel better once they have access to safety and support. But then when they

leave, if there aren't resources, then the depression comes back. So, again, thinking about the context. Sometimes when people are safe, symptoms come up because they have room in safety to feel when they are not just in survival mode and having to make sure that they keep their kids safe and they have a place to go. So, again, it is all those nuances.

Next. Oh, wait. Let me go back to that.

So then, as we were moving forward, what advocates started to recognize and what was also coming out in the mental health system, that many survivors of current domestic violence have experienced multiple forms of trauma or abuse and violence in their lives. And DV programs were more focused more on the current crisis. Mental health systems, with SAMHSA's input, are focusing on trauma that occurred in childhood, that occurred in the past.

So, again, it was thinking about how do you integrate all that? How do you feel while you are still under siege?

And then the next issue was the survivors who experienced psychiatric disabilities, and the

primary source of services was in the publicly funded mental health system who were excluded from the DV program. It used to be if you were taking Prozac, you would be not eligible for a DV shelter, and that has changed a lot.

But again, there is a wide range around the country of what happens and whether programs feel like they are adequately resourced, plus the stigma around mental illness that these programs exclude women. And there is a big push from the HPSA office around accessibility now and around the ADA for housing.

So we're providing a lot of technical assistance to these State coalitions and programs around how to be fully accessible and welcoming and accommodating and trauma informed and [inaudible], and that requires collaboration with mental health providers in the communities because DV programs were not designed to address all the complex issues that women actually come in, and we help.

Next slide.

So I think some of the others. The other issue is in any residential setting, it can be

retraumatizing just hearing other people's stories, having to have rules, living with strangers in an unfamiliar environment. So lots of things come up in DV shelters, both for women and for advocates who are not so trained to address all the complicated issues and their own responses. So that is another whole layer of work that we end up doing is kind of how people deal.

When you think about the complex, sophisticated training that a clinician may have to deal with those issues, and how do we translate that to people who don't have that background or training who are working in public systems? We also fund that in the public mental health system as well to actually provide the kind of services that people need.

One of the ways that came up is trauma-informed services, so people at least -- the "do no harm" level or DV-informed services, you are not doing things that jeopardize safety and then to create services that are actually trauma competent and DV competent and culture competent is a whole other level of labor-intensive resources and need for support to

be able to provide what people need.

So when we would think about -- well, I'll get to this in a minute. We'll come back it. Next slide.

One of the things that we were told by advocates and by survivors, that interfacing with the mental health system was problematic for two reasons. One was actually accessibility. The services weren't available, and there were 6-week waits. But that there were major philosophical barriers as well, that survival strategies would be seen as disorders, people didn't understand the context of ongoing danger and control, that people would get medication and no one would ask about safety, that it was better to be involved in treatment. They would refer -- 50 percent of community mental health centers when we started said they would refer to couples therapy when they identified domestic violence.

And advocacy was -- the expertise of advocates was not recognized at all. If people couldn't talk clinical language, they were not taken seriously when they tried to advocate for women they

were working with.

Next slide.

So traditional models, people present with symptoms, diagnosed with disorder, treat pathology.

Next slide.

So then the person isn't part of the picture. And then the next one, this is really more about couples therapy, that it assumes equal power in the relationship and equal responsibility for creating change when the dynamic is really more like --

Next slide.

It is supposed to have loud crashing sounds to go --

[Laughter.]

FEMALE VOICE: We've been having trouble with our audio all day.

DR. CAROLE WARSHAW: My brother is the artist, and I have to be the doctor.

So next slide.

So it's, you know, this is philosophical -- you know, what is the problem? Is it an abuse of power and control, or is it an individual family or

system pathology? What are the goals? Safety and empowerment or control of the symptoms. And what are the resources that you use to do that?

And obviously, if someone is dealing with all of these issues, there has to be a way to do both. So part of our framework work is to kind of find a way to layer those rather than have them be polarized the way they have been.

Next slide. You can go through all of that.

One of the things that people -- I already mentioned this, that just people couldn't access community mental health services for all the reasons that we know -- transportation, childcare, actually getting a provider who knows something about domestic violence, gender-specific services. I know this is an issue that comes up in the mental health system that in DV shelters, they are gender specific. But any type of residential programs on the mental health side -- not substance abuse, but mental health -- is often not gender specific, and that can be both retraumatizing and unsafe.

One of the other issues is abuser control of

insurance. So if someone uses -- has insurance and tries to use it, and the information goes to an abuser, that's problematic. With HIPAA, there are some provisions that you can have billing sent to another address, but whether it gets back to him or not, it is unclear that that is actually where we stand.

So next slide.

And then for mental health providers, there are all of the constraints that we have, and lack of support for the long-term trauma issues, which is hopefully changing.

Next slide.

Let's see. I think these are the facilities issues. One of the things in DV programs that's been problematic is rules. Because often shelters are dealing with lots of safety issues, they also become much more rule bound. So part of being trauma informed is helping people have other ways to work to create a culture, an agency culture that doesn't rely on rules and relies more on a sense of accountability. We're seeing the women's model, sanctuary model of the

four kinds of safety.

This is what survivors told us that they wanted long-term counseling in DV programs. It is sort of like wherever people get most connected, they want to be able to stay there and have the other services come to them. And that came up in a project we were doing with the health department where we had three centers of excellence on the mental health side and three DV programs that had shelters and walk-in programs that were partnered.

And one of the things that happened was the health department said we can do a fast-track referral, that if a woman is referred from one of the DV programs, they could be seen within 24 to 48 hours and get an eval, which is a big issue. That even DV programs that have a social worker or clinician on staff can’t get psychiatric evaluations when someone needs medicine in a timely way.

So, but we have found that people did not want to go to the other agency. Wherever they were most comfortable, they didn’t necessarily want to go to the other one. So it ended up being kind of cross

consultation a lot of times rather than literal cross referral. They also wanted us to train mental health providers to really understand domestic violence and not blame victims and be careful about abusers' involvement.

And we also did surveys with mental health consumer groups, people in WRAP group, Lucy Sajdak, who is one of our partners who runs the Growing Place Empowerment Organization for another project, that survivors, they wanted information. They wanted access to resources, and they wanted support, and that no one had asked them about these issues.

Some of the training we have done -- to take you back, Illinois had one of the SAMHSA reducing coercive practices grants for the State hospitals, psychiatric hospitals for three years, and they were doing a lot of work on creating trauma-informed services. And we sort of piggybacked our training on top of theirs. And they said they hadn't thought about current exposure to domestic violence, whether it was from a partner or family member or someone in the person's network. So it just added another layer.

Next.

So, again, common roles, different focus depending which field we come from, and obviously, for survivors, all of those issues are potentially salient.

How much time do I have left? How much?

MS. NEVINE GAHED: I've got 5 minutes.

DR. CAROLE WARSHAW: Okay. I better go through these quickly. When I'm doing them myself, I can go much more quickly.

[Laughter.]

DR. CAROLE WARSHAW: You know what I am going to do? I am going to -- it is easier if I don't do it that way. I am going to just talk from -- why don't you go to the next one? One more, two more. Next one. Next one. Okay, this one.

One of the things that -- one of the ways that we have been thinking about is that when you use the DV framework it is adding in all of the things that we have been thinking about, that I just talked about. When you add a trauma framework, you add the injury model and understanding symptoms as

adaptations.

When you add in the perspective from the disability rights movement, it raises issues around universal access and inclusive design and the ADA, which has been very helpful to advocates in thinking of this as a human rights issue, which helps undercut the stigma.

And then the other piece we have been adding is working with mental health care support advocates in trying to develop peer support models for addressing both trauma and safety. And then there is a book called “Safety Planning with Battered Women,” by Jill Davies and Eleanor Lyon, that really talks about women-defined advocacy and comprehensive solutions. So how do we meet people where they are, rather than follow the silos that we have?

Next slide.

So what that means is when we add a DV/social justice perspective is we design services that foster safety, empowerment, and accountability, perpetrate accountability and social change. When we add a trauma lens, it is designing services that take

into account the impact of trauma across the lifespan on survivors, on providers, on organizations, and ways to counteract those effects.

Then when we add in the disability rights, consumer advocacy peer support, then it is designing services that actively counter stigma, foster recovery, are fully inclusive and welcoming, and have survivors at the home, and that, again, with cultural attunement, ones that are culturally relevant and attuned and that actually meet people where they are.

So next, let us go -- this is my Roger and Maxine slide. They're here. I just have them up so Roger can see that they're --

[Laughter.]

DR. CAROLE WARSHAW: So I have two more quick things I want to do. One is when you're looking at a trauma in a context -- next slide -- of domestic violence.

Next slide. Next slide.

Often the trauma is not post, and symptoms may be an appropriate response to ongoing danger and victimization. So you hear a loud noise and dive

under the table. If you are coming back from Iraq, it's probably PTSD, and if you have just left an abusive partner, it may be that you are being shot at.

But also the overreaction to minor stimuli that is considered part of the disorder may be an exquisite sense of radar that you've developed that may keep you out of the emergency room the next time. So we only use a clinical lens. We depoliticize and take out the social context, and we lose the context of recurrent social retraumatization.

Next slide.

So when we're looking at empowerment in context of child sexual abuse treatment or the reframe the borderline personality disorder, what is liberating is understanding the childhood antecedents of everything that is going on in the present so you can free yourself from that.

Next slide.

But when someone is still under siege -- keep going with the -- then that can be victim blaming. So, again, it's context. When someone says, "This is the third time I've been in a situation.

What can I do?" Versus "what are you unconsciously doing to get yourself in an abusive relationship [inaudible] to safety and support?" So, again, it is the kind of nuanced layers.

Next slide. Go through that quickly.

So we're talking about reenactment or reentrapment. I was once on a panel with [inaudible] and Sandy Bowman, and they were talking about reenactment. And I said, "Well, what about reentrapment?"

So next slide.

So why is it okay for a perpetrator to target people who have experienced more violence in their life since childhood? And again, people try to stop the abuse, manage the impact, and then escape. So it is that kind of reframing from a DV perspective.

Next slide.

So, again, we have moved from a biomedical phenomenon, to a response to the trauma of abuse, to a response to the social realities of entrapment and isolation and danger -- next slide -- and then adding in the kind of micro-trauma of racism and homophobia

and stigma. So how do you walk through the world when you keep being re-violated? Again, so how do you heal when you are still under siege?

The triple traumas [inaudible] so are we talking about traumatic triggers? Are we talking about ongoing revictimization? Are we talking about individual disorders that cause disruption of functioning or ongoing adaptation to the traumatic social conflict? So, again, it's always keeping those in mind.

Next slide.

And these are kind of all the things that we're working with an individual survivor who is dealing with all of these complicated things.

Next slide. We will skip these. Go to the end. I'll just go to the end.

But the thing I wanted to talk about in my last minute or two is some of the projects that we've been doing. I mentioned the health department project, and that took a long time, a lot of thoughtful planning, a lot of working out information and sharing agreements, a lot of working out informed

consent and confidentiality, a lot of cross training on trauma and culture to have this project where the people worked together.

And part of what we did was we had done a lot of intensive training. People had done -- created a lot of change in their agencies, and what they said was it is not enough for us to actually change practice. And we listened to people talk about their -- do presentations about people they were working with, we realized they just didn't have the sophistication to deal with such complicated issues. These people who were very committed to the work and were very overwhelmed.

So we hired someone, a wonderful person, Terri Pease, who was on site three times a month in all six agencies as a consultant. And it made a huge difference, but then we thought that the supervisors would be able to carry that after a year, and they couldn't do it. They just [inaudible].

And so, again, it's thinking about what does it mean to do capacity building in under resourced agencies? And how do you have a clinical supervisor

structure that is not -- that is either on-site or that people can contract with to actually hold and carry that?

And how do you do that kind of supervision in a reflective practice model so that people feel safe enough to be open, to be themselves, and then create that in their agencies? And I know that a lot of what Roger does in trauma-informed practice addresses those issues.

Another project that we're doing with the OBW funding is to create collaborative models with a DV program, a State psychiatric hospital, and a community mental health center using the peer support, recovery support specialist. And Shirley is involved in that project.

We haven't gotten to the implement stages to work with Mary Ellen Copeland to use WRAP to create a DV safety plan version of that and work with recovery support specialists and create models where people could be cross trained and advocates could be supporting each other in each system.

Another project that we're working on is the

Child Trauma Capacity Building Project. Susan Blumenfeld from our shop has done two curricula, one with Patricia Van Horn from UCSF that is for advocates and really supports the parenting capacity of mothers. And so, their model is one of the national child traumatic stress evidence-based practices that really supports the parenting capacity of mothers of young children exposed to domestic violence.

And that model is we did a 2-day intensive training and then have a peer supervision group that meets once a month for 18 months. One with the clinical supervisor in each of the DV agencies and one with the staff who worked with kids in a kind of parallel process, and we're doing an evaluation of that.

And then the last one is a multi-State initiative that we're doing from our national center, working with officially eight and another couple of State domestic violence coalitions, helping them build collaboration with their State mental health systems and with programs and local mental health partners to address all of the issues internally to each agency

and to develop the kind of community collaboration and State-level collaboration that can actually try to institutionalize some of those changes. So I will stop there.

MS. KANA ENOMOTO: Thank you very much, Dr. Warshaw.

Do we have questions from our group? I will just start with a question. You talked a lot about mental health, and I see there are some little nuanced references to substance abuse in the slides, but we didn't really get to talk about it. When you are talking about mental health, do you mean mental health and substance abuse, or are you really bifurcating between the two?

DR. CAROLE WARSHAW: Well, because our expertise hasn't been in substance abuse, we haven't focused on it. But we know that is a critical issue, and a lot of our partners are doing projects that are focusing all of those issues. So Stephanie is on our advisory, our steering committee, and so we are planning to bring her into our multi-State initiative to help us develop that capacity.

There is also another woman, Patti Bland, who is working with a lot of the States that we are working on it domestic violence and substance abuse. So we're figuring out ways to kind of combine that work.

So you are absolutely right, and it has really been a deficit in our own capacity right now that we're trying to address.

MS. KANA ENOMOTO: I was just wondering if there is any sense of the scope of the issues there. Are people using -- I would imagine people --

DR. CAROLE WARSHAW: It is complicated.

MS. KANA ENOMOTO: -- who are victimized are also using substances to cope.

DR. CAROLE WARSHAW: That is a huge issue. And it is again similar to -- what DV programs have done is often excluded people. And so, as programs are developing more capacity and getting training, they are either including women who are using or developing special programs, hiring substance abuse counselor, partnering with the substance abuse agency.

So people are starting -- but what has

happened is it has been kind of siloed. So there is like, “Okay, now this is an issue. So I have got to figure out how to do this, and there’s funding for this.” And so, having it be more integrated, as it is [inaudible] is really critical.

I think that is partly why, you know, the SAMHSA women, violence, and co-occurring disorders multi-site programs that started out with where women are and adding all of the layers are much more comprehensive. One response of the agencies is -- they weren’t designed to be comprehensive. So one of the things that we have been pushing as part of a national dialogue is that if you are going to provide services that are fully accessible, then they have to be comprehensive.

Their notion was, well, we just need shelter and some resources, and we should be able to go on our way. And even some of the State administrators think, well, why should we put resources to comprehensive services when we could serve most of the women the way we are, which isn’t true.

So, again, it is pushing to get people to

think about, okay, then we have to rethink what the nature of this is or the nature of partnerships that we've stayed away from because we don't trust them because the information has been misused in the past.

MS. GAIL HUTCHINGS: I am quite sure this is something that we haven't talked about. So we know that the domestic violence shelters have often screened the women out, are not providing services for substance abuse. But on the other hand, substance abuse providers also don't assess for domestic violence and have a lot of mythology. Someone gets clean and sober, then the battering stops and all this kind of stuff.

Do you get many people asking anyone -- do you get people in the substance abuse field asking for training in domestic violence?

DR. CAROLE WARSHAW: Yes. Yes.

MS. GAIL HUTCHINGS: Okay, good. Because that is the weakness also on the other side of this is --

DR. CAROLE WARSHAW: No, you are absolutely right. It's both ways. Especially on mental health,

they ask about childhood trauma and not about current domestic violence.

MS. GAIL HUTCHINGS: Current, right. Or they don't know what to do. It's fragmented. And yet we're all seeing the same person.

DR. CAROLE WARSHAW: Right.

MS. GAIL HUTCHINGS: The women we're talking about are in all of these systems getting little pieces of help.

MS. KANA ENOMOTO: I think it was interesting when we had our meeting on the trauma-informed systems guidebook, there was a very strong temptation for the group to kind of devolve into a 3-hour conversation of defining trauma because it just started to go kind of around and around and the experience, is it childhood? Is it adult?

And it is very challenging. It is all of these things. It is the refugee experience. It is current domestic violence. It is childhood sexual abuse. But how do we come up with language that is meaningful and yet inclusive and conceptualizes?

Because I think many people are still in

their trauma as well. You know, there is the DV silo, and there is the child trauma silo, and the disaster silo. And they're all kind of different -- different parts, different conceptions of trauma, and getting ourselves over that hump and appreciating the nuanced difference. And you have also then the commonalities and that the intersection with all of these other issues, the addictions, the criminal justice, the mental illnesses --

DR. CAROLE WARSHAW: Yes, they're all -- a part of it is they get carved out because one of your colleagues is the one doing that. So you are trying not to step on their toes, but then figuring out ways that we all work together is clearly what was needed.

One of the things that's interesting, you know, OBW has a disabilities grant program and that a lot of people who are doing the disability work are now coming around to think about trauma. So it is interesting.

There is a New Yorker's cartoon about trauma. It is a news correspondent sitting at the news desk, and there is a little tiny chicken there,

and it says, “Now here is our environmental correspondent with some alarming news about the sky.”

[Laughter.]

MS. KANA ENOMOTO: Well, thank you very much, Carole.

[Applause.]

MS. KANA ENOMOTO: Now it is my pleasure to introduce an old friend, Dr. Linda Teplin, who is very well known for her work on psychiatric epidemiology in the criminal justice population. She is the Owen L. Coon Professor of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine at Northwestern University, where she directs the psycho-legal studies program. And her work look in the interface between criminal justice, mental health systems, substance abuse is very well respected and supported across multiple Federal agencies.

We’re fortunate to have Dr. Teplin here. She is the recipient of an NIMH MERIT Award, the APA career award for distinguished contributions to research in public policy, the NAMI Young Scientist Award, and the National Commission on Correctional

Healthcare's Bernard Harrison Award of Merit.

Dr. Teplin?

DR. LINDA TEPLIN: Thank you.

Well, it is a pleasure to be here today. We are old friends with SAMHSA. They have supported our research for -- hello, Gail. I didn't see you sneak in. They've supported our research for many, many years. So I'm delighted to be at this important meeting and share some of our key findings with you.

Most researchers are pretty boring, actually.

[Laughter.]

DR. LINDA TEPLIN: It's okay. You can admit that. It's all right. But for many years, we've studied very interesting topics. We've studied criminalization of the mentally ill. We have studied prevalence of psychiatric disorders among men in jail, among women in jail. We've studied violent victimization, perpetration of violence.

So, actually, at cocktail parties, instead of having people hide from me, they actually often approach me and say, "Well, what are you studying

these days?" When we started the Northwestern Juvenile Project, I was very proud of this study, and I would explain that we were studying mental health needs and outcomes of youth processed in the juvenile justice system.

And invariably, they would get a dazed look in their eye, but they were able to mutter politely, "Well, don't we know that already?" And surprisingly, we don't because if you look at all of the articles that have "delinquency" in their title, most often they are looking at general population kids, to look at who becomes delinquent. And nobody to date, really, I always joke that our study is not the best study of mental health needs and outcomes of youth in the juvenile justice system, it's not the best. It's the only one.

When we first began planning this study and I realized that everybody else studied general population kids to see who becomes delinquent, I then began to think, well, maybe these kids, these very high-risk kids are studied and they're captured in studies of the general population. Maybe they're

studied in investigations using school-based populations or in studies where they sampled using household-based surveys.

And I began to think about this and realized that not only had no one studied detained kids, but these kids were not even captured in general population studies. And that's because when you think about it, they're not part of school-based studies because if they're truant, they can't be sampled. And a lot of these kids are truant. If they're detained, they can't be sampled. They're not part of household-based surveys because usually they belong to families that are so highly mobile that they can't be drawn.

And what's ironic is that even if these kids become part of general population studies, they are lost to follow-up as soon as they become detained. That's because HHS, in their effort to make sure that correctional populations are not abused in research, have very strict regulations governing what kind of research can be done, and you need special permission from HHS to retain people in your study once they become incarcerated. Relatively few researchers of

general populations go through that difficulty of obtaining those special permissions.

So, ironically, here we have a situation where detained kids are among the highest-risk kids in terms of having mental health needs and having poor outcomes. They're not likely to be sampled in studies of the general population. And even if they are sampled in studies of the general population, they're gone from those studies and simply categorized as lost follow-up.

So when we started planning this study, which was actually -- the planning started in 1994, we were amazed to see that so few studies have looked at detained kids.

Today, I'll be presenting some background data demonstrating why these types of studies are so important and then also waltz you through some of our key findings. If you have questions, be sure to send me an email. I'm also glad to send you PDFs electronically because many of the data that I'm presenting today, we actually have articles on, which will provide you more information.

Let's start by just giving you a little bit of background on why it's important to study kids who are detained. What we see from this chart is that about 1.4 million cases are disposed each year in delinquency court, 1.4 million cases. That's a lot of kids.

And the 1-day count of kids who are detained on a given day is about 93,000. It's gone down somewhat, but it's still 93,000 kids are detained on an average day.

We also see from this chart that the proportion of court cases that involve females is rising. So that now it's about 28 percent of all court cases that involve females.

Now, so we want to study detained kids because there's a lot of them, but also studying detained kids is necessary to address health disparities. Because minorities, especially African Americans, are both disproportionately arrested and detained and also have other problems. So what this chart shows is that although African American -- this is for females only -- comprise about 13 percent of

the population, African-American females comprise 33 percent of females who are detained, juveniles and adults.

By the way, for males, it's even a greater disparity for males. It's about 12, 13 percent of the population, yet they comprise, African-American males, 39 percent of males who are incarcerated. So we have this huge disparity in terms of who is incarcerated.

Also incarceration is related to many mental health problems, as well as HIV. So that African Americans suffer disproportionately from the HIV epidemic, and African-American women especially -- it won't go.

[Pause.]

DR. LINDA TEPLIN: And African-American women especially suffer from HIV. So the rate of HIV among women in corrections is nearly double that of HIV among males.

So, today, what will I present data on? On psychiatric disorders, on the baseline interview where they had just been detained. I will be presenting information on psychiatric disorders and the follow-up

interviews, and then I will present information looking at death rates and other outcomes.

So let me take you, describe a little bit about our study. Again, in our articles, we have much more information. It took a stratified random sample of kids as they entered detention here in Cook County. We had terrific cooperation from Cook County, and they actually let us park in their detention center for 2.5 years, gave us offices, and allowed us to take a random sample of kids.

It was stratified, meaning that although it was random, we over sampled certain groups to have enough people in that category to analyze the data. Ironically, by the way, usually in a lot of research they over sample minorities. But in corrections, you have to over sample whites.

So we over sampled girls to make sure that we would have a large enough number. We over sampled non-Hispanic whites. We over sampled younger kids, and we also over sampled kids who were processed as adults.

That’s an important category because kids

processed as adults are disproportionately African American because many of the crimes, especially at this period of time when we collected the baseline data -- it was ’95 to ’98 -- in those days, many crimes that involved selling drugs near a housing project, selling drugs near a school would result in automatically being transferred to adult court.

Now if you live in Kenilworth or Winnetka and you sell drugs, changes are it’s not going to be near a housing project. But if you’re a poor kid living in the inner city, then that’s far more likely to get you transferred into adult court.

We had a very low refusal rate. We had independent interviewers who administered the Diagnostic Interview Schedule for children, parts of the DIS for substance abuse disorder, as well as a long list of other instruments. The refusal rate was extremely low, and not only because we paid these kids. We paid them $15 for the interview when they entered the study, $10 for a urine sample, which we tested for drugs. But that wasn’t why they participated.

So many of our kids said to us, “You don’t have to pay me. It’s enough you listen.” So for many of these troubled kids, they’ve not ever had an adult who sat with them for 2 or 2.5 hours, or however long the interview took, and really listened to their problems.

This is a longitudinal study, meaning that we have actually been tracking and re-interviewing our subjects since we enrolled them between ’95 and ’98. And what is unusual about our study is that unlike other investigations where subjects are dropped when they’re incarcerated, we re-interview everybody when their interview is due, irrespective of where they live.

So if they’re on the eighth floor of Cabrini-Green, and we have to trek up eight floors of urine-soaked hallways to get there, we go there. If they’re down in a prison down in the State of Illinois, we go there. If they’re back in Cook County Jail, we go there. So we keep everyone in our study.

And because of that and because I have a wonderful associate director who organizes the field,

Karen Abram, we have a participation rate in the follow-up interviews of between 82 and 97 percent, depending on the time of follow-up. So we have a very good participation rate. It's a quite unusual project.

This slide shows the demographic characteristics of the sample, and again, remember that we over sampled females. We over sampled non-Hispanic whites. We over sampled younger kids, and we over sampled kids who were processed as adults.

Next, please.

This shows the prevalence of disorders at the baseline interview. And what we see, interestingly, is that girls have larger prevalences of many disorders, larger than boys. The bottom-line statistic here, and these data were published in the Archives of General Psychiatry, is that about two-thirds of males and about three-quarters of boys had one or more of the psychiatric disorders that we assessed.

Also, comorbid disorders are the rule, not the exception. People who are researchers often

recoil when they see this slide, but let me tell you, the bottom-line message of this. This slide shows the overlap of disorders. If this slide showed circles that did not overlap, that would be good news because that meant that people have one or another disorder, but not more than one.

The degree of overlap here demonstrates that most of these kids who have one disorder also had another category of disorder, which makes them very difficult to treat. This is the slide showing the comorbidity among males, and the next slide shows patterns of comorbidity among females. What's important here is that the patterns of comorbidity differ for males and females. So not only do the prevalences of disorders differ, but the patterns of comorbid disorders also differ for males and for females.

Patterns of substance use disorders, comorbid substance use disorders also differ for males and females. This slide, again, is another Venn diagram, and once again, it is another very bad news slide because it shows that so many of these kids who

have one substance use disorder -- and remember, this is disorder, not just use, which means it's abuse or dependence. So many of these kids who have one substance use disorder also have another substance use disorder.

We found that a lot of these kids needed mental health treatment. We actually ran an analysis. These data were published in the American Journal of Public Health, where we wanted to see among kids who had really serious disorders, major affective disorders, psychosis, in that group of kids where nobody could argue that they needed treatment, what proportion of them received treatment?

We found overall that only about 19 percent of kids who needed treatment received it either in the detention center or within 6 months after they returned to their communities. Interestingly, girls were much more likely to receive services than boys, probably because of the special programs that they then had down at the detention center.

This slide shows the prevalences of disorders between the baseline interview and the -- I

can’t read it, actually. Is it the 3-year or the 5-year interview? I can’t actually see it here.

Thank you. So what we see is that the disorders drops, but that, in fact, they are still highly prevalent. And so, for example, just under 20 percent of the females 3 years after the baseline interview had a substance use disorder, and about 15 percent of them had an affective disorder.

Next, please.

That prior slide was about prevalence. This slide looks at the persistence of disorders. In other words, this slide looks at individuals to see among youth who had these disorders at baseline, what proportion of them persisted in these disorders. And what we see is that persistence is extremely common, especially for substance use disorders, and that’s the case for both males and females.

We also see that if you look at the bottom line that about half of girls and about half of boys who had one disorder at baseline still have one or more disorders by the 3-year follow-up.

We also looked at the development of

disorders. Here, what we mean by that is among kids who didn't have a disorder at the baseline interview, what proportion of them had a disorder at follow-up? And here again, for some categories -- not affective, but the other ones -- not affective or anxiety, but the other ones, the girls seemed to do a little bit better than the boys do. But we still see that nearly one quarter of girls who didn't have a disorder at baseline had developed one or more disorders by the follow-up.

HIV risk behaviors are a key feature of our study, and our findings are quite alarming. We have a couple of papers published on this -- one in AJPH, one in the medical journal Pediatrics. And the bottom line is that these kids are at great risk of contracting HIV as they age. And that's critical in terms of understanding their needs for substance use treatment because so many of these kids have substance use disorders, which then result in their engaging in HIV and AIDS risk behaviors.

Many of these kids are also reincarcerated. So this looks at reincarceration 5 years after the

baseline interview, and about more than half of African-American girls were reincarcerated one or more times. Thanks.

Death. You can't read this slide, and that's because we've had so many deaths that I had to keep decreasing the font. To put these death rates into perspective, the Columbine shootings and incidents like those, which resulted in a National Academy of Sciences panel -- I was actually on that panel, and all of us were embarrassed at being on that panel and studying the Columbine shootings because over 20 years in the entire country, the Columbine shootings and other incidents like that took the lives of fewer than 200 people, fewer than 200.

In my sample of 1,829 kids over about 11 years, 94 have died -- 94. And deaths occur among females as well as males. We have a paper on this published in Pediatrics, where we found death rate in our sample of girls was about 8 times that for a demographically adjusted general population sample, about 8 times.

Let me just say a few words about

implications for public health policy before they shut off my mike.

[Laughter.]

FEMALE VOICE: I'm sorry, but I just can't help this, and I'm sure you're going to talk about it. But I think it's so important to know what these kids died of and how violent this was. And we talk about integrating primary care all day and now it's 25 years lost to side effects from not adjusting primary care. These are violent deaths.

DR. LINDA TEPLIN: Right.

FEMALE VOICE: So it's the polar opposite really of what we're doing. I'm just sorry. Can you say what all these deaths mean?

DR. LINDA TEPLIN: Exactly. Could you please advance another, two more slides? That one, the next one. Great. Yes, 95 percent of our kids die from homicide or legal intervention. And we have another pie chart where we compare it to the general population. The general population kids died from auto accidents and disease, by and large.

A few words about implications. People say,

"Well, what are your recommendations?" The first recommendation actually is not for detention centers. Rather, it's for the community because so many of these kids are detained, especially the girls. They are abused at home. They run away to support themselves. They get involved in drugs. They get involved with bad partners. They get involved in prostitution and the bad lifestyle associated with that.

And so, who is detained? It's poor kids. When you go into a detention center in any city, you are shocked by the paucity of non-Hispanic white people. You know, there is probably no one in this room whose kid would go to detention. Chances are you would be able to facilitate them getting treatment instead of going to detention, or else once they were at the police station, you would have your lawyer there.

I actually know lots of kids of my friends who get into trouble. I do not know any of those kids who have ever been detained.

And so, what happens is that these kids get

detained because of the paucity of services that are provided for them in the community. And all the systems are problematic -- primary care, the school system, child welfare system, the larger mental health care system. When these systems fail, these kids fall into the cracks, and they fall into the juvenile justice network.

The second recommendation is to provide services in detention for kids who are there. That means screening. It means treatment. It means services that are different for girls and boys because their treatment needs are different, as I've demonstrated. And it means especially treatments designed for kids with comorbidity because what we saw from the Venn diagram is that comorbid disorders are the rule and not the exception.

Lastly is to make sure that kids get linked up with services when they leave. Otherwise, they're going to fall through the cracks of the care-giving systems and simply go back through the revolving door into the detention center. These kids are often not welcomed by the community mental health system. Many

of them, as I said, have comorbid disorders, which are often difficult to get treated in the community.

But we must provide services for these kids because they're not going to be detained forever. On average, these kids are released within 2 weeks. So it's not as if we can forget about them because they're locked away, and they're never going to make problems for the good people in the community. They're back out in the system.

Finally, just to mention that these services, although not being cheap, are so important in the long run, when we did our first 3-year follow-up interview, we interviewed a lot of our girls where they lived in apartments. And remember, these kids were 10 to 17 when they entered our study. So they were now 13 to 20. All of these girls had one or two toddlers running around, or more. And most of them were pregnant again.

So that we must provide resources and treatment programs and fund the kind of programs that SAMHSA funds to look at treatment effectiveness to break the cycle of disorder.

Thanks very much.

[Applause.]

DR. LINDA TEPLIN: And you're right, I missed the clicking, too. I can use dramatic pauses when I'm in control.

[Laughter.]

MS. KANA ENOMOTO: Britt?

DR. BRITT RIOS-ELLIS: Yes. I'm curious. Did the comorbid patterns that you showed up on the screen, did they differ by ethnicity or race?

DR. LINDA TEPLIN: Yes. Interestingly, the non-Hispanic whites have more disorders and a greater degree of comorbid disorders. And that really reflects the bias in terms of who gets detained. Because what kind of white kid gets detained? It's someone who is really pretty messed up, compared to the African-American youths for whom detention is not normative, but approaching being normative.

There was one study published in JAMA that looked at poor inner-city African-American males that found that 1 out of 4 were arrested one or more times before age 18. So we have a lot of information on

that. And actually, I can send that to you. We have a paper on that.

DR. BRITT RIOS-ELLIS: And I have one more comment. On the HIV data, you showed some HIV/AIDS data. And so, that's either --

DR. LINDA TEPLIN: Those are risk -- well, initially, that slide was on HIV infection, and those are from CDC statistics. However, we added a great many items on risk behaviors in our sample. So we have several papers published on risk behaviors engaged in by our subjects.

DR. BRITT RIOS-ELLIS: Okay. I just want to -- about 40 percent of the Latino population is missing from the HIV data just because of the name-based reporting. So just when I looked at that, I thought, wow, the numbers are coming out -- as more States go on named based, we're seeing much higher numbers.

DR. LINDA TEPLIN: But there's a new paper published in JAMA that now extrapolates to all 50 States based on the other reporting, and what they found is that the number of cases of HIV are 40

percent higher than they thought with this new count.

DR. BRITT RIOS-ELLIS: Yes. And they're probably higher in certain groups.

DR. LINDA TEPLIN: Absolutely. Absolutely.

MS. KANA ENOMOTO: Stephanie?

DR. STEPHANIE COVINGTON: Linda, one of the early slides, you were comparing the girls and the boys, and there was one comparison there that surprised me. The girls had more behavioral issues than the boys. Slide number 9. And I would have thought that boys would be -- all the other things, the anxiety, the depression, that made sense to me. But the percentage --

Could you -- slide 9? I'm just curious what you were looking at there. Nine.

DR. LINDA TEPLIN: It was just a slight difference that would not have been significant, statistically significant.

DR. STEPHANIE COVINGTON: Okay.

DR. LINDA TEPLIN: So you're talking about the prevalence of disorders on this slide?

DR. STEPHANIE COVINGTON: Yes, right. And

it says behavior --

DR. LINDA TEPLIN: This is not a statistically significant difference.

DR. STEPHANIE COVINGTON: Right. But what were you looking at behavioral there?

DR. LINDA TEPLIN: ADHD, conduct disorder, and two other subcategories -- oppositional defiant disorder.

DR. STEPHANIE COVINGTON: Things that I always think of more with boys than girls.

DR. LINDA TEPLIN: Well, they are. But remember, think about what kind of girls end up detained. Again, we found that the girls on average had more disorders than the boys because what kind of girl ends up detained? It's often one with a great many problems.

DR. STEPHANIE COVINGTON: Right. But even the girls that I've seen in a lot of these detention centers -- I don't know. That just surprises me.

DR. LINDA TEPLIN: I could check to see if that's statistically significant because there will always be some differences. The issue is whether

they’re systematic or random. So I can check. And actually, we have a paper on this that would run that test.

DR. STEPHANIE COVINGTON: Okay. I’ll send you my information.

[Laughter.]

MS. GAIL HUTCHINGS: Linda, first of all, thank you very much.

DR. LINDA TEPLIN: Thanks for all your support over the years.

MS. GAIL HUTCHINGS: I’ve always been so impressed and grateful for probably one of the most stunning research --

[Laughter.]

MS. GAIL HUTCHINGS: Can you remind me -- first, I was surprised because I guess I had forgotten about 2 weeks being the average stay --

DR. LINDA TEPLIN: For kids in detention. For adults in jail, it’s 3 days.

MS. GAIL HUTCHINGS: Where do they get discharged to typically?

DR. LINDA TEPLIN: Their home. Their home

or some relative or friend comes to pick them up.

MS. GAIL HUTCHINGS: Under supervision usually or no?

DR. LINDA TEPLIN: You mean court supervision?

MS. GAIL HUTCHINGS: Yes.

DR. LINDA TEPLIN: It varies. Yes, it depends. And that's the median length of stay. So some kids are in for a long time. Some kids are out -- if the family is savvy enough to get an attorney, they're out right away.

MS. KANA ENOMOTO: Thank you very much, Linda.

DR. LINDA TEPLIN: My pleasure. It's lovely to be here because SAMHSA was so important to us in terms of our getting our study going. So I'm delighted to be here. Thanks for this opportunity.

MS. KANA ENOMOTO: Thank you.

And I think it's a nice tie-in to talk about some of the issues that we see with these kids, and now Janelle Prueter is going to talk to us about alternatives for safe communities. What we can do for

people -- what these needs are for people who are incarcerated or who are on their way back into their communities. It's a nice partnership that you have with the Illinois Department of Corrections and the community service providers in the Windy State.

So Ms. Prueter develops and implements plans and programs that help formerly incarcerated individuals successfully reintegrate into their communities and reduces recidivism in the State of Illinois, which it's startling to see from Linda's data that 95 percent of African-American boys are re-arrested within 5 years. And that's tragic. So it's important to hear about things like what TASC is doing to bring those numbers down.

MS. JANELLE PRUETER: Great. Thank you. Thank you very much for asking me to be here.

I had the same thought. I'm like this is a perfect order because now I get to talk a little bit about some of the programs and the innovative things that we're doing in Illinois related to not only reentry, but services across the justice system and in different types of court systems throughout the State.

That predominantly we work with people affected by mental illness, substance abuse, domestic violence, and most of the other issues that come with women attempting to reenter and be successful in their communities. TASC is -- if you're not familiar with TASC, we are an independent case management agency that specializes in -- oh, I'm sorry.

Next slide. I'll try to remember to do this. And you can go all the way to the -- yes.

That really specializes in working with people that have behavioral health issues that are involved in the justice system. We -- Illinois TASC has been in business since 1976. The TASC programs throughout the country are actually independent TASC programs. So there are 200 TASC programs throughout the country, but Illinois is the largest and the only State-wide TASC program that exists in the country.

Just, I thought this was just interesting to note because it gives us a particular kind of credibility to the work that we've done in Illinois, but we have actually been named as the designated agent to provide substance abuse case management for

both probationers and parolees in the State of Illinois. So on the probation side, we're designated by the Illinois Department of Human Services to provide substance abuse assessments and treatment recommendations for the courts throughout the State of Illinois, and that's actually found in statute.

And then the next slide, also in an administrative role, we're the designated agency to provide assessment and case management services to people being released from the Illinois Department of Corrections on supervision.

Just a little bit about our overall services before I get more specifically into some of the programs where we serve women. I'm going to talk mostly about women. I neglected to bring girls into the picture today, but if we have time, I'll talk a little bit about that.

In Fiscal Year 2008, we served over 28,000 clients in the State of Illinois in 30 programs. Almost all of those clients were in justice programs. We have some health programs that are not related to justice programs, but predominantly, our emphasis is

on clients in the justice system.

And as you can see, overall, 20 percent of those clients were women or girls. So not as many women and girls served in our programs. It was interesting because, given the amount of presentations that we do in our agency, when I was asked to do this, I sent around an email, and I said, “Okay, who’s got a presentation on women and girls?” No one.

So I really appreciate the opportunity to start thinking about what do we need to do at our agency to make sure that there is a greater emphasis on our work with women and girls because, clearly, that’s something that’s been underrepresented even in our own agency.

So specifically related to women and girls, we had 15 programs that serve either women and girls in the justice system. And if you think about the justice system as a continuum -- and I’ll talk a little bit about this -- they fall all throughout the continuum of the justice system from early intervention to people on parole to people -- or I’m sorry, people on probation and then people that

advance in the system and are on parole. So we're really located throughout the justice system with an emphasis of trying to move people out as early in the process as possible.

So that, hopefully, if somebody comes in and they get into a program like the drug school program I'll talk about, our goals is to have them be successful and exit the justice system very quickly. But as they advance, there are other interventions along the way that we provide and serve people, again, with the ultimate goal of getting them out of the justice system and not having them advance in the justice system. But as we know, not everybody is successful in doing that.

So I'm going to talk about three of our programs today that really focus a lot on serving women. One is the Recovery Coach Program, which we do out of the Cook County family court, the abuse and delinquency court, and then also recently expanded to the Metro East area outside of St. Louis.

I'm going to talk about something that -- the Recovery Coach Program is much my passion. But my

current passion is the women's reentry services that we're doing in the State of Illinois and then talk a little bit also about the mental health court, which if you're not familiar with that, it was really founded on a drug court model designed to serve men and women that have co-occurring disorders, and I'll talk a little bit about how that program is set up and why that is so unique.

So let me start with the Recovery Coach Program. Again, this particular program we do out of the Cook County abuse and delinquency courts, and the majority of the clients in this program are, in fact, women. It tends to run about 80 percent women and 20 percent men, which was interesting because when we were asked to design this program, I never -- the thing that never occurred to me is that we'd actually have men in the program.

So we did some modifications to ensure that we were providing gender-relevant services for them, but 20 percent of the population is men and 80 percent of the population is women. This particular program we do with the Illinois Department of Children and

Family Services, but it's actually funded on a IV-E Federal waiver, which makes it a little bit unique, and I'll talk about some of the implications of that in a minute.

But the Illinois Department of Children and Family Services contracted with us to create what we call recovery coaches, which are really designed to work with the parents, to have them address in the beginning predominantly are their substance abuse issues, but now also there is a very heavy emphasis on mental health and domestic violence in that program. So working with them to access the services that they need, be stable, and hopefully, in the end, be able to reunify with their children, if that's what's appropriate.

And so, we're the independent case management agency that links them to all of those services and provides kind of like the hub, if you will, to all the necessary services that a parent may need to ultimately become reunified with their children.

We work in collaboration with the

caseworker, with the child welfare worker, but we're not a replacement for them. So they have a very important and distinct role in the case. We tend to look at ourselves as the clinical experts, the clinical experts around substance abuse, mental illness, and domestic violence.

One of the things that I love about this program, which is sometimes difficult to pull off programmatically, is that the person that initially gets the case -- the recovery coach that initially gets the case is assigned to that case for the life of the case. So only when we have turnover is a case reassigned.

And oftentimes, we tend to segment sometimes our larger programs into assessment and placement and case management. In this particular program, one person follows the family through the life of the case, and I think that's one of the reasons it's very unique and also been very successful.

We provide assertive outreach, engagement, and reengagement. And I do mean by that hitting the streets. This is not an office-based program.

Probably one of the most interesting experiences that I had in the program is when we first decided to hire the peer recovery-type person to go out and really see if they could be more effective in engaging people and pulling them back into the program. And the first person I hired, I gave her 32 cases. And I kind of said, “Good luck, I hope you can find these people.” And she went out and found 25 in the first 2 weeks and was able to reengage them back into services.

So there is a clinical case management component to it, but there’s also very much of a peer support component to it. And then I think that’s good. We can go on to the next one.

Some of the specific interventions that I haven’t covered. Let me see if there’s anything else. We do do a comprehensive assessment to determine what the needs are and to make sure that we’re addressing all of those needs. There is a very heavy drug testing component to this program because it involves parents attempting to reunify with their children, and the court is very interested in ensuring that the

parents are, in fact, not continuing to use substances. And then, in this program, we also provide court testimony, and we work a lot with the courts to help them make the appropriate permanency recommendations.

So how are we doing?

Next slide, please.

There is also a dedicated research component to this program because it is a Federal IV-E waiver, and so there are three research questions that the evaluators are ongoingly looking at. And one is, are parents in a demonstration group more likely to access treatment services? And what we're seeing is that, yes, they are.

Seventy-one percent of the parents in the demonstration group in the Recovery Coach Program access treatment versus 52 percent in the control group. That is, overall, a very high number. That we're getting 71 percent of the parents we're working with actually into and started in treatment.

The parents are -- this is the stat that really breaks my heart in a lot of ways, but it is

statistically significant, even though very low. The impact on reunification remains very, very small. Eighteen percent of the families in the demonstration group were reunited with their children versus only 13 percent in the control.

Unfortunately, the reunification statistics in Cook County overall are dismal. Eighteen percent is actually -- when the project started, the reunification rate in Cook County was 8 percent. So while it's a lot better than what we've been able to do, it's still, in my view, very low.

And then in terms of future maltreatment, 25 percent in the demonstration group had another abuse or neglect report versus 31 percent in the control group.

And then substance exposed infants, 13 percent in the demonstration group, deliberate substance exposed infant, 21 percent in the control group.

Now the thing that's not on there and is part of the Federal IV-E waiver is that one of the conditions of the waiver is that the State actually

saves money in providing the program. And so, one of the things that is very significant about this program is in a 5-year study, the State saved $5 million by having this program. And largely, the savings were in while parents did not reunify with their children as much as we would have liked, the permanency decisions happened much quicker because the courts had the kind of information they felt they needed to make a solid permanency decision.

Where cases in the past had been continuing for 3 years, 4 years, 5 years, in this program, those numbers have gone closer down to 2 years or 3 years in the court system. So there is still some issues with that, which I won't go into now. But overall, the cost savings are very, very significant and one of the reasons why we've been allowed to continue the program and, hopefully, improve our reunification numbers as we move forward.

So the second thing I want to talk about is our women's reentry services. I'm going to move from family court to parole and reentry. One of the things that we've been really fortunate about in the State of

Illinois is over the last few years, there's been a lot of innovations with respect to prisoner reentry programs in the State of Illinois, both how people are coming in and also how they're leaving the system.

And so, because predominantly in the State of Illinois the majority of the people incarcerated are men, although, as Linda notes and as we're seeing, the numbers of women incarcerated is continuing to grow, a lot of the innovations have started in the programs that serve men. What we've been fortunate about, however, is a lot of those have trickled over into the services for women.

And so, while some of these things were initially brought to the men's programs, we've also been able to get them in and start doing some really innovative things in the women's programs as well.

It starts -- Linda mentioned screening, the need for screening. One of the things that has been a big improvement in the State of Illinois is that every person coming into the Illinois Department of Corrections is now screened for a substance abuse problem as well as mental health problems.

TASC actually provides that service at the women's reception center in the State of Illinois, but that really is something that was not comprehensive, not done very well in the past. And over the last couple of years, we've really improved that process so that when people are coming in, they're screened, their issues are identified, and then we attempt to direct them to the right program. So that while they're incarcerated, they can get the types of services they need so that their issues will be addressed, and they won't come back into the system.

One of the things, as Carole was talking, is it dawned on me I don't know what the screening is for domestic violence coming in at the women's intake. And so, that's something that I intend to take back and look at what kind of screening are we doing for domestic violence? Are we insuring? Are we looking at orders of protection? Are we asking those questions?

Because it's a big hole right now, I'm sure. I'm sure it's not being done. So I will take that back and start working on that right away.

And then, from there, what TASC does is we are in one particular institution, Decatur Correctional Center. We're accountable for doing all the pre-release discharge planning for women that are in the substance abuse treatment program there.

So they have about an 80-bed treatment program for women. It's a therapeutic community. And as the women are coming up on the point of their release, TASC is accountable for working with the treatment provider to determine what kind of services this woman will need in the community to be successful -- substance abuse treatment, mental health, domestic violence, housing.

And then we're accountable for ensuring that those services are put in place before that woman ever walks out the door. So that that woman leaves with all the appointments, not just, "Well, you should go down to the community substance abuse program." No. "You're going to see Sally at 10:00 a.m. in 2 days. That's your intake appointment."

So that there's no -- so that the bridge is very clear and defined. Because how we've mostly done

that is say, “Well, we know you have substance and drug problems, and we know you have mental health problems. So this is in your file, and here’s a couple of places. You should go there.” And it never works because they never go.

So we’ve taken on really very solid clinical discharge planning out the door, and it’s had a very positive impact. Because what we’re seeing is women are transitioning into the services that they need. They are completing those services. And as they start to address those issues, they’re much less likely to come back into the system. And then we follow them as they’re released.

So we have case managers throughout the State of Illinois, and we see the woman within 1 to 2 days of release. Sometimes in the more remote areas, that’s a little more difficult. So we may talk to her on the phone and then follow that up with a face-to-face visit within 7 days. But it’s very immediate. It’s very directed so that -- because we know that first 30-day period is so critical for them.

It is the time when most people coming out

of prison fail is within that first 30- to 45-day window. So the services are very intense during that period, ensuring that they are engaging with the services they need to be successful.

And then real quick, I've got, what, about 4 minutes? Oh, I started at 3:00 p.m. Don't I have like 4 minutes?

[Laughter.]

MS. JANELLE PRUETER: Two minutes. I have 2 minutes. I'm going to skip the women and babies program. Next slide, please. But I just wanted you to know that -- next slide, please. Okay, I get a minute back for this. Oh, it's doing that funny thing.

All right. The other thing just to tell you is that recently at the Decatur Correctional Center, there was a program started where moms are actually allowed to have their babies in prison with them. Some people think that's a good idea. Some people don't think that's a good idea.

But it allows for that initial period for the mom to have her infant there. It is a separately

segregated, very secure unit. It's beautiful. I've been there, and one of the things that we've taken on is also doing all the reentry planning for those women coming out of that program. It's new. The numbers are still very small.

But couple all the issues we've talked about already with child welfare issues and now parenting issues and you are leaving prison with your baby. So we felt it was very important while we're not funded to do that service that we provide that service for the women coming out of that program.

Okay, and then very quickly, I'm going to do 1 minute on mental health court. Okay. The last thing I want to talk about is our mental health court here in Cook County because it does serve a large number of women, women with co-occurring disorders, women that have persistent severe mental illness, as well as chronic substance abuse.

The program is voluntary. It's run like a drug court program so that there is one judge, one probation officer, several TASC case managers. So it really is run like a multidisciplinary team.

And one of the things I just wanted to highlight about that, if you could go to the next slide, and one of the very unique things about this program is the clinical crisis intervention team that is actually part of the Chicago Police Department.

So there is a crisis intervention team where there are specially trained police officers that will go out when a warrant is issued on somebody that is in the mental health court, and they're especially trained in how to deal with mental illness. So they're not going out doing the knock down the door, "Where is so and so? I need to arrest you on this warrant."

But they go from very much of a clinical perspective, knowing that they could walk into a situation where somebody has been off their medication. And so, they're trained in all the things that they need to know about mental illness so that they can approach the person in the proper way.

Now, they still have to bring them in. They're still arrested and processed back through the jail, but it tends to prevent things like additional

charges, you know, resisting arrest and all those kinds of things that sometimes come along back.

Okay, and then the final thing, as you can suspect, this program has done a lot to decrease criminal activity, hospitalizations, incarceration. And then, if you go to the next slide, some of those outcomes are highlighted. But I wanted to highlight one specific thing that’s not up there.

We took a cohort of people that had gone through the mental health court. I believe it was about 25 people. And we looked at the number of arrests one year prior to them coming into mental health court, and then what happened after mental health court. And in this 25-person sample, the total number of arrests was 112 for the year before, and the average was about 4. Post mental health court, 12 arrests total and 0.43 average per person.

So we know that this is a population that tends to get arrested over and over and over again and cycle over and over again through the jail and through the court system. And by providing these kinds of interventions, we’re able to really stop that, get

them on the right track and keep them out of the justice system.

And then, just a couple of final recommendations and challenges that I had. The criminal justice system is not a public health model. I mean, and Linda talked about we need to be treating these people in the community. This is not the right place.

Now some of these programs do very well and do very innovative things and are working. But we could do a lot better and spend a lot less money if we did this in the community. And all the things like zero tolerance and no recognition of incremental change makes it very difficult to have these kind of programs because what we have to do over and over again is educate the system about mental health, about domestic violence, about addiction. And so, it’s a big challenge and not the place necessarily to be always addressing these issues.

Some people will always be in the criminal justice system, and we need to provide these programs. They will get there because of things that they’ve

done. And these programs help get them out of the system, but at the end of the day, we'd be a lot better off doing this in the community.

Thank you.

[Applause.]

MS. KANA ENOMOTO: Are there any questions for Janelle?

It's interesting, at SAMHSA, in our conversations around healthcare reform, we invited representatives of a number of organizations that work in corrections, so ACA and NIJ and NIC. One of the things that those groups made very clear to us was that, actually, they said correctional health is public health and that these folks are part of the community. And they stay with us, many of them only stay for a short period of time, and they will come back to the community health system.

And so, we need to be working in partnership, mostly to try to keep people out of the jails and prisons but also to help manage that continuity of care because when we drop people, they just get sicker. And ultimately, it's going to cost

everybody more, not to mention the human cost.

Any other questions for Janelle, comments?

MS. JANELLE PRUETER: One of the interesting things is we have a new State director of corrections, and one of the things that's so refreshing about him is he has said at every meeting that I've seen him at so far, "Look, I'm more interested in finding programs that keep the people from coming to me. I really don't want them here."

And that was like such a refreshing perspective. He's like, "Let's figure out a way to keep them from even getting here." So he's focusing not just on what's happening in his shop, but what I can do? What can we be focusing on so that they don't ever come? So a very unique perspective.

MS. KANA ENOMOTO: Carole?

DR. CAROLE WARSHAW: I had a comment that was not related, but I didn't say that I think it's important around healthcare.

MS. KANA ENOMOTO: Okay. Gail --

MS. GAIL HUTCHINGS: Like it should be, this is a tough conversation because many people that we

work with or on behalf of do some -- their criminal acts are violent and have their own patterns of victimization that they create, and abuse is a good example of this. And I think it's kind of long overdue that we have to have a pretty tough conversation around -- there is not only a reason to keep some of these services in correctional settings for people that may end up there, but that some people need to be there.

And I know this is tough and I know it's not PC, but I think there's a balance part of this conversation that we don't always have. And part of the reason that we don't is because it's always been used against us so badly that we've never gotten to have that side. But I'm really coming out it with the crime victim being helped.

I struggle with a lot of this, too. I will sort of admit that I'm not so sure that we always have these balanced conversations because we're so -- in part, we're so worried about losing what little we have. And I have to say the women's data always reminds me that we talk about racism and bigotry all

the time. And you look at any of these stats and you don't see [inaudible] this is part of what we have to figure out, that we've accepted as a society, we've accepted this deplorable situation.

If you're an African-American parent right now, you raise your kid and know that there's a 1 in 4 chance of your boy going through the system. It's just -- and we need to talk about resiliency and blah, blah, blah, blah. And it's kind of cracking through this along with getting to the nut of these things. I guess it's a long way of saying how much I admire what you're doing, and I'm grateful for it.

MS. KANA ENOMOTO: To Carole, then Britt.

DR. CAROLE WARSHAW: I'm just thinking here, the response, what you said. Part of what happens is we talk about silos in substance abuse, mental health, and trauma, but it's also silos around services and economic policies and other political. So we're doing a snapshot and not looking at the overall picture of what creates poverty, people making decisions. It's not just there as a risk factor.

And so, one of the things that I would love

to see is that SAMHSA is not just talking about healthcare reform, but also larger economic policy issues, that we have those kinds of conversations about how you shape that because you could fix it if there was the well-to-do, and there isn't. So then we're ending up like [inaudible].

The other thing I was going to say that was unrelated was about the JAMA just came out with an article about screening for domestic violence not being effective, and the U.S. Preventive Health Services Task Force has also given it a C rating. One of the problems with that is because of trying to fit into a medical model when you screen, which needs to have certain kinds of data behind it, as opposed to why would you not ask someone what's happened in their lives that might be affecting their health and mental health?

So it's gotten so far off track, and I just want to make sure that SAMHSA is thinking about that and can weigh in on this kind of ridiculous way that things have gone. I mean, it doesn't make sense to screen if you don't know what to do when someone tells

you what's going on. But that needs to be discussed.

MS. KANA ENOMOTO: Well, we're struggling with the B-rated interventions. So if it's okay to screen for alcohol, but you know, while you're asking them if they're using alcohol, you can't ask them if they're using illicit drugs. It's challenges on many fronts.

Britt?

DR. BRITT RIOS-ELLIS: On that comment, add culture and language and immigration experience and all of that to getting screened.

I did have a question for you on the babies program, so maybe I'll give you back 30 seconds earlier. I wanted to know more about what the outcomes have been, like were the mothers -- was this leading to feeding and care practices different? Are there any evaluations around if they're more likely to breastfeed? How long do they get to stay with them, et cetera, et cetera?

MS. JANELLE PRUETER: You know, I don't have that data, and it's a very new program. There's only been probably a handful of women that have gone

through it so far. So I think that's been, honestly, one of the things that's been a little disappointing to the department is they built this whole program, and the numbers have been really small so far. And I don't really know the reason for that.

My focus tends to be more on the outside than the inside. So I'm not familiar with all of the stuff that's going on on the inside. So --

MS. GAIL HUTCHINGS: Janelle, is it -- you know, Bedford Hills in New York has a long, long standing very, very similar program. I think there has been quite a bit of data published. Is your program modeled on theirs, do you know?

MS. JANELLE PRUETER: I don't.

MS. GAIL HUTCHINGS: Women's correctional facility in Bedford Hills.

MS. JANELLE PRUETER: Yes.

MS. GAIL HUTCHINGS: I can help hook you up with some data.

MS. JANELLE PRUETER: Yes, yes. And I can get -- if you give me your card, I'll find out some of that information and get that to you.

DR. BRITT RIOS-ELLIS: I'm just curious. I have been working on this in L.A.

DR. STEPHANIE COVINGTON: Well, in California, that's become that huge politicized thing, and CIW is not going to get the baby nursery after all these years.

I just want to make a note about nurseries on the inside. There are many countries where when women go to prison, there are nurseries in the women's prisons. We are one of the few countries that does not have that. We have probably four, I think, in the country, and that's -- and many countries look at us and can't imagine that we don't provide this.

DR. LINDA TEPLIN: Especially given our incarceration rate, which is the highest of any country in the world.

DR. STEPHANIE COVINGTON: In the world for women. We have to incarcerate more women per capita than any country in the world.

DR. LINDA TEPLIN: And men.

DR. STEPHANIE COVINGTON: And men. And California has the world's largest women's prison. So

we have so much to be proud of.

[Laughter.]

MS. KANA ENOMOTO: Well, I want to give a round of applause to our panelists.

[Applause.]

MS. KANA ENOMOTO: And at this point, we do need to move to our public comment session. We have three members of the public who have requested to make comment, and I would let Nevine help us navigate that.

MS. NEVINE GAHED: Operator, what we're going to do is this is the public comment session, and we would welcome -- and I know that we have two people here who would like to make some public comments. Please try and limit them, only because we've got to rush to another facility, to another venue.

Operator?

OPERATOR: Certainly, do you want all mikes open on these?

MS. NEVINE GAHED: Let's find out if there's anyone who would like to make public comment. I think I have in mind specifically somebody from the American Legacy Foundation.

OPERATOR: If you would like to make a comment, please press *1. One moment, please.

MS. NEVINE GAHED: Thank you.

OPERATOR: Once again, to make a comment, please press *1.

MS. NEVINE GAHED: Okay. Well, maybe they're not on. So we're going to move on to the next --

MS. STEPHENIE FOSTER: We're here. We're here.

[Laughter.]

MS. STEPHENIE FOSTER: Sorry. We didn't know we were supposed to also talk. We were waiting. Sorry. I'm here from American Legacy. So I'm more than happy to do my comment now, if that's appropriate.

MS. NEVINE GAHED: It is. And as I said, if you would just state your name, and we know you're with the American Legacy Foundation. And please, keep your comments to 2 minutes.

MS. STEPHENIE FOSTER: Sure.

MS. NEVINE GAHED: Thank you.

MS. STEPHENIE FOSTER: First, could I just make sure that everyone can hear me?

MS. NEVINE GAHED: Yes.

MS. STEPHENIE FOSTER: Okay, great. Fabulous. Well, thank you so much.

My name is Stephenie Foster, and I am the senior vice president for government affairs at the American Legacy Foundation. For those of you who are not familiar with American Legacy, we are a national independent public health foundation that was created in 1999 as a result of the land loss master settlement agreement with the tobacco companies, 46 State governments, and 5 U.S. territories.

We work on tobacco issues, both on the prevention and cessation side and work with all sorts of priority populations, one of them being women. And so, we're really happy to make these comments. We appreciate the opportunity to talk to you today, and we're very happy that you place such a large emphasis on working with women's services, especially as we move forward and talk about all the various issues around healthcare reform and how we can ensure that

people have access to the care they need on so many fronts.

We wanted to just make a few comments to urge SAMHSA not only to focus its discussions on tobacco prevention and cessation services geared toward women, but also looking at how these services can improve the lives of women who suffer from mental illness and substance abuse issues.

In addition, as I'm sure you know, to the health problems that everyone who smokes is at risk for, such as lung cancer, heart disease, COPD, smoking has additional negative impacts on women's health. Women of reproductive age who smoke are at increased risk for multiple adverse pregnancy-related health outcomes, including difficulties with infertility, spontaneous abortion, premature rupture of membrane, low birth weight, stillbirth, preterm delivery, and SIDS.

As you know as well, I'm sure, smoking rates among people with mental illnesses are nearly twice that of the general population, and we really want to just encourage you, as you're working on these issues,

to look at the interface between women smokers and women with mental illnesses. The Surgeon General's report on women and smoking that was done in the year 2001 indicated that smokers are much more likely to be depressed than nonsmokers, and women are much more likely to be diagnosed with depression than men.

So we really think there's a critical need for more research into these connections between tobacco use and those dealing with mental illness, particularly women. And we certainly hope that as you continue to do the great work that you do and keep this in mind as you're setting priorities for the SAMHSA women's health services and that you will also think about these issues, explore and take action on other issues that you are working on.

So I really want to thank you for the opportunity to talk. We did also submit a little bit more of an extended version of these comments in writing a couple of days ago. So you should have them in the record as well.

We're also happy at any time to answer any questions that you have on issues around smoking,

tobacco use, prevention, public health, and the need to ensure that as we all work on those issues, that we're looking at the kind of interventions that really can help particular populations either, in our case, not start smoking or quit.

So, again, we're really more than happy to be a resource to you in any way, and thank you for your great work.

MS. NEVINE GAHED: Thank you, Stephenie.

MS. KANA ENOMOTO: Thank you, Stephenie.

I just want to thank American Legacy Foundation for your comments and also let you know we've enjoyed our conversations with Dr. Healton, that Dr. Robert, Dr. Cline, and I have had the opportunity to meet with Cheryl Healton, who is the director of the foundation and brief her about our pioneers, Census Pioneers Project, where we're working with 100 of our grantees to implement some of the cessation and prevention programs within their grant programs.

And we look forward to continued partnership with this organization leadership center, as well as the American Legacy Foundation.

MS. STEPHENIE FOSTER: Well, thanks very much. I'll pass along your kind words and greeting to her as well. So thank you very much.

MS. NEVINE GAHED: Thank you, Stephenie.

I think Frederick Quinn from the Illinois -- yes, there's a mike right there.

OPERATOR: I'm showing no further questions or comments on the audio portion.

MS. NEVINE GAHED: Thank you, Operator.

MR. FREDERICK QUINN: Hi. I'm Frederick Quinn. I'm representing the Illinois Department of Human Services, Division of Mental Health.

And just wanted to let you know help is on the way, and help is on the way for the young ladies that we are seeing currently as part of a trauma project that we're doing. We've been off for the last 7 weeks due to a furlough, but we are back in business as of last week.

So we're going to help with the trauma piece as far as what's going on with the young ladies. And as they are called in the Illinois youth centers, fabulous females, I believe is what they call

themselves. So the fabulous females -- working with them to give them tools or basically a toolbox on how to work with trauma. We've got to first identify trauma.

Not only with trauma are we working with giving them the tools and the toolbox, but we're also working with the things that they're using to numb themselves -- substance abuse, pot, marijuana, whatever they may call it. To numb it, it's a really just thinking of these particular things as numbing effects or as normalized.

So that's our connection. That's with the substance abuse piece. The mental health piece is to help with the trauma, and we're State wide right now, but our focus is to go nation wide. So just wanted to let you know who we are and who we're representing.

Thank you.

MS. NEVINE GAHED: Lisa Goodale from Depression and Bipolar Support Alliance.

MS. LISA GOODALE: One minute or less. Promise.

MS. NEVINE GAHED: Thank you.

MS. LISA GOODALE: Hello, everybody. I have two things to say, one of which is that DBSA, for those of you who don't know, is the largest consumer-directed mental health organization in the country, and we're here in Chicago, based here.

And I wanted to thank SAMHSA for what it has done and what I've heard today in terms of promoting peer support because that's what we're all about, and it was heartening to hear positions are being filled by people with the lens experience, volunteers, other people like that. So thank you on behalf of those of us who are working on peer support.

And the second thing I wanted to say, until last week, I didn't know you all existed. I feel bad about that because I've been around a while. And I know you know you're a credible resource, and I really enjoyed -- and I think we've all enjoyed -- hearing your resource people. Please let us know what we can do to help increase your visibility because I think what you do is incredible. And your reach, your potential reach is incredible, and there could have been a whole bunch more people here, too, I think.

So, please, do. That's not an idle request. If there are ways we can help get out the word about what you're doing or help you do what you're doing, there are a lot of us out here who would like to do that.

So, thank you.

MS. NEVINE GAHED: Thank you.

Operator, I think you don't have any other - -

OPERATOR: I do have one. Our next comment is from Stephanie Moles.

MS. NEVINE GAHED: Okay.

MS. STEPHANIE MOLES: Hello. Can you hear me? I have a little bit of breakup on my end.

MS. NEVINE GAHED: We can hear you, Stephanie.

OPERATOR: Yes, we can hear you. Your line is open.

MS. STEPHANIE MOLES: Okay. Great. Thank you.

This is Stephanie Moles from Grace After Fire. And I, too, thank you for the opportunity to

speak. I did not -- I was not aware of this event until yesterday, actually. But -- hello, Stephanie Covington.

DR. STEPHANIE COVINGTON: Hi, Stephanie Moles.

MS. STEPHANIE MOLES: You have been very much aware of the program that we're offering. It's the trauma and -- military sexual trauma, depression, and addictions with our women veterans, and what we're working towards is rolling out at a national level very slowly and then focusing on a tri-State with California, Texas, and we're one other State to identify. We have 27 States identifying just under 200 women. We varied it a lot.

The State of California just put out a woman veteran's needs report. It is significant, it is accurate, and it is nation wide. And I'll make sure that you all have access to that information. But looking to make sure that this special population, and as was spoken earlier, smoking. We have many of these women coming back from war are of child-bearing age. Working with the Society for Women's Health Research,

so looking at reproductive impact.

The women are suffering terribly. The access to services is very challenged. And that's what we're focusing on is to increase access to services, VA and community based. Many communities are actually very resourceful, but they're not well connected. And so, we're hoping with that to do some online pre- and post treatment support, as well as continuing education.

So just thank you for coming together, bringing the experts together, and then working together to bring that goodness into the hands of the women who need that help. So we want to be connected and look forward to working with you all.

MS. NEVINE GAHED: Thank you, Stephanie.

MS. KANA ENOMOTO: And just as a follow-up to Stephanie's comment, SAMHSA has had very good luck working with it jail diversion program with a focus on providing trauma-informed services particularly to those people who are returning veterans, and we will have a new set of grants in the next year. And we're also looking forward to doing another policy academy

for States on returning veterans in 2010.

So --

MS. STEPHANIE MOLES: Wonderful.

MS. KANA ENOMOTO: So the needs of veterans, and I think in our last one we did have a track on women veterans, and we'll continue to do so in the next round of academy. So thank you very much.

MS. STEPHANIE MOLES: Wonderful. Thank you.

MS. KANA ENOMOTO: Stephanie?

DR. STEPHANIE COVINGTON: Just let me make one quick comment. That report out of California, the statistic is this was a report on women veterans returning in California. Eighty percent of the women had experienced military sexual trauma, which ranged from sexual harassment to rape, 80 percent.

MS. KANA ENOMOTO: Very, very sobering numbers.

Well, this concludes our public comment session, and we'll go ahead and adjourn the meeting. We think -- I'm sorry. Francine?

MS. FRANCINE FEINBERG: I didn't sign up, but could I say something?

MS. KANA ENOMOTO: Please step to the mike.

MS. FRANCINE FEINBERG: Thank you.

Really, they're just kind of follow-ups on some of the things that were said today. Just let me introduce myself. I'm Francine Feinberg, and I'm executive director of Meta House, which is just up north in Milwaukee. I'm also a past member of this committee.

There were a couple of things that were said that I would like to ask about. I don't know if anybody is still here regarding the medical care clinic, but I just wanted to bring this up since trauma is the kind of issue of the day here.

One of the things that we recognize with the women that we treat -- I have a women and children's treatment program -- is that the women's health is not bad. It's horrible. And we often have a difficult time because the women have a difficult time having OB/GYN exams, relating directly to the trauma.

Nobody really talked about that in the medical home model, and I was just wondering if anybody had given that any thought because we can use

all the help that we can get, actually, to help that along. Maybe that's something you can talk about later? You don't want that one?

MS. KANA ENOMOTO: I think it's an excellent issue to talk about in our listening session as we go over to the NACHC meeting and talk with the community health folks because our community health representatives have left here today.

MS. FRANCINE FEINBERG: And one other thing that is related to some things that was talked about. We are working on a child welfare pilot, doing very much -- very similar things to what you were talking about and also similar for the courts. The treatment gap, though, is enormous. We keep coming up with these wonderful programs, and we cannot handle the referrals. And I'm just not quite sure that we're doing anybody a favor when you're putting someone on a waiting list after giving them hope for something different in their lives.

So that's just a comment about the shortage of treatment, which gets into the funding and so forth.

MS. JANELLE PRUETER: Can I say something about that? Is that allowed or no?

[Laughter.]

MS. KANA ENOMOTO: No, I'm sorry. I'd love for you to connect as soon as we adjourn the meeting.

And with that, I think we will adjourn this session of the Advisory Committee for Women's Services, and we'll reconvene at 4:45 p.m. at the Chicago Hilton in a listening session with the National Association of Community Health Centers.

So thank you to our panel. Thank you for our audience today, our public participants today. It was an excellent conversation, and we look forward to seeing you a little bit later.

[Break.]

MS. KANA ENOMOTO: -- in the statute to have 10 members who are drawn from across the fields of mental health prevention -- mental health and addictions prevention and treatment. Today, it is a great pleasure that I bring you six of our members whom I will let introduce themselves, and we're really pleased to be here today to talk to the members of the

NACHC or affiliates of NACHC, as well as our constituents who are interested in women's behavioral health, to have the conversation about how do we integrate trauma in general healthcare, and how are we bringing these two things together?

For those of you who know about the Average Childhood Experiences study, and I'm sure we'll hear a little bit more about that later, the role of trauma in women's lives and in their subsequent healthcare needs is so vital that we all need to understand this better, how to address it, how to intervene earlier, and how to help women and girls heal.

So, with that, I'm going to allow our members to introduce themselves, and then we'll get into the presentations from Drs. Covington and Fallot.

DR. STEPHANIE COVINGTON: Stephanie Covington, co-director of the Center for Gender and Justice in La Jolla, California.

DR. ROGER FALLOT: Hi, I'm Roger Fallot. I'm director of research and evaluation at Community Connections in Washington, D.C.

MS. RENATA HENRY: Good evening. I'm Renata

Henry. I'm the Deputy Secretary for Behavioral Health and Disabilities with the Maryland Department of Health and Mental Hygiene.

DR. BRITT RIOS-ELLIS: Hi. I'm Britt Rios-Ellis. I'm a professor at Cal State University-Long Beach and the director of the NCLR Center for Latino Community Health.

MS. SUSAN AYERS: Good afternoon. I'm Susan Ayers. I'm the president and CEO of the Guidance Center, which is a child and family agency that serves about 3,500 children and families in the Cambridge and Somerville area, which is right across the river from Boston.

MS. AMANDA MANBECK: I'm Amanda Manbeck. I'm the executive director of White Bison. We're located in Colorado Springs, Colorado.

MS. KANA ENOMOTO: Many thanks to the members of the public who are here joining us today at the last session of the last day of the community health center meeting. We're really grateful for your participation, and actually, it's a bigger crowd than we expected. So we're really pleased. We were

prepared to talk amongst ourselves.

[Laughter.]

MS. KANA ENOMOTO: Just in case, and luckily, we won't need to do that. And just as a matter of explanation, we are live via Web conference as well. And so, this presentation is sort of being simultaneously broadcast over the phone and on the Internet.

So, with that, I will bring you Dr. Covington, who literally wrote the book on women and recovery. And everywhere we go, when we talk about trauma and we're talking about different systems, they're like, "Oh, and we know Dr. Covington. Hi, Stephanie."

Because she's just -- she's been everywhere, and she, together with Roger, they're just really leading lights in the field of trauma and women, mental health, and addictions. So we're so pleased to be able to bring them to you today to introduce the topic of women and trauma and healthcare.

DR. STEPHANIE COVINGTON: Good afternoon, as it moves into evening. I've been asked to do kind of

a quick -- oops, this is very touchy.

A very quick overview, sort of the basic 101 thinking about trauma in women's lives, and this first slide really talks about evolution and the evolution of women's treatment, particularly substance abuse treatment. And if we look at the '60s, we really had a male model of services. And over time, we have evolved into now talking about services being gender responsive.

In the intervening time, people began to talk about gender-specific treatment, which actually for some people meant they would put women in groups and say we're doing women's treatment, and the women would be given exactly the same services the men had. But we realize now that we have to do this a little differently, and through the process of creating gender-responsive services for women, we've realized that trauma is a core issue.

And as far as I'm concerned, I don't believe you can do gender-responsive services without being trauma informed.

The definition I use, the one a colleague

and I developed. It's -- let me back up just a minute. I know when you have very little time, it means you start talking too fast and really get muddled. But a lot of people believe that you can pick up a manual and take it into a program, and therefore, your program is now gender responsive. And as someone who writes those manuals, let me say it isn't that simple.

I believe that being gender responsive means looking at the whole, and so the definition we use, it's creating an environment through site selection, staff selection, program development, content, and materials that reflects an understanding of the realities of the lives of women and girls, and it deals with their strengths and their challenges. So it's both the environment of the program, as well as the content and looking at all of these multiple issues.

In some ways, I believe it's really looking through the lens of the lives of women and girls and you see what's reflected back to you, and then you begin to develop and provide services accordingly.

Now when we talk specifically about trauma, let me just ask, do you any of you know anyone who's had no suffering in their life? No.

Yes, well, so suffering seems to be part of the nature of life. But I divide this into two categories, if you will -- natural suffering and created suffering. And I think natural suffering comes from the experience of being born and growing up and moving into later years in which there are life events that are painful. And I don't think there is anything unnatural about that. I think it's just the nature of life.

I think natural suffering also comes from natural disasters -- earthquakes, fires, floods, those things that happen somewhat randomly in nature. But I want to contrast that to created suffering.

I believe created suffering are the things that we as human beings do to each other, and I don't think there's anything natural about that and that it's much more difficult to heal from created suffering than from natural suffering.

Now, there's a definition of trauma that's

in the DSM about it being an event, that there's a particular kind of response to the event. And in a phone call that Roger and I had a couple of -- well, a couple of weeks ago, a different definition that I really like and have included is, "Trauma occurs when an external threat overwhelms a person's internal and external positive coping resources."

So in the material, you have the definition that comes out of the Diagnostic Manual, but I believe this is a much more elegant definition, if you will.

And certainly traumatic events can take many forms. You know, it can be all different forms of abuse, interpersonal violence. It can be frightening medical procedures. It can be illnesses. It can be muggings. It can be automobile accidents. It can be the process of immigrating to this country. It certainly can be the natural disasters, the terrorism, the witnessing violence.

Loss of a loved one, combat, torture, kidnapping, and then intergenerational or cultural trauma, the kind of trauma that happens to groups of people in our society because of what has happened

generationally. And certainly, we see that with our African-American population, our Native American population. In California, some of our Japanese families that were put in internment camps during World War II.

So there are groups of people in our society that have had this generational trauma. Of all these various forms of traumatic events, it's the interpersonal abuse that women are the greatest risk of experiencing, more so than men.

So we've learned over the years about a variety of different forms -- the sexual abuse, the physical abuse, the emotional abuse, the self-inflicted violence. We have a new one on the list called military sexual assault or military sexual trauma.

Earlier today, talking about the report that just came from California about women veterans returning, and the statistic is 80 percent of them have experienced either sexual harassment and/or rape that has been perpetrated by the men they are serving with.

There is another kind, I believe, of trauma we speak very little about, and that's the trauma of stigmatization. What happens for a woman or a girl who belongs to a group of people that our society looks at with levels of disdain and often hatred, and so very often, when we're working with women or girls, they've actually experience multiple levels and different kinds of abuse coming from a variety of different places.

There is also a gender difference with trauma that people very seldom talk about, and it's when we look at trauma over the lifespan. So if we look at boys and girls, children, we know both boys and girls are at risk of physical and sexual abuse in their childhood, greatest risk that the perpetrator will be someone they know, family member or someone they know.

But when we look over the course of the lifespan, we begin to see the differences. So, in adolescence, for a teenage young man, his greatest risk for abuse is if he's a gay young man or a young man of color. His risk for abuse comes from his peers

and from the police. If he's a member of a gang, his risk for abuse comes from an oppositional gang. Essentially, his risk for abuse comes from people who dislike him.

In her teenage years, a girl's greatest risk for abuse comes from her relationships from the person to whom she's saying "I love you."

You move into adult life, a man's greatest risk for harm, if he's serving in the military, his greatest risk for harm comes from the enemy. If he's living in our communities, his greatest risk for harm comes from being a victim of crime perpetrated by a stranger.

For a woman, we now know that if she's serving in the military, her greatest risk for harm comes from the men she's serving with. And if she's living in our communities, her greatest risk for harm comes again from her relationships from the person to whom she's saying "I love you."

Now, while all violence is abhorrent, to be harmed by the person to whom you're saying "I love you" is a much more, I believe, frightening and

difficult process to understand, accept, and to heal from. And when we're working with our clients, we will very seldom ever work with a man who was physically and sexually abused in his childhood, physically and sexually abused in his adolescence, and physically and sexually abused in his adult life by someone he was in a relationship with. But that scenario is common in the lives of the women we work with.

Chart showing the process of trauma. I'm going to go through this quickly. There is the event. There is the initial response. A person ends up with a sensitized nervous system, changes in the brain, particularly if it's multiple instances of childhood sexual abuse. Then there's a current stressor that can come from a whole variety of different places. Person is in a painful emotional state, and we see some categories of responses.

The retreat response is the isolation, the dissociation, depression, anxiety. The self-destructive action -- the eating disorders, substance abuse, the self-harming behaviors, the suicidal

action. And then we have the destructive action -- the aggression, the violence, and the rages.

Here, again, we see a gender difference. Women are more likely to do the middle box and the left-hand box. Men are more likely to do the middle box and the right-hand box. So, again, all these gender differences have an impact on how we design our services.

The ACE study, which Kana mentioned, has been a very important study. Seventeen thousand people participated in this, which means it's got a lot of power. I want to take a couple of minutes on this because I want you each to answer eight questions, okay?

I'm going to give you eight questions, and you answer them yes or no. I'd like you to answer them for yourselves, and I'd like you to answer them for a typical woman that you would be working with, okay? So we'll do this really quickly.

Did you grow up with recurrent and severe emotional abuse? Did you experience recurrent severe emotional abuse as a child? So you answer that yes or

no. And then think about a typical woman or girl you work with. Has she experienced recurrent and severe emotional abuse in her childhood?

Second question has to do with physical abuse? Did you experience recurrent severe physical abuse, and then your client?

Contact sexual abuse? Again, answering it twice.

Did you grow up in a household with an alcoholic or a drug-using family member? Again, yes or no.

A family member who was imprisoned?

A mentally ill, chronically depressed, or institutionalized family member?

Seventh question, was your mother being treated violently?

And the last question, were both biological parents not physically present, such as growing up in foster care?

So how you score this is each yes answer you gave for yourself, you get one point and each yes answer for a client get one point. So you're going to

end up from 0 to 8. Score for yourself from 0 to 8, and score for a client.

And let me just ask you, give me some client scores, some women you might work with. I'm not going to ask you your personal scores. Give me some numbers.

AUDIENCE MEMBERS: Eight.

DR. STEPHANIE COVINGTON: Eight. Any other numbers? If I say 5 or more, will I pick up most of the people you think that we're talking about this afternoon?

Well, the cutoff on this was 5 or more, and at first, they looked at smoking, alcoholism, the injection of illegal drugs, and obesity, and they found that people who had a score of 5 or more yeses on this 8-point scale were the people 30 and 40 years later that were struggling with these four issues, that these adverse childhood experiences could predict some of these later behaviors.

They also took this study and they looked at chronic health problems. They looked at pulmonary problems. They looked at diabetes. They looked at

heart condition. They looked at a lot of physical health problems, and they found that people who had experienced these adverse childhood experiences, many years later, were the ones struggling with chronic health problems.

Now the same study was taken into the criminal justice system, and again, the results were similar. Women who had the higher scores were the women who had the most severe physical health problems. They found that mental health was impacted even more so. That the women who had the highest scores were the women who had more mental health problems, more psychotropic medications, more suicidal attempts, et cetera.

But the next statistic really blew them away. The women who had 7 or more yeses on that 8-point scale, it increased their risk of having a mental health problem by over 980 percent. So it’s not rocket science to realize that mental health issues -- physical health issues are connected to trauma and mental issues are connected to trauma and to begin to think about our systems of care.

So we have substance abuse, mental health, trauma, and physical health all interrelated in the lives of our clients, and yet we have systems of care that are fragmented and separated.

Some of the mental health statistics on women, again, the differences than men. Women having more depression than men, more anxiety disorders than men, more suicide attempts than men. And having all of that and the history of violence, trauma, and abuse, it increases women's risk of having these mental health problems.

I think there are three key issues that our clients need, as well as staff, and that one is learning what abuse and trauma actually are. You cannot assume that even women who've been abused know that they've been abused. Understanding what the typical responses are, and developing coping skills. But staff need to be able to do exactly these same things.

There are four particular curriculum that are generally responsive for providing services for women with trauma -- Atrium, Beyond Trauma, Seeking

Safety, and TREM.

And then Roger is going to talk about how do you start to create a trauma-informed system of care?

DR. ROGER FALLOT: Thanks, Stephanie.

I'm going to violate to start every known rule of pedagogy, and I'm going to show you the most important slide first. So then you can all fall asleep or go out and leave the room or whatever you want to do.

But you've gotten the most important slide that I've got to talk about, which is the five core values of trauma-informed care -- safety, trustworthiness, choice, collaboration, and empowerment. To what extent do you think your service systems embody these five values?

That is, to what extent do they ensure the physical and emotional safety of everyone who comes to service there? To what extent do they maximize trustworthiness, making the tasks clear and they maintain appropriate boundaries between providers and consumers? To what extent do they prioritize consumer choice and control? Do they maximize collaboration

and the sharing of power? Do they prioritize consumer empowerment and skill building?

There is a gold standard working behind these values. If you can really say that in every contact, every service setting, every physical aspect of your service setting, every service relationship, if you can say that each of those embodies all five of these values consistently, then you've created a trauma-informed setting.

We call it a culture shift because it goes way beyond simply the kinds of things that are involved in most new services. It involves all aspects of program activity settings, relationships, and atmosphere.

You know, if Stephanie mentioned that as she writes her manuals, the idea that these things can be done easily or remedied on a basis of a manual is suspect, then the idea of changing a culture quickly and readily is certainly suspect. The idea that you can learn how to do a new service is that you can provide a new group, even those great groups like Beyond Trauma and TREM and Seeking Safety and Atrium,

those kinds of group interventions can be learned in a relatively quick kind of time period and with supervision over several months, people think you become pretty adept at doing those sorts of group interventions.

But in terms of changing all aspects of program activities, setting, relationships, and atmosphere, we're talking about a long period of time. We think in terms of 2 years at least.

The other thing that differs between a culture shift like I'm talking about and the sorts of changes that take place with the EBPs or ethnic-based practices and new services is that this sort of culture shift necessarily involves all groups. It involves administrators, supervisors, direct service staff, support staff, and consumers.

In many changed systems, we've focused primarily on the service providers. We say, "You're going to do things differently now," and we provide some guidelines for their behavior changes. We expect them to be followed, and that's pretty much that. In this sort of approach, we involve everybody in the

entire system in making the changes. I'll talk a bit more about that as we go along.

And it involves making trauma-informed change into a new routine, a new way of thinking and acting. We call this trauma-informed, but it goes way beyond information. There is a -- all of you got some information about this session, and it was probably pretty good information because you all showed up here, unless somebody is lost, in which case it wasn't such good information.

But the information you got and training in this sort of approach is only beginning, and changing the way you think and act in relationship to trauma requires a great deal more motivation and time. It specifically involves changes in both understanding and changes in practice. It involves thinking differently as a prelude to acting differently. The fact is that thinking differently also initiates and sustains changes in practice and setting, and that acting differently can reinforce and clarify the changes in understanding.

So let me talk abut some of the changes in

understanding we emphasize when we talk about trauma-informed care. First of all, we make a fundamental distinction between trauma-informed services and trauma-specific services. By trauma-specific services, I'm talking about those that are specifically designed to address the impact of trauma and to facilitate trauma recovery.

So things like all the groups that Stephanie mentioned, individual interventions like EMDR, trauma-focused cognitive behavioral therapy for kids, all of those kinds of interventions that are focused specifically on helping people get past the effects of trauma in their individual lives are trauma-specific services.

Trauma-informed services, though, can be any kind of service. It can be a general healthcare setting. It can be an educational setting. It can be a substance abuse or a mental health setting. It can be a jail. It can be a correctional setting. When those sorts of service settings incorporate the knowledge we have about trauma, its prevalence, its impact. and the various paths people take to trauma

recovery, in every aspect of service delivery and practice, they would become trauma informed.

But what looks at that point to start happening is that the trauma-informed services become more hospitable and engaging for survivors. One way we really talk about this very importantly is that they minimize revictimization. They do no harm.

If there is a single rule about trauma-informed services it's that they avoid revictimizing and retraumatizing individuals that come for services. They do that by facilitating healing, recovery, and empowerment and emphasizing collaboration throughout the system.

Why trauma-informed services are so important we've talked about already, and I don't want to belabor any of this, except I'll skip down to about the fifth or sixth one here. The trauma affects how people approach services. Those five core principles are in some ways best thought of as antidotes to the toxic effects of trauma in people's lives.

If you've grown up in a world that feels dangerous and is dangerous, then safety becomes a top

priority. If you felt like you could not trust people on whom you rely for care and betrayed your trust and reliance on them, then trustworthiness becomes a top priority. If you felt like life has been forced on you, you've had no choice, no voice, no control, then choice becomes a top priority.

You feel like everything has been arrayed one up and one down, and you've been in the one down position fairly consistently, then collaboration and power sharing becomes a top priority. If you've felt helpless to do anything about any of these things, then empowerment becomes a top priority.

So it's understandable that trauma affects how people approach services and services relationships. When they come into your setting, if they've been hurt -- and who hasn't been -- then their head is likely to be on a swivel. They're going to looking for signs and danger signs in particular, so especially when the service system has itself so often been retraumatizing. In mental health systems particularly, coercion and the use of forced approaches is all too common.

The other thing we talk about that I want to emphasize is that staff members are deeply affected by systemic stressors, and the fact is that staff members are as affected by trauma as our consumers, that we are asked consistently to do more and more with less and less resources. Fewer and fewer resources are available to support our work in this economy, and the kind of stressors that staff members face are very similar to those that the consumers face.

It’s, frankly, unfair to expect staff members to pass along values of safety, trustworthiness, choice, collaboration, and empowerment unless they experience those in their own work setting, unless they feel safe, unless they feel they can trust their supervisors and administrators, unless they feel like they have some choice about the way they do their jobs, unless they feel like they’re collaborating with the people who are running the place, unless they feel empowered by having the right resources to do their jobs well. So staff members are as much a part of this culture change as are consumers.

Changes in understanding -- the paradigm shift here involves changes in understanding of the trauma, trauma survivor, services, and service relationship. I'll just give you a hint of some of these changes we talk about in this sort of thing.

Sandy Bloom has become known for changing our understanding of the trauma survivor. When we asked the old question, "What is your problem?" The new question becomes, "What has happened to you?" We shift the question away from a problem focus, deficit focus question to a life focus question, a lived experience question.

And to that, the services-related question then is and the service relationship would move to asking not if you have a problem, what I can do to fix you, but if you have experienced a particular kind of event in your life, how can you and I work together to further your goals for recovery and healing? So the question becomes more a collaborative goal setting.

In our changes in practice then -- we're shifting now from changes in understanding to changes in practice -- we've developed a protocol for

developing trauma-informed services. One of the things I say when sometimes when I'm doing a longer version of this kind of talk is if there is a word I would change here is "protocol." I've gotten increasingly skeptical about protocols.

Especially when I went to an emergency room with a young woman a few years back, who was being examined for a psychiatric hospitalization, and the first question that she had to answer was where she would like to take off her clothes. The second -- and when we asked is there any place she could talk with somebody with her clothes on, they answered, "That's not in our protocol."

And says is there a way she could talk to a woman? "That's not in our protocol." Is there a way she could be given a break here around her physical exam? "That's not in our protocol."

This emergency department had a very strict protocol, and there's a new bumper sticker working in my future here. It's "question protocols." It's not "question authority," it's "question protocols." All the protocols in the world, except this one, of

course, which is the single exception to the question protocols.

We invite people to look at services level changes, particularly service procedures and settings, formal service policies, whether they do trauma screening universally, whether there is a trauma assessment is appropriate, whether there's trauma involved in the service planning, and whether they offer trauma-specific services.

That the systems are administrative level, questions have to do with the administrative support for program-wide trauma-informed culture changes, the existence of trauma training and education for all staff, not just for clinicians. And human resources practices need to be trauma informed as well.

I just want to say a few words about the first of these because it's really -- it's the most engaging one. And it's really one that you could think of imaginally as you go home tonight, if you get really bored on the way home. And that is to think about what it would be like to come into your service setting for the first time.

Think about the person you would first talk to. They'd be on the phone or if you'd talk to them in person or if you would, in some way, contact them by email or some other indirect way. How would that person sound? What would they say? Would that voice mail message be manageable if you were really in distress, or could you follow all the options you were given if you were really in a moment of serious distress?

Then you show up to the place for the first time, and you walk in the door. What's the first thing you see? What does it smell like? How does it feel to you? Does it feel welcoming? Does it feel engaging? Does it feel like a place you'd like to come for services? Does it feel like it's likely to be helpful to you, or does it feel like it's institutional and cold and indifferent and hard? And is the first thing you see is a security guard with a gun?

Those kinds of things are very important in the first impressions we face when we come into settings. And the contrast between the ones that are

warm and hospitable and engaging for people and those that are not are very striking. The most recent study I've seen still confirms what we know about many of the services in which we work, that is in mental health the mobile number of visits to a psychiatrist or psychologist is still one. People come one time. They don't come back.

And that means that something is happening in that session that undermines their capacity to come back. If there is one thing we ought to be confident of in our services -- and we know this about substance abuse, and we're fairly confident about it in mental health as well -- is that the longer people stay engaged in it, the better they're going to do. Trauma-informed services are a way of engaging people in services.

Then think on through to the next phase. Where do you go for that first meeting? Does the person you're going to see for services, how do they greet you? Do they offer you options? Do you have choices about the way you work together?

One of my hard and fast rules for the first

7 years I was in practice was to always close the door when someone came into my office. I was told that there was a cardinal rule of therapy. There weren't very many cardinal rules, but that a cardinal rule of therapy was you had to close the door or nothing was going to happen.

That worked very fine for about 6 or 7 years, as I said, until a woman screamed at me when I closed the door and said, "What the hell do you think you're doing, closing that door with me in here? Open that door back up."

Not being a total buffoon, I walk over and open the door back up. It took her 6 months to tell me about her history of childhood sexual abuse that prompted her to demand that open door. Now the change I made in my practice since then is that the first thing I ask is, "Would you like the door open or closed?" It communicates the capacity to choose. And that sort of thing is common, I think, among people who have gotten the message about trauma.

So, to think through every aspect of your system around those five principles. How safe is it?

How does it facilitate trustworthiness? How does it facilitate choice, collaboration, and empowerment? You do that once for the consumers. You do it again for the staff, and then you make some plans about how you'd like to change that sort of system in a realistic way.

There's lots more to be said about this. I'm going to stop now because I'm about out of time, and a friend of mine once said that no matter how long you talk, they're only going to remember three things anyway. So you ought to just put them on a slide for them.

These are the three things you can remember if you need to remember three things. And I wanted to draw your attention especially to the last one, which is that the possibility here is really for enhanced collaboration for all participants in the system. We have all too often gotten ourselves in the position of these two guys who are out in the lifeboat, where one guy got mad at the other one, and he said, "If you don't shut up, I'm going to come down there and drill a hole in your end of the boat."

[Laughter.]

DR. ROGER FALLOT: There is no “us” and “them” in this system any longer. There are only “us” and “us.” We’re all together in this system. And until we get that message and we communicate it clearly to our consumers, to the line staff, to the support staff, to the supervisors and administrators, and to the systems administrators, we’re going to continue to be at a disadvantage in providing good quality, trauma-informed, gender-responsive services.

Thank you.

[Applause.]

MS. KANA ENOMOTO: Didn’t I tell you they were great? They are. So thank you very much to our presenters, and the idea here today is to really have a listening session. So I would like to open it up to the floor and have you all --

[Laughter.]

MS. KANA ENOMOTO: She’s ready. It’s what she came for. Okay, if you would just say your name and where you’re from and make your comment.

MS. DEBORAH WOOLFORD: Good evening. My

name is Deborah Woolford. Although I'm a board member from Park West, I happen to work at a recovery house that have a long-term for men, women, children, and those with mental illness. And they're all housed in this one building, you know, one unit is for the mental, those who've got. And then we have the women and children, and then we have the men.

I find, for me, that it's an unhealthy environment because I don't think that all of them should be housed in the same building. It just scares me because as they become clean after the first couple of days, things start rising like hormones and all those type of feelings and everything, which leads to a bad environment.

Then you have children I feel that are not getting the psychiatric or care that they need because they come in traumatized. You can tell by the way they -- I mean violent 7- and 6-year-olds. I mean actually screaming and raging because they've been traumatized for so long.

And then I'm finding out that the men between the ages of 35 and 45, they've just gone

through so much, particularly the African-American males, that anger is just one of the major, major trauma. And as I've talked to the women, they go through everything you just said, the sexual abuse, the obesity.

But one of the things I'm finding out is that I don't know if this is a financial thing that we're going through in the State of Maryland -- and I'm glad you're here.

[Laughter.]

MS. DEBORAH WOOLFORD: But the more and more clienteles we're getting because of money, as more mental illness than ever before, and that's scaring me as a staff. I mean, I'm getting to the point where I don't feel safe.

And I don't -- I work in the dietary department, which I see everybody because I have to feed them three times a day. And whatever happens on a unit that the treatment they're not getting reflects in the behavior that comes into the dining room, even where food has become another addiction for them. So they just substitute.

So, as a staff member, what can I do? And I just might look for a new job soon, basically, because I'm getting scareder by the moment because, seriously, because of funding, we're getting more and more mental ill patients. And because of funding, they're not putting them out. They can just have their violent outreaches, and it's just so scary.

And to come here and hear everything that you've just said confirms what I've been feeling. I thank you. I thank you. I thank you because I thought I was losing my mind there for a minute.

But because of the 5 million people that's unemployed, I don't want to be a 5,000,001. So I've been holding on and holding on and holding on. But I don't know how much more I can hold on. So what can I do, and one of my philosophy is where is this common ground can we find a mirror such as ourselves? And maybe I'm seeing myself. So I have to take that into consideration, too.

But I'm more concerned with the children that are coming through there that are not being addressed with the mental illness that they're going

through and women, hmm. Oh, my God. You just don't know. I'm just so overwhelmed right now. I'm really -- this has been the best session I've been to. It's the last session, but they always say save the best for last.

[Laughter.]

MS. DEBORAH WOOLFORD: But it is just so reassuring to know that it's not me. It's not me, and I think it's a money issue in the State of Maryland. It is a money issue. And we're taking more and more clients that just don't need to be in a rehab facility. They don't. They really don't.

MS. RENATA HENRY: So, thank you for you comments, really thank you. And let me say from the perspective of the Department of Health and Mental Hygiene, I want to make sure that I hear --

MS. DEBORAH WOOLFORD: I'm scared. I'm scared.

MS. RENATA HENRY: I can see that. And so, two things. Two things I'm going to offer. One is that I will -- after the general session is over, I'd like to talk to you just a little bit more --

MS. DEBORAH WOOLFORD: Yes, I want to talk to you, too.

MS. RENATA HENRY: -- to understand where you're working so I can acquaint myself with the facility and understand.

And you are correct that Maryland, like at least 47 other States -- I think there are only 2 States in the Union that have said that they're not experiencing financial difficulties. So the States are really struggling with dollars. That is on the table. And tomorrow, in Maryland, there will be an announcement of some additional cuts.

We need to -- so the things that Stephanie and Roger talked about in terms of safety and trust and choice and collaboration and empowerment are really, you struggle with that when --

MS. DEBORAH WOOLFORD: Right.

MS. RENATA HENRY: -- just basic resources, am I going to have a job tomorrow?

MS. DEBORAH WOOLFORD: And the powers that be are just letting them come through the door like running water.

MS. RENATA HENRY: So I will offer -- what I'd offer to you is that since it's specific to Maryland, and I'm sure that there are other issues in the audience, that after the session is over, I'd like to spend a few minutes with you to understand some more and help you because we don't want to lose workers, an individual such as yourself that are in the public sector doing the work that needs to be done. So, definitely, we will respond.

I think for all of us sitting in the room, and I'll talk from a State perspective, that knowing financially where States are and the kinds of impact it is having on direct service providers, all of us. Are we going to be laid off tomorrow? Is our job not going to be there? So that those kinds of things are stress producing and stress invoking.

So to the extent that if any of you are leaders in terms of running agencies, you must -- communication is absolutely necessary because your staffs, more than ever, need that support right now because things are so tenuous. I think the issue of the challenge always for me in the days of shrinking

dollars, how are we going to change systems again, yet another time being asked to do something more with already less.

But I think that trauma-informed services, trauma-informed systems are particularly necessary in times where, to some degree, we're all experiencing trauma around the financial and the fiscal environment whether it's where you work, where we live, on the job.

So I thank you for your comments. Hang in there. We will talk after the session, and the importance of trauma-informed systems and the development of those systems is absolutely necessary.

In Maryland, there are efforts to do trauma-informed care and lots of training out there. So that's the other reason I want to find out where you work to make sure that because there's a part of the training in the system, both from the substance abuse side and the mental health side, trauma-informed training around trauma-informed care and interventions is available in Maryland.

MS. DEBORAH WOOLFORD: Good.

DR. ROGER FALLOT: Let me just add a bit to what Renata said, which is certainly accurate, and I agree with all of it. The issue around staff in trauma-informed systems is very, very important, and you're not going crazy at all. Your experiences are shared by an awful lot of folks. What you've done is put voice to them, and for that you are to be commended.

The fact is that many of us in these systems feel afraid every day of work, and many of us feel overwhelmed and swamped that we can't keep up with the demands of our jobs either emotionally or physically, certainly financially. Yet demands for productivity in many settings have gotten so high that people feel like they can't even take a lunch break.

So that those kinds of realities are pervasive these days, and it highlights the importance, I think, of staff that are feeling like they have a voice. So I really do want to reinforce the fact that you spoke up today, and I hope that there is someplace you can find at the place you work, and I would say this to anyone who is feeling these

kinds of things, to voice the same sorts of concerns. Whether it's with a safe and trusted coworker or a safe and trusted adviser or supervisor or administrator.

If there is anyone in these kinds of places that you can start addressing these sorts of concerns, because often administrators, believe it or not, are feeling almost as swamped as you are. They're feeling that the reason there are more and more people coming is to keep the place open, in their minds, and their concerns are to keep the agency and program afloat.

And they, in the midst of that, sometimes lose sight of the fact that their staff is drowning. So for everyone to feel like they're working together and collaboratively in this sort of process is very important. So to find the colleague or a supervisor who shares your perspective would be a first stop.

MS. KANA ENOMOTO: Stephanie, and then we'll have your comment.

DR. STEPHANIE COVINGTON: Just a couple of comments. There is actually something called secondary PTSD or vicarious traumatization that

happens to people who are working a lot with trauma survivors. It happens to staff.

And you know, when I did the ACE study, I asked you to answer the questions for yourself because so many of us come into the helping professions with our own history. And one of the things we're often not very good at is self care. Self care meaning getting enough sleep, eating appropriately, exercising, watching a funny movie.

So just a thought out there, a little self care can go a long way when working in a very stressful environment.

DR. ROGER FALLOT: Including mental health days.

DR. STEPHANIE COVINGTON: Including taking mental health days, absolutely.

MS. KIRSTEN HARRIS: How do you take those?

DR. ROGER FALLOT: One day at a time.

MS. KIRSTEN HARRIS: I know people, and I should have gone to the mike. But they have all this sick time, but they won't take a mental health day, and I'm like I don't know if it's lying or you just

need a wellness day. But so many organizations don't classify it as that. It's either sick time or vacation time. So how do you do that?

DR. STEPHANIE COVINGTON: It's very challenging, very challenging. This is about the systems of care we don't have for staff.

DR. ROGER FALLOT: And how to create them.

MS. GERI MEADE: Is this on? It is? All right.

Okie-dokie. I'm Geri Meade, and I'm from Hawaii. And what I have to say here is you know how they talk about all that's happening? I don't think we, as a nation, were aware that this was going to come upon us. And by that, I mean when you look at the economy, when you look at families, et cetera, we've been very comfortable, and all of a sudden, this came at us.

Unless you were brought up in a family that's [inaudible] as we say in Hawaii, you'll have to go through this. We as a nation will have to go through this for another year and a half. And all these problems are going to compound, but we have to,

as I said, talk to the gentleman upstairs, look at your family, because they are the things who are going to make it with you.

And it's from there, if you can survive this, my dear, you're going to survive for the next 50 years. Mahalo.

[Applause.]

MS. KANA ENOMOTO: I saw a lot of nodding heads when you were speaking. So I know you're not alone, and there are others who understand that. Are there other folks who have a -- we have someone else coming to the mike.

MS. PAMELA PERRY: Good evening. My name is Pamela Perry, and I am a veteran. I live at St. Leo's residence, which is a pilot program between the VA and Catholic Charities. They provide housing for veterans who were either at risk for homelessness or were formerly homeless. They provide 141 single units for veterans there, along with -- they're supposed to be providing programs and services for the facility, and everything is there to do that.

I want to say a couple of things in terms of

the trauma, one in terms of the trauma that I'm feeling personally as a resident there. I just had to make a police report the other day from a co-veteran in front of 30 or 40 people threatening me, and this is the level of trauma that people are feeling there, not only myself, and I'm having extreme difficulty in getting people to respond.

It's well known and understood among the veterans who live in the field and the VA, Catholic Charities, and anybody who is paying attention that St. Leo's is an accident waiting to happen. But I feel like the person out in the wilderness that's constantly trying to say we need some changes here. We need some changes with the staff, who is supposed to be there to help to veterans to become self-sufficient and meet their needs and deal with the trauma that they've been faced with. But they're facing their own trauma and not really prepared.

So I'm wondering if you have any advice in terms of how to get the VA and particularly Catholic Charities to recognize the trauma that's there and begin to respond to it? Because I'm afraid one day

that either I'm going to have to jump out of the window to keep from somebody going postal or whatever in that building. I don't want to be a victim. Neither do I want any of my co-residents or even the staff or anyone else to be a victim there.

But it's not if it's going to happen. It's a matter of when it's going to happen. So I'd like some suggestions in terms of how, what resources, and who might I consult with to help Catholic Charities to recognize the situation there in terms of trauma education, educating them so that they can also educate the staff who is working in the building?

DR. STEPHANIE COVINGTON: You know, Pamela, I have your email address that you gave me earlier. And so, when I send you the report, I'm going to send you the names of a couple of women in the VA who are very involved in working with women veterans around trauma. So I'll send you a couple of contacts.

What State? Where are you?

MS. PAMELA PERRY: Right here.

DR. STEPHANIE COVINGTON: Right here. Okay. I don't know if there is anyone directly -- I'll have

to look at my list, okay? But I can send you a couple of references, a couple of contacts of people you can try. I have no idea how responsive they are. That I can't guarantee you, but I can send you some resources.

MS. PAMELA PERRY: Thank you.

MS. RENATA HENRY: I was just -- I mean, this is the kind of thing that -- so you're in Chicago. I mean, Catholic Charities, I'm going to make an assumption that they are funded by some city dollars, some State dollars?

MS. PAMELA PERRY: A little bit of everybody. This was a pilot project. And so, a lot of the funding was backed by the Veterans Administration. They get funds from the Government and private donations as well.

MS. RENATA HENRY: So I don't have any contacts with the VA, but you could always do an email to your State mental health or substance abuse agency that probably has some money and outline your concerns. In Illinois, the mental health director is Lorrie Rickman Jones, and I don't -- I'm blocking on

the substance abuse director's name. But the mental health director -- I think they're both in the Department of Health or Social Services. And you can go up on the Web and find out the substance abuse director's name.

But you can certainly email those offices. I know that they have constituent relations persons. Or in the case of Lorrie, you could email her directly. Lorrie Rickman Jones.

MS. MARIE FRENCH: I would also recommend that you contact the diocese here that probably has some jurisdiction as a Catholic Charities. Contact the monsignor or that entity, and perhaps they can address it from a faith-based approach. I know earlier we talked about the two kinds of trauma, natural and created, and this is a potential for created trauma. And so, we really want to put our faith into action.

This is a perfect opportunity for the Catholic diocese and Catholic Charities to look at some innovative interventions and strategies to address this and to make everyone feel -- not only

feel, but be safer.

MS. SUSAN AYERS: I would just have one other speculative comment, which would be if this is a pilot program, somebody is probably evaluating it. So there has got to be somebody that's kind of in charge of having dreamed up this idea and have probably put it out to bid, which means the VA looked for a partner. Catholic Charities stepped up to the plate, and there's got to be someone evaluating it if it's a pilot program.

So you just have to find out like who's in the charge of the pilot? Like who's flying this pilot? Who's the pilot of the pilot? So I would just try and wiggle your way along that route and see what you can find.

I'm just really struck by how much of what's here today has to do with workforce issues, workforce training, workforce development, and just how I'm also struck, as an administrator, but one who has been managing a lot of change and have tried very, very hard to communicate with the staff all the time about kind of what's going on and get that feedback. But

it’s a tough, tough time out there for everybody. And being able to find a safe place to talk about that with other dieticians or with other whoever it is you’re working with to try and create some space for yourselves to be able to do some kind of talking and sharing about it I think would be really important.

MS. DEBORAH WOOLFORD: Well, we have EAP, and I have gone to them on a couple of occasions. But I don’t want to keep going back this -- it’s not me. If I’m not the only one on my job that’s having the same low morale, we have a high turnover rate. Something has to be wrong with the system there, or the protocol as this guy keeps talking about.

[Laughter.]

MS. DEBORAH WOOLFORD: Something’s wrong with the protocol that if you have such a high turnover rate, there is something wrong with that system.

MS. MARIE FRENCH: I’d love to ask Dr. Roger, Dr. Stephanie, when we talk about created trauma, how much of this is due to mental emotional issues and how much of it is due to a lack of a moral

compass? Lack of faith values and just genuine regard for another human being?

DR. STEPHANIE COVINGTON: I want to hear what he says first.

[Laughter.]

DR. ROGER FALLOT: That's a great question. It's also a question I rarely get asked in public, and I appreciate your thoughtfulness in asking it. I think, in fact, all of us have the capacity to do harm to other folks, and we know that from a wide variety of psychological studies, as well as just living in this world long enough to know ourselves and other people well enough to know that it's not just a few people who have the capacity to be violent. It's all of us who have the capacity to be violent.

Now what triggers that violence is, I think, largely being the recipient of violence. Not entirely, but often. And the fact is that the more we learn about violence, the more we know that it's shaped by one's own experience. And that people who are themselves victims of violence are more likely to become perpetrators.

And that's -- so we start talking about mental health and substance abuse problems that certainly do predispose people to be more violent in some ways, that those are in themselves caused by violence often in the first place. We know that the ACE study tells us that they are, in fact, predisposing factors. Those childhood experiences are predisposing factors for a whole host of adult behaviors that are problematic, including becoming aggressive and violent and stuff.

Now how moral compass fits in that I think is something that it has to do with the source of other exposures we have in life. And when we're exposed to a solid faith community, a community that has supported whether it designates itself as a faith-based community or not, if it has a moral code that demands respect for other people, that demands caring for other people, these are the antidotes as well to a traumatic childhood.

And those sorts of antidotes come from sometimes a single person. One thing we know about trauma relationships is that they can often -- that

trauma survivors are often one person has turned their life around. They've been able to make a connection to one positive, caring, supportive person who knows about boundaries. They've been able to turn their lives around on the basis of that relationship.

I think those relationships become the fundamental building blocks of a moral compass.

DR. STEPHANIE COVINGTON: Well, I would agree with everything that Roger has said, and let me just share a couple of thoughts with you about some things I've been learning. A lot of my work is with women and girls in correctional settings and, more recently, working with women who have committed violent or aggressive crimes. And something I don't know a lot about, but I'm learning. Steep learning curve.

And clearly, the research shows if someone has had an abusive background, they're at higher risk of doing violent, aggressive things. But let me share with you a few things women have told me, okay?

And these are things they said in response to questions I've asked them, such as what is it you

would need in order to change your life? What would make a difference? What would help so that this doesn't happen again?

So here's some things women have said. One of the women who'd been addicted to drugs talked about doing things out of desperation, desperately feeling the need for drugs that they do things that they would not have done. They feel that they don't get on drugs again.

And as one woman said to me, she said, "Before I did this crime, I would have told you I couldn't do this crime. I wouldn't do this crime because it's against my values."

But she said -- and she was in a focus group that I saw a couple of times over a few days. So she came back on the second day and said, "You know, I went back and thought about those questions you asked." And she said, "The truth is I could do this again." She said, "What I know is once you have crossed a line in yourself, you know you have the potential to do it again."

And she also told me, the same woman

actually said that she realized when you're first arrested, she said you do nothing but sit. And she said, "I've never thought about it before, but what you do when you sit in jail with nothing else to do is you go over that crime and the arrest experience." And she said, "Actually, what you're doing is you're actually perfecting the crime because you're thinking about how you got caught." And she said, "I've never thought about it before."

So, in listening to women, I'm learning things I didn't understand. But in thinking about writing something for them, it's very clear to me that interventions have to be on multiple levels, that I think it's important for we as a society, as Roger said, within each of us, we have the capacity to do atrocities. We see this in history that human beings do things that are unthinkable and unspeakable, really.

So we live in a violent society. So we live in a violent world. So you've got that level. We live in a violent country. We've got that level. We have families where there is violence. We've got

individuals.

And I think there is also a piece in this about acknowledging the multiple levels of also thinking about what it means to be an ethical human being, and that's your question about those values and how do we begin to instill that in people that have never had that opportunity. I think violence is a learned behavior. I don't think it's a knack. It's a learned behavior, and it's always harder to unlearn something.

So I think it's a huge question that you ask, but I do think this whole issue about what it means to live an ethical life is something we were working with people who've crossed a line within themselves.

MS. RENATA HENRY: Just one other response to that would be that the kinds of things that keep you from getting overwhelmed is that, in fact, if you then -- you have that ethical life. You have your space in the world. And if you can help one person or two people -- I can't think about helping hundreds and thousands of people. I can think about helping this

person and then the next person and the next person.

Because I've found that if you start thinking about the big, big picture, it just gets too overwhelming, and you do what you can within the ethical boundaries that you've set for yourself and the faith that you have and the life that you live. And that's what mentoring is about. That's what the one-to-one relationship with young kids is about.

But that's what I've found that kind of keeps me centered. I'll do it here, and if I can do it, then over here and over here. I can't do hundreds of thousands. I can't.

DR. BRITT RIOS-ELLIS: And I would say as a parent, I think the violence now is so fused into the technology that our children are playing with. So it's no longer just something that happens to you. You see it every single day. You see it on television and the interactions that children have oftentimes are with the technology. They're no longer with each other.

So I think -- and everyone says just that's the parent's fault. Well, as our lives get more

demanding, different things happen, whether it's in our home or whether it's in someone else's home. I think we need to take a look at that, and I think we need to examine how those relationships become violent with technology through the violent messages that the technology is giving and how that transcends into violence between children, between adolescents.

And I would say in Spanish, we have two -- and this is something that I feel like we're losing all the time through the work that we do. We have two ways of being educated. When you say someone is educado, you don't necessarily mean that they have a degree. It means that they are morally educated. Right? And I think in our society, oftentimes we're losing that as we go along.

And those two educados, those two forms of being educated really need to be reinforced again so that people begin to understand what it means to be morally and ethically educated and what are the influences that we have that are really impinging on especially our children and our adolescents' ability to act as humanity once indicated it should, I think.

DR. ROGER FALLOT: Let me make one final recommendation, if you're interested in the place of spirituality and recovery, to read a book called "How God Changes Your Brain." It's written by Andrew Newberg. It came out just this past year, and it's probably mistitled because it's not really how God changes your brain. It's how you think about God changes your brain.

Because what Newberg has found in a variety of studies -- he works at the University of Pennsylvania -- is that people who can spend a certain amount of time each day meditating on a positive image or thoughts, images of peace and love and care, brain function starts to change so that the centers of their brain that are able to be activated under stress also start to change and become more peaceful, more reactive in a positive way. Whereas, if you're thinking about a vengeful, angry, wrathful God, you're going to be more wrathful and more angry, not surprisingly.

So it's an interesting sort of approach to controlling some things that we sometimes write off as

that’s beyond my control what my brain is doing. He’s saying it’s not so beyond your control. There are ways and you can learn to manage some of those responses more helpfully.

MS. JANE SMITH: Hi. I’d like to take just a couple of comments, and it’s really kind of evolving, but back to what you were saying about youth. And I think somebody mentioned about being in care.

And before I came back to Ohio, which has been about a month and a half ago, I ran an organization in Boston called Adoption and Foster Care Mentoring. And we believed that youth who were in care because of a lot of the issues that we’ve talked about, whether it’s substance abuse, sexual abuse, just so many different things, that children are taken away from their families, and they lose everything that is familiar to them. But their families, their schools, their neighborhoods, and they’re put into homes.

And the organization was started simply because we know that it works to mentor a young person

who is in care and provide that positive role model. We find that crime is reduced. Graduation rates are increased. I know that all of you probably know the stats.

But my question for you from a behavioral health perspective is oftentimes children's services like to try to keep the family together above all cost, and we know that with the decreased dollars that are available for services, I'm just wondering what your thoughts are in regards to how effective do you think this really is for our young people and for the families themselves, the women and children?

MS. SUSAN AYERS: Well, that's one more good question that's pretty challenging. Families are such complex units, and I think that the head of household faces tremendous challenges and so many layers of complexity. I personally feel like so many parents aren't really given the tools or given opportunities to learn the skills that you need.

You know, we buy a television set or something, and we get this 50-page manual to help us try and figure it out. For me, it's beyond me these

days, but anyhow. And people have babies, and where is that manual? For so many people, if you don't have some family, some community, some extended family, you're really on your own in one of the most scary, challenging kind of adventures that you and your child will ever be on.

So I guess in my experience running a community agency, and we don't have foster placements. We have been able to sort of really be in the community and go to the mat for families, and there have been so many families where everybody just sort of said -- in fact, I've had child welfare people say to me, "Oh, Susan, get over yourself. This woman has lost her kids twice, and she'll never, ever get them back."

And then 10 years later, they'll see me someplace, and they'll say, "Man, I don't know what you guys did with Sylvia, but it was really a miracle." We've got families like that where it's been a miracle. There are other families you're going to go to the mat, and you know what? You're never going to be able to help that parent develop the

skills that they want to develop. And in that case, we have to say what it is and then work on another plan for those kids.

But I've met very few people who don't want to be a good parent, and that's your leverage. And the hope is that if you can make early intervention accessible, be able to find ways to have the parents find one another and begin to create their own kind of community of support and be able to have a nonblaming kind of environment, I think it's that blaming and the shame I think that is at the heart of really so much of our mental illness, substance abuse, and all the rest of it. It's hard to be a really good parent, and yet most people want to make it happen.

So it's about trying to get our policies and our practice into the community. And I don't know what to tell you about I think when kids go into foster care, it is trying to find that one person. And being from Massachusetts, the commissioner we did have several years ago said, "I just want kids to come out of our protective services system having one adult in their life that they can rely on." And that has

been sort of a goal of the department. I don't know that they're all that successful doing it.

But the flip side of that is people say, "Well, oh, we have so many kids they don't have any family members. They don't have a family for us to work with." And then I say, "Well, guess what? When they're 16 and they can blow the pop stand, where do you think they're going to go?" They're going to go find that mother. They're going to go find that father. They're going to find an aunt or an uncle or somebody out there.

So I think it's really in our best interest to keep doing whatever it is that we can to support families and listen to them and see what it is that they need to be able to hold themselves together.

MS. KANA ENOMOTO: I think we have time for a last comment.

FEMALE VOICE: I guess I was going to go back to talking about -- Roger, you were talking about do no harm and that aspect of trauma-informed services, and I was thinking as everybody was talking, that a good way, one way that's really important to do

that is to simply be aware that people have different experiences, and the way that one person sees something is not the way that another one does.

The story that you told about the person not -- the woman not wanting you to close the door behind is really something, and that can be with anything. And I think that’s a really important aspect. And coming from that, it makes me think about how important it is to be culturally informed and educated about different people and to really try to do that more in agencies. And I don’t see that spoken of a lot.

And along with that, different cultures, different ethnicities, also LGBTQ populations -- lesbian, gay, bi, transgender -- and really being more aware and educated about that and realizing that we don’t know how people identify. We don’t a lot of things about each other and so keeping that in mind.

And really it was great to see it for a second up there talking about bi and lesbian and transgender women because sometimes I think when we’re talking about gender-specific or gender-responsive

services, we don't think outside of men or women, and there are more options than that. Or even if somebody is a woman, there are a lot of different ways to be that.

So, anyway, thank you.

MS. RENATA HENRY: So thank you so much for your comments, and I think you're right on target. And I'm glad you brought that up because cultural competence is, in fact, this. Trauma-informed is huge, it's being culturally competent. It's being culturally responsive. They're inextricable in my book.

So the good thing about that is that many of us in this room have had some exposure to cultural competence training and understand something about cultural competence, which means that a lot of us then are on the path to understanding trauma informed and being gender responsive. When a new concept is introduced, I always try to find something that we already know something about that and we don't have to start from all over again. So we all know something about cultural competence. We've all been exposed to

that.

That was the I call it in the ‘90s and early 2000s, we all went to those cultural competence training, and why do that? So, in fact, every one of us in this room knows something about trauma-informed care. We now just have to learn more because we all have been exposed to that cultural competency experiences.

DR. BRITT RIOS-ELLIS: And if I could say something about because I think the transgender issue right now is something that is really, really critical. I work a lot in HIV, and for so we’re going on decades now where there is not a classification, right? So if you’re a male to female transgender, you’re still classified as a gay male, right? And we’re working with -- and I was so happy when I came onboard with SAMHSA because SAMHSA actually does have a classification for transgender. The CDC still doesn’t.

So I mean, these are the times -- and I’m not saying that to -- I know the CDC is working on it, and I literally know that. But these are times now

where we're undergoing that shift, and we really need to raise people's consciousness around those issues, and I really appreciate you bringing them up. Because I think it's something that people don't understand, and maybe they've never sat down and spoken with someone, and they've never really engaged with anyone. So it stays as a very, very stigmatized issue.

But it's something that we really need to begin to understand beyond looking at gender and looking at what that means and how that manifests in so many different ways within a human's life. So thanks so much for bringing that up.

MS. SUSAN AYERS: Just one more reflective thing. Roger, I think we should take your five principles there and put together a parenting manual. When I think about this, when you sort of think about that answer, I could have done this.

But safety -- what does every family need to have? It would be a safe place. You need to have some trust and predictability. You want to help your kids learn how to make good choices. You're looking for ways to bring them up so that they share in the

decision-making and what not, and then to become self-reliant and find their own voice and their empowerment. And it's a great -- I love your framework.

DR. ROGER FALLOT: Thanks. And let me just say something about what I think of as values-based approaches because that's really sort of what we're talking about. We're talking about the fact that there are overlaps, in fact, between cultural competence and trauma-informed services and gender-responsive services, and the fourth one, which we haven't mentioned, is recovery-oriented services. Those four are overarching cultural issues in most agencies and programs. They go far beyond simply the kind of service we provide.

And to the extent that there is overlap and they need to be integrated in a meaning way is something that we're starting to understand and to work on. Renata has been particularly forceful and direct about saying that these four kinds of initiatives can't be siloed because they aren't silos conceptually or practically, and they can't live in

their own worlds in the real way in which we provide services.

So we need to come up with some creative ways to do these four kinds of values-based approaches that provide the context then for evidence-based practices.

DR. STEPHANIE COVINGTON: I want to put a little challenge out there as sort of a parting story, and the story is about my dentist. I go to a trauma-informed dentist, a dentist who several years ago said to me, “You know, Stephanie, I think I need to learn about trauma because so many of my patients seem anxious.”

She never does a trauma assessment, but here’s how she’s changed her dental practice. She has a TV in the ceiling so people can look at the television. They have earphones. They can listen to music. They’re told if they ever feel anxious in the dental chair, “If you feel uncomfortable, you can get up and walk around.” They’re told if their dental appointments feel like it’s too long, they will make shorter appointments. The word “abuse” is never used.

People are told and they put the heavy plate on the chest, the people in her office say, “Do you want to take a couple of deep breaths first? And I’m going to put this on you.” So in this short tutorial I did with her staff and the dentist, they are now trauma informed.

Now if my dentist can be trauma informed, it’s not outside any of our scope of practice. Substance abuse counselors need to be trauma informed. Mental health professionals need to become trauma informed. Primary care staff need to become trauma informed. I think we need to think about this as a universal precaution in all of our systems of care.

MS. KANA ENOMOTO: And with that, I thank our advisory committee for women’s services, and I thank all of you. So if we could just give ourselves a hand?

[Applause.]

MS. KANA ENOMOTO: And many thanks to the National Association of Community Health Centers, partnering with SAMHSA and having the vision and the flexibility to bring us here today and allow us to

have this session. So, thank you to everybody.

[Whereupon, at 6:28 p.m., the meeting was adjourned.]