SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

Advisory Committee for Women's Services

12:43 p.m.

Wednesday, March 30, 2011

1 Choke Cherry Road

Rockville, Maryland 20857

P R O C E E D I N G S

MS. NEVINE GAHED: Good afternoon everyone and welcome to SAMHSA.

I'm Nevine Gahed, I'm the designated Federal officer for the Advisory Committee for Women's Services. And we do have quorum so I'm going to pass it on to Ms. Enomoto.

MS. KANA ENOMOTO: Good morning. No, I'm sorry, good afternoon. It's been a rush. I'm sorry that I wasn't able to join you all yesterday. I understand it was a lively conversation followed up by another lively conversation this morning. So I'll look forward to getting caught up on some of that.

I was, this morning, after being at the National Advisory Council for a brief time, I was over with the SAMHSA Tribal and Technical Advisory Committee. And they also raised some important issues about women and youth and the struggles in Indian country.

And so that was -- you know I think we have great opportunities for cross-fertilization among the Committees as you probably heard all day yesterday there are some shared interests and shared directions.

And I think -- I actually like walking here this morning, and I'm sorry I wasn't here to enjoy it yesterday.

But there is a certain energy in the building with all the different Council Members here and the level of activity. And you know I think it's very electric and you can feel it. So I think we'll look forward to more of such meetings that we have in the future.

It certainly is the Administrator's wish to keep us going with a shared vision and to make sure that people have an understanding of kind of the somewhat nuanced and complex way in which we're trying to embrace both everything that needs to be done but also communicated in a manner that's straightforward enough for everyone else to understand.

We've had a lot of challenges around terminology and language. Sort of the behavioral health one being a major one that people sometimes struggle with. And you know when we are talking amongst ourselves, so to speak or within the mental health and addictions field, treatment and prevention people really want to

see themselves within that and so we can get very lengthy in our descriptions of what we do because we know that what we do is some complex, so important, so far reaching.

At the same time, when we're trying to be at the table with others, like the Department of Defense, CMS, Medicaid, Medicare, HRSA and others, it's important that we can communicate in a way that they can understand relatively quickly and in a way that's meaningful to them. Otherwise, we run the risk of keeping ourselves separate and siloed which is where we have been for many years.

But you know for example, in the conversation around health information technology, we want to make sure that our issues, our folks, our data are included in that movement. At the same time, we need to make sure that there's appropriate attention paid to issues of confidentiality, consent, privacy, et cetera that are inherent to behavioral health.

But balancing that fine line of talking to folks in a way that they can understand but not losing some of the important nuance specific to our field is

challenging. And so I look forward to you all helping us and really holding our feet to the fire and say well you can use broader language but don't forget, you still have a responsibility to these folks and you still need to stay focused on your -- internally and when you communicate you have a responsibility to make sure people do eventually get the nuanced priorities that SAMHSA has and that the field has.

So you know, I appreciate folks joining the conversation with all of the Councils yesterday and I look forward today to having a more targeted focus on what we are doing, what we can do, and what we should do for women and girls.

So with that, we'll have -- the Administrator is going to be joining us this morning. She has a very few minutes. She is -- her schedule has changed today because she has a meeting at the White House. And so we'll have her for a short time. I would like for us -- so we'll be changing our agenda for that.

I think for now we'll go ahead and let people do introductions. I'd like to start with our -- I think we're going to do very quick, if our Members could

very quickly introduce themselves and we have a few minutes with the Administrator.

HONORABLE PAMELA HYDE:. I'm sorry to interrupt. I'll be here about five minutes.

MS. KANA ENOMOTO: We actually just started.

HONORABLE PAMELA HYDE:. Okay.

MS. KANA ENOMOTO:. And so I think rather than going through a roll call of folks, you've had a chance to meet -- just let you say a few words and let them respond with a couple of thoughts that they had.

HONORABLE PAMELA HYDE:. It might be better if you just respond. I mean some of you have sat in on some of the other meetings and we've had some good conversation about women and girls and their role in our work and the importance we put on those particular needs that they have.

So I think rather than me spending time, it'd be better for me to hear from you for a few minutes because I'm literally being pulled in six ways. I was supposed to be with you longer this afternoon, but White House trumps, I'm sorry.

MS. STARLEEN SCOTT ROBBINS:. Are you sure?

HONORABLE PAMELA HYDE:. Well now if I had my way, trust me, especially this meeting I have to go to, I would be here, trust me.

DR. STEPHANIE COVINGTON:. Well let me ask a question. Not to redrill the concerns, the document's done, what I'd like and I'm sure most of the people here would like to know is what can we expect from SAMHSA in terms of action plans in terms of women, women and girls? Can we get some sort of document that follows up this document that pinpoints some direction or some commitment?

HONORABLE PAMELA HYDE:. Actually, let me say that this way, because given Kana was sick yesterday, she didn’t get to hear -- she heard some of it, she was on the phone for some of it, but she didn’t get to hear all of those conversations and literally because of what's been going on I haven't had a chance to grab her.

And it is on my Kana list that we need to talk about women and girls. So let us do that and then we'll get back to you and this group about that.

We are, and Kana can talk about this more than I,

but we are -- the next step is to do a set of action steps within each of the initiatives. So let us think about how to put these concerns together and we'll get back to you. Is that a fair way to do it?

DR. STEPHANIE COVINGTON:. And not just to belabor this, when you say getting back to, are we talking about a month, six months? I don't -- you know I don't -- just so that I know if I don't hear back from you --

HONORABLE PAMELA HYDE:. Can we hire her?

[Laughter.]

HONORABLE PAMELA HYDE:. We neèd that kind of whip.

DR. STEPHANIE COVINGTON:. Where does the getting back to fall in the scope of time lines?

HONORABLE PAMELA HYDE:. I don't know. Again, we just need to talk. We -- Kana's taken on a whole bunch of new things lately including trying to bring up OPPI. And there's a whole bunch of other stuff coming at us. We're right in the middle of trying to get RFAs out and contracts out and dealing with budget and all that stuff.

So I would hesitate to tell you something and then not live up to it. So I mean we probably should -- as soon as we have a chance to talk we will at least tell you what we can do next. But let us at least do that and then we'll let you know. That shouldn't take very long.

But it's like the conversation you listen to about the FDA thing. Everybody thinks that's going to happen next week. Trust me, we're talking months if we're lucky, years more likely, but we will keep on it.

And the other thing, frankly, about the Strategic Initiatives that I mentioned at one point, and I don't know how well it came through, is that's a four year plan. And even at that, we know we can't get everything done in there in four years. And so the next thing we need to do, and we made a conscience decision not to put timelines in there, because things change.

I mean something we might think we could get done because we got a grant program, they take it away from us and now we can't. So it's a four year issue

instead of a one year issue. Or vice-versa, something we felt might take some time we get some money for or something.

So we're in the process of, I think trying to figure out how we lay out -- what's something we can do in six months, what's something we can do in two years, what's something we can do in four years. So all of that is right where we at in this process.

DR. STEPHANIE COVINGTON:. Okay, thanks.

MS. JEAN CAMPBELL:. Yeah I was curious if there were going to be separate initiatives for women's services or are women's services going to be cross-cutting across the initiatives?

HONORABLE PAMELA HYDE:. We're not doing another initiative. Eight initiatives is what we have. On the other hand, I think as I said -- yeah, it kind of squeals when we do that -- what I said yesterday or this morning is that every one of the initiatives have population issues that are diverse depending on the population that's at question.

The only initiative that is population based is military families. And of course, it cuts every age,

every sex, every diverse group across the board. So it's not like we're going to do another initiative about that --

MS. JEAN CAMPBELL:. I misspoke there, I meant sort of like small like programs. Would they be -- are there identified women's programs in the initiatives or is it more of a cross-cutting issue?

HONORABLE PAMELA HYDE:. I think the answer to that is that it's probably both. It's probably some of both. But again, I think some of your conversation today will help inform that.

So I know this group has existèd beyond and before the initiatives but now that we have the initiatives pretty clearly there, part of what we need from you is how can we make sure women and girls are addressed appropriately in those initiatives. Again, is that a fair way to say that?

MS. KANA ENOMOTO:. I think similarly I was at the STAC this morning, Pam's going to the STAC right now, but they had asked for something like a quarterly reporting or some kind of feedback on a regular basis on what progress is made within the initiatives on the

Tribes and the tribal issues that had been brought up.

But something, I don't know if it could be quarterly, because that ends up being quite a bit of work and fairly ambitious. But some kind of regular report back on how we're doing with specific populations might be more feasible.

HONORABLE PAMELA HYDE:. Yeah, I'm -- I have to admit I'm very sensitive right now, and I'm sure you're picking it up, on what we commit to because we are so unclear about what resources we're going to have. And our expectation is we're going to have less rather than more.

So even the idea of reporting to an Advisory Committee is a set of work that I've got to have somebody do, or Kana's got to direct somebody to do. So we're just very leery about committing to things. We don't know exactly what we're living with at the moment. And we're also right in the middle of trying to get these contracts and grants and RFAs and RFPs and stuff out the door. And so that's first priority.

So again, I apologize for feeling or acting like we're not responsive. It's not that, it's just we

don’t want to promise stuff that we don't know we can do. And I am very conscience, because we've been through the first round of, okay if we had to take these cuts, what would we cut and there is no pretty picture there.

Let me be very clear, there is no pretty picture there. And there's no easy wins. There's no like oh well, that one doesn’t work or that one's not a very good program, or that staff person -- it's not even about staff people, but about staff efforts, can easily be shifted.

So we're just -- we're in a funny position here right now in terms of just not knowing what we're going to have work with. So forgive us for being a little cautious and we will get back to you about how we can move this forward a little bit.

MS. STARLEEN SCOTT ROBBINS:. But as you have those conversations please know that, I think as a Committee, that if you could consider what our role could be in helping in that process.

So if you kind of layout what you are considering, that we've got a lot of brain power,

knowledge, years of experience around this table that could help kind of flesh out some of that. So I think we would want to be an active part and role in helping you get to where you want to be with the plan overall.

HONORABLE PAMELA HYDE:. I think that's kind of your fundamental role.

MS. STARLEEN SCOTT ROBBINS:. Yes.

HONORABLE PAMELA HYDE:. And you'll hopefully delve into that this afternoon. Again, I've said it this morning and yesterday in several ways, but everything we care about whether it's groups of people or being clear about equity or whether it's the Strategic Initiatives themselves, we can no longer thing about as just a line item. Because if we do, we do that to our peril.

So regardless of what's in our budget, but that's kind of overwhelmingly looming at the moment. And regardless of what has to get cut or what has to get preserved or anything of that nature, we need to look at how the behavioral health of women and girls are getting met across what we have to work with. And that's where I think that you guys are the best suited

to help us figure that out.

And you know, I appreciate Stephanie and others who continue to raise the issue because it is -- there's so much swirling that it's easy to forget, not because we don't care, but because it's easy to forget because we get pushed by this group on that day and we get pushed by another group on another day or the White House on this day and some other part of the White House on that day, and the Congress on this day.

So it is important to have your voice and that's why this Committee I think is so critical. It's just to keep that voice up there and to keep that perspective up there. So please, don't be shy and I can't imagine any of you will be since I know many of you around the table.

DR. VINCENT FELITTI:. There is a huge resistance to working with problem oriented information in medical practices.

HONORABLE PAMELA HYDE:. I'm sorry, what kind of practice?

DR. VINCENT FELITTI:. There is a huge resistance to working with trauma oriented information in medical

practice. I don't know if you're aware of it, believe me I am, Kaiser Permanente is a wonderful place to see that in operation. I sent you a lengthy and complex email on that matter last night with copies to Kana and Nevine, yours bounced back, hopefully they will --

[Laughter.]

HONORABLE PAMELA HYDE:. What did you send it to?

DR. VINCENT FELITTI:. The addressed that's published which is --

HONORABLE PAMELA HYDE:. She forwarded it.

DR. VINCENT FELITTI:. -- Pamela.Hyde.

HONORABLE PAMELA HYDE:. It's Pam.Hyde.

DR. VINCENT FELITTI:. Yeah, okay.

HONORABLE PAMELA HYDE:. So that's the issue.

DR. VINCENT FELITTI:. I think this is the number one issue that needs to be recognized. And I've not heard anyone mention it. All of our discussions have been further downstream. But the necessary first step, in other words, clinical recognition or recognition in clinical settings is not being mentioned. I'd simply like to bring that point up for everyone's information. It needs to be addressed it's

a complex issue.

HONORABLE PAMELA HYDE:. Yeah, and actually there's nobody better at keeping that on the radar than Kana.

DR. VINCENT FELITTI:. Okay.

HONORABLE PAMELA HYDE:. So please feel free to talk about that.

DR. VINCENT FELITTI:. Part of the issue undoubtedly is awakening of personal ghosts. But there are other issues as well.

HONORABLE PAMELA HYDE:. Yeah, and we have some interesting -- you know once in awhile there are things going on kind of under the radar that we're not yet allowed to talk about publicly and this is one of them. We're trying to do some work in that area. And to the extent that Kana can describe that to you, and to the extent you feel comfortable describing what we you know, can describe.

[Laughter.]

MS. KANA ENOMOTO:. We actually have --

HONORABLE PAMELA HYDE:. You have time to do that? Okay, great.

MS. KANA ENOMOTO:. Yeah.

HONORABLE PAMELA HYDE:. So there's an opportunity on the agenda to talk about that. We are very aware of that and trying to figure out how we can do it. And in fact, I think I did say yesterday or talked about the interface with NIMH and talked about this is an example of where we're trying to look at brief intervention around trauma and what we can do to sort of pilot some of that so that it can then be taken to a bigger research agenda.

And you know for a long time, in fact you'll still see it in writing, for a long`time people would say SAMHSA can't do research. That's not true. There's nothing in Congress that says we can't do research. There is clearly an organization whose job is to mental health research. And they have much more resources to do the big research efforts and we want them to do that.

But the issue is how to partner with them about that. That's the theme that y'all have heard all two days. Because we just don’t have all the resources or all the money or all the authority or all the people

to do all of this. But we try to think about how can we pilots or how can we create the environment in which the bigger research can take place.

Or vice versa, when they learn something how can we put it into practice in a way that -- because that's where we touch the ground. So we're trying to do -- trying to think about that more as well. I think we have a burgeoning relationship with NIMH that's better than it's been for awhile. So that’s a positive. And NIDA and NIAAA as well.

I'm being told I have to leave. So anything else that you can't live without asking me, Kana knows everything and more.

MS. KANA ENOMOTO:. No, thank you very much for spending the time with us.

HONORABLE PAMELA HYDE:. Thanks, I appreciate it.

MS. KANA ENOMOTO:. Thanks.

HONORABLE PAMELA HYDE:. Have a great meeting.

MS. KANA ENOMOTO:. Alright, with that I think -- I appreciate the comments and I hope you all can understand that right now with major potential budget cuts looming of you know, in the scopes of hundreds of

millions of dollars, it really is hard to commit to a certain set of actions on any domain.

So I think that's probably what Pam is getting to because there are issues, not only are programmatic but even operations. How is this level of cut going to affect our agency operations. Because we're not sure how they'll be -- how much flexibility we will have in determining where to take those cuts. But I think there is an ongoing commitment to keep a level of activity going.

And so you can rest assured that that -- the concerns that you expressed about not seeing women's specific issues outlined in the initiative paper -- I mean I've heard it and I think it's good that it was raised here, and you know I think like Pam said, we get pressures from many different areas to -- what about this, what about that.

And to the degree that this Committee continues to say, what about women, what about girls, what about the issues that pertain to them, what about gender specific services, it's important because it helps us to make sure that does keep getting addressed and

doesn’t fall off the radar.

One of the issues around new initiatives that you had talked about Jean -- I think I might make the distinction between programs and activities. So there are probably -- I mean given what we are looking at in terms of the budge, there probably won't be major new grant programs focused on any single population other than what we're already seeing.

It's very hard to do a new grant program where -- either under a continuing resolution or in an environment of fiscal conservatism. In that there's -- we're trying to preserve the core of what is. However, that doesn’t mean that we can't have activities or a thematic focus on women and girls within the programs that we have.

And then there will continue to be certain specific women's -- I mean pregnant and post-partum women's program will continue, FASD activities. Things like that where we do have a focus, an explicit focus on women also will keep going to the degree our budget allows it to keep going. And that's sort of the unknown.

MS. HARRIET FORMAN:. Could I just ask one quick question?

MS. KANA ENOMOTO:. Sure.

MS. HARRIET FORMAN:. I just wondered whether you had within the Department a time line for developing the action plans that Pam referred to? I mean if you have a rough time line then as it's being developed we could expect some sort of feedback.

MS. KANA ENOMOTO:. I think the -- well I think the first answer is, no we don't have a rough time line on developing the action plans because I think the -- our grants and contracts process of this year has really thrown us into a loop of you know, when you're revising and rewriting and reviewing 150 pretty lengthy big funding documents it's a lengthy and time consuming process.

And so with me being in the midst of that and trying to stand up the OPPI organization, with fantastic staff support, but and being somewhat understaffed at the moment, I don't think we've clearly said that this work can commence at this point and we'll end at that point. Because I don't think we

even know what we have to work with yet. But hopefully you know, what is it now, March, so I think -- I look forward to spending our summer on developing these work plans.

So I'm imagining you know, it's sort of like children off to school. I mean I think these grants and contracts they have to get out the door and they have to get sort of launched before we can turn our attention to other things.

I think you don't want to see us lapsing tens of millions of dollars because we can't get a grant announcement out on the street fast`enough. Or that people only have 30 days to respond to a massive grant announcement.

So I think we're given just sort of Federal procurement and award kind of deadlines, that's the priority as she said. But certainly not far on the tails of that the next priority is getting these work plans in place.

Now I think we probably need to start with our business of the Committee and taking our roll call and approving our minutes. So I'll hand it over to

Nevine.

MS. NEVINE GAHED:. So I think what we're going to try to do is you know, just go around introductions and move from there. We have on the phone with us also Bobbie Benavente from Guam who couldn’t make it today, but at least she's attending.

So do we want to start. Stephanie?

DR. STEPHANIE COVINGTON:. You probably heard enough from me already. Stephanie Covington, Institute for Relational Developmental and Center for Gender and Justice in La Jolla, California.

MS. KANA ENOMOTO:. Actually, if I could -- I don't know if you guys were able to do this at the NAC meeting yesterday. Were they able to say sort of who they are and what they did? Because we have several new folks here today and they may not have had a chance to kind of know sort of why are you on the Advisory Committee for Women's Services.

DR. STEPHANIE COVINGTON:. I think I'm on because I'm an advocate for women's services. I've done this work for probably, I don't know 30 years, but who's counting. I do a lot of training and speaking and

writing and commotion.

MS. KANA ENOMOTO:. She literally wrote the book on women in recovery for those who don't know Stephanie.

MS. STARLEEN SCOTT ROBBINS:. And commotion.

[Laughter.]

MS. STARLEEN SCOTT ROBBINS:. I'm Starleen Scott Robbins. I'm with the North Carolina Division of Mental Health Developmental Disabilities and Substance Abuse Services, and I'm the state Women's Services Coordinator for North Carolina.

I'm also currently the President of the Women's Services Network for the National Association of State Alcohol and Drug Abuse Directors, which represents all of the women's services coordinators for the states and territories.

And I have been in the field for over 20 years and women's treatment is my passion and I've had the opportunity to sit at this table and learn from all of the wonderful minds and women and men who also share that passion and I really and truly am grateful and appreciate that. Thank you.

MS. HARRIET FORMAN:. Hi, I'm Harriet Forman and I'm actually wondering myself about my role on this Committee. I'm a retired educator. My last position was as a pre-school special education consultant at a state department of education. I was a principle.

I've worked with young children and have seen -- and children at the elementary level and certainly seen the impact of substance abuse and mental health issues on their lives and their education. And the last several days I've been trying to find the threads of the discussions to help me see what role I can play on this Committee.

I currently live in Vancouver, Washington. And I'd appreciate any help that you can give in terms of understanding my role on this Committee. I've been active in feminist politics since the 70's. I bring a lesbian viewpoint to the table and I'm here available to do all I can to help the cause.

DR. VINCENT FELITTI:. I'm Vincent Felitti. I'm an internist with Kaiser Permanente in San Diego. I believe I'm here because I'm the co-principle investigator of the ACE Study, the Adverse Childhood

Experiences study, a 17,000 person study that's been going on for 15 years now matching 10 categories of adverse life experiences in childhood with adult health and well being about a half century later. The relationship is extraordinarily powerful and untouched by most people.

MS. JOAN GILLECE:. And you're the token man.

DR. VINCENT FELITTI:. And I'm the token man.

[Laughter.]

MS. JOAN GILLECE:. And he's a good one to have if you have to.

DR. VINCENT FELITTI:. And I'm`sure my oldest daughter would warn me not to sound like a 19th Century Sicilian while I'm here.

[Laughter.]

MS. JOAN GILLECE:. Do you want us to introduce ourselves as well?

MS. NEVINE GAHED:. Why don't you go ahead.

MS. JOAN GILLECE:. Hi, I'm Joan Gillece and I'm the former recipient of several SAMHSA grants to do work on women in trauma. And about six years ago I joined NASMHPD, the National Association of State

Mental Health Program Directors, where I've had the privilege of overseeing several SAMHSA initiatives on trauma and the prevention of seclusion and restraint.

MS. ANDREA BLANCH:. I'm Andy Blanch and I've been working on issues of women and violence for several decades now I guess. I know many of you around the table and I work as a consultant with Joan and Tonier and others at the National Center for Trauma Informed Care.

MS. TONIER CAIN:. I'm Tonier Cain, I work with Joan and Andy and I am very heavily passionate about the trauma informed care contracts that we receive at the National Association of State Mental Health Program Directors.

MS. KANA ENOMOTO:. And Joan, Andy and Tonier are going to be doing part of the presentation that we're going to have at 3:15, so thank you.

MS. JOHANNA BERGAN:. Hello, I'm Johanna Bergan. Thanks for asking why we're here instead of what we do. During the day I work out of a natural foods grocery co-op, which I love but doesn’t connect well to this platform.

Although I'm switching my position a bit to do education and my primary focus is teaching moms in low income or younger age, some sort of kind of minority within women population how to cook and how to bring that home to their children.

But I have -- I serve on Youth M.O.V.E National as a National Board Member and I work as a youth advocate in all my spare time, primarily from experience within the mental health system, but my experiences are broadening all the time. And our organization is moving towards a lot of work with child welfare and particularly the foster care system.

And I will probably be quiet this afternoon. I'm expecting and I'm very sure my child is a boy who is causing me lots of trouble today. I kind of have like all day sickness instead of just morning sickness.

MS. AMANDA MANBECK:. Hi, I'm Amanda Manbeck. I'm the Former Executive Director of White Bison. I left that position to go back to school so I'm about four months away from receiving my B.A. in Psychology.

[Applause.]

MS. AMANDA MANBECK:. Probably by the next time I

see you guys I'll have that done. I think that my role is, of course I always ask what's going on with natives, you know, what's in it for natives. But more than that, what's in it for young girls. You know I think that there's so much that we can do to change the world if we just give young girls the direction and path that they need to.

Women are stronger than they know and I believe that there's a lot of young girls that are growing up in today's world doubting themselves because of being put in situations where they do experience trauma and take the wrong road. So I'm really`grateful to be here as always and I learn so much every time. Thanks.

MS. JEAN CAMPBELL:. Hi, my name is Jean Campbell and I'm a Research Associate Professor at the Missouri Institute of Mental Health which is part of the University of Missouri in St. Louis. And I direct their program in Consumer Studies and Training.

And I was trying to figure out why I was on this group. I was a little perplexed about the invitation, but thought that I could make a contribution. First,

I'm a mental health consumer, I've been through the system and I have that, I had that lived experience.

Also that I've taken that lived experience and my training as a researcher to really empower through research consumer voice. And if there's any possibilities of my training and work could make contributions in that way then I think I could be helpful. Plus, I always have opinions on everything.

MS. HARRIET FORMAN:. Unlike the rest of us.

MS. JEAN CAMPBELL:. Yes.

MS. YOLANDA BRISCOE:. Hi, my name's Yolanda Briscoe and I have a Masters in Educȧtion so I have a background in education as well as a Doctorate in Psychology. I've worked with women in recovery, women in treatment, women and children. I've also worked with the DD population.

I currently run a residential and outpatient services and do quite a bit of work with the Pueblos in New Mexico and partner with quite a few of them as far as training, supervision, evaluation. And I represent, gosh, probably all of the above. There's a little African-American in me, there's Hispanic,

there's Native American, there's White. I'm 50 so I have an AARP card now.

So I represent all walks including -- the other day somebody I asked in my culturally relevant evaluation, in terms of sexuality how do you identify, she said "flexible". And so that would be me. I liked that. So I am very, very honored to be here with these icons and whoo, I hope I can -- my style is usually listen more, talk less so I'm going to push myself to share a little bit more but I'm looking forward to what I can learn from this esteemed group. Thank you.

MS. KANA ENOMOTO:. You are a part of the esteemed group so thank you very much. I think we have -- we will go around to the rest of the room to get introductions but I want all of our new members to feel welcome. And I think some folks who don't talk a lot often when they speak it's quite powerful.

We've learned a lot from Amanda, and Amanda you said you've learned a lot from being here. But you know for I think a few meetings Amanda was pretty quiet, maybe said one or two things, but every time

she spoke everyone in the room was silent and everyone felt that it was a powerful moment.

And so she is a fantastic leader and an example of someone who comes from a different walk of life and isn't necessarily a tenure track professor or a world famous researcher. But you know I think everyone who's here has that kind of lens to bring and was chosen because you are leader of some sort wherever you are.

And so I think you know, the goal is not just to have marquee names but the goal is to have a full compliment of perspectives and people who are passionate and articulate about bringing those perspectives.

And so not everyone may be focused on women and girls in your every day life or in your work, but you have an expertise or a lens that is valuable and from the Administrator's perspective, my perspective, the Secretary's perspective is needed to move the ball forward for women and girls.

So for example Harriet, you know being from an education background and with the early childhood

background, we know that that's where we need to go. But we don't know all of the players there. We don't know how that necessarily plays out at the state or local level.

And so that's a lens that you bring to us as we say, well we really need to do this for women and girls or we need to do this in the area of early childhood and you can say, well have you thought about that, have you talked to these people.

You know we've often sort of been -- is it sort of spent a lot of time admiring our own reflection or sort of talking to the behavioral health folks, and not necessarily getting outside of that box. And as we try to do that we often go to the people who are coming to us already.

But what we might need to do for some things, like early childhood, where we don't have as many far reaching tendrils is to you know, call the person who's not expecting our call, which we haven't done yet. And so getting these varied perspectives and these really wise lenses on the issues of women and girls is I think going to enrich the conversation.

So I'm grateful to all of you for being here. I'm grateful to our presenters. So I'd like to also go around the room and have our folks -- I don't like having meetings where we don't know who's around us. So if we could do that.

MS. NEVINE GAHED:. Bobbie's on the phone.

MS. KANA ENOMOTO:. Oh, I'm sorry, Bobbie you're on the phone. The famous Bobbie Benavente.

MS. BARBARA BENAVENTE:. [Via telephone.] Good morning, it's 2:21 a.m. here tomorrow.

MS. KANA ENOMOTO:. Thank you Bobbie for being with us.

[Laughter.]

MS. BARBARA BENAVENTE:. [Via telephone.] I wasn't sure -- can you hear me clearly because there's some difficulty hearing you and then there's this loud beep that is really piercing my ears and it repeats itself like every two minutes so I have to hold the phone away from my ear.

MS. KANA ENOMOTO:. Is there -- we're looking at our -- Katie says she's going to get on it and I have a lot of faith in Katie so that's great, thank you.

So Bobbie if you would introduce yourself. Bobbie's very, very well known in Asian-American Pacific Islander circles for her leadership around behavioral health issues.

And Bobbie if you could talk a little bit about what's going on for you. And then I don't know if you have any updates about folks in Guam and how things are going there.

MS. BARBARA BENAVENTE:. [Via telephone.] Just real quickly I'm also new to the Committee. I think it's about a year now and that's still fairly new as far as my experience goes with contributing to the discussions.

And I've been -- I'm a Chamoru woman, I live on Guam and Guam is my home. I serve on several national boards that serve Asian and Pacific Islanders. One there close to my heart is the Pacific Behavioral Health Collaborating Council which is comprised of members from each of the island in Micronesia. It's 3:00 in the morning --

[Whereupon, the telephone connection was lost.]

MS. KANA ENOMOTO:. Bobbie, I'm not sure if you

can hear me but we have lost you.

MS. BARBARA BENAVENTE:. [Via telephone.] -- feel that -- yeah really vulnerable right now because it's early morning and I haven't had coffee and I'm not -- but wanted to share that I am a victim of trauma and so I can really be the voice for women and girls who need the services and attention that may be lacking, at least in this part of the world, to try to bring that to the forefront for some national policies. And I just wanted to put that out there.

MS. KANA ENOMOTO:. Thank you Bobbie, I appreciate that. We did miss you fòr a moment so I don't know if you want to go back to -- I think we heard you first say that it was 3 o'clock in the morning.

MS. BARBARA BENAVENTE:. [Via telephone.] That is a message for me. Yeah, that beep came through again and then everything kind of goes dead and then it will come alive again and then I can hear you or you can hear me.

I was saying that what I bring to the table other than my professional involvement in national boards

that serve Asian and Pacific Islanders, is that I am also a victim of trauma as a child and as an adult and have worked through a lot of issues around healing and ensuring that access for treatment services for women and children on Guam is provided based on the personal experience, the survival that I've done and that I've made and just advocating for what is lacking. So I bring that to the discussions in terms of some real life experiences.

MS. KANA ENOMOTO:. Thank you. Thank you. And Bobbie did you have any update on -- are people seeing an behavioral response around the issues in Japan and with the risk of things having a ripple effect throughout the Pacific?

MS. BARBARA BENAVENTE:. [Via telephone.] Oh, absolutely which is one of the reasons why I decided to not travel as planned to be with you all. As you know, we're close to Japan, we're two, three hours away and our communities are tied closely in terms of you know, a lot of Japanese tourists who come to Guam, a lot of the Chamoru people married into Japanese families and vice versa.

And some of our family members have lost or have lost contact with people who live in Japan and were not sure whether they are alive or just missing and can still be found. But there's a lot of activity around helping with the Japanese who live on Guam, who are touring Guam.

We're still investigating something that just happened a couple of days ago. This week a Japanese tourist, a 20 year old girl, jumped off one of the hotel floors and died. She died by suicide and they're investigating the connection to loss of family members during the tsunami.

And so there's a lot of mobilization for fund raisers and you know, working with our local you know, Japan Club of Guam and Chamber of Commerce and other groups to send money and resources towards Japan. Not to mention the whole fear of the radiation that’s now in the food and water, milk and veggies. And we import a lot of food from that country.

MS. KANA ENOMOTO:. So Bobbie we should also follow up, I'd like to connect you or if you can help connect the Department with our Disaster Coordinator,

our Emergency Coordinator Terri Spear to the degree that there's some things that SAMHSA could do to be supportive I think we're happy to do that.

MS. BARBARA BENAVENTE:. [Via telephone.] Alright, thank you.

MS. KANA ENOMOTO:. Thanks. So continuing around the table and around the room.

MS. BEVERLIE FALLIK:. Hi, my name is Beverly Fallik and I'm with CSAP and the Project Officer of our data analysis contract. And I'm recently joined the Federal workgroup and I'm very happy. My work prior to joining the government included research on gender differences in cognitive development. So I'm very happy to be back to looking at women's issues.

MS. SHARON AMATETTI:. Good afternoon, I'm Sharon Amatetti and I'm with SAMHSA's Center for Substance Abuse Treatment. I've been with SAMHSA's Center for Substance Abuse Treatment for a long time now, 18 or so years and have been working pretty much that entire time with my colleague Linda White-Young really to advance CSAT's women's portfolio.

Our Director, Dr. Clark is very committed to

providing services for women and looking at gender issues. And so we've been able to operate in a supportive environment. I've managed contracts that host our women's conference, that do our women's leadership training.

And I also manage a project which is a National Center for Substance Abuse and Child Welfare which really looks at working with family members and particularly mothers whose children are in the child welfare system because of maternal substance use disorders. So glad to see all of you here today. Thank you.

MS. JASMIN CARMONA:. Hi, my name is Jasmin Carmona, I'm a research associate as the National Association of State Alcohol and Drug Abuse Directors. I'm also one of the liaisons to the Women's Services Network. I'm here pretty much to further my own knowledge about women's treatment and recovery services and also to work with SAMHSA.

MS. SARAH WURZBURG:. Hi, I'm Sarah Wurzburg, I'm the co-liaison with Jasmin to the Women's Service Network at NASADAD and I'm a research analyst.

MS. MARYLYN MCCANTS:. Hello, I'm Marlyn McCants and this is my first meeting. I currently am working with JBS International which is a consulting firm working with SAMHSA around the women, children and families grantees providing technical assistance.

MS. LINDA WHITE-YOUNG:. Hi, I'm Linda White-Young. I'm one of the Federal Project Officer having the pleasure to work with Sharon for 16 years. She was here when I got here actually. And we have enjoyed the opportunity to work on women's issues. I also focus on young children, children 17 and under and fathers of children.

So I hope in the future when I'm feeling a little better, I'm not trying to be cute back here, but I went to the eye doctor this morning and they rushed me into emergency surgery because they said that I had a rip in my retina so they had to put it back together right away. But I came in just to give you, a little bit later on, about what's going on with our program.

UNKNOWN SPEAKER:. You are very cute though.

[Laughter.]

MS. IRENE SAUNDERS GOLDSTEIN:. I'm Irene

Saunders Goldstein and my position is to write the minutes of this meeting.

MS. KATIE KOSTIC:. I'm Katie Kostic, I'm the contractor and work with the ACWS.

MS. KANA ENOMOTO:. Okay, and we have seven people joining us online by phone today. So I think this is -- which is great considering we are, that we're sort having the dueling banjos, multiple dueling banjos with all the Centers having their meetings at the same time. So we thank you those of you who are joining us on the phone.

Dr. Velma McBride Murry is unable to join us today, she had a previous commitment. But she is another new ACWS member that we're looking forward to welcoming at our next meeting.

I appreciate that we are a little bit behind our schedule. So what I'm going to do is very quickly look at the minutes and we'll do our business, get the minutes approved.

In September we were, as part of the ACWS traveling road show, in San Diego where we were able to participate in the National Partnership to End

Interpersonal Violence Across the Lifespan, and the 15th International Conference on Violence, Abuse and Trauma.

I think that was an experience that probably met with some mixed reviews. As the group in some ways is very advanced and very thoughtful and in other ways is probably a little bit not as familiar with some of the policy work and advocacy that's been going on for some time that many of us are familiar with at the national level.

But it was a fascinating group to work with and certainly impassioned in trying to do the right thing. So we were glad to be there. We had a listening session with participants at that conference. And I think we had in total about 40 --

MS. NEVINE GAHED:. Yeah, almost 40 people.

MS. KANA ENOMOTO:. -- 40 folks who participated and gave us good feedback. They told us we needed to disseminate the ACE Study finding Dr. Felitti and that we needed to work with -- you know, I think there was a lot workforce.

It was I think primarily a provider group that

joined us and said, and really emphasized the need to do more trauma informed training for behavioral -- people in behavioral health as well as other social services. So there were a lot of, not our behavioral health folks but child welfare and other social services type of groups there.

We had our ACWS roundtable and then we had the opportunity to hear from three SAMHSA grantees who were operating in the San Diego area and they were -- we have many grantees in San Diego but these were ones that were highlighted by our program staff as really exemplary.

So we heard from the Mental Health North San Diego group which I think is a primary behavioral health care integration grantee. We heard from Charles Wilson who has had a child trauma grant.

And Mary Baum with Social Advocates for Youth San Diego, which has been a -- although she talked about the role of promotoras in delivering services, they're actually one of our DFC, Drug Free Communities grantees, ours and ONDCP's.

And that was our parting meeting with Gail

Hutchings and Susan Ayers who both offered some very nice presentations on their perspectives, some parting words for us.

And so with that, may I have a motion to approve these -- or does anyone have any amendments or comments about the minutes?

[No response.]

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

[No response.]

MS. KANA ENOMOTO:. Maybe someone who was at the meeting.

MS. STARLEEN SCOTT ROBBINS:. I motion to approve.

MS. KANA ENOMOTO:. Okay.

MS. YOLANDA BRISCOE:. Second.

MS. KANA ENOMOTO:. And Yolanda motions to second that so they are approved, the minutes are approved.

So now I had -- it's on here for me to talk a little bit more about OPPI's role in leading SAMHSA's Strategic Initiatives. I think Pam's alluded to it and I've covered it a little bit in that it's really

still forming, what OPPI's role will be. But certainly we have a policy innovation role so to look at where are there gaps, where do we need to do something, where we're not doing something.

So fresh ideas, emerging needs in consultation with our stakeholders, with our committees, with the centers and offices and our other Federal partners. That's part of the -- some of the innovation will sit inside of OPPI. Policy liaison, we have Toian Vaughn, who is the DFO for our committee, lead on committee management. We have many liaison roles.

We actually have a Tiger Team.` I started in February, I said we would do Tiger Team for 100 days where any of the staff who wanted to participate in shaping the organization could join us. And so we did get about 25 of the staff who, or 20 of the staff who agreed to join the Tiger Team.

And so we've done a number of brainstorming sessions. And when we came up we were sorting of putting up all of our liaison roles. People in OPPI who have a job, a primary function of liaisoning with another outside entity, we have many.

So it's the office that -- we have a liaison with OMB on our clearances. We have a liaison with the Department on our correspondence. We liaison with ONDCP. The Assistant Secretary for Preparedness and Response, the Office of Global Health Affairs, CMS, Office of Minority Health. The list goes on.

So much of what happens in OPPI is when things come from other agencies and other departments to SAMHSA, it gets handled or triaged in OPPI and then we coordinate a response from across the Centers. So that is something that keeps us quite busy.

And then another major bucket of the OPPI activity is policy coordination. And so we will help -- and this is where, we're the ones who are going to be helping with the work plans across the Strategic Initiatives.

But even beyond, or in addition to, coordinating that work, OPPI has a role in looking at our grants and contracts and making sure that the policy agenda for SAMHSA is carried out through everything that we're doing, through our financial activities, our grants and contracts but also through our

correspondence and to some degree through our other communications. Certainly policy communications, any policy documents, the Strategic Initiative paper was developed in OPPI.

And as Pam mentioned earlier, her office now is quite small and so OPPI's role really is the extension -- in the past our Administrators had a number of Senior Advisors, to the point we were joking about having a baseball team of Senior Advisors in the Administrator's Office. So we got quite heavy and it -- and then it was harder to steer sort of, with lots of people with their own independent portfolios.

And so Pam, Administrator Hyde, had thought it would better to put that in more of a structured environment so that we can have a good sense of what's happening and making sure that we have not wasted motion. Sort of you know, getting a good golf swing or a good tennis swing. You know, you can't be wobbling around here and there you want it to be one smooth motion.

And I think that's our goal for our public policy efforts. That we don't have a lot of noise of

activity that’s not related and not supporting and not integrated in some way. So that's OPPI's small charge.

Right now, we're a little bit of the Bad News Bears where we're sort of trying to figure out who's on which base and who's approving whose time cards. And so we're not quite the smooth operating machine that we'd like to be. But we do have a fantastic group of folks and I think we're all very committed to the work.

So one way in which the ACWS can have a role, is because you have a liaison within OPPI, you know we'll have a sense of what's happening across the Agency and can feed that to you. And whether or not that's in a report, I don't know, but somehow we will feed that information to you and then you can feedback your perspectives and then you have a in-road to SAMHSA that has, again has a broader reach in terms of providing that feedback to our Centers and Offices.

So that’s OPPI in a nut shell. Did I need to read this?

MS. NEVINE GAHED:. You're okay.

MS. KANA ENOMOTO:. I'm sorry, I'm so bad at following a script. So with that, I guess if we could back around to our Members and get some updates from you, or I know we had a very short conversation with the Administrator, if you wanted to have some follow up to that we could also do that for the next bit of time before we have Stephanie's presentation. So we have about 40 minutes to do that for roundtable discussion.

DR. VINCENT FELITTI:. I'd like to register an idea for people to consider. Basically it seems to me that SAMHSA is in the business of producing change and one of the approaches that I've not heard discussed is the possible use of broadcast television, particularly soap opera, to provide change by means of narrative.

This has worked out well in Africa in terms of prevention of AIDS, far better than the usual public health approaches wherein information was provided in storylines that were written into soap operas reaching enormous audiences that essentially no governmental cost because advertisers were paying for it.

One of the underlying themes in everything that

we have been discussing has to do with the failure of parenting skills. And if one looks at the issue of parenting, how one might improve it across the country it strikes me that the low-hanging fruit would be that huge portion of the population which has had no personal experience with supportive parenting themselves.

To that end, would it not be possible to work into the storyline of soap operas illustrations of what supportive parenting looks like and how it plays out over time. Contrasting that will illustrations of destructive parenting and how it plàys out over time. The premise being that many people with no experience in that themselves might do better if they only knew what it looked like.

The audiences are huge. There would not be any funding needed for this. The material would certainly be thematically lurid and not dull in the hands of any capable writer, et cetera. An organization already exists called Hollywood Health and Society, which is a partnership of the CDC and the Annenberg Center at the University of Southern California.

I've not been impressed with the utility of that organization in moving any of this forward. There are a number of very bright people on it, but basically operating as a consortium of dead wood that's not making itself known.

I bring the idea up because I think it has merit for all sorts of reasons, particularly at a time when money obviously in short order for new fundings.

MS. KANA ENOMOTO:. I think it is a -- getting into mainstream media is an important avenue of getting our message out. And that is why public awareness and support is a major Strategic Initiative for us.

We are actually the day after tomorrow cosponsoring, with the Entertainment Industry Council and the National Association of Social Workers, an event with the Writer's Guild of America. So I know that Dr. Felitti you were able to join us when we had a meeting with the -- another, I think it was a group of writers and producers working on shows in Los Angeles --

DR. VINCENT FELITTI:. In L.A., yes.

MS. KANA ENOMOTO:. In L.A.

DR. VINCENT FELITTI:. So you know Marie Dyak, obviously.

MS. KANA ENOMOTO:. Yes, I'm the one that asked Marie Dyak to give you a call.

DR. VINCENT FELITTI:. Okay.

MS. KANA ENOMOTO:. And so we are trying to expose, give accurate and science based information to the entertainment industry so that they can get compelling portrayals of these issues in to the mainstream consciousness.

Part of it is to reduce prejudice and discrimination as well as to raise awareness for people to recognize, oh my goodness something like that happened to me and maybe that explains some of these other things.

It's sort of helping people connect those dots. As well as I think showing positive social roles and examples for folks. So yes, we are trying to do that. And we've also worked with Health in Hollywood, I think specifically around a 90210 episode they did on bipolar illness.

But you know we do have a thread of activity trying to recognize positive portrayals as well as accurate portrayals of mental illnesses and addictions as well as prevention efforts in mainstream media. So we have the Voice Awards as well as the PRISM Awards. So to the degree other people have good ideas and other good connections for ways to do that we're happy to think about it.

DR. VINCENT FELITTI:. A related idea would be to develop a pilot in some university setting or community college setting where the key pieces are already salaried. In other words, the head of a drama department, the head of the psychology department, et cetera, the head of an information technology department.

It would certainly be a very interesting Ph.D. thesis to develop a pilot for such a show.

DR. STEPHANIE COVINGTON:. If you're not going to say anything about the ACE Study I think I will.

DR. VINCENT FELITTI:. Please.

DR. STEPHANIE COVINGTON:. Well I told Vincent at the end of the day yesterday, I said I picked up the

women's thing and sort of did this and I thought he would take the ACE Study and do this but I didn't want to grab your story. But I'll do it today.

I was amazed yesterday as I sat there, well I had many moments of amazement but listening to the dialogue, the discussion, what SAMHSA's trying to do, how this links with that, how this links with that. There was no discussion of the ACE Study.

Somebody in the back of the room mentioned it as a passing remark with about the same emphasis as the word woman was used by somebody else. It was just this sort of passing thing. And yet, it is so the connective tissue that cross-cuts these initiatives, the groups you want to work with, what the issues are, how you link mental health to physical health.

All these things and yet it wasn’t mentioned and I was flabbergasted. How can this, at this point in time can this be an omission. So that's a concern.

DR. VINCENT FELITTI:. Well apropos that. I mean I truly have no idea whether people in the room are familiar with it at all. But maybe a practical thing would be for you all to distribute by email a copy of

the Lanius chapter, Chapter 8 in the Lanius Vermetten book which is probably the best overview of the ACE Study. And if people are not familiar with it then it would certainly be a simple way of becoming so.

MS. KANA ENOMOTO:. And we'd be happy to distribute that to the joint --

DR. VINCENT FELITTI:. And that's fine with the publisher as long as you know, the attribution of who the publisher is and what the book is there and it's -- you know, they're, Cambridge Press is certainly comfortable with that.

MS. KANA ENOMOTO:. Okay, great.

DR. STEPHANIE COVINGTON:. Can I also suggest they also use the article out of the New Yorker?

DR. VINCENT FELITTI:. Oh, yeah. Sure.

DR. STEPHANIE COVINGTON:. I think the article in the New Yorker that came out a couple weeks ago, I think that that was also a very good article to help.

MS. JEAN CAMPBELL:. Do you have any?

DR. STEPHANIE COVINGTON:. Well I mean I could get it.

DR. VINCENT FELITTI:. We have digital copies

that are very easy to distribute. And if Kana has a digital copy or I'll send you a digital copy that you can then pass on. It was the lead article in the March 21st issue of the New Yorker about the implementation of essential aspects from the ACE Study and a large poverty clinic in San Francisco.

The interesting thing about the ACE Study, and this is really a big idea that has to do with virtually everything that we've been talking about, is the widespread resistance to using this information, to obtaining the information in the first place.

I mean one can have the most wònderful referral services in the world that are available to you, not that they commonly are, but you know if you did, that really wouldn’t matter because the initial problem is that people don’t, are not comfortable getting the information and therefore, are unaware of the trauma histories of patients in clinical settings. Or overwhelmingly unaware and therefore, would have no basis for a referral even if superb referral services were available.

I mean I've spoken with probably 2,000 patients

over the past 20 years in detail and at length and often repetitively about these matters. And any time any one of them was institutionalized, I would always ask them you know, did this come up? And overwhelmingly the answer was no, nobody ever asked.

A small number of people were bold enough to say that they had brought it up on their own. And overwhelmingly the response to them was well look, you've got a lot of trouble, let's deal with the current issues first and if we have any time then we'll you know, then we'll go back to those issues. Which means that the root causes were of course comfortably never recognized.

MS. JEAN CAMPBELL:. Can I comment on that?

DR. VINCENT FELITTI:. Most physicians, or many physicians -- well most I think, are uncomfortable with dealing with this information. Certainly, many of my colleagues told me when we you know, put together the ACE Study questionnaire, you know you're crazy you can't ask patients questions like that, they'll be furious. And besides, nobody will tell you the truth.

Well we have done that now with literally 440,000 people over an eight year period. To my awareness, nobody's been furious. Now, some people undoubtedly may have lied and said no, but that's okay. I mean the number of yes answers were overwhelming, et cetera.

So this is a very big issue that must be recognized and figure out how to either deal with it or circumvent it. Namely, the resistance in clinical settings to obtaining the core information that underlies everything that we're talking about. I mean it's the issue under suicide. It’s`the issue under alcoholism. It's the issue under drug use.

You know a useful insight to remember, you take the demonized street drug crystal meth. Well if you go to any big medical library and take down the 1940 bound issue of the Journal of the American Medical Association, you will enumerable advertisements, full page ads, for the latest, greatest anti-depressant medication.

The first prescription anti-depressant medication introduced for sale in the United States in 1940 began

with "M", it was methamphetamine. So does it mean anything that the most commonly sold street drug in the country has potent anti-depressant activity?

MS. KANA ENOMOTO:. Thank you. Jean.

MS. JEAN CAMPBELL:. Yeah I was interested about the resistance to hearing the news, the information, the research. And it struck me in this case that many years ago, and I can't remember his first name, his last name was Rose, but he was -- and he asked that when you did the intake information, collected the intake information when people were being admitted to psychiatric hospitals or other sorts of treatment, that they ask about the abuse history. Because he had searched through records of you know, data collection and found very little.

And what was interesting is that there were some groups that actually opposed that information because of the issue of blame, like parents that had abused their son or daughter. But it was the attitude of the providers that you know, not wanting to collect the information, not wanting to deal with the results of the information.

And I don't know, but I don’t think it every successfully got in to like the standardized 40 item data sets or whatever the states were collecting to have that. He was like the sole voice for quite awhile and then there was silence.

DR. VINCENT FELITTI:. Certainly so, which is the basis for the lengthy and complex email that I sent to Kana and to Pamela and to Nevine last night proposing that a -- and we have a big background in doing this at Kaiser Permanente only in San Diego, it is not a popular idea to propagate through the organization, to develop and put free on the internet a comprehensive medical questionnaire with biomedical, psychological, social and in particular, trauma oriented components.

It would take maybe 45 minutes or an hour to fill out at home. And if patients wish, they could do that. And if they wish they could print it out and if they wished to give a copy of that to their physicians.

The covert idea is that we would be using patients as a market force to bring about change in the medical profession to move from its current

symptom reactive style of practice to the more comprehensive style that was originally conceived for primary care but never attained.

I believe that if that were well done and posted on the internet that within a few years several million people would likely find their way to that and fill it out.

So rather than taking on the fruitless task of trying to change individual physicians or even more difficult, medical schools, basically what we're using is patients as a market force to bring about change by flooding the market with comprehensive, detailed legible in-depth, in-breadth information at a level that most physicians have never had the opportunity to work with. And which many would prefer not to.

I mean there's no question that having --

MS. KANA ENOMOTO:. Right.

DR. VINCENT FELITTI:. -- having such information imposes a responsibility on you. It's easier to deal with the symptom of the moment. There's no question about that than it is to work in a setting of comprehensive understanding.

MS. KANA ENOMOTO:. Yeah.

DR. VINCENT FELITTI:. That’s the change that needs to be brought about.

MS. KANA ENOMOTO:. Okay. Sharon you had wanted to make a comment then I think Starleen, you're next.

MS. SHARON AMATETTI:. I was just going to say that I think that most to the professional staff at SAMHSA has recd in the past information about the ACE Study. We've had in-services about that. We've distributed different articles and publications.

So it's not so much that we don't know about the study, but it's -- I was going to rècommend, and it sounds like you’ve already started to do that through your email conversations that what we really need to think about now is what to do with this information and how does it apply Strategic Initiatives and also our individual grant programs and you know, where are opportunities to make use of the knowledge.

So it's really the next step more than disseminating the basic information. Because I think that that has sort of been covered, it's the next piece. And I'm glad to hear that you're you know,

suggesting some ideas.

DR. VINCENT FELITTI:. Get Nevine to pass on the information that I sent to her.

MS. KANA ENOMOTO:. You're going to have an opportunity a little bit later to hear from Dr. Larke Huang who's going to talk to you about our trauma screening and brief intervention work that we are doing based on input from Dr. Felitti and others. And I think we're aware that there is a resistance to asking the questions.

I remember actually I was a clinical supervisor back in the day and I had a student, where our protocol did include questions about unwanted sexual experiences. And I had a student who just -- I'm like I'm going to have to flunk you unless you can get yourself to ask this question. And I think he would have rather flunked than figure out how to ask that question of his clients at the time.

So I think it is personally challenging for people. And one of the things that I think we are going to look at in our upcoming work is -- and you'll there is a goal -- I mean I guess we may not have

named the ACE Study in particular Stephanie, but I think the whole trauma initiative is born out of knowledge and our deep understanding of these issues.

And the idea of trying to create a public health approach to trauma is that, is based on the ACE Study. That these are wide spread ubiquitous issues and that as people go along the continuum of having increased exposures they are at increased risk.

And so we need to take -- I mean that's what a public health -- that's something that calls for a public health approach. And so if we -- even though we have many, many people, and maybe that's arguable too, but though we have screening instruments, what's really a gab is the brief intervention. Because the resistance is yes, well I know what to do with the person who is very distressed.

So they screen positive for trauma but they're also probably homeless or you know, have an addiction or having you know, incarcerated or some other thing is really bringing them to our system. Then they get into behavioral health services. Then they get into the trauma specific, trauma informed environment.

But what do we do about that vast swath of people who are not yet there? Couldn't we do something earlier in the trajectory so that we can have -- so that we can prevent that downward slide. And we'd like to do that.

So we do have a project that's coming along to look at what are some potential brief interventions, can we collect some -- can we develop some strong models and can we collect data on their effectiveness and how they can be adopted and implemented. So that is -- we are actually going along this next step.

So in addition to the screening, what do we tell you know, the nurses, the social workers, the health aides and the primary care physicians who are seeing folks, asking these questions, someone comes in positive. I know Dr. Felitti had said you know, and how has this affected you later in life was sort of a very simple brief intervention that your physicians did.

Because I tell you, that even when we brought this idea of this project up at SAMHSA, people said oh, you can't do that, people will decompensate on the

spot.

DR. VINCENT FELITTI:. Well that was certainly the answer given to us for an eight month period by our IRB.

MS. KANA ENOMOTO:. Right.

DR. VINCENT FELITTI:. I mean otherwise sensible people were repeatedly you know, you can't ask patients questions like that, they're going to decompensate, you may make people suicidal. As though it were generally agreed that repression is the best approach to the reality of what light. Certainly the most comfortable for other people. `

MS. KANA ENOMOTO:. Right.

DR. VINCENT FELITTI:. Finally, we got them to agree by having someone carry a cell phone 24 hours a day for three years to accept calls from these people that we were going to cause to decompensate. We never got one call.

Instead, I have a notebook of letters, largely from elderly women, one of which is prototype on lined paper, this handwritten note reads; thank you for asking I feared I would die and no one would ever know

what had happened. And it was a very poignant letter.

Two things I would like to expand on that you mentioned. One, there's a huge difference between asking questions initially by well devised questionnaire versus asking them initially face to face. The latter is vastly more difficult for inexperienced people.

Once it's out on the questionnaire, then it becomes a lot easier. Oh, so I see on the questionnaire that you know, you were the one who discovered your mother's body when she hanged herself, etcetera, how has that affected you`later in your life? That works. It's not too difficult to do once it's out on paper.

The other point that you make is what are you going to do in essence. And what we found was a very important and simple observation. Namely, that asking was an intervention.

Because in an enormous sample of 130,000 people undergoing comprehensive medical evaluate with a trauma oriented questionnaire built into a general medical questionnaire, an outside group found that

there was a 35 percent reduction in doctor office visits in the subsequent year.

And you know, people have said to me, how did you do that? You sent everyone to therapy, right? Hell no. Rarely, if ever, did we. And believe me, we've thought a great deal about this because a 35 percent reduction in DOB's is of enormous economic consequence.

And as near as we understand the situation, having thought a lot about it, we believe that what went on was we asked about things that are ordinarily buried in shame and secrecy, allowed people to talk about that, listened and enabled them to go home feeling still acceptable as human beings.

So it's clear that asking and listening is itself a major therapeutic intervention. A technique that's been used in the Catholic Church under the name of confession for about 1,8000 years, suggesting that it meets some basic human need.

[Laughter.]

MS. KANA ENOMOTO:. I'm not sure we want to go there but I think Starleen has a comment, then Amanda,

then Jean.

MS. STARLEEN SCOTT ROBBINS:. In North Carolina we have as a part of our outcomes evaluation questions around trauma. And we have had a lot of difficulty with our mental health partners at the table and it is now not required for mental health but is required for substance abuse and our women's treatment programs actually were asking the questions on a routine basis.

And we are at our 25th Annual Addiction Focus on Women Conference focusing the whole conference, the four day conference on trauma. And Dr. Covington is going to be one of our keynote speakers and also I think you're doing a plenary as well. And she's also one of the founders of that conference by the way.

But we're going to be training on five different evidence based practices around trauma. What we find is that upwards of 85 percent of the women in our programs have experienced extreme sexual, physical abuse from early childhood through adulthood.

And that is asking the question in the first session. That's not, you know they've been in treatment for six months. So we are really trying to

kind of push forward with it. But there is still a lot of resistance within the behavioral health settings to do that.

MS. AMANDA MANBECK:. I think that when it comes to early intervention that there needs to be a gender specific I guess intent to forming the questions and the dialogue but also a culturally competent factor that needs to be addressed.

A lot of times, like in Indian country, the kids are suffering from inter-generational trauma that they don't even know exists. I mean this type of abuse, the mental illness, the poverty, depression, all of that has been lasting for generations.

So you know, and I'm sure it's like that for other minority populations. Specifically you know, with woman, you know my grandmother just recently passed away and you know as I was sitting there and I was thinking about her, and her an I were never really close because she was an awful grandmother, she really was, but her mother was an awful mother, and her mother was an awful mother.

And you know it really took my mom going to

counseling and being diligent in her effort to break that cycle. You know and so that's why I was saying about gender specific is that you know we learn, most of the time, how to be mothers from our mothers.

You know, and I think that a lot of the population doesn't really understand what trauma is so how are they going to identify with that. A lot times -- you know with my experience working with White Bison you know when you said, you know your community is suffering through trauma, it's like no they're a bunch of alcoholics. And it's like -- you know -- that is the symptom.

DR. VINCENT FELITTI:. Alcohol is the treatment.

MS. AMANDA MANBECK:. Right, right. But they look at the symptoms, they don't look at the underlying. And you know I think that that's the same for an individual. I think that you know, a lot of times it's easy to say well you know I just behave this way and if I stopped then all my problems would go away.

And that's an issue with substance abuse, you know that trauma of people not working through their

feeling and their emotions and going through that process you take the alcohol away, that trauma is still there.

So I would just say that as a part of the initiative, you know that there be some kind of way of distributing information about what trauma is. You know, giving clarification.

And I don't know whether it would be signs or symptoms, but also a message that it's okay. You know, that this happens to people and that it's not always their fault. You know it's not always that they -- something that they did on purpose or whatever. But yeah -- you know, that's just -- that's my thoughts.

MS. JEAN CAMPBELL:. For persons with mental illness one of the most powerful tools for recovery is telling one's story through structured peer support, informal peer support, giving testimony, in all sorts of ways because it activates, according to my research, we found that it activates elements of well-being within the person.

So it's has this therapeutic effect in terms of

building well-being, offering hope, self-efficacy, a sense of empowerment, purpose. Those types of things are potential through telling one's story. And it's a common element in peer support practices.

So I was thinking, imbedded within the initiatives are these peer support practices. Not just in the Peer Support Initiative under community, but that’s a good place to start and that it sounds like tweaking might be involved.

I have some little pilot to think about telling one's -- using that avenue to gain more information. Using peer support, telling one's story, that would be one way to get -- address the issue of piloting and integrating it within the initiative.

MS. KANA ENOMOTO:. We actually, and Larke will talk more about it. I think we don’t -- we are open to different ways of folks proposing to do these kinds of primary care based interventions.

And I think the idea of peers has been brought up, partly because we know that primary care physicians don't have time to listen to people to tell their stories. And so for the most part I think it

would just be a financial challenge and a time challenge.

But what are other ways. And I think certainly written pre-screening, sort of universal written pre-screening documents has been the way that we've done it with the alcohol and illicit drug SBIRT program. And so getting kind of a universal screen where people who screen positive or with some elevated risk get further follow up.

And then whether that follow up is with a licensed clinician or a certified peer specialist or however that can be done, I think we're very -- I think we want to explore all those different kinds of options and it will depend on what folks bring to us. It's not really -- we're not designing it and telling people to go do it. We're asking -- we're going to be asking the field to design it and come back to us and do a study on it.

But I think you're right. I think educating -- part of the idea behind introducing universal screens is to -- I mean people ask you your blood pressure, people ask you, you know, if you're in treatment for

diabetes or if you have migraine headaches and you don’t get offended.

MS. YOLANDA BRISCOE:. They even ask your weight.

MS. KANA ENOMOTO:. Right.

[Laughter.]

MS. KANA ENOMOTO:. So for some reason, you know -- and yet, that's normal and that's okay and you know I think we want to in some ways normalize these things. That these are unfortunate things that happen to many people in the course of life and they affect your health and they affect your well being and we can do something about it.

And you know in the health care system and the human service system we're here to help you achieve the wellness that you should have regardless of what's happened to you. So I think that’s the intent behind what's in the Trauma and Justice Initiative. And where it says to come up with a public health approach to trauma.

And I think, you know Jean as you noted, the idea behind recovery support, peer involvement, mutual support, that really is something that we hope to have

permeate throughout. I mean it's in health -- it's all over health reform, it's certainly in Trauma and Justice. You know it's not just isolated in one sort of quadrant of the Recovery Support Initiative.

MS. YOLANDA BRISCOE:. Maybe things have changed but when I went through my Masters program I had one class in grief and nothing on trauma. And grief is underlying, underneath so many of what we deal with in depression, anxiety and on, and on, and on.

And then at the Doctoral level, nothing on trauma and actually nothing on grief and a class in substance abuse. And this was an A.P.A. accrèdited university. So I don't know if things have changed but that -- you would think that that would be required reading dealing with trauma.

And I don’t think it's changed that much because we have quite a few interns and I did a training on trauma informed services and used the ACE examples and one of our young recent graduates raised his hand and he said well, I did this and I thought of this client and she's pretty much yes to all of them but you know what, she's doing great. I said, oh my gosh Will,

she's at a treatment facility, a residential treatment facility, how great is she doing?

[Laughter.]

MS. YOLANDA BRISCOE:. I try not to be sarcastic, but I gave the analogy that I was doing a group with women in treatment in San Francisco and the women just couldn’t understand why I didn’t allow them to spank their babies. Why can't we spank our babies? So I'm trying to explain and then one woman said, well you know what I was spanked and I turned out -- never mind.

[Laughter.]

MS. YOLANDA BRISCOE:. So I -- maybe I think that should be required reading at the -- for counselors.

MS. KANA ENOMOTO:. Well we should ask our National Center for Trauma Informed Care what they're doing about getting into the curriculum of our graduate programs.

I'll let Joan speak very briefly and then I'm going to have to end this conversation and we'll go into our next session on Invisible Women: Gender and Crime. So Joan.

MS. JOAN GILLECE:. Yeah, we are doing quite a bit. We have been at the Emery School of Nursing, we're going back again. We've been at the University of Buffalo, Department of Social Work. We've been -- Tonier has spoken at Yale Law School. We've been at Catholic University, Department of Nursing. You did American University.

So I mean we have, really pockets I think of some really good work that we've been able to bring forward. University of Maryland has done, in the School of Social Work, a track on trauma. It's very slow going.

We actually, last year did a training for the American Psychiatric Association, which was a miracle. It was amazing. We actually had a full room of psychiatrist who we were like talking another language to them about trauma. But they invited us back this year without applying, to do another whole nother day long training. So we are getting there.

And just quickly what I wanted to say in terms of the discussion about the ACE Study. We at the National Center for Trauma Informed Care and the newly

funded National Technical Assistance Center to Promote Trauma Informed Practice and Prevent Seclusion and Restraint, two SAMHSA initiatives, we do a lot of inter-agency work.

I mean we are following the Strategic Initiatives and we really believe in the more we can do cross-agency and with our Federal partners the better. We are having an easier time moving the ACE Study and getting people to hear it in criminal justice, juvenile justice, foster care than we are in mental health. They get it.

So I think we are getting it out there. We are using it. We at the National Center are using it and we'll tell you a little bit later all of the work we're doing for women and girls.

MS. KANA ENOMOTO:. Thanks Joan. And with that, we are very fortunate to have Stephanie presenting a brief, an overview I think of the series that she did for the -- is it Oprah Network, right, on women and the criminal justice system.

MS. JOAN GILLECE:. And she looked great on TV.

DR. STEPHANIE COVINGTON:. Okay, well they've

asked me to do something brief on women in the criminal justice system and use some clips out of a show that actually just finished last night. And I want to just tell you quickly, the new Oprah owned network decided to do seven segments on women in prison. And so it was quite the experience, to say the least.

I titled this Invisible Women. After yesterday's experience I probably would title this, The Most Invisible Women since women were generally invisible yesterday and this became a group that's most --

I'm sorry, I'm pushing this to`push the slides which tells you something about where my mind is. And I want to thank Katie. There would be no video if there hadn't been for Katie because we've had many technological issues with video.

But a million women are currently under criminal justice supervision. That's 17 percent of the total offenders. 84 percent are in community supervision. We incarcerate more women per capita than any country in the world.

The number of women going into the criminal

justice system is the highest percentage of new people in the criminal justice system. The number of girls in the juvenile system are the largest percentage wise new people in the system. So this is a major issue.

The fastest growing prison population, the dramatic increase in incarceration is for drug related crimes. Either because they've been using illegal drugs or they've committed a property crime in order to take care of their addiction.

Who are the women? This is our national profile. Disproportionately women of color, early to mid-30's, again, the drug offense, many have had family members in the criminal justice system, survivors of physical and/or sexual abuse, substance abuse problems, mental health problems, physical problems, unmarried mothers.

I mean people say, well what should we be doing. All you have to do is look at the profile of who's in the system, it tells you what we need to be providing. Okay, this is not rocket science.

Eighty percent of incarcerated women are mothers. Between four and seven percent of them enter prison pregnant. So that gives us between 5,000 and 10,000

babies each year are born to imprisoned mothers every year. In almost every case, not all, within 24 hours that infant is separated from the mother because prisons do not have nurseries.

There are a couple of, Bedford Hills in New York does but most places do not have places for children. That's very different in European countries by the way. In most prisons in other countries women are allowed to keep their infants.

I show you this profile. These are the girls in the juvenile justice system. And what you'll see is exactly the same profile. The important thing to realize, the girls who are in the juvenile system today will be the woman, they're at high risk to be the women in the adult system as they age.

And the women who are in the system today, many of them were the girls in our juvenile system. Which tells me, the system doesn't work because it's not preventing movement from adolescent to adult.

Okay, let's play this. This is just to give you, if you've never been in a prison, this is just to give you a flavor.

[Video Presentation.]

DR. STEPHANIE COVINGTON:. This is what happens at times when it doesn’t quite load the whole thing.

[Video Presentation.]

DR. STEPHANIE COVINGTON:. Well I'll let you fiddle with that part, okay?

MS. KATIE KOSTIC:. Okay.

DR. STEPHANIE COVINGTON:. This is what -- when you asked me if it was working on my laptop I said no because you couldn't load a whole video clip. Now I know you didn’t have trouble but.

MS. KATIE KOSTIC:. And it worked earlier too.

DR. STEPHANIE COVINGTON:. Okay. Well let me -- while she fiddles with that for a minute. What this show's about in these seven episodes is they picked these women to follow over a course of time. And what I've done in the clips is just taken little pieces to show you. So I wanted you to see here, just if you’ve never been a jail or a prison, just to get an idea of a sense of it, okay? The sounds, and so forth.

What do you want to do about these video clips?

MS. KATIE KOSTIC:. Let's go to the next one.

DR. STEPHANIE COVINGTON:. Okay.

MS. KATIE KOSTIC:. Because it all ran through earlier this morning.

DR. STEPHANIE COVINGTON:. Okay, well then I'm going to go to the next slide okay? Because the next three clips, I want to say something before we see them.

MS. KATIE KOSTIC:. Okay. I'll click when you're ready.

DR. STEPHANIE COVINGTON:. Okay, great. So thinking about women, my sense, this is a way that I think about it is bringing in services, they're integrated, thinking about right -- this is where we are, sorry. Yeah, okay.

Using a definition about what it means -- here's an example of a system that was designed for men that we put women in to. And if you keep doing what you do with men with women in prison you will be totally unsuccessful as most places have been.

When we begin to think about women and what their needs are and become gender responsive women begin to do better in services. This is a definition I use for

being gender responsive.

You have to think about the environment, you have to think about your staff, how you develop your program, what's the content and material, you have to have an understanding of the realities and lives of women and girls and deal with both their strengths and their challenges.

There's some guiding principles. These are some things that were developed with my colleagues Dr. Bloom and Dr. Owen for the National Institute of Corrections. But they cut across everything.

The first is, you have acknowlèdge that gender makes a difference. If gender doesn’t make a difference you will never get good services for women and girls. It's just that simple.

And the environment based on safety, respect and dignity. And this is particularly challenging in correctional settings. Policies and programs need to be relational. You need integrated services; substance abuse, trauma and mental health.

You have to deal with, particularly for women in correctional settings, the socio-economic issues often

are what's driving them into the prison system. And then what happens in the community when they come out of these custodial settings.

The theme that permeates all of this is trauma. And the women in the criminal justice system have higher rates of trauma than women who are in the free world. And so how do you take the system and become trauma informed. And how do you try to adjust and work in a system that was never intended to be this way essentially.

So they have higher rates. Often their trauma histories are associated with alcohol and drug dependence, high risk behaviors, sex work, a lot of health disorders. And prison itself can be a retraumatizing experience.

This is the ACE Study again, but this was taken into the California prison setting. The same questions were asked and they found that the women who were in the med line, the women who had more medical problems of course were the women who had the highest ACE score.

But also, the largest effect was on mental

health. They were on more psychotropic medication, more attempted suicide. And if a women on that 10 -- could have been a 10 point scale, if she had 7 or more yeses to these childhood traumatic events, it increased her risk of having a mental health problem by 980 percent.

And Vince, I'm going to send you this paper. I didn't do it last night but tonight, okay.

So again, how important this issue is in thinking about women in this particular setting. We're going to see, hopefully three clips here. And these three clips are -- this is a reality show, okay? This wasn't staged.

And you're just going to see three clips. And these are clips of a woman, the first day she's admitted to this facility. So you're going to see some things, her first day being admitted to this facility.

[Video Presentation.]

DR. STEPHANIE COVINGTON:. It should be clip two. And you could get it to play when it was in that file?

MS. KATIE KOSTIC:. That was the whole part.

DR. STEPHANIE COVINGTON:. Well then let me describe it to you and we'll go to the next one in just a second.

What she says is she wants them to come in, strip down and don’t say to me, do you include my bra and pants, and she says she wants everything. And what you see is then the women go in, they're stripped down nude and then they have to bend over and they're doing a search. Okay, so that’s the first day.

Okay, let's see clip two.

[Video Presentation.]

DR. STEPHANIE COVINGTON:. It's not going to work. Okay, what she talks about is, you're here, you're in a room, you don't know who you're rooming with, you have no idea who anyone is. And you'll see that the case manager said, remember you're not here to make friends, stay out of it.

The reality is, if the women don’t make connection with each other they're not going to survive.

UNKNOWN SPEAKER:. [Off microphone.] Fifteen years is a long time not to make --

DR. STEPHANIE COVINGTON:. Not to make -- yeah. 15 years is a long -- right. That's crazy. Let's see and this is the end of -- this is the end of her first day, Abby's first day.

[Video Presentation.]

MS. KATIE KOSTIC:. It was a 10 second clip that one.

DR. STEPHANIE COVINGTON:. Well usually the lights go off in her cell. So this stopped also. So what you see here -- okay, so I don't think it's going to work either.

So I picked out those three clips so you could just get a sense, if we think about what the women bring with them into jails and prisons; who they are, they have this trauma history.

You saw three -- this is a woman coming the first day to prison, young, she has a 15 year sentence. You hear what she's told by the staff and now she's locked into a cell with a group of people she's never met before. So when you say prison can be retraumatizing, I mean -- right? Okay.

So there are many, many challenges in this

system. So I thought of -- some of them are the beliefs, some of them are the culture and the environment, the standard operating practices and the lack of services.

Okay, next slide.

People who work in corrections sort of, if you can divide people into two camps, sort of fall into some people believe that if you have someone in a jail or prison, that's the punishment. But there are other people who work in these settings who believe now someone is in custody they need to be punished. And so there are things that they do to`try to punish people once they're there. So you have beliefs and attitudes that are a challenge.

You have a culture clash. Essentially, the culture of corrections is a culture of control. And actually, corrections has a mandate which is care, custody and control. Let me tell you, they're heavier on custody and control then they are on care.

The culture of treatment is the culture of change. And so when you do see these treatment programs and things happening inside of custodial

settings you have a culture clash between this culture of control and this culture of change.

If we look at standard operating practices, the searches that are done, the restraints that are used, the use of isolation, all of these things are retraumatizing. And these are just standard operating practices.

I've met many women who stopped going to the visiting room to visit their children because they cannot tolerate the search policy when they leave the visiting room. They can't have a cavity search one more time. Particularly, if they hàve a trauma history. They just can't go through that.

So the next clip that you're probably not going to see --

[Laughter.]

DR. STEPHANIE COVINGTON:. -- but we'll try. Let's see what happens with the next one. This is about restraint.

[Video Presentation.]

DR. STEPHANIE COVINGTON:. We'll talk about her if you want to.

[Video Presentation.]

DR. STEPHANIE COVINGTON:. Okay, what she's talking about is Loretha has been put into isolation, you could barely see her going into this isolation cell, for 18 days. Where she will be out for an hour a day and she's shackled.

I don't know if you can see that she's got the -- around her wrist and around her waist. Now you would think that the way she's being treated with the chains and the isolation, you would think that she must have done something really horrible, right? That she was a threat to someone, violent, they coùldn’t --

UNKNOWN SPEAKER:. Disruptive.

DR. STEPHANIE COVINGTON:. -- disruptive. Here's what she did. She's housed in Unit A and you're not allowed to go in a different housing unit. And she walked from housing A into housing B to talk to a woman that she had had an attachment with that the prison did not approve of, because they had been separated and she wanted to see if she was okay. That's what she did, she broke a rule.

So for 18 days she's put into isolation and she's

moved from place to place in these chains. She never was violent. She never was aggressive. Even when they said to her, you can't be in this unit, she said just a minute and she said to "Sally" are you okay, and "Sally" said I'm okay, and she said okay I'll go back to housing A. And this was what she got.

So one of the major challenges, besides the belief system and the culture that women are in, the standard operating practices, also the lack of services, in all these institutions there is a lack of drug treatment, a lack of mental health services, a lack of understanding about trauma, a lack of services for education and vocational, a lack of services to reenter.

Even in places that have drug treatment programs, people say well our prison has a drug treatment program but if you look at the number of women who have a drug problem and you see the number of slots they have in drug treatment, it's a joke.

In California we have 12,000 women incarcerated and we have 500 treatment slots for women in prison. So people will say, oh yeah California, we do drug

treatment in prison. Ah, plus then you -- we're not even discussing the quality of that intervention, just the fact that they have it.

So you have all these lack of services. Reentry issues for women into the community are huge and very different than some of the problems that the men have.

We have two more clips here, but good luck, we could try it. These are two women that I worked with. This is Abby, you've seen already. She's going to tell us a little bit about her drug history here.

[Video Presentation.]

DR. STEPHANIE COVINGTON:. The`next thing she tells us about is that when she was 16 she was in a automobile accident and she went through the windshield and they gave her pain medication and she got addicted to the pain medication. And then she started abusing -- she would get illegal methadone pills and then in order to support her habit when she ran out of money she started selling methadone pills.

She got a 15 year sentence, which I always thought was really long. And I didn't find out until later that someone she sold those meth pills to died.

And therefore, that gave her a longer sentence than normally might happen. But sentencing is rather random.

Let's see the next clip.

[Video Presentation.]

DR. STEPHANIE COVINGTON:. So what she's saying is she was short of money and she was short of heroin. So what she did, her boyfriend -- now she's I think 18 here, this is Hannah, her boyfriend's 31, he had two children and she took their air pellet gun and she went into a hotel and said to the person behind the counter in the hotel, give me money, and the woman said no, and she walked out. But she got an attempted armed robbery charge and so she got a long sentence also.

So this is a sort of -- talk about brief videos, we have a brief video about the show. I had two goals in mind why I wanted to do this show. One, I wanted people to see women in prison and the reality of their lives. And I had no control over how the show was done, nothing.

They had started the show, they'd picked the

women and my job was to go in to Indiana and make multiple trips there. I ran six groups with this group of women and I had two individual sessions with each one of them.

I then, many months later, I went back and met with a couple of the women who had been released from prison and also I had a family session with one of the women and her parents.

So quite honestly, I was really pleased when I finally saw this, that they hadn't overly sensationalized it and they had done I think a credible job of showing women, showing people what it looks like for women in prison.

One, I wanted people to see that. And the other reason is, I wanted to have an opportunity to do -- run these groups and intervene with the women hoping that it would, could be caught on taps as to sort of give an example of what you could be doing in prison. What kind of services or things you could do. So those were my goals.

Let's see the next slide.

So what's happened? As I said, the show finished

yesterday. I haven't seen last night's, the last episode, I couldn’t see it in my TV room.

MS. STARLEEN SCOTT ROBBINS:. It was really good.

DR. STEPHANIE COVINGTON:. Was it good?

MS. STARLEEN SCOTT ROBBINS:. It was really good.

DR. STEPHANIE COVINGTON:. Well I'll get to see it this weekend when I get home. People are seeing reality and many people are very surprised by what they see. And we can tell that by people write in on Facebook to Oprah or there's an OWN page or they email me. People are surprised at how young women are. They're surprised at the length of their sentences.

One of the things in this prison you don't really see I don't think the real racial disparity that happens in our prisons because this particular Indiana prison has a lot of white women in it. But when -- so you don’t see it really quite the overrepresentation we should see of women of color.

Some of the things I hadn't anticipated is many mothers are saying, I'm seeing this with my teenage daughter and what she's seeing is you can make a split second error in judgment and it can impact your life.

And I never thought about what a wonderful thing that could be for girls to get it. That you could -- luck of the draw.

The other thing about women and families asking for help. One of the things that's happened, I had not anticipated either, is the number of emails and actually phone calls I get from people looking for help. Which why -- to contact someone who's on TV for help says you're desperate really.

You don't know where to go in your own community or you don't know -- everything from 29 year old young man calling the office saying my mother's in this prison she's going to court in two days and what can I do to help her, and then having a conversation with him.

Or the woman who emails and says, I've just had my fifth beer, you're the first person I've ever told I'm a alcoholic. I'm 30 years old, where do I get help. I mean it's all over the place. So a lot of people in pain looking for help.

I want to leave you with this quote from Archbishop Desmond Tutu in South Africa. And when he

was celebrating 25 years he wanted to celebrate a mass and he was trying to figure out where to celebrate that mass.

And what he said was he decided to celebrate the mass in a women's prison because he felt that women's prisons carry more pain and suffering than any other place on earth. And from my experience, I think that's quite true.

So thank you. And I don't know, I guess we have a couple of minutes for questions or if there's anything anyone wants to know.

MS. JOAN GILLECE:. [Off microphone.] I just wanted to comment. This is really such important work, you know my passion is [inaudible] women in prisons too. But there is a beacon of light.

There's this amazing man in Hawaii who runs the women's prison. His name is Mark Patterson and he has told us that when women walk into his prison he has the motto that it's a place of forgiveness. And everything changes you know, as a result of it.

I'm thinking, what if we said that? It's a place of forgiveness and it's a place where the women leave

their pasts behind. And I think they -- there was a spot on this series with Hawaii, right? No? I thought -- maybe it was another.

DR. STEPHANIE COVINGTON:. No, this --

MS. JOAN GILLECE:. Maybe it was another one that they did it on.

DR. STEPHANIE COVINGTON:. Yeah.

MS. JOAN GILLECE:. This was all Indiana, right?

DR. STEPHANIE COVINGTON:. This was all Indiana. And they're trying to figure out if they're going to renew this. And they'll be a conversation about it actually the end of this week and actually Hawaii's one of the prisons being considered.

MS. JOAN GILLECE:. Well it's amazing.

DR. STEPHANIE COVINGTON:. Okay.

MS. JOAN GILLECE:. Because the women -- Tonier's been there several times. And they're doing organic gardening and all this you know, therapeutic interventions and chanting and --

MS. TONIER CAIN:. Everything.

MS. JOAN GILLECE:. Yeah.

MS. TONIER CAIN:. What he liked to do is have

the women see how they can start something and watch it grow and they can become who they are, how they watch themselves grow.

And I was put to shame you know. I was -- I went there and every time I left I felt like I got it wrong even within myself because they -- these women were incarcerated and they were more free than I could ever imagine myself being walking around.

And me in prison so many times I would have never, ever felt like that about any prison. And the respect that they had for him and the officers says a lot. And how he, he says he cannot`hand pick his officers, he can't as we know, but he can weave them out he says. And that’s very important to his commitment to the women there. It's just incredible.

DR. STEPHANIE COVINGTON:. You asked about the woman who's on there if she's been fired. One of the things that was amazing to me is the only group that had any editorial power was the prison. The prison allowed the production company to come in and film this, but they also could say take this out, take this out.

And I was amazed how much they left in. They did not take things out. And they left staff person in who I would have thought -- if I had been the warden I would have cut her out. I wouldn't want people to see her attitude. I don't know if that's because they didn’t notice --

UNKNOWN SPEAKER:. Or they supported the attitude.

UNKNOWN SPEAKER:. It might be the norm.

DR. STEPHANIE COVINGTON:. I don't know. It was really interesting to me.

UNKNOWN SPEAKER:. Yeah.

DR. STEPHANIE COVINGTON:. But you can see just some of -- you'll see various staff with various attitudes. The thing about Hawaii that’s interesting and maybe they’ve changed this, Hawaii used to have 80 women in Oklahoma because of the overcrowding.

MS. TONIER CAIN:. Yeah.

DR. STEPHANIE COVINGTON:. Do they still have women in Oklahoma or have they moved them back?

MS. TONIER CAIN:. They were trying to stop that because with the women -- the women were going there

and they were saying I want to go back to prison in Hawaii.

DR. STEPHANIE COVINGTON:. Right.

MS. TONIER CAIN:. Because it was awful --

DR. STEPHANIE COVINGTON:. Right.

MS. JOAN GILLECE:. Well go figure.

DR. STEPHANIE COVINGTON:. Well and their families, they couldn’t have any visits.

MS. TONIER CAIN:. Right, but what they told me was that leaving this environment, a trauma informed environment, because that’s what it really is, and going to this prison there it's like -- they were treated like nothing.

DR. STEPHANIE COVINGTON:. Horrible.

MS. TONIER CAIN:. They wanted to go back you know, even the ones that was going to finish their sentence there, get the treatment -- get what they call treatment there and get released, was like I'd rather go back and do my full sentence in Hawaii.

DR. STEPHANIE COVINGTON:. Right.

MS. TONIER CAIN:. And that's sad.

DR. STEPHANIE COVINGTON:. So there still are

women in Oklahoma?

MS. TONIER CAIN:. Yes.

DR. STEPHANIE COVINGTON:. Yeah, I was afraid of that. That's another thing --

MS. TONIER CAIN:. -- we just don't --

DR. STEPHANIE COVINGTON:. Right, if when a prison is overcrowded they very often send people to other states that have available beds. So when the women's prison in Hawaii became overcrowded they shipped 80 women to Oklahoma.

Talk about a culture shock, talk about no visitation with your family, just all kinds of things. All these subtle things that we know nothing about really, about how this system works or doesn't work as the case may be.

MS. TONIER CAIN:. Well if I could say something about -- I mean Hawaii in that --

MS. JOAN GILLECE:. Push your button.

MS. TONIER CAIN:. Often I till Warden Patterson this, I visit the youth facility for girls. And I tell him, every single one of those girls in the youth facility you will see. And I set there and I had

focus groups with these girls, and I'm telling you, it was painful.

You know, even living underneath a bridge going in and out of prison I had a dream that one day I wouldn't. And I asked them, what do you want to be when you grow up, what do you want to be? Nothing. I don't know. I don't care.

You know, and a lot of them were in this facility because they were running away but nobody was asking, what are you running away from? I mean what -- you know, what's going on. So he will continue to get women -- it's wonderful -- he might`not get the same women that he have in his prison, but he will get those girls.

UNKNOWN SPEAKER:. [Off microphone.] Unfortunately.

MS. NEVINE GAHED:. Now this was actually an amazing revelation when I actually watched that. And I saw the first couple of episodes and then after that -- I will go back and watch them all.

But it's definitely a discussion that we're going to you know, want to continue that we would want to

follow up on. And thank you. Thank you for doing this.

Are there any other questions?

[No response.]

Do we want to take a 15 minute break? And we will be right back at 3:05. thank you.

[Whereupon, at 2:50 p.m., a brief recess was taken.]

[Whereupon, at 3:07 p.m., the meeting resumed.]

MS. KANA ENOMOTO:. Okay, if we could ask everybody to take a seat. I apologize for my brief absence and I understand the presentation though went very well Stephanie to thank you. We have an impressive crew here. I love it. It's great.

I did -- I don't -- some of you may already know this but I did want to share a little bit of sad news that would explain the absence of one of our stalwart SAMHSA Women's Coordinating Committee Members from the meeting today, and that's Susan Salasin.

Susan's husband passed away suddenly and unexpectedly over the weekend. And so though she had wanted to be here today and had a key role in getting

the panel that we have later on here today, she's unable to join us. And so our hearts go out to Susan and her family.

And we have a card for those of you who know Susan, who has been a champion of women's issues and trauma issues at the Federal level for as -- probably as long as she can remember, certainly as long as I can remember.

And Susan's been a close friend and a mentor of mine since I started in government. So we're all sad about her absence here this week and the loss of her husband.

Moving on. We are -- I'm glad actually that Bev has joined the SAMHSA Women's Coordinating Committee as a CSAP representative and thrilled to have her presenting.

We have for, oh these many years, really tried to land on a solid CSAP partner. And so the fact that she said well you guys might want to mention that there's this data that I've been looking at. And I was like, yes, absolutely, that’s fantastic.

Because we haven't really, though we've asked a

number of times, we haven't been able to get our arms wrapped around how prevention is different for boys and girls or women and men and what the gender specific needs are. And so we're really pleased to have Bev here today to talk to us a little bit about that.

MS. BEVERLIE FALLIK:. Hi, well I'm glad to be here too. So my job is basically to look at data and provide it to management to help them make program and policy decisions. So I don’t have a particular program.

So what we do is we look at national trends and we have an annual trends and directions report. We look at our program outcomes and we have an annual accountability report. And then we do special studies which vary year to year based on recommendations from our Steering Committee and our Senior Staff.

So this is an example, we have kind of -- they call them tomes of these reports. But this is an example of a finding that is not surprising because we keep finding this over time. Where for example, in this case binge drinking 30 day use.

We see that even though the males are, for 21 to 25, I want you to focus on the young adults now, because we're making a little headway with the youth, we're so targeted on the youth we're actually having some kind of an effect.

But the young adults are starting to show problematic behaviors and more so for the females. So if you follow the female trend line, which is the orange with the circle, you see that it's going up. And if you look at the males it's very, very slightly going up.

So we're closing the gender gap, but not in the right way. And we see this over and over again in different kinds of trend lines for different prevalence and incidents and risk factors.

So and we know that binge drinking is very strongly associated with risky behaviors, certainly date rape is among them. So this -- I just wanted to bring this to your attention. We've brought it to senior management's attention as well.

Okay, this is an example of program outcomes where we find gender differences. If you look at --

this is looking at disapproval of peer substance use in general, alcohol, cigarette, this is a composite measure.

And again, if you look at this we looked at matched pre/post scores for our program. And we find that we were doing pretty well for the guys but we were -- the girls were worse off then they were when they came in.

And so what are we doing? You know are our programs male focused? We need to look at our programs to make sure that we're gender specific or at least attending to the different risk factors for males and females.

This is our meth program. This was a much smaller program so the data are not huge and I wouldn't draw any massive conclusions from it. Except that there are gender differences. So here you find that for perceived risk of smoking females got a little bit worse, males got a little bit better.

And if you go to the next one. Do they think that their friends would disapprove of using meth? Again, pre/post this is the opposite. Girls' scores

did improve a little but male scores got worse.

So the message here is we really have to pay attention to gender differences in our programs. It doesn't look like it's big here, but it's consistent year after year after year. Actually this year was a little bit less than last year. But it's still the same kind of trend.

We also, I don't have a slide for this, but we also do special reports, sometimes looking at gender differences. And this year we looked at the relationship between body image and substance use.

And it was preliminary finding`but what we found was that perceived obesity for women was associated with increased alcohol use. No relationship with alcohol for males. However, for males a result was expected which was perceived underweight was associated with increased steroid use.

So again, the drug of choice for men and women vary even though they have a, you know the same construct that we're looking at. So we just do this every year.

Our new trends and directions is coming out this

month. The accountability report comes out every August in time for the Congressional justification. And any input or guidance or comments you have about this I'd love to hear.

MS. KANA ENOMOTO:. Thank you Bev. Stephanie.

DR. STEPHANIE COVINGTON:. Quick question. So these are prevention programs but they're just, they're for males and females, there's no thinking about how to do prevention differently for girls or boys?

MS. BEVERLIE FALLIK:. I'm not a program person. But the programs -- if you're in this grant program and St. Louis, it doesn't have a separate track.

DR. STEPHANIE COVINGTON:. Right. Okay. And did they do anything with body image and tobacco, with cigarettes?

MS. BEVERLIE FALLIK:. I'm so glad you asked, because I raised that, because I'm a living example of that. And no they did not. I think it's a huge, a huge factor.

DR. STEPHANIE COVINGTON:. Girls who are smoking and girls who use meth, when you talk to them about

stopping, the first thing they say to you is no, I'll gain weight.

MS. BEVERLIE FALLIK:. Twenty pounds.

DR. STEPHANIE COVINGTON:. No, I'll gain weight is the first response.

MS. BEVERLIE FALLIK:. So are you recommending that we do that or do you think that's been studied enough?

DR. STEPHANIE COVINGTON:. Well if SAMHSA's not studying it and reporting on it it's probably not impacting prevention so I think you should do whatever you need to do so you can do something about it.

You know it's out there but you know, I don't know. At this point I'm sort of, I have no idea what would be the best recommendation to SAMHSA about women and girls. I'm at a loss.

DR. VINCENT FELITTI:. Does anyone every express concern that perhaps the wrong thing is being measured? That smoking for instance is not the problem, it's -- I mean it's certainly a problem, but it's not the core issue, it's really a marker for the core issue. It's easily visible. It's easily

measurable.

MS. BEVERLIE FALLIK:. Not that I know of.

DR. VINCENT FELITTI:. Okay, I mean when one things of the psychoactive benefits of nicotine, which you know are available in 15 or 20 seconds on inhalation, and this has been well established in the first two-thirds of the 20th Century the world's medical literature about the psychoactive benefits of nicotine as an anti-anxiety agent, as an anti-depressant agent, as an anger suppressant, as an appetite suppressant.

I mean that's really why peoplè smoke. The risk is very real, but it's 15 or 20 years downstream. And I think most of us understand that if the pressure is high enough that we'll sell out the future to gain current relief. So I'm always intrigued that we really don’t address the core issue, which is much harder to measure but it's what we're talking about.

I mean why would somebody need to buy anti-depressants on the street in the form of methamphetamine in unknown dose and in impure form? I mean that's kind of hazardous to do. Just as it would

be hazardous to buy digitalis on the street in an unknown and in an impure form.

So I guess my question is with that as background, does anyone ever bring up the issue that maybe we're not studying the core issue, we're studying a response to the core issue?

MS. BEVERLIE FALLIK:. That's a very good point. We certainly aren't doing a --

MS. KANA ENOMOTO:. Right, I think the issue has been raised that our current National Survey of Drug Use and Health doesn’t have a measure of trauma or ACE's or -- it has actually not even exposure to violence but participation in violence.

So violent acts committed by respondents but not their victimization at any point in their lifespan. So as we are going forward I think that is, that's been -- I think it -- I don't know if it's one of the action steps within the Trauma and Justice Initiative or the Data Initiative.

But it's certainly something that we are looking at is how do you -- a measure of recovery, a measure on trauma and then refining our measurement around

military families because I think that's what -- what you're talking about is being able to get at -- is this a sort of central organizing factor for these other behaviors that we measure.

DR. VINCENT FELITTI:. Yeah, putting it as a metaphor, there's a real public health paradox. That many of the things that we define as public health problems are indeed public health problems. They're discomforting and annoying to many other people. But very often, they're attempted solutions by the person who's involved.

I mean no one smokes to get lung cancer. People smoke because of the psychoactive benefits of nicotine. No one drinks to get cirrhosis. People drink because of the relaxing effects of it.

MS. BEVERLIE FALLIK:. But there's also the gender related factors like typically a teenager will have her first drink because her boyfriend gave it to her.

MS. JEAN CAMPBELL:. Because what?

MS. BEVERLIE FALLIK:. Her boyfriend gave it to her.

MS. KANA ENOMOTO:. So Bev would that speak to the need for a gender specific prevention programming?

MS. BEVERLIE FALLIK:. I think so.

MS. JEAN CAMPBELL:. I was just curious what the source of this data is? Because it's just hard to look at it out of context.

MS. BEVERLIE FALLIK:. Sure. We collect data from all our programs. So we had a meth program. We had a program to prevent meth use among high risk youth. Well high risk populations, most of them youth.

MS. JEAN CAMPBELL:. So this wàs --

MS. BEVERLIE FALLIK:. CSAP --

MS. JEAN CAMPBELL:. -- data collection on an intervention that you were testing?

MS. BEVERLIE FALLIK:. Multiple interventions. We have 13 meth grants. So they all submitted their pre/post data to us.

UNKNOWN SPEAKER:. So it's pre/post?

MS. BEVERLIE FALLIK:. Right. Same with the HIV. We have many more HIV grants.

MS. KANA ENOMOTO:. And I would probably clarify

that these, this isn't interventions that we were testing but that they're evidence based --

MS. JEAN CAMPBELL:. Evaluating?

MS. KANA ENOMOTO:. Yeah, evidence based interventions that communities were funded to implement. So this is measuring those outcomes.

MS. BEVERLIE FALLIK:. Right. Thank you.

DR. VINCENT FELITTI:. Is it conceivable that in the national longitudinal studies that you mentioned a few minutes ago, that childhood sexual abuse routinely would be sought after and inquired?

MS. KANA ENOMOTO:. I think it`is -- well just to clarify, the National Survey on Drug Use and Health isn't a longitudinal study. So we don't follow up with the same cohort of people over time. What it is, is it's a national survey that I think right now gets to like 66,000 households.

And so it's a fairly lengthy and thorough in person interview or computer based, computer assisted interview at the household level. And so it is the largest scale epidemiological survey on drug use and increasingly on mental health as well.

And so yes, it is conceivable that in the near future we're going to have some portion of that, some cohort within that overall national survey get questions on, I don't know what aspect of traumatic experience but some aspect of trauma history so that we can see what the relationship is with trauma history to these other behaviors.

So that would include -- it includes some chronic disease and physical illness as well as criminal justice involvement, insurance, poverty, and substance use and mental health. So we're --

MS. JEAN CAMPBELL:. Just one more question on the data. So this is really -- the results are more the effectiveness of the program than they would be a survey of the attitudes and behaviors?

MS. BEVERLIE FALLIK:. This is the effect of the program on the attitudes and behaviors.

MS. JEAN CAMPBELL:. Right.

MS. KANA ENOMOTO:. Right, so as you can see girls were already had a more -- had a greater perception of disapproval of methamphetamine, or perceived disapproval and it became even greater than

boys. The second and third columns. But it's the Deltas that I think where we are seeing --

MS. BEVERLIE FALLIK:. Right.

MS. KANA ENOMOTO:. -- another gender difference.

MS. BEVERLIE FALLIK:. Right.

MS. KANA ENOMOTO:. So the absolute views are different and then the impact of the program is going in the opposite direction for several of the programs. So I think the really key point of Bev's presentation is for us to look at our prevention programming and saying well, you know the way girls look at things and they way they think their friends lòok at things is different from how boys are looking at things.

MS. BEVERLIE FALLIK:. Right.

MS. KANA ENOMOTO:. And then what you need to change their opinions is also probably different. It may be that there is some -- with girls, if they have a perception that no one's doing this, then you do one of these interventions and they go, wow a whole bunch of people do it.

And so we may need to adjust the messaging and the structure of our programming to figure out how do

you do prevention most effectively with girls and most effectively with boys separately.

MS. BEVERLIE FALLIK:. Thank you.

MS. KANA ENOMOTO:. Amanda and then we'll get to Mary and to crew.

MS. AMANDA MANBECK:. My question, when we -- when I was a part of the RSSP grant, which was the Recovery Support Services Program, it was peer to peer.

What we found in like our data, just looking at it as much as we could is those in recovery had a, I guess a greater opportunity you know, to grow in their recovery based on who they surrounded themselves with, whether it was their family or any you know, kind of spiritual support.

And so I was just wondering, in studies like this, I do think that there would be a gender difference if you were to put parents in there. Because I think boys and girls or young men and young women do view their parents' attitudes differently. And I think that it opens up that you know, that issue of whether parents are addressing you know, the issue

that their kids could be at risk for using drugs.

So I was just wondering -- and a lot of the prevention studies that I've seen, parents aren't really -- or the kids perceived idea of what their parents would think or what they would say, what they know isn't usually apparent.

MS. KANA ENOMOTO:. Actually I think kids' perceptions of parental disapproval is a major risk factor, or it's a known predictive factor. And so it is something that we've targeted in our activities. And that's why the whole underage drinking campaign is about talk to your kids.

But I think one of the things that this raises, and that you're raising is, okay so how do we tell parents of girls to talk a little bit differently to their girls, to their daughters then you would tell their sons.

And there probably are different, different sort of messages for parents based on the gender of the children and maybe based on the gender of the parent.

MS. BEVERLIE FALLIK:. And unfortunately we didn’t have sufficient budget to do a cross side of

the meth program. But we are doing a cross side of the HIV program.

So we will be able to say well okay, this grant program used this approach maybe with or without parents, compared to this one. So we'll know which kinds of approaches worked best with males versus females. So we're looking forward to that at the end of the year.

MS. HARRIET FORMAN:. Question. So then do you -- I mean if you can use this information to structure the grants that you put out to determine, to set some parameters that proposals should inċlude different approaches for males and females.

I'm just asking if that's how this information could be put to use. And then does it have to be tested, which approaches should be used with boys and with girls. I mean how can that be used?

MS. BEVERLIE FALLIK:. That would be my recommendation.

MS. KANA ENOMOTO:. I think we do already ask in all of our grant programs to identify which populations you'll be working with and how the, how

the evidence based practices that you suggest using have demonstrated effectiveness or how you would adapt it to be effective with your particular population.

But I think with this data we can emphasize, we can bring out more emphasis in that we encourage people to think about it with a gender specific lends. So that's certainly a possibility.

I think also the issue around who does the research on what thing. You know I think that's -- most of our programs aren't currently -- well none of our programs really are set up to be research studies per se. And we do have partners at`the National Institutes of Health who are, that's their specific charge is to do the research.

But as Pam noted, there's nothing prohibiting us from doing research now, other than our financial limitations. And so thinking about what are the, where are the strategic places that we would want to invest those more intensive evaluation resources or limited services research funds would have to be driven by both data and need and priority.

But I do think that this is the kind of thing

that lends itself to saying, well gee we've done very little in this area and there seems to be a gap in the literature base. So perhaps SAMHSA could do preliminary work which would then get handed back to the Institutes to say that we have something promising here and would you be willing to follow up on it.

MS. JEAN CAMPBELL:. [Off microphone.] Your suggestion would be perfect for --

MS. KANA ENOMOTO:. Okay, so thank you very much Bev. I was glad to hear that.

So next we have Mary Blake from the Center for Mental Health Services at SAMHSA. She's a Public Health Advisor and the Program Manager for the Trauma Informed Care Program. And she has brought to us the team from the NCTIC and/or National Center for the Trauma Informed Care and the Prevention of Seclusion and Restraint to talk to us about the Peer Engagement Guide.

MS. MARY BLAKE:. Thanks Kana and it's really great to be here with all these strong and wonderful women and with all kinds of expertise, and also with the male at the table. Just kidding.

Yeah I just wanted to give a brief overview from the perspective of what we've been doing and why this guide came to be through the work we've doing through the National Center for Trauma Informed Care.

And it really does draw upon a long history of work. Some of you were part of that work going back to Dare to Vision, Dare to Act, the Women Co-Occurring Disorders and Violence Study.

But basically as we've been moving the work forward through the National Center for Trauma Informed Care building on everything that has come prior, it became clearer and clearer to us that the role of people who have experienced trauma was seen as a very important to trauma informed systems change, to empowerment, to recovery.

The ideas of peer support, and we also started to see in our dialogues around the country that people who are working in the areas of recovery and the areas of mental health, people who've been involved in the criminal justice system, these places where we're seeing more and more movement to this idea of peer support. They were feeling as if they were

not getting all of the tools that they needed in order to really understand trauma and understand its role to the peer support relationship.

We did multiple focus groups. We've convened stakeholder groups, expert groups to give us more and more information about the kinds of things that might be needed out in the field.

We also, through various activities, through some of our grant programs and also through our work with the Federal Partners Workgroup on women, girls and trauma came to see that it was really particularly significant to kind of take a look at issues around peer support and women in particular and women who've been impacted by violence and trauma.

And so we convened a stakeholder group about a year and a half ago to give us some of their thinking and guidance in terms of what might be needed as a first product and what we envision will be a suite of products to help develop the mutual support arena as well as the workforce development for peers working in a variety of different settings as well as developing community response to this issue of violence against

people with multiple issues and also violence against women. That's kind of the back drip to how this guide started to develop.

And I'm going to pass it over to Andy Blanch who has worked with us in the development of the guide and she's going to basically give some more information about the actual development of the guide.

And then we'll hear from Joan Gillece who will talk about the guide in the context of some of the other activities with NCTIC. And then we'll be lucky to hear from Tonier Cain who will kind of pull all of these threads together. And then hòpefully we'll have a robust conversation with you all. Thank you.

MS. ANDREA BLANCH:. So before I get started, on the theme of invisibility of women -- I should point out that the agenda is missing one important word. It should read SAMHSA's Peer Engagement Guidance for Working with Women Trauma Survivors. Just want to make sure everybody knows that.

So for the sake of time I'm just going to hit the highpoints of my slides here. There's a lot more detail on the slides and we can get into that detail

during discussion periods.

But this project was really based on 20 years of research that we're all familiar with. Research that demonstrates that the rate of violence against women and girls is disturbingly high and that trauma from a whole host of different sources has a profound impact on all aspect of women's lives.

And as we know, SAMHSA has been involved in a multi-year, multi-pronged coordinated response and this guide was one part of that. One of the more important concepts to come out of SAMHSA's work is that which we're talking about as trauma informed care.

That in order to adequately address this problem we need a systemic approach. That in addition to specific treatment programs for trauma related symptoms, we need widespread dissemination of these and awareness of these concepts. And that's what we've been talking about today.

The cool thing about trauma informed care is that it involves everybody. Everybody in the community, or it can potentially and it can be done in any setting.

This project also rests on 20 years of research on the effectiveness of self-help or mutual support. What we're calling here peer support.

I'm not going to go into this in detail. Jean Campbell is one of the national experts in research and trauma and peer support, and she can answer questions later. I will point out that peer support has roots both in the feminist practice of consciousness raising and in 12 step models. And that consistently the research does show that people benefit from participation.

Why peer support works. There's a lot of reasons. This particular framework was originally put forward by Ed Knight, another peer researcher who suggests, and this has born out, that peer support works because it helps to overcome isolation.

It improves self-esteem by giving people a chance to be a helper as well as always being helped. That people naturally teach each other coping skills and coping strategies, it provides meaning as determined by the people who are participating in the peer support.

And finally, and Tonier is a great example of this, people who have made some progress in dealing with the challenges in their life are able to provide role models to others.

The next two show graphically what the conceptual model is that underlies this guide. This slide shows that violence against women and the trauma that results for it underlies not just mental health and substance abuse problems, but it underlies women's problems in forming healthy relationships, their ability to get and keep jobs or homes, it underlies school problems, school performance`problems, people's ability to be good parents.

This is again what we've been saying this morning is that we have to broaden our lens when we're talking about trauma and look at it as underlying all of these conditions.

This slide shows the process that we use in the guide promoting a systemic approach. What this slide shows is that the healing piece, we have to remember that that’s only one piece of an overall process.

That women can't start to heal until first they

become aware of the ways in which trauma has affected them and not everybody is aware of that until they get into a safe place so that they can begin healing.

It also -- in the manual we try to talk always about healing as a process that doesn’t stop, leads to reconnection with other people and with society. And very often entails a component of getting into action after you’ve healed to a certain point there's a tendency to want to try to make the world a better place so other women don’t have to suffer the way you've suffered. And peer support is one part of that social action.

The specific goals of the Peer Engagement Guide follow that process. It's intended to facilitate a process of self-exploration, to provide peer supporters with the concrete knowledge that they need to be advocates and the skills that they need to support others.

It's intended to encourage the development of peer support models across all human services and to promote a systemic approach. We drew on a wide variety of literatures from the research that I

mentioned on women and violence and self-help, clinical research on trauma healing. We also drew on the history of the women's movement, gender studies, a very broad range.

The development team, this was very clearly Mary Blake's vision. And it wouldn’t have happened without the support of Susan Salasin and Joan Gillece and others. The writing team included four of us, three primary authors and a cultural consultant. Two the three primary authors are themselves trauma survivors who are working in peer support in one way or another.

The organization of the guide.` The first section focuses on fundamentals, things that we think everybody should know about trauma. And that’s where we talk about the ACE Study because our assumption is that everybody should know about the ACE Study, what is trauma, what kind of impact does it have.

The second section is a how-to section with very concrete information about how to do this. And then the third deals with issues that sometimes arise. The guide includes information and statistics describing the problem, stories from survivors illustrating

specific points.

A very concrete discussion with techniques about how to deal with situations that arise in peer support including exercises. And every chapter ends with where you can go for more resources.

The fundamentals section really is a basic introduction to trauma, to peer support, to gender issues, to cultural considerations. And it also includes a short section on am I a trauma survivor. In which in this section we're really encouraging people to look at ways in which trauma has affected them and think about how it may havè affected people that they know.

Interestingly, this is one of the most powerful things. We find over and over that women are not aware of the degree to which their experiences in their lives have been traumatic.

You're probably familiar, you know the woman who says, yeah what happened to me wasn’t a rape because it was my fault for being with that jerk to start with. Or the woman who says, yeah I had an awful childhood but it was nothing compared to some of my

friends so it doesn’t really count as trauma.

I was working with a group of rabbis the other day and they were all aware of how the Holocaust had affected them. But until I asked them to fill out the ACE questionnaire for themselves, they had not realized that they had all kinds of other sources of trauma in their lives. People just don’t think through this lens yet. So that’s part of what we're trying to do here.

The section on trauma informed peer support really focuses on relationship and the skills of relationship. And teaching people what they need to know to be with people who are in extreme pain and dealing with grief and loss. How to take care of themselves. How trauma has affected them and how to work in a trauma informed relationship.

And finally, the section on applications. The last few chapters looks at specific issues that often arise regardless of the situation you're in. Things like the fact that trauma affects women differently depending on where in the life span it occurs. It affects different generations differently.

So in conclusion, the two things that we really hope that this guide accomplishes is that we believe trauma support will be strengthened by increasing peer involvement. and we believe that peer support will be strengthened by becoming trauma informed.

So I'm now going to pass it to Joan who's going to talk about, some about how we're planning to use this and roll it out into the field.

MS. JOAN GILLECE:. Okay, thank you Andy. Okay Nevine said five minutes so if I sound like I'm speeding it's because I am because I'm going to really try to stick to it.

What I want to talk a little bit about is what we're doing to roll out the Peer Engagement Guide. And a little bit about what the National Center for Trauma Informed Care is about.

Basically at NCTIC we really try to focus on the goals of SAMHSA's Strategic Initiative by developing a comprehensive public health approach and reducing the impact of violence and addressing the needs of people with trauma histories across systems. So our work is in juvenile justice, adult justice, homeless programs,

HIV programs.

We're working across CSAT. We're doing a lot with different CSAT grantees. What we're trying to do is take our limited funds and spread it as far as we can by really connecting with other Federal and state run entities.

As you can see, we're a little busy. In FY 2010 we conducted more than 315 trainings to consumers staff administrators across agencies. And this might be, for example going into a criminal justice facility and doing trainings around the clock so we train every officer.

So it might be doing the same thing in juvenile justice. So we're out there. We have a incredible group of faculty and consumer peers that work with us to really spread this message.

A few examples of the work that we do and where we will be rolling out the Peer Engagement Guide, and some of the work that I am doing cross-agency. National Institute of Corrections is doing a web-based training on women in the criminal justice system, and I've done the three chapters on trauma.

So that's no cost to us. It's my time and just being able to connect with another Federal agency to get this word out. This will be a free web-based program that we'll be able to put on our website as well, on the NCTIC website.

Alliance to Prevent Restraint, Averse Interventions and Seclusions is a group that we're working with in terms of bringing that trauma message forward to children and girls in the school systems. And the use of aversive interventions for girls there.

The National Gain Center, I brought you an example of a program brief that we've done with the Gain Center on creating a trauma informed criminal justice for women, it's in draft.

That's over there for you as is a copy of the Peer Engagement Guide in hard copy. And I made these little nifty jump drives for you that have, not just the Peer Engagement Guide but the other program that we use, TAMAR, Trauma, Addiction, Mental Health and Recovery. It's a 15 moduled intervention that we developed years ago through a SAMHSA grant for the Women in Violence Program.

So all of this is on this nifty little stick for you. As well as a film and this -- you'll hear Tonier's story. This is a DVD made of women that were in a SAMHSA funded program for pregnant incarcerated women and their children. So you'll hear these four women's stories. These are all here for you.

We have other DVDs that we're just out of. When you hear Tonier's story, there's one on her life and Dr. Felitti is prominently featured in the DVD. If you get in touch with us, as soon as our next order comes we'll be happy to send them to you free of charge.

We're working with the Bureau of Justice Assistance. We're working with their newly funded National Resource Center for Women in the Criminal Justice System. So we just provide that resource and the training for them.

The Bureau of Justice Assistance has contracted with the Council of State Governments to provide technical assistance around mental health and criminal justice. We are doing all the trauma work with them.

In CSAT, we've worked with the HIV grantees and

we're working with the criminal justice grantees. So the more that we can be of use, of service to our other Federal partners the better.

We're very excited about the initiative with military families. We're working with the bring at Miramar. This is where every woman who is arrested in the military goes. So Stephanie, your comments about the women not wanting to visit their kids because they're going to be stripped search, we've heard that loud and clear.

So imagine trying to implement trauma informed care, military and corrections. But they've been wonderful. They have been wonderful to work with and we will be going back for the third time. We're rolling out the Peer Engagement Guide there as well.

So these are all the places that we'll be just starting to roll it out. Baltimore City Mayor's Office of Homeless Women, we're working with their newly funded facility for women and kids doing Peer Engagement Guide and doing trauma based services.

As well as within the Health Department in Baltimore, the Maternal Health which we're very

excited about and something I would like to bring Dr. Felitti in to because we're looking at prevention and looking at the prevalence of trauma in the lives of these women. And looking at the mortality issues with infants born in Baltimore City.

So this is again, a gender specific rolling out the guide, really looking at it from the earliest intervention.

Framingham Women's Facility, Andy and Tonier just came back yesterday. The warden is this incredible woman, Linda Sinet who's done -- she's totally jumped on board and they trained 25 women to peer supports and to use the Peer Engagement Guide. And that's a real culture shift in the correction area.

Queens Specialty Courts, we're working their Mental Health Substance Abuse Courts, training their, the programs that the judge refers to in trauma as well as again, the Peer Engagement Guide will be used and will be handed out in the courts to women in the courts.

National Council for Community Behavioral Health, we're working with them. We're going to be rolling

out the guide at their conference that I think 4,000 people attend. We're going to be rolling out the guide there in San Diego in May.

And finally, working with peer groups, the Transformation Center in Massachusetts is another area where we'll be working to roll out the guide.

So there's just a few examples of where we're incorporating the training of trauma informed care to all staff, inter-agency work as well as training the staff to do the interventions and rolling out the Peer Engagement Guide.

So was that five?

MS. NEVINE GAHED:. Seven.

MS. JOAN GILLECE:. Seven, it was seven, good, okay. Seven okay, darn I wanted to give Tonier my name.

I'm really -- you know we're thrilled to have Tonier work with us at the National Center for Trauma Informed Care and the new National Center, there are actually two SAMHSA Centers that we're coordinating right now, but doing the same kind of trauma work that we've been doing for several years.

But Tonier has really just been an incredible asset to us with her incredible story of hope and recovery. And Tonier's recovery really was partially because of a SAMHSA funded program. Again, as I said TAMAR's Children for Pregnant Incarcerated Woman. And Tonier takes that message really across the country in a beautiful way. So I'm going to turn it to you Tonier.

MS. TONIER CAIN:. I just want to talk you a little bit this afternoon about how trauma impacted my life and what it took for me to heal and become the woman I am today. So I'm going to do this in 15 minutes because I have a daughter I want to get home to, so I promise you.

I just want to talk to you, I'm not going to go deep into my story, we don’t have the time. But I came from the home of a single parent who was alcoholic. She was alcoholic and she was abusive. And there was a lot of neglect and abandonment issues.

And because she was a alcoholic there was a lot of men in and out of the homes. So I was left to receive some of those sexual advancements. There was

a lot of sexual assaults, a lot of molestation. So many times I can't even put a number to it.

I also started drinking at age nine because to me, drinking helped me to deal with when I was smacked down and called names and when the men came at night. So it helped me to cope with my reality.

I didn’t go to school a lot but no one asked what happened to me after missing two or three days. That's a picture of me at age nine. And I always, always missed school, was never followed up on, why are you missing so many days? No one asked, and I would have told them because I had to take care of my sisters and brothers. I was the oldest of nine and I had eight brothers and sisters at the time.

Well eventually somebody made a complaint to the Department of Social Services against my mother. Made a complaint, Social Services came out and seen the filthy conditions we were living in and we were immediately removed from the household and we were placed into foster care.

And as you know, there's not one family sitting around waiting to foster nine kids, it's not. So we

were separated and we were put into nine different foster care homes. And it left me devastated because it was my sisters and brothers, they gave me the only joy I had in my life, the only reason I had to laugh out loud.

Eventually we went to court and we were placed to different family members, nine different family member homes. And I was doing well for awhile. And you know my mother eventually came around age 14 and asked me to come back home with her. She told me she loved me, I never heard her say that. I didn't hesitate. I packed my things and off into the sunset I went with her.

Well by then she had had three more kids and Social Services had given her more money and another public housing apartment. Within one week she severely beat me and stomped me in the street for trying to go to school. She needed a babysitter.

But you know I still didn't understand what was -- you know I just didn't understand how to get her love. So someone planted the seed, if you take a bottle of pills you'll die. I don't know who or when

but they told me that and I did.

And I woke up in the emergency room. No one asked why. Why you trying to kill yourself little girl? They talked to my mother who convinced them that I took an accidental overdose on my own prescribed medication I was released back into her care.

Only for her to come to me one night after drinking with a friend of hers who thought I was cute and wouldn’t mind making me his wife. And she told me he said if I married him she'll have a place to live because she was evicted again.

It was an opportunity to make my mother proud of me. I married him, I moved into his house. And as you can imagine I was soon pregnant. But at night I would stand there in total fear, my husband told me that I could not continue to go to school because I was a wife and a mother now. I was a minor. My mother had to sign the marriage license for me to marry him.

And when he came home, the lights would shine in the window and I would stand in total fear because I

knew when he came trough that house he was going to beat me until he seen blood because he wanted to know why I didn’t dust his house.

Well eventually it went back and forth being beaten almost every single night, somebody eventually came to me and told me try this. It was crack cocaine. It was the answer to all of my problems. I never had to feel anything ever again. I could take the beatings. I didn’t care. I could just numb out.

But unfortunately for me it introduced me to the criminal justice system. I racked up 83 arrests and 66 convictions. They told me I was`going to spend the rest of my life going in and out of prison or I was going to die in the street.

This is what the providers told me. Every time I came, see you when you come back Cain. And when I came back, I always did, they said welcome home I'll take you to your old cell, you want your old rubber room?

Still didn’t understand. People told me I was crazy and I needed medication. So they would send me -- I would check myself into our 72 hour mental health

unit at our county hospital. And it always depend upon what day of the week it was.

On a Wednesday I was schizophrenic. On a Friday I was bipolar. On the Thursday I was something else. But no -- and no one even considered the fact that I had been up smoking crack for seven days straight. They never allowed the street narcotics to get out my system before they truly gave me an assessment or evaluation.

This is me in my very first mug shot at a very young age. I want to go to -- I want to go directly to the retraumatization. I was a 30 day repeat offender as you can imagine. I could not achieve and maintain sobriety. I didn't understand why and I didn't want to. I just didn't want to. It just felt better. I was comfortable just using and numbing out.

And I would go back and forth in systems and every system I've been in I was retraumatized. By the police officers on the streets, in the correctional facilities I was doing -- I was given medication, mental health medication and I was doing sexual favors for the officers while I was medicated.

I went into the prison system told them I was pregnant. They didn't believe me see because she just manipulative. She just seeking some attention.

They told me I wasn't pregnant that I had a urinary tract infection only for me to wake up one morning early, go to the bathroom and have my baby hand come out and my baby was unable to fully abort. They allowed me to lay there with my dead baby stuck -- shackled down in the gurney for three hours in that position.

Well eventually I ended up going to court and some judge -- finally a judge after`40 arrests, all of my arrests are associated with my drug addiction, my alcoholism, my mental health. He said, well she must have a drug addiction, can we get her some help. They court ordered me to a 28 day program.

After 28 days of being in a program I realized I just got enough sleep to figure out how I was going to get high again. And they got -- certainly get the tools and the information, nor did I work on my trauma.

Nobody ever asked what happened to me. But I

told them everything about myself. I told them I been raped and beat so many times I can't even put a number to it. And I was assigned a male counselor.

And after -- and you know what, truthfully if you don't -- I always say if you don't get anything out of my presentation, please get this. When we come in to programs and we come -- we walk through your doors, we expect you to know what you're doing. We expect providers to know what they're doing. So if you tell me that man is the best thing for me, who am I to argue, you the expert.

So I worked with him. I told him the things that affected me most in my life only for him to give me a ride one night and rape me face down. And he threw me to the ground and told me I was nothing.

Always put into seclusion and restraint. I did all of my incarceration on lock. I was very angry, very out of control. And I was always put in seclusion and restraint.

I was always over medicated. And truthfully, I was an addict I didn't complain, I appreciated the free high, I did. Thanks a lot. But it certainly

didn’t help me to recover or heal. It took me further away from that.

This is me. For 19 years I lived underneath a bridge. I lived on the streets for 19 years. I wasn't allowed to go in anybody's house. Somebody threw a blanket out to me. That's how I lived for 19 years losing four kids to the system. I was giving birth as a result of rapes and prostitution. And Department of Social Services, rightfully so, was taking my babies.

But you know I would try to visit them and they say, didn’t you just get out of jail? Don’t you have pending charges? Aren't you on psychotropics? No one ever had hope for me. Nobody was ever willing to work with me or ask me what happened to you.

Well I end up the program -- I end up in prison, down at Maryland Correctional Institution for Women and I was pregnant again, terrified that I'm about to lose another baby and I just didn’t know how I was going live through that.

And they were telling me about this program called TAMAR Children. They said it works on your

trauma, I certainly didn't know what that is but I figured I had it, I had everything else. Your addiction, well that's a given, your mental health, yep. They say I was crazy and you recover and keep you baby with you.

It was a program -- it was an alternative sentencing program for pregnant inmates. And I remember when I was walking the grounds, the first person I seen Joan was down there scouting out pregnant women for her program, her SAMHSA funded TAMAR Children program.

She down there in prison walking the grounds looking for pregnant women and I was huge, you couldn't miss me. And she walked up to me and she said, what about her. And I told her I wanted to come to the program.

And after we had to go back and forth, me asking for more time and all the drama around trying to get into her program you know because her staff wouldn't -- they wouldn't relent. They were so determined to have me in their program they kept talking to the warden and everything.

So eventually they did allow me to go to the program. And when I walked through the doors of TAMAR Children somebody said, I am so glad you're here. After 19 years of living on the streets and people looking at me in disgust, spitting on me and kicking me, somebody told me they were glad to see me.

And I met with my trauma therapist who said now we gonna first work on the trauma, the trauma that first affected you in your life. And that was the issues with my mother. I was able to work through that, I cried about that. I realized I was adult now and her -- it doesn't you know, affèct my character. I was able to heal from that.

And then she said, now we're going to talk about all the times you was sexually, mentally and physically abused. I said Miss, I've been beat and raped so many times I can't even put a number to them.

She said, we're going to talk about the times you do remember. And see now that I was in a safe environment and these things were no longer happening to me and I was able to begin healing in that area.

Then I went to one session and she said now we're

going to talk about your kids. I said no. I wasn't willing to work that hard. I wasn't willing to feel that much pain.

I said Miss, how do I heal from something that continues to give me pain? Every day I wake up I realize I got four kids. If I walked past them on the streets I wouldn't even know it. How do you heal from that? She said you do, you just don't do it by yourself.

And I would become so distressed when I talk about my kids I always cross my arms and I would just rock and I would cry and I would rock. And my therapist, who always sat beside me, she never sat across the desk from me, always sat beside me, when I rocked she rocked.

She matched my emotions and she followed my lead. And she allowed me to be in the driver's seat of my own life, my own recovery. So I was able to begin healing in that area.

See people over the 19 years tried to give me bits and pieces of information, try to get clean. And it only get surface. I had so much pain, so much

trauma packed so tightly in there the good information couldn’t penetrate any of that you know to get down there to get rooted so I could build a foundation so my belief system could change from I am nothing to I am somebody and I can be anything I want in this world.

See when my belief system changed my thought process changed. I started to make the best decisions in my life. And one of the best decisions I made was to continue the one year course that TAMAR Children offers as to how to be a mother. See I knew how to give birth, that was easy. But I dìdn’t know how to be loving and nurturing.

And sometimes when you come from an abusive household it takes work not to be abusive. And I didn’t want to be abusive so I went through all the things that I need to learn to be a mother. To form that secure attachment with my baby.

I can tell you all the wonderful things that I was able to achieve throughout the six years that I was able to accomplish -- just the six years, some seven years now, I just celebrated my seventh year,

seven years since I lived underneath a bride, ate out of trash can, going in an out of prison system and mental health institution.

They told me I would be nothing. I would spend the rest of life going in and out of institution or I was going to die in the streets. But finally somebody asked me, what happened to you.

What if somebody asked me that at age nine? That same question and they had the tools to help me to heal at age nine just like they did at the TAMAR Children Program seven years ago. The same question, I was able to get the same treatment. Finally somebody helped me to identify, address and treat my trauma.

Isn't is possible I could have become the woman I am today without them trying to treat the symptoms of trauma? The substance abuse, the alcoholism, losing my kids, the homelessness, the prostitution. All these things that they trying to fix.

The things that they trying to fix that are so obvious but nobody was tapping into why I was using drugs. Why I was homeless. Why can't you take care

of your kids. So finally that happened. And I know I could have become the woman I am.

But you know what, they treated my trauma with the hopes that I stay out of their system. And it worked. It worked. Here I am sitting at your meeting. But I often wonder, did they even think that treating my trauma was going to break that inter-generational curse in my family.

See my daughter doesn’t know what it's like to live in the projects. She doesn’t know what it's like to wait for somebody to hustle to find food for her. She doesn’t know what it's like not`to be hugged and loved and protected. I'm a homeowner. My daughter go to one of the best private schools in Maryland.

So treating my trauma broke that inter-generational curse. She'll be able to give her children the same things she was given. And we begin to see a whole different generational path from here on out. All because somebody finally asked what happened to you and was prepared to hear the answer.

We don’t have the right to deem someone hopeless. That's not ours. Please, don’t give yourself this.

When people go into programs we need to view them as this, nothing is expected but everything is received, good or bad. We should expect nothing from them but realize that everything we do or say to them is received.

Treat the trauma. You'll get different results. I'm your evidence. Thank you.

[Applause.]

MS. MARY BLAKE:. Thank you very much Tonier and Andy and Joan. I wanted to say a couple of words about the guide. The guide is in draft form. It is not ready for public distribution. `We're going to be doing some audience testing before we send it up the wonderful clearance chain. But I think that your comments and your thoughts about the guide are very much welcome. Is that correct?

MS. JOAN GILLECE:. [Off microphone.] If I could maybe turn [inaudible].

MS. MARY BLAKE:. Yeah.

MS. JOAN GILLECE:. [Off microphone.] They did just use this at Framingham Women's Prison. Do you want to say some words about that experience

yesterday?

MS. TONIER CAIN:. I mean it was the first time that I was actually involved in this roll out and it was incredible. The women -- I mean they were there and they were like --- they taught us things. We remain teachable because we want as peers. You know most of us went as peers.

And they received it and they were talking about things that they can do around awareness and how they can continue to help, use that guide to help those that’s coming in and out of their system. And it was just incredible.

The warden -- what I was really impressed by was the fact that the warden the superintendent sat through the training the whole time. I have never been to a training -- I have seen other than her, when we went there before she sat through the training and Mark Patterson, but other than that, you don’t see -- you see administration come in and out.

They might peek their head in and out. But she sat there because she was fully invested in her women using this guide to help women come through her

system. And I just thought it was incredible.

MS. ANDREA BLANCH:. All I want to add to what Tonier just said is that prison was full of women who are smart and funny and wise. And sometimes there's a bit of tendency to exceptionalize our speakers. You know Tonier is an amazing woman. She is an amazing woman, but she's not the only amazing woman out there.

MS. TONIER CAIN:. That’s right.

MS. ANDREA BLANCH:. And it's really important to remember that. That our jails and prisons and mental hospitals --

MS. TONIER CAIN:. Yes.

MS. ANDREA BLANCH:. -- are full of people --

MS. TONIER CAIN:. Absolutely.

MS. ANDREA BLANCH:. -- who could potentially make the kind of contribution she's making.

MS. TONIER CAIN:. Absolutely.

UNKNOWN SPEAKER:. [Audience Member.] Can I ask a question? Thank you for your story and as you were talking and you said I finally broke that inter-generational curse. And I sort of flipped back to your mother and wondered what was her story, her

curse? How far did that curse go back? I know that you're not there but --

MS. TONIER CAIN:. Yeah, well I do know that I am the first homeowner in my family. My great-grandparents lived in the projects. They lived in public housing and low income housing.

She, her mother was on welfare or Department of Social Services, my mother was. There was a lot of babies that was born by different fathers and no goals, no education. And that's how it was for as far as I know.

I can go back to my great-grandparents, can't go further than that. But that's what I was told and that's how it was. So that’s the curse I talk about. You know, what is -- we only know what we know.

If we grow up and I always tell people, you know we grow up in this community and none of us get out. We don't fly to San Diego. We don’t go out and see different things. You know, all we know is what we know.

UNKNOWN SPEAKER:. Thank you.

MS. NANCY KENNEDY:. I have a question. Where is

this guide? Can I see this?

MS. TONIER CAIN:. It's on that flash drive.

MS. NANCY KENNEDY:. Oh, okay. It's in the flash drive?

MS. JOAN GILLECE:. We have it on the flash drive and I brought hard copies for you. But again, it's in draft. We're going to pilot test it but we certainly wanted to share it with you.

MS. NANCY KENNEDY:. Okay.

MS. JOAN GILLECE:. But it's right here. It's over there on the table. I just put it on the flash drive too.

MS. NANCY KENNEDY:. Okay, I did hear you say that, I apologize. Thank you.

MS. ANDREA BLANCH:. And just to reiterate, we're really looking for feedback. We expect to make revisions in this and to create other products associated with it. So you know, email me or give me a call if you have some suggestions.

MS. JOAN GILLECE:. And we do have another DVD that really goes into depth into Tonier's story. And we have an hour version. Again, if you get in touch

with us we're happy to send it to you.

MS. TONIER CAIN:. And what makes it also so amazing is the experts that's in the film. I mean the story is pretty much the same as the women that we see all the time. But to have the experts in there with Dr. Gillece and Dr. Felitti and Pat Shea, it's just really, really a good film for training.

UNKNOWN SPEAKER:. [Audience member.] Is your contact information in the [inaudible]?

MS. JOAN GILLECE:. I don't think it is. I think maybe you can get in touch with us, it's on our PowerPoints.

MS. KANA ENOMOTO:. Yeah, we can --

MS. JOAN GILLECE:. So if you get in touch with us we can get it to you.

MS. KANA ENOMOTO:. Yeah, we can kind of --

MS. JOAN GILLECE:. Everything's in the back of the PowerPoint I think.

MS. KANA ENOMOTO:. Starleen? I want to let Starleen make a comment.

MS. STARLEEN SCOTT ROBBINS:. If we could get a copy of -- well actually, would you be okay if we sent

a copy of the draft out to the Women's Services Coordinators and we could ask for feedback?

MS. JOAN GILLECE:. I think that's a great idea.

MS. STARLEEN SCOTT ROBBINS:. Okay.

MS. JOAN GILLECE:. I don't know how SAMHSA feels but I think that's a wonderful idea and would love that.

MS. MARY BLAKE:. The one thing though that we want to make clear is that if you're sending this out it's to be very clear as to what the purpose it and to really remind people that the guide is not for public distribution. That it is a draft dòcument that is we're seeking potential user feedback.

But then we also have to be very careful about that because of the OMB requirements. So I think that -- I think that you know, just be very careful if you send it out and ask people to give their comments that it's clear that this is a draft document. Thanks.

MS. ANDREA BLANCH:. One more comment on that. We're also you know interested in actually testing it in different settings and different situations. And there are trainers who can come out and train and help

do some of the initial developing of the peer support. So that's another option in addition to just giving feedback.

MS. STARLEEN SCOTT ROBBINS:. Would it be possible to get more information about that piece of it? Because I know that there are some stuff that we're actually trying to do through our Regional Partnership Grant with ACF around peer support at our site in North Carolina.

And I think we'd be very much interested in it. But I would like to also offer that opportunity to the other Women's Services Coordinators`who may also be looking at peer support services.

MS. JOAN GILLECE:. We can put these little cards that talks about what we do and what we can do. And on it is training and how to get in touch. So all you'd have to do is get in touch with us.

We'll have you fill out an application. We'll do some conference calls with you. We'd want to talk to you about outcomes and how we can follow up with you to see how the training went. But yeah, we'd be happy to.

MS. STARLEEN SCOTT ROBBINS:. Awesome. Thank you.

MS. KANA ENOMOTO:. I want to thank Tonier for sharing her story which is always inspiring and I know there are many exceptional, smart, funny women but Tonier really is among the best that I've seen anywhere in any setting.

MS. TONIER CAIN:. Thank you.

MS. KANA ENOMOTO:. So I think that is one --

MS. JEAN CAMPBELL:. [Off microphone.] Okay, I've looked at the slides, I still can't find any contact information.

MS. JOAN GILLECE:. Really?

MS. TONIER CAIN:. No, that's not it. Is that our slides?

MS. JEAN CAMPBELL:. Yeah.

MS. JOAN GILLECE:. There's some on this card but I can give you --

MS. KANA ENOMOTO:. But I mean I think Jean that’s also something that Nevine can serve as the point of contact for all of our Committee Members who want to know anything about what's happening at

SAMHSA, we can make those connections happen.

So also thank you for the whole team at NCTIC and the new center for all that you're doing. Because this is exciting work and we're going to -- we'll keep in touch. And in that sense, that will be at the next meeting if you want to know when.

Okay so now we have -- before we get into our next speaker, Larke Huang, who is our lead on Trauma and Justice, Nevine has a note of order.

MS. NEVINE GAHED:. If anyone is interested in making a public comment from you know, the public here whether in person or on the line, please let us know. And for those who are here who would like to make a public comment, there are cards on the back on the table, if you could just put your name and the organization name and you know, sort of a quick thing, a synopsis on the topic we would appreciate it and then you can just give that to me. Thank you.

MS. KANA ENOMOTO:. Larke is our Director of the Office Behavioral Health Equity which is the Office of Policy, Planning and Innovation. She's also our Senior Advisor on children. And she is the Strategic

Initiative lead on Trauma and Justice. So she's here to talk to today about some of the work that I was alluding to within the Trauma and Justice Initiative.

MS. LARKE HUANG:. Okay, thank Kana. I have a handout but I don't think I brought enough so there are more that are being made. So I'll pass some of them out here.

And then I also have an article that I think you all have probably referenced here. It's the article that was in the New Yorker that came out this month so here's a copy of it for you.

MS. HARRIET FORMAN:. [Off microphone.]

MS. LARKE HUANG:. I'm sorry, what?

MS. HARRIET FORMAN:. I just said, ask and it shall be given, we asked for it earlier.

MS. LARKE HUANG:. I'm Pam Hyde, what else to you want.

[Laughter.]

MS. LARKE HUANG:. Okay, I think I've presented to this group in the past and there were different configurations of people. So I didn't really do this as a presentation because I really want to -- I'm

really thinking about this as a listening session for us in the Trauma and Justice Initiative.

So I wanted to tell you a little bit just about the goals and the objectives and then where I would really like to really ask you some questions and have you do some thinking with us around this.

As you know, the Trauma and Justice Initiative is one of the eight Strategic Initiatives of the SAMHSA. And the handout you have has all the slides. And as Kana knows, I usually do like 30 slides for 10 minutes so this was really, it took an effort here.

So the second slide on the top`really just tells about what our purpose is in this particular Strategic Initiative. And it's really to look at reducing the pervasive, harmful and costly impact of violence and trauma by beginning to integrate trauma informed approaches throughout behavioral health, health, and other related systems.

And we've done a lot of work on trauma here at SAMHSA. And some of you in this room have been some of our leaders on that as well. And as you may have heard in our earlier Advisory Committee meeting that

we're also trying to look at how we can get much of the work that we do into other delivery systems.

And into other systems that may not be specifically geared to be health systems, but we know they have a lot of impact on health. So whether that's the criminal and juvenile justice system, the child welfare system.

Actually we're looking at other systems like the USDA, the Department of Agriculture is telling us they have huge network of cooperative extensions where they do a lot of health programming and violence and trauma prevention work.

And so, but they want to know what kinds of materials and information and interventions that we can share with them. So we're really looking at this as how do we move more of our trauma work into other systems where people who have mental health and substance abuse issues you know also are showing up.

And then the other piece of this initiative is also looking at the criminal and juvenile justice system. How can we look at all different points within that system from earliest entry or at risk for

entry all the way to being incarcerated, detained in some way and then reentering the community.

How do we look at the people who go through that system and at each of those points what are the mental health, substance abuse, behavioral health issue and needs and underlying often unaddressed trauma issues for those people at risk for or entering at some part of that criminal and juvenile justice system.

So we have about five general goals in this initiative. And they're on the third slide. And under each of those goals we have objectives and actions steps which you probably can go through in the Strategic Plan that you've received.

I want to just really focus on the first two. And that is really thinking about developing a comprehensive public health approach to trauma. And also thinking within that framework of making screening for trauma and early intervention and treatment common practice in some of our health and behavioral health care delivery systems.

So given our short amount of time here, I'd like to really kind of get your best thinking around that.

Of course for much of the work in this particular initiative, and I'd say probably a leading study that has really moved into the area of prevention has been Vince Felitti's study on the Adverse Childhood Experiences Study.

There's a lot of -- that under lays a lot of this work. And even beyond this particular initiative and having been a children's person before wearing some of these other hats, that was a critical study in terms of really looking what happens in childhood that leads to various kinds of health and behavioral health outcomes in adulthood.

And I think we have more and more evidence about the importance of looking at that, those adverse experiences and we are getting much more of the biological evidence around that where actually we're starting to do cortisol-salivary testing for stress and kids and families now as a first kind of biomarker for stress and perhaps at risk for trauma.

So anyway, so we're trying to think, how can move what we know about trauma into a system. And we've chosen, for example our primary care system. In

primary care we do a screening and a brief intervention, referral to treatment for substance use.

We do have an intervention that's looking at screening for this for people who are not diagnosed or identified with risky alcohol use or substance use. And we have been working with primary care and that we have a program around that.

And we've seen some success in terms of identifying people who don't present with an alcohol issue but are sub-threshold or sub-clinical but are at risk and engaged in risky alcohol.

So we're thinking can we something similar around trauma and if we look at trauma, can that also improve some of the interventions we have going in primary care.

So here are my questions. Are there commonly used and accepted screening tools for capturing adverse experiences and trauma response? You know in terms of your experience and the systems that you work in, you know ideas around that.

Secondly, if you're familiar with those or have thoughts around those, how might they be used in

primary care settings. If we think about screening for that in primary care settings, and one of the things we often get push back from any settings or asking for a screening, well what if you screen positive or what if you hit a certain cut-off in screening, what do then do.

In this other program we're screening for substance abuse we have brief interventions that can be done at the same time the screening's done so it minimizes any kind of hand off.

So it's not saying, you've screened positive, you've screened at this cut-off for`this come back next week and let's talk about what we're going to do around it. But there is a brief intervention that can be done on site.

So those are my, the first set of questions. I can go through all of them or do you want to start answering them now?

MS. KANA ENOMOTO:. And if I could just -- to clarify, I think when Larke is saying screenings -- so it's not, it's different from an assessment tool, right? So we're not talking about a 30 minute or 45

minute assessment tool. Because we know that those do exist for trauma and adverse experiences.

But the brief screens that they're using for the SBIRT I think are the audit and the assist. So that we're talking about 10 questions, two questions. And then for the BI, it's different -- differentiated from brief treatment.

So a brief treatment of an hour or less over the course of 10 weeks -- or an hour or less over the course of 10 weeks would be considered brief treatment. The brief interventions they're talking about are I think are less than, either less than 15 minutes or less than five minutes.

MS. LARKE HUANG:. Yeah. And also in terms of the screening in some places, sometimes it is like five to six questions and some primary care sites have actually integrated that as part of taking vital signs too. So it's not -- you're not going to have substance abuse, it's just part of taking vital signs, those couple questions are asked.

MS. KANA ENOMOTO:. So it doesn't mean then that doesn’t lead to further assessment. But that’s the

initial, a universal screen type of thing.

MS. LARKE HUANG:. Right. Now I guess the other thing, in the article that I just passed out that was in the New Yorker really talks about doing this in a -- actually it was pediatric primary care center in the San Francisco Bay area. And pediatrician who recognized that she needed to start asking questions about trauma as part of the checklist about what pediatricians were doing.

So that's the first set of questions. Any thoughts?

MS. JOHANNA BERGAN:. I don't have a great knowledge base on like assessments and things to tell you. But the thing that keeps popping up as you've been talking is how connected this can be the health information technology work.

So I'm experiencing a doctor with a computer for the first time in my home clinic. For the past two months he doesn't look at me. He mutters mostly words under his breath and hates every second of what's happening.

But just -- I've had one appointment, pediatric

appointment with my daughter with this new system and I've had two OB appointments. I've been flagged for substance abuse twice for the first time in 21 years, 25, 23 years of being at the same clinic.

And my daughter has growth issues which have been noted because there's a little visual chart that the doctor has to fill in. But never once had they connected that we've complained with GI problems with her since she was six months old.

And all that was is one new question for both of us in a new system that they got. And it was so easy and it's changed treatment for both`of us dramatically. And I don’t think that the doctors knew, like they had new information and they didn’t know what to follow up. So there isn't intervention happening.

They were like substance abuse, you're -- no, that's -- this must be wrong. And like then he tried to figure out why his computer was telling him something wrong. I'm like it's probably right but I'm in therapy. You know, but it just was like, okay you have the information now what do you do about it.

And so as everything's moving to the technology I feel like it will be easy to put in four extra questions, it's the what do they do next.

DR. VINCENT FELITTI:. [Off microphone.] Were those questions initially asked verbally or by questionnaire?

MS. JOHANNA BERGAN:. They were verbal. And they surprised the doctor. I mean he was reading the screen going what box do I check next.

MS. NANCY KENNEDY:. Hi, I have a question. Okay, so I have this client and she's come to me after continuing times into the emergency`rooms and treatment centers, and she comes, I run the local women's shelter, she comes in to us we talk to her over and over for a couple of days.

She can't sleep, she's out of her mind. She's tried all the different kinds of medicines. You guys have paid oodles and oodles of money for her over the few years.

We finally sit down and one of the counselors says to her, well what do you do when you wake up at night. She says I get up, I snack, I go to the

bathroom, blah, blah, blah. We have her bladder checked because she goes to the bathroom.

We notice that every single time she wakes up she goes straight to the bathroom. We get the bladder checked, send her to the doctor and get the bladder checked, get some bladder pills and guess what, everything is handled from there. Takes a little time, within three weeks she is leading a normal life.

All the issues that she had were lack of sleep, restlessness, all based on not knowing that the physical issues needed to be addressed and could have saved you know, five emergency room`visits just in the last six months based on her issues rising based on lack of the right kind of -- you know, somebody asking the right kind of questions. Do you know what I mean?

MS. LARKE HUANG:. Mm-hmm.

MS. NANCY KENNEDY:. So I really liked where you were going with that. Like what part, what do we need to ask in order to get some things. Now I know that's not the answer for everybody. But guess what, for that girl it was the answer. And she's still, and she's doing really well today it's three years later

almost.

MS. LARKE HUANG:. Okay. Okay, so we have like clinic experiences here you're talking about.

MS. NANCY KENNEDY:. Yeah.

MS. LARKE HUANG:. Sure.

MS. NANCY KENNEDY:. [Off microphone.] I mean she was in and out of emergency rooms and treatments. You know she says she gets off the track and she goes to the bathroom at 2:00 or 3:00 every single night. We just sent her to get the bladder checked, it's fixed and now she's leading a good life, a better life.

Of course in recovery, (inaudible) deal with everything else. The medicine all changed then from what everybody's (inaudible), now it's just -- it's light, do you know what I'm saying?

MS. LARKE HUANG:. Mm-hmm. So in that setting could you ask questions about previous adverse kind of experiences or has that ever come up in your clinic experience?

MS. NANCY KENNEDY:. [Off microphone.] We do. We do. We do. We work on that. We're a long term

safe house. So we do. And we do, we deal with the trauma and stuff. It's not no fast 20 days or 60 days in and out.

We also deal with the criminal justice system. And that is our goal, is being a place of forgiveness. Like the guy in Hawaii, we really believe in that sort of theory.

MS. LARKE HUANG:. Okay.

MS. KANA ENOMOTO:. Thanks. Starleen you had a comment?

MS. STARLEEN SCOTT ROBBINS:. I think part of the issue here is I think obviously scrèening can be done. But again, it's the education of those who are actually going to be delivering the screening and also what resources are available once you get the results of the screening.

We just worked with our Division of Medical Assistance with Medicaid and the Division of Public Health on identifying a screening tool for pregnant woman for a new pregnancy medical home model in North Carolina. And we chose to use the five piece plus from Norma Finkelstein's, Dr. Finkelstein's group in

Massachusetts.

And it includes the substance use questions, violence question, and smoking questions. And it's actually seven questions, it's five plus, but it's quick, it's used in primary care setting. The social workers and the health department and the nurses seem to be really comfortable with asking the questions.

They are getting training on utilizing it, but the biggest piece is their fear of what if somebody says yes. So you really do have to prepare folks in that way of what happens when people say yes.

MS. LARKE HUANG:. And so what`do you provide if someone says yes?

MS. STARLEEN SCOTT ROBBINS:. So we have a peri-natal substance use guide and an information guide for the different resources that are kind of state-wide. But also we asked them to put a guide together specifically for their community.

If there are domestic violence shelters, sexual assault shelters or programs so that they actually have those right at hand and also have communication and have them on their advisory groups, have them you

know, visit the programs in the local area so that they know where they're referring people, have folks come in and do in-services. So you really want them to feel comfortable with who they're making that phone call to within that community.

MS. LARKE HUANG:. Do you have a question?

MS. KANA ENOMOTO:. Yeah, well I think -- just to -- so what I hear is that it's screening and then referral. And so one of the missing pieces, I mean I think you're pointing it out, it's the brief intervention.

What is it that you do if someòne doesn't necessarily need you know, six month residential treatment or a trauma specific group, but they are still screening positive. It's what Tonier said, what if someone asked me that question when I was nine.

DR. STEPHANIE COVINGTON:. Vince.

DR. VINCENT FELITTI:. Yeah.

DR. STEPHANIE COVINGTON:. We've been hearing -- let me ask you a couple of questions.

DR. VINCENT FELITTI:. Yeah, sure.

DR. STEPHANIE COVINGTON:. Okay. I know what you

say. You say this is really better done if somone fills it out on paper.

DR. VINCENT FELITTI:. Well initially there's no question in my mind about that.

DR. STEPHANIE COVINGTON:. I know.

DR. VINCENT FELITTI:. I mean you know we've had enormous experience with that.

DR. STEPHANIE COVINGTON:. I know and so -- but I want you to -- I know that's been experience. But if you just -- is there a way, are you really saying that trying to get physicians to do -- well, I've heard you say a couple things.

One is, it's really better if it's done by someone filling out paper and pencil. You're pretty clear about that. And the second thing you've said is how difficult it is to get primary care doctors to deal with this.

So if those two things are true, let's step back from this and think about what would you suggest? What would you suggest for SAMHSA?

DR. VINCENT FELITTI:. Well a good sentence to keep in mind is this, I see on the questionnaire that,

tell me how that's effected you later in your life. Most important, it's easy to say. Which is a huge problem that's solved then. It's easy to hear.

It gives the possibility for somebody to lie and say it hasn't. That rarely happens. Nor does it open Pandora's Box. The answer is typically a minute, minute and a half long, people often cry, it's okay.

You know so I see on the questionnaire that you were molested as a kid. Tell me how -- so that's a fact now, that's out in the open, it's not being raised for the first time, tell me how that's effected you later in your life. So I see on the questionnaire that your brother's in prison. How has that effected you or the family in your life.

I mean we have found that in a large department with 28 examiners that that was sort of the favored response to start. And it really worked well. It's easy to remember.

For sure, not poison the water by apologizing for these questions. Well you understand you know, I ask these questions with all patients, et cetera. Which simply is a red flag for your own embarrassment and

clumsiness.

So that sentence, tell me how that's effected you later in your life really works quite well.

MS. LARKE HUANG:. And is that a brief intervention?

DR. VINCENT FELITTI:. Amazingly, it appears to be. And I say that based on an analysis of 130,000 patient records where whenever yes answers turned up that essentially was our response.

A couple of years later an outside organization, a data mining company, did an analysis of 130,000 patients using a questionnaire that`was our standard former biomedical questionnaire with a number of trauma oriented questions now added to it. And coincident with that they measured that there was a 35 percent reduction in doctor office visits in the year subsequent compared to the year before for that group.

When we -- a number of years earlier we had done a similar analysis but on a much smaller sample of the same biomedical base for that questionnaire and we had an 11 percent reduction which we assumed to more complete diagnosis, more efficient entry of people

into a complex medical care system, et cetera. That was largely the correct explanation.

But a 35 percent reduction is of extraordinary value. I mean the implications are enormous. Now you know you knock 35 percent off state's Medicare budget or national health budget you're talking about serious money.

The rest of the story however, is that two years later everything reverted back to its prior baseline. And so the question is, why the drop and why the reversion.

Near as we can figure, and believe me we've thought a lot about this, near as we can figure the drop was the result of asking people for the first time in their lives about the worst secrets of their lives, which they had essentially already acknowledged on a paper based questionnaire, and allowing them to talk about it and enabling them to go home feeling still acceptable as human beings. Huge, huge step. We believe that that simple asking and listening is profoundly beneficial.

Why the reversion two years later? Well we use a

unified medical record, look in the medical records and there are our notes printed literally with laser like clarity, they might just as well have been printed with invisible ink. Because no one touches that information henceforth. So it's kind of like you know, eating lunch. It resolves hunger for awhile but it doesn't cure hunger forever.

MS. LARKE HUANG:. So if you looked at, because you had so many cases, if you look at it did it outcome, did the health outcomes change in any way?

DR. VINCENT FELITTI:. I don't know. That's certainly a good question. I don't`know. All I can tell you is that doctor office visits dropped by 35 percent.

Now one of my colleagues said well it's obvious what's happened, you've so humiliated these people by forcing them to answer these questions that they're avoiding needed medical care. You know, conceivable. I mean you know it totally avoids the reality that anybody who wished to lie could have written down no and avoided the whole thing.

But several years earlier we had a rather unusual

event in the department for six months because I had, for six months on the staff on-site to see patients essentially immediately a psychiatrist who was a fully trained psychoanalyst.

And he would see patients right on the spot for a one hour interview with a dictated note. Our assumption was that that dictated note would provide good useful advice to other, you know primary care doctors or whatever in the system and somehow something good would have come out of it.

So when this guy left, and the examiners thought that was terrific because they didn't have to you know, wrestle with the idea of how am I going to refer this person to psychiatry and run the risk of, you know god damn it I'm not crazy et cetera.

So they were very happy to have this guy here. They could just say, well when we're through why don't we go down and talk with Dr. Shannon he's had a lot of experience with this kind of thing and not even bother identifying what Shannon did.

Anyway, so there's Shannon's nice notes in the chart and clearly nobody is paying attention to them.

I was kind of frustrated. I was talking with a friend of mine and he suggested, well maybe what you ought to do is wait a year and count doctor office visits.

Oh, oh sorry at six months I wrote every patient that Shannon saw a nice hand signed letter. You know, was the interview with Dr. Shannon helpful to you. I got an overwhelming response rate and all save one wrote back that they liked it. And I thought, damn I didn't ask whether you liked it I asked whether it was helpful. You know we could have given $10 bills away and people would have liked that.

So waiting a year and counting`doctor office visits then, we find that this one time contact basically high ACE score individuals with the psychiatrist, psychoanalyst for a one hour interview was associated with a 49 percent reduction in doctor office visits in the next year.

And the relevant point, as related to this lame criticism, was that people overwhelmingly liked it. So the reduction was not avoidance. The reduction was due to some other process in people who liked the contact. Who said in some way that it was beneficial,

helpful to them, et cetera.

MS. LARKE HUANG:. So you obviously have the huge database to reflect on and to help us think about how we might go forward you know, with thinking about some type of screening.

DR. VINCENT FELITTI:. Well I just sent you, it will go out in an hour or two when I can get on the internet again --

MS. LARKE HUANG:. Okay.

DR. VINCENT FELITTI:. -- a lengthy email proposing something specifically help me find someone in the government somewhere that might be interested in redeveloping this questionnaire in a digital format, a biomedical, psychological, social and in particular trauma oriented questionnaire, I mean this big complex thing. You know it asks about kidney stones, it's asks about hemocromatosis and lots of other things, extensive family history, et cetera, to put that on the internet free.

And the goal being to see whether in a couple of years a couple of million people, and I believe that that's realistic in a country this size, might chose

to answer that and print it out at home and if they wished, give it to their physicians.

Essentially it's using patients as a market force to bring a change about in primary care practice moving it from its current symptom reactive approach to the more comprehensive approach that was originally conceived for primary care but obviously not attained.

The advantage of a digital format is that it allows one to provide little bits of feedback along the way. Partially for educational value and partly as a present to people for answering.

MS. KANA ENOMOTO:. Amanda.

MS. AMANDA MANBECK:. I think you just became one of my most favorite people in the world.

[Laughter.]

MS. AMANDA MANBECK:. When you said digital, free for everyone, oh my face was lit up. You know I really -- you know I think, I was just talking to Nevine and I was like -- I walked in and she's like why are you looking at me like that. I'm like I want to know how Indians can take the ACE Study. I want to know how you can get all sorts of populations that are

rural --

DR. VINCENT FELITTI:. I'd be delighted because I mean that's about a tough a problem as you're going to run into.

MS. AMANDA MANBECK:. Yeah, you want to --

DR. VINCENT FELITTI:. And if you can solve it there you got a winner.

MS. AMANDA MANBECK:. Right.

DR. VINCENT FELITTI:. Now the other idea, you know about using broadcast television for story telling, story telling being code for teaching --

MS. AMANDA MANBECK:. Right.

DR. VINCENT FELITTI:. -- I mean certainly fits in with what I understand about Indian culture --

MS. AMANDA MANBECK:. Right.

DR. VINCENT FELITTI:. I mean that was sort of the way teaching was passed on through generations forever.

MS. AMANDA MANBECK:. Right. Well and like you know, they won't go in and talk. They won't go to the doctor. They won't.

DR. VINCENT FELITTI:. The nice thing about a

digital format as well is that if somebody is illiterate --

MS. AMANDA MANBECK:. Yeah.

DR. VINCENT FELITTI:. -- not a problem.

MS. AMANDA MANBECK:. Right.

DR. VINCENT FELITTI:. You know one question per screen, you speak it at the same time.

MS. AMANDA MANBECK:. Right.

DR. VINCENT FELITTI:. You know if you touch the green spot for yes, the red spot for no, the yellow spot for unsure.

MS. AMANDA MANBECK:. Well then and in a way it would be --

DR. VINCENT FELITTI:. Run the thing in Polish, run it in any language you want.

MS. AMANDA MANBECK:. I mean in a way it would keep their anonymity. Because that is one of the major reasons why natives will not go to the doctor or go to counseling or go to receive help is because everybody knows what their car looks like.

DR. VINCENT FELITTI:. Absolutely. Another thing that we saw here that really is an important piece, to

do this face to face is theoretically possible if you have endless amounts of time and endless amounts of money and so forth, but it's fraught with difficulty.

MS. AMANDA MANBECK:. Right.

DR. VINCENT FELITTI:. There are mismatches in age, and sex, and race, and ethnicity. You know, I don’t feel comfortable talking with a young white woman or a you know, an old Indian or what have you.

MS. AMANDA MANBECK:. Right.

DR. VINCENT FELITTI:. People we say tended to impute to a well devised questionnaire whatever the characteristics are that they would`need in an idealized interviewer.

MS. AMANDA MANBECK:. Right.

DR. VINCENT FELITTI:. Once the information is out then you know a regular live human interviewer, it's a vastly easier task because you know in advance before even walking in to introduce yourself where you need to go.

In staff training, and believe me you know staff was not exactly wildly enthusiastic about this correctly perceiving that I had abruptly raised the

performance bar substantially. We had, we met with people, small groups of six, we'd give them a real case, you know laser printed out, looked nice, several pages long.

Two questions, a, how do you intellectually tie all of this together. That's the easier one. And b, what's the first thing you're going to say after you say hello. In other words, how are you going to move from social nicety to talking with a stranger about things that nice people don't discuss.

MS. AMANDA MANBECK:. Right. But see in the native culture, I mean you have to be competent in order to be able to facilitate that process. Oh and just think about what IHS could do with that knowledge.

MS. KANA ENOMOTO:. That's what Larke just asked, if we had talked to them.

MS. AMANDA MANBECK:. I mean I'm serious, like what they could do. I mean because like everybody says, don't get sick after June. But if they knew, there's not that many identifiers for you know, age and when diabetes starts and which tribes, whether

it's affected by diet. Thank you.

MS. LARKE HUANG:. So you're talking about different modalities for doing the screening and how you might put it into a system --

DR. VINCENT FELITTI:. Yes.

MS. LARKE HUANG:. -- how providers might most accept it. So I -- because I have limited time, I think we're over it actually.

I'd like to move to the brief intervention piece. And if there are people here or in your experience besides the just even asking the question and having a discussion, if there are other brief intervention pieces that you can think about.

DR. VINCENT FELITTI:. Let me just point out an analogous situation. You know after we had been doing this for awhile and had been thinking about it a great deal you know, what's going on here that this happens.

And it slowly began to dawn on me, this is really directly analogous to confession in the Catholic Church. You know, you tell something really bad about yourself, something you're ashamed of to an important person, in that sense called a priest, but you know it

could be a nurse practitioner, could be a physician.

You're basically told you're still an acceptable person to us. That technique has been in use for 1,800 years suggesting that it meets some deep human need. The idea of confession and absolution.

DR. STEPHANIE COVINGTON:. You know can I just make a quick comment? I know you're -- I hear you and I hear you and I just want to make a really strong recommendation. That SAMHSA consider taking one step back, listen the years of experience with this tool.

It's used in San Diego but Kaiser didn't move it into their other facilities because of resistance I'm going to guess from the primary care doctors. It's not easy to get them to do things. I really think you have to think about it differently.

And I would really suggest, underline 47 times, that take the expertise that Vince has with the ACE Study and figure out how to make that work and give it a shot. Don't try to reinvent the wheel. Don't try to find something else. You've got how many years, how many patients, how much -- you're not going to find anything that has this kind of data out there,

nothing. So why not take this.

MS. LARKE HUANG:. And by taking this you're saying take the ACE items --

DR. VINCENT FELITTI:. No, no to --

MS. LARKE HUANG:. -- or take the --

DR. VINCENT FELITTI:. -- to take what we've learned and use it to develop in a, to redevelop in a digital format a comprehensive medical questionnaire that would have biomedical, psychological, social, and in particular trauma oriented components to it. Put that free on the internet, figure out what the search words would be that would lead people to it.

I believe that it is quite reasonable that several million people might use that in a relatively short period of time. I mean you know, the fact is that after pornography, which is the number one use of the internet --

[Laughter.]

DR. VINCENT FELITTI:. No, I'm quite serious, the number two use of the internet is for health related matters.

UNKNOWN SPEAKER:. [Off microphone.] WebMD.

MS. JEAN CAMPBELL:. [Off microphone.] WebMD.

UNKNOWN SPEAKER:. [Off microphone.] Exactly.

DR. VINCENT FELITTI:. Huh?

MS. JEAN CAMPBELL:. [Off microphone.] WebMD.

DR. VINCENT FELITTI:. Okay.

MS. KANA ENOMOTO:. So I think Stephanie that we're -- where we're trying to get with it is not reinventing the wheel. It's figuring out what's the gas that we need to get the wheel going. So I mean you know, Vincent already brought up that if -- you know, you have a one year effect of the, of the, sort of the reduced doctor's office visits but then after two years it goes back up.

So I think what we're looking for is -- I think we get that there's a good, there is some good tools out here. We also get that there was resistance through the rest of Kaiser and elsewhere where people haven't known what to do with it.

So I think what we'd like to do is go forward -- is to -- we're trying to see the thinking around or to grow the knowledge around what do you do -- what do we tell providers that they can do other than give a

pamphlet on here are all the services for the women's treatment around or for the trauma groups.

DR. VINCENT FELITTI:. Okay, one thing that has occurred to us to do there, yet to be tested, would be to create a DVD showing providers of different ages, sexes and races talking comfortably with patients about subjects that ordinarily they would not want to touch.

And send that with a nice cover letter from some, you know prestigious person, President of the American Academy of Pediatrics or the AMA or what have you, to every physician in a test state and`see what happens.

MS. KANA ENOMOTO:. Yeah, no I think any of these kinds of ideas are fine. I think it's -- so what's in that DVD? After the doctor says, and so how has this affected you later in life, I imagine the DVD's got to go on past that and that's what we're --

DR. VINCENT FELITTI:. Yeah, you know that is certainly possible.

MS. KANA ENOMOTO:. Yeah.

DR. VINCENT FELITTI:. I mean an important thing to realize is that no matter what, how wonderful a

referral system you might have available, unless the initial contact person is comfortable dealing with that information, you're not going to get patients into it.

MS. KANA ENOMOTO:. No, I --

DR. VINCENT FELITTI:. Because you will unconsciously not to recognize the problem.

MS. KANA ENOMOTO:. Right, no I think we're in agreement with that. So what we're looking for is how do we build a chest of tools for people to access so that they are comfortable asking those questions.

And I would also acknowledge that many, many, many people who experience trauma are resilient. And so many of the people who have -- are somewhere along the continuum on the ACE --

DR. VINCENT FELITTI:. Well --

MS. KANA ENOMOTO:. Or there are people who are on one end of the continuum that we know need referrals to treatment of some kind. So it may not be behavioral health but it may be obesity or tobacco or something else. But there are the people at the lower end.

And so the clinician is equally scared of all of them. Whether you've got an ACE score of two or an ACE score of eight, I'm sort of afraid of you responding positively on a couple of those and so I don't want to ask you.

DR. VINCENT FELITTI:. That would --

MS. KANA ENOMOTO:. We have to teach them what to do whether they have a two or an eight.

DR. VINCENT FELITTI:. That would be something to demonstrate on a DVD. And I'll send you such a DVD when I get home. You'll perhaps get the idea.

MS. KANA ENOMOTO:. Right, so --

DR. VINCENT FELITTI:. Resiliency is a -- you know obviously it exists. It's certainly to be better to be a working alcoholic than to be a suicide or institutionalized forever.

But resiliency is often an idea that is broached to avoid recognizing that one chooses not to recognize what's going on. I mean there are many people who lead lives of quiet anguish that are comfortable to everyone else around them.

There's a woman named Emmy Werner who has written

extensively about resiliency. On page, I think it's 169, of one of her books she makes the statement that they were surprised to learn that in their most resilient group of people, the level of biomedical disease was remarkably and unexpectedly high.

MS. KANA ENOMOTO:. Jean.

MS. JEAN CAMPBELL:. I'm just curious about your thinking, why would you start with primary care physicians being one of the most -- attitudes are very hard to change. And then also they take this expert attitude to begin with. You're starting off with one of the hardest groups to change attitudes.

And also people have been burnt by their primary care providers in many cases. Lots of people say they hate to go to the doctor, they don’t like their doctor, there's lot of doctor shopping because -- when you look at the issues around the Therapeutic Alliance and physicians, physicians always do really poorly around communication, I mean that's number one is the issue of -- in the Therapeutic Alliance literature, they're terrible around communication, exchanging information.

So I would wonder why -- you know I was thinking maybe it's because you're going to have that bio-directional integration of health and mental health and that would lead you to think this might be a good place. But on the other hand, it might not really make sense.

You know I think well what would be the best, the best group to do if you wanted to a brief screening like a confessional would be peer specialist. Train them, have the -- you know that would be -- but you know that may not be consistent with how you want to integrate your strategic -- I understand that.

But between the peer specialist, which I would say you'd have the most success with and follow up, and I would say primary care physicians which would be the most difficult, that there might be other -- I meant to start off I meant.

MS. KANA ENOMOTO:. Right. Well just to clarify, Larke's question is in primary care settings. So it's not necessarily with the physicians.

MS. JEAN CAMPBELL:. The added in primary care settings, if you had a peer specialist that might help

although that isn't the best setting for a peer specialist. Being in a peer structure service center is much better.

But the whole environment of the place I would question, again I mean somebody -- normally just like in a mental health services, the tone is set at the top and down to the people who you know, watch the lobby, they have the same attitudes. So I mean it's -- I mean you have a cultural attitude as well.

I mean think about even when I was being treated for breast cancer and I was sitting there, I was thinking of all the ways in which the environment was alienating to me in that experience. So I mean I just -- you know I just question that you're making it a lot harder and you might not succeed in what you really want to do.

I mean you could different environments, that's another thing to see which would be the best, which would be the best people to ask those questions. I mean since we're talking about piloting, you know this is another thing that you could pilot to see which would be the best model as well. So it's more of a

question of something to think about.

MS. LARKE HUANG:. I think you know we're just starting to think about this so I appreciate your input on that. And that maybe in fact in those -- we're trying to go to settings where there are a lot of people come through the setting.

So we're trying to think about you know large volume settings where like education schools, primary care. And it may be that peer specialist you know might be the best to do the brief interventions area if they meet a certain cutoff score.

We haven't gotten to that but I think it's really important for us to throw that into the mix as you're talking about that. And also what systems where the peer specialist are also going to be readily integrated and readily available to do that, to perhaps either do the screening or the brief intervention would be kind of another thing we need to consider.

MS. KANA ENOMOTO:. Andy.

MS. ANDREA BLANCH:. Yeah, I just wanted to build on what Jean was saying. I'm not a Committee Member

but I just couldn't help it. I think what is being reflected here is that it's hard to introduce a trauma anything into a culture that's not trauma informed. And we've had that experience in mental health and in very setting.

That there has to be the organizational development component that starts to make the environment more receptive in order for any intervention, a brief one or a screening or anything else to take hold.

And one suggestion, sort of along the same line, there are a few medical care, primary care settings in the country that are trying to become trauma informed. They are you know, not all the way there, but there's a general hospital in Missouri that's going quite down the road in terms of looking at issues of how are we not trauma informed and how can we change our practice.

And I suspect that they would have some things to offer in terms of how are they selling this to their nurses and their doctors. So even though it's not specific to a screening and a brief intervention, take

a look at how primary care settings are trying to introduce it and there's probably some lessons there.

MS. LARKE HUANG:. And it's interesting you mention that because I think we see a little bit more of that in pediatric care where they're really trying to be more trauma informed around children with different kinds of special health care needs or invasive surgeries and the parents. And also, beginning to see that in some OB/GYN if you consider that primary care. And that's where they're actually starting to do some screenings.

MS. ANDREA BLANCH:. And dentistry.

MS. LARKE HUANG:. Yeah.

MS. ANDREA BLANCH:. Yeah, they're doing some great work in dentistry.

MS. JEAN CAMPBELL:. [Off microphone.] Women's health centers [inaudible] wellness centers.

MS. KANA ENOMOTO:. [Off microphone.] [Inaudible] not something you learn [inaudible] primary care.

MS. JEAN CAMPBELL:. [Off microphone.] Yeah, but there's a different environment then just saying

primary care, which is still a male dominated in many environments and offer a traditional biomedical approach as opposed to a women's health center, which can have very progressive attitudes or a wellness center.

Those are different. They have -- they may have -- they have some medical approaches but they also establish a trusting relationship as part of their practice.

MS. YOLANDA BRISCOE:. Just pragmatically, when you offer something new to somebody and they tell you that they don’t want to do it, they'll usually tell you why if you just ask them.

And I would venture to guess that the major obstacle is people saying, I don’t have time. I was a Kaiser member and not a provider when I lived in California and you have to be like this [snapping].

MS. KANA ENOMOTO:. 22 patients --

MS. YOLANDA BRISCOE:. Yeah, 22 patients a day.

DR. VINCENT FELITTI:. That sounds reasonable.

MS. YOLANDA BRISCOE:. Yeah, it just --

DR. VINCENT FELITTI:. That's its virtue, it

sounds reasonable and hence it's a way of terminating a serious discussion. There was about 40 years ago a small monograph came out of the Tavastock Clinic in London titled Six Minutes for the Patient.

It posed the ridiculous question, can anything of psychotherapeutic value be accomplished in six minutes, which was then the standard national health service appointment time. I mean don't be ridiculous. Well what they found was, that if you really wanted to do it and were willing to think about it, yes.

Think also in this vein about the enormous cost of television advertising to buy on`broadcast television a 30 second or one minute piece of commercial time. And if you're going to spend millions of dollars to buy one minute of time you spend a lot of time thinking how the hell you're going to get something meaningful transmitted in that one minute of time.

MS. YOLANDA BRISCOE:. Well it's just a confirmation bias that you feel like, well you can't do it in a certain amount of time, but you can. But if you were able to show somebody that yes you can do

it in that amount of time and get quite a bit of information --

DR. VINCENT FELITTI:. Yes, time is indeed a real issue, it's not the crux issue. The crux issue is that we are uncomfortable dealing with these matters and time or you know, insurance doesn't cover it sounds reasonable and gets rid of this question.

So what I'm talking about is simply circumventing the entire system of resistance and moving into a different system instead of primarily trying to change physician behavior or even more improbably medical school patterns. Trying to change patient expectations and then using them as a way of flooding the market with a desire for change.

It's an experiment. Might it work? Yes, I think there's a real possibility. It could fail. It's not a brutally expensive approach to test any more than distributing a DVD demonstrating what I was talking about before. You know, you're talking a couple of thousand dollars to develop such a thing and a dollar per DVD.

MS. YOLANDA BRISCOE:. Well I'm for if

something's not working let's try something new.

MS. KANA ENOMOTO:. Okay.

DR. VINCENT FELITTI:. I mean for instance if you took a rural state like Maine which is typically individual physicians practicing alone in isolated settings, this would be a very, very simple place to test this kind of idea.

There are 700 pediatricians in the State of Maine. You know to have the President of the Maine Academy of Pediatrics write a cover letter to every pediatrician in the state is a very feasible kind of thing.

So the experiment maybe costs five or ten thousand dollars. Either it works or it doesn't. If it works, it's a huge step forward. If it fails, it's an affordable expense.

MS. KANA ENOMOTO:. Well I think there are a lot of clinical practice issues to think about and research issues as well as for us the policy issues.

So for whatever reason they managed to find the time to check my blood pressure every time I go to the doctor even though I have like zero risk for high

blood pressure or any other related problems because I'm a 120 pound Asian-American woman who has no history of heart disease in her family.

So you know some of it is also what people get paid to do and what becomes standard practice and then what are the steps that it takes for something to become standard practice and to become paid for. So I know that there are a lot of questions about this approach and why we're taking it.

But you know, I think keep in mind that we do, it is sometimes a matter of the Director of a state medical association writing a letter but sometimes it's a matter of the state Medicaid plan including something.

And so those are all the kinds of things that we're trying to keep into consideration as we are approaching this. So it's not that we want to reinvent the wheel. But I think we're trying to strategically think about how do we move this forward into the broader kind of taking to scale.

It's not that there aren't good things already out there that work. It's how do we build what we

need to build because kind of either moral righteousness or you know, that we know that it takes 17 years to get something that with a strong evidence base into common clinical practice.

Right, and so there are lots of reasons for that. And there are many, many, many evidence based interventions that are not in common practice. And so the issue is not just you take what works and like magically waive a wand and make it go to scale.

I think we're trying to, in our own sort of pedestrian way, you know we slowly have a very -- we have a very weighty magic wand that`we waive in a far way but that is exactly what we're trying to do is make it go to scale. But there are some steps that you need to go through to get a practice.

I mean SBIRT, I think Larke's been looking a lot at SBIRT which has a strong evidence base, it's endorsed by the USPSTF, it's part of health reform, it's got C-codes and G-codes and it's reimbursed by Medicare universally, it can also be reimbursed by Medicaid, and we have very poor uptake. We have very poor uptake. We have a huge grant program. It's easy

to do. It's got great outcomes. You know, but people aren't doing it.

So you know there are some things that we know we need to do some thinking. People who want to do the right thing, who have their heads in the right direction, they'll do it. I think that's right. I think probably women's health centers would be an easier place to start because they have an interest in seeing women get better.

But the question of how you take something to scale in the broader system that’s less interested in doing, from what we would see as thè right thing, is part of the policy challenge that SAMHSA's trying to take on here. So I appreciate Larke's time.

MS. LARKE HUANG:. I just want to really suggest you read this article because it really is talking about a pediatrician who did basically a systems change. Modifying what was an inner -- it's very interesting, it was an inner-city pediatric checklist.

So they're already looking at what might be some of the other determinants in that particular population and how we might be able to build off of

that.

MS. KANA ENOMOTO:. I know we are running behind our schedule. But I do need to check if there are any public comments?

[No response.]

MS. NEVINE GAHED:. Any public comments online?

[No response.]

MS. NEVINE GAHED:. No public comments.

MS. KANA ENOMOTO:. Okay. And I would just like to end by allowing the Members, especially those who haven't spoken up very much to give some thoughts or feedback on the meeting today, if you'd like. Especially our new members, if you have any reflections at the end of the day and at the end of the two day meeting that you'd like to offer.

MS. JOHANNA BERGAN:. It's been a lot. I'm just thinking and taking notes. I did want to take a second to thank Larke. Although you're not the only person's that's mentioned this, but I've heard it most from you. About some partnerships or potential partnerships with other large U.S. organizations that we normally don't think about partnering with.

I was listening and waiting and hoping to hear more about work with the education system. And hoping and thinking that they could turn into something more than the place that identifies the problems and then tries to refer them somewhere else. But really what can you do -- what can they do if they have our children for eight to ten hours a day.

But the one that I was most excited about was work, potentially working with the USDA and your talk about extension offices. And coming from a rural where agriculture is king, I mean our extension offices are amazing.

Every county has one. There are leaders in the community that work there. We throw like city-wide parties when one of them retires. They serve as a hub for youth programming, primarily with 4-H.

But especially in Iowa, I'm in the northeast corner and extending throughout the state there, partnering and working to improve nutrition and physical health. And it just would make so much sense, at where our leaders are in Iowa, to add a behavioral health message to their work.

And so I would just be really excited to know if that gets to go anywhere.

MS. LARKE HUANG:. We actually have, next week, about 30 people coming in from Cooperative Extensions. Because they're coming to us. You know they are dealing with substance use issues, mental health issues, youth development stuff. And so we're excited because they have a vast, like you say, every county has one.

MS. JOHANNA BERGAN:. [Off microphone.] Yeah, [inaudible].

MS. LARKE HUANG:. And so we're excited about how we can partner more around that.

MS. JOHANNA BERGAN:. Yeah, and a network already set up. It seems like a perfect match. And I know that they definitely react and help after traumatic events, and for Iowa that's a flood. But a flooding can be very impactful and that's the most I've seen their messaging speak to any behavioral health issues. So it would be fun to hear more.

MS. YOLANDA BRISCOE:. I just want to say thank you to the Committee for their tireless work in

working with women and being the voice for people who don’t have a voice. I didn’t say anything after your presentation Stephanie because I was just speechless. Wow.

And we forget, or at least I should say, I do, because you drive by the prison and you don’t see what's going on inside. And I used to work with prisons and then you kind of get desensitized, you forget, oh yeah, that's right, it's still going on.

And where 80 percent of the people in prisons are there because of drug -- and their sentences are much worse than the perpetrators who got`them there in the first place with the trauma. And so thank you so much and to everybody here for doing the work that you're doing and fighting the fight for those who don’t have a voice. Thank you.

DR. STEPHANIE COVINGTON:. I think I've already shared by voice. Thanks.

MS. HARRIET FORMAN:. I just want to say that have really appreciated all that I have learned the last several days. It's been quite a load between my ears. I've been very impressed with the, all of the

participants.

I've been very impressed with the staff, with the openness and the -- well non-defensiveness in terms of listening. I know that as a formal principal when you're out front you become kind of a javelin catcher. And it's hard to go out there time after time.

But you're there and I'm hoping that the feedback you're getting, I feel has been delivered in a real positive way and a hopeful way and that I feel hopeful. And I'm very pleased to be a part of this group and to meet each and every one of you. It's really been a wonderful experience and I appreciate it.

DR. VINCENT FELITTI:. A little experience that might be useful for some of you, several small town newspapers have published one page versions of the ACE Study questionnaire requesting their readers to respond anonymously. And then pooled the data and published that and used it as a jumping off point for a couple of articles on human development. It attracted enormous amounts of attention.

And the same thing when we did this a couple of

years ago at the medical school in Iceland asking the students to fill out anonymously the ACE Study questionnaire, a one page version of it, a 10 question version of it. And then pooled the data and the presented it back to them. It's a useful technique for disseminating interest, disseminating information and then heightening interest in the subject.

MS. KANA ENOMOTO:. I appreciate everyone staying for the little bit over that we've gone today. I think it was a robust conversation. I think we got good feedback. And you know it's helpful, believe it or not.

I know Stephanie feels like she's been a squeaky wheel, but actually I need that squeaky wheel, right. So that helps me to go back and say, this is something we really need to pay attention to and if we haven't done it here how else can we do that. How else can we make our commitment clear. And so we need a vocal constituency.

And you know if you think about it, other than the Women's Services Network, we don’t have a lot of gender specific behavioral health groups. And so this

is a -- you know most of our consumer groups are both men and women, most of our state policy groups are for men and women.

And so other than the WSN, which is sort of a subset, although now you guys are independent I think, we don’t have many folks advocating around the women's issues in behavioral health as a national organization. And so this is, you guys are really it.

And so to the degree that this platform allowed for that voice to be heard, I think it's much appreciated and very helpful to us. So thank you for the time and the energy and the passion that you all put in to the work here and that you'll put in to your work going forward.

Okay, and so with that I think we are adjourned. Thank you.

UNKNOWN SPEAKER:. [Audience member.] Can I say something?

MS. KANA ENOMOTO:. Go ahead.

UNKNOWN SPEAKER:. [Audience member.] Stephanie I'm sorry I missed your presentation I had a doctor's appointment. And I appreciate your work on the

criminal justice system. I just want us to know that there are no, no stats in how the people [inaudible] having to do with the criminal justice system. So that's something we may want to take a look at because it really impacts women in the community with [inaudible] program there's nothing [inaudible].

MS. KANA ENOMOTO:. Thank you.

MS. NEVINE GAHED:. We're adjourned.

MS. KANA ENOMOTO:. Thank you.

[Whereupon, at 5:21 p.m., the meeting was adjourned.]

TRANSCRIBER'S CERTIFICATE

I, JENNIFER YOUNG, hereby certify that I am the transcriber who transcribed the audio recording provided to Alderson Reporting Company to the best of my ability and reduced to typewriting the indicated portions of the provided audio recording in this matter.

_____

Jennifer Young