Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

Advisory Committee for Women's Services

Wednesday,

May 26, 2010

Rockville, Maryland

PRESENT:

Kana Enomoto, Acting Chair,

Nevine Gahed, Designated Federal Official,

COMMITTEE MEMBERS:

Susan C. Ayers, LICSW

Barbara S.N. Benavente, M.P.A

Stephanie S. Covington, Ph.D., LCSW

Roger D. Fallot, Ph.D.

Renata J. Henry

Gail P. Hutchings, M.P.A

Amanda Manbeck

Britt Rios-Ellis, Ph.D

Starleen Scott-Robbins, M.S.W., LCSW

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P R O C E E D I N G S

(9:08 AM)

MS. GAHED: Good morning, everyone. We are going to begin. So, welcome to SAMHSA. I'm Nevine Gahed. I'm the Designated Federal Official for the SAMHSA Advisory Committee for Women's Services, and I just have a few matters of administration before we call the meeting to order.

As you see, we do have some cameras today. They're videotaping the meeting, and it is being streamed online to provide maximum access to the public to attend the ACWS Meeting. So, we're quite pleased. We're going to get a number actually for you so you can gauge how many people are online with us. We are assured that these cameras are going to be as obtrusive as possible, so please bear with us and enjoy the experience.

To members of the public who are joining us via Web stream and would like to provide a public comment, you'll have an opportunity to do so later at approximately 4:00 p.m. Eastern time. You will also have another opportunity to comment tomorrow morning at 11:30. There will be a slide that will appear on your screen to alert

you of the contact number and instructions for dialing. Please provide the operator with your name and affiliation in front of the instructions that he or she will provide you.

We have a quorum, and I now call the meeting to order.

Ms. Enomoto?

MS. ENOMOTO: Great. Good morning. Thank you, Nevine.

All right, well, welcome. Welcome to members of the public, our SAMHSA staff, and to our members. We're so excited because we have two new members joining us today. One of them is also, by the miracle of technology, joining us from Guam. We have Bobbie Benavente, who works in the Guam Department of Mental Health and Substance Abuse Prevention and Training and a sort of longtime friend and grantee of SAMHSA is joining us. She is 14 hours ahead of us, so it's 11:00 p.m. her time.

Bobbie, are you there?

MS. BENAVENTE: Good morning.

MS. ENOMOTO: Good morning, Bobbie. Thank you.

And Bobbie's actually also going to try to join

us for the Military Family Session, which will be at 3:15 Guam time in the morning. So she was with us for orientation yesterday and very dedicated. But we're going to get her here in person for the next meeting.

We're also very pleased to have Starleen Scott-Robbins joining us. She's the women's treatment coordinator for the North Carolina Division of Mental Health Developmental Disabilities and Substance Abuse Services. She's also the current president of the Women's Services Network, which is part of the NASADAD Organization.

So we're very pleased to have Starleen joining us, and her boss, Flo, is on our SAMHSA National Advisory Council. So we're getting a strong North Carolina contingent here.

We're going to begin today with a quick roll call. I just want to make sure we get through everything. The administrator will be joining us at 9:30 to give us an update on her strategic initiatives and priorities for SAMHSA. So if each of you would introduce yourselves, and there are a couple of you with some new developments in your life. If you want to share that with the rest of the

members, that would be great. Thank you. So we'll start with Susan.

MS. AYERS: Susan Ayers. I'm now the former executive director of the Guidance Center, which served Cambridge and Somerville families. I sort of took the leadership of doing a merger with a much larger organization in order to ensure the future of the Guidance Center, which we've done.

And we're now a division of a much larger organization, and my leadership team is in place and the work continues, and I have the great good fortune of being able to step out and sort of renew my little batteries and figure out what my next good run is going to be. It probably won't be another 22 years at something, but it's going to be a good run at something having to do with advocacy for families and children.

MS. ENOMOTO: Congratulations.

MS. AYERS: Thank you.

MS. MANBECK: Hi. My name is Amanda Manbeck. I was the former executive director program manager for White Bison. It's a Native American non-profit based out of Colorado Springs, Colorado. We work on a national

level, but probably in January, I have decided to take the next step, and I was about a year away from obtaining my bachelor's in psychology, so I'm going to take a little time for me, I think for the greater good, having an education is really a priority. So that is basically what I'm doing now. I do still volunteer at White Bison and try to help out when I can, and I'm just really grateful to be here.

MS. ENOMOTO: Thank you.

DR. FALLOT: My name is Roger Fallot. I'm glad to be here, also.

The things that have been most exciting for me recently have been an opportunity to develop further some ideas I've been having about what I think of as values-based approaches to mental health and substance abuse care around things like recovery orientation and trauma-informed care, gender responsive care, cultural competences, the big four I think of as the four primary values based approaches, and specifically, Stephanie Covington and I are working on a trauma-informed and gender responsive model for the State of Connecticut in an area that would be fascinating, I think, for us in the next year or two.

So, thank you. I'm glad to be here.

MS. HENRY: Renata Henry, and I'm also glad to be here.

I think the most exciting thing that's going on in Maryland for us is the passage of health reform, and from the perspective of substance abuse, mental health, and developmental disabilities, we're going to be working with the University of Maryland, Howard Goldman's shop, to lay out in parallel with our state, who has a coordinating committee on health reform at the state level, and we're going to put one together for developmental disabilities and behavioral health and kind of over these next four years, walk through where we need to be with our providers, advocates, and others to maximize what we see as wonderful opportunities for integration under health reform.

DR. COVINGTON: Stephanie Covington.

Well, Roger mentioned the work we're doing together, which I'm really enjoying and pleased to be doing. Sort of the two other main things, I'm just finishing writing a curriculum for women who commit violent, aggressive crimes, and that'll be finished in the next week or so. Of course, many of them have their own

trauma histories, as well as abuse of alcohol and other drugs.

And the other thing I'm doing, which we'll see whether it was a good idea or not, is the new Oprah Winfrey Network is going to have a show on women in prison, and we're filming six segments on women in prison that will air in early 2011. So I'm working on that project of filming in the Indiana Prison for Women.

MS. SCOTT-ROBBINS: And I'm Starleen Scott-Robbins, and as Kana said, I'm one of the new members of the Advisory Committee, and I'm quite honored and privileged to be here. I just recently also became the president of the Women's Services Network under NASADAD because our former president had to step down because of some role changes. So, it all kind of happened in the same week for me. So, I'm very excited, and I really look forward to working with the committee towards ensuring that women and girls and their families receive integrative services. Thank you.

MS. HUTCHINGS: I'm Gail Hutchings. A very warm welcome to our new colleagues, Barbara and Starleen. It's wonderful to have both of you on, and I can't respect more

someone that stays up to 3:30 in the morning to participate in this, too. So, my hat is already off to Barbara, and we haven't even met yet.

I'm so thrilled and excited really. I'm continuing to work on smoking cessation for behavioral health populations. I find that so important, and it's really, I think, beginning to take hold. It's not so much of a shocking and surprising conversation to want to have, and frankly, an expectation to finally set out for our systems, and literally saving lives, and for people in my family who have died from smoking related diseases, I'm hoping that this is a sort of paying it forward to try to prevent someone else's life from ending.

So, also doing work on primary care and behavioral health integration. I'm very excited by the opportunities, and particularly, as Renata was mentioning, of health care reform and what will come or perhaps not come with that, too. So, it's a thrilling time. Watching parity and parity regs, what's happening closely, and trying to hope that comes out the right way, and we can talk about what that right way might be and how we might differ.

And, finally, I'm doing some work with the National Council for Behavioral Health Care, and who's recently become very, very interested in trauma-informed care. I had a wonderful meeting with Kana and Susan Salasin here, have been talking to Sharon Amatetti, and I think we'll see some exciting things with their 1,700 member organizations coming over the next couple months, next year, and the timing is so right for that. So thrilling.

MS. ENOMOTO: Bobbie?

MS. BENAVENTE: Yes.

MS. ENOMOTO: Can we go ahead and have you introduce yourself and then if you could mute your phone after that? Because of the recording, they need to close the line, if you wouldn't mind. So if you would just go ahead and introduce yourself. Thanks.

MS. BENAVENTE: All right. My name is Barbara Benavente. I go by Bobbie. I work for the Department of Mental Health and Substance Abuse, Tamuning, Guam, for about 28 years, but 30 years in government services. I'm a council member officer for the Pacific Substance Abuse and Mental Health Collaborating Council for the Western Pacific

jurisdictions and inclusive of the Republic of the Marshall Islands and the American Samoa.

My work has primarily been in the field of prevention, and I've been involved with organizations that serve Asian and Pacific American families, like the appeal organization for tobacco prevention control, as well as the NAPAFASA Organization that Dr. Ford Kuramoto has done for many years.

This is my first committee meeting. I'm glad I'm able to do this at least long distance, and it is close to midnight. So I will stick it out as long as I'm able to. I promise.

MS. ENOMOTO: Thanks very much, Bobbie. We appreciate it. So, you just go ahead and we'll mute the line, but then if you would like to speak--

MS. GAHED: Un-mute it.

MS. ENOMOTO: Oh, just un-mute it? Is she online, also?

MS. BENAVENTE: Yes, how do I mute it? I did the star six, but that didn't work.

MS. GAHED: She needs to mute it. Can you mute it right off of your phone? If not, we'll tell the

operator to put you back on mute, okay?

MS. BENAVENTE: All right, great. Thank you.

DR. RIOS-ELLIS: Hi, I'm Britt Rios-Ellis. I also would like to welcome our new members. It's great to have you.

And, for us at the Center for Latino Community Health, it's been an interesting time, and for the National Council of La Raza. As you all may know, we're leading the national boycott in Arizona. So, it's been something that has been somewhat difficult at the work front. We've had to lock doors because of threatening calls and all kinds of things.

But, in the meantime, we're thriving as an organization. So, we have new projects. We have a Youth Empowerment for Success Project, working with at-risk youth and right up on the border between Compton and Long Beach, which is just going wonderfully. And another project, a five-year project, working with Latinos and their adolescent daughters. And yet, another project. So we've been working very, very hard.

And, at the same time, we're working a lot on Latino-specific values-based issues, and how they can

reinforce health behavior. So, we're working a lot with familismo, respeto, simpatia and all of these other really core, positive values-based attributes within the Latino community, and looking to really seek out how that can reinforce HIV prevention behavior. So, that's something that we're working with now with NIH and moving forward on.

So, we've been busy. It's been a little stressful, but I think we're weathering it well.

MS. ENOMOTO: As you can see, we have no shrinking violets on this committee. Just for members of the public who are online, the bios of our very impressive members are available on the Web stream site, and for those of you who are in the room, the bios are available in the back of the room as handouts. So, if you'd like to learn more about any of our members, that information is available.

The administrator is going to be joining us in about 10 minutes. She, as you know, was, I think, able to join us by phone briefly in the December meeting.

Since then, we've had a lot of developments at SAMHSA. It's been an exciting only six months, but it's gone by in stretches seeming years, and other times seeming

minutes, so it’s hard; we’ve had a little time warp in terms of the amount of progress that's happened and the volume of work, but it’s been amazing.

The administrator has a very clear vision for SAMHSA, and frankly, for the field of behavioral health, and she’s taken a very proactive role in working with the other departments, with the other agencies within the department.

She’s clearly delivering a message that SAMHSA is a leader in behavioral health, and behavioral health is essential to everyone else’s business. Not just health, but also criminal justice. Not just criminal justice, but also education, also housing. Everywhere people are, behavioral health is present and essential, and so she’s done a fabulous job of getting out there and delivering that message, and people are calling us now.

S, we have an embarrassment of riches in terms of opportunity, which translates into, again, a lot of work for the folks here at SAMHSA. So I think it’s a wonderful time for us to have this meeting because this committee can say where in all of this new work, where in health reform, where in HIT, where in the various agendas that we’ve set

for ourselves is the role of women and girls, and how are we addressing those needs and how do we make sure that we continue to have an eye on this particular population when there is so much on our plate?

The administrator has been very clear that we are taking a broad approach, so we are really challenging ourselves to get out of the silos that we've had, even historically, within SAMHSA. So it's not just prevention is here, mental health is there, and substance abuse treatment is there or every initiative is led by one of our center office directors or senior advisors, and they are leading for the whole agency. So, it's not just Dr. Clark is leading HIT for substance abuse; he's leading HIT for behavioral health, and similarly, Kathryn Power leading military families, but not just with the mental health perspective, but with a prevention perspective, with a substance abuse treatment perspective, as well as a Mental Health Services perspective.

So it's really stretching all of us, and it's creating great opportunities, and we're trying to leverage what we know across the agency, and then finding opportunities to kind of lean up a little bit where we have

some redundancy, well, oh, wow, you're doing an evaluation on that, we're doing an evaluation on it. Maybe we can bring those two things together and not do a separate substance abuse one and a mental health one, but do a combined one.

So, all of that is fantastic. We've had incredible support from the staff. It's been a lot of work, but I think people have the sense that it's the right thing to do, and so they've been onboard and very supportive.

That being said, there's still a lot more work to do. 2014 is sort of the time when health reform really goes live. It's not four years away, it's now, because right as we speak, putting the final touches on a 2012 budget submission, so that means that we're thinking 2 years ahead budget-wise, and 4 years ahead programmatically because anything that's going to go live which requires legislative change or authority change or budget changes, we need to be doing that background work as we speak. So, it's exciting and challenging.

I just saw Pam, there she is. I'm going to ask each of you to kind of give a two or three-minute

introduction of yourself to the administrator and kind of where you're coming from, what your perspectives are, what your key questions are, and then she's going to run through her initiatives and some of her policy priorities, and then we'll have a good amount of time for discussion following that. So if that's okay, we're going to have folks introduce themselves to you.

ADMINISTRATOR HYDE: Cool.

MS. ENOMOTO: Okay. Great. So welcome to Administrator Hyde, and we'll start the time with Britt and do some introductions.

DR. RIOS-ELLIS: Hi. It's great to meet you. I'm Britt Rios-Ellis; I'm a professor and the director of the NCLR/CSULB Center for Latino Community Health, Evaluation & Leadership Training, which is actually housed at California State University, Long Beach.

We started through a congressional earmark that was then spearheaded by then-Congresswoman, now Secretary of Labor, Hilda Solis. And our work is as National Council La Raza. It's the largest Latino advocacy organization in the country. Our work is centered around two things: We have our own programs at Cal State University, Long Beach,

which impact not only communities in California, but Latino communities throughout the country, and our other role is to really carefully evaluate, and from a culturally-linguistic standpoint, measure and evaluate what the National Council of La Raza is doing with its almost 300 affiliate organizations and other organizations that seek to meet the needs of Latino communities.

We have several funded programs at the center focusing on HIV-AIDS, focusing on youth empowerment, and focusing on maternal-child health and nutrition and obesity. So those are kind of our four core avenues in terms of our work. So it’s an interesting kind of relationship because we’re the second largest university in California where we’re housed and we’re a Hispanic-serving institution, and then we work hand-in-hand with the National Council of La Raza. So we have both names on our front doors.

And, recently, as I said earlier, we are leading the national boycott against Arizona. So that's been an interesting challenge and something that we’re dealing with on a daily basis from phone calls and locking our front doors and all kinds of things. But we’re very much trying

to support culture and linguistically-relevant services for the Latino community.

MS. HUTCHINGS: Good morning. Thanks for being here. I appreciate it.

With your permission, instead of talking about myself, I'd like to talk about something I know is a point of pride for you. I want to do an announcement to the other members, something that we would like to join in being prideful of.

Kana recently won the HHS Department's 2010 Arthur S. Fleming Award that Pam sponsored.

ADMINISTRATOR HYDE: Embarrassing her.

MS. HUTCHINGS: I live to embarrass Kana Enomoto. We knew she was special already, but now we have more reinforcement. She was 1 of only 12 federal employees throughout the country to receive this award. Very prestigious. It's a 58-year-old national public service leadership award. It recognizes a select few outstanding individuals in the Federal Government. The award cites that ''Kana is a versatile, innovative, and thoughtful federal leader with expertise spanning policy and program administration.''

So Kana, all of us are so proud of you and offer our congratulations. Thank you, Pam, for putting her up. It's wonderful.

(Applause.)

MS. HUTCHINGS: So, I yield the rest of my time to my new colleague.

ADMINISTRATOR HYDE: This is because I know Gail pretty well.

MS. SCOTT-ROBBINS: Congratulations, Kana. And it's a pleasure meeting you.

My name is Starleen Scott-Robbins, and I'm one of the new members of the committee. I work for the North Carolina Division of Mental Health Developmental Disabilities and Substance Abuse Services. I have been the Women's Services coordinator and program manager for Women's Services since 1994.

I am responsible for the management and oversight of all the state and federal dollars that go towards specialized services for pregnant and parenting women. I also manage and coordinate the Capacity Management System for the residential beds that we have in North Carolina. I work also on the Best Practice Team, which is, of course,

disability, mental health, developmental disability, and substance abuse team under Flo Stein, our SSA for North Carolina, and I'm responsible for a program, clinical policy for mental health and substance abuse. I work very closely with our Division of Medical Assistants with our Division of Public Health, and also with our Social Services and other agencies that we must collaborate with in order to ensure that we have comprehensive services for women and their families.

I'm also recently the new president of the Women's Services Network under the National Association of Alcohol and Drug Abuse Directors, and we have been working over the last year on a resolution to send letters to all of the pregnancy-testing companies across the country to include information about Fetal Alcohol Spectrum Disorders so that we can let women know that any alcohol use during pregnancy is not good for the baby. We've also been working on a fact sheet to help states educate people within their communities about pregnancy, drug use during pregnancy, and the fact that prevention and treatment work.

So it's a pleasure to be here, and it's an honor to serve on this committee.

DR. COVINGTON: It made me tired hearing about all of that, Starleen.

Hello, I'm Stephanie Covington. Nice to meet you.

Let's see, my title is co-director of the Institute for Relational Development and co-director of the Center for Gender and Justice. And so, my work that is outside the criminal justice system usually falls under the systems change work Institute for Relational Development, and I do a lot of training and consulting, particularly of women who have substance abuse issues and/or trauma issues. So I'm a consultant. I used to be a clinician. I don't do clinical work anymore. And I also write a lot of program materials, designing program interventions for women, again, with substance abuse problems and/or trauma. Women and girls, actually.

Probably 80 to 90 percent of my work is in the criminal justice system, where I do a lot of work sometimes directly with the women, but, more often, systems change work with either the State Department of Corrections or some of the smaller jurisdictions, trying to improve both the environment and the programming for women and girls.

And then Roger Fallot and I are working on a project in Connecticut, where we're working with their Department of Mental Health and Addiction Services in terms of their programming becoming more gender responsive and trauma-informed across their system.

MS. HENRY: Good morning. How are you?

ADMINISTRATOR HYDE: Good.

MS. HENRY: Good. Well, I know Administrator Hyde, so I guess from my perspective, I am the charge for the next several years as how do I ensure that behavioral health and disabilities moves with the state and doesn't get forgotten by the state in terms of rolling out health reform and looking for all of the opportunities? And so, that's what I'm focused on kind of full-time for the next several years. Yes.

DR. FALLOT: Good morning. My name is Roger Fallot. It's nice to meet you in person instead of on the phone.

My interest in this committee especially had to do with women's experiences around trauma, and I've worked with Maxine Harris and some people with community

connections to develop the Trauma Recovery and Empowerment Model for Men, as well as for following on her work with the TREM groups for women.

The other thing I've been doing a lot of, as Stephanie mentioned, is trauma-informed care consultations, which have been fascinating with me, and have taken up an increasingly amount of my time over the last few years to really get into the issues of culture change that are necessary in an agency or program and requires a lot of time and input, and it's been a fascinating opportunity to see which places are really able to catch it and take it on and which places are more reluctant and unable to really get the sort of shifts we're talking about in trauma-informed care at the cultural change level.

The other thing I'm into is spirituality and mental health services. I've been doing some work on, in fact, spirituality and trauma recovery increasingly, which is bringing together, for me, the two main interests of my work. And certainly, I think we've come a long way since the 1998 meeting, I remember well, in which raised the issue of whether in women co-occurring disorders and violence, we should ask some spirituality questions as part

of the inventory, and was told that, no, we can't do that because that's only interesting to African-American women in D.C. It's not interesting to other women anywhere else, and I'm glad to say that comment, I hope--

ADMINISTRATOR HYDE: Nobody else is spiritual, right?

(Laughter.)

MS. MANBECK: It's an honor to meet you. I've heard a lot of really good things about you.

My name is Amanda Manbeck, and for the past seven years, I've been working for an organization called White Bison. We were a RSCSP grantee for about 12 years through CSTAT, where our effort really flourished under that program. What we do is we provide culturally-relevant recovery support services. We rely a lot on peer-to-peer support. So that's what I did for the last seven years.

In January, I decided to further my own education so that I can be of greater service. There's a lot of disparity when it comes to education in Indian Country. So that's really where my goal is, to go and be of service there.

I think my interest in this committee is very

mixed. On the one hand, I see a lot of struggles that go on with women all over the country, but I also see it particularly with Native Americans. There are a lot of problems culturally with regards to single parenting, trauma, and domestic violence, but I also see that these young girls are growing up in that.

So intergenerationally, that's becoming a huge issue. They do not always have the positive role model to help them to achieve and feel like they're good enough to be able to succeed. So I really hope that I can bring that cultural perspective, but also, being a young person myself -- add that kind of, I guess, inspiration to this committee. It's been a really wonderful experience for me to be able to work with all of these people and hear their ideas and kind of gain their wisdom, and I've been really honored. So, thank you.

MS. AYERS: So I'm Susan Ayers, the former executive director of the Guidance Center.

And what am I doing here? I have wondered that sometimes myself. I'm here as a voice from the trenches, I think is why I'm here. I have, for the last 22 years, operated and grown very kind of innovative, community-based

child and family-serving agency that begins 4 families with teenagers before the birth of their first child, and we're able to serve really the developmental needs, as well as the mental health, substance abuse, and other needs that any parent really faces as they raise their family.

We have excellent trauma services, child witness to violence services, we work with pediatricians, and we consult in child care centers. It's sort of everything you'd hope that you would have in every community in America, and yet, I think the odds have been against community mental health centers in many areas from really succeeding. It's a private-public partnership.

I often feel like we see the elephant in the room because, from my business perspective, I am a clinical social worker, so I am one of these people that lives both as a clinician, but also as one who's trying to sustain cutting edge, innovative practices that can support children and families in their homes and in the community and being a key player in the village.

And it's been interesting to try and understand how the federal perspectives and what happens at the

federal level, in fact, either makes it or doesn't make it down into the community. And in large part, so much of it is really based on the leadership that you find, and then sustainable business models because we don't have sustainable business models, at least not in Massachusetts in community-based settings. Many of our resources have been in residential placements and a lot of our resources have moved out of community settings and into residential programs.

Happily in Massachusetts it's shifting in the opposite direction. People are trying to bring kids and families back into the community and I feel like a lot of the programs we've had have really demonstrated that very challenging families that face a real web of difficulties can absolutely be sustained and supported in their homes. They can have safe homes, and they can be survivors of trauma and other tremendous difficulties if they're given the right sorts of supports that they know they need and they want.

So in order to be sustainable, the Guidance Center chose to--and our board of directors joined a much larger behavioral health organization. We became their

Division of Children and Families. And the kind of aspirations, we've had to do research and get an electronic medical record and to do all of the things that we read about that we want to have to hopefully be able to realize those aspirations as part of a much larger organization.

But it's been a tremendous honor to be here. It's a lot of fun. We have co-authored a couple of chapters in an Oxford Press book on a handbook of community-based clinical practice, and it's just been a privilege, and to be able to try and take what we're learning and also try and really contribute to the science because I don't think that for the last 20 years what we've known and what we've been able to read about is what really works on the ground, so we've all had a passion for trying to take that knowledge and sort of bring it forward so that we can meet in a place that benefits children and families. Thanks.

MS. ENOMOTO: We have Bobbie Benavente joining us from Guam on the phone. It's now midnight there.

So Bobbie, I think your line is open.

MS. BENAVENTE: Hello.

MS. ENOMOTO: Hi, Bobbie.

MS. BENAVENTE: Hi.

MS. ENOMOTO: We have Administrator Hyde here if you want to introduce yourself.

MS. BENAVENTE: Yes, I can see you on my computer screen.

Good evening. My name is Bobbie Benavente, and I work for the Guam Department of Mental Health and Substance Abuse. I've been with the Government of Guam for about 30 years, and 28 of those years have been working in the field of prevention for the government.

I'm really pleased to have been invited and nominated and sworn in to serve on the Advisory Committee for Women Services. I'm really a grassroots person, although, I work for the State Government of Guam, I'm really the mom in the villages that work with other moms and youth to take a look at situations in our life that create a lot of hardship.

I'm currently managing the SPF-SIG Grant for Guam. We were part of Cohort 1, and also managing the Garrett Lee Smith Memorial Grant. It's our second year of our third year grant, and the work that we've been doing has been very exciting in helping to build community

capacity to address all the areas of hurt and trauma that we've not been able to do comprehensively for the island.

I also work as a councilmember for the Pacific Substance Abuse and Mental Health Collaborating Council for the Western Pacific, the U.S.-affiliated Pacific Island, and we have a regional plan or a united plan as a specific combination to address the issues of mental health and substance abuse, and so I think I'm probably going to get more than what I may be able to offer to the committee.

I do look forward to the challenges. I do look forward to offering the experiences of the Pacific women and the ways in which we've used our culture and our heritage to really strengthen the work that we do in this field. So, thank you for the opportunity.

DR. RIOS-ELLIS: Bobbie's very humble. She, as you can imagine, is a very seasoned professional and I know will have a lot to offer this group and to SAMHSA. I mean, in general, we have a dream team as everyone's going around and introducing themselves, and so I just love this committee, and I think we have fantastic members, and they are poised and ready to hear what you have to say, and I'm sure give their thoughts on how we can help fine-tune the

focus on women and girls within all of our initiatives.

So with that, I'll let you go.

ADMINISTRATOR HYDE: Great. Well, it's good to be here again. This is the second time I've been with this committee. So I think it's the only committee I've been with twice. So I'm not sure if that's just timing of your meetings or if it says something more.

Obviously, I've been interested in the issue of women and girls since I was born, I guess, as a woman or as a girl. Being in this kind of an environment reminds me of some of the work I got to do years and years ago, and to remind you of some of the things that I remember.

Sometimes when we work on these issues--I was very young out of law school and got to work on, if you remember when Title 20 first became a set of funding, and at the same time, domestic violence shelters were just becoming a thing, at least where I lived. And so, I got an opportunity to work with a domestic violence shelter and help them put together their legal papers to become an organization and get one of the first Title 20 grants. We had no idea what we were doing. But they took off, and they're still actively working in Ohio.

And then back in the years, you may remember this, these are old things that bring back these memories, but you remember the time when there was a big thing about pornography and the ACLU and all the work they were doing. I was a card-carrying ACLU member, and yet, I was very concerned about the fact that we were defending the right of pornographers to say what they said, which I believe totally in free speech, but nobody was saying yes, but there are messages here that we need to do something about.

So I, along with a friend of mine, started a group called Women Against Media Violence Against Women, and I had the distinction for awhile--I probably shouldn't say this on film--but of having an entire room of pornography because we were going through everything from actually just TV ads and magazine ads to pornographic material showing the images that people portray about women, and frankly, it wasn't all that different between pornography and media and TV images back then, and trying to make the point about the images we give of women and girls and what that means. And I remember doing the presentation to the ACLU board, and there was this dumbstruck silence about what do you want us to do about

this? Because it's free speech.

So we were concerned as much about what that free speech said as the ACLU's defense of, you may recall the-- I'm sorry to digress here, but it raises these issues. The Neo Nazi groups that were marching in the Jewish communities in Illinois, the ACLU defended them but it started an entire discussion within ACLU about as we defend free speech, what does it mean for the people that are the targets of this speech?

Unfortunately for the women's issue they never had that discussion, they never had the discussion as yeah, we're going to defend these images and these derogatory and degrading images, but never talk about what that does to women and girls and their future.

So anyway, I had an opportunity to do some of that work, and I've gotten thrown out of lots of good places doing women's work from trying to create a pro se divorce manual for women to take into court on their own and having the court, as a young lawyer, threaten me with debarment if I did that anymore. This is back in the days when that wasn't allowed.

So anyway, our work on women's issues, which I've

not gotten to do quite as much of as my more recent career, but in New Mexico, most recently, I was responsible for the TANF Program in addition to behavioral health and Medicaid and a lot of other things. And in the TANF Program, we were very particularly looking at the impact on women of domestic violence and behavioral health problems, substance abuse, mental health, and that keeping women out of the workforce and those kinds of issues.

So these issues keep cropping up because women are over-represented in our delivery systems, especially around poverty, as you well know, and many of you work in those areas, and the way we approach the roles of women and children. I also actually got to do one of the first or at least help fund one of the first programs on post-partum depression. This was long before we really knew what it was, and people just thought women should buck up and get over it, and one of the things that that early research came out with was that it really does have something to do with roles, that you shift from being a professional woman to being a mom, and you shift from having some relationship of your own to having only your relationship through your child, and the importance of getting women back into their

roles, whatever the roles were before they were pregnant and had their babies.

So anyway, lots of stuff early on that were pleasures of mine to work in these areas.

I'm glad to see you all doing that work, and glad to see you advising us, and I think my goal here for the next few minutes, it's a little bit long, but I want to try to lay out for you because it wasn't well formed or thought through at the point that I met with you first, which is the 10 initiatives that SAMHSA had identified as those things that will control our time, our resources, and that we will spend our time on for the next two or three years.

You have some materials, and I'm going to go through some of these hopefully fairly quickly, but yet, since there's 10 of them, there are quite a few things that I'd like to just share with you about what we're doing, and the goal is for you to react and to tell us what we should be thinking about or remembering about or assuring that we get in there for women and girls as we finalize the work on this. This is a work in progress. We're trying to finalize a draft plan that will go out to the public for comment. This is in the context of the Health and Human

Services Department, which we are, of course, a part of, doing their strategic plan, so our work will fit within that, as well as fit within the things that we believe are current opportunities and challenges.

So for example, the economy is a current challenge, as well as an opportunity, or military families is a current challenge because of the amount of deployment going on and the number of veterans coming back and their families, and we really are trying to focus those issues on family issues, not just on the deployed individual or the veteran. But I'll talk more about that in a little bit.

So we're looking at both challenges and opportunities that present themselves to us, as well as fundamental work that we think that we, as an agency, ought to be doing in our leadership roles and then just sort of the obvious functional roles that we play.

Do we have this up here, as well? Is this in their packets?

MS. ENOMOTO: Yes.

ADMINISTRATOR HYDE: All right. So we'll see if we can go back and forth here a little bit.

So these four messages that are up here on this

first slide and should be in your packet are something that we're trying to hammer home, that behavioral health is a part of health that is so critical as health reform unfolds, it's important that behavioral health be right there in it and not somehow over to the side.

That prevention works. You're going to hear me talk a little bit more about prevention. It is our number one priority at the moment, and we are trying to infuse prevention, thinking throughout everything that we do. That treatment is effective, so we're doing a lot of work around quality and outcomes and stuff like that, and then that people do recover.

So our first and foremost effort is to keep our focus on the people that we serve and the fact that it's not the services that are the goal; it is their life that is the goal. And we just keep trying to make that clear, it's their life in the community, it's communities, families, and in fact, we sort of redefined our mission a little bit to frame it as to reduce the impact of substance abuse and mental illness on America's communities, and we, of course, do that by trying to help build resilience and focus on and facilitate recovery for individuals and for

families and for communities, frankly. So all of those are the messages that we are sort of trying to live by.

So let me take you through the work. We're trying to think about where we are as a field and where SAMHSA's leadership role is most legitimately placed right now, and how this committee can help shape that direction. So, everybody that we talk to about this, we're interested in your input about our goals and directions from your perspective. So, you may have lots of perspectives around the table, but, collectively, your perspective is about women and girls, and so we want that perspective as we finish this.

I've already talked about our mission, but let me just say, there's a role document in your materials, and I'm not going to spend too much time on it, except to say that SAMHSA has, I think in many eyes, been viewed as a grant-making organization, and we are, we are a grant-making organization, that is clearly one of our key functions, but it's not the only one, and we really are trying to focus much more right now on our leadership and voice role.

And why is that? Well, it's not because we're

not going to keep giving funding out, but it's because, frankly, the funding streams for behavioral health is already well over into the Medicaid world. It is going to be with health reform implementation increasingly Medicaid-funded and commercial insurance-funded. We are going to try to take our block grant dollars and our discretionary funding and make sure that they do things other than what Medicaid and commercial insurance can do. So that has pretty big implications in our role in grant-making and funding with the states and otherwise, and you'll see more about that later.

So really where we can provide the most effective voice for behavioral health in the country is sitting at the table where these other decisions about service packages, service definitions, about expected outcomes, about other programs like TANF, like Medicaid, like the HRSA programs for workforce and those kinds of things which are, in fact, growing. Our funding is growing in 2011, at least the president's budget proposes a small growth, but it's nothing compared to the growth in other systems; in justice systems, in military systems, and otherwise. So, we believe at this point our role as leadership and voice

and being at the table is as important if not more important than our funding role.

We also have a huge role in information and communications. You'll see that as one of our strategic initiatives and we have a major role in regulation and standard-setting that sometimes people doing see as much of, but we do, and then a lot of work that we do around trying to improve practice, and as that practice gets infused more in primary care or in medical homes or other places, or, frankly, in general, human services, it's more and more important that we help and try to improve that practice.

So you have, as I said, the one-pager about our role. This is actually a work-in-progress, too. We're actually working with a couple of other entities in HHS to refine what our role is and be clear about that with everyone.

Yes, will you do this? You can follow where I'm at.

Kana is very good at many things, as you all know, including following and including leading, both.

So, the 10 strategic initiatives are more than

just sort of words on paper. We've already in our strategic plan as a document, it's not completely done, begun to infuse these initiatives in our grant-making and in our contracts and in our budget, and you will see that more and more as there's some in our 2011 and certainly in our 2012 budget, which I heard Kana talking about as I came in, that we're already working on 2012. So, more and more, you will see our resources, both human and financial, aligned around these initiatives and trying to create a consistent message about what we're trying to accomplish.

We know I can't do everything. SAMHSA cannot do everything, as much as we might like. And we sometimes get pulled into every single issue there is out there, because there's almost nothing that doesn't touch behavioral health in some way or another, but we're trying to focus our efforts on these 10 strategic initiatives, which are listed here, and I'll go through each of them one-by-one, are the places we want to focus our attention.

These are a lot. So there's more than enough to do in each of these 10 areas, and even within each of the 10 areas, we can't do everything. So we're trying to pick 3 or 4, maybe 5 things that we really want to accomplish

and make a measurable difference within each of these 10 areas.

So, let’s go to the prevention, number one, our prevention of substance abuse and mental illness, and this is our number one initiative. You should have actually two pieces of paper: One is facts associated with these initiatives, which also is a work-in-progress, but those are fast facts that just sort of tell you a little bit about why we picked this as an important area to work on. And then, secondly, you should have what's up here to tell you kind of what we think we’re going to focus on within each of those areas.

So at this point, I’m going to run through these fairly quickly so we have a little bit of time for you to give me some immediate feedback, and then I don't know what the rest of your day is like, but maybe you’ll have more opportunity to talk about it throughout the day.

So under prevention, we are looking at this as both prevention and sort of a universal prevention point of view, as well as a promotion of mental health. So everything from very young children and how emotional health gets developed and looking at the risk factors

associated with genetic risk factors, psychosocial risk factors, and social risk factors.

Now, I have been accused of taking on poverty, war and peace, and the economy, and yes, we probably are going to try to take on all of those things on some level, but the point is we have to look at what it takes in a community to develop emotionally healthy kids. We have enough science, we think, now to tell us how to do that, and we have partners who want to do it with us, and so we're taking a prevention-prepared community approach to try and do both a universal prevention kind of approach, as well as early intervention for those individuals who may be at risk.

And there's increasing evidence there, as well, about how we can do that for substance abuse, for adolescent depression, for conduct disorders, for other kinds of early childhood stuff, and then, frankly, increasing work going on, which I'm really excited about, about early intervention into diseases, at least at this point, are not curable or preventable, like schizophrenia. Maybe at some point they will be, but there is great research going on about that that we want to also be a part

of. So prevention-prepared communities working with communities through states to try to get those communities prepared to take this on and understand prevention science.

The other thing that we want to do is really look at suicide. Suicide is maybe flat or going down a little bit in the country, but going up among military families and among certain types of individuals and among certain communities. So we want to look at that issue and do more there.

Underage drinking has always been something that we're focusing on, but we really are trying with CDC and the National Institute of Alcohol--I can never say all those As, NIAAA, looking at alcohol policies. We actually have some research now around what kind of policies, like taxes, keg policies, happy hour policies, or things like that that really do have an impact on underage drinking, if we can work on those.

We're also going to look at tobacco use among persons with substance abuse and mental illness. Thanks to Gail, we threw that in and learned a lot more about it, and you'll be glad to know, Gail, that it was actually a couple of other people who brought that to the fore, as well. So,

there are other folks within HHS besides just us that are very on this issue.

So we're having all kinds of interesting conversations between us, CDC, and other tobacco cessation groups about why the tobacco use is higher among our populations. So, we're looking at then.

And then we knew it was an issue, but we've been asked to call out prescription drug abuse by tribal communities and for seniors and just for kids and a lot of other places that this is a growing issue, and so, it's something we're going to take on specifically.

So, those are our prevention areas.

The second one is trauma and justice. This is an area I know that you all care about tremendously. We are here to look at making sure that our workforce is trauma-informed, whether they're primary care professionals or mental health professionals, trauma-informed care and screening, and then in this one, we talk about trauma and justice, because they're connected, but it's not trauma in justice, it's trauma and justice.

So prevention and diversion from juvenile justice and adult criminal justice systems and not just on the drug

side but on the mental health side. So we're looking at maybe shifting from drug courts to problem-solving courts and giving communities the option of what kind of court they think would best work.

We want to look at the impacts of violence and trauma on children and youth, so in addition to taking on war and peace and the economy and everything else, we may take on community violence. And we know that if we can reduce the incidents of community violence and the incidents of kids that are either victims or witnesses to that violence, that we can have an impact on trauma and behavioral health.

So I'm not going to go over the facts on each of these. You can read those and see sort of why we think these are big issues.

Third one is military families, and I ought to say, by the way, these top three initiatives are the three initiatives that the secretary asked each of the agencies to come up, so each agency within HHS was requested to come up with the top three initiatives that would be built into the overall Health and Human Services Department Strategic Plan.

So those three are in there, but, frankly, all the rest of them are sprinkled throughout there, as well, but our top three are the two that I've just said and then military families.

In this area, we're doing a lot of work with the Interagency Policy Council that the White House has set up on military families. There's a lot of interest at DoD. The head of the Joint Chiefs of Staff has just come up with a press release and major kind of call to the troops to say the most courageous thing you can do is come forward if you need help trying to get over that myth that to be a warrior, you have to be strong enough not to have a mental health problem. Well, they're talking a lot about psychological health and their interest in making sure that the Armed Forces are psychologically health, as well as physically healthy.

We see that as a very positive thing, and then working with the Veterans' Administration, the National Guard, and others. We've had great dialogue with them. They're all extremely interested in partnering and working with us further, and we already have.

On homelessness, it's something the Veterans'

Administration has taken on to end homelessness among veterans. So we want to be helpful there.

Prevention for military families, we have all kinds of data about the kids in military families doing less well in school and having more possibility of drug use and more, frankly, possibility of suicidal thoughts and other kinds of things, so we want to work on that.

We want to do a specific set of work around getting access for the civilian workforce to TRICARE and contracts with the Veterans' Administration, et cetera, especially in rural areas, where they don't have existing providers so much, and TRICARE is a little bit of an old-fashioned view of these services at this point where it's kind of all have to go through your doc, which means it's all got to go through either a psychiatrist or psychologist, and there's just not enough of those human beings and those professionals to do all the treatment that is needed out there.

So we're trying to work with TRICARE on that and also with the Veterans' Administration, which I just had a call with Kathryn Power about this week, and then looking at suicide among military families. As I said earlier, the

rates are going up here.

We just got an agreement from a major military leader to co-chair our national alliance or national work on national suicide prevention framework update, so we're really excited about that.

The next one is health reform. This one, in some ways, we could make this one number one because it's all over everything, but we have four areas here that we're working on, and we have brought on special staff. John O'Brien, who is a special expert, has come to us and is nose-deep in this.

We want to implement or make sure we're at the table on all the right things about the Affordable Care Act, as this gets implemented, and that's everything from how services are defined and how essential benefit packages are defined and how Medicaid benefit packages are defined, and also making sure that we're at the table on our medical homes, because those work both ways; you can have a medical home in a medical setting or you can have a medical home in a psychiatric or a mental health setting. So, we want to make sure that our opportunities are there.

And there's also workforce issues that HRSA is

leading, but we are going to co-chair with, and then there is a special effort on our part to look at preparedness by practitioners and providers to move into things like Electronic Health Records, and we'll talk about that again in a minute. But, especially in the substance abuse side, being able to bill, it's not always something that substance abuse providers have been used to doing. So we want to get them up and ready to go. So a lot of provider preparedness and also to help consumer families and groups be prepared to get signed up and also to be active participants in maybe a different kind of system.

Just to give you a couple of numbers here, because they are important, we think there are about 32 million people who will be insured through this process, and about half of those, about 16 million, will be on Medicaid. These are people who have never been Medicaid-eligible before, mostly childless adults, low-income, childless adults without a disability, but with significant problems, and of that, about 5 to 6 million we think will have behavioral health problems. So, either substance abuse or mental health issues, and these are folks we can kind of guess from current estimates, this is not even

counting the people who are maybe not presenting with depression, anxiety, drug use, or alcohol use that's inappropriate because they've never had insurance before, so they just don't go to the doctor or don't deal with it. So, there are lots of opportunities there.

The other thing that we're doing is major interface with Medicaid and Medicare, where we're getting to review and are reviewing all the rules that they're developing and having input on that. We're on a lot of the committees where they're working, developing the changes that they're going through, and we will continue to be at that table with them.

We are preparing for Medicaid a paper called ''Modern and Good Behavioral Healthcare Delivery System.'' The idea is if we could say in 2010 what's the best service package delivery system for behavioral health, what would it look like, and then after we get that in place, Medicaid actually wants that so they can then determine what portion of that Medicaid should be covering in their framework, and that goes to the block grants because we've been providing services through our block grants that are going to eventually be able to be funded either for the service or

for the person by Medicaid, or, in some cases, commercial insurance, but mostly by Medicaid.

That means we need to step back and rethink what our block grants are going to be used for. So what we want to do is make sure they're used to cover people who are not covered for some reason and to cover services that are not coverable through the Medicaid and commercial insurance reimbursement process.

This requires us to rethink the block grants, rethink what we're asking states to do. We also want to take some of our discretionary programs that we know work and begin to infuse them into the block grants so that they are everywhere, as opposed to just in the grants in the communities where we provide those grants. So, we're thinking about all of those things.

And, finally, parity, which is a huge one. It's not only parity the reg and parity the law, but, also, the parity implications in health care, the Health Affordable Care Act. So there is lots to do there, as we say.

So some of what you see in the next few ones of these just have to do essentially with some of the stuff I've said in what's in the Affordable Care Act for

behavioral health. There are several pages here. If you see the 2010 next to them, that means they're happening right now. This is not all about 2014. It's all about things that are going into place right now, and then there are things that will happen in 2011 in the budget for 2012. We are proposing some things to prepare our systems for the 2014 switchover, but if you can see some of those things, like elimination of pre-existing conditions, this is huge for our system because we have a lot of people with behavioral health needs who can't get coverage or who can't get coverage for those issues because of their pre-existing condition nature, and that will no longer be the case.

So, there are also within the Affordable Care Act a couple of other things I didn't talk about. There are also a whole lot of prevention efforts or possibilities in there. There's a prevention fund that we have applied to get some dollars from. There are training and research efforts that are being led by both AHRQ and HRSA that we are trying to be a part of and are being a part of. And then there are things in the costs and funding section of, or page in your overheads, where there are actually a significant number of small business, including providers.

So some of our providers are actually eligible for some of these tax credits if they're profit-making. If they're not profit, obviously, those tax credits don't help quite as much, but for small businesses offering coverage, for them to help them keep insurance for their employees.

All right, there's a lot going on in health care. So let me move on to number five.

Our fifth initiative is housing and homelessness. I've already talked about homelessness among veterans, and it's frankly not just men veterans; there are an increasing number of female veterans, and they are subject to some of the same pressures and issues. So, we're looking at permanent support of housing.

We have an initiative with HUD in the 2011 budget that would allow us to provide essentially the wraparound services that Medicaid can't provide and Medicaid will provide the health-related and be health-related services. HUD will provide the vouchers so we can actually demonstrate that we can, in fact, get chronically homeless individuals with substance abuse and mental health problems off the streets permanently and in a permanent home. We kind of know that from demonstration projects, but we want

to demonstrate it at a little bit of a scale, and then, hopefully, be able to take it from there.

We also are trying to focus a little on homeless families because we know that, frankly, a lot of kids who are homeless are homeless for a couple of reasons. One is because of their parents' drug use or mental health, but, primarily, substance abuse, and frankly, there are also a fairly higher proportion of homeless adolescents who are gay and lesbian and have differences with their parents, and that results in homelessness.

So, these are issues that we want to look at. We also want to look at some of the policy and financial barriers and capacity barriers here.

There was an Interagency Council on Homelessness report that should be out any moment, which we have been participating on, and they are producing strategies to try to address homelessness among the people we've talked about, about veterans, among families, among youth, and among tribal individuals, I believe, as well. And then persons who are chronically homeless.

Jobs and economy is our sixth initiative, and this one is one of those that I call a challenge and

opportunity. We probably wouldn't have this one on here, but for the current economic situation, we have some indicators about what the economy does in a particular community around certain kinds of things like binge drinking, maybe some domestic violence issues, and others.

We are trying to see if we can test and have put out an RFP or an RFA that is a place-based initiative, which basically will allow a distressed community to come forward and get three or four different programs at the same time instead of having to go through multiple RFA processes and see and demonstrate. We call it our proof of concept, to see whether or not it can make a difference in that community if we put more resources to that particular community as opposed to a particular program in a community.

So, looking at the behavioral health impacts of the economic situation and then the second area under this one is jobs for people with substance abuse and mental illness supported employment kinds of efforts, and then we also want to look at the workplace and businesses and get employers intrigued by their role in both preventing behavioral health issues and supporting people who have

behavioral health issues. We know that a significant number of people with substance abuse, with depression, and other kinds of things, in fact, work. Their impact on employer costs is high, and employers are starting to get that, and some of the national business groups are working with us and working among themselves at trying to help employers provide access to services and treatments that will allow people to be in a workplace in a more effective way with less cost to the employer. So we're trying to make it clear that behavioral health treatment is cost-effective, as well as effective from a treatment point of view.

The seventh area of our priorities is health information technology and Electronic Health Records, and here, we have three major areas that we're trying to focus on just helping providers adopt and implement Electronic Health Records. We know that the numbers of behavioral health providers who are taking up, adopting, or utilizing Electronic Health Records is even lower than in the primary care sector, and we also know that the dollars and resources available to behavioral health for this area is a little harder to come by. So we have within that 2011

budget $4 million in the Office of the National Coordinator for health information technology. We call it ONC. They have $4 million specifically for behavioral health, and we are working with them on what those dollars will be used for.

A second area is we're going to look at Electronic Health Record standards and quality measures.

So a lot of times, the vendors who are developing Electronic Health Records are sort of just saying I can't deal with behavioral health; it's too unclear, the quality measures aren't clear, the indicators aren't clear, and the privacy issues are too crazy. So I'm just not even going to deal with it, which means that in some of these programs, we don't even have behavioral health in there, which leaves us open to lots of medication problems, interaction problems, or just not doing the right issues. And, obviously, there are privacy and confidentiality issues in behavioral health that are unique to behavioral health that we are trying to look at what we can do about there. Those are tall orders, all of them.

Workforce is our next one, it's the eighth one, and here, we're looking at sort of the obvious, the numbers

in distribution of workforce which are low to start with, and even worse as you look at 5, 6 million more people coming into the ability to pay for behavioral health-related care. We're also in this context looking at primary care behavioral health integration. We're working very closely with HRSA to do integration models both directions, both behavioral health into primary care and primary care into behavioral health settings. A lot of work going on there.

We also want to in the workforce area really enhance the use of peers, recovery coaches, paraprofessionals, and others, and by enhancement, we mean just getting the ability of people to do that, but also getting payment processes for it. So we're working with Medicaid and others about that and with some of the states and other practices that have come up with certification processes and other things that might allow that to happen.

And then evidence-based practice and thinking is something our workforce needs more and more help to do. And then one of my particular issues is trying to get the concept of recovery infused into all the curriculum in the professional schools. We have an increasing number of

places in which recovery, as a construct, is in competency requirements, but it's not necessarily in curriculum. So how do you teach a recovery orientation, which is a different issue, and there's relatively few, although, there are a couple of places that are starting to build that kind of concept, but we need it in every school and every professional everywhere.

So I have two more. The last two are data outcomes and quality, and in this area, some of this is internal.

We want to move to a single SAMHSA data platform, and we're actively in that process from the three that we currently have. We want to get some common data requirements for states because those are kind of all over the map. We want some common evaluation service system research framework because, again, in our different centers, we do that differently, and we just had a meeting about this, this morning. We want to take on the issue of what are the quality indicators that we ought to be seeing everywhere as infused in our systems, and this is actually not outcomes. That's a different issue. This is the quality indicators in behavioral health. It's exactly why

Electronic Health Records don't know what to do with us because we don't have them agreed to, and so we're trying to work on that.

We're also going to come up with prevention billing codes, which is kind of an odd thing to think about, but if you're a practitioner and you're dealing with a mentally-ill mom and the daughter is sitting there and you have an interaction with the daughter, you can't really bill for the daughter and call it prevention; you have to have some sort of diagnosis to call it an intervention.

So, the first thing you have to do in order to get anybody to even think about letting somebody bill for that is to create a billing code concept. So we want to think about that issue, as well.

And then, finally, we want to try to come up with a cross behavioral health, substance abuse, and mental health set of measures for recovery, and that doesn't mean --recovery's a very individualized process and journey. We're clear about that. So an individual can say whether they're in recovery or not and what their recovery looks like. But if we, as a system, want to say did our services move us toward recovery for 50 percent of the population we

served, then we have to have some way to measure that.

So there are constructs about recovery in both behavioral health and both substance abuse and mental health. They are somewhat common, but not completely common, and sometimes they're the common construct, but not the common words. So that's also something we're working on there.

Public awareness and support is the last one, and this has a little bit to do with, again, some internal stuff. We're trying to do SAMHSA branding not just because we like SAMHSA, although we do, but because we want people to know SAMHSA is a place to go get information about behavioral health as much as people know that CDC is a good place to go to get information about public health issues. And we need to brand SAMHSA in order to do that.

We have at the current time 88 different websites that we're consolidating into at least fewer, if not into 1. We have different looks to all of our fact sheets that are going to be one look or moving from a jillion 800 numbers to one 1-800 number. If any of you know anything about communications, you know it's how often you say it and how many times you repeat it. It's not how many of it

you have. So that's why we're trying to really focus down on saying it over and over again, which kind of brings us back to our four messages that we're just trying to pound over and over again.

And, finally, we have cracked the nut of using social media. We have gotten around some of the firewalls that the Federal Government throws up, and we are starting an active plan on utilization of Twitter and Facebook and all these kinds of things for getting everything from information to messages to input to just dialogue out there. So we're trying to come into the 21st Century about that.

So that is a lot, and I apologize for taking so long, but we're doing a lot of stuff, or, as we've said, we've actually in our social media way have actually coined an acronym for texting that is TLTD, which we call tilted, which means there's a lot to do. So, if you see us text you a message and say TLTD, you'll know what we mean.

So, anyway, I'll stop and see if you have comments, thoughts, or reactions, and then you can spend--I don't know if the rest of your day is on this or on something else.

MS. ENOMOTO: We have John O'Brien coming.

ADMINISTRATOR HYDE: Okay. So, maybe you can hold your health reform comments a little bit because John's going to come, and you have a whole section on that. So let's talk about the other things besides that.

MS. ENOMOTO: All right. Susan and then Renata.

MS. AYERS: I was struck with the notion that we're all struggling with, which is how many dollars are being funneled through Medicaid. And what that does in terms of how you actually can offer more flexible services to families. And it's exciting to hear that maybe there will be other billing codes.

We had this Rosie D. Lawsuit in Massachusetts, and we are billing in 15 minute increments for the work that the parent partner does, as well as the clinician, which is just completely ridiculous and untenable. But we do it anyway.

ADMINISTRATOR HYDE: Please raise that again when John is here.

MS. AYERS: Okay.

ADMINISTRATOR HYDE: Because anything and everything Medicaid, he knows to know what your concerns

are.

MS. AYERS: Okay, because it would be wonderful, back to your pediatrician or your well visit thing. What about a family billing code? And what about the family focuses?

As I took a lens and looked through 10 initiatives, the military family captures the family concept, but you could take family into all of these things, and see a place and a focus that would help really ground so much. Because even with behavioral health, when we've interviewed folks trying to get this electronic medical record piece, there are some that are trying to put together client information systems that actually can have more of a family focus, and so, it's not the individual; it's just trying to broaden that focus which would be so much more sensible for probably 80 percent of the work that gets done out there.

MS. HENRY: So, I just wanted to say from the bottom of my heart thank you for the work that is coming out of SAMHSA around this blurring and elimination of the silos between mental health and substance abuse.

For those of us who've been in the field for a

long time, this is going to make our work much easier in terms of whether it's families, whether it's children, where we talk about prevention and earlier intervention. If there's one place where the issues of mental health and substance abuse come together, as well as developmental disabilities, but where it comes together, it's in working with children.

So, I've made notes all the way through because I want to share this with our leadership at the state level, both in public health and Medicaid, this kind of looking at this as an integrated system is going to make the work wherever we are, children, families, cultural competence, across the board so much easier, and it's long, long overdue, so I just really appreciate that.

DR. COVINGTON: Yes, this is really ambitious.

ADMINISTRATOR HYDE: Yes, it is.

DR. COVINGTON: I hope you'll be around for at least 20 or 30 years to do this. I want to say this very respectfully: You're a breath of fresh air.

Then the thing that I'm really struck with here though or what's not said, we're here talking about women and only in the trauma and justice do we have anything

that's gender-related in terms of talking about girls.

And so, the other thing that's really missing to me, I'm looking at the top three things on here, prevention of substance abuse and mental illness, and there's no discussion of trauma. And that we can't even talk about prevention in terms of the way I look at this, of substance abuse and mental health problems, and eliminate our understanding of trauma.

So, I would say that there needs to be something about services for substance abuse and mental health being trauma-informed, and then there are gender differences in terms of mental health and substance abuse, and that's not listed at all. So that would be my concern, for one.

For two, the trauma and justice one, some of the stats that are in here, as far as I know the research, are actually facts about youth in general. Really, the facts that are in here aren't necessarily about youth that are in the juvenile justice system, because you'd see higher statistics in terms of how many of them have witnessed violence, how many of them have experienced physical assault, how many of them the prevalence of sexual assault. So, I think these facts belong more in our substance abuse

and mental health general facts.

ADMINISTRATOR HYDE: Actually, you're raising an issue that we have struggled with, which is sometimes people are reading the trauma and justice, and put them together because we thought there was, in fact, a link, but it's not trauma in justice. So it is trauma in general and justice, and then there is a link.

DR. COVINGTON: Yes.

ADMINISTRATOR HYDE: But we haven't yet landed on the best way to call this particular one because people have gotten that confused. So, those data are, in fact, general.

DR. COVINGTON: They are general, right.

ADMINISTRATOR HYDE: Yes.

DR. COVINGTON: And if you link trauma and justice in one of your points, you're missing the fact that it permeates so many of these areas. I mean, trauma permeates the substance abuse and mental health, and if you put it into justice, I think you'd lose that.

In military families, again, there's no gender difference here about what happens with women who are veterans versus male veterans, and military sexual assault

is a huge issue for women in the military system, and I think the facts around that are so appalling that they need to be a fast fact.

So I would just be concerned in all three of these that the issue of gender is totally missing except under trauma and justice and that the trauma needs to be mentioned, I think, in other places, or it'll get lost.

ADMINISTRATOR HYDE: Thank you.

DR. COVINGTON: Okay.

ADMINISTRATOR HYDE: Great.

DR. RIOS-ELLIS: This is wonderful. I mean, I'm looking at all this, and I'm thinking wow, this is incredible, and I see the issues of gender, but also the issues of culture, and I'm looking at this thinking--as I went along, I was so excited to see peer education, especially with recovery, but I'm also thinking in terms of prevention because we do all of our work through Promotores de Salud, so this is something that is really integral to the work of National Council of La Raza, as well as our center work. Without those women in the communities, many of the communities would be completely unaware of the issues.

And I'm thinking of just last Saturday, we have a sixth grade very high-risk program with at-risk youth, and they're tweaking meth, and how do we get around these issues and how do we even begin to help families who are linguistically-challenged understand what their kids are going through?

And, at the same time, what we're seeing within our Latino communities is a lot of internalized racism and a lot of internalized stigma. We have it associated with mental illness and we have it associated with behavioral health issues, but now with all of the ostracizing and scapegoating of the Latino community, we have it associated with just being Latino.

So when we go in and we begin to dialogue around issues, we say well, we can't do that because we don't plan or we don't take care of that, and yet, the issues are so associated with immediate survival, and we're seeing this now especially around HIV with people going on waiting lists and calling right away when the Arizona thing happened, where am I going to get my treatment, even if they're documented, because they're threatened because one member in their family might not be documented. So having

to leave Arizona and get some segue of treatment, especially with aid app lists growing.

So, I think in the midst of all of this at National Council of La Raza, we recognize that many of our immigrant communities bring vibrant resilience strengths, and it kind of goes back to what President Reagan said, strong people immigrate. So at the same time, and not just speaking to the immigrant communities, but seeing what happens as people acculturate, and how we want them to hang on to those cultural values, because if they can hang on to things like respect, family unity, harmony, and all of those things, they're going to be more likely to not become ill or not suffer from some of the behavioral issues we see that more acculturated Latinos are dealing with.

So in all of this, I saw the issue of culture, and I also want to speak to what Susan brought up because we have programs at the center that are just geared because of funding mechanisms toward women and girls, but, at the same point, the women are telling us we need to link in our husbands or we need to link in our partners or our families. If not, we can’t get permission to come.

So I think the family base is often the way to

get to, and I know there are certain communities where we can get directly to women, but there's certain communities where in getting to women, we have to gear things towards families. So because so many of the gender-based issues are also cultural for us, as well, within the Latino community, I think that's something that I would love to see, the culture and linguistic access raised in this, and also the peer education raised throughout what peer educators can do for prevention issues, especially now with the community health worker designation on the Department of Labor in terms of an occupation.

ADMINISTRATOR HYDE: Let me just make a comment about this because it's come up in almost meeting we've had. We made an affirmative decision not to call out certain cultural groups, cultural competence, or cultural issues as an initiative, but what happens in the overheads is you don't have the paper, and we have a whole section in the paper that is about cultural issues and we're trying to incorporate that much better, so I accept that.

From what you've seen here, you don't get a flavor of that. Obviously, having spent many years in New Mexico, I get a lot of the same issues that you're talking

about, including the give somebody 10 years and they're just as bad as the United States because they've lost all those protective factors, but that's too bad. We need to do something different.

But anyway, so culture is definitely on our minds, cultural and linguistic competence, and infusing that in here. So is the concept of recovery. It doesn't come through quite as strongly as a lot of the consumer groups would like, and we talk about it, but you don't see it on a piece of paper. So, I accept that and, hopefully, when you see the plan, it'll be a little stronger.

DR. RIOS-ELLIS: And that's what I was thinking. I'm thinking this must be here; I'm just not seeing it in the detailed point.

ADMINISTRATOR HYDE: We think of it as everywhere, and not just as its own little thing over here, so that's why we thought of it that way, but it has certainly not come across well in the documents to date. So, take that for good input.

DR. FALLOT: Let me just pick up on that one a bit because, before you came in, I think I was mentioning that it seems to me there are four fundamental, value-based

approaches that are underlying a lot of the work you're talking about: recovery orientation, gender responsiveness, trauma-informed care, and cultural competence. And this document especially seems high on trauma because it's got it in the top three, but, as Stephanie says, the gender responsiveness issues are diluted here. Cultural competence is not really picked up, and recovery orientation, which is sort of the umbrella of all of them, in some ways, is also sort of submerged.

And so, I'm looking forward to seeing what the rest of the document will look like in a way to pick out those others, as well. And I wondered particularly if it doesn't fractionalize things too much to develop some fast facts around men and women and some fast facts around the cultural, racial differences, and maybe even some class differences, which would--

ADMINISTRATOR HYDE: Class differences.

DR. FALLOT: Class differences, social class differences, which are certainly fueling a lot of the current controversies in the country and it might be helpful for people to have as supplementary material to the main document.

MS. ENOMOTO: Susan and Britt?

MS. AYERS: Two more pieces. One, your bullying number is awfully low, 5 percent. There was a 5 percent reduction or a 5 percent improvement with some bullying. After some bullying intervention, I hope it's higher than that because there's something I'm missing in the reading of it.

ADMINISTRATOR HYDE: Actually, I think that fact was from one specific program that we did, so it's not to say that there aren't other programs that wouldn't have more of an impact.

MS. AYERS: Yes.

ADMINISTRATOR HYDE: It was just the ones that we funded.

MS. AYERS: I mean, maybe it's because I'm from Massachusetts, and we've had some suicides as a result of bullying and very high-profile and we're doing a lot of kind of trauma work around that. And so, I know it just doesn't show all that well.

And then the whole other piece and maybe it's another federal place that has responsibility, infant mental heath. That link around brain science and whatever,

I mean, infant mental health is a really important field, it's a burgeoning field, and they'll link also with maternal depression. I know that post-partum depressions, you mentioned earlier, but those are huge, and while it seems kind of just like oh, well, everybody knows about it, I don't think that people really necessarily do know about it.

So just that whole early childhood, because I know you have Project Launch, which is terrific, but to try and put more of a focus because I'm convinced if we put money in the front end, we wouldn't have so many big numbers on the other end, and I know prevention is in here.

ADMINISTRATOR HYDE: I totally agree with you, and New Mexico was one of the few states that I'm aware of that had an infant mental health plan. But people didn't get it very much. So I think maybe increasingly states are doing that but, yes, it's a good point.

DR. RIOS-ELLIS: The other place on Roger's point that I would make sure that we have some representation is in the workforce development piece, making sure that we're

really stating that we need representation of diverse cultural groups that are under-represented. So, really looking at racial and ethnic minorities that aren't at the table and making sure that our work is really stimulating that.

And the other thing that I was thinking, back to kind of what Roger and Susan are both saying, is really looking at ways in which we can reinforce positive behaviors or I guess use positive cultural assets and values to promote behavioral health. So that we make sure that we're reinforcing what the resilience pieces that people already bring to the table and recognizing them as resilient because I think in working with the Latino community, that's what we're seeing, these really wonderful things that people bring to the table aren't recognized within them as being wonderful, and that leads to so many behavioral, mental health issues, and self-esteem issues that with the suicide rate among Latino adolescence, which is just appalling, and it also leads to family dissonance in terms of the parents, as well as the children, and we see that often.

And I think there's some wonderful work coming

out of North Carolina, actually, a project called Entre do Mundos, Between Two Worlds, which is amazing stuff.

MS. MANBECK: I, myself, think this is a really awesome endeavor. Your undertaking. I haven't really seen SAMHSA have, I guess, this much oomph in a long time. I'm going to just go around the room, and I do understand that you stated that the cultural disparities aren't represented in this document, but when we look at tribal communities, 80 percent of all women have been sexually molested. That's huge. Native boys between the ages of 12 to 17 are 5 times more likely than any population to commit suicide.

So when I think about trauma and I understand about the justice, but in a lot of our communities, they are like I don't even know how to say it, a huge ratio of our youth go from the community to jails or to drug courts or to prison eventually. And I think that having trauma-informed care and screening is very, very important, but I do believe, and I'm going to be probably really biased here, but especially with regards to Native people going on to a tribal reservation, a lot of the people that treat them are non-Native. So not knowing that 80 percent of the women that you're seeing having been sexually molested, to

me, is a huge issue. Like you will not be able to help them.

And so, with regards to cultural competency, I think trying to integrate that, and I don't really have the solution for this, but I do think that a lot of community-based organizations look towards SAMHSA for the tips and the tools and all of that. So I really think that cultural competency is huge.

And then my second point that kind of ties into that is we've been really struggling with evidence-based programming.

On the NREPP website, there are five programs listed. To the best of my knowledge, by most people that use evidence-based programs in Indian Country, they are not culturally competent, and I'll probably get in a lot of trouble for saying that, but that's what I've seen.

So there's not any funding. Native people, they don't have the resources, the knowledge, or the management ability to take upon a three-year commitment to become an evidence-based program. So when you look at that and then you say okay, well, our communities are struggling, and then really the only thing that's going to help them is

getting them back to their culture, but there's no program that they can use to get grant funding. I mean, it's just a vicious cycle.

So I know that SAMHSA has had to go about it as with a lot of other federal agencies, but if looking at this trauma-informed care and these different cultural competency initiatives, if you could give even some kind of starting dollars to begin that process, some sort of outreach, people going into the community that are able to help get this process started, I really think that that would be helpful.

I do know that CSAT worked with NAC to start a Native initiative, and that's been really helpful, but that's only a handful, and usually, the people are just trying to get the programs going, they kind of start to lose their oomph for the full-blown, evidence-based data because it is an endeavor.

So I really appreciate your time and sharing this with us, and I really think that this is going to be great, and I'm really proud of SAMHSA for doing all of this.

ADMINISTRATOR HYDE: Thanks for all of that. We've actually done quite a bit of work on thinking about

the tribal issues, and we have special programs in all of our centers trying to make it easier for tribal applicants to get access to services and try to get the capacity built up to be able to take advantage of some of these dollars, but we do have a fundamental problem with our grant programs, which are they are, by definition, a time-limited set of money, and we're actually trying to think about that around the tribal issues and have some ideas, which we have to work through various sundry department processes before we're allowed to talk about, but just know that we've heard that and we're trying to see what we can do about it.

MS. HUTCHINGS: Congratulations. I mean, literally, firsthand, I know how hard this is to do, and it's really very impressive.

Part of the way I interpret what I'm hearing, you're asking us to look through, sort of I see this like sort of beautiful glass window of stained glass, and there's different colors and pieces that you're asking people to look through in order to be able to consider and think about this.

And one of the pieces I'd like to see added or emphasized more is evidence-based practices. And I try not

to use this word often, but I think we failed at the whole science to services cycle and the fact that, frankly, that's supposed to be a cycle that has a 360 degree turn, which we have more traffic circles going off of it than we do have one complete circle. And I'm concerned about making sure that promising practices come up as part of that and the research is done on communities of color and other communities to make sure they're specific. At the same time, I worry that sometimes we'll dilute EBPs so much in order to make them PC, which is, of course, not what we wanted to do either.

So, sort of it goes to the values that you laid out, those value propositions, and I'd love to see a fifth on there that we do the best we can with the best we know that we make accessible to everybody and customize, and I'd love to see that as a piece of that stained glass window.

And, specifically, this is an idea I put out years ago, and I couldn't have laid it out better now than you have for me Amanda, but I'd love to see some sort of low money, low demand, but some sort of technical assistance resource that is provided to NREPP interested programs.

I still think NREPP is one of the best things SAMHSA has going. I was thrilled to be able to be someone, when I was at SAMHSA, to put money in there to see it, bring it to mental health, and see CSAP pick it up. And the idea that we have brilliant people that work in our field that do this, how do you take a program and help shepherd it through to see it become?

And we just don't have the resources for everybody to keep wondering what's out there on X population and what works. And so, some sort of a mini swat team approach to here's two or three competent people that can go into Arizona, look at a particular program, see what it would take to get it NREPP-eligible, shepherd it through the process in sort of a learning community approach, not spend millions of bucks, not have to put an RFA out to do it, I think would be a great idea. So, I just want to offer that up again as something for your consideration.

I'm interested in your thoughts about EBP in the science service cycle, too.

ADMINISTRATOR HYDE: There are lots we can say about this, and there are other hands up, and the time is

running out. So I don't know if you want to just continue this conversation, but I got to go, and John's here, and other people want to talk.

MS. ENOMOTO: I want to let Starleen make a comment, and then I'll let you have a last word in the wrap-up.

ADMINISTRATOR HYDE: Okay.

MS. SCOTT-ROBBINS: I know that we can talk more about this with John, but around the health care reform and the use of the block grants, there are a number of states who have rather robust Medicaid programs for mental health and substance abuse. There are a few out there, and I think that SAMHSA could actually have an opportunity to learn from those states because we have in North Carolina a nice continuum of mental health and substance abuse services that are supported by Medicaid, and so, we have actually been using the block grant in ways that there are still gaps in the Medicaid system. So I would hope that you would look to the states to get some input about the use of the block grants in that situation.

ADMINISTRATOR HYDE: This is a great segue to Mr. O'Brien, who is here. I told them, John, that they

couldn’t ask any questions about health reform until you got here. This is great input. Thank you very much.

MR. O'BRIEN: (Off microphone.)

ADMINISTRATOR HYDE: Yes. I would love to stay and talk to you some more about these issues, but please keep raising issues throughout the day in whatever context you’re talking and Kana and the other staff here will take that and bring it back and we’ll keep going. So hopefully, they’ll be a paper out soon that you can respond to, and then you’ll get to do real edits.

So, thank you.

(Applause.)

MS. ENOMOTO: Okay. We’re going to take a five-minute stretch break and then come back and start right at 11:00. Thank you.

(Recess.)

MS. ENOMOTO: So we are very lucky to have John O’Brien who joined SAMHSA in March and definitely hit the ground running. He can tell you himself.

We actually changed his title. It had been senior advisor for health reform, and then we thought no, we better just make it for financing in case the health

reform doesn't pass, and then by a great stroke of luck and political genius, health reform did pass, and so, John is our senior advisor for health reform and financing, and he’s here to talk to you a little bit more about the initiative.

Thank you.

MR. O'BRIEN: Thanks, Kana. Well, again, thank you for having me here. I really do welcome any time I get to talk a little bit about health care reform, and I have more than two minutes to talk about it. So, I’m glad you can indulge me a little bit.

As Kana said, I came in mid-March. Just to give you a little background, I had dinner with Administrator Hyde on January 15 of this year, where we talked a little bit about the possibilities as it relates to health care reform, and perhaps, even thinking about coming to SAMHSA for awhile. Five days later, that Tuesday, we had an election in my great State of Massachusetts, where we weren't so sure what health care reform was going to look like, and I had this oh, darn moment where I called up Pam and said now what do we do? And we said well, there's always parity. I was like that's true, there’s always

parity. I said, but there was something that I instinctively knew was going to come out of the sausage-making process that I think we were going to like.

So I decided to take a leap and to come to SAMHSA and to do this, and as Kana said, one of the first things I was struck about being in D.C. versus living in rural America was that your first 25 channels on TV are completely related to news and reruns of news. I mean, who could think you'd see Diane Sawyer three times in one night, but you do. But it was terrific because I always felt like even when I didn't quite know what was going on, I could probably find out what was going on, and it was really an exciting time for that first week, and it's now been an amazing time the last 9 or 10 weeks that I've been here.

So the good news is health care reform got passed, the better news is that behavioral health has some front and center places in health care reform, which I'm not so sure would have been the case 15, 18 years ago, when this was initially tried.

So, kudos probably to most, if not all of you, because my guess is you had some hand in making some of

this happen.

There are 453 provisions in the Health Care Reform Bill. I was going to talk about each one of them, but Kana told me I could not. So, I boiled them down to the ones that I thought were important for this conversation. I want to talk a little bit about those provisions. I want to talk a little bit about the impact it has, I think, on our field and to SAMHSA, and then I want to talk a little bit about what SAMHSA is doing as it relates to the health care reform piece.

So, here are the big provisions, and I apologize if there are other big provisions out there. We haven't time to talk about those, but these are the ones that I think are keeping me up at night, other people up at night, even though they are many years out.

The expansion of health care is critical to the law. As you may or may not know, there is going to be an additional 32 million people covered by the bill. That's the hope. Half of those people are going to be in the newly-eligible group, which is those individuals who are under 133 percent of the federal poverty level. They are, in some respects, a fair amount of the individuals that

come to our service systems seeking free help, and when we got the money, we can see the money, and when we don't, sometimes we see them, but for all practical purposes, they're the target for what folks are calling the Medicaid expanded piece of the Health Care Bill.

The other provision, and these really are multiple provisions around expanded options around home and community-based services, and it's not just about the traditional ways we've been thinking about home and community-based services; there are some changes in Medicaid around some of their waiver programs or their state plan programs which are good, some of which I know are still a little controversial, but I think the important piece here is that prevention is identified as a Medicaid-coverage service, and I think for many individuals, that will be a very important piece of the things that they can get if the state chooses to cover them.

The focus that mental health and substance abuse services are important in the health care delivery system is crucial. Unlike many other bills where there's a fair amount of kind verbiage or sections that are specific to mental health, most of the time that they talk about mental

health and addiction services, it's in the context of looking at the individual holistically, looking at the system holistically so the relationships between mental health and substance abuse and primary care. Again, it's not only that we were mentioned 50-something times in terms of mental health, addictions, or preventions, it's the context that we were mentioned in, I think, that is critical because it really does set the stage for what's our work as we move forward? It's not just more of what we do. It's some of more of what we do, but so more of how we do that differently and different with other players.

Continued efforts to share information between providers to ensure better care and to eliminate inefficiency. That's code for a number of pieces in the legislation that talk about the need and the desire to have Electronic Health Records and other ways of being able to communicate with individuals, with their family members, and amongst providers that are efficient and make sure good care happens. And then certainly in a number of pieces in the bill, the continued mantra that we saw in the Parity Act that really emphasize that mental and substance abuse conditions need to be treated similar to other health care

conditions.

So, those are, again, some of the major provisions that are really impacting some of what we're doing as it relates to some of our immediate work.

So, what's the general impact? More individuals will have health coverage. That's the good news. Again, based on the 32 million new people who will get coverage, there's a range somewhere between 4 to 6 million of those individuals will need some mental health, some addiction services, which include prevention in that, as well.

Benefits that are in the bill include mental health and substance use disorder services. I think I've got it down now in terms of where the major benefit parts are. A lot of them kick in on January 1, 2014. There is a benchmark benefit that is going to be available to those individuals who are newly-eligible, 133 percent of the federal poverty and below. There will be the essential benefits that will be available to those folks that participate in the heath insurance exchanges, and we can talk a little bit about that.

And then in a number of the provisions, they talk about home and community-based services. They have

discreet grant programs, like the school-based health centers that really do say if you're going to be a school-based health center, you have to provide this array of mental health and addiction services. So, again, a major impact of some of what's in the law. I think we're up to five different opportunities to be able to have ways to integrate primary care and mental health and addiction services.

As you may know, we were in the legislation. In order for us to expand upon what we're doing relative to primary care and behavioral health integration, the Centers for Medicare and Medicaid Services, in conjunction with us, are to develop a health home program. AHRQ is responsible for also doing a medical home program, and then HRSA is also doing some work in charge with--actually, it's two bits of work; that's why we're up to five--around some integration between mental health, substance abuse, and primary care. And if I forget to talk about what we're doing around that, remind me because I think it's really important. We being SAMHSA and the coordinating role.

Policy decisions are moving at warp speed. Now, I could do a show of hands, but I would assume that it's

going to be everyone in the room, in terms of whoever's worked in any level of government, state, county, federal, wherever, things don't move at warp speed, and there's the plus side of government that sometimes because it doesn't move at warp speed, you tend to have some more thoughtful discussions. Not better decisions, more thoughtful discussions.

But, in this case, I have to say that I get a chance every now and then to sit at the big kids' table, that's like where Pam sits and Cindy Mann sits, and they talk about some really meaty issues that has to get decided in short amount of time, and the level of brain power in those discussions gives me some comfort when I kind of come back here and either explain it or know that a decision's being reached because it's good information they're basing a decision on or at least guess what, it's good enough for right now, and if we need to go fix it in six months or a year, we're going to do that. So understand that it's a way of doing business in government that's very different than what I've seen before in terms of having to make those decisions quickly.

They're under pressure to make those decisions

quickly because there are specific timeframes in the bill that they have to meet in order for--legally, because it's in the bill, but also let's be clear, there are a number of people who really want this to succeed, and there are others who probably don't. And so, missing a mark would be a good reason of a little bit about a got you of why we're running behind on this, and so the pressure is on. That's the point.

And I think, frankly, the changes in both benefit packages, as well as some of the other pieces in the legislation, allow us to kind of rethink of what we're buying. Under the block grant, under our discretionary program, we have to; we can't just operate in a vacuum. And Starleen, you were getting there in terms of kind of what is it that we know that we can use our block grant for in terms of wrapping around individuals, wrapping around communities that makes sense, but that's the kind of rethinking we're going to need to do as part of health care reform.

So what's the work that needs to be done? And I'll talk a little bit about some of what we're doing. Obviously, preparing the field to expand access. We know

that we're not serving the number of individuals who are seeking treatment, much let alone need treatment. And some of that directly is related to the number of people that we have being able to deliver services, which is directly related to the resources.

Well, we'll have more resources. We won't have everything we need, but the point is we're going to have to find out smart ways of increasing capacity to provide mental health and addiction services. And some of it will be kind of the same old, same old that works, which is how do we recruit, retain, and retrain in order to be able to provide the services? Some of it is also the use of technology in delivering services, which I think is going to be incredibly powerful over the next 10 years.

In addition to things like telemedicine, there are a number of things that are being worked on as we speak that have to do with Facebook and Twittering, neither of which I do, but are really relevant to folks who are 18 to I won't go up that far, but for a generation of individuals who that's the way that they communicate. And so, in order to be able to engage them into services, in order to engage them to continue to make the most out of what we have to

offer, we have to use their technology as part of whatever we do to be able to get those services out to them.

Accessing and developing strategies to improve infrastructure. We know that there are a number of our providers out there that do good work, but they have not had much experience with having to deal with Medicaid third-party insurers. So we need to work with them, and we've got some strategies where we're working with the provider associations on how to improve their plumbing. It's some basic things that they can do now at least in order to be able to convert what they do as a service into a bill, into a payment, and hopefully, a way that they can keep their payment.

Some of the things that aren't going to go away under this is there will be continued pressure on those types of providers to figure out how to generate a bill, how to do it electronically, how to work their accounts receivable so they make sure that they get paid, or if they don't get paid, try to get paid. And compliance. Compliance is not going to go away. And again, people are very concerned about it and we've got to support them.

And then, last but not least, facilitating

linkage with primary care and other providers. We have some programs in place that have that as a goal. We will need more programs to be able to do that. I didn't forget the five programs that are in the bill or five responsibilities in the bill around primary care and behavioral health integration, medical homes, health homes, all those languages.

We're convening a group in the next two weeks so that we're bringing the agencies together and say okay, we can either do five separate initiatives and figure out how to do this five separate ways, or we can figure out okay, let's come up with a couple of initiatives that make sense, that have behavioral health throughout them. We think that that's important. They're looking to us. I will say that both CMS and HRSA are looking to us to say okay, if we're going to do primary care and behavioral health integration, how should we do it? What are the models, or at least what don't we want to do, and have asked us and tasked us to come up with that.

This next bullet, I was called old on this by a younger staff person. Identifying service that comprise a good and modern mental health and addiction service system.

Now, let me tell you what I mean by good and what I mean by modern because once I explained it, she said you sound like an old pharmacist when you talk that way.

But we were tasked, again, and I mean we were going in this direction anyway. We were tasked by other HHS agencies that said okay, what is it that we should buy up there in terms of mental health and addiction services?

In conversations with them, what we decided is that we would put down what is a good system. Not an ideal system. We can do the ideal, but we know where we're at right now. Let's identify what is good and what is modern, meaning it's not necessarily going to include those things that we were buying 10, 15, 20, or 30 years ago. It needs to reflect what needs to be bought now and maybe for the first five years, the next five years because it should change.

So we're doing that because it's foundational work. It's foundational work for us to make changes or make some decisions around how we might want to think about using our block grants. It's certainly going to be the foundational work that we hope will be used in some decisions around the benefit packages.

It will be used even now in terms of making some decisions about state plan amendments. Renata and I were just talking about some conversations between states and CMS around different types of services and whether or not the service a state asks is a service that they should buy, and right now, they're relying on kind of their own instinct about whether or not that makes sense, and it's time for us to step up to the plate, be the expert, say this is what we think right now makes sense. We know not everyone is going to agree with us, but we have to go out there and do that because someone else is going to do it if we don't define it.

And then the block grant spending. Again, some discussions and now actions around having a planful process around block grant spending that includes both some good work internally, but working with our stakeholders, the national state associations around that, and other groups so that we're planful about this.

Everyone is treating January 1, 2014, as kind of like the date. We're going to have Medicaid eligibility; we're going to have the exchanges in place. Turn of the switch, great. I'm like no, this is a dimmer switch, and

the lights are going up, folks, not down. It's a dimmer switch because we're going to have to start turning the switch up sooner rather than later to prepare states and communities and individuals in order to be able to make that transition, whatever that transition looks like.

And we also know, I mean, the good news about being in Massachusetts, despite whatever you think about the election, is that we've had health care reforms for now three years. It was not pretty when we turned on the switch. People did not know whether or not they should enroll in Medicaid or whether or not they should go with our health exchanges. People did not know what benefits they were or weren't available for. Providers did not know how to get in a network in this exchange or become into the Medicaid network. So there are a lot of things that happen a little bit before January 1 and well after January 1 that we have to account for.

There are also a lot of changes that have to occur at the state. We know that if there are changes that we recommend, sometimes you're going to have to make changes in your regulations, sometimes you're going to have to make changes in your information systems. We're just

going to have to be planful. That's my point.

And then here are a few other things that are about the work that needs to get done that we're working on now.

Developing additional services that can be used for the exchange. One of the things that we're doing in terms of defining this array of services is certain services are kind of yet to be defined because we, as a field, kind of sort of have a sense of what they are, but it's time to get a little clearer about the definition, especially as it relates to prevention recovery services, consumer operated services, and wrap-around services. And so, we're going to be doing some work internally and then with our stakeholders in terms of drilling down on those a little bit so that we can be clear about we need, at least initially, about some prevention services. It's not the exhausted list; it's what we mean Version 1.0 right now around prevention, recovery, consumer-operated, and wrap-around services.

Supporting states' providers, individuals, and families to understand the changing environment. We are going to get some information out on some basic concepts.

We have to have people understand what an exchange is. We have to have people understand what a high-risk pool is. We should have people understand what a medical home is or a health home is. There is lots of confusion out there. So, we're invested in getting that information out there now.

SAMHSA is an active participant in all the HHS health care reform workgroups. There are seven workgroups. There are more subgroups that are forming, and we are on each one. I will tell you, again, the good news is that we've got a fair amount of people going to those groups who are informed and making decisions collectively about both mental health addictions and prevention.

From my perspective, it's getting a little overwhelming for me. I'm like oh, my gosh, there are like 30 workgroups that got to pay attention to what are the big policy issues because we don't want to go get an oops on a big policy issue just because we're moving too fast.

And then there are a number of places having to do some specific work around some of the other provisions in the bill that are assigned to us. Some work with HRSA around post-partum depression, and then the centers are

excellent for depression. There's another one in there about health homes and our work with CMS, as well.

So generally, kind of what we're looking at, what we're doing right now. I'll entertain questions.

MS. ENOMOTO: Renata?

MS. HENRY: So, when you mentioned that SAMHSA was collaborating with five other agencies or maybe it's five agencies are collaborating around the Medical Home Program, primary care integration, I'm assuming it's SAMHSA.

MR. O'BRIEN: SAMSHA, it's HRSA. HRSA has two of those.

MS. HENRY: Okay.

MR. O'BRIEN: CMS.

MS. HENRY: Okay.

MR. O'BRIEN: And A-H-R-Q, ARHQ. And if you ask me what ARHQ means, I'm going to blow it, and so, someone else--Agency for Health--

MS. HUTCHINGS: Quality.

MR. O'BRIEN: Quality. Thank you.

MS. HENRY: Right. Okay.

MR. O'BRIEN: See, just AHRQ. And I will tell

you that the first meeting is really going to be a show and tell because we have to really understand what we're all doing relative to that. I mean, for some of you who have been or are in agencies, part of it is just having a baseline of understanding what you're doing, what are your time pressures so we collectively can help you triage some of your time pressures? This is when it's really helpful to have time pressures because sometimes when you say is there something we can do to help, people at this point in time are saying do this, and that's helpful.

MR. O'BRIEN: Gail?

MS. HUTCHINGS: Is there any update on the parity that you can publicly provide?

MR. O'BRIEN: On the suit itself?

MS. HUTCHINGS: Or the status and timeline, if we know of any?

MR. O'BRIEN: I don't have the most up-to-date information on it. I mean, what I have right now is just kind of where we're at in the process with the comments.

Now, this isn't around the lawsuit, but around parity itself. The comments to the interim final regulations were due earlier this month. They are now all

in. We are now in the process of working with ASBE, CMS, Labor, and Treasury around going through those comments and trying to figure out how to respond to them. So I think it's going to be awhile on that piece.

We are still awaiting the parity regulations as it relates to Medicaid and Medicaid-managed care. Those were a separate set of regulations. We don't have a due date on those. And then I will find out though now that you remind me kind of what the status is. I saw our legal counsel, and I forgot to ask last week.

MS. HUTCHINGS: This probably goes without saying, but every time you think something goes without saying, then you just say it.

MR. O'BRIEN: Say it.

MS. HUTCHINGS: Having spent just this week some time in a state system, a mental health system, we have so much work to do to remind people that the parity legislation included addictions, thank goodness, and what that really means. Mental-healthers have been talking about it for a long, long time. Of course, we wanted to see addictions in years ago. It failed on both sides. And now that it passed for both, so I'm hoping that we can work

together and see some leadership out of SAMHSA about sort of translating that at an operational level, what does it mean for provider and his or her clients now that parity is coming for addictions in particular and then, of course, co-occurring and on the mental health side, too.

MR. O'BRIEN: Okay. That'd be helpful. Okay.

MS. HUTCHINGS: But it just seems that title stops after it mentions mental health.

MR. O'BRIEN: Yes.

MS. ENOMOTO: Renata and then Susan.

MS. HENRY: Just one other suggestion in reference to when you said state systems, it reminded me that State Mental Health Authorities and State Substance Abuse Authorities, whether they are combined or not, are going to be having to respond to this, so what SAMHSA might want to think about is how they know what states are doing so that as states prepare, organize, they can be an example for other states because they'll be some states that are early adopters on this, states that are already doing things, states that are already organizing, and that could be very helpful to other states.

MR. O'BRIEN: Agreed. I want to piggyback some

on your comment in a conversation we had earlier today, which is if you just look at what's reported around--and I'm going to pick on the addiction block grants because that's where we have the most information, you would say well, you're not really providing any recovery services. Well, the reason you don't see it is because you don't ask for it that way. And the fact remains that we know that some of you, a lot of you out there are actually doing, at least to the block grant, using some of that money for recovery services. So, that's number one.

Number two is let's take some of the folks that had been doing it and help with some learning sessions with some of the other state agencies so that, number one, they know they're not alone, number two, that there is a bit of a roadmap, and then number three, there are smart people out there that can help them. Good suggestion.

MS. AYERS: Hi, I actually am from Massachusetts, as well, operate an agency up there or have for many years, that really addresses the needs of children and families. So, you've probably been involved with the Rosie D. Lawsuit.

MR. O'BRIEN: Is that a setup?

MS. AYERS: No, not at all, because I probably should have met you someplace along the line and I haven't, so but I've been close to that.

What happened in Massachusetts as we got sued, the state got sued for not providing enough access for children and families to receive services in the community, and it's only Medicaid. It's under the EPSDT, whatever it is.

MR. O'BRIEN: No, no, you got it right.

MS. AYERS: Yes, okay. Good. How? Wow. So, this lawsuit was filed, the state lost, and now, finally, Massachusetts, I feel like, is catching up with the rest of the world when it comes to where are you trying to invest your money, which ought to be, in my mind, in the community because there are not many community services because it's very hard to sustain an agency offering these services.

So, there are a couple of issues with it. The good news is the leadership has really tried to use this as a way of bringing together all the child and family-serving agencies so that we don't have one more silo and we're trying to be able to have this offer some kind of more integrative approach, but I guess my two pieces are, one,

the private insurers are not even considering buying this robust set of offerings in the community. We built these systems in the community now, and are pretty good at doing a lot of community-based intervention with families and whatnot, and the private insurers are just not at the table, and I know our commissioner at the Department of Mental Health is sort of beating on them because she came out of that world and they're still not showing up. So, I don't know whether this goes back to whatever the parity lawsuit piece is or not.

And then the other piece that I'm interested in is as people and states, again, in Massachusetts, have thought well, we're going to get the Medicaid dollars to pay for those services. Other dollars are withdrawn from the community that are used to sort of support the surround sound so that you actually can do something more than just a 45-minute hour. And, so all the flexibility goes out of the system, and there's not a lot of flexibility in the Medicaid dollars, although I know they're to become more flexible.

So, I worry about how we're all thinking about moving this huge shift of dollars because then they'll have

to be the match, the huge shift of dollars into Medicaid, and then where are the rest of the resources going to come from for the private payer and also for the other flexible services that need to build around that?

MR. O'BRIEN: Well, I didn't want to be flippant, but about the Rosie D. remark, it's just that I was the monitor's right-hand person for the last two years. Karen Snyder is fabulous. Yes, she's terrific. So, it's actually, I think, one of the most fortunate events, frankly, that's happened in Massachusetts. A very expensive event, but, nonetheless, it was time for that expense.

So, let me try to address a couple of the things that you just talked about.

One is I think we have to be concerned. I'm going to go from back to front in terms of your comments. We have to be concerned about assumptions, I think, that are being made now at all levels of government about the extent to which health care reform is going to fix what's not right, and mostly in terms of fix what resources aren't currently available for the things that are needed. And if those assumptions are that we're going to have a pretty

robust benefit package, whether it's for the newly-eligible Medicaids or for even just the exchange folks. I won't even do the private insurance folks yet.

I think we have to temper people's expectation and say we don't know what those services are. Most of the language in the bill references services that are similar to federal employees or similar to what's called benchmark plans that don't include the kind of robust case management that kids with SED and their families need. Don't include family partners, don't include in-home services, don't include crisis stabilization services. They don't, so I don't think we're going to see those in those plans. I could be wrong, but I think to assume that those will is bad because then what will be happening in a matter of one more budget year is people will start making assumptions around what's going to be covered and then moving the money around.

We saw it in Massachusetts. Literally, once we got the state plan amendment approved in Massachusetts with the new services, the budgets in DMH, the budgets in DSS, which is the child welfare agency around case management, in-home services, things that we were paying pretty much

full freight state dollars from went to another agency or were backed out as part of the governor's effort to have to balance the budget.

And so, I think although be excited about the opportunity, we need to temper what we actually think might be covered. So I think that's a really important point.

I welcome any smart thoughts to have conversations with insurers around some of these benefits. They aren't clear about behavioral health benefits in general, even just the ones they offer now, and I think it's incumbent on us to do things: One is to really give them some good education. Just three things, like what are these benefits?

Number two. Let's talk about the benefits in the same way because if you talk about in-home services and I talk about in-home services and Gail talks about in-home services, and we don't do it the same way, it confuses them.

And then the third piece and I think this is the most important piece. I walked in on this conversation at 10:45, but we are going to have to make sure that we have some information about the efficacy of what it is that

we're asking them to buy. And that's where it gets hard. Now, we have some good information out there. We need to use that information. We're doing things that we think kind of work. We need to get information to make sure that we know that they kind of work. And then there are some things that we know don't work, but we keeping buying. We can't ask them to do that.

So, I mean, I think we can't just stop once we feel like we've done a nice job on Medicaid and the exchanges. We have to talk about the private plans.

MS. ENOMOTO: Starleen and then Renata.

MS. SCOTT-ROBBINS: What we also have to do is a very good job at educating our other partners about addiction. This is not the time to go back to the 28-day model. It wasn't the fix then, it's not the fix now. It is a chronic disease, and people need to understand that and that we're not talking about purchasing six or eight weeks of treatment, that we are talking a chronic disease that needs a like response.

So, I think this is a real opportunity as SAMHSA is sitting at the table with the other partners to be sure that that message gets across, that we're not in a place

where we want to put the Band-Aid on, that we want to help people take that journey into recovery and not just give that little shot that's going to stop it for a moment.

MR. O'BRIEN: And if we're going to ask other partners to do that, we need to do that ourselves because we do buy a fair amount of that.

MS. HENRY: So, I think it's really incumbent on the White Paper or the paper that SAMHSA is developing about the system, what a good system looks like or be really clear and inclusive of even things that Medicaid doesn't currently cover, but we all know it's an essential piece of a good system, and I think we need to get this concise about that as we can.

MR. O'BRIEN: Yes.

MS. HENRY: Because I would assume that this paper is ultimately going to be looked at by the experts kind of saying this is what the basis of what should be included in a benefit, and so, that discussion about states starting to plan what money that they can take out of the substance abuse and mental health systems because now you have more people covered. It needs to be highlight, but, remember, the benefit as it traditionally has been does not

cover X, Y, and Z.

MR. O'BRIEN: That’s right.

MS. HENRY: So, therefore, that's part of this good system. Then it’s going to be the thinking you have to leave some of that money in there because that either won't be covered because we can’t sell it. So, that's a real critical piece because that planning about what dollars they're forecasting about, what dollars can potentially come out of systems because of reform. It’s taking place right now. Right now.

MR. O'BRIEN: Yes, yes.

MS. ENOMOTO: Britt?

DR. RIOS-ELLIS: When you were talking about what works and basing what works, we were having--you probably came in on this discussion of evidence-based practices, and I would just love to see something about what works and for whom, right? So we really know clearly who this model has been tested on and who it hasn’t been tested on.

MR. O'BRIEN: Yes.

DR. RIOS-ELLIS: And who has been involved in the development of it and who hasn’t been involved in the development of it because I think for so many times we’re

really trying to wear pants that are too big or just don't fit.

And the other issue that I think that is really important in terms of working with this, and I know it's a really uncomfortable issue, is the issue of mixed families, because within the Latino community, we have so many families, and there was just a study that came out that said over 50 percent of immigrant families have some level of mixed within them. So if we're treating one member of the family who's documented and eligible, there's another member of the family, sometimes a child, who's undocumented, and just keeping that around what our best practices look like.

And in Los Angeles, this is just so, so commonplace. There's one child who's eligible for this, there's one who isn't, or the parents are eligible, but went back to Mexico and had their kids there and the kids aren't.

So, all of these issues I hope somewhere would be mentioned.

MS. ENOMOTO: Renata and then Susan.

MS. HENRY: Just one of the estimates that SAMHSA

has, the 5 to 6 million individuals of the newly-insured, that 5 to 6 million of them. Any work being done to kind of say what does that mean for Alaska? What does that mean for Maryland? What does that mean for New York? I think that would be helpful in guidance for states.

MR. O'BRIEN: Yes.

MS. HENRY: Some estimates.

MR. O'BRIEN: So, yes and yes. We've actually tasked our Financing Center of Excellence to give us a projected state-by-state breakdown based on the formula that they've used, and I will say we decided to be conservative just because it made sense to go in that direction.

I do need to say one thing, and then we can go to the next question. Something that's happening simultaneously this morning is that Kaiser is releasing a report about the impact of health care reform on states individually and collectively. Let me just say it. One of the things that they didn't do was to include what were some of the cost offsets around providing health insurance, and so the dollar amount that is going to be presented and discussed I think is going to be problematic and

challenging.

So, it may be that there's some event today that kind of overshadows that, but there is some concern. And so, to the extent that if people talked to you about that over the next days, weeks, months, first of all, take a look at the report, but second of all, understand that there are some things--and they fully noted that it doesn't include some of the offsets that were presumed when some of the other projections that were done. I'm sorry, that just came to my mind.

MS. HENRY: I think that's good to know because it will be the argument of why you shouldn't or it shouldn't include this.

MR. O'BRIEN: Yes.

MS. HENRY: Or why we need to get on the lean side more.

MR. O'BRIEN: Yes.

MS. HENRY: So that's good to know.

MS. AYERS: I just wanted to tag-team with Britt about mixed families. I wasn't quite sure what she was talking about in terms of which mix we're talking about, but we have many families where the child has Medicaid and

the mom doesn’t, and we’re always in that bind. That we’re always trying to find a way around, like what do you do because there isn’t the right kind of code to be able to bill under. So, it’s very difficult.

Now, I don’t mean to be facetious. Is there like a site where you can go and find the latest research on what doesn’t work? I don’t mean to be facetious, but I’m hearing more and more well, we buy a lot of stuff, that it’s been proven over and over again doesn’t work. It would be really helpful to kind of know okay, well, where is that research that we know that X, Y, or Z doesn’t work. So, I should probably Google what doesn’t work. Maybe it’ll help.

MR. O'BRIEN: You mean the non-NREPP?

(Laughter.)

MS. AYERS: Yes, there you go. Does anybody--

DR. COVINGTON: Well, not exactly, but I can tell you this: That if people give their materials to NREPP to go through that process, if you fail the process, you are listed on NREPP as someone who failed the process. Now, but most of the things, by the way, to even--I mean, this whole thing about evidence-based practice is such a

nightmare. In order to even go through the NREPP prep process, you have to have randomized control studies and at least two peer review journal articles to even get into the process.

MS. AYERS: Yes.

DR. COVINGTON: But once you're in the process, you sign that says if your material is--

PARTICIPANT: Rejected.

DR. COVINGTON: Thank you. I'm trying to think. Discard, but rejected, thank you. Language barrier. If it's rejected by NREPP, you are listed as an NREPP reject. Now, that doesn't necessarily mean it doesn't work; it just means NREPP, because they have a very small, tight criteria, and but I think there will be more discussion on evidence-based, but that's the only thing I know of. I think you have to talk to practitioners, people in the field about what's working and I don't know why we continue to use things that don't work.

MS. AYERS: Yes. I mean, I don't disagree there's a lot of stuff out there that's a waste of money.

DR. COVINGTON: Yes, absolutely. Absolutely.

MS. AYERS: But it would be nice to be able to

start marshalling the information on those particular things. And then I'd love to have a whole session on evidence-based practice in a future meeting.

I think it would be fun to do that because certainly, again, as a community provider, it's so expensive to be able to pull your staff offline even to be trained. I mean, we've got John Weisz, who I love and adore, who has done a ton on research on working with behavior modalities or whatever, and he's more than willing to do X, Y, or Z, but when we costed it out, we can't afford to do that. It's just not possible, and so then when you even figure out how you could afford it, then you've got so much turnover in the system because the salaries are so bad and the sustainable business models are so not sustainable or fragile, it's just that when you look at the special, big, federal things and you go wow, there it is, let's go get it, it's a long way between there and here.

DR. RIOS-ELLIS: And along that, I think that, as Amanda was saying, seed dollars for training, seed dollars for--I don't even say evidence-based practices with my community because it just isn't a good thing, and it will

wreck the whole meeting. But I think when we talk about culturally-relevant successful strategies and different things like that and whether that meets criteria or not, that's the dialogue that we're using now. But I think that would be something that would be so important because I think we share, I think there are things that are shared, I think that they're community-specific, and we were just talking about although there are some things that are common, we don't all share the same anatomy. So, we can't always think that the science works.

And I guess I should specify this. Gail and I were talking about if you're going to have a heart transplant, you want the best science on the heart transplant to be used whether you're an adolescent female or whether you're an African-American, older male, or whatever it is, but there are certain cultural constructs wherein we don't share the same anatomy in terms of these best practices and really defining what that needs to look like for our communities to be able to receive it and for it to make sense to us is something that we just haven't had that dialogue around.

And I also want to make one comment around the

paying structure because I'm kind of worried. I sit on the advisory board for a large, children's clinic, and now a mini children's hospital, and the paying structure in California has been the window, now we're up to 18 months to 2 years to get paid, and we've had to take out loans to be able to just pay staff, and so I'm wondering what that paying structure is going to look like and how quick that will move along or if that's a comment that--

MR. O'BRIEN: Well, first of all, there are federal laws about how soon you're supposed to get paid. So, I believe the federal law is one year. I mean, they have up to one year. If anyone has better reconnaissance. I can find that out. Some states have shorter periods of time, but I believe it is up to 365 days of submitting a claim, you have to have some sort of response back.

MS. AYERS: (Off microphone.)

MR. O'BRIEN: So, two years--

MS. AYERS: (Off microphone.)

MR. O'BRIEN: Yes.

MS. ENOMOTO: Okay, we'll take one last comment from Roger, and then I'll let John kind of sum up. Thanks.

DR. FALLOT: Thanks. I just wanted to pick up on

I guess there's sort of a theme that's emerging here, which is around really listening closely to what's going on, on the ground when you get into the issues around recovery supports and other sorts of supports, especially whether they're consumer-operated or wrap-around services, however they're labeled, because I think it's really part of the dilemma that Susan's talking about when you can't pull somebody off of the work status to get trained in an EBP because they're not able to meet their productivity requirements if they're not doing certain activities.

In our agency, I know that many of those activities are unfunded, but very necessary activities that are offering support of other funded ones. So that if somebody needs to go to a doctor, for instance, they can go to a doctor, but the case management, the robust case management you mentioned, is not paid for for transportation and accompanying somebody to the doctor, only paying the doctor. But it might pay for 15 minutes of the case manager's time, but not for the hour-and-a-half it actually took.

So that kind of thing is really very limiting and a very powerful factor that I think everybody knows about

who’s actually working in these places and can fill you in on, that if you’re not filled in on them in detail. So, just ask.

MR. O'BRIEN: I’m wrapped up. I mean, feel free to contact Kana or myself if you have some follow-up questions. A couple of things I will say, a few things about kind of some previews.

We’re hoping to get the Good and Modern Paper out in the next week. At this particular point in time, I’m willing to kind of throw it out there. It’s Version 1.0. There’s going to be things that people say well, where is it? And we’re willing to have that conversation. That's number one.

Number two is that we are rolling out some infomercials or Webinars on some basic concepts around health care reform that I think our field probably needs to note just some more things about in order to be able to have conversations with their providers, their states, their consumers, and stay tuned.

Again, we’re trying to give relevant information with the caveat that the decisions that we really want to be made aren't getting made for awhile, so we can give you

the best information that we can give you based on where we're at in the process. But stay excited and stay informed. That's kind of what I'm telling people at this point in time.

MS. ENOMOTO: And thank you, John, for that presentation, and I will extend the offer to this committee as Administrator Hyde extended to the National Advisory Committee, which is if you have questions and comments about health reform, certainly, anything can come to me, but I think she's encouraging our stakeholders and our council members to contact the initiative leaves for additional sort of conversation input, thinking ideas that you have.

So, thanks very much, and with that, we'll break for lunch for one hour.

(Applause.)

(Whereupon, at 11:58 a.m., a luncheon recess was taken.)

A F T E R N O O N  S E S S I O N

(1:05 PM)

MS. ENOMOTO: All right, we're going to go ahead and start. Thank you very much for reconvening after a very swift lunch.

Before we get into the meat of things, we have our SAMHSA staff here, our SAMSHA's Women Coordinating Committee to have a conversation with the committee, but I would like to acknowledge and thank all of the people we have making this meeting happen, beginning with Nevine Gahed, our designated federal official, who really does the lion share of the organizing here.

(Applause.)

MS. ENOMOTO: And you see them hard at work as we speak. Toian Vaughn, who heads up our committee structure at SAMHSA and Carol Watkins, who's the DFO for the Center for Mental Health Services. It used to be the ACWS Designated Federal Official who helped with the care and feeding of you all.

We also have a number of technological people who are making the miracle of the meeting happen on the Web. So beginning with our videographers is Mark McKittrick, J.D.

Mack, Brad Gentile, and Adam Kelly. So thank you to you guys for making sure we're all well-lit.

(Laughter.)

MS. ENOMOTO: Just kidding. Just kidding. Our Cabezon folks. Katie especially I think has been involved with everyone, and also Theresa. Christine on the transcription, and Irene Goldstein, who's been our writer forever whom we love and makes as all sound a little bit better than we really are.

(Laughter.)

MS. ENOMOTO: So, thank you to those folks. And we don't have them in the room, but they are out virtually somewhere listening to us. So wherever you are, Ed Hieronymus, Jeff Ruffing, and Nick Balte from Verizon and Chorus Call, thank you very much for making sure that technology is working, and we're probably as smooth as any of these meetings have ever been. So I think together, we have a system down. So, thank you very much. Also, our SAMHSA IT Team, Michael Mclendon and Maron Selby have been flawless in this process. So thanks a lot to everyone.

And with that, we will open it back up to this dialogue with our SAMHSA Women's Coordinating Committee and

our Advisory Committee members so that you have a sense of kind of the activity that's going on here at SAMHSA and have a chance to give us your input and your ideas.

So we have CMHS and CSAT and our Office of Policy Program and Budget representative. We don't have a CSAP person. Nancy Kennedy was going to join us online, but she's not able to today. So, I'm going to start it off with Susan.

MS. SALASIN: Hi, I'm Susan Salasin from the Center for Mental Health Services, and the one activity that it was suggested that I give you, just a brief overview of, though some of you will be familiar with it because you were actually present at it, but it's the federal roundtable that we sponsored through the Mental Health Transportation Program that was established as a federal interagency group about five years ago after the president's New Freedom Report came out and Kathryn Power become director of CMHS, and it was established as part of that process.

And they have had a number of committees going for the five years: Employment, Suicide, several others, and made a decision about a year ago to add a couple of new

committees, and Women and Trauma was one of them. And I was asked to kind of pull it together and provide some structure and get it going.

We had strong, intense interest amongst the federal agencies ranging from Department of Defense through Labor, through Justice, through Education, through really the range of agencies and membership on the committee, and it was clear that some of them were interested in trauma, but didn't know very much. Others were very deeply involved in, for example, research around it or other issues or aspects of it, and there didn't seem to be a kind of common ground of knowledge.

So we decided to sponsor a federal roundtable, and our plans were really modest at first, really, to draw together the federal partners and who they wanted to invite, and then some key leaders in the field to simply spend a day both in learning from presentations and then discussion in small groups. We expected maybe 30 or 40, and we could have had 500. We had to limit to about 85 because of the room size, and even so, it was pretty cramped.

But the thing seemed to really blossom and

balloon and really gain momentum as it went along.

Stephanie Covington we asked to be our kickoff person, mascot, set the tone for the day, and she did a great job of that. And so the style of panels of three or four sort of expert people on trauma, trauma-informed care, and then some of it's applications across the public health system, and then breaking into groups on a kind of random basis to discuss recommendations, and we know from evaluations that the meeting was a great success. We were looking forward to have a chance to be deliberative and make recommendations. We have had more requests flooding in since that happened than we can even count, and we haven't even met for the first time again yet.

I'll give you just a flavor of some of the kinds of requests that we're getting, and really on a very large scale. There are several states now that are going to replicate the whole process in their state, including the panels, the discuss groups, and in regions of their states, in some cases. Many federal agencies want to write it into their grant and contract requests and really make it a part of the award process and have been asking for consultation. Other agencies want all agency training in trauma-informed

care or program training or training for their leaders. They would really like us to synthesize knowledge around the various cultural approaches because there are pockets of knowledge that aren't being shared by the agencies and the programs now that people believe exist and could become much stronger if it were put together. Sort of developing ways of kind of training professionals to really validate this within professions, and then moving to training the professions.

And rethink screening and assessment. There’s a great deal of dissatisfaction with the way screening and assessment, including all of the available tools currently happens, and there’s s strong feeling about that.

And then the last, but not least, was finding ways in terms of working with staff in these human services agencies to give them a chance to validate their own experiences and to really kind of level the playing field a little more in terms of who has access to this kind of care.

So that, in a nutshell, is what we’re doing, what we’re learning, and we’re probably going to set up various committees out of our committee to handle these various

areas or at least to be consulting on it because we don't want one agency to kind of like just give their prescription and we want to have some agreement amongst a group about how we approach these things.

And, beyond that, Kana asked me to mention that I've been selected to be the SAMHSA representative on the Secretary's Committee on Violence Against Women. Thanks.

MS. ENOMOTO: Congratulations.

MS. AMATETTI: Good afternoon, everyone. I'm Sharon Amatetti, and I'm in SAMHSA's Center for Substance Abuse Treatment, and I wanted to tell you about some work that we're doing really around workforce development. Three initiatives.

The first one that we're urgently working on is our SAMHSA's Women's Conference. It's the fourth national conference on women, addiction, and treatment. It's going to be held in July, July 26 through 28 in Chicago, Illinois. We do this conference every other year, and as you can imagine, we are trying to keep things fresh and new and exciting, and I think they're going to be fresh and new and exciting.

We have a wonderful program planned. Stephanie

is going to be there, Starleen is going to be there, Lisa Najavits is going to be there, and I hope all of you are going to be there, but we have an interesting agenda with many topics that cover all of the priorities of our administrator, as well as a lot of different formats. We're doing the plenaries and workshops, but we also have a lot of discussion groups.

We have things we call invigorators, they're kind of quick hits. We're doing a tease with experts in a very informal sort of salon way, and I think it's going to be a very nice program.

Some big names that you'll recognize, and I encourage you to go to our conference website and look and see what we have planned. It's SAMSHAWomensConference.org. So very easy to find. That's coming up in July.

Other activities that I wanted to let you know about is that we are in the process of organizing our second Women's Addictions Services Leadership Institute, which is a program that we've designed, really built off our Leadership Institute Center, ATTC's developed, but this is a women-specific leadership program, and we felt strongly that women needed a safe place to develop their

leadership skills in a women-only setting, and we've created something for them, and it's for women who are in the addiction treatment field who really have committed their work, their life's work to this area. We're looking for people sort of mid-career who have a long track record and are committed to staying in the field.

And the next one is planned for October. We're right now in the process of reviewing the nominations for this next round. The first round was very exciting, and I think it's going to have a long reach in terms of the commitment of the women that we worked with to really continue to provide leadership to the field. So, we're excited about that.

And then, finally, I wanted to tell you that we're also working on an online course on substance abuse disorders in women, and this a course that is really geared towards newer clinicians, as well as their supervisors. It's going to be free. It'll be on our website. It'll have 10 modules.

It's planned to be about 10 hours long if you take the whole thing, but we'll also have supervisor workbooks and participant workbooks if people want to take

it and use it as an in-person training. You can do it online by yourself or you can do it within a classroom-type setting, and so we're working on the development of that product right now. We probably will be done with all of the development work around this time next year, and then hope to get it launched on the website not too much longer after that.

And I'm doing all of this work with a wonderful contractor, Advocates for Human Potential, and Deborah Warner is the project director there. Some of you may know her. They're very experienced and knowledgeable in this area, so we have a lot of support.

So, that's what I wanted to tell you about. Thank you.

MS. TOMOYASU: Good afternoon. I'm probably the newest member of this wonderful workgroup. My name is Naomi Tomoyasu, and I work in the Health Systems Branch within CSAT treatment, and I was asked to give you a brief overview about SBIRT.

I don't know, probably many of you know what SBIRT stands for. It's Screening Brief Intervention Referral to Treatment. And with health care reform, we've

gotten really, really popular, it seems like, because there is a need to identify and implement cost effective, as well as programmatically effective screening brief intervention in primary care settings. So we've been working with a variety of sister agencies to help their grantees implement SBIRT, and then, also, try to get some information to get reimbursement for SBIRT services.

We're very excited. I have to tell you that this year we passed, as with McDonald's, the 1 million served mark. We screened 1.3 million people in primary care centers, emergency departments, schools, EAPs, you name it, and of the 60 percent were women. So even though this is not a gender-specific, women-specific program, we're reaching a lot of women. And we're finding out that about overall 13 percent of the women score positive on the screens that we use for either hazardous drinking or substance use, and we're providing them with either brief intervention, evidence-based brief intervention, or brief treatment.

We're also excited that we're working with CMS. This was a development that just recently occurred, and we're working with them very closely through their Medicare

Learning Network to provide information across their network of Medicare providers. And they tell me that it's about 100,000 providers. So we're hoping to get the information out on SBIRT. But we have a lot of things going on, but we're very excited about the movement.

MS. ENOMOTO: And when Naomi says that SBIRT has become very popular, there's a conversation going on right now about kind of a trauma SBIRT because we know we have a lot of evidence about what to do when we know people have trauma and they need services specific to that, but we also know from the ACE study and other things that there are far more people with trauma that we don't pick up and who show up with heart disease, diabetes, or cancer and other things and have lower levels of the problems that we generally deal with in terms of mental illness and addiction.

And so, trying to pick up trauma and come up with a model for screening that works and then a brief intervention would fill some of the gap between only getting people when it's quite late in terms of the course of their lives and disorders.

Thank you, Naomi.

MS. MILLS: Good afternoon, everyone. I'm M.

Valerie Mills, and I'm with the Office of Program Policy and Budget, the Division of Program Coordination. I'm going to share with you today just some brief updates on what's happening with the department.

I serve on the Department Coordination Committee for our women's heath. This is an organization I think many of you have heard about through Wanda Jones, who presented at one of the meetings sometime ago. Organization, but I mean committee that's been around for over 28 years.

Anyway, the department presently, along with the secretary, who's been very much involved in the work we've been doing around addressing women and girl issues beyond 2010.

Just recently, SAMHSA, along with other agencies that's a part of the Coordinating Committee, responded to the three action agendas that the secretary would like to address immediately. We've been working with this committee since June of last year. They have received feedback from over 1,000 stakeholders around the country, and there were 7 subcommittees.

I worked directly on the Subcommittee for Trauma

and Violence Against Women and Girls. We have extended a lot of work over the past year, however, the secretary wanted us to address three issues that she felt the department could work on immediately, and those three issues are to commit HHS to an ethics of zero tolerance for violence against women and girls, expand work for its capacity to provide culturally-competent, quality health services for all women and girls, and third, to use data to identify and address differences in health outcomes.

SAMHSA reviewed the document, and we agreed with the initial agenda with some things that we wanted to make sure that trauma and violence is involved, and it is, and also, we wanted to make sure that some other agencies will be collaborated with.

So right now, this is where we are, but, also, you need to know that, in addition to these three action agendas, there are several others that will be addressed around workforce, around violence, around bullying, and around other things. I mean, there is an extensive amount of recommendations made, and I'll keep you or someone will definitely keep you updated on these as the department moves forward.

Thank you.

MS. ENOMOTO: Thanks, Valerie. And Nevine has a couple of updates. Go ahead.

MS. GAHED: We were approached towards the end of the year by the OWH, Office of Women's Health in Region 5 Chicago, and we worked with Michelle Hoersch, who is the heading the office in Chicago for a series of Webinars that they wanted to launch. It was going to be monthly Webinars that are an hour long that would basically talk about women, girls, trauma across the lifespan.

So we've actually been working with them off and on and the whole SWCC Group, the Women's Coordinating Group here in SAMHSA, to update the agenda, to make sure that all the needs as far as substance use and mental health were being met, and to also recommend some of the presenters, and I understand Dr. Covington is going to be one. I know that Susan is also going to be presenting. As soon as we get this going, it should start. The plan is to start in July. So as soon as that starts, I'll be happy to send you the Web links, and you can watch and provide your input on that.

The good thing about this, and that was the

biggest thing that we were talking about, is how many people would they be able to reach via the Webinar because they were talking about possibly 4,000 people coming in, which is worry about crashing the whole system. So we're working those technical pieces in there.

The first of the series is going to be the life course effects of trauma in the lives of girls and women. Part of the A study. It's going to be presented by Dr. Valerie Edwards of the CDC. And I'll let you know how it goes.

The second thing that I have is an update, and I know you've always been interested in the TIPS dissemination, and there is actually a plan. Linda White-Young could not come to the meeting today, so she's asked me to basically just disseminate this, distribute it, and is asking for your input, as well. So if there was anything that was missed for the marketing plan, please let her know. So, we're trying to be responsive as far as that's concerned. Thank you.

MS. ENOMOTO: Thank you. Renata and then Gail.

MS. HENRY: Naomi, on the SBIRT, wasn't SBIRT being required in Level I trauma centers, used in Level I

trauma centers? Do we have any information or data on that initiative? I mean, are they using it? What are the finding? Is it gender-specific? I mean--

MS. TOMOYASU: I'm glad you asked that, because I was going to talk more on the collaborations, but I'm glad you asked. We have been collaborating with NHTSA, National Highway Traffic Safety Administration, and actually, for the last 18 months, we've been doing trainings for Level I and II trauma centers in the implementation of SBIRT, and I believe we've covered something. We've done trainings in about 15 cities across the country, and we've gotten the collaboration of the regional trauma centers there, as well.

We've gotten very good feedback. I don't have the data with me, but in terms of the satisfaction ratings and the interest in learning more about SBIRT, we found that the interest is very huge out there. So, we're trying to collaborate more with NHTSA, the National Highway Traffic Safety Administration, this year.

MS. HENRY: So just as a follow-up to that, in the state that I was in before, we tried to work with--we only have the one trauma center in Delaware.

MS. TOMOYASU: Right

MS. HENRY: And actually, the state authority funded a part-time social worker to help do the follow-up that sometimes doesn't occur because trauma centers are about patching up people.

MS. TOMOYASU: Exactly.

MS. HENRY: And getting them to where they need to go, but there needs to be that follow-up.

MS. TOMOYASU: Yes.

MS. HENRY: So when you do the screening, then what's the follow-up? So, I'd be real interested to find out, look at the data, because I think that's a place that when we talk about reform and linkages with primary care, that that would be a good one.

MS. ENOMOTO: We can get you that data.

MS. TOMOYASU: We can, yes. We started collecting that. About 4 percent are usually referred for intensive care.

MS. HENRY: Okay.

MS. TOMOYASU: So, we can get you that information.

MS. HUTCHINGS: Can I work my way down the row?

So Nevine, thank you for the information, particularly about the Illinois Webinars, and having just been in the state yesterday working with the Division of Mental Health, it's because everyone is so busy, it's often shocking how little time they have to let each other know what's going on. So I think it'd be just a great partnership if SAMHSA could make sure it lets the Mental Health and the Addictions Divisions know of the Webinars and its sponsorship and sort of help sew together the communication in state there. So, that was great to hear.

Susan, congratulations. The federal meeting, I have heard nothing but wonderful things about. And I think we'll hear from some people tomorrow about literally being life changing for some people that were somewhat new. And, A, I wanted to congratulate you and everyone else that contributed to it. I think it was phenomenal.

And two, it reminds me that we have to be so careful not to get ahead of people that might be new champions for us, and there's always got to be a place to go and do some of those original awareness, just basic education.

We'll welcome you to come in with us, and I think

sometimes as we strive rightly to get more and more sophisticated and customize what we do, we forget about people that weren't early adopters or middle adopters or they even miss the late adopters, maybe. And, so go back and do that.

So congratulations. That was very nice work, and I was really pleased to hear about it. I was bummed I wasn't there. I would have tried to crash.

Sharon, and likewise, the agenda for the Women's Conference looks so good, and I know how much work that is, so it's really looking great, too.

And finally, it's a word about SBIRT. I really try to cover the waterfront. I truly believe that one of the reasons that SBIRT is so successful, not only that it filled such a huge need out there at the right system point, but because it has the data to show. In fundamental ways, you know, I love the way it's titrated of how many people, you know, congratulations on the McDonald's benchmark. And then how many people below that are indicated of needing treatment and how many get referred on, and I think it's because of the data and the way it's been able to be out in sort of a plain, straightforward

manner that's contributed to its success.

So I still have yet to get a straight answer on something else. If you are the source, I'll buy you coffee, although, I'm sure it's going to be under 20 cents.

I can't get a straight answer about whether smoking cessation is included in SBIRT screening regularly or not or if it's an idiosyncratic thing. And the reason I go there for the purpose of this committee conversation is I believe one of the things we haven't tapped in smoking cessation and customizing it to behavioral health is gender-specific and age-specific cessation tools, and I can't get much further down that road without people helping me about what do we have? And if it's not in there, I'm calling Westley.

MS. TOMOYASU: He'll be down soon.

MS. HUTCHINGS: Yes, yes, well, I'm calling him out. No, I'm kidding. Totally kidding. So, thank you.

MS. TOMOYASU: Well, I'm glad you asked about smoking. It's not one of those things that we have traditionally tracked, but we have the ASSIST, which we have required. That's the screening tool in the last cohort of our phase, and that does capture smoking, as well

as gender-specific information, as well as age.

And just out of curiosity, since I'm really into data, and thank you so much for the commendation on the data because Dr. Clark, as well as a number of people at CSAT, really believe in it because we always felt that that's what gives us the little oomph in order to show that it works. But we're looking at the data now through our cross-site evaluation project, and although it wasn't something that we have emphasized in our RFAs, our grantees have, and that's one of the things that we're really trying to look at now because of the emphasis in health care reform and prevention services, like smoking cessation. So we'll get back to you on the data.

MS. HUTCHINGS: So, just an early heads-up of what I'm going to say next time I see you and being this warm, is I'm going to be looking to see not only that it's selective on the part of the grantees, the states that they can choose to use us ASSIST, but that's part of the requirement of the program.

MS. TOMOYASU: Yes.

MS. HUTCHINGS: As we talked about the funders getting a little bit more requirement-heavy. And so, and I

understand the flexibility issues. I could care less, but in this case, I'm going to be looking to see that's actually required that they use some evidence-based tool and that anything that we can do to contribute to the gender-specificity of those tools.

So, thank you very much.

MS. TOMOYASU: You're welcome and I'm for it.

MS. ENOMOTO: Great. Anymore comments for our fabulous staff, our team here?

(No Response.)

MS. ENOMOTO: No? Thank you very much. Thanks to all of you for the work that you continue to do for women and girls.

So I have one item of business that I skipped over earlier in my excitement, which is to approve and vote on the minutes of December 29, 2009.

(Laughter.)

MS. ENOMOTO: You've all received the minutes electronically, and they were reviewed to you for your review and comments. They were certified in accordance with the Federal Advisory Committee Act Regulations. You were all given the opportunity to review it and comment on

the draft. You also received a copy of the certified minutes. So if you have any changes or additions, they will be incorporated in this meeting's minutes. So I will now entertain a motion to adopt the minutes from the December 29, 2009, meeting.

MS. AYERS: So moved.

DR. RIOS-ELLIS: Second.

MS. ENOMOTO: It is moved and seconded. Those in favor please say aye.

PARTICIPANTS: Aye.

MS. ENOMOTO: Any opposed?

(No response.)

MS. ENOMOTO: Okay, the minutes are adopted. Thank you, and thank you to our SWC members.

(Applause.)

MS. HUTCHINGS: Kana, while we were backing up and covering things we missed, can I ask something? John O'Brien's slides, I'm sure they're on the disk.

MS. ENOMOTO: Yes.

MS. HUTCHINGS: Okay, I just wanted to double-check. Oh, they're over there?

MS. ENOMOTO: They're back there.

MS. HUTCHINGS: In the back of the room. Okay. Thank you. No, I can walk all the way back there. I'll get it.

MS. ENOMOTO: We have Dr. Trish Getty joining us. You have her bio in your books. She is here on behalf of Fran Harding, who's leading the initiative for the prevention of mental illnesses and substance abuse. So, thank you, Trish.

DR. GETTY: I have one of those voices that I really don't need it, but we'll go with this.

Welcome to all of you, and Fran wanted me to extend her regrets that she wasn't able to meet with you. She had some conflicts, and even though she felt this was a real priority, sometimes, we don't have control over our schedules, and so she was not able to be here. She asked me if I would take some time and discuss with you what is going on in the area of prevention, as well as what the women's issues are and what types of programs that we are implementing within the Center for Substance Abuse Prevention.

To explain a little bit how I'm sure you're going to be talking about the mental health and the substance

abuse treatment aspect, but I wanted to share with you a little bit what we're doing in prevention.

Prevention takes a little bit different approach in how we deal with things, and the priority is to take a look at communities, how do we help communities assess what they're doing, how do we help them take a look at what are the issues, and then select programs monitoring the whole time specifically. Are they effective? Do they work? And what are the outcomes?

We want to make sure that families, schools, the workplace environment, all the entities within a community collaborate and work together to assure that we have emotional health and prevention, as well as to take a look at reducing mental illness, substance abuse, including tobacco and suicide across the life spans, which is no simple task, but we really want to take a look at all areas of a community to make sure that we prevent or reduce substance abuse and mental health issues within the community.

Some of the issues that we've taken a look at and really want to focus on is the cost of what it takes when we do not make efforts to reduce the mental, emotional, and

behavioral disorders, and one of the things that we've discovered and are very concerned about is that it takes $247 billion that are drained from our budgets due to these issues, and the focus, even though we're working at the federal level and we collaborate with the states, the real critical issue is based at the community level.

The annual total cost estimates for youth involved in substance abuse issues is $510.8 billion. I can't even say the word billion. That's a lot of money, and we really want to take a look at how we can reduce the cost, and the way we do that is to improve the lifestyles of the people within our communities.

Nearly 5,000 deaths are annually attributed to underage drinking, and that's one of the areas that I think has been sorely neglected. That is a priority within CSAP is how do we take a look at communities partnering within their communities, as well as with federal agencies, to reduce the underage drinking in our society?

Tobacco use. It was interesting, I was thinking back as I was preparing my presentation, when I first started originally at the state level and eventually at the federal level that within SAMHSA itself, it was like was

everybody was smoking at their desk, and when you wander the halls right now and take a look, I looked out my window at 10:30 this morning. There were three people over by the flagpole smoking. And when you think about what are our successes, and I think that's one of those that really stuck out in my mind is where it used to be universal within this agency, there are now three people standing by the flagpole smoking.

So I think we have successes in tobacco cessation, eliminating people smoking. We have a long ways to go yet, but you're seeing things associated around you. When was the last time you actually smelled tobacco? I had to go to Europe to have that experience. And it's one of those successes that we really know prevention can make a difference, and it's around us all the time; we're just not aware of it.

It is still the leading cause of death and disease in the United States; 443,000 deaths annually attributed to smoking. I can say that my older sister is one of that statistics, and she doesn't smoke, but her husband did, and through second-hand smoke, she developed lung cancer and added to the statistics. We want to stop

that, we want to reduce it or eliminate those types of statistics.

Almost half of those deaths occur among people with mental health and substance abuse disorders. I worked in treatment programs for a long period of time, and we had the debate about while we're helping people with their addictions, with their alcoholism, should we allow them to smoke in treatment programs or not? These are kind of some of the issues we've evolved out of, and now we're identifying that those individuals with mental health and substance abuse disorders, specifically one of the factors is tobacco use.

And, lastly, one of the major concerns that we have is over 30,000 Americans take their own lives due to suicide.

So what I want to talk to you about is the four goals that we have within CSAP, that these are our priorities. These are not all of the things that we work on, but these are the things that are very, very important to us. And our first goal is specifically to reduce and eliminate substance abuse and mental illness nationally. And if you will notice, this crosses the lines of CSAT and

CMHS, that prevention is a partner in working with the other two agencies to reduce and eliminate the issues that we're dealing with.

Also, one of the programs that we're now working on is called prevention prepared communities, and we are working with ONDCP, the Department of Education, and the Department of Justice. It is a joint collaborative effort to really promote a data-driven, strategic prevention framework, and what we're saying is that we need a consistent, logical process for determining what the issues are and working collaboratively so that we could eliminate these problems. The other issue that we're doing is providing comprehensive technical assistance to make that happen.

Our second goal is to prevent and eliminate underage drinking throughout the nation. And, as I already described, this is one of the major problems that we have in our high schools, our junior highs, and very strongly in our college campuses is to really take a look at establishing a comprehensive prevention of underage drinking. This has to be a priority for our communities, for our states, and all of our tribal entities.

Number three is eliminating tobacco use among youth and young adults, as well as to help individuals with cessation. We have a program; it's called Synar, and Synar is a program jointly working with the law enforcement entities within a state to take a look at the purchase and sales of tobacco to young adults. It's been extremely successful, and I think it's evident in the activities that we have. This is where we have really made progress through the collaboration of all of the agencies within Health and Human Service.

FDA is going to be taking over the funding of this starting in the Summer of 2010, and so we're encouraged that not only the efforts that we've made have been successful, but we want to assure that they continue.

We also have a federal tobacco HHS Tobacco Prevention and Control Workgroup, and the agencies that work with that, CDC, FDA, NIH, CMS, IHS, and the list goes on. We don't speak in words anymore, we speak in alphabet.

And goal number four, which I think is a real concern, is the suicide among military families, particularly those that have been engaged in conflict, as well as their families, and members of tribal entities.

And so, we really want to narrow the gap and collaborate with the VA and the Department of Defense to make sure that we provide support to individuals within our military community, as well as members of the tribal entity.

This is all in your packets, so I'm not going to go through it, but it's exciting to see--I think when I first started working for the Federal Government, we worked in silos, and we're now beginning to say this isn't effective, it's not working, but we want to reach across federal agencies and work together individually, collaboratively, and across all programs. So I've listed here all of the various agencies that SAMHSA works directly with in all of our programs and the things that we're working on. I think it's pretty impressive, if you really take a look at the fact that we're sharing responsibilities, we're sharing resources, and we're also collaborating on programs.

What I'd like to do is spend the next couple of minutes talking to you about the specific programs that CSAP is involved in, but focused directly on women's programs. And we have what we call the Service to Science Initiative, and what that means is truly helping local

programs, doing pilot programs at the local level to determine what kinds of activities we can help them improve their data, to demonstrate that they are successful programs, and then take a look at analyzing that data and then sharing that information. So, what is successful in one community would carryover into another community.

The first one, and this is called Stop HIV-AIDS and Addiction Through Prevention and Education, or SHAPE, this is located in the State of Michigan, and the purpose of the program basically is to reduce HIV-AIDS and substance abuse in a variety of populations: minority, homeless, veterans, women, as well as women that are 50 or older.

The second one is called Back to the Boards. It’s located in Oregon, and it’s the Confederated Tribes of Warm Springs. This is helping women avoid having children with SIDS, and they’re using this by moving back to some of the old traditions. If you remember the cradle boards that Native populations had really helping keep children so that they are sleeping on their back, and we have seen a reduction in SIDS incidences through the implementation of this program.

And the last one is the Wise Women Gathering Place. This is in the Oneida Reservation in Wisconsin, and this is taking a look at the women-to-women interaction and support when women are having babies. It's bringing back some of the women through the midwife situation. And this is the one that is near and dear to my heart.

In addition to being branch chief, I have the privilege of being the project director for the FASD Center for Excellence, and we have three subcontracts: One is Project CHOICES, Screening and Brief Intervention, the Parent-Child Assistance Program, and the diagnosis and intervention.

And I just have a few minute left. I just got a notice that I'm short on time. But I wanted to touch base with you a little bit about Project CHOICES. This is offered in WIC programs, in public health programs, in local health care programs, and it is helping women who are pregnant to reduce or eliminate drinking during pregnancy, as well as women that are in recovery, assisting them either through abstinence or use of some type of contraception as a backup so that if they are sexually-active and they do relapse, there is a backup to help them

from having a child that is affected with FASD.

The screening and brief intervention is also within Women Health Care Programs. We've seen a 25 percent alcohol abstinence rate after receiving only 1 brief intervention. This is exciting because women are becoming aware of the relationship between drinking, pregnancy, and having a child that is impacted by Fetal Alcohol.

The last one is the PCAP, and this is a home visitation program that we're using to support women and what they do.

And the last one, this is one of our faith-based initiatives, and these are for women who are returning from the prison or incarcerated environment. It's located in Baltimore, just down the street, and it provides support for women reentering into our society.

So, while I've just given you a smattering of some of the types of programs that we're doing, it's exciting that the focus is on specific women's issues and how we can help women have better lives within our society.

The bottom line of all of this is it's critical that we collaborate both across agencies, but also within SAMHSA itself to move and improve the programs and the

delivery that we have.

And, at this time, I'd like to open it up for questions.

MS. ENOMOTO: Stephanie and then Gail.

DR. COVINGTON: Thank you very much. One of the things that I was curious about in looking particularly at those four points, your objectives in terms of prevention for substance abuse and mental health, I didn't see any mention of trauma, and since we have considerable data now that shows that trauma is heavily linked to substance abuse and mental health, I'm wondering how you're using trauma-informed services as part of your prevention work.

DR. GETTY: Thank you. Trauma is one of those issues that is woven into all of these programs. The assumption is if a woman is involved with substance abuse or mental health, I really believe that it's part of the whole package. And, so while we didn't separate it out as a specific goal, the underlying theme and the assumption is that it is heavily connected with all of those issues. And, so it's not a breakout or a separate focus, but it is part of the focus of every program that we work with.

DR. COVINGTON: So then, when you're funding

prevention programs, are those all trauma-informed prevention programs?

DR. GETTY: Not specifically, no. And I think that's an area that we need to expand into.

DR. COVINGTON: Thank you.

MS. HUTCHINGS: I'm struggling, so bear with me.

DR. GETTY: Sure.

MS. HUTCHINGS: The comments about how successful we've been with smoking have no place in behavioral health, much less in this building. The reason there's three people out at the flagpole, of course, is because it was prioritized that you couldn't smoke in this building anymore, you couldn't smoke on the grounds anymore, and then in the transition, we gave help to all HHS employees to try to help with that. We have done zippo uniformly and sporadically in mental health or in addictions to help with any of that.

So when the national prevalence is a success, I couldn't agree with you more, down to 19 percent, yet, we have 80 to 90 percent of people with serious behavioral health disorders. We are so far from being able to declare a victory on anything that my pulse is racing at the

moment, to be honest. And I not only want to focus on clients and consumers that we work with, but behavioral health staff smoke at the highest rate of any health care workers in the country. Dentists, docs. You name it. And actually, the one bonding experience we ever often get to with our clients is out the backdoor and smoking. And frankly, the last time that I went through a wave of smoking was in an AA meeting. When I went to pick somebody up, you can't get through the smoke.

So I just want to make sure we don't mistake huge upticks in public policy, taxes on cigarettes for people that can afford them, from the days that we used to and still do use cigarettes in inpatient and outpatient settings as behavior modification and reward for people, if you're a good client. We have really one state that I think has taken the most leadership and has regs in substance abuse clinics where you can't smoke, staff can't smoke, et cetera.

So we got to rollback this flag we're putting up the pole until we can get it up there further, respectfully, I suggest.

DR. GETTY: I totally agree with you. I think

that we have made major changes in our society, but we have pockets, which is what I was referring to, remembering when I was working in treatment programs, is that's the one area. It was like well, we need to concentrate more on other things rather than looking at the holistic individual, that tobacco cessation is an integral part of both mental health and treatment entities.

I think we have ignored that, but it is now beginning to come to the forefront, and I think that's where our next battle is, is health care providers, as well as individuals in mental health and treatment settings. Globally, that has been our focus, but we have these pockets of individuals that we have ignored, and I think that next step is really focusing in on those specific populations.

MS. HUTCHINGS: I guess, I agree, and I appreciate it. When we talk about pockets though, we’re talking about we cite the prevalence of people that have behavioral health disorders. They’re not pockets anymore. The majority of the population, yet, we found another way to say how unimportant people are that have these disorders because the one thing that kills them the most, we work so

hard to get everyone in recovery, only to have them die 25 years early from smoking-related diseases. So we have a long way to go, and to say that we've frankly even started it is just inaccurate.

DR. GETTY: Thank you.

MS. ENOMOTO: I know Trish was able to highlight some of the programs that CSAP is doing, but the prevention initiative does cross all three centers. And so, a big part of the CMHS portfolio is about prevention of school violence, suicide prevention, and as well as the promotion of mental health and emotional health as we have it in programs like Project Launch and in upcoming programs that we'll have prevention-prepared communities, which Fran Harding is doing a fantastic job of leading a federal-wide working group with ONDCP and Justice and the institutes at the table where we're going to look at kids 8 to 25, I think, and getting communities to do kind of comprehensive community planning and measurement and then programming to address not only substance abuse prevention, but also mental illness prevention, mental health promotion, and keeping kids out of CJ problems and educational failure, that kind of thing.

So the prevention initiative is really broad. It's for all of SAMHSA; it's not just for CSAP, and I think the tobacco piece of it, the administrator really does want it to be a priority, a focus on tobacco cessation or prevention for our treated populations.

I think she does see that as a major oversight of our field, a failure of our field to address, and I think exactly the thing that Gail just said, we have invested too much in our treatment systems to get people into recovery that we don't want to let that go to waste by not paying attention to their overall health.

So we also have the Primary Behavioral Health Care Integration Program, which has a major focus on overall health. It's a bidirectional integration program where we're trying to get primary care into our community health centers and our substance abuse treatment facilities, as well as getting behavioral health into community health centers. So that's a new partnership that we have with HRSA that's coming out.

The RFA is out on the street right now for a training and technical assistance center, and that will also have a major component on tobacco and overall

wellness, exercise, nutrition, et cetera, so that the folks that we're trying to serve have behavioral health as well as physical health. Thank you.

DR. GETTY: One of the things I find is very exciting is when I first started in the prevention field, we talked primary prevention, which basically is anyone third grade or less, and in some cases, it's not even that much. But prevention was isolated, and we treated it as such.

We're learning a lot, and the goal that specifically says prevention of substance abuse and mental health is truly showing how much we have grown and understanding that prevention overlays all of it, and it's all levels of individuals that are with all of our systems, whether it's mental health, substance abuse, some of the other areas that we've talked about.

Prevention is an integral component of it, and I think we've been mistaken by separating that out, that we really have to look at every component of an individual's life because prevention is intertwined, interwoven with all of that. And the exciting thing is for the very first time, you see up there prevention of mental health and

substance abuse issues, which is exciting for me.

MS. ENOMOTO: Britt and then Renata.

DR. RIOS-ELLIS: And the other question I'm going to ask, which is similar to Stephanie's question, and that is the question of cultural and linguistically-responsive prevention programs, and I'm thinking that that's probably woven in, as well.

DR. GETTY: We do have specific programs culturally. For example, and I'll speak to the one that I'm most familiar with, and that's the FASD. We have specific components for tribal entities, addressing other cultural issues, and I don't have a picture of it, but the strategic prevention framework as a five-step planning model for communities and all of our other entities, in the center is the cultural and societal issues, and it's built into all of those components of the strategic prevention framework.

MS. ENOMOTO: Renata.

MS. HENRY: So a couple of comments. I'm trying to combine all of these things together. So, we have the strategic prevention framework, state incentive grants, and then you focus on prevention of mental illness and

prevention of substance use. And then we have this RFA or RFP out for the technical assistance centered around integration, primarily, and one of the places that a lot of primary care occurs for the people that would traditionally be in our substance abuse and mental health programs is in the federally-qualified health care centers, which serves a large population of women and children because they can do OB-GYN services. So, how to roll all of that together, and it's a clear partnership with public health because while the FQHCs don't kind of report to public health, there's a big public health focus in states.

So, I would ask that some thought be given to how we do that guidance for states on how to collaborate. Specifically with the SPF-SIG, as they do a strategic prevention framework, it now cannot not include, double negative, but we have to include public health and the piece that prevention and wellness play on the primary care side. So, as we do this bidirectional integration, I don't want to leave out prevention, public health, primary care, FQHCs, and how to bring that all together.

DR. GETTY: And this is all a new, innovative direction for us. One of the struggles we've had is when a

state is given a SPF-SIG and they are then working with communities for this collaborative effort, which one of the tenants of the strategic prevention framework is getting communities, all entities at all levels, collaborating and working together. It is a learning process, and it's very, very difficult, and we're not there yet. But that's the direction we're taking, and that's what our primary goal is, is all of us working together. We can't by ourselves. We've tried for too many years. And it's exciting to see, but it's still a very, very difficult process.

MS. ENOMOTO: Go ahead, Amanda.

MS. MANBECK: With regard to the SPF-SIG, I do understand what you're saying, but one of the major problems with the SPF-SIG grant is when it is awarded to the state, the amount that is funneled down to the communities is very limited and it is based on what the state deems appropriate. And with regard to the SPF-SIG grant, that is something that I would really like to see different. Like with tribal communities, they had to align themselves with the state so that state controls their money.

So I understand what you're saying about the

strategic, with the culture in the middle, but when the person has the money, they don't necessarily care about that middle part. That's just to be competent. So I understand what you're saying, but with that grant, it is very, very difficult to have those funds divided equally. So, that's all I have.

DR. GETTY: I totally agree, and I think that's one of the challenges we face, is taking a look at where are those issues and how can we improve the situation?

MS. ENOMOTO: Right, but to both of your points, I think you're right on target, and it's as if you're listening in on our sort of closed conference room conversations because I think one of the major thrusts of the prevention initiative overall, it's not one of the overt goals, but I think one of the behind-the-scenes goals needs to be how do we align all of these programs? Right? We have prevention and promotion happening in lots of different pockets, sometimes differently.

How do we create both a common parlance across mental health, mental illness, and substance abuse? How do we do this with states that don't necessarily have, say, a mental illness prevention infrastructure yet or a mental

health promotion infrastructure? And then how do we get our own programs to be aligned so that we're not sort of overlapping or using different models or different frameworks to try to accomplish parts of the same thing?

So that's certainly a conversation that's happening internally and with our partners. The work, again, that Fran is doing in terms of leading the Interagency Working Group on prevention-prepared communities is very important and exactly to that point.

The tribal issues, Amanda. You raised it kind of about the block grant, as well, and Administrator Hyde mentioned that that's very consistent with--she's been out in the tribal consultations and done some listening sessions, and certainly, that's a very consistent theme that we've heard is that the states use numbers from Indian Country to get their grants, and yet, they don't kind of then proportionally divvy out the funds.

MS. MANBECK: (Off microphone.)

(Laughter.)

MS. ENOMOTO: Right, so you know it's a struggle. And so, Administrator Hyde definitely has ideas about how we can make sure that we can better meet the needs of

tribes where we know that the need for prevention of substance abuse, suicide, and trauma are so profound. And how do you do that in a way that respects the government-to-government relationships, and at the same time, kind of accommodates the incredible diversity and the number of tribes or tribal entities?

So it’s a challenge, but we are certainly taking that head-on and with, I think, a very clear understanding of the points that you’re making. That the funds to get to tribes have to go through states isn’t necessarily consistent with what's supposed to be a government-to-government relationship. And culture, even though it’s supposed to be at the center, if the needs of that community aren't particularly valued or understood, then the funds don’t end up going there. And, of course, the evidence-based issue kind of is consistent with that, as well.

So, I think on the prevention side, we really are looking at both of the issues that you raised. Integration across the systems, as well as the needs of tribes and communities of color.

DR. RIOS-ELLIS: And I think on that note, then

what can happen without it being intended in any way is that culture continues to be a liability for communities of culture. So, the streamline to acculturation becomes that much more urgent in terms of leaving my cultural values behind so that I can fit in, whether it's an agency, whether it's an individual, without it being intended at all. But Amanda said something earlier this morning that I just sat with, but the cure is in the culture for a lot of our communities. So in order for them to really become healthy again, those roots need to be there. So, I just wanted to--

MS. ENOMOTO: Starleen?

MS. SCOTT-ROBBINS: Are there any initiatives that are kind of focused on the children of the individuals who are entering mental health and substance abuse treatment because it seems like what an opportunity. We know that these children are at risk. Their parents are coming into treatment. Usually, sometimes they can't even participate in treatment because they can't get childcare.

What a great opportunity to provide prevention services while they're in treatment. And it's a population that we kind of have right in front of us.

DR. GETTY: No, but I think it's a wonderful starting point, and it's meetings like this and groups coming together to really point out populations that we need to focus on. I mean, when you talk about it, I immediately think well, yes, we should. We need to, we have to.

MS. ENOMOTO: I'm going to just jump in. We may not have programs in Center for Substance Abuse Prevention focused on that.

DR. GETTY: Right.

MS. ENOMOTO: Linda White-Young wasn't able to join us this afternoon, but, obviously, in the PPW Program, there is a movement and an effort to focus on the kids that are coming in with the women in treatment, and not just the kids that are in the residential setting, but kids that are not in custody or in the care of others, and then kind of taking that overall family approach.

And, certainly, as we move forward, Larke Huang, who is leading our trauma initiative, the trauma and justice, as well as jobs and the economy, and so under jobs and economy, she's sort of leading some of our place-based work, and she's a strong advocate of looking at kind of a

family-based approach. And it's not just the person who's covered for the treatment that they're getting currently, but then their partner, their children, their extended family.

And so, it's certainly on our minds in terms of how to do that, but how do you finance that? How do you set that up? What's the evidence base around that? I mean, it's a big ball of wax, but I think it is kind of the way of the future, that you have an audience of kids, I mean, especially the children of people who in treatment.

And Joanne Nicholson does this on the depression side, and we did this in the women co-occurring disorders and violence study. We did have a children study within that, and it develops protocols for working with kids of women who had these issues. So, we know it's an issue, it's a prime opportunity to reach an at-risk population, and so, we're trying to figure out ways how do we optimize that opportunity?

DR. GETTY: I can't speak for mental health because that's an area that I have not actually worked in, but I do know that there are a number of substance abuse treatment programs in which the women actually bring their

children preschool into the program and not only have them present and focusing on the substance abuse component for the women, but also parenting. It's like a daycare, and I visited a number of them, and they're very effective not only for providing support for the children, but also helping increase that bond with the mother, as well as helping the mother with how to be a good parent, as well as deal with her own issues.

MS. ENOMOTO: Renata?

MS. HENRY: So I noticed that the Parent-Child Assistance Program is a home visitation. One place that I think very quickly there could be some alignment on these are the Nurse Practitioner Visitation Programs that I believe there's ARRA money out, and that's dead focused on high-risk women and their pregnancies and their babies, talk about infant mental health.

MS. ENOMOTO: Yes.

MS. HENRY: I mean, there's a whole lot there.

MS. ENOMOTO: And we've been actively involved in the workgroups around that, trying to come up with the core set of services, being very vocal about the need to look at trauma, as well as the array of our behavioral health

issues in those programs. It's an incredible opportunity.

MS. HENRY: No state should be allowed to get ARRA money for nurse practitioner partnerships visitation if they don't include behavioral health.

MS. ENOMOTO: From your mouth to God's ears.

(Laughter.)

MS. HENRY: I'm so serious about that only because it's such a population that the reason they get into visitation is that they're high risk. So, and I'm really serious, they should not be allowed to pull down that ARRA money unless behavioral health is included in that.

MS. ENOMOTO: I think you can rest assured that with Larke representing us, no one's going to get out of the door without doing that.

So, all right, I want to thank Dr. Getty for coming and representing Fran and presenting on the prevention initiative. We do have Eileen Zeller here, who is going to talk to us about military families. So, thank you to Trish very much.

(Applause.)

MS. ENOMOTO: So, Eileen is here from the Center

for Mental Health Services. She's representing Kathryn Power. Eileen is the staff lead on the Military Families, Active Guard, Reserve, and Veteran Initiative.

As Administrator Hyde spoke to you this morning, this is one of our top three initiatives. Even though SAMHSA doesn't have clear authorities for serving active-duty service members or veterans, we know that these folks come into our systems, and we know that their families are coming into our systems, and so it's important. So, the administrator has taken it on that SAMHSA is going to make itself responsible for improving the behavioral health of this population.

So with that, I will open it up to Eileen. Thank you.

MS. ZELLER: Thank you, Kana. Thank you for asking me to present today. So, I appreciate being here today. Thank you.

And I want to offer Kathryn Power's apologies for not being able to be here today. She had a prior commitment. She wanted me to tell you how much she appreciates the work that you do and the advice that you've given her in the past. So, thank you for that.

Are there any veterans in the room? Okay, so on behalf of folks who have served this country, thank you for the advice that you're about to give us.

This is the Military Families Initiative, but when we talk about military families, that's really shorthand. What we're really talking about are active-duty service members, reservists, national guardsmen, and their families. So military families is shorthand.

Our goal is to support these folks and their families by leading efforts to ensure that behavioral health care services are accessible and that outcomes are successful.

So since 9/11, we've had about 2 million troops deployed to Iraq and Afghanistan. There are about 1.86 million kids in the United States who have parents who have at some point deployed, and it's about 1.2 million whose families right now who have a mother, a father right now who are overseas in support of this effort. A significant number of these troops come back, as you all know, with PTSD, with traumatic brain injury, with depression, with all kinds of trauma-related problems. With substance use, primarily alcohol and prescription drugs, actually. And

with a variety of other problems, including the higher number of troops who have killed themselves.

And what happens is among active-duty service members, they are eligible to receive care through the Department of Defense and anyone who is deployed, including Guard members, have five years after they get back during which they can receive care from the Department of Veterans Affairs, however, for whatever reason, a number of these returned veterans choose not to receive care through DoD or VA and instead come into the community, and we see them every day, the states see them every day, our grantees see them every day.

So, we have obviously known about this since practically the beginning. SAMHSA became more involved with military families in 2006, when Kathryn Power sat on the DoD Mental Health Taskforce and provided recommendations to the secretary, and then upwards to the president. And since then, we've done a number of things.

Those of us who've been working on this initiative, we're very happy when Administrator Hyde made it one of the 10 strategic initiatives. It's the only strategic initiative, the only priority that cuts across

the other initiatives because it’s the only one that's population-based.

So I’ve gotten ahead of myself. You’ve probably seen a lot of fast facts today. I’m not going to go through them all, but I will say that we know that more than 18 percent of returning troops are going to have Post-Traumatic Stress Disorder or depression. We know that on any given night in 2009, there were more than 100,000 homeless veterans in this country, and that was men and women. We know that 1 out of 5 suicides, 20 percent of all suicides in this country are by veterans.

There’s a growing body of research on the impact of spouses and families on deployment and on trauma-related stress, and some of the things that we do know is that it’s the accumulative length of deployment as opposed to the number of deployments. Research is saying it’s accumulative length of deployments, it seems to have the biggest impact, that you have more emotional difficulties among children and more mental health diagnoses among at least Army wives, and I’m saying wives because the research hasn’t been done on husbands.

We also know that children of deployed military

personnel have more school, peer, and family problems than when matched for age and sex on a national sample, and that's worse for teens and for girls of all ages.

And this impacts all the strategic initiatives, including what should be here and isn't, is trauma. So we cut across everything.

There are six major initiatives that I'm going to briefly touch on today, and I want to spend most of my time hearing from you with your questions and getting your ideas.

So the first one is the Federal Interagency Policy Committee. This is a charge from the White House. It is a very high-level interagency committee. Every federal agency is a part of it. Administrator Hyde is our representative on that. The goal is to take a look at and enhance conditions for military families in the country.

There are two what they call sub-IPCs, which basically are committees. And Kathryn heads one along with the Department of Veterans' Affairs and the Department of Defense on behavioral health needs of military service members, veterans, and their families. And what that group is going to do is provide I think they call it a discussion

guide. They call it a strategic statement, so it's not quite recommendations, but it's a strategic statement which will go through the full IPC and then go to the president for what they call a presidential decision process. So, he will consider this to make policy changes.

The second of our major initiatives that I want to talk about is they're turning service members, veterans, and their families' policy academy. That's taking place June 7 through 9 of this year. The purpose of the policy academy is to bring together in this case nine states and one territory to work on a behavioral health care strategic plan for their state or territory, and it's interagency, and you get very high-level policy folks.

So what we do is we do a site visit to each of these states where we pull together these 10-member teams, get them to do a SWOT analysis to look at what's working, what's not working, where the gaps are, who needs to be at the table, who may be shouldn't be at the table, who should step out. We bring them into D.C. for two-and-a-half days, where we put them into rooms; they get intensive technical assistance with professional facilitators, with national experts to pull in to help them as they grapple with some

of these issues. They come out of that with a strategic plan well underway, which a couple of months later they send to us, and then we're able to give them one additional site visit.

It's an amazing process because, nowadays, as with any system, there are lacks of systems. The behavioral health care system for military families is just like the behavioral health care system for all of us because they are us. So, it's an amazing kind of process, and we're very excited about that.

Federal Partners Reintegration Workgroup is a group that's part of the mental health transformation effort. It's, again, composed of almost all federal agencies. What we do is we meet once a month, we talk about what we are doing for military members and their families, and how we can coordinate better and not overlap. Some pretty wonderful things have come out of it. You see the list there of our priority areas, and one of them is military families.

I'm the Suicide Prevention Branch, and that's my priority, is suicide prevention among military families, and I left out that slide. So, that's not a good thing.

One of the things that we're very proud of at AMHSA is a partnership that we have with the Department of Veterans' Affairs. I hope that you know that we have something called the National Suicide Prevention Lifeline, which is a toll-free, 24-hour hotline. You can call one number from any place in the country, and you will get connected to one of 147 crisis centers, the one that is closest to you geographically.

In 2007, when the VA decided that they wanted to do something similar for veterans, they decided to partner with us. The National Suicide Prevention Lifeline is about to celebrate its 2 millionth call this week, and in fact, Kathryn has been doing interviews about that all day. Over a quarter of those calls are from people who have pressed one to get into the Veterans' Suicide Prevention Hotline. They're getting about 400 calls a day, and we know that we have saved the lives of more than 8,000 veterans. Those are people who were in such critical shape when they called that emergency rescue were sent out. So, it's one of the things we're very proud of.

Another centerpiece of what we do is we have memorandum of understanding with the National Guard Bureau,

and we are currently doing a pilot project in New Mexico and Kansas, where we are tracking veterans by ZIP code. There's no personal information given. And we're mapping that onto behavioral health care providers, public providers in the state. So, this will help the states plan, and eventually, it will go online. It will let families know who they can call for help.

And the last piece that I'm going to mention is data collection efforts. We're always working on improving and enhancing what we do here. So, we're developing sets of standard questions for our grantees, as well as performance measures, and that will be SAMHSA-wide.

We have a couple of programs that do some specific work, but it's not the only work they do, related to the needs of military and veteran women and families, and one of them is the National Child Traumatic Stress Network, which has a military family's knowledge bank and learning community. So, if you go on their website, there's a lot of good stuff. They're doing some wonderful research, some wonderful practices.

And then we have the National Center for Trauma-Informed Care. You probably know that about 15 percent of

women in the military--I don't think it's just those who returned from Iraq and Afghanistan--have experienced some kind of military sexual trauma. And, so this is one of the technical assistance centers that provides a knowledge base for that and helps people translate research into practice.

And so, with that, I'm going to end, and we'll walk over to the table and be happy to respond to any questions.

MS. ENOMOTO: Great, thank you. Thank you, Eileen, especially for being able to speak off of the cuff about the suicide numbers because that was going to be one of my questions. A lot of great work happening.

Okay, Britt, go ahead.

DR. RIOS-ELLIS: I just want to congratulate you on that 2 millionth call. Was it two or three? Two?

MS. ZELLER: I think it's two.

DR. RIOS-ELLIS: That is just so wonderful.

MS. ZELLER: Thank you.

DR. RIOS-ELLIS: And I'm wondering are there centers where you know that they're providing services, for example, with our Latino or Asian Pacific Islanders who, perhaps, are suicide prevention in distinct languages?

MS. ENOMOTO: Well, one of the numbers that feeds into it is 1-800-SUICIDA.

DR. RIOS-ELLIS: Suicida?

MS. ENOMOTO: Yes.

MR. RIOS-ELLIS: Okay.

MS. ENOMOTO: So, we know that that goes directly to Spanish-language centers or Spanish language capacity. I don't know about the other languages.

MS. ZELLER: That’s right, we do have I want to say nine crisis centers now that are part of our Spanish sub-network. So whether you call the regular number or the specific Spanish number, you will get transferred to a Spanish speaker.

There’s also a translation service that is available to all of our crisis centers, and so if they get someone who speaks another language, they can get hooked up to a translator. Not ideal, absolutely not ideal. But we can handle it, and I don’t have any numbers on that.

DR. RIOS-ELLIS: But that's great that that's happening.

MS. ZELLER: Yes.

DR. RIOS-ELLIS: Thank you.

MS. HUTCHINGS: I agree it's great as a resource and, of course, appalling--we had a sidebar here--some of the numbers. Given that the VA partnership, which is tremendous both ways, that they knew enough to come to you and not replicate things and that you guys were--and the lifeline, actually, I'm a huge fan of. I think it does wonderful work. And, as a suicide survivor, I'm particularly grateful for you and your work.

I'm not sure that all of us understand that the option to press one is only what, two-years-old now?

MS. ZELLER: July 2007, yes.

MS. HUTCHINGS: So given how long Lifeline has existed, and before that, 1-800-SUICIDE, and TALK and all of the iterations. The numbers and the percentages that you're seeing that are military-related were appalling is the only thing, and saddening and all those kinds of things, too. So I think we probably need some more focus on.

And I don't know if you have any breakdowns of gender in those and age, et cetera, but that might be something we'd be interested in. I'm not putting you on the spot for it, but have a follow-up conversation sometime

about. But thank you very much.

MS. ZELLER: Sure, and we're all interested in-- the breakdown of sex I can probably get. In fact, I know I can. The breakdown of age, we'll never be able to get because the VA maintains its own statistics, and they're not allowed to ask those kinds of questions.

The other thing we don't know is how many veterans are calling the hotline that decide not to press one.

MS. HUTCHINGS: Right, right.

MS. ZELLER: And we've just recently gotten approval for a call log, and we're rolling that in. So, we hope to get that information soon.

DR. RIOS-ELLIS: (Off microphone.)

MS. ZELLER: The call log will also give race and ethnicity. What we're finding is that the counselors are reluctant to ask, and so we're working on it. Yes.

DR. COVINGTON: I don't know why, it seems like towards the end of the day or whatever, but I found this really distressing, really distressing, and I hear a lot of distressing things every day, but there was something about this that had particular heaviness to it, I think.

A question, and then a comment. You said that 15 percent of women in the military reporting some kind of sexual assault.

MS. ZELLER: Military sexual trauma.

DR. COVINGTON: Military sexual trauma. Two reports. One that I saw most recently was one that the percentage was 41 percent, and the report that came for California veterans women was 85 percent of the woman had some form of sexual harassment and/or military sexual assault. So the 15 percent isn't a number I've seen anywhere, so I'm just curious where that one came from, and I'd be happy to e-mail and send you references on the one I have.

MS. ZELLER: I would love to get that.

DR. COVINGTON: Okay.

MS. ZELLER: I could probably give you the citation for every statistic except for that one.

DR. COVINGTON: Okay.

MS. ZELLER: And mea culpa, this actually came from an NPR report from last week.

DR. COVINGTON: Okay.

MS. ZELLER: And I normally don't do that.

DR. COVINGTON: Okay. Well, I'm happy to send you some other things.

MS. ZELLER: Yes, yes.

DR. COVINGTON: Whatever the percentage is, it's too high.

MS. ZELLER: Yes.

DR. COVINGTON: But your number seems so considerably lower than the ones that I have.

MS. ZELLER: I'm going to take a guess since this focused on the Department of Veterans' Affairs. It may be that women who are seeking care from the VA, that that's what they're reporting.

DR. COVINGTON: Right.

MS. ZELLER: So I would love that.

DR. COVINGTON: Okay.

MS. ZELLER: And I've written that down.

DR. COVINGTON: And I've got your e-mail, so I'll do that.

MS. ZELLER: Yes, that would be great.

DR. COVINGTON: And my comment really is if we go back to our previous presenter that was talking about preventing substance abuse and mental health problems, it

seems to me that preventing war would be the most important thing. That if we stopped war, we might have less substance abuse and mental health problems. So, I just want to put that out as an option. Just as an option.

MS. ZELLER: Is that in our mission statement?

MS. ENOMOTO: Actually, when Administrator Hyde was joking earlier today, she said, I'm taking on peace, war, the economy. That's what she meant.

MS. ZELLER: Absolutely.

MS. ENOMOTO: And poverty. We have to get to the root cause of these things.

MS. ZELLER: Exactly. Exactly.

MS. ENOMOTO: Do we have comments on this side of the room? Susan?

MS. AYERS: I'm sort of wondering where you do get your statistics. Particularly, we had a close friend who actually took his life probably two years after he'd come back from a second tour. He was in the National Guard, and he'd been sort of troubled and up and down and had these mood swings, and sometimes would look for help and other times didn't, and I don't know if the military would have any idea that he shot himself in the head in bed

one day.

MS. ZELLER: Right. I'm sorry for your loss. That's first.

MS. AYERS: Well, it's one of so many stories.

MS. ZELLER: Yes.

MS. AYERS: But it is really just appalling. I mean, because the whole family was really destroyed. But I'm curious, so does that person get to be counted or--

MS. ZELLER: Okay, the 20 percent, the 1 in 5 comes from a database that the Centers for Disease Control keeps, called the National Violent Death Reporting System. It's only 17 states that participate in that. They only have funding for 17 states. There are a variety of death certificates that are used in the country, but most states use a standard one, and one of the questions is whether the person has ever served in the U.S. military.

So, according to the National Violent Death Reporting System, it's 1 in 5, it's 20 percent. How accurate is that? It's about as accurate as we can get, at least at this point in time.

The Department of Defense gets real-time statistics on suicide, and each service branch keeps its

own, and so the DoD can tell you today how many suicides they've had and in what service branch.

The National Guard becomes much more difficult because, as you probably know, assuming they haven't been activated and they're actually in a unit and overseas or in a unit training on a military base, normally, the National Guard is only going to see one another in their unit one weekend a month and two weeks during the summer. And, so I've never heard of a suicide among a Guard member that's actually occurred during drill weekend. So, if that man or woman is going to kill him or herself, it's going to be at home. And so, they don't show up for drill weekend, and someone calls and says where is John? Well, he died. Is that going to be down as a suicide? No.

So, we know that suicide is underreported in general. The best information we have right now is one in five.

MS. MANBECK: I would just like to say that it's my understanding--I live in Colorado Spring, Colorado. We have three bases. Fort Carson is Fourth Infantry Division that's constantly going and coming, and I think that the reason that they don't go to see anybody, especially in

Colorado Springs, is that clinic is swamped. I mean, you can't even get evaluated for two months. It's a long waiting period. And then you have to go to Denver, and you have to get tested, and then you have to go back and try to make an appointment.

So, I'm really happy that SAMHSA is taking a look at this because the VA is what it is, and there's no helping that. So, I'm really, really excited that SAMHSA is willing to try and alleviate some of that.

It's scary, it's hard.

In Colorado Springs, we hear all the time. They'll go out to the bars and they'll get in fights or they'll shoot themselves or their families, and they come back, and the whole process of debriefing, I mean, let's talk about that. So, they get a horrible debrief when they come back, and they get a horrible debrief when they're discharged from the military.

So I'm really excited that SAMHSA is making this an initiative because they need it. It's hard when you reach out for help and it makes you not want to reach out anymore. So, thank you. I really appreciate that.

MS. ZELLER: Well, and I think all of us feel

pretty passionately about this, but in defense of DoD and VA, they're all working hard, too.

MS. MANBECK: Right.

MS. ZELLER: They're all trying to take a look at what's going on right now and make it better. And Fort Carson, it's tough in Colorado. Yes.

MS. ENOMOTO: Renata and then Gail.

MS. HENRY: We found in Maryland that many of the--we look at the data because the lieutenant governor has a special initiative for veterans' services, but behavioral health in particular, but the number of veterans that are being served in the public mental health and substance abuse system are far greater than those who are reporting that they're getting their services at the VA. So, part of what I still find uneven across the country is the willingness of local VISN or the local VA to contract with community providers.

So to the extent that that can still be an issue that SAMHSA continues to work on and it's okay, they should do it, but it is uneven the willingness, and just between Perry Point, Baltimore, and Washington, because we have all three, it's different, and the rural area issue is big.

So, the Eastern Shore--SAMHSA needs to continue to work on that.

MS. ZELLER: And you've hit the nail on the head, that the VISNs, for those of you who don't know, VA is divided into different regions and they're called VISNs. And each VISN, I mean, obviously, there are certain policies that cut across, but there's a lot of leeway in terms of how they're run. The new Omnibus Caregivers Budget Act that was just passed has implications for exactly what you're talking about, and it directs the VA under what circumstances they should be contracting with states and with private providers.

At the Policy Academy coming up, we have a couple of people who are going to be talking to us about that, including the National Guard Association, which did a lot of the lobbying for that. So, we hear this all the time. Yes.

MS. HENRY: So, to the extent that what maybe is said at that conference or at the Policy Academy can be shared because you have 10 states coming to the Policy Academy. I can't do the math real quick, but there are how many, 40 other states?

(Laughter.)

MS. ZELLER: Forty-four if you include--

MS. HENRY: Other states that won't have that information. Get that out because that's really valuable, and when states would run their data, my guess would be that they would find that they're serving lots and lots of veterans that, for whatever reason, those folks either are not eligible to get VA service or don't want to go.

MS. ZELLER: Right. Yes, we'll figure out a mechanism to get that word out.

MS. ENOMOTO: And there is a plan to kind of take the Policy Academy approach to scale because we did have a Policy Academy before with 10 states. We're getting 10 new states, but they're still lots of states and tribes that for whom this is relevant and could benefit from the process.

MS. HENRY: And then the guidance to providers about what that means to contract with the VA because it's just not all on them. I mean, they're reluctant, but then I've heard well, we can't. So, what do providers need to be able to do that? And, again, the issues with the trauma and the gender issues are huge.

MS. ZELLER: And I do know that Administrator Hyde and Kathryn and John Moore, who's another colleague or working on the provider issue with TRICARE, not necessarily with the VA, but with TRICARE. But I'm taking notes.

MS. HENRY: This is my last comment. The standard that all of those programs do understand trauma and the impact of trauma. I mean, if I were the VA, I would want my providers that I contract with to be responsive to that issue.

MS. ZELLER: That's a huge issue because both the DoD and VA are the experts at providing this kind of care, and so part of their reluctance is going to be yes, we want our people to get care, but we want it to be quality care. And just because you want to help veterans doesn't mean that you know how to diagnose or treat TBI, PTSD, or anything else. So, yes.

MS. HUTCHINGS: If I think of this particular issue in sort of a cube and corners of the cube, I think of people who have served and get no services at all, and of course, we've had a lot of national conversation around that and trying to promote access, et cetera. So, at least we're talking and actually have made some pretty

fundamental steps toward that. Wonderful.

Then, of course, we've had lots of national federal agency collaboration, certainly conversation around people who access care: VA, DoD, TRICARE, et cetera. Great. We're starting to have, not much doing, but at least more conversation about people that don't go in corner one and corner two.

We're now seeing people who access the public system, and little to nothing, and this is something that somebody at the Washington Business Group on Health, which represents, of course, and you probably know what I'm going to say already, the nation's largest Fortune 500 employers, about so many people that are returning vets who go back to their job and go to their employer-based health care insurance, and we really have had, that I'm aware of, and if I'm wrong, please, please, little to no conversation, much less activity in that last corner of the cube, I think.

And I'm sure there's many, many corners of the cube that I'm not identifying, but to kind of keep it simple. So I'm wondering have you had a private sector, private employer, private health care plan conversation

particular to behavioral health, and if not, can we leverage parity to try to jumpstart that?

MS. ZELLER: Yes, and it's growing. We work with the Federal Partners Reintegration Group. We work closely with the Department of Labor that is doing this. We have worked with Ron Finch at the National Business Group on this. I think in the states, it's becoming more and more clear how important employment is. I mean, the VA wants to end homelessness among veterans. We all would like to end homelessness among veterans, but you need to get folks jobs in addition to everything else.

So yes, we're doing some things, and we probably need to do more.

MS. ENOMOTO: I'm going to take Britt as the last comment, and I'll let Eileen wrap up.

DR. RIOS-ELLIS: Our university, which is the second-largest in California, sits on the back of the largest VA in the country, and what we did was we tore down the wall that separates the two campuses. So, we have an active veterans' program with veterans coming to our university on the VA Bill. There's been a specific transition.

One of the things that we've had issues with though is actually going in and educating the professors around issues and sensitivity issues around what the veterans are facing, but by and large, it's worked fairly well, and we have a larger and larger population, and they know they can come on campus and the wall is completely torn down.

So I think we're really fortunate just because of our geographic proximity, but we also have large symposiums every year with the VA. So a lot of us that are doing health-related anything are coalescing with people that are doing work at the VA, as well.

MS. ZELLER: That's wonderful, and that's not just we're fortunate because, that because you've actually done something proactive. With the GI Bill, more and more troops are coming back and not going into employment, but going onto college campuses. So if you don't already have one, there's something called Student Veterans of America.

There are, I think, about 200 chapters in college campuses across the country. They are support groups for returning vets who find it really hard to relate to 18-year-olds who are still being paid for by their parents.

And not only do these groups provide support for returning vets, but the vets will often help you educate your faculty and staff. So, they're a wonderful resource. You can go online and get them.

No closing comments, but thank you, and keep my number and e-mail. I'd be happy to talk with any of you. Thank you.

MS. ENOMOTO: All right. Eileen is very modest, but she's a fabulous resource not only on the veterans' issues, but really fantastic on suicide. So, we're very lucky to have her here at SAMHSA.

So we're a little bit ahead of schedule. We're going to take a brief break, and then Dr. Clark will be here at 3:00.

I just want to thank Eileen. Thank you very much.

(Applause.)

(Recess.)

MS. ENOMOTO: Okay, I'm very grateful to Dr. Clark for his flexibility in the schedule. We're starting a few minutes early, but I'm really pleased. Dr. Clark has the auspicious job of leading two of the administrator

strategic initiatives, and two of them without their own budget. So he has to pull a rabbit out of his hat, which we all know the magician that he is. I'm sure that it will happen.

He has not only health information technology, but also behavioral health workforce in primary and specialty care settings. So, this workforce initiative is also where our primary care behavioral health integration work is going on because we see it largely as an issue of cross-training folks.

So with that, I thank Dr. Clark and welcome him to begin his presentations.

DR. CLARK: The pleasure is mine. Thank you, Kana, and it's a pleasure to be with this group again. Before I start my presentation, I know you've seen the Women's TIP, but, as many of you have asked for it, and I just wanted to reiterate that we got it out on budget and in some time.

(Laughter.)

DR. CLARK: The behavioral health workforce issue is one of the two topics that I am working as the lead, as Pam Hyde has articulated, the 10 initiatives.

As a backdrop, according to our 2008 NSDUH survey, an estimated 22.2 million people 12 and older were classified as having substance use or dependence. Eight point two million of these were women. Of the 4.8 million who received treatment in 2008, approximately 1.3 million were women. An estimated 9.8 million adults 18 and older had a serious mental illness during the past year according to our NSDUH data from 2008, 6.5 million of whom were women, and it's an important thing for us to see that when it comes to serious mental illness, there's a larger percentage of affected individuals who are women. Of the 5.7 million who use mental health services in 2008, 4 million were women.

When we look at the reasons reported for not receiving substance abuse treatment by those who sought it, the issue is lack of coverage, 37.4 percent. And their primary reason for not receiving mental health service was inability to afford the cost at 42.7 percent. And another 14 percent said health insurance didn't cover all of or part of the treatment.

So these are things that we need to keep in mind when we start off with the issue of workforce is the

service issue, who's affected by alcohol and drug abuse, who's affected by serious mental illness or mental illness?

We estimate that 32 million people are expected to gain access to health insurance through health insurance reform legislation. And that, from the substance abuse point of view, could add to the client population an estimated 87,000 people who would present for substance abuse treatment, but would be denied substance abuse treatment because it is not available or because they had no insurance.

We estimate as many as 2 million new mental health clients would be eligible, but health insurance reform with its focus on early screening and brief intervention might actually open the floodgates to as many 20 million people who need substance abuse treatment but don't recognize it, and 5.1 million who need it, but didn't receive mental health services in the past year.

So the projections are going to be very soft projections, but whether you use conservative numbers or liberal numbers, there are a lot of people who will suddenly have access to treatment who previously didn't have access to treatment.

What we say is that there will be not enough treatment providers from a workforce point of view. This is an issue. When you look at the most recent data available, 55 percent of U.S. counties had no practicing psychiatrists, psychologists, or social workers, and most of these counties were rural.

So, what do we do with women in rural areas? There's projected need by 2020 for 12,624 child and adolescent psychologists, but a projected supply of 8,300. So there is a paucity of practicing psychologists.

The U.S. Census Bureau projects by 2030, 1 in every 5 U.S. residents will be 65 or older, but only 700 practicing psychologists, and this was 10 years ago view, older adults as their principal population. So we need to recognize that the concentration of women and the older population increases, and so psychological needs of women who are older who have multiple issues will not be adequately addressed by the number of practitioners available.

We also recognize that there is as much as a 50 percent turnover in frontline staff and directors of substance abuse disorder treatment agencies, and when we

look at non-profit organizations, we see that same prevalence rate. So one can assume that in mental health services, you also have the kind of turnover that creates an understaffing and lack of experience and an inability to meet the future demands of a delivery system that is going to be fueled by health insurance.

We're going to make great strides within the health professions. In the past decades, you can look at women in schools for selected health professions, and you'll see increases in the prevalence rate of women in public health, pharmacy, osteopathic medicine, medicine in generally. And then, oddly enough, there's a decrease in the number of women going into nursing.

So I think increasing opportunities, that should come as no surprise, but the key issue is we want to be able to meet the needs.

The increase in numbers of females in health professions is a significant step forward. Female health professionals should be more sensitive to the unique challenges faced by women who enter treatment. It's a cultural phenomenon. People can identify and understand what's going on and use their academic and clinical

training to assist them in facilitating the appropriate treatment of, in this case, women in the delivery system. Dealing with issues, there’s trauma. I notice that's on the agenda.

The importance of relationships, both healthy and unhealthy. One of the things that the literature shows is that women place a greater emphasis on relationships.

The challenges faced by the increasing number of female veterans returning from Iraq and Afghanistan, as we change how we do war, women are playing a greater role.

The treatment needs of females in the criminal justice system. Although there are more men going to prison, the number of women entering prison is growing at a faster rate. So, not only are we dealing the traditional health needs of women, but some of the criminal justice issues are becoming important.

We had a Behavioral Health Taskforce Workgroup constituent meeting on April 26. We had approximately 60 people in attendance, including behavioral health provider organizations, professional guilds, medical societies, organizations representing state authorities, consumer group representatives from private employers. Other

presenters were from HRSA, the Centers for Medicare and Medicaid, Faces and Voices of Recovery, the National Business Group on Health. The agenda included presentations and dialogue with stakeholders, the opportunity of health care reform, the role of peers, communities, employers, and behavioral health workforce development, primary care, behavioral health integration, and implications for health professions.

The major issues raised from the constituents' meeting were the need to prepare providers to operate in the new systems that will be created by health insurance reform, training, including evidence-based practices; screening, brief intervention, and referral to treatment. Understanding recovery. Co-occurring disorders and working with primary care providers. The need to address disparities in rural and inner city areas. The behavioral health workforce needs to become more diverse and culturally competent.

The recruitment of workers is critical because of anticipated increase in demand and the aging of the workforce itself. Heretofore, the behavioral health workforce has not been as attractive as other occupations,

which then creates the compelling problem of a lack of individuals who can help meet the anticipated increase in demand.

So our objective is to provide a coordinated approach to address workforce development issues affecting the behavioral health and general health service delivery community promoting the integration of services and training and the use of behavioral health screening, brief intervention and a referral to treatment and primary care settings.

The behavioral health initiative, the initiative support, SAMHSA's efforts to increase the number of individuals trained in specific behavioral health-related practices, the number of organizations using integrated health care delivery approaches, the number of consumers credentialed to provide health-related practices. The number of model curriculums developed for bidirectional primary and behavioral health-integrated practice, and the number of health providers trained in the concept of wellness and behavioral health recovery.

We have some activity at SAMHSA. We have our Screening Brief Intervention Referral to Treatment, SBIRT,

the Minority Fellowship Program, the National Centers for the Application of Prevention Technologies, the National Center for Trauma-Informed Care, a knowledge application program in the workforce development, and a new initiative that CMHS is stewarding, and that is the Training and Technical Assistance Center for Primary and Behavioral Health Care Integration. I'll talk about that.

Under the SBIRT Initiative, we have a total of 17 grantees. The goal is to establish SBIRT training as a component of residency programs in a variety of disciplines, including emergency medicine, trauma, pediatrics, family medicine, surgery, et cetera. We're trying to promote screening and brief intervention and reveal wider dissemination of practices through physicians, nurses, physician assistants, nurse practitioners, social workers, and other health care providers. I even got a request for dentists because they can play a critical role.

Training must be expanded to include mental health providers and other behavioral health providers working in this integrated setting so that, in fact, we benefit individuals.

Even though we have the 17 programs, you can see

the wide areas on the map where we don't have programs under SBIRT, and at a recent SAMHSA Council meeting, people said well, what about our states? And that is the issue. We need to make sure that we can facilitate appropriate training across the country so that issues can be addressed.

In the meantime, we have trained 554 residents in our Phase 1 grantees. Sixty-four percent of the grantees are female. Grantees also trained almost 1,600 non-medical residents, and that includes physician assistants, psychologists, social workers, nurse practitioners, and other health practitioners.

Specialty area training include internal medicine and family medicines, psychiatry, pediatrics, OB-GYN, addiction medicine, emergency medicine, trauma surgery. The key issue is that we're outreaching a wide range of primary care activities so that we can address the issue of substance abuse and now mental health issues from a screening and brief interview point of view.

Many of you are aware that AHRQ, through the U.S. Preventive Taskforce, has targeted depression and alcohol screening as a priority screening activities.

The Training and Technical Assistance Center for Primary and Behavioral Health Care Integration, which has an application due date of June 17, it's going to be a collaboration between SAMHSA and HRSA. The purpose of the program is to serve as a national training and technical assistance on the bidirectional integration of primary and behavioral health care and related workforce development.

We're trying to promote integrated primary and behavioral health care services across the health care delivery system, and as a national resource, the TA Center will provide technical assistance to grantees in SAMHSA's Primary and Behavioral Health Care Integration Program and entities funded through HRSA, principally, the community health care centers.

The objective is to address health care needs of individuals with mental illness, substance use, and co-occurring disorders, including individuals seen in health centers funded under Section 330 of the Public Health Care Services Act.

Thank you. I think I made my time. Questions?

MS. ENOMOTO: He's an overachiever in everything he does. Thank you, Dr. Clark.

We have--Susan.

MS. AYERS: This isn't so much a question as something I've been meaning to reference.

The BlueCross BlueShield Foundation in Massachusetts did a fabulous report. It came out last fall on workforce development and really talked about the churn in the workforce and it had a lot of good statistics about who's coming and who's going, and we're losing way more people than are coming into the field. But it's a very nice report. You can get it on a website.

DR. CLARK: Thank you.

Renata?

MS. HENRY: So, could you talk a little bit more about this Technical Assistance Center. And, so there's an RFA or RP out for that.

MS. HUTCHINGS: Renata? I'm sorry. I need to recuse myself because I'm actually working on the proposal.

MS. HENRY: Whoops.

MS. HUTCHINGS: No, no, I'm going to leave.

MS. HENRY: Okay.

(Ms. Hutchings exits.)

MS. HENRY: No, I'm so sensitive to that issue.

So is that going to be in preparation then for a grant that opportunity--I guess I'm asking for clarification on the opportunities both for the technical assistance, and is there a grant opportunity around the integration?

DR. CLARK: There is that opportunity, but the beauty of the TA Center is that the activity is broader than the specific grant, and I guess that's what I want to focus on. That indeed, as Kana pointed out, we don't have an independent appropriation as such. Most of the training dollars go to HRSA, and that's as it is. But we do recognize the need to create training opportunities, and this TA Center, especially given that HRSA is joining SAMHSA.

MS. HENRY: Okay.

DR. CLARK: And it offers us an opportunity to look more broadly than the specific activity of placing a primary care activity within community mental health centers.

MS. ENOMOTO: And the grant program, there was an RFA last year.

MS. HENRY: Right, Okay.

MS. ENOMOTO: That was specifically open to

community mental health centers to integrate primary care into their settings, but with the ARRA funding and the other funding for HRSA to integrate behavioral health into health centers, Administrator Hyde took advantage of that opportunity to approach Administrator Wakefield, and they agreed to collaborate on creating a bidirectional TA Center that, as Dr. Clark noted, bigger than the Grant Program, but complementary to that.

MS. HENRY: So Milbank, did you see their paper that they just put out, the report that they just put on about integration? They did a -- well, I don't know if it's a report on -- that specifically looks at, I think it's eight models of integration for primary care and behavioral health.

So I mean, it's a big issue, and to the extent that the field has options and choices, but I think what are the best practices? Because the Milbank Report kind of speaks to here are eight models, but what are the best practices? What really--

DR. CLARK: I think there is a lot of interest in just those questions, and part of what we want to do is to exert some leadership in identifying those, and not

necessarily spelling out the specific models. We can point to that because we note that a number of communities are already pursuing the integration, and the ultimate question is what happens to the people in the delivery system, whether it's dealing with mental health and primary care or primary care and mental health? The issue is we're trying to promote recovery and wellness, and we see integration as one way to facilitate that, but the objective remains the quality of care that a person receives and the outcomes associated with the care that a person receives.

MS. HENRY: And have we been getting good interest from the primary care physicians as a whole? Because each time that I've had the opportunity to kind of push into this, it's been the primary care physicians really struggling with just one more thing that they have to do and how do we -- I'll address that to the physician--

DR. CLARK: Oh, no. That theme is obviously a very contemporary concern, one more thing we have to do, one more screening we have to do, et cetera. And, so it depends on the commitment of the setting. Things like health homes and other organizational strategies where screening can be done.

The use of technology to help facilitate screening and the identification of problems associated with an individual's presentation. How do we use that information?

So we have a limited amount of time, admittedly, but we do have some time, and as we press for health information technology, a compilation of standards, we are--under Pam's leadership, we've already met with David Blumenthal at ONC, and looking at the issues of standards. They have $4 million in the 2011 that is targeted toward behavioral health and the requirement of the president is that they collaborate with us. And, so we're already meeting with them on that, and even though the budget may or may not happen, the expectation is that it will, and so we want to be in place so that we'll have something that everybody can support.

So your observations are correct. Our medical residency programs are occurring in primary care settings so that we're taking first, second, third-year residents and then viewing them with the expectation that we'll deal with behavioral health issues.

MS. ENOMOTO: And just to follow-up on that,

Renata, it doesn’t always have to be the physicians, right?

DR. CLARK: And that's a good point.

MS. ENOMOTO: And I think when you look at SBIRT, we screened 1 million-plus people. It wasn’t all docs doing the screenings.

DR. CLARK: And that, I think, is an important part and that's why we’re training social workers, counselors, health educators, and nurses, and we allow the facilities to define how they want to approach it or as Mary Wakefield’s staff pointed out, some community health centers only want to do screenings. Others might want to do more than screenings. So it varies.

So we have to work with them and work with the systems in place.

So as you pointed out, promoting different models, we allow local communities to adopt those models most appropriate for them, and then the evaluation process allows you to access whether those choices were appropriate because, again, this is an evolutionary process, so we shouldn’t assume that we’re all going to arrive tomorrow morning at 8:35. The idea is to get people to arrive in a timely fashion, based on their local resources and

expectations.

DR. COVINGTON: First, I want to thank you for, on your slides, pulling out the statistics on women. I think that's particularly useful for our Women's Committee, and it's been happening more, but doesn't always happen. So, thank you.

The other thing, I wanted to go back to one of your slides where you talked about having the majority of behavioral health folks be women, and therefore, they would understand women, which I think is certainly a potential and a possibility, and we hope that's so.

But I think there's another workforce development issue, and that is many women who are staff have some of the same life experiences as the women they're trying to serve, and often those issues, they haven't had the time, the opportunity, the resources to deal with those issues, and I'm particularly thinking about trauma.

And so, as we try to get our substance abuse and mental health field more trauma-informed, often, one of the barriers, unfortunately, are actually the women staff because they haven't had the ability to work on that issue themselves, and I would like to see that, and as we talk

about workforce development, how do we help our workforce be able to work on their own issues to the point that they're actually able to help those that are there to serve?

DR. CLARK: And that, I think, is an important component of any strategy, especially in the behavioral health arena. What motivates people, what is the magnet that pulls an individual into a practice, into a career choice? So, sometimes, either conscious or unconscious experiences functions as that magnet, and then we need to figure out how to deal with that. So, that's also true not just for trauma; it is true for depression.

DR. COVINGTON: Right.

DR. CLARK: It's true for a number of other conditions, as well as even medical conditions. So, we recognize that, and need appropriate strategies to tiptoe through that garden because it is an issue. It has to be managed appropriately.

DR. FALLOT: Yes, I'd like to follow-up. Stephanie and I have been on sort of the same wavelength today on a bunch of these things, but, certainly, the statistic that struck me from your slides was that 50

percent turnover in a substance abuse treatment agency in a single year. And that's very common in my experience, also, unfortunately.

The question I have is how we can help staff become more connected to their ongoing professional development, and it seems to me that a lot of that revolves around some of the things we were talking about earlier today around the productivity demands, on staff time, and the supervisory crunches there are in terms of supervision time and the consultation time with regular staff so that people really can start to feel like they're there for a career and not just to get a paycheck, because if they're getting a paycheck, it's going to be minimal anyway.

So it's really the idea of development and the professional life needs supervision and consultation on an ongoing basis and what kind of support can there be to agencies to provide that sort of help?

DR. CLARK: Well, we are looking at those as background issues that control whether people stay. We know that if you are solely in an entry-level position, as soon as something a little more attractive comes along, you're out of there.

I'm fond of citing the experience in Noorvik, Alaska, where they point out that we can't get a master's level person, whether it's a psychologist, social worker, substance abuse, as soon as someone gets their master's, they're out of there. And there a number of reasons for that: A lack of support, a lack of resources, and higher salaries elsewhere.

So these are issues that SAMHSA can't resolve alone, but we need to work with the field. Hopefully, with an increased demand for services, in order to reduce the overall cost of health care, we'll be able to pay health practitioners a little more, so that that's one thing. And then if you're able to pay a little more, you can begin to deal with some of these other issues in terms of productivity and demands and education.

The education issue is one of the reasons we have the TIPS, because we don't want to compete with the private sector. There are documents in the private sectors, but our providers can't afford those documents. So if we want them to be knowledgeable, having SAMHSA as a public sector entity providing them helps the patient or the client because that information is then made available, and we

can’t wait until someone can afford a $200 book to go out and buy it if we’re concerned about the quality of care that they received today. So we found that in talking to other groups that have publishing activities like Hazelton, they don’t see us as competing with them because we have different markets.

So a host of issues in terms of why a person chooses a profession, why a person remains in the profession. We need to continue to tease those things out, and then address those things that we can.

DR. FALLOT: Let me follow-up just briefly because it strikes me that the TIP is a great example of kind of a tool that can be used in many agencies to provide a workgroup, a study group, a group of people getting together and going through these materials and learning from each other, and then their consumer clients, as well, but it’s a difficult thing to find time and energy to do that when you’re working 45, 50 hours, and then they’re going home at night to do paperwork.

And that's the dilemma I think that increasingly I hear from provider agencies in both the mental health and substance abuse worlds is that the people are just beat by

the end of the day. They don't have any time for the professional development that they need to stay connected to the field.

DR. CLARK: That remains true, and our hope is with health care reform, the increased demand will also help increase the demand for workers.

If using substance abuse as an example, 95 percent of the people who meet criteria for abuse, are dependents of substances, do not perceive a need for treatment. They don't demand treatment, which means that in order to have a treatment program extent, you have to respond to the demand. If the demand is underwhelming, you can never hire enough people to meet the true demand because the true demand is offset by the denial. Increase the true demand, and then I can hire enough people.

So our waiting list is estimated to be 233,000. Those are the number of people who acknowledge that they have a problem, have presented for treatment, and we're unable to give treatment. Twenty million meet criteria the same as that two-hundred thirty-three thousand, but they don't acknowledge they have a problem, and they're not looking for treatment, and they don't present to treatment.

So, what happens is when harm occurs, those people show up for treatment through criminal justice, child welfare, physical health, domestic violence, or marital discord, but you're waiting for that iceberg to melt so that tip pops up a little?

So if we, through screening, brief intervention, changing cultural norms get more people to say gee, I have a problem, then the treatment provider is able to say okay, I'm going to get 100 people demanding services instead of 25. So I need to staff for 100 people instead of 25, and then you get economies of scale where we can hopefully deal with some of these other environmental issues in the workforce like need for training, study groups, supervision, et cetera. But if I'm only operating on a shoestring because the demand is underwhelming, then it's hard for me to do that.

MS. ENOMOTO: Roger had brought up a concept of value propositions, of four themes that sort of run throughout a lot of our programs and the initiatives, but I think really need to come out in the workforce.

I wonder, Roger, if you would talk to Dr. Clark a little bit about that.

DR. FALLOT: The four things I talked about are recovery orientation, trauma-informed care, gender-responsive care, and culturally-competent care as the four overarching themes that I keep hearing repeatedly in many of the discussions we have at the two places I work a lot, and when it comes to the workforce, what we've talked about is increasingly the fact that the workforce needs to participate in the same culture that the clients and consumers are participating in.

In terms of trauma-informed care, for instance, we emphasize safety, physical and emotional safety, trustworthiness, choice, collaboration, and empowerment, and the basic thing I've learned over the years from the staff I've talked to is that if they don't feel that they've encountered those five values in their work, then they can't create a culture of safety or trustworthiness to the clients they're working with.

So when I enter into a place, and I think the gender-responsive issues are the same, that men and women who are working in an environment need to be able to respectful of each other and their strengths and challenges so that they can respect the gender differences of the

people that they're working with.

So that's an overarching sort of frame for this, but I think it's important to recognize that unless we really focus on these workforce concerns, we're never going to get effectively to the consumer and clients.

DR. CLARK: That without a doubt is an issue, and indeed, the four things work well; we can incorporate those in what it is that we do. And part of what we are trying to achieve is a system transformation, and we should keep those principles in the dialogue, as we also have to deal with salary and we have to deal with people's own experiences.

And as Stephanie pointed out with trauma-informed care, how do you deal with kind of transference, i.e. your own trauma issues and those that you have with your client that you're trying to assist? And then evidence-based practices. So, those four themes are certainly admirable and need to be incorporated.

MS. HENRY: So, it's a nice segue into SAMHSA needs to continue to be kind of setting the standard as more emphasis is focused on pre-service workforce development so colleges and universities, as they're

designing curricula that SAMHSA is right there at the forefront helping them make those choices and decisions and providing the data and the basis for why curriculum should include that, encompassing what Roger has said.

So I just want to encourage SAMHSA to continue in that role as kind of the voice and setting the standard and setting the bar.

MS. SCOTT-ROBBINS: And along that same line, Renata, SAMHSA is also working on publishing the core competencies for working with women and girls in substance abuse and mental health and setting that standard and putting that out there for the universities and for the states to use in their RFAs and what have you, so we really look forward to that document being approved and disseminated.

Thank you.

DR. COVINGTON: Let me just play the devil’s advocate for a moment. You’re suggesting with the demand for more services therefore places can increase their workforce. There are many places that can’t get the staff they need now with the demand they have now, and that's because it’s very hard. Many young people have no interest

in coming into behavioral health.

So I think there's another workforce piece here, which is how do we get people to want to be part of this workforce?

DR. CLARK: Indeed, and that, I think, is part of the issue of seeing behavioral health as an attractive occupation, one that can provide, shall we say, extensive satisfaction. Why does an individual go into a job? Some task associated in the behavioral health arena are not as, shall we say, complex as others, but we find people not interested in the behavioral health arena at all at the level necessary to provide incentives.

So we've got Minority Fellowship Programs that CMHS monitors. We've got some research out of NIH. We're now working with HRSA in terms of some post-baccalaureate issues in terms of loan forgiveness. So trying to figure out how to dangle, shall we say, the incentives to individuals.

We also need to think in terms of the use of technology and those people that are interested in technological strategies to address needs. That issue is now surfacing not only in terms of telemedicine,

telepsychiatry, telehealth, but also, using a social marketing or portable social marketing as strategies like PDAs, using text messages as a way.

So the field has a number of opportunities that we need to exploit, and we need not to be fearful of them. And there are already questions. Well, is it ethical to do this? So unfortunately, we can woolgather and not create the strategies that appeal to young people who are interested in the themes, but maybe turned off by the reluctance. Nevertheless, they're using these things all the time.

I just saw a little blurb online where young kids text message more than they talk. So, they don't use the phone for voice, they use the voice for texts. And we need to recognize that because part of cultural-appropriate care is also dealing with these generational dynamics, because, indeed, if I see it as very boring and not interesting, I may change my mind when I'm 45, but you will have lost 25 years of my productivity and interests. We want to reach that person when they're 20 and let them change their mind when they're 45, so we've gotten 25 years of productivity out of that person before they wander off to do something

else.

MS. AYERS: On this workforce piece, I think there are people that want to go into the field, but can't afford to, and the discrepancy between salaries that are able to be paid by community providers that are private, not-for-profit, but actually do service delivery for the state as they do in Massachusetts or these competitively bid processes, and then you can have a master's degree and be paid $30,000, which is sort of what you get paid, and then if you go into a state similar position, you could be doing $40,000, and if you go into a federal position, you can $60,000 or something. You know what I mean?

I think it'd be really interesting to sort of take a look at across the country kind of what are the funding mechanisms and the ranges and salaries that are out there because I just think that people said oh, good for you, what an angel you are. You're going into that field. And it's like I'm sorry, but this is work I would really love to do, but I just can't afford it.

And so, then look at who the workforce ends up being. People that either come from privileged backgrounds, and so they can afford it, or folks who don't

really have a lot of other options, and so they'll go in and sort of be a mental health counselor or maybe a residential treatment provider or whatever it is.

So I just really think it's a huge problem in terms of how in the world we're going to be able to continue to attract people into the field, and I know with the horrible economy, we're getting more résumés, but as soon as the economy perks up, they'll be gone, and how many lawsuits can we have?

I mean, states where they have great lawsuits, like in Connecticut, people just go to Connecticut to get jobs because you're going to get paid another $10,000 or $20,000 down there because they've had better lawsuits than we have.

DR. CLARK: We recognize that low salaries are an issue that we have to deal with. So, we are trying very much to acknowledge that, and I think reimbursement rates constitute one of the issues associated with salaries.

So under parity with health care reform, our hope is that the reimbursement rate will compensate somewhat, but we also have to deal with the issue of cost. We can't have a sudden, tremendous increase in cost associated with

the delivery of services. So there a host of complexities with which we are dealing. We do recognize that salary is one of those issues.

MS. ENOMOTO: Okay, well, I want to thank Dr. Clark for his presentation and the time that he took to come talk with us today. Thank you.

(Applause.)

DR. CLARK: Thank you.

MS. ENOMOTO: Okay. We have one public comment from someone who is online, and by the way, we've had I think between 40 and 80 people watching the live stream, so that's great. Some of them are probably in the building and they just didn't want to come downstairs. But it's actually a nice thing for our staff who can drop in and out as they have time in their offices.

We have a comment. Do you want to go ahead and narrate that for me, Nevine?

MS. GAHED: Sure. Operator?

OPERATOR: Thank you. Vicky Lynch, your line is now open if you'd like to make a comment.

MS. LYNCH: Thank you. This is Vicky Lynch, and I am an addict in recovery for over 16 years, and

therefore, I'm quite familiar with the disease of addiction, as well as what may prevent substance use and abuse and what may assist in recovery and especially prevent relapse.

I would like to say I have previously worked with a residential recovery center in Bogor, Indonesia, and in fact, we had a quite successful program that received donations from around the world. However, since my return to the United States, I'm still in awe that this is available in the Third World and not in my community.

In fact, one of the major problems for addicts in my area is that there is a temporary residential program for men, but essentially, there's nothing available for women and girls.

And it goes without saying that our community has hundreds of women and girls more than we would like to admit, having nowhere to go and no help at all. There are some outpatient programs, but I don't think it's taken advantage of as it could be in residential recovery centers that was available, and there are no inpatient programs.

I have a Bachelor's in Addiction Studies, and I am attempting to work on the Master's, but I would like

more than anything else to see the needed changes in my community.

I think Ms. Robbins said that addiction is a chronic disease. It needs much more than a 28-day treatment program, and I know this is true because recovery is a lifelong process, and again, there's nothing available here, and I want to see that end; I want to see it change, happen at soon as possible.

But I would like to ask if there are any suggestions as to what opportunities may possibly be available for a community such as ours? Thank you.

DR. RIOS-ELLIS: Our members are thinking. I don't know Starleen or Renata might have some suggestions, both being from the state government.

MS. HENRY: Her last comment, I missed your very last sentence there. You wanted to know specifically what's available in your community?

MS. LYNCH: There's nothing essentially available in my community, so if you have any suggestions as to what opportunities may be available, possibly available even, for a community such as ours? Our census is around 50,000, and we're in a city that's surrounded by heavy-populated

counties, but there's nothing available in this entire area.

MS. HENRY: Okay, my first suggestion to you would be to engage in a dialogue.

In Virginia, in Richmond, you have your state agency for substance abuse treatment and for mental health. I believe in Virginia it is a combined agency for mental health, substance abuse, and developmental disabilities, and there is a point of contact for the substance abuse director, but you can go online probably to your state, Virginia.gov, and look for state agencies and then look for the state agency that is mental health, substance abuse, and developmental disabilities, and then get in contact with them.

You want to speak to the person who has responsibility for substance abuse services and share your comments, your thoughts, find out where in your area there might be a local community service board that you can make contact with, but they would be able to give you guidance on how to both contact someone in your local area and it would be appropriate for you to share your concerns about the lack of services or gaps of services in the area in

which you live.

MS. LYNCH: Okay. Thank you so much.

MS. SCOTT-ROBBINS: Can I just add? This is Starleen Scott-Robbins. You can also speak to in that same agency your women's services coordinator and for Virginia, that's Martha Kurgans, K-u-r-g-a-n-s, and she would also be familiar with the women's treatment resources throughout your state and what types of plans are happening throughout the state and in your community for women's treatment specifically.

MS. ENOMOTO: Great. So thank you very much, Ms. Lynch. We appreciate your comment, and I hope that answers your questions.

All right, so with that, it's been a good day. It's been a long day, a lot of presentations and some good questions and dialogue. I think there's obviously more to think about, and this is kind of the appetizer so you can know a little bit in-depth the committee voted on the topics of which initiatives to hear from because we could have gone the other way and given you all 10 initiatives, but then you'd really be brain-dead, and the discussion would be very truncated.

So, we dove in-depth into a few of the initiatives that the committee identified as priorities. But it’s an ongoing process. The PowerPoints change on a weekly basis because there’s more thinking, there’s more conversation, we get input. It’s like a snowball, as we keep going.

I saw Dr. Clark writing some notes, so after you guys made your comments, he’ll change his slide presentation, Pam will change her slide presentation, and that's the intention of it. These are living documents, the initiatives are living things. And it’s exactly what advisory committees are for; you’re here to advise us and give us the perspectives from the fields from the very different levels that you guys represent and the different perspectives. So, I think it was helpful to get your input.

Tomorrow, we’re very lucky to have both the trauma and justice initiative presented. Dr. Larke Huang will be here and Lisa Najavits, as well, will be here to talk about kind of developments in her work and in trauma-informed care. So I think there will be a very lively dialogue, and we’ll also have some time to talk amongst

ourselves in terms of after you've heard from the initiatives we've identified, some kind of the crosscutting themes.

I mean, we've already heard some where women and girls in need, et cetera, but once we've digested it, what's kind of a plan of action for getting the needs of women and girls met throughout the SAMHSA Strategic Initiatives?

So with that, if there are any other comments or questions that people want to close out the day?

Stephanie?

DR. COVINGTON: I'm never a shortage for words. I just want to thank you that the tone, the flavor, the energy in SAMHSA is different than it was a couple of years ago. There's a difference in this meeting. This administration is making a difference, and you can feel it just from sitting in a meeting like this today. So, I think it's very good news.

Thank you.

MS. HENRY: I certainly appreciated the presentations. I thought they were direct and to the point. I tell Dr. Clark this all the time: I do really

appreciate his data. I know that's been a hallmark of his.

I think I would just encourage the entire committee to think about all that we do, but really in this context of what I think is a really exciting time around health reform and how we can accomplish a lot of the things that we have all along said we want to do, and I think we have an opportunity to do that.

So to the extent that we continue to get kind of educated and kept abreast of what's happening in reform, I think it's important for all of us, whether we're leading a state agency or whether we are delivering service or whether we're doing research or whatever it might be, I think there are these huge opportunities that are presenting themselves that we certainly ought to take advantage of. I know Susan says she's trying to find her third reincarnation. Think about it in the context of what you know and all we can do in health reform moving forward.

So I just think it's really important. Particularly as it focuses on women and girls, because the more we kind of think of integration with health and the whole person, I think that benefits women and children significantly.

MS. ENOMOTO: All right. We look like we need a walk outside.

(Laughter.)

MS. ENOMOTO: All right, with that, we will adjourn for the day. Thank you very much.

(Whereupon, at 3:53 p.m., the meeting was adjourned.)