1 Department of Health and Human Services
2 Substance Abuse and Mental Health Services Administration
3 Advisory Committee for Women's Services
4
5 Thursday,
6 May 27, 2010
7
8 Rockville, Maryland
9
10 PRESENT:
11 Kana Enomoto, Acting Chair,
12 Nevine Gahed, Designated Federal Official,
13 COMMITTEE MEMBERS:
14 Susan C. Ayers, LICSW
15 Barbara S.N. Benavente, M.P.A
16 Stephanie S. Covington, Ph.D., LCSW
17 Roger D. Fallot, Ph.D.
18 Renata J. Henry
19 Gail P. Hutchings, M.P.A
20 Amanda Manbeck
21 Britt Rios-Ellis, Ph.D
22 Starleen Scott-Robbins, M.S.W., LCSW

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1 P R O C E E D I N G S

2 (9:02 a.m.)

3 MS. GAHED: Good morning, and welcome to SAMHSA.

4 This is Nevine Gahed, Designated Federal Officer for

5 SAMHSA's Advisory Committee on Women's Services. And I now

6 call the meeting to order.

7 Ms. Enomoto?

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

9 PARTICIPANTS: Good morning.

10 MS. ENOMOTO: Good morning. We had a very robust

11 discussion yesterday and set of presentations, so, I thank

12 our presenters, as well as our members who participated

13 very actively, and, I think, gave some excellent feedback.

14 I think the perspectives that you're bringing to

15 the table are fresh and much needed. So there's been

16 further discussion and backchannels even after the meeting

17 yesterday with folks of like oh, this was really good;

18 we're going to put that in there, and we definitely need to

19 have this conversation about evidence-based practices,

20 diverse communities, and there's clearly messages that are

21 getting sent that are not congruent, and we have to get

22 people on the same page and know what flexibilities we do

1 have and how SAMHSA does understand the issues of diverse
2 communities and how they relate to evidence-based
3 practices.
4 And then the consistent feedback that we've
5 gotten about making sure that our attention to different
6 populations is made clear upfront when we talk about the
7 strategic initiatives, that the absolute value of consumer
8 and persons in recovery and community involvement is clear,
9 that the attention that we're paying to cultural and
10 linguistic diversity, as well as the gender-specific needs,
11 and different socioeconomic status.
12 In addition to military families, we are really
13 trying to look at the different communities and populations
14 across the lifespan. So that will be in our next
15 iteration; we'll get that right upfront and center.
16 It's exciting. Nevine just gave me this list of
17 the 80 or so folks that signed on to join us via the Web
18 yesterday. And so, we had people from all over the
19 country. We had some federal partners; we had HUD, OMH,
20 NIMH. So it's exciting.
21 We didn't have a huge crowd in the room, and I
22 think that's probably part of it, that we facilitated

1 people joining on in a new and different way, which looks
2 like it really worked. We had people in Missouri,
3 Wisconsin, Minnesota, New Jersey, California, New Orleans.
4 So, it’s wonderful. We really had a diverse group joining
5 us on the Web, and, again, I think we do today. We also
6 have Bobbie online. Bobbie’s a little bit under the
7 weather, so, she asked to be kept on mute. And, so, we
8 have Guam represented even via the Internet. So, that's
9 wonderful.
10 Today, we have a great agenda. I think it’s
11 going to be an exciting conversation. We have Larke Huang
12 talking to us about the initiative on trauma and justice,
13 as well as Lisa Najavits joining us to talk about
14 implementing evidence-based practices in trauma and
15 addictions, themes, and next steps. So, this is obviously
16 something that will be of interest to many of our members,
17 as well as our audience.
18 So, with that, I want to go ahead and open it up
19 to our members just to see if you had any comments about
20 yesterday’s dialogue or anything you reflected on over the
21 evening and wanted to add?
22 (No response.)

1 MS. ENOMOTO: No? We are in a reflective mood.

2 (Laughter.)

3 MS. ENOMOTO: Okay. All right, so, that makes us

4 ready to start with Larke.

5 As many people know, Larke is our senior advisor

6 for Children and Families, but she stepped into the breach,

7 and is leading two of SAMHSA's strategic initiative: The

8 initiative on trauma and justice, as well as the initiative

9 on jobs and the economy. She's doing a fantastic job, and

10 we're all very pleased to have her here today.

11 DR. HUANG: Okay, thank you, Kana, and welcome to

12 all of you. I know you've had a really interesting and

13 exciting agenda, and I see that I know a number of you from

14 really different areas in my life, way back over there.

15 Okay, so, I'm going to speak to you about one of

16 our strategic initiatives. It's strategic initiative on

17 trauma and justice, and, as Kana mentioned, I have the

18 honor of leading this initiative, and I do have to say a

19 lot of the groundwork for this was laid by Kana Enomoto and

20 many of you all.

21 As I was saying, I wanted to start off actually

22 first with some of the fast facts, and I don't know if

1 people have this or not. Kana, do you have this?
2 Okay, so, I'm not going to really read through
3 this necessarily, but I would like to really ground our
4 initiatives in some of the existing data that pertain to
5 the particular initiative, and we know that, for example,
6 trauma is really central to many of our mental health and
7 addiction disorders. And this is across the lifespan, as
8 well.
9 We see that homicide and suicide are some of the
10 leading causes of death among 15 to 34-year-olds. We see a
11 high suicide rate particularly among American Indian,
12 Alaska Native, particularly among the young males. It's
13 probably highest among that particular group in terms of
14 our youth.
15 We see that more than 60 percent of youth have
16 been exposed to some kind of violence within the past year.
17 One of our own recent studies based on our national
18 household survey data showed that one in four adolescent
19 girls have engaged in violent behavior in the past year.
20 We know that actually when you see this kind of behavior
21 that it often gets associated with other conditions such as
22 depression, and we know that adolescents with depression

1 are more likely to initiative substance use.

2 So we see a whole cluster of problematic and

3 high-risk behaviors often associated with trauma or some

4 kind of violence exposure.

5 We see youth engaged in violent behavior in the

6 past two years two to three times more likely to use drugs

7 or alcohol, and you can go on and on and see that we are

8 finding increasing support for understanding really the

9 centrality of trauma in many of the conditions that we're

10 concerned with and many of the population that we're

11 particularly focused on.

12 We also look at this not as just individual level

13 trauma or family trauma, but also how groups are affected

14 by trauma and how historical trauma, which has been

15 particularly captured in the American Indian population by

16 some of the work of Maria Yellow Braveheart --

17 MS. KOSTIUK: Yellow Horse.

18 DR. HUANG: Pardon?

19 MS. KOSTIUK: Yellow Horse.

20 DR. HUANG: Yellow Horse Braveheart, really sort

21 of capturing that concept for us and moving it forward, and

22 it becoming a really important sort of conceptual framework

1 understanding for many of other populations, particularly
2 populations of color.
3 This initiative is called trauma and justice
4 because we're looking at trauma across the lifespan, but
5 also across different settings, and one of the settings we
6 wanted to bring out in particular was that in the criminal
7 and juvenile justice system. So, I have some statistics
8 here in terms of looking at the rates of mental illnesses,
9 mental disorders, substance use, drug use, drug use
10 dependence that we see in the criminal and juvenile justice
11 system.
12 Okay, I pulled out some data on a study that
13 really helps us think about trauma and its association with
14 behavioral health conditions, as well as other chronic
15 physical health conditions, and, also, really moves us to
16 thinking about prevention, early intervention, and
17 treatment.
18 This adverse childhood experiences study, are
19 most of you familiar with this study? Okay, so, I'm not go
20 into the details of it, but it's basically a study
21 conducted by Kaiser in San Diego, in conjunction with CDC
22 of about 17,000 Kaiser patients, and this is not a clinical

1 population. Just really getting a sense of their
2 retrospectively adverse childhood experiences, such as
3 physical abuse, sexual abuse, having a parent incarcerated,
4 living with a parent who may be experiencing a mental
5 disorder or substance use disorder, and really just
6 counting these up, not even looking at severity, not
7 looking at repetition, not looking at intensity, but just a
8 simple count, and looked at the association with those
9 counts.
10 They were called ACEs for Adverse Childhood
11 Experiences. The association of those counts with
12 different kinds of conditions later on in adulthood. So,
13 if you just look at the counts, you see a direct
14 correlation between the ACEs scores and chronic depression.
15 You see another striking correlation between that and
16 suicide between adverse ACEs and current smoking, ACEs in
17 adult alcoholism, and then there were quite a number of
18 different variables they looked at, and I just pulled out
19 some here. And then, also looking at indicators of
20 impaired work performance. Affected ACEs on mortality
21 rates. Dying before or after age 65.
22 So we see a really compelling case, I think, for

1 looking at the prevention of trauma through this ACEs
2 Study.
3 This slide shows some of the multiple efforts we
4 have ongoing at SAMHSA that have a particular focus on
5 trauma. The first set of bullets are grant programs that
6 have a particular focus on trauma or violence, and that is
7 our Safe Schools Healthy Students Program, our national
8 child traumatic stress initiative, alternative to seclusion
9 and restraint.
10 We've done quite a bit of work on seclusion and
11 restraint reduction or prevention, and we're also including
12 that in this particular initiative, given that those are
13 often traumatizing or re-traumatizing experiences for
14 people who are in treatment settings, or not even in
15 treatment settings. We're getting more questions about
16 this and requests for help for even school settings, where
17 particularly our children who may have serious emotional
18 behavior disorders are more likely to be those who are
19 restrained in schools and more likely to be those injured
20 and even who die from that in schools.
21 Our Jail Diversion and Trauma Recovery Program.
22 We're incorporating getting a trauma focus more in our

1 juvenile and family treatment drug courts, initiatives, and
2 our Crisis Counseling Program. We also have some contracts
3 that focus on trauma, and I've listed some of the contracts
4 there.
5 And then we have other programs that also have
6 increasingly included a trauma focus on it, such as our
7 Pregnant Post-Partum Women Program, our children's mental
8 health initiative, and our adolescent substance abuse
9 treatment. Some of those problems have even actually
10 started to take some of the framework from the ACEs Study
11 that I just went over very briefly and looked at how that
12 applies in their study.
13 So, for example, the children's mental health
14 initiative, which is a program based on children with
15 serious emotional disorders, are now looking at some of
16 their data, looking at proxies for the ACE variables, and
17 finding levels of trauma in their children and families in
18 the program, whereas trauma had not been a significant
19 focus of that program, they're now looking at how they need
20 to begin to address that.
21 I also want to say in terms of the PPW Program,
22 and I want to give a little bit of a shout out to Linda

1 White-Young, who is in the audience there, because I just
2 got this news clipping today. We were out in Santa Maria
3 in Santa Barbara County, where they have incorporated in
4 their program trauma focus, and we actually were able to
5 sit in on their drug court, and they got a really nice
6 article in a paper locally talking about the work that
7 they've been doing there around drug courts, substance use,
8 and really bringing a trauma focus to that. And that was
9 at her PPW Grantee Meeting.
10 Okay so, we have work going on here. We
11 understand increasingly how trauma connects with the
12 conditions that we're very concerned. So, we try to think
13 about these initiatives in terms of framing questions. We
14 don't know if we absolutely have these right yet, and so, I
15 often use these presentations as kind of listening sessions
16 to get input from the people that we're speaking with. But
17 this is how we're going for it at this point.
18 So we framed our work here in terms of what can
19 SAMHSA do to one, prevent the occurrence of an exposure to
20 trauma for families and communities? Secondly, how can we
21 decrease the number of children and particularly women and
22 girls experiencing and exposed to trauma and violence?

1 Three, how can we reduce the physical and behavioral impact
2 of trauma for those who have experienced it, been exposed
3 to, witnessed trauma? Fourth, how can we work with the
4 criminal and juvenile justice system to divert youth and
5 adults with mental and substance use disorders into
6 treatment and recovery instead of into incarceration? And
7 how can we ensure that our service systems and supports are
8 not re-traumatizing, that many people who are going into
9 our service is already with trauma histories are not again
10 re-traumatized by our treatment efforts.
11 Okay so, we pulled out each one of those targets
12 and tried to think what is our goal in that target and what
13 are some of our opportunities there? We haven't
14 specifically laid out our work plan for how we’re going to
15 meet each of those goals, and so, that's what we’re hoping
16 to hearing about from you.
17 So I just listed some of the opportunities that
18 we think about in each particular goal and target area.
19 So, one of our opportunities we have, with the help of many
20 of you in this room, an increasingly better understanding
21 of trauma and how trauma relates to our conditions, and so,
22 can we actually begin to leverage the information and the

1 knowledge that you've helped us develop or that we've
2 learned from you? And implement some kind of national
3 education and awareness effort. And that would also
4 involve better defining and measuring individual family and
5 community trauma, and we're trying to do that now in
6 conjunction with our Office of Applied Studies and what
7 would be trauma measures? What would be trauma indicators
8 that we could even consider collecting throughout our grant
9 programs and in our household survey data? And how can we
10 begin to better communicate the centrality of trauma to
11 behavioral health disorders?
12 Part of this is how do we infuse this trauma
13 education knowledge in tools, prevention, and health
14 promotion activities? Our number one initiative is on
15 prevention. We're looking at prevention-prepared
16 communities. Well, how can we work with them to think
17 about how can trauma be a part of their focus as they're
18 developing that particular initiative and looking at what
19 they mean by prevention-prepared communities? How can
20 trauma be a component of that?
21 As we look at some of our family and community
22 strengthening initiatives, how can we also make sure that

1 trauma is a focus in those initiatives? We are working, as
2 you know, that SAMHSA is working 24-7 or maybe like 48-14
3 or whatever, nonstop, and you’ve probably met Pam, and you
4 know that she goes nonstop. So we all are at warp speed
5 right now. But we are working on various provisions in
6 health reform.
7 One of the provisions is home visiting, and this
8 is to be a major grant program to states that's going to be
9 administered by HRSA and the Maternal Child Health Bureau
10 in conjunction with ACF and in conjunction with any other
11 OP DIVs that were mentioned in that provision.
12 We were involved in that because substance abuse
13 is mentioned as part of what they want to see in the home
14 visiting pieces. So we’re pleased that we have substance
15 use in there and we’ve been able to get into the initial
16 design of that program that signoffs for the proposal have
17 to include the single state agency substance abuse
18 director.
19 And I don't know, this is a very uphill battle,
20 but also trying to get a focus on depression and trauma in
21 home visiting, and we have kind of rallied some of home-
22 visiting trauma experts, and at least have them now

1 hopefully going to be on the National Advisory Committee
2 for the program.
3 But we really have good work actually showing
4 that you can actually address trauma issues and doing
5 screening for trauma and home-visiting, and some of the
6 outcomes around that. So, we're working hard to get that
7 into the home-visiting RFA, which is appropriations
8 actually for this one, and the first year, it's $100
9 million appropriation, which goes to states to put in
10 proposals around this, and this is all to be done by
11 September of this year, so, that's Fiscal 10 money. It
12 goes up the next year to $150 million, up to $1 billion
13 over 5 years.
14 So, we're learning to get on the ground early in
15 this one, and, initially, they said well, we'll bring in
16 substance use in next. We said no, no, we don't want it
17 coming in next because then it may never get in there. So,
18 we were pleased that we got that in, and now we're really
19 trying hard to get the trauma piece.
20 Target two, to decrease the number of children,
21 women, and girls experiencing and exposed to trauma and
22 violence, and it's certainly where you can help us a lot in

1 sort of better detailing out what are our opportunities
2 here, and what do we want to put into a work plan here? We
3 look at intervening early with families at risk to reduce
4 level of child maltreatment. We look at education training
5 and TA on gender-specific and trauma interventions for our
6 current grant programs and federal interagency work.
7 I wanted to also just call your attention.
8 Things are always moving very quickly here, and I didn't
9 even get a chance to put this in the slides, but in our
10 Center for Substance Abuse Treatment, we had the analysis
11 of looking at some of our NSDUH data by gender and are
12 finding alarmingly and strikingly higher rates of alcohol
13 use, alcohol dependence, and binge drinking among girls 12
14 to 17. So and we're also finding that a high need, but a
15 high level of unmet need and poor utilization of services.
16 So some of the states have even said when they
17 have gender-specific treatment services for girls, the
18 girls are not getting into them or they're filled to
19 capacity already. So this is just kind of a very recent
20 and new analysis or data. I'll give it to Kana. We
21 actually have a PowerPoint on it, and I couldn't get it
22 into these slides quickly enough.

1 But we also think okay, we're seeing those
2 increased alcohol rates. What are other kinds of issues
3 going on with those girls and what been a structure and
4 what's their peer supports around that, their family
5 supports, or what might be some of their trauma histories
6 that are really increasingly higher now than boys in quite
7 a number of states?
8 We also want to look at reducing the physical and
9 behavioral health impact of trauma, and much of this comes
10 from our own trauma studies, as well as the ACE Study and
11 how can we really begin to disseminate, train, and provide
12 TA on effective approaches to screening, early
13 intervention, and treatment of trauma in behavioral health
14 and actually other service sectors?
15 We want to look at this in terms of other health
16 sectors, child welfare, criminal and juvenile justice,
17 education, and housing. We're working very closely now
18 with HUD on a number of initiatives.
19 And can we also utilize our faith-based networks?
20 We're increasingly involved with the faith community who
21 says we are a very ready population that deals with many of
22 your issues, and not just the faith leaders, like the

1 ministers and the priests and all, but their lay community.
2 It is their peers and their neighbors who are coming to
3 them with their stories of domestic violence or their
4 stories of depression, and so, the lay communities and
5 these faith organizations are wanting to know what training
6 do we need to know how to even handle this as a first
7 responder?
8 And, again, identify how can we better identify
9 participants in our programs, whether it's through trauma
10 screening items or trauma screening tools so we can better
11 meet the needs of our treatment and early intervention
12 programs?
13 And our third target, it's really to work with
14 the criminal and juvenile justice system to divert youth
15 and adults into treatment and recovery, and, again, how can
16 we improve the availability of trauma-informed care in the
17 criminal and juvenile justice systems? And, actually, I
18 think through this group that we had a visit to Dorchester
19 County Jail, where it was amazing how they had completely
20 turned around the culture of their jail to become much more
21 trauma-informed.
22 Also, I think I've mentioned this, but they also

1 had the opportunity--I think Gail was with us when we
2 visited the L.A. County Jail, which was really sort of an
3 ad hoc treatment facility for many people who were not
4 getting into mental health or substance abuse treatment and
5 how the levels and rates of trauma and unmet there was very
6 much talked to us by Sheriff Baca at that visit.
7 And how do we provide community services support
8 reentry and prevent recidivism and we often hear, and you
9 are probably more familiar with the studies than I am. I
10 hear more anecdotally that people cycle in and out of jails
11 and prisons because their trauma histories are not met,
12 that they go back to whatever their substance use or the
13 mental health issues, the criminal behavior until they can
14 really get a better handle on earlier trauma histories that
15 are really the underlying issue for many of their
16 behaviors.
17 Okay, and then our target five is really to look
18 at how can we ensure that the service systems that are
19 there to support people, whether they're children, young
20 people, adults, or the elderly, that they're not, in fact,
21 re-traumatizing? How can we begin to export our models of
22 trauma-informed care to multiple service actors and provide

1 training and technical assistance?

2 And certainly Susan Salasin--I don't know if

3 Susan is here, but she’s been leading our National Center

4 for Trauma-Informed Care, and really looking at how can we

5 get that out on a wider scale to service providers and

6 other sectors where our population are seeking treatment or

7 seeking services, and I see Jeannie Campbell here, and

8 we’re really talking with also the National Council with

9 their widespread, tremendous network of 1,700 or whatever

10 providers, how can move our information, our materials, and

11 our trainings about trauma-informed care to these broad

12 provider networks?

13 We’re also looking at continuing to expand our

14 efforts on preventing and reducing the use of seclusion and

15 restraint in multiple sectors.

16 Some of you may know about the legislation

17 sponsored by George Miller to look at preventing use of

18 seclusion restraint in schools, and so, we have been

19 working with the Department of Education, and there was

20 actually a hearing that Congressman Miller had that

21 identified, the SAMHSA work on the prevention of seclusion

22 and restraint, and can that be transferable to school

1 settings? And we have some materials and some workgroups
2 going on that, and so, we're looking at that. It's another
3 sector to think about, ensuring that we're not traumatizing
4 children in the school setting.
5 And then partnering at the federal level with
6 other agencies where these practices are particularly
7 prevalent and highly problematic, and also just some of the
8 federal partners that we've identified that we already have
9 a working relationship with and some that we're in the
10 process of cultivating that.
11 So, questions to think about, how can we sort of
12 maximize the benefit from our multiple trauma-related
13 efforts? How can we continue to leverage our knowledge and
14 investments in trauma? Should we have a consultative
15 session on a place-based initiative?
16 You probably heard that a big focus of this
17 administration is really looking at place-based
18 initiatives, and we're involved with multiple place-based
19 initiatives, and it makes me think if everybody has a
20 place-based initiative, it's really not a place-based
21 initiative. We could, in fact, get really siloed place-
22 based initiatives. But that's to be handled later, I

1 guess.

2 But one of the things that we're also thinking
3 about, if we tried to do a place-based initiative in terms
4 of thinking about how we organize our own funding care and
5 our investments, could we, in fact, have a more
6 comprehensive system of care or treatment focus with trauma
7 as a central foundational piece of a place-based
8 initiative?

9 We have some very interesting place-based work
10 going on with some of our other departments, where they are
11 looking at major grant programs in their particular
12 sectors. The first one to come out with that is the
13 Department of Education and their Promise Neighborhood
14 Schools, and HUD has just released their announcement of
15 their program that is going to be announced on Choice
16 Neighborhoods. So, those are large place-based
17 neighborhoods where they want to see, can we blend funds
18 across the different departments to really focus in on
19 combining efforts in particular places and see can we
20 really handle our issues more efficiently and have more
21 impact in that sense?

22 As we're looking at that, we're also looking at

1 can we infuse the trauma focus in that, as well?

2 And, certainly, we’re also looking at how can we

3 consider special populations such as tribes or diverse

4 ethnic, racial populations with historical trauma and high

5 rates of behavioral health issues often associated with

6 that level of community trauma? How can we intervene with

7 those communities? How can we bring our information about

8 knowledge and also learn from them about strengthening our

9 own approaches to trauma.

10 I think that's it. So, I’m certainly open to

11 your input and directions you want to take. We actually

12 have other things that we’ve started doing, which I can end

13 the discussion. We can leave with you some of that, as

14 well. Okay.

15 MS. ENOMOTO: Thank you, Larke. One of the

16 things that I think there is reference to, but didn’t get

17 expanded, and maybe it’s one of those things that you were

18 thinking of adding on, is measurement of trauma. We’re not

19 currently measuring trauma in the NSDUH, and we don’t have

20 a common measure of trauma in our GRPA measures for all of

21 our grantees, and so, we’re starting to think about that,

22 and I guess this is a good group to start with in terms of

1 what kinds of measures are meaningful and yet amenable to
2 large-scale national survey, widespread GPRA measures that
3 cut across all of our programs. So I guess some thoughts
4 on that I think would be appreciated.
5 DR. HUANG: Yes. I just very quickly alluded to
6 that because Pete Delany, head of OES is convening us to
7 think about what might be those trauma measures.
8 I think we're also trying to think about, as
9 we've used our SBIRT Program in community health centers
10 and in primary care, are there quick screening items for
11 trauma that we could also use in those, given the
12 connection of trauma histories also with other chronic,
13 physical health diseases?
14 MS. HUTCHINGS: Larke, nicely done, and exciting.
15 So, it's really, really nice to see. Thinking of the
16 millions and millions of dollars every year that SAMHSA
17 invests in its TA centers, whether they're regionally
18 organized, CAPS, and ATTCs for the two CSAP and CSAT or
19 topically organizing CMHSs over two dozen.
20 DR. HUANG: Right.
21 MS. HUTCHINGS: Off the top of my head, I can't
22 think of one of those that aren't relevant, and it's nice

1 to see that they're specialized ones, of course, but that
2 aren't relevant, and as someone who's started and run
3 several of those TA centers in her career, I can't think of
4 the last time they were convened together and sort of
5 issued a priority from the head of SAMHSA that says we'd
6 like to see your works plans infused with trauma-informed
7 care approaches, and we'd like to offer your particular
8 training because I love the way you just said we want to
9 expand our reach and our depth, and this is probably a
10 relatively low-demand, low-cost, high yield way to
11 potentially do that.
12 DR. HUANG: Yes.
13 MS. HUTCHINGS: And I'd love to try to be helpful
14 in any way I can. But just an idea.
15 DR. HUANG: That's great. That's a great idea.
16 We see a little bit of kind of leaking out, but nothing
17 systematic. So I think to sort of have a systematic
18 approach to how can we work with the TA centers and convene
19 them? And educate them around this, I think, would be
20 great.
21 MS. HUTCHINGS: And some of the leaks are so
22 beautifully done and some are just downright scary.

1 DR. HUANG: Yes.

2 MS. HUTCHINGS: So you could do informed

3 leakages.

4 DR. HUANG: Yes.

5 MS. HUTCHINGS: That would be wonderful.

6 DR. HUANG: Informed leakages. That's a great,

7 new concept.

8 (Laughter.)

9 MS. HUTCHINGS: Don't attribute it to me. It's

10 really pretty poor.

11 DR. HUANG: Gail Hutchings, informed leakages."

12 Okay, we got it.

13 Any other ideas?

14 DR. RIOS-ELLIS: Well, one of the things that I

15 was just thinking about is immigration-related trauma,

16 especially within everything that's going on, and I think

17 everybody knows this here, but it's not just people coming

18 from Mexico and Latin America who are filtering through the

19 border. So people come from all over the world, and then

20 try to get through, and I think that because we hear so

21 many stories, especially around sexual violence and

22 especially now with the level of violence along the border,

1 and that might be a way to both honor the resilience of
2 immigrants, but also begin to raise the level of national
3 understanding and compassion towards different situations.
4 DR. HUANG: Okay, that's great. Thanks, Britt.
5 DR. FALLOT: Larke, thanks very much--
6 DR. HUANG: Yes.
7 DR. FALLOT: --for the emphasis on trauma, and I
8 wanted to, I guess, raise an issue around trauma-informed
9 care, especially, because it's used in such a variety of
10 ways, and the idea of training somebody to do trauma-
11 informed care is, I think, an easy fix that is not really
12 going to work in the long run. It's a concept that I think
13 needs to be reshaped in terms of culture change, and what
14 we're talking about when we talk about trauma-informed care
15 in a specific mental health or substance abuse agency, for
16 instance, is a really a shift around the fundamental values
17 that animate the people who work there.
18 And that kind of shift can only occur over a
19 considerable period of time so that the idea of training
20 somebody to do that kind of thing in a day or two days is a
21 nice idea, but it just hasn't worked out in most places in
22 the long run.

1 The idea of having ongoing connections, as
2 Stephanie Covington and I are working in Connecticut on a
3 trauma-informed and gender-responsive initiative that is
4 focused on the different trauma experiences of women and
5 men and the ways in which those are seen in substance abuse
6 agencies particularly in this state.
7 What we decided is we're going to be there for
8 the long run in order to make this work because we're
9 swimming against the stream here of history, and it's a
10 powerful stream, and I think as much as people understand
11 trauma and they can get it on the basis of the VA study
12 data and some of those other kinds of things you're talking
13 about, there are many people for whom the idea of changing
14 the way they actually deal with other folks is a long-term
15 process that needs to be enabled to both the administrative
16 level and at the staff level.
17 DR. HUANG: That makes me think about what are
18 sort of graduated steps we need to think about taking, and
19 we had a meeting here sort of acknowledging facilities that
20 had significantly reduced the use of seclusion and
21 restraint in their treatment facilities, and as we had that
22 discussion, people were talking about well, they could

1 change the culture with a recovery framework, but some had
2 a lot of difficulty using a trauma-informed framework
3 because they weren't ready for that yet, and, actually,
4 many of their staff weren't ready for that.
5 So I think understanding sort of what is the
6 readiness, what is the progression we need to think about.
7 There might be some quick things, but there are going to be
8 some things that are much longer-term. So, we are very
9 open to learning more and hearing more from you around
10 that.
11 DR. FALLOT: Terrific. I think you're absolutely
12 right that readiness is a primary issue for many agencies.
13 DR. HUANG: Yes.
14 DR. FALLOT: And to identify places where they
15 have in the past, as we do with individuals all the time;
16 we identify places where individuals have conquered, have
17 survived, have gotten through, demonstrated resilience,
18 recovery skills, and capacities, but we are reluctant and
19 unable, often, to identify the same sorts of skills and
20 strengths in agencies or states even who also bring their
21 own histories of resilience, recovery, change, and positive
22 growth and development.

1 DR. HUANG: Yes.
2 DR. FALLOT: If a place to recovery orientation,
3 then it's a smaller step, I think, to trauma-informed care.
4 But to identify the places that they've been able to make
5 any kind of culture change is a real advantage.
6 DR. HUANG: Yes. So, are you coming up with like
7 a template for us for the readiness piece and stuff like
8 that?
9 DR. FALLOT: Sure.
10 DR. HUANG: Okay, got it. Thanks.
11 DR. COVINGTON: I'd like to see it, Roger.
12 I want to underscore what Roger said, and also
13 that I think we live in a society that always looks for
14 simple solutions, and I think one of the things that we've
15 learned in this project that we're beginning is that these
16 agencies may actually be using various curriculum with
17 their clients, but, in fact, they are not operating a
18 trauma-informed environment at all. It is much easier to
19 pick up a piece of paper and run an intervention than it is
20 to become trauma-informed. And, so, we're seeing all kinds
21 of things. So it's really this whole bigger picture, I
22 think.

1 But in looking at this initiative, I mean, I
2 think both things are really critical. I guess if I have a
3 disappointment, it is that somehow they got merged, because
4 my concern is I know that when this was introduced
5 yesterday, it was very clear these are two separate things,
6 but, in fact, the way they’re here, and anytime they’re on
7 paper, they look merged.
8 And one of the things I think you’re going to be
9 really challenged by is how do you get the trauma piece
10 infused throughout all of these strategic initiatives so it
11 doesn’t just sort of sit here as this initiative and then
12 having it connect to the criminal justice is particularly
13 problematic because that population probably has the
14 highest rates of trauma in their lives. So, it’s kind of a
15 Catch-22.
16 One of the things I haven't heard mentioned that
17 sort of occurred to me in listening to you, and I don't
18 know if you’re aware of it; I’m assuming you are, but I
19 personally have found it really helpful in this latest work
20 I’m doing, and this model of violence that comes out of the
21 World Health Organization.
22 Have you looked at that ecological model that

1 they have? And you can find this on the Web or I’ll it
2 shoot it to you by e-mail.
3 The World Health Organization has what they call
4 an ecological model of violence, and they talk about there
5 are four levels to look at: individual, relationships,
6 community, and society. And the idea is the risk factors
7 to be a victim of violence and the risk factor to be a
8 perpetrator of violence are the same risk facts at these
9 four levels. And, so, when you start looking at violence
10 prevention, which I think people often talk about trauma.
11 I’m glad to see you even mentioned the word
12 violence because it’s often left out of the discussion
13 because, ultimately, that's what we’re talking about. But
14 when you start talking about violence prevention, then we
15 have to look at some really fundamental issues as to our
16 values in our society and how society is structured. And,
17 so, we’re also looking at trauma in this individual, but
18 when you put it in a larger social context, it’s a huge
19 issue.
20 So I’ve been working on this program for women
21 who commit violent acts and thinking about how do you even
22 prevent violence and how do you think about it? But that

1 model has helped me think about sort of how to structure an
2 intervention.
3 DR. HUANG: Sure.
4 DR. COVINGTON: So I’m just going to suggest that
5 as kind of a way to think about it because I’ve heard
6 prevention yesterday, I heard it today, but I don’t think
7 we think about prevention in a deep enough way. I think we
8 sort of throw the term around, but I don't know that we’re
9 really willing to do what it would take to really prevent
10 violence or to prevent substance abuse. I don’t think
11 we’re willing to do that.
12 DR. HUANG: Yes. Well, I’ve heard that, that
13 particular framework when I’ve heard you speak. So, that's
14 the most I’m familiar with it. So, if you have anything to
15 send, that would be great.
16 DR. COVINGTON: I’d be happy to. Sure.
17 DR. HUANG: And I think that many of our
18 interventions, if we start from our interventions, they are
19 more clinically-focused, but we also have some
20 interventions that are connected with settings. So, there
21 are sometimes individual-focused or setting-focused.
22 Like we have a school, we have a lot of school-

1 based violence prevention work. One of the things, and I
2 tried to mention a little bit about that in terms of trying
3 to look at historical trauma, but really trying to look at
4 community trauma, and I actually am a community person, so,
5 that's my background in training, so, that ecological model
6 is the concept around it.
7 Specific to violence, I’m not as familiar with,
8 but the ecological framework is something that I think is
9 it’s transformed a little bit in this way. People talk
10 about social determinance and that's, to me, another way of
11 looking at sort of the ecological pieces. And I think that
12 is important for us to look at. We haven't gone world in
13 society yet, but I think we’re trying to look at it as
14 community violence and community trauma and that so much
15 connected up with what happens with individuals and
16 families that we don’t want to not look at that piece.
17 We have a harder time figuring exactly how to
18 look at that piece, too, and how to measure that and how to
19 measure if we’re making progress. What should be our
20 benchmarks around looking at community violence or
21 community trauma? But so, certainly having discussions
22 about it, I’m very open to that, and certainly our

1 workgroup, I think, would very open to hearing from
2 different people and different perspectives as we shape
3 this.
4 And our framing questions are what we’re starting
5 out with now. As you probably heard from the other
6 strategic initiative presenters, that these are ever
7 evolving; we needed to start someplace, but to me it’s not
8 -- that's why I said opportunities are not objectives yet,
9 it’s kind of opportunities that are directions to go in.
10 But I’d be very open to discussions around that. Thanks.
11 MS. ENOMOTO: I would add that SAMHSA is
12 beginning a partnership with IOM. The project hasn’t quite
13 launched yet, but the IOM is doing, I think, a study group
14 on global violence prevention, and so, we’ll be partnering
15 with CDC and others in that study. So, we’ll keep you up
16 to date on where we go with that.
17 Amanda?
18 MS. MANBECK: I really appreciated how you put in
19 there the historical trauma that affects Indian Country.
20 In all of the communities, we believe that historical
21 trauma is the root to all of the problems that go on. It’s
22 the reason behind substance abuse, domestic violence,

1 poverty, consciousness. I mean, all of that. And I was
2 thinking about I guess the measurements that we've done so
3 far with the communities because it is difficult to measure
4 a community.
5 One of our greatest resources that has at least
6 given some light is the Community Readiness Assessment out
7 of the Tri-Ethnic Center that Pam Jumper-Thurman helped to
8 create.
9 The thing that we found in this assessment when
10 we've done the communities is that the two dimensions that
11 are normally scored the lowest are the community climate,
12 as well as the leadership. So to me, these are huge
13 indicators as to where things need to be strengthened. If
14 a community believes that substance abuse is just a norm,
15 then you need to change the social norm. You need to go
16 into the community and work towards helping them to believe
17 that having domestic violence, substance abuse, or youth
18 suicide is not normal, even though for them, it is.
19 There's not one person in the community that
20 hasn't been touched by youth suicide, especially recently
21 with the rash of suicides around the country because it's a
22 trickle down effect, one youth will commit suicide, and

1 usually from that, several will follow. So you get in a
2 small community, it affects every person. So, that trauma
3 in itself is hard.
4 And then with the leadership, the whole idea of
5 intergenerational trauma is something that the native
6 communities have existed in for so long that they've become
7 numb to how far-reaching it is. It affects in what we see
8 the four directions: the individual, family, community,
9 and nation. So starting at the individual level, somebody
10 is traumatized; it affects their family, and the family
11 affects the community, and so on.
12 And what we found is a hard part is that a lot of
13 the people that are affected, they don't know how to say
14 out loud. There's not a safe place, there's not a method.
15 And I don't think it's due to lack of willingness; I think
16 it's due to lack of knowledge. A lot of time, the tribal
17 councils have other things that they need to be aware of,
18 and I think it's probably they don't even know where to
19 start.
20 And so, if it were me, normally, the protocol
21 when you're working in Indian Country is that you would
22 address the council, then you would address the community.

1 And I really think it’s about raising awareness and it’s
2 about letting them know that even though they’re struggling
3 now, that's not necessarily the way that it has to stay.
4 So, that would be my suggestion with regards to
5 handling that. And it’s so far reaching and the people
6 that are affected the most are the youth. They’re growing
7 up in communities where they think that that's what they’re
8 going to be. They’re going to grow up and they’re going to
9 be alcoholics and they’re going to go to treatment and
10 they're going to come back. And it’s like the stigma has
11 perpetrated itself into the communities, and it’s become a
12 part of their belief system.
13 So I really appreciated that you included that
14 because historical trauma at a community level is not
15 normally talked about. It’s concentrated on individuals or
16 families. And when you see a whole nation or a whole
17 community affected, it’s really hard to go in there with a
18 lot of hope.
19 So, thank you.
20 DR. HUANG: Well, thanks very much for your
21 comments, and I mean, I think that what you’re raising is
22 also so far beyond our usual interventions, and that's why

1 I think somehow organizing ourselves around these strategic
2 initiatives might get at more community-wide and community
3 level things. I think that to really break the
4 intergenerational trauma in defined communities or
5 community historical trauma, it's not going to just take
6 our mental health and substance abuse preventions; we do a
7 lot around tribal suicide prevention and it's still not
8 doing it.
9 So, I think it's sort of going back to what to
10 also what Stephanie was saying, and I lead this jobs and
11 economy initiative, also, and I think jobs and economic
12 development is going to be as salient as mental health
13 treatments and suicide prevention in some of the
14 communities, the housing pieces. I mean, I think all of
15 those things enter into the fabric of whether a community
16 is feeling good about itself or not.
17 So our clinical interventions are one limited
18 focus when we're really doing it with community-wide
19 trauma, and that's why, in some ways, looking at sort of
20 place-based pieces and what can we think about for place-
21 based, even with tribes, to really hit at the multiple
22 issues going on that are so closely intertwined that lead

1 people, and particularly young people, in troubles, to get
2 engaged in cluster suicides and all.
3 So, thanks for your comments.
4 Yes?
5 DR. FALLOT: Yes, I just wanted to commend the
6 idea of place-based initiatives. We're working with a
7 group in Rochester, New York, right now, for instance, who
8 started consulting with us about a trauma-informed approach
9 in their Jail Diversion Programs. They've since expanded
10 it to draw in some monies from the Safe School Healthy
11 Initiatives, Safe School Healthy Start, whatever. You know
12 what I'm talking about.
13 DR. HUANG: Who's doing that? Is that--
14 DR. FALLOT: Dave Putney is the project director.
15 DR. HUANG: Okay.
16 DR. FALLOT: Elizabeth Meeker is the other person
17 working on it with us.
18 DR. HUANG: Okay. Yes.
19 DR. FALLOT: They've expanded it from the jail
20 diversion beginning to include a safe schools initiative to
21 include an outpatient mental health setting, and now,
22 they've invited us to work with the family drug courts, as

1 well. And that's a fairly expansive view already in that
2 community of the spread of a trauma-informed approach. And
3 we could have started with a more comprehensive model.
4 that would have been a wonderful opportunity, I think, to
5 address all of these things simultaneously. But it happens
6 in communities when one area really gets the idea and
7 starts working with it, it easily passes to other areas, as
8 well.
9 DR. HUANG: Right, right.
10 DR. FALLOT: But I just think the idea of a
11 place-based initiative makes a lot of sense to me.
12 DR. HUANG: Yes. So, maybe you can help us think
13 about that if that's already happening sort of de facto as
14 opposed to within 10. Yes, okay.
15 DR. FALLOT: Yes, and there are some places. Ann
16 Jennings, also, is working with Rockland, Maine. It’s her
17 home community. Around developing a trauma-informed
18 community, is her understanding of what she’s up to anyway,
19 and I think that's what she’s doing. She’s working with
20 the schools and with the public libraries to make sure that
21 the librarians understand there are children’s books that
22 are going to be helpful in prevention and early

1 identification of trauma. Those kinds of things are part
2 of her work, as well.
3 And, finally, let me commend to you Sandy Bloom,
4 who's doing the work in Philadelphia in the inner city
5 there around non-violence. Because I think Stephanie is
6 right. I mean, what we're talking about here is that it's
7 really a commitment to non-violence in all aspects of what
8 we're doing in these communities.
9 DR. HUANG: Right, thank you.
10 MS. AYERS: Hi. This actually could be a
11 tagalong on Roger. I'm sitting here just struck with how
12 many ingenious, ambitious people there are out there in the
13 community working on different models of care and
14 developing these new initiatives that they think, in fact,
15 could be very practical solutions to very big problems,
16 and, yet, I feel like the door into the information stream
17 is very narrow. If you can't figure out how to write a
18 SAMHSA grant or if you can't figure out sort of how you
19 kind of get connected to a higher level of information and
20 importance to get that flow through, you pretty much are
21 continuing to just figure out how to stay viable in the
22 community and be able to continue to pay your way.

1 In our area, there's a wonderful group call
2 Girls' LEAP, and they do this fabulous work; they train
3 college students in different curricula or at a curricula
4 they've developed for young women who are like I think 12
5 to 18 who are in the Boston Public Schools who are at-risk.
6 And it's this really amazing little model, and the question
7 is: All right, well, how do you get that someplace where
8 it could become sustainable and elevated?
9 And I'm just sitting here thinking that in every
10 state, your funders, the state funders do become very
11 familiar with where the really interesting innovations are
12 happening, and I wonder if there isn't a way to have
13 another door in which could come through whoever the
14 authorities are through the Department of Mental Health or
15 Substance Abuse or however that works where some technical
16 assistance could be offered or whatever those next steps
17 would be so that you could, in fact, find these different
18 places where people are doing really phenomenal work, and,
19 yet, it's difficult to elevate them.
20 And the ones who get elevated, like our friends
21 that do national wrap around stuff, they built all of that
22 on federal dollars, and then it becomes proprietary. And

1 then, sorry, that's it. If you can't afford the fancy
2 people to come in to help you figure out how to do this,
3 then--I mean, that's not all of them, but a lot of the
4 really prominent ones on the children's side are.
5 So that was just one comment. I'd love to see
6 another door open and maybe it could come through state
7 administrators who, in fact, are funding a lot of these
8 areas.
9 And then the other piece, back to your trying to
10 figure out community measures is the United Way in
11 Massachusetts in the Boston area--
12 DR. HUANG: I'm sorry, is the what?
13 MS. AYERS: United Way.
14 DR. HUANG: Oh, United Way.
15 MS. AYERS: Has, I think, a really bold and
16 ambitious move convened both state and private
17 stakeholders, and they're working on trying to demonstrate
18 and focus resources so that they can demonstrate community-
19 wide impact so that Massachusetts is going to be the best
20 place to raise children by the year 2014 or maybe it's
21 2020, but this is a piece where there could be all this
22 joint learning stuff, back to your issue about the TA,

1 these centers, where they get together, they talk, they
2 share information.
3 So, I commend the collaboration that's happening
4 at the federal level, and wonder if there aren't other ways
5 to create selective, but still wider doors into the
6 conversation.
7 DR. HUANG: Yes. I think you have a really
8 interesting point there, and something that is not a
9 thought unfamiliar to us, and I have another initiative
10 that kind of addresses that issue of when you have these
11 pockets of excellence in innovative work from the community
12 that seems to be working in the community, but maybe it's
13 not as strongly science-based to be in our national
14 registry of effective programs and practices. How do you
15 build the science base and how do you move that out and get
16 broader sharing of that or uptake of it?
17 We do have sort of a national network. It's
18 really focused on minority communities because that's
19 oftentimes where they are. They are not necessarily in the
20 cycle of getting big grants, federal grants, but they're
21 doing very innovative work with little bits of money in
22 their communities, and we actually have networked them

1 together so they can start to learn from each other, also
2 trying to bring them into the stream of federal funding.
3 So and then we have some efforts here, actually,
4 in CSAP, where they have some programs, what they're
5 calling Service to Science, where they're actually working
6 with those small programs to build capacity for evaluating
7 and beginning to demonstrate results so that they can go to
8 their state legislators or they can go within their states
9 and say here's what we're doing, here's our results, and
10 appropriate some funding for it.
11 So, but that is constantly an issue that we can't
12 do everything top down from the government, and how do we
13 capture those really innovative programs and interventions
14 that are having staying power and showing to have results
15 in their communities? So, it's a question we grapple with.
16 MS. ENOMOTO: Okay, I'd like to thank Larke for
17 your presentation. Thank you.
18 (Applause.)
19 MS. ENOMOTO: And I don't know if you have time
20 to join us at the table and listen to the next one or if
21 you have to leave.
22 DR. HUANG: (Off microphone.)

1 MS. ENOMOTO: Well, we did have Susan here, who
2 mentioned the Federal Roundtable last time. So, thank you.
3 So next, we have Lisa Najavits, who's a professor
4 of psychiatry at Boston University School of Medicine and
5 lecturer at Harvard Medical School, as well as the director
6 of Treatment Innovations and the author of Seeking Safety,
7 who's here to talk to us about both the model that she
8 works on, as well as other sort of emerging innovations in
9 the field.
10 So, thank you, Lisa.
11 DR. NAJAVITS: Thank you. I am truly delighted
12 to be here and to be part of what is really a wonderful
13 think-tank and brain trust around really trying to improve
14 care at so many different levels.
15 I'm going to be talking a little bit about the
16 Seeking Safety Model. I was asked to present on that, and
17 it's an example of a trauma-informed, specific intervention
18 to try to work on both trauma and addiction at the same
19 time. And then, I'm going to reflect a bit on some
20 broader, big picture issues on implementation of evidence-
21 based practices generally, and I think we're really in a
22 historic period right now where there has been both a lot

1 of wonderful work to develop new models, to create a lot of
2 innovation, and, yet, also, a very long way to go to
3 thinking out how to best structure, promote, and encourage
4 various efforts and ways that really work for so many
5 different settings and clinical needs.
6 Briefly, Seeking Safety is a model that is
7 typically run as a treatment, a therapy, or counseling
8 model, but can also be done as a training in some settings
9 where they may be relevant, such as schools or the
10 military, where people may not want to admit that they have
11 problems are trauma and addiction. It's designed for a
12 very high level of flexibility, and I emphasize that
13 because clients or people more broadly with both trauma and
14 addiction show up in so many different settings: in
15 primary care, criminal justice, in mental health, substance
16 abuse, so many different places that it is important to
17 create flexibility. So, the model is very much designed to
18 vary in length, in format, group versus individual
19 delivery, any way that can sort of work in the setting.
20 Easy to conduct, not that recovery is easy or
21 that these clients are easy, but that the work itself, when
22 using the model, the feedback we consistently get is it is

1 an easy model to implement. It has handouts, it’s a
2 relatively quick to learn. And low-cost. Very much
3 designed from a public health perspective, not requiring
4 specific training, not requiring specific credentials of
5 the providers, really just needing sort of the handouts to
6 be able to run the model.
7 Implemented successfully in diverse settings. It
8 can be done by any clinical staff. Used for over 15 years,
9 and sometimes used as a general stabilization model for any
10 patient coming in rather than specifically those who have
11 diagnosed PTSD and/or substance use disorder. So it
12 sometimes gets applied much more broadly, designed for any
13 type of trauma, any type of substance, and for both
14 genders.
15 I won't get into detail here, but just will
16 highlight a couple of points. So far, it is the most
17 studied model for co-occurring PTSD and substance abuse, a
18 variety of pilot studies, controlled trials, multi-site
19 trials, and some dissemination projects, and I think the
20 wide array of them really speaks again to just how many
21 different places these clients show up.
22 The website seekingsafety.org does have the full

1 published reports of the research studies, as well as the
2 wide variety of other freely downloadable materials related
3 to trauma and substance abuse. And, overall, I think both
4 with this model and also with other models that have been
5 developed, the really good news is that when people are
6 given focused attention on trauma and addiction, they tend
7 to improve. The results generally are positive, and this
8 really flies in the face of where the field was for most of
9 the 20th Century, where people said you could not
10 concurrently on trauma and addiction.
11 And really, that's been a fundamental shift, a
12 real turnaround to now say if a client’s walking in with
13 both sets of issues, deal with both from the front-end.
14 So, that really is, I think, a major achievement broadly in
15 the area of trauma and addiction.
16 The Seeking Safety Model harkens back to a really
17 beautiful book on trauma, now a classic in the field, by
18 Judith Herman, Trauma and Recovery, in which she identified
19 these three core pieces of work in the recovery process.
20 The first being safety, to establish better relationships,
21 get out of unsafe situations, stop misusing substances,
22 learn coping skills, learn about their disorder. Then,

1 having done that work, they can go on and do the work of
2 mourning, which is essentially really facing the past,
3 really telling the narrative of what happened and how it
4 affected them, and working through those feelings. And,
5 finally, reconnection, establishing good work life, good
6 social life, and, often, they are becoming an advocate to
7 other survivors.
8 So I decided to focus just on that first phase on
9 safety in relation to both the trauma and the addiction
10 piece. So in the model, very much a focus on helping the
11 person understand for themselves in their own lives that
12 distinction of safety versus danger, and particularly for
13 people who grew up in unsafe families, unsafe communities.
14 That distinction is often unknown at this point, that it
15 takes a lot of work for them to get their own sense of
16 what's safe and unsafe for them in their thinking, in their
17 behavior, and in their relationships.
18 So the model focus is on coping skills in the
19 present, which is part of, I think, what makes it a very
20 transportable model and a model that can be done in so many
21 different settings and among so many providers. It can be
22 combined with any other model, some of the more intensive

1 past-focused models such exposure therapy, certainly other
2 addiction models, but in and of itself has this focus.
3 Twenty-five topics evenly divided between
4 cognitive behavioral and interpersonal. However, one
5 doesn’t have to have all of them. The idea is as much as
6 there is time for, to at least do something. So, sometimes
7 people just do a few, some people will do many. Group or
8 individual, open or closed groups, women, men, or mixed
9 gender, although, when possible, certainly, I think most
10 people advocate for single gender just because of the
11 intensity of sometimes the trauma history. Adult or
12 adolescent, outpatient, inpatient, residential can be
13 conducted by counselors or any clinician provider in that
14 setting. Case managers, crisis workers, mental health
15 aides, and so on, and topics and handouts can be done in
16 any order.
17 I won't go in detail into these; I’ll just name
18 them to give a feel for what the model addresses.
19 Introduction and case management, very important
20 to connect these clients up with additional services. They
21 are often under-treated. Safety, where they’re asked to
22 imagine what safety would look like for them and how their

1 lives would be different. PTSD and trauma, taking back
2 your power.
3 Substance abuse, asking for help. Detaching from
4 emotional pain called grounding. Taking good care of
5 yourself, setting boundaries in relationships. Community
6 resources, recovery thinking, compassion, creating meaning.
7 Commitment, honesty, coping with triggers, healing from
8 anger, and the final set; discovery, self-nurturing,
9 getting others to support your recovery, respecting your
10 time, healthy relationships, integrating the split self,
11 red and green flags, life choices game, which is
12 essentially a review topic, and termination.
13 And I'll just mention that the website
14 seekingsafety.org does have a more full description and
15 elaboration on the topics and other aspects.
16 Now, more broadly, to go onto the idea of
17 implementation of EBPs, Evidence-Based Practices, more
18 generally, this is something I thought about a lot, and
19 certainly the field, I think, has really begun to think
20 about a lot, and the first point to highlight here is that
21 we currently live in an era of efficacy. The gold
22 standard, R01-funded trials to look at the efficacy of a

1 model, randomized controlled trials, but it’s not yet
2 converged with effectiveness, which really is what happens
3 when you take it out on the road, when you take it out into
4 frontline programs where you have real clinicians, real
5 clients of much broader spectrum?
6 The efficacy trial is a very pure model with
7 carefully-selected, trained, monitor clinicians, and a much
8 more narrow segment of clients, and, often, there’s a huge
9 gap between efficacy and effectiveness, but, currently, all
10 the list of EBPs, all of the focus, all of the sort of
11 adoption really focuses on efficacy, and so, the hope is
12 that this next decade and beyond will really integrate
13 these two because, for example, you can have, and this is
14 well known at this point, models that clearly have
15 efficacy, but are not widely adopted, and there are real
16 reasons for that.
17 I’ve recently completed a survey of clinicians in
18 VA, over 200 clinicians, asking their views of 15 different
19 models, specific models relative to PTSD and/or substance
20 abuse, and there were wide divergences in which models they
21 liked and which ones they felt were most helpful for their
22 clients. So you can presume equivalent efficacy, but not

1 equivalent adoption, popularity, and so on, and it gets
2 into issues such as costs. You can have two models that
3 are equally efficacious, and, yet, very different in cost
4 or aspects like delivery. Who can deliver, and how much
5 training do they need? A whole host of issues like that.
6 Can it be done in pure format or not? So effectiveness is
7 where a lot of the action is going to be.
8 Similarly, a recent study I did on clients asked
9 them about their views of different models of therapy
10 related to PTSD and addiction, and there, too, you find
11 significant differences on which models they prefer. So I
12 think a lot more in that domain is needed.
13 How is efficacy defined? Even though we do live
14 in this current area where efficacy is the gold standard,
15 the preeminent thing, we actually don't have an agreed on
16 set of standards on efficacy. So just to name a few, we
17 have the NREPP standards, we have Chambliss and Holland,
18 which is what Division 12 of the American Psychological
19 Association uses to define the efficacy of treatments and
20 is used for their list on their website.
21 I'll just mention as an aside, currently in my
22 hat as president of Division 50, which is the Addictions

1 Division of the American Psychological Association, we
2 actually are trying to create a list of EBPs in addiction.
3 So, if anyone has models that they want to put forth for
4 that list, I just invite you to contact me, and the website
5 seekingsafety.org does have my contact information, but we
6 are really trying to get the word out so we can create as
7 useful a list as possible.
8 So Chambliss and Holland is one criteria set.
9 The California Clearinghouse has other definitions. The
10 American Psychological Association is currently starting to
11 develop their list of criteria. The Cochrane Reports,
12 which do literature reviews on different models, has their
13 own list, and the Institute of Medicine has theirs. So
14 there’s not yet a set of standards.
15 Also, criteria sets don’t yet deal with a really
16 key issue, which is mixed evidence. So, most of these
17 standards, basically, once you hit a certain criteria,
18 let’s say Chambliss and Holland criteria, once it’s defined
19 as effective, there you are, but it could be that actually
20 the literature is much more mixed on the model. It
21 sometimes gets good results, sometimes not, but that's not
22 typically taken into account in these criteria sets.

1 The third issue is fidelity. There again, sort
2 of an important issue, certainly has really brought the
3 field very far along to try to develop good performance of
4 interventions, and, yet, there’s a lot that is murky in
5 this area. How much fidelity is needed to really create
6 good outcomes? Basically, what aspects of models really
7 are essential to have fidelity to? And when you think of
8 the development of these fidelity scales, it’s a
9 theoretical idea of the treatment developer.
10 So someone creates a model, and then they say I
11 think these are the 12 elements or the 50 elements that are
12 important for delivery of this model, but there’s really no
13 way to know that, and we don’t yet have data on which of
14 the elements of models are crucial since these scales sort
15 of have ideas that aren't yet empirically grounded.
16 Also, there’s the whole issue of not addressing
17 the differences among clinicians when addressing fidelity.
18 So, typically, fidelity research shows it does up the
19 quality of the outcomes, but that could be because it’s
20 drawing up let’s say the bottom-level of the clinicians.
21 The top-level people may not need it as much, people who
22 are already good clinicians. So a lot of issues around

1 fidelity and how much is needed and how to measure it.
2 The next point, it's not just the model, but also
3 the clinicians. One thing that is clear, based on a wide
4 variety of studies, is that the clinician is a much more
5 powerful determinate of outcome than models themselves,
6 and, yet, because we live in this era where the model is
7 sort of king, that point gets lost, and the issue of
8 selection of clinicians becomes a really key issue.
9 If the clinician is such an important
10 determinate, how do you select clinicians who are likely to
11 be able to be good? And there's very little focus on
12 criteria for selection of clinicians. And, typically, just
13 as with most fields, the way people get hired does not
14 relate necessarily to good outcomes in treatment. People
15 who interview well, people who look good on paper, who have
16 good degrees, good credentials does not necessarily equal
17 outcomes.
18 Training shows limited impact, so, why is
19 training so prominent? And this is one of those things on
20 the face of it makes sense. You develop a model or you
21 develop something important, an innovation in the field,
22 so, you should train on it. And, so, there are all these

1 trainings going on, and, yet, what we know from research
2 data is training has extremely limited impact on outcomes
3 and on basically improving quality of care. So much more
4 needed on that front.
5 Premature conclusions and headlines on models.
6 It's a fairly intense time in terms of looking at different
7 models and different models are touted as effective or it's
8 touted as no evidence or things like that, and, yet, it's
9 still very early, and it really takes a long time to
10 determine how models really do out in the field across a
11 lot of providers, and so, it is important not to sort of
12 have the list of the models and then stick to that. It can
13 get a little too entrenched too early.
14 The need to standardize designs and measurements,
15 certainly, a lot of these studies vary enormously in how
16 they're conducted in the quality of the data and so on, and
17 so, it's sort of apples and oranges sometimes in looking
18 across the literature.
19 Iatrogenesis or negative effect. People who get
20 worse when getting certain kinds of treatments and also
21 obstacles in implementation. These are areas that are not
22 addressed typically. Certainly treatment developers will

1 not typically point these issues out. Again, these go to
2 the issue of effectiveness rather than efficacy, and, yet,
3 we know that they exist, and there is no central place for
4 documentation of these issues. One hears about them
5 informally, anecdotally, and there needs to be much more
6 focus on documenting these things. Certainly in the
7 medical field, there's a lot more focus on medical
8 procedures and iatrogenesis and obstacles, but not in the
9 behavioral health field at this point.
10 Finally, unclear mechanisms of action. This is
11 one place where the data is very interesting. Most of the
12 hypothesized mechanisms do not actually show results when
13 you look at them empirically.
14 So, for example, cognitive behavioral therapy is
15 presumed to work by changing cognitions and behavior.
16 Well, the studies that have been done don't typically show
17 that that's what accounts for changes. Similarly,
18 interpersonal models. Every model out there, it's actually
19 relatively rare to find a model where the presumed
20 mechanism is the actual mechanism. So, much more work
21 needed on that. And the slide got cut off, but basically
22 said and essential elements of models, what aspects are

1 needed or not needed?

2 So let me pause there. But happy to address

3 questions, comments, and so on.

4 MS. AYERS: That was fun.

5 (Laughter.)

6 DR. RIOS-ELLIS: Could you read the last line

7 again? I'm sorry.

8 DR. NAJAVITS: Oh, sure. And essential elements

9 of models.

10 MS. ENOMOTO: Okay, Renata and then Stephanie.

11 MS. HENRY: So Lisa, thank you. A couple of

12 things. Well, one is that I'm hoping that SAMHSA can kind

13 of figure out what its role is going to be in

14 implementation kind of services, research the discussion

15 that was mentioned yesterday because the issue with

16 evidence-based practices with clinical trials, getting to

17 that point, then you have this dilemma, what I call the

18 adoption dissemination, implementation dilemma. How does

19 that happen? And no one's really paying a lot of

20 attention.

21 I mean, folks like yourself and some of this work

22 that's going on in south Florida and other places, but it's

1 really important to the field particularly as we move in
2 looking at reform, looking at quality, and what states are
3 going to pay for and what the plans and the benefits are
4 going to pay for, and, yet, implementation of evidence-
5 based practices is a big dilemma in the field for all of
6 the reasons that you listed up there. So, I think it's
7 extremely important.
8 And then maybe second, I'm hoping that you'll
9 have an opportunity to read SAMHSA's Good System Paper and
10 give some thoughts about that. That would be, I think,
11 helpful.
12 Thank you for your work. A lot of this is so on
13 target with what I know to be the downside of clinical
14 trials and in moving them into general practice and
15 generalizing them in different populations and the whole
16 issue of the variation in clinicians and why we don't get
17 uptake or sometimes people do get worse as opposed to
18 better. So, thank you much.
19 DR. NAJAVITS: Well, thank you for your comments,
20 and really appreciate some of the themes that you're
21 raising, as well.
22 So, for example, this whole notion that states

1 and other sort of entities are now requiring adoption of
2 EBPs, and they create these lists. In and of themselves,
3 that's a whole question mark of how those are developed.
4 But then there's often the sort of unfunded mandate, and
5 then it suddenly changed the entire structure of these
6 treatment systems with little to no funding. And, often,
7 these models do vary substantially in costs, training, and
8 so on, and so, a lot of issues from that sort of
9 perspective from a systems and public health perspective.
10 DR. COVINGTON: This is great. Are you asked to
11 talk about this in lots of places?
12 (Laughter.)
13 DR. NAJAVITS: It's very interesting; there is
14 definitely an emerging literature on this. There's a huge
15 area, for example, in VA, which is one of my settings.
16 There's a major effort on health services research, on
17 implementation science, and those sorts of things. So, I
18 think this really is a huge and emerging area. It isn't
19 talked about as much as it ought to be.
20 DR. COVINGTON: Yes, and I think this is one of
21 the issues, is this drive towards evidence-based practice,
22 while, on some level, the intention is to improve services,

1 and we all support that, but this is a train that left the
2 station without anybody thinking about the destination and
3 where it needed to stop on the way. People talk about cans
4 of worms. This is the can of worms, evidence-based
5 practice. And I think this is what people need to be
6 looking at.
7 I mean, you and I well know, Roger, that those of
8 us who've written these materials and curriculum, and then
9 the issue of research and so forth, and then you see how
10 they're implemented, and we see models, and I'm not going
11 to name names, where the evidence shows a protocol that no
12 one could ever implement, and people are saying I'm using
13 this as an evidence-based practice, and they're not doing
14 the protocol at all. And it's just people don't read the
15 research, they don't know what it's saying, they don't know
16 what the protocols are. People want these quick solutions
17 to complex issues, and it's a nightmare, I think.
18 And I feel badly. And I love number four. I
19 think there are 1,000 studies that say it's the therapeutic
20 alliance that makes a difference. It's not what's on a
21 piece of paper; it's the interaction between the person
22 seeking help and the person providing help.

1 DR. NAJAVITS: Well, first of all, very much
2 appreciate your comments. That last one is tricky. It’s
3 actually not just alliance; alliance essential for outcome.
4 DR. COVINGTON: Right.
5 DR. NAJAVITS: But alliance combined with models
6 is more powerful than alliance alone. But I appreciate
7 what--
8 DR. COVINGTON: Yes, I mean, it’s--
9 DR. NAJAVITS: --you’re brining up more broadly,
10 and, also, just that these things need to get identified.
11 DR. COVINGTON: Exactly. Exactly. And I’m
12 wondering in the VA, I want to ask you about particular
13 kind of things, what about the use of exposure with trauma?
14 DR. NAJAVITS: Yes.
15 DR. COVINGTON: Which is something in the
16 substance abuse field, we do very little exposure therapy,
17 and most clinicians don’t want to use it, and most clients
18 don’t want to experience it, but in the VA, they use it a
19 lot with trauma. Is there any research looking at exposure
20 versus other trauma models?
21 DR. NAJAVITS: Well, that's so interesting,
22 especially with all the returning veterans and all these

1 issues.

2 DR. COVINGTON: Right, right.

3 DR. NAJAVITS: And VA being one of the biggest

4 providers of health care in the U.S. and really even

5 globally. So, exposure is one of their treatments that is

6 being rolled out, sort of formally trained, and lots of

7 consultation and so on.

8 To really implement it, every VA now is required

9 to have someone there who provides exposure therapy, and,

10 yet, what is interesting, and I think what you're sort of

11 getting at, there isn't outcome data being collected

12 concurrently with that necessarily. Some places, I think,

13 are trying to do it, but it's more of an independent thing;

14 it's not part of that rollout initiative per se. There are

15 huge issues around the use of exposure-based treatments,

16 and so, things like readiness, how do you decide someone's

17 ready for it? What do you do with clinicians who don't

18 feel it's appropriate; who feel that it's too intense?

19 What do you do with iatrogenesis, which can happen?

20 DR. COVINGTON: Right.

21 DR. NAJAVITS: Certainly with that model, as with

22 others, as well. So a huge set of issues around that.

1 It’s a good example of where you take a treatment that has
2 been defined in the sort of RCT format.
3 DR. COVINGTON: Right.
4 DR. NAJAVITS: And then take it out more broadly
5 without necessarily the translation occurring.
6 DR. HUANG: Well, thanks very much for your
7 presentation. It was really great.
8 I have a lot of questions around this, and I
9 think Renata’s caveat that we have to really get a handle
10 on this because health reform is going to say what’s going
11 to be that minimum benefit package, and which three do we
12 choose to fund is very frightening, actually.
13 I just wanted to mention some of the things going
14 on in the children’s world around this, and I guess one of
15 the things I didn’t see here, and I think actually it is in
16 the APA’s definition of evidence-based practices, that
17 patient preference is also part of that. And I think there
18 are some studies that show with children when there’s
19 family involvement and family choice that those kids
20 actually get better regardless of the intervention.
21 So I think that we lose a little bit when we just
22 focus on the evidence-based practice, and I think we

1 struggle with implementation and implementation science.
2 Maybe we'll solve some of those issues, but I think we've
3 lost a little bit of the whole what we stride for so much
4 in the work at SAMHSA, that things should also be consumer-
5 driven. So, how does particular concept fit into this?
6 I think the other thing is that in the children's
7 world, now, particularly children's mental health, not as
8 much substance use, there are some really interesting
9 efforts going on actually by John Weisz up at Judge Baker
10 Clinic at Harvard and Bruce Chorpita at UCLA on this
11 MacArthur Network, where they were really looking at what
12 are the key components of evidence-based interventions, and
13 then modularizing those components and having a platform
14 where they're working with clinicians around that, and it's
15 also data-driven so that the clinician and the family or
16 the youth sort of think about their goals in stages, and
17 they work on these modules that are also highly supervised
18 in the setting, and some of it might just be starting out
19 with engagement. I mean, they aren't getting to whether
20 it's CBT or interpersonal therapy, but really just the
21 engagement piece might be something that's common in all of
22 these interventions, but it's not really handled

1 sufficiently.

2 And, so, it’s really modulized almost

3 interventions, and then feedback is given to the clinicians

4 and to the families and the youth, and they progress

5 through these modules with this feedback system which is

6 really based on sort of a quality improvement piece, and

7 it’s not so much that you have to do everything fidelity

8 exactly to the intervention, but it’s component

9 modularized, and it’s very exciting their outcomes.

10 They’ve just started to do a report on some of

11 the outcomes on it. Are very positive. The challenge in

12 it is that initial investment for the training and getting

13 the modules and getting the data platforms in the treatment

14 settings. But I think it’s another way, it’s an adaptation

15 of evidence-based interventions that might actually work,

16 have more effectiveness and application, and easier to

17 implement than just sticking with the fidelity to an

18 evidence-based intervention.

19 I don't know if I made that clear, but I can just

20 send you articles on it and we can always talk to John

21 Weisz up in Boston.

22 DR. NAJAVITS: No, thank you very much.

1 DR. HUANG: It's very exciting work going on in
2 the children's world.
3 DR. NAJAVITS: Yes, and I really appreciate
4 those, and your first point about the consumer preferences,
5 so important to address, and it's not addressed in so far
6 any criteria. APA definitely highlights the importance of
7 it, but APA hasn't yet developed their criteria set of
8 EBPs. So, they talk about the importance of using EBPs,
9 but that's something that they've actually shied away from
10 for a very long time, and now we're starting to move into
11 that, but hugely important and very under-addressed.
12 Your second point, and there are some different
13 efforts, and great to hear about the one in the children's
14 field. There are some efforts, also, in the adult area to
15 sort of take common elements of different EBPs. It's
16 tricky. It's very tricky because, on the one hand, what
17 you're essentially developing at that point is a new EBP
18 that then has to be tested in and of itself. And,
19 certainly, the goal is sort of that there are these common
20 factors.
21 No question, there are common factors, but
22 whether it loses some potency in terms of the spark, the

1 inspiration, the originality of the original model when you
2 sort of streamline it. There are a lot of questions in
3 terms of when people try and do that kind of what--but,
4 certainly, data is being collected, which is fantastic, and
5 it's certainly wonderful efforts and a different kind of
6 effort around the EBP field. So the more the better in
7 terms of all that stuff.
8 DR. HUANG: I think one other thing is that it's
9 just looking at adaptations for different communities,
10 also, and diversity, many of these are not necessarily
11 built on different populations, and so, that addresses the
12 fidelity to culture or fidelity to model and how do you
13 kind of balance that, too?
14 DR. NAJAVITS: And I'm glad you mentioned that.
15 That should be another point up here is adaptation. How
16 much is needed, and how do you decide because, for example,
17 one very counterintuitive thing is that there are models,
18 and I can tell you I've experienced this, is Seeking
19 Safety, for example, where people will sometimes say on the
20 front-end this looks great, but it won't work with my male
21 veterans or it won't work with my ethnic minority group or
22 so on, and, yet, when you actually try it out, they are

1 highly satisfied with it un-adapted.

2 Now, it doesn't mean that there aren't

3 adaptations that could make it even better, but the whole

4 question of adaptation and how you decided and so on is a

5 really key one so often like when people contact me about

6 adaptation, what I'll say is first, try running it as-is,

7 see what outcome data you get without changing anything.

8 Then, adapt it, and see what data you get. Because until

9 you do that kind of study, part of the problem is people

10 often adapt on the front-end before they see what it's like

11 un-adapted, and then you can't tell scientifically what you

12 have.

13 So, I'm just really glad you raised that. It's a

14 huge issue.

15 DR. HUANG: This is my last point.

16 (Laughter.)

17 DR. HUANG: Sorry, this is a long question, it's

18 multi-pronged. I think the other thing is that we don't

19 look enough at the engagement piece, and we don't really

20 know what that effective engagement is, and I think for

21 different populations, the model may work, but it's that

22 engagement, that sort of frontline piece that we haven't

1 really developed enough or really evidence-based kinds of
2 assessments for different populations.
3 DR. NAJAVITS: Absolutely. That's huge.
4 MS. ENOMOTO: Okay, Susan and then Starleen,
5 Renata, and then Roger.
6 MS. AYERS: I think I found a new best friend.
7 And you’re right in my community.
8 I can’t tell you how really thrilling it is to
9 see this fabulous list and how affirming it is, because
10 those of us that work in the community every day feel all
11 of these pressures and say yes, but on evidence-based
12 practice, how are we going to adapt this, or how can we
13 adopt it? Or is it really going to work, and you keep
14 getting this pressure to do it, and you say well, but have
15 you got 10 points there? What about those 10 points, 9
16 points? I mean, so, to actually see it on a slide, these
17 really are the challenges that have to be addressed is very
18 affirming, and I really appreciate that because these
19 really are the challenges.
20 I’m very familiar with John Weisz. We’re good
21 buddies. We wanted to, and he’s wanted us to do this work
22 in our clinics, and it’s just too expensive. We cannot

1 pull people offline. We've costed it out; it's a couple
2 hundred thousand dollars worth of lost time in terms of
3 training, but I believe the model is probably that part of
4 it is how much support the clinician is able to get support
5 and training.
6 I'm wondering about your number five, that
7 training shows limited impact. Is the training showing
8 limited impact because you go to a training and then you go
9 home and that's it, or what about cases where you go to the
10 training, you go home, the next day you start with a
11 supervisor on the phone, you begin to have this very
12 rigorous kind of program that John, in fact, can offer if
13 you can afford to have it. So, I'm curious about what we
14 need to do about training.
15 And then the third piece is, in Massachusetts,
16 and I'm sure you're very familiar with the Rosie D.
17 lawsuit, and now, all of our community service agencies are
18 doing what are called fidelity to the wraparound model, and
19 we have people flying in from around the country to meet
20 with these teams. It's a care coordinator and a parent
21 partner, and they say well, we're going to do fidelity to
22 the model. Well, guess what? You can't really do fidelity

1 to the model because, one, it's a medical. I mean, we bill
2 in 15-minute increments. It's kind of a medical model; it
3 doesn't work all that well.
4 Two, we have absolutely no flex funds so that you
5 can't really do that piece of wraparound, which is
6 prominent in probably 60 percent of the things. Three, you
7 can't bill for supervision or team time, talking to one
8 another within the team.
9 So are we talking about fidelity to the
10 Massachusetts Wraparound Model, or are we talking about
11 fidelity to the national model, and we have the national
12 people onsite training us.
13 So, and I'm just raising these issues like you
14 are, which is where you're either popular or not. How
15 often do you get to present this? How often do you get to
16 talk about it? But, given the fact that you're in
17 Massachusetts, I'd love to get you together with some of
18 the people that are doing this Children's Behavioral Health
19 Initiative, CBHI, and really work out and bring another
20 voice of experience into this discussion so that we can
21 figure out, given our limited resources, what's realistic?
22 Because, honest to God, let's just tell the truth, what's

1 realistic, what can happen, what can we afford, and what
2 can't we afford? And then let us proceed in reducing the
3 burden of suffering in children and families.
4 DR. NAJAVITS: Yes, and I'm happy to continue the
5 conversation back at home. So that's lovely. And just to
6 pull out one of your many excellent points, the whole topic
7 of training, I'll give you some examples of studies I'd
8 like to see.
9 Take a model and train clinicians in it the way
10 the developer says they should be trained, and then don't,
11 and see whether you get differences and what those
12 differences are determined by, like the initiative skill
13 level of the clinicians, the clientele, and so forth and so
14 on, but what we do by way of training at this point is
15 we've really moved toward empirical basis for the models,
16 but not for the training, and so, people say oh, you need
17 three days of training, you need two days, you need this,
18 you need that, you need ongoing one-year--no one knows, and
19 it's not studied. And, also, there may be much more
20 efficient, much lower-cost ways of training. Web-based
21 training may be just as good as an expensive, in-person
22 training. So lots of issues. Yes.

1 MS. SCOTT-ROBBINS: I would really like to thank
2 you for having that stuff up on the board because, in North
3 Carolina, we have been working on the adoption of evidence-
4 based practice over the last several years, and we have the
5 North Carolina Practice Improvement Collaborative, which is
6 made up of clinicians, researchers, and providers from
7 across the state, where we've been looking at various
8 evidence-based practices, including the Seeking Safety
9 Model, which, by the way, thank you again, because it is
10 easy, flexible, cost effective, and it is actually one of
11 the models that providers actually support and thank us for
12 identifying as one of the models we will pay for.
13 But we struggle with these questions literally
14 every single time we talk about implementation, and how we
15 want to increase quality, how people deserve quality, how
16 we want to measure quality, but, again and again, we keep
17 hitting the wall, and there are some models that we've been
18 able to kind of answer some of these questions with, but
19 I'm really interested in hearing more about the list of
20 evidence-based practices in substance abuse that you are
21 trying to put together and kind of the criteria for that.
22 And again, I really appreciate you bringing this

1 to the table.

2 DR. NAJAVITS: Thank you.

3 MS. HENRY: My comment was basically in the IOM’s

4 definition of a quality system, it’s effectiveness, but

5 it’s also patient-centered. So, does the IOM speak to

6 anything of how to rectify that issue around patient

7 preference being patient-centered, yet be effective and

8 effective as defined as evidence-based practices, what we

9 know works?

10 DR. NAJAVITS: Yes, that’s a good question. I

11 mean, the IOM is certainly doing really important work in

12 different sort of areas within medicine to identify lists

13 of models of where the evidence is and where it’s not. I

14 mean, it’s a very rigorous attempt. I’d have to look that

15 up, and it is worth looking up because these sets do

16 differ.

17 DR. FALLOT: Okay. This is terrific. Lisa, I

18 thank you, also.

19 The questions it leaves me with though have to do

20 more with the context around the context here, which is

21 really I think of as trauma-informed care.

22 For instance, Larke’s raising the question about

1 engagement, which is certainly a key one for all of our
2 interventions, and, yet, it seems to me this is what would
3 be called pre-engagement, that is obviously for some places
4 the biggest obstacle.
5 For instance, I walked into a substance abuse
6 treatment center that had a big sign right over the door to
7 the treatment area, and it said denial stops here.
8 (Laughter.)
9 DR. FALLOT: And I'm stopping here. They
10 couldn't get to engage anybody who was put off by that
11 sign. So, that's what we talk about in terms of trauma-
12 informed care is how you make those signs more welcoming,
13 how you make the reception area more welcoming, how you
14 make the receptionist more welcoming, how you make the
15 security guard who might be there anyway more welcoming to
16 get people engaged in the agency as a whole and it's a
17 context for effective surfaces. And then we can get into
18 all the implementation questions about how you implement
19 trauma-informed care in the context.
20 But I just wanted to raise that because it's a
21 parallel question that I think came up in the evidence-
22 based practice initiative that was started by SAMHSA

1 several years ago, many years ago, that, in addition to
2 developing a fidelity measure for each evidence-based
3 practice, they had to develop a fidelity measure for the
4 organizational context that was supportive of the evidence-
5 based practice. And that proved to be a very important
6 element in the implementation process is how open the
7 agency is as whole was to implementing the EBP and how
8 supportive it was and how consistent the culture really is
9 the evidence-based practice culture. And that's really
10 what we're talking about, I think, with trauma-informed
11 care. That's one point.
12 The other one is around the patient preference or
13 client preference and the importance of what I continue to
14 think of as values-based approaches that are side by side
15 with the evidence-based practices because they emphasize
16 that in a recovery orientation you have to client, consumer
17 preferences. There's a central element in that model. And
18 it's part of the collaborative decision-making approaches
19 that have gotten a lot of play in work with--who have
20 serious mental disorders, been diagnosed with serious
21 mental illnesses, that the idea of sitting down with
22 somebody and sharing what the clinician knows or thinks

1 they know or claims to know about the array of options that
2 are available to somebody who's facing a particular
3 problem, challenge, and a goal, and then talking with the
4 person about what they know about that array of options and
5 getting their opinion about them and sounding them out and
6 really talking through the options with them is a more
7 micro way of approaching engagement kinds of questions.
8 But it's certainly demonstrated to be effective, and it's a
9 fascinating part of this process, also. So, thanks.
10 DR. NAJAVITS: Thank you for those comments. And
11 taking the one, for example, that a number of people have
12 raised around client preference and the importance of that,
13 I'll just mention one strategy, and this is just a very
14 tiny thing, but I think it does make a difference.
15 For example, when I and my team train on Seeking
16 Safety, what we encourage clinicians and programs to do is
17 let clients try out three sessions of the model, no
18 questions asked, no entry criteria, no filtering, just you
19 can try it out and then determine whether you want to
20 continue. And what it does is it allows the client to
21 leave if they don't like it, sort of no harm, no foul. If
22 they don't like it, no questions asked, but if they do,

1 they get to engage in it without having to decide on the
2 front-end, because I think the client preference thing is
3 important, but it’s often unclear how to determine client
4 preference when they haven't experienced it. So, there are
5 a lot of dilemmas around how to create that, but definitely
6 important.
7 And your other point about trauma-informed care
8 and all the efforts you, Stephanie, everyone else, and
9 SAMHSA broadly is doing on trauma-informed care, obviously
10 hugely important, and really world changing. It is a
11 fundamental shift in consciousness.
12 I always feel lucky that I work in the area of
13 specific interventions because I think changing cultures is
14 a lot harder. So, I admire people who take that on. I
15 think it is a really challenging task both to do the
16 interventions at that level and also to measure it. So,
17 definitely lots of work needed.
18 DR. COVINGTON: Let me ask a couple of questions
19 and make a comment.
20 So I know the APA definition talks about client
21 preference. Doesn’t the Institute of Medicine
22 definition of evidence-based practice also have a piece in

1 there called clinical wisdom? So, I think the Institute of
2 Medicine says you use evidence-based practice according to
3 the best research, but you also blend it with clinical
4 wisdom. But, in the psychological field, we pick part of
5 the IOM information, but we dropped out the clinical wisdom
6 and the judgment of the person providing the service, which
7 I think is an unfortunately omission, that there is
8 something to do with clinical wisdom.
9 The training piece that I've been interested in
10 since I do lots of training, because, again, what's its
11 value? I think it is a question mark. But the thing that
12 I have been suggesting to people that seems to be effective
13 is instead of spending time and energy on being trained, I
14 suggest that people get staff groups together and that the
15 staff go through the material themselves, and on a lunch
16 break every week, they rotate facilitation and go through
17 the models themselves. It's a self-training way, it's less
18 expensive, a good facilitator guide tells you what to do,
19 and that a different person on the staff facilitate each
20 one of these staff groups so that they learn facilitation
21 skills from each other.
22 The program directors who have done this said

1 it’s the best thing they’ve ever done with their staff.
2 Often, they’ve had people leading groups who should not be
3 leading groups. They have staff members that don’t prepare
4 ahead, but they had no idea, plus, the women, since the
5 material I do is for women really, they find out where
6 their own issues are, and they find that out in the group,
7 not in the client group, because so many of the women carry
8 the same issues as the clients.
9 I’ve had staff members say to me I don’t want to
10 be in a group with my other staff members because it won't
11 be safe. Well, that's an important thing to know because
12 if you’re not safe with the staff, what makes you think the
13 clients feel safe with the staff? So, I have found this
14 self-training model to be a way for programs to try to get
15 what they need in terms of understanding different models
16 by doing it themselves.
17 DR. NAJAVITS: Fantastic.
18 DR. COVINGTON: So, it’s just a different thing
19 than showing up with someone doing what we all do.
20 DR. NAJAVITS: And that’s the kind of innovation.
21 I mean, I will adopt that now, I will cite you. It’s
22 fantastic. It’s really good stuff, and that's the kind of

1 thing that there needs to be some central place to take
2 these sorts of innovations that are aside from the model
3 per se, but really apply broadly. That could help improve
4 implementation of a lot of models.
5 MS. ENOMOTO: Gail?
6 MS. HUTCHINGS: Just very, very quickly, I'm
7 fascinated to hear this from Stephanie because the CMHS,
8 SAMHSA evidence-based toolkits that I reviewed, I believe
9 all of them used that model. I mean, they recommend
10 bringing in consultants for fidelity reasons, et cetera,
11 but the training piece and the media, DVDs, CD-ROMs are all
12 based on that exact implementation strategy. So, that's
13 actually really heartening to hear.
14 MS. AYERS: This is another little quirky aside
15 around what works. We've always been strapped for space in
16 our community settings so that we just kept putting more
17 and more people in desks, into whatever space we had, and
18 we've used Parent Outreach workers or Parent Partners,
19 whatever they're called, to be working with our clinical
20 staffs since like 1989. So I mean, we've been doing this a
21 long time, and what we've learned is the more wraparound,
22 home-based, team-based kind of models so benefit from

1 having everybody in a really tight space because they can
2 hear each other's phone calls, they can sit and--seriously,
3 it's a weird thing, but it's really true. You can grab
4 somebody when they're in the office, because a lot of the
5 work is out of the office.
6 I mean, so when you're in the office, you're
7 either on the phone or you're solving problems, or you're
8 doing whatever, and this has been--so that now we've got a
9 new space that we actually created in a way that has
10 couches, desks, phones, and then private areas, obviously,
11 for the client meetings or if you have to have a private
12 conversation. But to really forget those individual office
13 spaces, and I'm sure a lot of people got rid of those a
14 long time ago, but for team work to be able to be really
15 working with each other and listening to each other work,
16 because you get these rookies in, I mean, even people out
17 of social work school these days are just rookies, and they
18 are in these very complex families that have sort of layers
19 of difficulties and challenges, and they're terrified when
20 somebody comes knocking on their door.
21 And so, what do you know when you're even 25 or
22 30, how are you managing that? So it's a great way to

1 learn.

2 MS. HENRY: One thought, when Gail said something

3 about the toolkits and the six EBPs, that CMS endorses--

4 number three, how much fidelity is needed?

5 I would just maybe think about when CMS in their

6 reviews, program integrity, and all of those things, do we

7 know how much fidelity is, and, yet, we have this whole set

8 of fidelity measures for ACT and everything, so, I just,

9 again, reconciling all of that for as we move in the

10 future, and CMS is going to be more and more a payer for

11 more and more folks. So, again, kind of thinking about how

12 we, even with our famous six, figure that out I think is

13 really important.

14 MS. ENOMOTO: Larke? Larke, and then I have one

15 last question, and then we'll wrap up.

16 DR. HUANG: I just want to throw out this idea,

17 also, as we're talking about culture change and evidence-

18 based practices that we might want to think about it as--

19 and I guess I'm thinking about because our new

20 administrator is always saying so, are the people getting

21 better? You've got training, you've got your intervention,

22 you've got your climate, but are the people getting better?

1 And so, I think we sometimes lose that as kind of
2 our goal and our endpoint.
3 So I'm thinking also as we talked about training,
4 we talked about engagement, we talked about interventions,
5 I'm thinking all of those in some way have to be a part of
6 the culture of using whatever the evidence may be, and the
7 evidence should be your people moving along in some way.
8 So, it's not, I think, just the evidence-based
9 intervention, but thinking more broadly is our decision-
10 making, is our training, are people changing their practice
11 with all these different training models we do? And can we
12 collect that evidence to see whether they are or not? So,
13 it's almost thinking about is our culture of the
14 organization really in some way evidence or data, however
15 we want to define the culture, are we using that to make
16 wise decisions and to help people get better?
17 DR. NAJAVITS: Yes, really, really good points,
18 and it sort of reminds me of one of the most, let's say,
19 egregious things I've ever heard around the area of EBPs,
20 which is a program that will go unnamed where, apparently,
21 if the clients don't get better, they clinicians are told
22 they're not doing the models correctly. And it's a

1 complete over idealization of models at the expense of
2 learning why aren't they getting better? A kind of open
3 ended question mark that may be many different factors.
4 DR. HUANG: I think that's a quality improvement
5 piece that could be the frame for much of this work, too.
6 DR. NAJAVITS: Yes.
7 MS. ENOMOTO: So a final question that I have,
8 which touches, perhaps, on the study you're doing at the VA
9 on consumer preferences, but I guess I'm not sure, I know
10 TREM has a peer-led version or it can be peer-led, and I
11 don't know about the other models and whether or not
12 there's if differential effectiveness or differential
13 preference for peer-led, trauma-specific models?
14 DR. NAJAVITS: Yes.
15 MS. ENOMOTO: And that's for all of our folks.
16 DR. NAJAVITS: And that is a great question, and
17 certainly just such an important area. I can tell you that
18 in this one study I did, which was outside the VA; it was
19 on about 105 community-based people with PTSD and co-
20 occurring problem gambling, who also had multiple other
21 addictions. There was a clear preference that around the
22 gambling, they wanted peer-led, and around PTSD, they did

1 not. It was a complete difference. So, the whole need for
2 more data on this is just, I think, huge.
3 DR. COVINGTON: I don’t think the data on peer-
4 led is--we don't know, I think, yet. I think, I mean, when
5 you think about this whole evidence-based thing, it’s
6 probably about this deep. And comparing different things
7 and comparing this and that, I think it’s --
8 DR. FALLOT: I think Stephanie is absolutely
9 right. We just don't know enough yet about either peer-led
10 or the adaptation questions, which is sort of a similar
11 issue, I think, how much cultural adaptation is necessary.
12 One of the things that your presentation raised,
13 for instance, how much gender adaptation is necessary?
14 We start with the assumption that men and women
15 are going to be different in their responses to trauma. We
16 didn’t start with a unified model and then branch it out
17 into two approaches. We started with an assumption because
18 we were working with women primarily at the beginning of
19 the adventure, and then we turned to men later on. But
20 that's a good, empirical question, I think, about whether
21 adaptations like gender adaptations, cultural adaptations,
22 and peer adaptations are really going to be necessary or

1 helpful.

2 DR. RIOS-ELLIS: I was just thinking about both

3 because gender is so different in different cultures. So,

4 when you were saying that, I was thinking wow, I mean, not

5 only gender and not only culture, but the synergy of both,

6 how would that be? Because when I'm looking at this,

7 Stephanie, you brought up the train, and I'm thinking the

8 additional questions that I would ask from a cultural

9 perspective, is that train my train, and are they going to

10 let me ride on it? Right? And those two things, just the

11 train analogy, just all of a sudden I started writing.

12 DR. COVINGTON: Last week, I think, I had lunch

13 with Hortensia Amaro who had adapted the TREM model, and

14 now it's a Spanish version, and listening to all the

15 changes they had to make in that from that culture piece

16 and how important that was for women, but then the cultural

17 piece. I think really important questions.

18 I just want to give you an anecdotal thing

19 because we said so little about criminal justice, I feel.

20 In many of the criminal justice settings where they use my

21 material, I have trained the lifers and long-termers to co-

22 facilitators in the groups.

1 So I've taken the women who are incarcerated,
2 many of them for the rest of their lives, and trained them
3 to use the materials and then go back and observe on this
4 issue of fidelity, and I can tell you the women who are the
5 lifers and the long-termers who are co-facilitating the
6 groups are really the superior facilitators and not the
7 staff. The prison would never let these groups be peer-
8 led. That has to do with fundamentals in a prison. But in
9 terms of impact, preparation, getting the material, ability
10 to connect, therapeutic alliance, I would hire them, and
11 we've also made it the highest-paying job in the prison.
12 Now, in a prison, that might mean 25 cents an hour.
13 So it's not a lot of money. But whatever the
14 prison standard is for payment, I make sure that they get
15 so that that becomes a prestigious job for them. So it's
16 about how do you add meaning to life, really, if this is
17 how you're spending your life?
18 So I think we don't know a lot about peer-led,
19 and there are many things out there that are happening that
20 there's no research, but I can tell you from observing.
21 MS. ENOMOTO: Well, Lisa, thank you. I think
22 this is probably the single most thought-provoking

1 conversation-promoting slide I've seen in many months. So,
2 I appreciate your presentation, and I think we all are
3 grateful for it.
4 (Applause).
5 MS. ENOMOTO: We'll take a five-minute stretch
6 break and come back. Thank you.
7 (Recess.)
8 MS. ENOMOTO: Okay, I think we're about ready.
9 Now, where did my folks go? I'm missing a couple of
10 members.
11 We have one piece of business, which is to talk
12 about the next meeting, and then offer you some final
13 opportunities now that we've heard from four of the
14 strategic initiatives. Your thoughts, kind of some summary
15 thoughts and where SAMHSA could go in terms of women's and
16 girl services.
17 Renata? Okay, all right, Nevine has handed out
18 to you a list of conference. Nevine, do you want to go
19 ahead and talk about that?
20 MS. GAHED: Well, since we seem to be doing
21 really well with an offsite visit on a yearly basis, well,
22 it's time again to start thinking about what your thoughts

1 are and where you would like to go or visit, and get your
2 input on newer things. But I've compiled a list of some
3 conferences that we could tag onto. And, as you can see,
4 some of them are July and June, so, I don't know if that
5 would work, however, there are a couple of meetings, number
6 one, number two, that are actually in September.
7 The first one is the Institute on Violence,
8 Abuse, and Trauma. It's with the Alliant International
9 University, "Uniting for Peace." It's in San Diego,
10 September 12 and 15, and I think there are copies that are
11 being passed around for you to see.
12 What is good about it is that it's a
13 collaborative opportunity, as well, with the National
14 Partnership to End Interpersonal Violence Across the
15 Lifespan. They have a think-tank that is happening on
16 September 11, and we might be able to actually present or
17 be at that think-tank meeting on that day. So, get our
18 input in there. See what it is that we can find out and
19 what it is that we can input.
20 The other one is the National Centers for Victims
21 of Crime. It's in New Orleans, September 14 and 16. I'm
22 not sure--I'm sorry, I didn't give you a copy here?

1 MS. ENOMOTO: No, no, I have it.

2 MS. GAHED: Okay.

3 MS. ENOMOTO: I'm just wondering if there are any

4 SAMHSA grantee meetings.

5 MS. GAHED: There are no SAMHSA grantee meetings that

6 I could find, or I think I've asked some of the ASWC

7 members, and they couldn't find anything for me that would

8 be ready in time for us. The PPW, I think I checked on

9 that, and there isn't anything. They've actually just had

10 their meeting.

11 There's the IPSCAN International Congress in

12 Honolulu.

13 (Laughter.)

14 MS. HUTCHINGS: You can just stop. But no one

15 would go for that.

16 MS. GAHED: And then, another one actually, Rural

17 and Behavioral Health Symposium, September 21, 23, in

18 Arizona. And the IHS is doing again--our interest in some

19 of the things that we were talking about would be mental

20 health, but also, if possible, youth and tribal matters.

21 So the IHS Bureau of Indian Affairs is having its

22 National Behavioral Health Conference in Sacramento, but

1 that's in July. So that's coming up pretty quickly.
2 The Interdepartmental Tribal Justice Safety and
3 Wellness was a great conference that actually we attended
4 and Amanda had presented back in December, and
5 unfortunately, the only time that I have is June 16 and 18.
6 There may be another one, but the way I hear it is it won't
7 be until December, and probably in Palm Springs, but it
8 isn’t until December. And so, that takes our fiscal year
9 meeting that we have to actually have before the end of
10 September.
11 The other options that are at the bottom, they’re
12 in blue, are all great opportunities, but they are for next
13 year. I think one of the interesting pieces, the National
14 Conference on Mental Health and Addiction, that's the
15 National Council Meeting. Thank you. And that's in spring
16 in March in San Diego.
17 MS. CAMPBELL: In May.
18 MS. GAHED: Oh, in May. In May.
19 PARTICIPANT: Oh, that's even better.
20 MS. GAHED: So that's May in San Diego. There’s
21 the CADCA Annual Conference which is always here in the
22 area in February. And the Children’s Mental Health

1 Research and Policy Conference, which the University of
2 South Florida, and that is also a very interesting one. I
3 think that SAMHSA has a lot of representation in that one,
4 as well. And that's also in March or spring of 2011.
5 So choices, and we'll leave that up to you to
6 decide.
7 DR. RIOS-ELLIS: (Off microphone.)
8 MS. ENOMOTO: We will have a meeting before the
9 end of the year, before the end of the fiscal year, so
10 before September 30. We could do it here again or we could
11 do it offsite. So that's the option that's available to
12 us. The ones that would be next year's, I think we're
13 giving that as a context if we wanted to trade off and just
14 stay here for awhile and then do one next year. That's
15 also a possibility.
16 Susan?
17 MS. AYERS: I wondered, Georgetown runs one in
18 July, but I think it's more focused on children and
19 families. They've got a training piece that--okay, is that
20 what that is? So, people--
21 MS. ENOMOTO: (Off microphone.)
22 MS. AYERS: Maybe that's not as relevant.

1 MS. ENOMOTO: No, no, that is relevant.
2 MS. AYERS: Yes, it is here in Washington in
3 July.
4 DR. RIOS-ELLIS: July is the World AIDS
5 Conference, so I'll be gone. I don't know.
6 MS. HENRY: From a very practical standpoint,
7 July is like right around the corner.
8 MS. GAHED: Yes, I know.
9 MS. HUTCHINGS: Well, and so are the June 18. I
10 think MHA and the tribal one, unfortunately, that's so soon
11 and however else. So, just unfortunately, by process of
12 elimination, might be six and seven, I think, are off, and
13 up here in July isn't working so hot.
14 The Rural and Behavioral Health interests me
15 because we don't speak enough about rural, and I'm
16 presuming that would also be frontier-related, too. That's
17 of interest as our one and two, to me.
18 DR. RIOS-ELLIS: Number one seems like it goes
19 closer with Pam Hyde's description of where preventing
20 more, we're doing this. I mean, it really has this very,
21 very broad Uniting for Peace: Linking Research Policy.
22 That looks good.

1 MS. HUTCHINGS: Kana, what sense, or Nevine, if
2 any, do you have that we could have some opportunity to
3 influence the agenda, if any, of the ones that are still
4 viable?
5 I mean, frankly, one of the things that would
6 pull me is if I thought there were exclusively relevant
7 topics of interests to us. Not that I don't want to expand
8 my horizons either, but, of course, we still want it to be
9 germane.
10 So do we have any sense of that? We need to kind
11 of focus down on a couple, at least, or pick.
12 MS. ENOMOTO: Right. I haven't gone and asked
13 would you change your agenda for us if we decided to come
14 to your meeting?
15 MS. HUTCHINGS: I didn't suggest that.
16 MS. ENOMOTO: We're considering 20 different
17 meetings.
18 MS. HUTCHINGS: Is it still open for input?
19 MS. ENOMOTO: I don't have a sense for that.
20 MS. HUTCHINGS: Yes.
21 MS. ENOMOTO: Well, I guess in terms of number
22 one, I mean, what I imagine is that, at minimum, any one of

1 these conferences would give us a listening session.

2 MS. HUTCHINGS: Yes.

3 MS. ENOMOTO: And that's really what my main

4 focus for going offsite would be, to do some listening to a

5 different group or in a different setting to give some

6 people the opportunity to make comment to the committee and

7 to SAMHSA who wouldn’t normally get that opportunity. So,

8 I don't know so much about changing--

9 MS. HUTCHINGS: Yes.

10 MS. ENOMOTO: Or influencing the overall

11 conference agenda.

12 MS. HUTCHINGS: Yes. So, my preference in order

13 would be one and four, just to try to kick us off for

14 decision-making.

15 DR. COVINGTON: Let me tell you a little bit

16 about the conference that's one that's held every year.

17 I’m out of the country, so, irrelevant to me where you go

18 or what you do, because I can’t many of the first seven,

19 but that conference, I’m sure they would give you a

20 listening session. It’s a huge conference. You would have

21 at any timeslot, there are probably between 10 and 20

22 things going on at the same time.

1 So it’s huge, it’s very spread out, and if you
2 had a listening session, you also would have many other
3 things happening at the same time, but I would imagine Bob
4 would give you something. But it’s huge. It’s huge.
5 MS. HENRY: You’re talking about number one?
6 DR. COVINGTON: Yes, number one. And then the
7 one underneath it is really sort of a sidebar of the same.
8 Bob Geffner runs both of those. And but just to let you
9 know what the context is of that. I wouldn’t think there’d
10 be any trouble of getting--just hoping the conference
11 center had an empty room would probably be the issue.
12 MS. HUTCHINGS: Is the sidebar one more intimate?
13 DR. COVINGTON: That’s essentially something, a
14 newer thing that he’s developed. So, I don't know that
15 much about that one.
16 DR. RIOS-ELLIS: I mean, based on organization,
17 I’d have trouble with Arizona right now. And I don't know
18 if that conference is even going to be held in Arizona
19 anymore.
20 MS. HENRY: Good point on the Arizona issues. I
21 know a lot of entities, organizations are wondering,
22 questioning whether they should continue to hold scheduled

1 conferences in Arizona.

2 MS. AYERS: I’d go with one, now that four is out

3 of the ballpark. I’d put one first, as well, actually.

4 PARTICIPANT: I agree.

5 MS. HUTCHINGS: 1-B I’m much more interested than

6 a huge one. So, if there is a distinction, if there is a

7 opportunity, I think the listening forum goes with a think-

8 tank model a little bit better than it does with a very,

9 very large conference, too.

10 MS. HENRY: And I was going to do a pitch for

11 number eight. And again, that's a huge conference.

12 MS. HUTCHINGS: It’s next time. We have to do it

13 before September.

14 MS. HENRY: No, no. What I heard Kana say is

15 that the tradeoff would be is that we would have our next

16 meeting in September or before the end of the fiscal year.

17 We could come back here, and that to then if we went into

18 next fiscal year, we could do the listening session then.

19 That's a huge conference, big, but it is Mental

20 Health and Addictions. The community behavioral

21 organizations, I think we’d get a lot of participation if

22 planning that far in advance in a listening session.

1 And the flip of that is I think there’s a lot for
2 council members, if they could stay or choose to stay, to
3 gain from that conference.
4 MS. HUTCHINGS: Disclosure-wise, I do some
5 consulting for the National Council, so, I want to be open
6 and honest about that. I believe regardless of that, it’s
7 hands down the best conference on behavioral health as far
8 as I’m concerned. And I think doing the public comment
9 period we’re going to hear from Jeannie Campbell about some
10 interests they have, and that's very relevant to our
11 discussions the last day or so. So, I’m all for that.
12 DR. RIOS-ELLIS: Kana? Couldn’t we do, I mean,
13 some of us this will be our last meeting, I think, because
14 there’s a few of us that are finishing. And so, being that
15 it’s the fiscal year, the fiscal year will then commence
16 again. If I’m thinking correctly, I mean, we could do
17 number one and potentially you all could do number eight,
18 as well. Am I right?
19 MS. ENOMOTO: Yes.
20 DR. RIOS-ELLIS: Okay, because I would really go
21 for number one.
22 MS. ENOMOTO: The other option that the National

1 Advisory Council is considering is to allow members of the
2 committee to host their meeting in their state or their
3 city. So I think last year they went to Oregon, where two
4 of the council members live and work.
5 And so, not that they had to literally do the
6 logistics or have people stay at their house, but they did
7 sort of connect them with sites, visitors, and speakers in
8 that community. So that's another option that's available
9 to us.
10 MS. SCOTT-ROBBINS: A couch.
11 MS. HUTCHINGS: A couch.
12 MS. ENOMOTO: A couch.
13 (Laughter.)
14 MS. ENOMOTO: Stephanie?
15 DR. COVINGTON: Well, if you decide to have it
16 here at the end of the last week in September, I could be
17 here, but I do want to put in my two bits for number eight
18 in the spring as a conference to go to.
19 MS. ENOMOTO: Okay.
20 DR. COVINGTON: And to organize ourselves around
21 for that next time period.
22 MS. ENOMOTO: Okay. Roger, go ahead.

1 DR. FALLOT: Yes, I agree. I think number eight,
2 in terms of our agendas and the capacity of the conference
3 to really both inform us and for us to inform them, number
4 eight is the way to go. Whether we want to add in one or
5 two would be fine, also, I guess, but I have less strong
6 feelings about that one.
7 MS. ENOMOTO: Okay.
8 DR. FALLOT: Having been to it, it is a large,
9 diverse conference with lots of things going on and it's
10 sort of chaotic. On the positive side of that conference
11 is that the people come from all over the place and they
12 have lots of different perspectives. If we were to do a
13 good listening session, we'd probably get a lot of people
14 there to form our conversations.
15 MS. ENOMOTO: Great.
16 DR. RIOS-ELLIS: I like the fact that it's
17 talking about homes. And I don't know whether that's what
18 it always is and it really doesn't have that much to do
19 with homes and communities, but when I saw it, I thought
20 oh, yes.
21 MS. ENOMOTO: Okay. Well, thank you very much
22 for that feedback. I think that's helpful and gives us

1 something to work with. So, we'll talk to conference
2 organizers and see what we can come up with. Appreciate
3 it.
4 So, with that piece of business taken care of, I
5 guess I'd like to ask you all your sort of final thoughts
6 on the presentations we had these couple of days and
7 directions for the strategic initiatives. As you can hear
8 from all of our presenters, there's a lot of work being
9 done, and nothing is fixed in stone yet, so your input at
10 this time is actually really, really meaningful and
11 important.
12 DR. COVINGTON: I'm going to make this suggestion
13 to you, and I guess you'll decide where it goes. I
14 understand that Pam Hyde is going to be at the Women's
15 Conference in July, and so, she'll probably be talking
16 about these 10 strategies. I think it'd be very important
17 that she have statistics on women and pull the data out and
18 separate it particularly at that conference, even if the
19 administration hasn't made a decision to do that within
20 this document as it is, but I think in July, it would be
21 very disappointing if that did not happen.
22 MS. HUTCHINGS: I'm actually very, very pleased.

1 With my tension issues, it doesn't always work for a day-
2 and-a-half, and everybody's been really interesting and
3 great, and particularly the last one I thought I'd love to
4 have her back again when she figures it all out.
5 One thing I think, and there's so many good
6 things to say, I'm just going to skip to the hopefully
7 constructive criticism, which is the front door application
8 of everything in the 10 strategies is supposed to be read
9 in the context of is broken and needs to -- I understand
10 the document will come out and people are supposed to read
11 the format, but I think depiction-wise, it needs much more
12 about its umbrella.
13 A term used yesterday, an umbrella
14 of recovery, the lenses of which things are expected, and
15 not only hoped to, but expected to be read, and
16 particularly Stephanie's many comments about permeating the
17 other strategic objectives in addition to trauma and
18 justice for trauma-informed care, the cultural competency,
19 eliminating disparities, what we used to call the
20 crosscutting principles aren't showing through, aren't
21 clearly being communicated, and it really needs work to
22 help that occur in not only a social marketing way, but in

1 a true implementation carry through way to.

2 MS. AYERS: I really enjoyed yesterday. I hadn't

3 heard Pam Hyde before, so, it was a lot of fun to just have

4 sense about who she is. And I thought John O'Brien's

5 presentation was also very interesting, and health reform

6 is the elephant in the room. And, apparently, we're going

7 to have to feed that sucker and get it right.

8 Which takes me to number three, which is this

9 evidence-based practice piece. I mean, when you say the

10 train's out of the station, SAMHSA is right up there at the

11 locomotive, and I think the cautionary note that Lisa

12 brought to us about and Stephanie and others have been

13 talking about, you can't imagine the pressure in the

14 community system to either produce or be doing evidence-

15 based practice. And there is a kind of really special-ness

16 about it.

17 And I love what we're doing on the Rosie D. piece

18 and whatever, but this fidelity to the model and people's

19 like insistence that absolutely, this is what we're doing

20 as opposed to being open to dialogue about what is

21 possible, what isn't possible, I'd be right back at SAMHSA

22 and other places where the pressure really is sort of

1 coming from in a certain sense, to say let’s be real about
2 this.
3 Let’s recognize where we are in the science and
4 trying to get it to practice, and let’s really have some
5 more--if we came back here next time, I think it’d be
6 interesting to have a real working group on all right,
7 well, what does it look like on the ground and could we
8 have John Weisz, Lisa, and others back to like have an
9 honest dialogue about it and be able to have a sense about
10 how to begin to moderate it and make it better because I
11 don’t have any argument with we’ve got to do things better,
12 but I don’t believe that we’ve got on the national radar
13 screen many interventions that actually -- I mean, there
14 are many more interventions out there that aren't on that
15 radar screen that, in fact, are very effective, and I’d
16 love to see more of a dialogue about how to find those and
17 how to embrace them, and what more to do about efficacy and
18 effectiveness because that is, in fact, where we’re at.
19 MS. ENOMOTO: Yes, I think that’s actually an
20 issue. I think I mentioned it earlier. It’s sort of
21 bigger than this particular committee, and it’s a
22 conversation we need to have SAMHSA-wide, and probably with

1 our partners at NIMH, NIAAA, and NIDA, and maybe even CMS
2 and HRSA, as well, and IHS, but what do we have? What are
3 the tools we have to work with? How can we make them work
4 reasonably in the context of health reform and in the
5 context of real-life communities and real-life people?
6 So, getting some thought leaders from different
7 perspectives in here. Ken Martinez comes to mind, his
8 emphasis, and work he's doing on practice-based evidence
9 and making sure that evidence-based practices -- or that
10 we're promoting models that work well for communities of
11 color, as well. So, that's great. I think it's stuff to
12 think about.
13 Roger and then Britt.
14 DR. FALLOT: Yes, I want to reiterate just a bit
15 of Gail said about the importance of keeping the focus
16 clear in terms of the priorities and initiatives. An old
17 colleague of mine once said no matter how long I talk;
18 people are only going to remember three things you say
19 anyway.
20 And I was sort of glad that HHS asked for three
21 priorities rather than all 10 because I think the top three
22 make good sense to me, especially if you're going to start

1 infusing trauma-informed approaches throughout the three
2 because the presentation that Larke did this morning is a
3 clear indication of how closely prevention is tied to
4 preventing violence, and that's a conclusion, I think, that
5 we can draw very closely through the first initiative, and
6 the second initiative is directly trauma-related, and the
7 third initiative around military families also expands the
8 trauma to include the impact on the families across
9 generations, actually.
10 So, that's a very nice emphasis, I think. And I
11 would encourage SAMHSA to really focus on those three. Not
12 to let the other seven go, but that if it comes to a point
13 where there needs to be some emphasis given to one rather
14 than the other, that those three are nice places to start.
15 DR. RIOS-ELLIS: I really appreciated the chance
16 to talk to Pam yesterday and to really see what those were,
17 and I really appreciated the way she was taking notes. I
18 felt like she was just veraciously, as quickly as she
19 could, take notes, and so, I really have the sense, and, I
20 mean, Amanda and I were chiming in yesterday, we were
21 talking in the elevator, just because of our lenses,
22 they're just so distinct, and I think I feel very honored

1 to be able to put in, to have that input, and to be able to
2 contribute so that that lens does stay there, especially
3 during that time.
4 And I also want to make a comment on the
5 evidence-based practice because I stayed up last night
6 until about 3:30; we were working on an evidence-based
7 practice grant right now, and that fidelity to the model, I
8 think that however it's going, but that fidelity to the
9 model piece, and this, thankfully, is ¡Cuídate! so it was
10 written for Latinos, so, it's a little bit easier to be
11 that faithful.
12 But I think that agencies can have such a role in
13 how they write that fidelity to the model piece within an
14 RFP and really talking about and really soliciting
15 adaptations as opposed to saying we want you to be faithful
16 in the model and we want you to be faithful in the model
17 three or four times, and then how are you going to adapt
18 it, which the message is be absolutely faithful to the
19 model, don't change anything, and whoever can show the
20 randomization model is correctly and elaborated as
21 carefully as they can in terms of power, would most likely
22 be the one chosen.

1 So, I think within that, I would really recommend
2 that SAMHSA, as whatever you’re doing around anything like
3 that, really welcome those adaptations and really challenge
4 organizations to really ground them in community as much as
5 possible, because I know with a lot of the RFPs we’re
6 working on, it’s very boldly stated, and it’s also
7 understated that, as faithful as you will be, and as
8 faithful as they trust that you will be, is more than
9 likely who will receive the dollars to do the work.
10 MS. ENOMOTO: I think on that front though, as
11 Lisa noted, that the evidence is mixed, that there folks,
12 Stan Huey, Jeannie, Miranda, they’re doing this work that's
13 showing that, despite some protestation that evidence-based
14 practices flat out won't work for our populations, that
15 when they’re implemented with fidelity, they are effective
16 across multiple different populations.
17 I think it’s a conundrum, as Lisa noted, to kind
18 of assume that they’re not going to work and start with
19 adaptation from the front-end, there’s also some logic
20 there, too. So, finding the middle ground in that, I
21 think, is probably right because whether you’re working
22 with exactly the same population as the practice was

1 developed on, you’re not working on exactly the same
2 leadership, same culture, same resources, and the same
3 county-state structures, and so, there’s always some
4 thought that needs to be given to how do we make it work
5 here for these people? And even if the people aren't
6 exactly the same, the here is not the same, and the time is
7 not the same, the clinicians aren't the same. So, I think
8 it’s certainly the implementation science needs to be
9 brought to bear on the work that we do.
10 DR. RIOS-ELLIS: And you’re probably aware of
11 this, there’s a new text on framing models, and I cannot
12 remember what it is. We just ordered three or four of them
13 for our office, but it’s literally about how to take these
14 and begin to reframe them and restructure them for distinct
15 communities. I’ll send it to you, but I think looking
16 through it, it looks great.
17 MS. HENRY: I would like to thank the committee
18 because the committee has done exactly what it’s supposed
19 to do, keep the issues of women and children on the
20 forefront and reminding the administrator of that.
21 So, I’m going to flip to the other side and say
22 also what I do appreciate about the initiatives and the

1 paying attention to the health reform is the fact that
2 SAMHSA in the background, the strategic initiatives,
3 focused the agency's work on improving lives and
4 capitalizing on emerging opportunities, and I think
5 capitalizing on emerging opportunities is extremely
6 important in this day and age.
7 One, SAMHSA has to work this fine line of
8 continuing to say that we are a relevant agency in the
9 context of moving forward in an environment that is going
10 to force substance abuse and mental health to become part
11 of the general health care system. And, so, how do you do
12 that, maintain the relevancy of the agency that is focusing
13 on substance abuse and mental illness and prevention? So,
14 I think it's a fine line to walk.
15 I think Administrator Hyde is working hard to do
16 that, and there will always be the various constituency
17 groups like ours, they're going to say and remember this
18 and remember us, but I don't think we should be confused
19 because I think SAMHSA is listening to all of those
20 constituency groups and still trying to walk that line of
21 keeping the agency relevant in a time where it could be
22 easy to say well, look, you're part of the general health

1 care system now, and what else do you want?

2 So, congratulations on that, and the seizing me

3 from a state perspective, I'm keenly aware of this

4 capitalizing on the emerging opportunities of health reform

5 is going to be important for our field so that four, five,

6 six years from now, we can still have our specific

7 constituencies to be able to say that because it would be

8 too easy to get lost.

9 So, thank you for that.

10 MS. SCOTT-ROBBINS: Well, I've made it through my

11 first meeting.

12 (Laughter.)

13 MS. SCOTT-ROBBINS: And it was absolutely

14 everything that I expected it to be and more. What an

15 opportunity to be here and to meet Pam Hyde and what a

16 perfect time to start in the committee because all of the

17 initiatives for states are just number one on our list, as

18 well, and I feel so fortunate to be a part of this and to

19 actually have the opportunity to have input in the process.

20 Keeping the focus on women and girls as a part of

21 this committee, the health care reform is an extremely

22 important piece, particularly for the women that we serve

1 day in and day out at the state level, at the local level,
2 and pregnant women in particular and the benefits that they
3 receive currently, and the needed benefits, the expanded
4 benefits that they need to continue to receive treatment
5 after having the baby.

6 Right now, it's very limited. It's about six to
7 eight weeks after delivery that a woman can continue to
8 receive Medicaid, and that's one of the things that I would
9 really like to get put on the table, that, again, this is a
10 chronic disease and that six to eight weeks after having a
11 child is something that we really need to be focusing on in
12 terms of length of services.

13 So, again, it's been a real pleasure. It's been
14 wonderful meeting all of you, and thank you again for the
15 opportunity for participating.

16 MS. ENOMOTO: Well, thanks to all of you. I
17 think each of you brings a unique and very important
18 perspective to this table. We've heard a lot of important
19 stuff.

20 I think the point that Gail Rogers, Stephanie,
21 and many of you made is about the lens, that we really need
22 to make clear the lens that through which one should view

1 the strategic initiatives, and that that lens can be
2 adapted at different times and for different populations.
3 I think that's really good input, and I think you’ve put
4 some good clarity on how we could do that. So, I
5 appreciate it, and, certainly, that's something we’ll sort
6 of -- at 12:30, we’re going to start working on that. You
7 can trust we keep moving.
8 The conversation around evidence-based practices
9 and doing something bigger and in depth and really allow
10 that conversation to happen, which I think we’ve been
11 moving so fast, we just haven't stopped to catch our breath
12 and think about all these things and how they’re getting
13 actualized in our programs. I think that's an important
14 thing that we can follow-up on.
15 The top three priorities that we’ve put forward
16 to the secretary’s strategic plan; those certainly have
17 provided some focus. I mean, I think what you are
18 suggesting, Roger, is really happening, that we are
19 investing in all 10 initiatives, but at certain points of
20 the day and the year, you have to really dedicate resources
21 and energy to a few things, and that is happening. So, I
22 think you can rest assured that you’ll more to come,

1 especially on those top three.

2 And the challenge of weaving gender issues,

3 trauma issues throughout all 10, you can believe I'll

4 champion that, Larke will champion that. Pam will champion

5 that. I mean, she's really very connected to our issues.

6 And then focusing on improving lives,

7 capitalizing on emerging opportunities. The challenge we

8 have is that there are so many emerging opportunities,

9 which ones really need SAMHSA there, and which ones can we

10 rely on some of our very good partners who have a shared

11 interest in improving the lives of people with or at risk

12 for mental illnesses and addictions?

13 I mean, because we're tiny, and we can't be at

14 every single table all the time, and so, we need allies,

15 and so, we're developing those allies as we speak and

16 trying to galvanize not just the energies of SAMHSA, but

17 the energies outside, across the department, and in other

18 departments so that we're not the only ones signing the

19 song of behavioral health, that other people are bringing

20 that lens to the table because we need to focus our

21 energies on those emerging opportunities which really

22 require our expertise, our time, and our attention, and

1 kind of have direct relevance to our programs and to our
2 populations.
3 So, that's really the challenge that we have now:
4 How do you map 10 initiatives on top of everything that's
5 happening with health reform, parity, the economy, and
6 changing situations in communities and states? It’s great
7 work, it’s fun work, and I think the fact that we do have
8 these opportunities to listen and focus on a population in
9 a couple of settings at one time is good. We need that.
10 So, this has all been, I think, a very productive meeting.
11 Now, I’d like to open it up for public comment.
12 We do have one comment from Jeannie Campbell, the much
13 touted and anticipated Jeannie Campbell from the National
14 Council on Community Behavioral Health Care.
15 MS. CAMPBELL: Thank you, Kana. This has been a
16 wonderful meeting today, and I really appreciate the
17 opportunity. I love the rich discussion by so many experts
18 in the room, and it’s been too great to sit in the back of
19 the room and just kind of soak it up and to listen and to
20 learn, and I’ve learned a lot. And my head is just going
21 everywhere of all the opportunities that I see in front of
22 us that we could do in terms of partnering with one another

1 to really make a difference in the field and where services
2 are actually delivered.
3 I am Jeannie Campbell. I'm the executive vice
4 president of the National Council for Community Behavioral
5 Health Care. A long name, but we're the trade association
6 that represents mental health and addiction treatment
7 provider organizations all over the country. We have
8 members in 48 states. I have to get a member in South
9 Carolina and Idaho, but we have 1,700 organizational
10 members. They serve about 6 million adults, children, and
11 families each year. They employ well over 300,000 folks
12 who serve those 6 million adults, children, and families
13 each year.
14 So, we're a large organization that represents a
15 large base of community-based providers, but a relatively
16 small staff of 20 people. But we're doers. We want to
17 make things happen. It's not enough for us to talk about
18 it, but we want to make a difference, and how can we
19 contribute, and how can we contribute to those in the room
20 that are so expert on this particular topic?
21 I'd like to applaud and thank SAMHSA for their
22 leadership on this topic, the fact that it's one of the

1 strategic initiatives of Pam Hyde and the rest of the
2 SAMHSA Team. I think that's very important.
3 My own personal story around trauma is short,
4 actually, and I didn’t really become interested in this
5 issue really until about a month ago. And I went to a
6 meeting, the Federal Women on Trauma downtown and got to
7 hear from Lisa, Larke, Stephanie, Kana, and several other
8 people and was blown away by the prevalence of trauma in
9 our society. And it made me think about what we can do as
10 a trade association, the largest trade association that
11 represents providers. How can we make a difference? And
12 how can I personally make a difference?
13 And so, I’m the champion in the room for the
14 National Council and for all those providers out there, and
15 I want to be a doer, and I want to be helpful, and I need
16 direction, and I need your expertise, and I need you to
17 help partner with us.
18 We’re committed to this issue. It’s a priority
19 issue for us, and we want to move out and move out quickly.
20 There’s a lot that we have to do, just as Kana said, but we
21 need to get started now in terms of really making a
22 difference. So, I’m very interested in very concrete

1 things that we could implement.

2 The National Council has a large bully pulpit, if

3 you will, with all those members. We can make change

4 happen. Roger, Lisa, and Stephanie talked about how

5 difficult that change is, but we can certainly influence

6 how that change happens and how quickly that uptake that

7 begins to happen and we want to do that.

8 We want to build on the expertise on this room.

9 We know that we’re not the experts in this arena. We

10 talked about shared learning. We have lots of learning

11 communities. We know how to disseminate information. We

12 have a very robust dissemination process at the National

13 Council with our Webinars, our website, the annual

14 conference, so on and so forth, and I think that's an

15 excellent way for us to get training and information out to

16 our members, and we want to do that.

17 I was also thinking about the Federally-Qualified

18 Health Centers, and looking around the room and wondering

19 if any of those were in the room, because it seems to me

20 since so much of the mental health and addiction services

21 are provided in those community health centers, they need

22 to be a part of this. SAMHSA has the expertise, but we

1 somehow need to partner with them around this particular
2 topic, and how can the National Council help with that? we
3 certainly have the relationship with the National
4 Association of Community Health Centers.
5 But, again, I thank you for this opportunity,
6 and, Kana, when you were going around the room talking
7 about where your next meeting might be, we would welcome
8 you come to the National Council's Office downtown, but we
9 would also welcome the opportunity for you to come and have
10 your committee meeting at our San Diego conference next May
11 because I think that would really send a message to people
12 that we're serious.
13 Again, that we're doing something. We're calling
14 attention to this issue, and we really want to make a
15 difference in the community where the services are actually
16 delivered. Thank you.
17 MS. ENOMOTO: Thank you very much, Jeannie.
18 Thank you for coming and for our members, I'm sure you
19 appreciate that that's a really valuable offer, and we
20 certainly are going to take you up on that, Jeannie, in
21 terms of partnership and ideas. We have a table full of
22 people with good, concrete, forward-thinking ideas, and I'm

1 sure they will not be shy to share them with you.
2 So, thank you. Thank you to the National
3 Council. We're really looking forward to that partnership.
4 With that, I think we're about ready to close
5 out. I do want to thank our fantastic videographers again.
6 Mark, J.D., Brad, and Adam, and then also the folks from
7 Cabezon, who have sort of seamlessly and quietly made this
8 all happen very well, Katie, Theresa, Christine, and Irene.
9 And Verizon and Chorus Call, where we've had I guess about
10 50 people joining us today via live stream. So, that's
11 wonderful.
12 I put on lipstick this morning.
13 (Laughter.)
14 MS. ENOMOTO: So Ed, Jeff, and Nick, thank you
15 very much for that, and, of course, our SAMHSA staff, who
16 have been just fantastic. This meeting is right on the
17 heels of the National Advisory Council Meeting. So Toian,
18 Carol, Maron, Michael, and of course, Nevine. You've have
19 just been so fantastic.
20 So thank you to all of you for making this
21 happen. I appreciate it very much, and thank you to our
22 members.

1 (Applause.)

2 MS. ENOMOTO: So, and with that, the meeting of
3 the Advisory Committee for Women Services of SAMHSA is
4 adjourned.

5 (Whereupon, 11:47 a.m., the meeting was
6 adjourned.)

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