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SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES
ADMINISTRATION (SAMHSA)

Advisory Committee for Women's Services
Net Conference

3:05 p.m.
Monday, December 14, 2009

1 Choke Cherry Road
Rockville, Maryland 20857

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P R O C E E D I N G S

MS. NEVINE GAHED: Thank you, and good afternoon.

I'm Nevine Gahed, and I'm the designated Federal official for the Advisory Committee for Women's Services that is chaired by Ms. Kana Enomoto. And we have quorum, and I now call the meeting to order.

Ms. Enomoto?

MS. KANA ENOMOTO: Thank you, Nevine.

And thank you, members and members of the public and the staff, who are attending the meeting both in person and via audio or net conference. Once again, ACWS is leading the way in our use of technology and these convenings, which I think is wonderful that we're able to engage more of the public than we would otherwise have, as well as more of our members.

Members, please know you'll have open access to the lines. But remember to state your name before speaking so that the transcriber can identify you for the record.

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And as a reminder, members of the public will be on mute and will remain so until we are ready to open the floor for public comment. That will be approximately 5:00 p.m. If you wish to speak and you're a member of the public, please let the operator know ahead of time. You'll have 2 to 3 minutes in which to make your comments.

Nevine, what is the mechanism for them to let the operator know?

MS. NEVINE GAHED: The operator will know, and she will actually send me a message.

MS. KANA ENOMOTO: So you raise hand on the net conference. You click on "raise hand."

We're going to begin with a quick roll call and then followed by consideration of the minutes. And then I will let you all know that we have a surprise guest visitor.

So let's start with the roll call. This is Kana Enomoto, acting chair of the Advisory Committee for Women's Services, SAMHSA.

MS. NEVINE GAHED: And I'm Nevine Gahed, the DFO.

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MS. GAIL HUTCHINGS: [on telephone] This is Gail Hutchings from the Behavioral Health Policy Collaborative.

DR. STEPHANIE COVINGTON: [on telephone] Stephanie Covington, Center for Gender and Justice.

DR. ROGER FALLOT: [on telephone] Roger Fallot from Community Connection.

MS. AMANDA MANBECK: [on telephone] This is Amanda Manbeck with White Bison.

DR. BRITT RIOS-ELLIS: [on telephone] Britt Rios-Ellis with NCLR CSULB.

MS. SUSAN AYERS: [on telephone] Susan Ayers with the Guidance Center.

MS. KANA ENOMOTO: Is Stephanie?

MS. NEVINE GAHED: Yes, and Dr. Covington?

DR. STEPHANIE COVINGTON: Yes?

MS. NEVINE GAHED: Okay. And Dr. Covington is with us as well.

MS. KANA ENOMOTO: Okay. Great. And people in this room, if you'd like to announce yourself?

MS. IRENE SAUNDERS GOLDSTEIN: Irene Saunders Goldstein.

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MS. TOIAN VAUGHN: Toian Vaughn. I am the SAMHSA committee management officer and the designated Federal official for the SAMHSA National Advisory Council.

MS. KANA ENOMOTO: And we are also very fortunate that Administrator Hyde has been able to join us this afternoon. So we'll introduce Ms. Hyde in a moment.

Let's just consider the minutes of the July 29 ACWS meeting. This is -- for our members, as you recall -- also a net conference that we had -- NIMH, NIDA, and NIAAA presenting their emerging research and findings around women and girls and behavioral health.

So I will ask for a motion for formal consideration and approval of the minutes for the July 29 meeting.

MS. GAIL HUTCHINGS: This is Gail Hutchings. I'm happy to move. I thought they were very well done.

Again, thank you so much for pulling that -- I know it was a lot of work for everyone to pull together. I thought it was a wonderful, very

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informative session. So I propose the move.

MS. KANA ENOMOTO: Thank you. Do we have --

[Second.]

MS. KANA ENOMOTO: Wonderful.

These minutes were certified in accordance with the Federal Advisory Committees Act, FACA, regulations. Members were given the opportunity to review and comment on the draft minutes.

There are no changes or additions to the meeting's minutes, and we have approved them. We've had a motion and a second to approve the minutes.

We've sent you the minutes for the August meeting for your review and comments. We'll formally consider them in our spring meeting. We just wanted to get them out so that you could have them in front of you as we do a little debrief of our Chicago meeting today.

But with that formality out of the way, I'd like to introduce you all to our -- virtually introduce you to our new Administrator, Pam Hyde. We are so pleased that she was able to join us, confirmed by the Senate 3 weeks ago.

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MS. PAMELA HYDE: Something like that.

MS. KANA ENOMOTO: Joined us last week and has since then shaken about 800 hands all over the Washington metropolitan area and throughout the SAMHSA building. Everyone is just thrilled to have her here, and we are looking forward to the direction and the vision that she's bringing to SAMHSA.

So, Pam?

MS. PAMELA HYDE: Thank you.

Thank you, Kana, and thanks to all of you for letting me join you for just a few minutes.

I am very pleased to know that there is a committee looking out for women and girls and the services that they need that SAMHSA can have a role in.

I was asked to talk to you just a little bit about my observations from my first week. I don't know that I've synthesized my observations yet. As Kana said, I think within the first week, I did three speeches and shook 800 hands and sat in on a billion different meetings with different kinds of topics.

So right now, I'm sort of a big sponge,

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absorbing all of this stuff. But I wanted to let you know that, obviously, over the years, I've been very interested in women's issues, ranging all the way from my very young time in working with rape crisis centers and domestic violence issues and pro se divorce issues and all of those things way back in my youth -- my youth, my young professional life -- as well as over the course of my work in behavioral health, as well as healthcare, looking at women's issues and issues that affect young girls that will soon the women leaders of the future.

So I'm pleased that you are here. I'm just really here to listen a little bit today, get a flavor of what you all are working on, try to let everyone know that I'm very interested in -- well, I think SAMHSA is doing great things and terrific work. There are always things that we can do better, and I'm very interested in your feedback about that.

I understand that I may have an opportunity to meet more of the members in the spring. Is that right, Kana? So I'm looking forward to that. And maybe at that point, I'll have a little bit more time

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under my belt and will be able to interact with you all a little bit more on the content of what we're working on.

I will say, it goes without saying that this is an incredible set of -- incredible time. There are a lot of things coming together that offers us real opportunities, between healthcare reform and the focus on prevention and just a ton of issues, all the people that are being put in place in HHS and around the administration. I'm very pleased about that. I think it gives us an opportunity to work together in ways that are maybe, hopefully, will be real change making.

Some of you that I know know that I've spent most of my professional career being involved in trying to make things change, change for the better. So I'm looking forward to that, and it's part of the reason I'm here, frankly. I wouldn't have been willing to come and do this work had I not thought both SAMHSA, as well as HHS and President Obama and the administration, is really focused on being willing to make some difference. And that's important to me.

So let me stop with that and just -- well,

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one other comment. I have, over the years, had wonderful opportunities to work with terrific councils that advise, that advocate, that pressure us, and that's part of your role to keep the pressure on and just bring your expertise to bear on what we're doing. I think that it doesn't take very long for anybody sitting in any position to get insulated and get focused on what you're doing on a day-to-day basis.

So it's your job to let us know that there's another world out there and that you can remind us of the things that we should be paying attention to if we get off track. So I'm really pleased to be here, and I'm going to listen for just a little while. And then I look forward to meeting you in the spring.

So, thanks. I'm happy to take -- if there are questions or you want to do any of that, I'm happy to do that. But mostly I'm just here to listen today.

MS. KANA ENOMOTO: I'd love to let the members introduce themselves to you virtually, just let you know who they are, what they're working on, kind of what they're bringing to the table as members of the Advisory Committee for Women's Services,

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because this is your committee.

MS. PAMELA HYDE: Great.

MS. KANA ENOMOTO: Does one of our members want to start off? Amanda, you're at the top of my list.

MS. AMANDA MANBECK: Okay. All right. My name is Amanda Manbeck. I work for White Bison. We're based out of Colorado Springs, Colorado. I've been with this organization for over 6 years.

I think the thing that I bring to the table is we've done a lot of work in Indian Country and around the country regarding prevention and recovery. And for me, a lot of that focus for us has been on the youth and how to encourage them to find it within themselves through their culture and through their family a different way of coping and handling things.

On a lot of the reservations, there is poverty and a high rate of alcoholism and drug abuse. So, really, we've just been spending the last 2 or 3 years heavily on working towards preventive measures and helping the communities build capacity in that area.

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MS. PAMELA HYDE: Amanda, what does White Bison do?

MS. AMANDA MANBECK: Well, we work nationally with both training and resources. And basically, what we do is we take culturally relevant materials and we incorporate them into training, and we go out into the communities and help them, do some consulting and some onsite training.

And in the next couple of months, we're going to be debuting a training institute so that we can make our programs more readily available to people that can't necessarily bring a whole training to their community but that want to send a few people to training. So we're trying to branch out in different ways to help keep the movement going.

MS. PAMELA HYDE: Great. It's good to meet you.

MS. AMANDA MANBECK: Thank you.

DR. BRITT RIOS-ELLIS: Hi. My name is Dr. Britt Rio-Ellis. I'm a professor and a director of the National Council of La Raza at Cal State University-Long Beach Center for Latino Community

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Health Evaluation and Leadership Training. I apologize for the length of the name.

We work with the National Council of La Raza. We were established in 2005 through a congressional earmark, then spearheaded by then-Congresswoman, now Secretary of Labor Hilda Solis to really work with the network of community-based organizations and community-based affiliates, which is almost 300 nationwide, of the National Council of La Raza as the largest Latino advocacy organization in the country.

So we combine our work with NCLR’s work to ensure that our programs are culturally and linguistically relevant as well as really meeting the needs of our community-based affiliates, many of whom are Federally Qualified Health Centers. We work with health programs in underserved Latino communities, provide technical assistance to organizations who are already doing this kind of work, and also furnish Latino communities with the research and education needed to facilitate their work.

So a lot of what we do is community-based

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participatory research with community-based organizations, and a lot of our work has to do with alignment of community health worker programs. So we work with what we say in Spanish “Promotores de Salud.”

At the center, we have several projects, one of which was just funded by the Office of Women’s Health to work with Latina mothers and their daughters around HIV and STI prevention and reduction of risk behavior, trying to facilitate interfamilial -- especially around women -- support systems and also communications within the Latino family in areas that haven’t traditionally been discussed much in the home.

We also were recently funded by the Office of Minority Health to set up a youth center for at-risk youth in North Long Beach, and we’re doing this work with the YWCA -- or YMCA, excuse me. And we also work with the National Institutes for Health, looking at HIV-relevant, community-based relevant research and approaches that address more than just behavior, but also the context of risk within diverse Latino communities.

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MS. PAMELA HYDE: Great. Do you know my friend Jeanne Miranda?

DR. BRITT RIOS-ELLIS: Jeanne Miranda? Yes, it sounds very familiar.

MS. PAMELA HYDE: She's at UCLA, but she does a lot of work on women and girls in Latina --

DR. BRITT RIOS-ELLIS: I think I met her through Vickie Mays.

MS. PAMELA HYDE: Yes. Could be. Great.

DR. BRITT RIOS-ELLIS: Yes.

MS. KANA ENOMOTO: Thank you, Britt.

Gail? Gail?

MS. GAIL HUTCHINGS: Hi, Pam. Welcome.

MS. PAMELA HYDE: Hey, Gail.

MS. GAIL HUTCHINGS: I'm going to be really short. I still keep my hands in a myriad of policy and TA issues, mostly with States and the national organizations, a bunch of great providers, too, around the country. Still very interested in trauma-informed care, which I think is one of the things that led me to the honor to being on the committee, and I'm really happy to serve you in this role.

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The thing that has me jazzed up the most and sort of excited and dedicated now is to try to address nicotine addiction by bringing smoking cessation services, particularly peer-run services, to people with behavioral health problems. And SAMHSA has really been an incredible partner with that, and I know we're going to look back and be excited about this as a kind of important step forward in trying to prevent what's killing folks that we serve. So I'm really jazzed up.

But more importantly, I just want to tell you, you've created such an excitement and a wonderful buzz in the entire field -- both fields, all fields -- that you're here. And we're just -- we're really thrilled that somebody with so much expertise and knowledge is now leading SAMHSA.

And I know I don't have to tell you this, but I'd be remiss not to tell you that Kana has been just an incredible leader of this committee. Her leadership has been wonderful, her policy direction, and Nevine has been wonderful, too.

So just my warmest welcome, Pam. Any way we

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can be of service, please don't hesitate to use us.

MS. PAMELA HYDE: Thanks, Gail.

We'll let Kana and Nevine keep going.

[Laughter.]

MS. GAIL HUTCHINGS: Thank you.

MS. PAMELA HYDE: Good to see you -- or talk to you.

MS. SUSAN AYERS: So I'm Susan Ayers, and I reside up here in the Cambridge/Somerville, Massachusetts, area. And I've been the executive director of the Guidance Center, which is a child and family agency that serves children and families from pre-birth really, with a great program for pregnant teenagers called Healthy Families, pretty much right through the continuum of your child-rearing years.

Certainly my passion is parents actually more than kids in that sense that you really want to be able to see moms particularly and dads. We see more moms than intact families, but either moms or dads, to acquire the kinds of skills that they need to be successful with their children.

The other piece I'm passionate about is how

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important it is to do this work in the community through prevention and intervention, and then in order so that we don't have out-of-home placements and that we're able to have safe and healthy families in the community. Because most parents really want to be successful, but very often when they run into a web of difficulty, they don't get those services unless they "fail up" into services that are more intensive.

And then, finally, I care an awful lot about policy. I think I ended up on the council because of this particular point of view I have about moms and parenting and children as they raise them and also because the "going from the trenches" piece is really about how do you put together excellent clinical services with a strong business model? The Guidance Center is where the rubber hits the road.

We've done a lot of innovative practice, but in our State, there just are not adequate rates to begin to pay for these kinds of services. But they really help families and kids do better, and as well with the schools and childcare centers, we consult in all the schools and the childcare centers in our area.

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And the last thing is here in Massachusetts, we are undergoing a big remedy for a Rosie D. lawsuit, a lawsuit that was brought, and the Department of Medical Assistance -- it's a Medicaid lawsuit -- is now putting together the remedy, which we're one of the community service agencies that will be doing the care management, the care coordination, and care partnership with families who have kids that are in more substantive difficulty.

So the Rosie D. piece is something apparently that for folks that watch what's happening in kids services and how do we design a service delivery system for kids and families, that's what's happening in Massachusetts.

MS. PAMELA HYDE: That's great. Is that the Baker lawsuit?

MS. SUSAN AYERS: It's called the Rosie D.

MS. PAMELA HYDE: Oh, okay.

MS. SUSAN AYERS: Baker, I think, was the developmental disabilities one.

MS. PAMELA HYDE: Oh, okay. All right. Great. Well, nice to meet you.

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MS. SUSAN AYERS: Well it's a real honor to be on this committee. Kudos to Kana as well and her staff. And so, I look forward to having a chance to meet you.

MS. PAMELA HYDE: Terrific. Thanks.

DR. ROGER FALLOT: My name's Roger Fallot. I'm director of research and evaluation at Community Connection, which is a large, not-for-profit, mental health and other supportive services agency in Washington, D.C., although I currently live in Connecticut. So I do a lot of commuting by train and by email and conference calls and other means of communication.

I think what I've brought to this committee is an interest in trauma primarily. I was one of the PIs on the Women, Co-Occurring Disorders, and Violence Study, which was the last large SAMHSA research project, as I understand it, which is now just over 10 years ago, believe it or not, Kana. So I have a hard time processing time at my age. But that was a very influential part of my own history.

And in addition to working on the Trauma

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Recovery and Empowerment Model groups as a researcher and evaluator, I've developed some ideas around trauma-informed care and have been consulting fairly widely on implementing trauma-informed services.

The thing that I think has animated my work most recently has been the idea that there are, in addition to all the important evidence-based practices that have been developed over the last decade or so, is that we need to give some equal validity to the context in which those evidence-based practices are implemented. And such ideas as trauma-informed care, and I'm lucky enough to be working with Stephanie Covington in Connecticut on developing a gender-responsive and trauma-informed initiative, which will combine the emphasis on gender and trauma, as well as recovery-oriented and culturally competent systems of care, which I think of as the four core values-based approaches which are so essential to providing any kind of evidence-based services.

So that's what I'm heading, and I'm very pleased to be a part of this committee.

MS. PAMELA HYDE: Great. Nice to meet you.

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I'm interested in your work on spirituality and recovery. You didn't mention that.

DR. ROGER FALLOT: No, I didn't. Although I'm still very interested and have been very pleased that SAMHSA has recently sponsored a couple of meetings on spirituality and trauma-informed care.

MS. PAMELA HYDE: Great, yes.

DR. ROGER FALLOT: One of which I was able to attend and one of which I was not. But they have been a very nice way of again blending I think the importance of some of the broader issues in the supportive context of recovery.

MS. PAMELA HYDE: I'll be happy to hear more about that later.

DR. ROGER FALLOT: Thank you.

DR. JEAN LAU CHIN: [on telephone] Hi, this is Jean Chin. I don't know if you can hear me now? Before I think I was only on a listening mode.

I am dean and professor at Adelphi University and am on the advisory committee, done a lot of work in terms of women and leadership issues, as well as cultural competence. And right now, focus

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is on training of psychologists in terms of being relevant to issues in our contemporary society, as well as developing the [inaudible].

I'm happy to be on the committee.

MS. PAMELA HYDE: Very nice to meet you.

DR. JEAN LAU CHIN: Thank you.

DR. STEPHANIE COVINGTON: And I'm Stephanie Covington, the co-director of the Institute for Relational Development in the Center for Gender and Justice, located in southern California. The Center for Gender and Justice works with local, State, and national -- I guess international -- groups trying to do system analysis and policy reviews. We do strategic planning as well as program development and training, trying to improve services for women and girls who are in the criminal justice system.

My work has -- over the years has really focused on women and substance abuse and also how that relates with trauma. And I've been doing this, I guess, for a very long time. I think what Roger mentioned, the project we're working on in Connecticut, which I'm really excited about, the idea

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of blending gender and trauma, getting both initiatives with the idea of really thinking about, hopefully, as we start with these two, moving into looking at that values-based system with all four values.

I think the other interesting thing in talking about the Connecticut project is the -- as we're talking about gender, we're expanding gender responsiveness to include gender for men. What does it mean to consider male social relation and how that impacts recovery?

The two things I'm hoping that the committee or SAMHSA can think about, one is the Women's Leadership Institute that Sharon Amatetti ran for this last year for women in the substance abuse field, I think that was a wonderful experience, and the whole idea of helping, how we can help expand the leadership in the substance abuse field because many people are aging out. And so, I think that's an important piece.

And the other thing is gender, when we've done work around gender, we've done most of it in substance abuse, but not in mental health. And I'm

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also wondering at some point if we can't bring this whole concept of what it means to be gender responsive to the mental health field.

So those are some of the things that I'm interested in, and personally, I'm working on a prison curriculum for women who commit violent aggressive crime. So that's my major project at the moment.

MS. PAMELA HYDE: Great. Look forward to talking to you more.

DR. STEPHANIE COVINGTON: Thank you.

MS. KANA ENOMOTO: Before I move on to giving an update on some of the health reform stuff, I want to introduce the two people who've come into the room. So I'll let you guys say hello to the committee yourselves.

MS. SUSAN SALASIN: My apologies for being late. I went to the wrong room.

I'm Susan Salasin, and I work in the community support program and have probably spent the last -- right now, my main area of concern is trauma-informed care, and I do project officer for the National Center for Trauma-Informed Care that we

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established out of earlier work.

And I'm also chairing an intergovernmental women and violence committee, where we're trying to build an agenda and plan activities that bring all the various agencies together to look at issues of women and trauma because the behavioral manifestations of trauma really touch all the public health agencies that these women come to and need. And so, we're trying to really promote a much more integrated look at it and I think have some good plans.

Thanks.

MS. KANA ENOMOTO: Susan can't believe it's been 10 years either, Roger. We all worked together on the women and violence.

MS. SUSAN SALASIN: 1998 to 2003.

MS. KANA ENOMOTO: That's right. My first task when I came to SAMHSA.

MS. MELISSA RAEL: Good afternoon. I apologize as well for being a little bit late with this meeting. This is Melissa Rael, and I'm with the Center for Substance Abuse Treatment with the Division of State and Community Assistance.

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I work with the Substance Abuse Prevention/Treatment Block Grant. And my task with the block grant primarily is -- my assignment is with the southwest States, and also the fact is I have the lead with the women's set-aside and take back a lot of information with all our other State project officers that oversee their operations monitoring with the block grant. So it's good to be back with you all.

MS. KANA ENOMOTO: There is probably some rule that says don't put your new boss on the spot, but --

[Laughter.]

MS. KANA ENOMOTO: -- I have to just ask if any of you had any questions that you wanted to ask Administrator Hyde. I wanted to take advantage of the time that we have with her. I know she's here to listen, but was there anyone who wanted to ask about vision, future plans, et cetera, here at SAMHSA?

MS. GAIL HUTCHINGS: Kana, this is Gail. I guess I could jump in with a very quick question, which is, Pam, do you have a preference for the method that you prefer communications and the way that works

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best for you? Would you like face-to-face or formal memoranda, or what's your preferred method?

MS. PAMELA HYDE: Actually, that's a great question. Several people have asked me that. I do a little bit of everything. I do the usual sort of emails and phone calls and face-to-face meetings and written communication.

Just in terms of the amount of time and the amount of material I'm trying to take in, at this point, when people give me big, thick books and say, "You really should take a look at this," it's really going to sit on the shelf for a while.

So if there's something that you think I should be aware of -- short. Either a short email or a short letter or memo or, frankly, you can talk to Kana. She and I are running into each other in the hall every 2 seconds. So she's been very good about getting things in front of me.

If you think we need a longer conversation, please let her or myself know. I'm obviously going through the process of trying to set up meetings with a lot of people. So the list is pretty long right now

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just in terms of my meet and greet. But if there's a topic that you think we need to sit down and have some face-to-face time, I'm willing to try to get that arranged as well.

And I would encourage you to just keep going through Kana, again not because I'm trying to screen anything, but just because I'm taking in so much right now -- if you'll give me just another week or two, or three or four. So you can do any of those things, I'm really pretty open.

MS. GAIL HUTCHINGS: Okay. Thank you.

MS. KANA ENOMOTO: Great. Okay, well, I think we will let her off the hook now and take her off the hot seat, and I will go ahead.

We're switching our -- we're flipping our format a little bit, which I think drives other people nuts, but it lets us go with the flow.

I wanted to -- actually, I'm sorry. Before I move on, I will let you know that the group part of our agenda today is to work on a message from the committee to you, and it will be a brief memo that they had started on in anticipation of your arrival

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and that we'll be probably finalizing today to communicate some of the group's priorities and issues of concern.

MS. PAMELA HYDE: Well, I only have a few more minutes. So if there is something in particular you want me to hear, if there is a way you can do your agenda to let that happen for a few minutes, and then I'll slip out and look forward to hearing from you even more.

MS. KANA ENOMOTO: I think -- let me go back to it. Well, I'll go ahead and speak for the group, if that's okay -- unless anyone else? I know that, Stephanie, you already noted the need to look at gender-responsive care in mental health, as well as the issue of women's leadership.

I think the group has identified, with Gail's help before she was a member of the committee, a set of priorities that we're looking at the role of consumers, criminal and juvenile justice. The number of women in the CJ and JJ systems has grown astronomically over the years. We don't necessarily have a portfolio of that here at SAMHSA.

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The continuing need to look at disparities, both cultural disparities as well as other dimensions, and how they adversely affect women and girls. Evidence-based practices, obviously looking at how to serve women and girls in that framework.

We do have a project that's going right now, looking at core competencies. Or I think it's actually renamed, and I have that in my agenda. I'm sorry. But we did start a project looking at core competencies, what do all behavioral health providers need to know if they're going to be working with women and girls?

Also, our models for integrating care. Primary care, many women don't get primary care in the traditional primary care setting that they're going through pediatrics. They're going through ob/gyn. How does that work differently for women?

Suicide prevention. We know the data on men and boys and completion. We also know there is staggering data on girls and attempts. So how do we begin to address that, and are we addressing that in our programs I think is the question that we need to

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ask.

Trauma, as you can hear. It's a competency of every one of our members and definitely a priority of the work that we're doing. SAMHSA has continued in the last 6 years, in the absence of sort of a directed trauma program, to keep our -- what do you call it, our irons in the fire in different ways. And given that we haven't had a large grant program around trauma, we really, I think with the power of our colleagues in the field, moved the ball quite a bit. But it's also really inspiring to think of what more we could achieve if we had a dedicated program in this area with some real funding behind it.

And then, wellness. This started, I think, as obesity a couple of years ago. When I first came onboard, this is I think sort of before the 25 years data were out, and people were saying, look, we are seeing an issue of women in treatment gaining a lot of weight and developing diabetes and developing metabolic disorders because they're gaining so much weight while they're in recovery. And so -- and then also the issue of disordered eating, in addition to

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obesity, and how this affects women and girls.

But we've brought in that because it's not just obesity. It's also smoking. It's also HIV. It's also reproductive health. And so, we want to look at our wellness for women and how that interacts with their behavioral health and data. I mean, linking what we have on the quantitative side with what we know qualitatively and also enhancing what reports we're generating and what data we're collecting on the quantitative side.

For example, there is not a trauma measure in the National Survey on Drug Use and Health.

MS. PAMELA HYDE: Really?

MS. KANA ENOMOTO: They're thinking very hard about a trauma measure in the survey, but they're not collecting it. So even though the ACE study data came out so many years ago, we still cannot draw a link between those adverse childhood experiences and behavioral health, as well as other chronic disease measures which we do collect. So I think data continues to be an issue for women and girls.

When this committee was first established,

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it was focused -- much of the focus was on actually the Federal workforce. So how many women do you have in positions of leadership in this agency and in our workforce? Clearly, I think we have, what, 60 or 70 percent women in organizations. So that's not so much of an issue, and no one is asking us -- no one in Congress is asking us for that report about SAMHSA's workforce and representation of women.

However, as we look at data in the field, I think we'll still note that there is a dearth of women in leadership positions at the State level and then even in kind of programmatic levels. We have some of the key leaders in the field on this group, which is -- I mean, we strove to get a group of people who were nationally recognized for their expertise, that there would be -- these are all of the folks who have just introduced themselves to you today are really kind of common-sense members.

There is no scratching your head like, "Wow, how did that person get on?" I mean, all of these folks are just incredible. They're well known. They're extremely well respected, and they are

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bringing us a broad perspective, and they've been very supportive of the work that SAMHSA has done, although I imagine, and I'll let them speak now. I mean, I think they have a lot of ideas for what more we could do particularly along those domains and as we move into health reform. We don't want -- there is a lot of conversation going on. We don't want the well-being of women and girls to get lost in that conversation.

MS. PAMELA HYDE: Are you guys doing anything about women veterans? Has this committee been taking on that issue? I mean, the veterans issue, for all kinds of reasons, may be an entree to get a lot of things done. So what -- are you paying any attention to that issue? Is that on your radar?

MS. SUSAN SALASIN: Yes. Yes, it is, from a couple of different perspectives. One of them being we started a jail diversion program for trauma recovery with a priority for veterans, and that means male and female.

And the basic is -- I mean, you've probably heard the figures from Vietnam, where 50 to 60 percent

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of the veterans eventually ended up going through the criminal justice system. I mean, it was really -- and being aware of that, we've proposed this new jail diversion program that, essentially, a State applies, and then they get -- they choose a couple of communities, one or two, to be service demonstration communities for the model they want to develop and in terms of diverting the veterans to care.

So there will be trauma-informed care training for all the agencies that work with them. They will receive trauma-integrated services and also have one kind of experience with a psychosocial educational empowerment group, a group sort of that would use TREM or seeking safety or any one of the other trauma interventions that are evidence based now and represented in the array. And so, there are fewer women in this, but they certainly present a profile that differs somewhat, and I think there's a lot of interest.

I was just on the steering committee for the Trauma Spectrum Disorders Conference that was just held at NIH last week. And we did try to focus as

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much as we could on women veterans, and there were a lot of interesting presentations that really did address that issue. So it's kind of like one of those things that you're trying to address any way that we can with current resources.

MS. PAMELA HYDE: I'd be interested, as you guys think about these things, about your thoughts on that because it's not only the increasing number of women in active military and therefore becoming veterans, but when you look at the veterans and the active military and their families, then you're picking up an awful lot of women and girls that are experiencing trauma of a different sort. So I would be interested in your thoughts about what we should be doing about that.

Great. I'm going to slip out, let you keep doing your work. Thanks to every one of you for what you're doing, and I'll look forward to hearing more from you.

Thanks.

MS. KANA ENOMOTO: Thanks very much.

Okay. All right. Well, thank you all very

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much for your patience. Any other -- any questions before we move into a summary on health reform? No? Okay.

So most of you probably know the House passed its version of the health reform bill on November 4th by a vote of 220-215, and the Senate has started its debate just a week or so ago on its version of the Patient Protection and Affordable Care Act bill.

If there's a Senate vote and the bill is passed, now the Senate needs to vote to allow the discussion to happen, I think, is what is the next step. And so, then the House and Senate will need to iron out their differences in conference and then report one bill that will get passed, hopefully -- will need to be passed by both sides of Congress. And we know that the President has been very clear that he wants a bill on his desk early in the new year.

That said, there are a number of analyses of the bills floating around. Some of our advocates have done some. One in particular that we thought might be helpful to you all has been done by Kaiser Permanente,

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is an assessment of both bills or draft bills on the broad topics. And Nevine will be sending out those links to all of the members.

And internally, we have a great group of folks. We have a healthcare reform workgroup. Rita Vandivort from CSAT and Bill Hudock from CMHS, as well as Kevin Hennessy and Bob Stephenson from CSAP, have really been doing amazing work under Mark Weber's leadership to look at the bills and identify those places with intersection to our business.

So I just -- I thought I'd point out a couple of places. Some of you may know this better than I do. Others of you may not have had anyone go through the 1,600-page bills and cull these nuggets out on your behalf. So if you are interested in taking a look, we can just point you to the direction of sections to look at.

So Section 5604 -- and we'll get all this out to you by email. So don't write it down crazily. But there is a section on co-locating primary and specialty care in community-based mental health settings. That's important. It's very consistent

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with the new grant program that SAMHSA has on primary and behavioral healthcare integration about ending the disparities in terms of lost years of life expectancy.

Also in that same Section on 5604, there is a description of State option for health homes for individuals with chronic conditions, including persons with severe mental illness. And are addictions included in that? Does someone else know that? I think it does include addictions, actually.

In Section 2703, coordination, I think we have actually considerable investment from our Office of the Administrator on this particular clause, saying, “directing States to consult and coordinate as appropriate with SAMHSA in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.” So there is really directive language in Section 2703.

And in 2707, there is described a Medicaid emergency psychiatric demo, which would be interesting to see where that fell because I don’t think there is language in there of where that demo should be

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conducted. But certainly it is of relevance to us.

Section 2951 describes maternal, infant, and early childhood home visiting programs. So that's nice to see in terms of really putting some evidence-based prevention programming out there.

And Section 3012 is the description of the interagency working group on healthcare quality. I think there has been work to get SAMHSA inserted in that as a member or spelled out as a member.

Section 4001, National Prevention, Health Promotion, and Public Health Council. And I think there is a section regarding mental health, behavioral health, and substance use disorder issues. So that's good. I think we might have gotten lost in some initial drafts, but we are there now.

In Section 2952, it specifies education and research for postpartum depression will be primarily NIH's responsibility, but it does involve a national campaign to increase awareness and knowledge of postpartum conditions that could be apportioned to SAMHSA. So I don't think it is apportioned to SAMHSA currently, but it could be.

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And then a workforce -- the behavioral health workforce is cited as a high priority in assessing its education and training capacity as well as projected demands and integration with healthcare delivery. And that's in Section 5103 on healthcare workforce assessment, which is, I think, particularly important as we take parity as -- I mean parity is coming along with health reform and is assumed to be the floor. So as we move toward parity in our systems, what does that mean in addition to what health reform will mean for the ability of our workforce to meet the needs?

And Section 5306 gives mental and behavioral health -- I'm not a fan of that term. And there are inconsistent terms used throughout here, obviously. But Section 5306 gives mental and behavioral health education and training grants. I'm not necessarily clear where those would be. Probably most likely in HRSA, but that's not been laid out yet.

So these are a few of the opportunities that we are looking at. We'll certainly be watching to see what the Senate does and how they all fair in

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conference. We can forward more detailed analysis to the committee when it's ready. And in the meantime, if any of you have any thoughts or questions about that, that summary?

Any other pieces that we've missed that you think others should know about, particularly I guess that was more the behavioral health, not necessarily women and girls relevant analysis. So has anyone else heard anything about the bills that others should be aware of?

MS. GAIL HUTCHINGS: Did you say you were going to send us a link to that list that you just went through?

MS. NEVINE GAHED: It's not a link, but I will be able to send you the sections from which the analysis was developed. So let me see what I can do to send you that. I can definitely send you to the link -- I mean, obviously, to the bill itself, and I could do that.

MS. GAIL HUTCHINGS: That's good, whatever.

MS. NEVINE GAHED: Right.

MS. KANA ENOMOTO: We'll send you to a link

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to the Kaiser analysis, right?

MS. GAIL HUTCHINGS: Okay.

MS. NEVINE GAHED: That would be fine.

MS. GAIL HUTCHINGS: Absolutely. I got you.

MS. KANA ENOMOTO: And then some summary version of what I just spewed off.

So, and then just as an update for you all in terms of our kind of internal HHS workings is that HHS has done a really wonderful job, albeit demanding on a small operating division like SAMHSA, of trying to engage all of its children in discussing this change that’s about to come upon us, we hope.

And so, there have been a number of working groups established around different aspects of the bills. And trying to be forward looking, what are we going to have to do, what will HHS need to put in place if the quality provisions come through or if there is -- what will we need to do around workforce, et cetera?

And so, we have people, I think, on 11 of the 13 workgroups that HHS has established, these interagency workgroups, and they’re really doing some

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workforce planning around what may eventually come our way. And that's been an important thing. Even though we aren't front and center in benefit design, at least we're at the table. And so, when behavioral health does or doesn't come up, but should come up, we are there to speak to that.

We're also -- and we're just incredibly fortunate to have Administrator Hyde joining us because she's intimately aware of kind of the goings on behind the curtain around the drafting of these bills and is very adamant that SAMHSA will be at the table. SAMHSA will be a partner. We will give in the hopes of receiving, and we're going to be meaningful contributors to the process.

And I think that all signs would point to that as also how the department and the White House see her. So it's a very exciting time for us.

Third -- well, third and fourth, I'm going to do a couple of programmatic updates as well. We are putting final touches on the core competencies for working with women and girls project, and I'm sorry I didn't remember the actual new title, but it's

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Addressing the Needs of Women and Girls: Developing Core Competencies for Mental Health and Substance Abuse Service Professionals.

So I think Stephanie participated in this project, as well as a couple of our former committee members that we had people from prevention, mental health, and treatment. Sharon Amatetti and Michelle Carnes from SAMHSA led that project. We now have an outline of competencies for all professionals that are working with these populations. And the next stage is going to be figuring out, okay, now we have a document. What are we going to do with it? What do we need to make it real for people in their daily lives and in their practice?

So we're looking forward to getting your suggestions on how we might take a document like this and take it to get it out into the field?

And on that topic, Sharon Amatetti and on behalf of all of you at CSAT, I want to show that the Fourth National Conference on Women, Addiction, and Recovery has a call for proposals that is now open. So the conference is going to be July 26th through

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28th in Chicago, and the Web site is samhsawomensconference.org. So, samhsawomensconference -- no punctuation there -- dot-org. And they would welcome proposals from anyone on our group.

And finally, a topic that Gail has already acknowledged is near and dear to her heart, also very close to mine is SAMHSA's tobacco-free campaign that we've invested a relatively small amount of money, but not a small amount of time and attention to look at how do we address the issue of tobacco for people with or at risk for mental illnesses and addictions?

I think most of you by now have heard the data about 44 percent of all cigarettes sold are consumed by people with substance use and/or mental disorders. Gail, I'll put you on notice that Richard Frank is asking questions about that number. He's --

MS. GAIL HUTCHINGS: Oh, God save me.

MS. KANA ENOMOTO: Yes. That and the 25 years. He wants to go back and double-check everybody's math.

MS. GAIL HUTCHINGS: Yes, I heard about the

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25 years thing, but at least the 44 percent number comes from CDC. So I'm sticking to my corner.

MS. KANA ENOMOTO: Yes, we'll have to -- Administrator Hyde has been very clear that, as a field, we need to come to agreement on our numbers and use the same numbers and use them over and over again. So that will mean SAMHSA has to do a little bit of homework, too, in terms of tidying up in different places where we may not always be using the same number.

But anyway, Gail, I'll start this off, but you may want to hop in here or feel free to hop in any time. But we're pleased to be partnering with the Smoking Cessation Leadership Center, which is headed up by Dr. Steve Schroeder, the former president of Robert Wood Johnson Foundation. And together with the SCLC, we've done mini grants to 100 pioneers for smoking cessation. We did sort of a virtual leadership academy.

We gave everyone a mini grant, and they received technical assistance, Web conference, kind of social networking. And they got tools for doing some

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kind of tobacco or smoking cessation project in their programs. So these were our grantees. We sent out a letter to all our grantees and said the best 100 who come up with an idea for what you could do locally to reduce the use of tobacco in your area, you'll be part of this pioneer program.

We did get 100 grantees who wanted to participate. We've had great data from this group. Smoking Cessation Leadership Center offered their in-kind support in terms of technical assistance and data collection and, I think, general care and feeding of the pioneers. And as a result, we've had virtually all of the pioneers got their projects off the ground.

Eighty-seven percent of them formed new partnerships or enhanced existing ones to conduct their project. Almost half of them have conducted an evaluation and to demonstrate their project's impact, and we're looking forward to getting more data as we go along.

But it just goes to show that just a tiny amount of money, $1,000, but really I think it was the camaraderie and the technical assistance that helped

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these groups with just a little push to get something going that they might not have otherwise done.

Gail, did you want to add any other thoughts about the project?

MS. GAIL HUTCHINGS: No, just to echo your point about it’s true that a nominal amount of money can really see some incredible efforts and initiatives and just focus on an issue and figure that the same thing in theory about bureaucracies can’t move without 2 years of pre-contemplative stage have also been defied in this, and I think SAMHSA really moved quickly in partnership with the Smoking Cessation Leadership Center.

For folks that are interested, there are some wonderful webinars that have been archived on the SCLC’s Web site, and we’ve done some incredible things together, including putting together a peer training curriculum so peers can train peers or help peers quite smoking. It has really been some fascinating and I think some of the most worthwhile work I’ve enjoyed working on. So any way I can be helpful for anyone looking for more info, I’m happy to do that.

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Thanks, Kana.

MS. KANA ENOMOTO: And this is important because I think we know -- we've seen in recent years the data on tobacco and girls is not good. I think teenage girls have not enjoyed -- Gail, you can correct me if I'm wrong. But I think teenage girls have not enjoyed the drops in initiation as we would have hoped, that we've seen in other age groups. Probably has to do with a lot of social, physical, other types of things.

But --

MS. SUSAN AYERS: Kana, here in Massachusetts, so many of the States got all their tobacco money for prevention, and that's -- I can tell you with the State budget crises that I'm sure are happening all across the country, at least in Massachusetts, that money has virtually disappeared. So all the good work that was being done and could be documented as having very positive effect is history at this point.

MS. KANA ENOMOTO: So that will be -- I know we've gotten to a low of 19 percent of the population

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reporting having smoked cigarettes in the past 30 days, and it will be interesting if we can keep to that low or keep the momentum of reduction without that energy behind it.

And as Dr. Broderick continuously notes, he does not believe that we can make a dent in that 19 percent unless we address the issues of people with mental disorders and addictions, that they are, if you look at the ACE study data, too, people with high ACE scores are the most likely to drop out of traditional tobacco cessation programs and will have failed out of tobacco cessation many times.

So the link between cigarettes and trauma and mental illnesses and addictions is so intrinsic that I think we're -- it behooves us to look at these issues together.

MS. GAIL HUTCHINGS: Kana, this is Gail again. I think a point that was well taken -- I'm not sure who was talking before, but from a policy and public policy perspective, we've got to get our act together a little bit more, whereas we're drying up the funds because there are no resources, of course,

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but we're taking away what came out of the tobacco settlement suits. And in some States like Oklahoma, much of that money went to people with addictions and those with higher prevalence of smoking.

And the same time, we're increasing taxes, which does, research will show, has a stimulating effect on people's desire to quit. So that increases calls to things like the national quit line and State quit lines. Yet there is nobody there to answer those phones in some places anymore.

So we've got to sort of take a higher view of what the ripple effect of some of these policy decisions are and make sure we're not literally shooting ourselves in the foot here by dismantling the services that serve people when we do things like increase taxes, et cetera.

MS. KANA ENOMOTO: Right. Well, thank you, Gail. And we're going to count on you to hold our feet to the fire on this committee on this topic.

Moving next, when we had the call scheduled in November, we had hoped to get Dr. Nadine Gracia, who is a White House fellow at the department, to talk

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to us about the White House Council on Women and Girls. Unfortunately, we had to reschedule, as did Dr. Gracia, and she is now on detail to the first lady's office. So we're not quite clear who the staffer is that we should be working with on this, but eventually, we'll find them.

I'm sure -- I mean, we know Wanda Jones is involved there, I think, as the primary staffer to the secretary. But just to let you all know that there are ongoing deliberations on how to use the reports from the agencies. I think we shared the SAMHSA document with you all and that OMB sort of identified four recurring themes in the agency reports, and they were violence against women, financial literacy, international outreach, and science, technology, engineering, and mathematics.

So the four recurring themes in the agency reports to the White House council were violence against women, financial literacy, international outreach, and science, technology, engineering, and mathematics.

And work-life balance was also a common

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theme, and the council will be working with the Office of Personnel Management and the first lady's office on developing an initiative on that issue. So I think they're already going in HHS. They've called us for a representative on a lactation support interagency workgroup. And luckily, SAMHSA has just developed its own brand-new lactation room. So we were well positioned for that.

That only took a year. And I'm sorry. I won't joke. But it did take a year.

DR. BRITT RIOS-ELLIS: That's great, though. That's really good.

MS. KANA ENOMOTO: It is good. I think we have growing number of new mothers in the building, and so to the degree we can support them to continue nursing their babies, that I think does everyone good.

DR. BRITT RIOS-ELLIS: Are you loaning out breast pumps?

MS. KANA ENOMOTO: Are we loaning out breast pumps? You know, we had actually discussed purchasing a hospital-grade breast pump and keeping it there, and then people could buy their own kits. But we -- for,

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you know, 8,000 OGC reasons we are not doing that.

DR. BRITT RIOS-ELLIS: Okay.

MS. KANA ENOMOTO: But we do have a space. It will have a sink and a refrigerator and a chair and soft music and a phone and computer so that people can kind of sit on their conference calls while they pump and eat their lunch probably.

DR. BRITT RIOS-ELLIS: That's great. You all might not know, breastfeeding is one of my major areas. So sorry if I'm asking a million questions, but this is something I think is just so important.

MS. KANA ENOMOTO: Is that Britt?

DR. BRITT RIOS-ELLIS: Especially with the rates of obesity as high as they are.

MS. KANA ENOMOTO: Is that Britt?

DR. BRITT RIOS-ELLIS: Yes.

MS. KANA ENOMOTO: Okay, yes.

Yes. Well, we also believe it's important. Now the thing for us is that, actually, the majority of staff at SAMHSA have their own offices.

DR. BRITT RIOS-ELLIS: Oh, okay.

MS. KANA ENOMOTO: And so, we'll be tracking

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the utilization of the room as we go on for our own purposes, and we'll probably be sharing that with the department as well. But in any case, it is certainly the right thing to do.

Lastly, Amanda, I'm hoping that you'll maybe make a little -- do a presentation and share about what we did in Alaska. I guess that was a week and a half ago.

MS. AMANDA MANBECK: Yes.

MS. KANA ENOMOTO: We presented to 200 tribal and village representatives in Anchorage, Alaska, at the 10th Intergovernmental Tribal Justice, Safety, and Wellness Conference. And that's a collaboration between DOJ and HHS and Department of Interior, I think. And we did a luncheon session, a dialogue on trauma-informed care in Indian Country.

So, Amanda, do you want to talk about that?

MS. AMANDA MANBECK: Sure. First, it was totally a different kind of cold than I'm used to in Colorado. I think that what I thought -- what I'm always very interested in is when I go to these conferences to see the people, and I think that what I

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saw that was really important is that there were a lot of grassroots people that are actually out in the field doing it. So I was pretty impressed by that.

The purpose of our dialogue was to go over trauma-informed care and suicide prevention in Indian Country. We had about an hour and a half. My co-presenter was Lisa Neel from Kaufman and Associates. Our main goal was to raise awareness about trauma in Indian Country and to go over the different principles and [inaudible] from the trauma-informed care workgroups that we went to a year ago.

So one of the biggest problems for me in talking about trauma-informed care is to get people to, I guess, understand the different aspects of trauma. Like we talked about in our meeting before that, a lot of times, people -- they don’t understand a specific part of trauma and the different ways that that can be carried out, whether it’s through families or [inaudible].

So, basically, Lisa and I, we just tried to lay out what historical trauma is -- that it represented, for most of the tribes, the trauma that

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occurred from the past all the way to yesterday. So, yes, and I think that Lisa, she did some evaluations on that, and I haven't seen the report yet. But she said that the participants were pretty excited about [inaudible]. It left them in a good place.

So does anyone have any specific questions or--

MS. KANA ENOMOTO: I have to say that Amanda did an amazing job. Amanda and Lisa both are very confident, articulate, passionate young women who got up to talk about a difficult topic in front of many people who are their elders and many who would not probably go have a conversation about trauma of their own accord. And so, it was really a brave challenge that they both rose to in terms of trying to get these folks -- because these are largely Department of Interior providers.

So they aren't behavioral health providers. I think they're probably human services, and many were elected officials. And one of our audience members got up and said, "Well, it was a sign to me when I walked into this meeting, to this convention

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center today, I saw one of my abusers."

And it's a small world. It's many close-knit communities. And when we were having these conversations, we weren't talking to survivors, we were talking to everybody, including perpetrators. And so, and maybe everybody is a survivor in their own right, but Lisa and Amanda did a wonderful, very skillful job of navigating that conversation.

And the other thing is the level of trauma that people are talking about is almost incomprehensible. I had a conversation with one tribal leader who had lost four brothers to suicide. And of nine children, lost one son to suicide and had sort of had recent confirmation that virtually all of his children were abuse survivors, had been sexually abused as children, and he, himself, is in recovery from alcohol and drug abuse and no idea where to go.

Revolving door of one mental health -- you know, a social worker who comes into the village and seems to leave every 6 months or 9 months or 12 months, and so just a complete absence of a services infrastructure. No privacy, and virtually everyone

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has been affected. So not sure where to go and how to develop a model, and I think Amanda provided very stirring language in that we have to do it ourselves.

So, thank you. Are there any questions?

[No response.]

MS. KANA ENOMOTO: Well, Amanda, thank you very much for doing that presentation. That was greatly appreciated.

MS. AMANDA MANBECK: Sure.

MS. KANA ENOMOTO: And it was a very long trip to Alaska, which we hope at some point we will have more than 24 hours to be on the ground.

MS. AMANDA MANBECK: Yes.

MS. KANA ENOMOTO: And there is some really rich stuff that is happening there, and I think we were sort of scouting for our future ACWS meeting.

FEMALE SPEAKER: That sounds like fun.

MS. KANA ENOMOTO: I think it would be an educational experience for all of us because there is just a different set of operating constraints that it’s hard to picture without being there.

Okay. So, Nevine, where are we?

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Do any of you -- I realize we've had introductions, and we've had some questions with the Administrator. Are there other additional updates that are critical for you, your States, or your organizations that you'd like to share with the group?

DR. STEPHANIE COVINGTON: Well, this is Stephanie. Can you hear me, or do I need to raise my hand?

MS. NEVINE GAHED: No, we're okay.

MS. KANA ENOMOTO: Although it would be really funny to imagine you raising your hand while you're talking.

DR. STEPHANIE COVINGTON: All of a sudden, it sounded like we're all plugged in, but I think there was also some discussion about that we need to -- I couldn't figure it all out.

I want to go back to a couple of things that I said earlier that is something you mentioned, and this whole issue of services for women and girls. You know, when I step back from this, I really do think that substance abuse has taken a lead in considering gender in terms of providing services. Not that

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everybody does it, but at least there is some conceptualization around it.

But when I look at mental health services, the concept of gender, essentially, in most cases is missing. And I'm wondering if there is some way to think about how we would impact the mental health side of SAMHSA with this issue of gender?

MS. KANA ENOMOTO: Well, I wouldn't limit it to just the mental health side of SAMHSA. I think we have a number of mental health folks on the phone as well.

Roger, Gail, would you care to jump in? Susan?

MS. GAIL HUTCHINGS: Yes, this is Gail. I would sort of offer -- I think for a while -- and I think part of it is congratulatory. I think both mental health and addictions did so well, and we have continued to and we need to continue in trying to address trauma and roll out the grant program like Roger and Susan spoke before, the TA center. But to some extent, we've confused a bit trauma and trauma-informed care as exact equality with gender and

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gender-informed care.

And I think to the extent that folks agree with that, I think some revisiting of that and some really thoughtful conversations about what are the distinctions between those and where are there overlaps and where are there, again, distinctions and how are there pockets of opportunity that we could address either as a treaty and/or with representation to SAMHSA.

So I agree and I disagree in part, I guess, Stephanie. But for the most part, I think it’s a bit of a laziness on our part to say, well, if we’ve taken care of trauma, we’ve taken care of gender. And that’s not acceptable.

DR. STEPHANIE COVINGTON: Right. Well, see I think that -- I don’t think you can be gender responsive unless you are trauma informed, but I think you can be trauma informed and not be gender responsive. And now that the new core competencies are out there for mental health and substance abuse, I see the substance abuse field as being in a position, how shall I say this, to either understand or at least

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not be surprised by it or having felt as though they've heard this before on some levels.

But many mental health providers have never considered gender differences when they think about mental health in terms of impact nor provision of services. So that's my question or concern if you will.

MS. SUSAN SALASIN: This is Susan. I have to agree with you to some extent, Stephanie, because I think that the only way that gender issues have come up was in the context of the Women and Violence study.

DR. STEPHANIE COVINGTON: Right.

MS. SUSAN SALASIN: And now within the Center for Trauma-Informed Care, we have a couple of year initiative going around peers and peer-to-peer trauma-informed care, looking at women specifically. I think that the mental health field, for a variety of reasons, really has been not resistant to looking at it. It's more or less almost like it's not there.

DR. STEPHANIE COVINGTON: Right.

MS. SUSAN SALASIN: And I'm not sure myself what all the reasons are for that. I think that it

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was unfortunate that after the Women and Violence study finished, we went into a period of time where there was no emphasis on women's issues for about 6 or 7 years. And I think that was certainly a deterrent in the face of what had been some progress. But I think you're right in making that observation.

DR. STEPHANIE COVINGTON: Well, and I'm thinking now that people are beginning to look at women veterans, and here is a really, I think, good example is what people are talking about. What the research is showing is many of the men returning, they've served in combat, they're coming back with a PTSD diagnosis. But many of the women come back with a depression diagnosis.

So if you don't have a mental health system that's considering gender and think, oh, trauma and it's PTSD, I think there are just many ways it's going to manifest if gender is not a consideration.

I think also because some of the women's trauma in combat is sexual harassment and sexual abuse that's occurred with the men they're serving with, and then the VA is treating them in coed groups.

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MS. SUSAN SALASIN: Well, I would have to agree with those observations from the point of view of what's being talked about from the military side about women and children and the family support and those issues. There is a real kind of resistance against treating anything that happened prior to the woman's entering the military as relevant or anything that should be supported in terms of treatment.

So it's a very strange experience when you're sitting and listening to all of that and realize that's what has happened, that the biggest calamity in life is not going to a dance or something still I think in their eyes in terms of women's roles. So it was very strange, but certainly does need to be thought about and addressed.

DR. STEPHANIE COVINGTON: Well, things I think we need to stay aware of, but I guess, Kana, the thing with the core competencies is really thinking about how they'll be moved into the field, both substance abuse and mental health.

MS. NEVINE GAHED: In the sense of -- oh, I'm sorry. Go ahead.

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MS. KANA ENOMOTO: No, no, no. I agree. Nevine, go ahead.

MS. NEVINE GAHED: No, it's okay. Oh, I'm sorry. I keep forgetting this.

Yes, that is something that we will definitely put through or share with Sharon when they get to the dissemination piece. So, thank you.

MS. GAIL HUTCHINGS: It's Gail. It sounds like there is a couple of key opportunities I'm wondering if we could spend some time brainstorming around. For example -- and I think, Stephanie, you're certainly more familiar with the content of it than I am. But if it's not "customized" to the piece now to be let's just say mental health oriented, for lack of a better term, might that be a project that we could suggest to CMHS to undertake?

Because there is no sense rolling out something that might not be -- I don't know, sort of fits within the culture of mental health and be received as such. So that's sort of a glaringly obvious one, I think, for at least discussion.

There are a whole bunch of others, including

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anything from in-service training at SAMHSA to trying to figure out a strategy with nominal resources to try to make sure that maybe there is a webinar held that gives an overview of the curriculum. I think all sorts of creative and not necessarily exceedingly time-consuming nor expensive ways to try to achieve which is a mutual goal among all of the things. I think the difference between another publication that sits on a shelf versus one that really gets out and gets used.

DR. STEPHANIE COVINGTON: Right. I think it needs to be on the radar how the field kind of operates and then how do you think about making an impact? Like you said, so it just doesn't sit on the shelf.

MS. GAIL HUTCHINGS: There is a traditional and necessary sort of way that many folks within SAMHSA centers send out publications, and then there is another layer I think that can be added and improved on, which is a real strategic approach as another layer on top of sort of the general conduit to something that, for example -- I'm just going to pull

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this off the top of my head -- but to try to position policy wise for NASADAD or NASMHPD to carry this in front of the State commissioners or to try to link with ASTHO about why this might be important for health departments to focus on, particularly those in the business of behavioral health.

I mean, we can kind of do this the same old, same old, or we can really rev up the engine here. It's up to us to, I think, collaborate with and to come up with some of these ideas and, hopefully, for them to be welcomed.

DR. STEPHANIE COVINGTON: Yes, I think those are good ideas.

MS. NEVINE GAHED: Okay. Point well taken. Thank you.

Would anyone else like to bring back some of the updates or some of the things that are working within your States, organizations, things that are of importance to you?

DR. STEPHANIE COVINGTON: Can I ask another question? It's Stephanie.

MS. NEVINE GAHED: Of course.

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DR. STEPHANIE COVINGTON: Okay. Has there been any thought to having the advisory group meet in Chicago in July at the SAMHSA conference similar to what we did in Tampa?

MS. NEVINE GAHED: We haven't. I think one of the things that Kana just alluded to is the possibility of doing something a little bit farther out than Chicago. However, we'll definitely consider what the members would like to do, and we'll go from there.

DR. STEPHANIE COVINGTON: I could tell everybody voted for Alaska before Chicago.

[Laughter.]

DR. BRITT RIOS-ELLIS: The other thing that I think makes -- July is such a packed month with all kinds of things. I know the NCLR conference is in July. Also the World AIDS Conference is in Vienna. So it's a heavy travel month.

DR. STEPHANIE COVINGTON: I was just throwing out a question.

MS. SUSAN AYERS: At our Chicago visit in August, I just thought the visit to the Cook County

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Jail was absolutely spectacular, which mostly leads me to thinking about doing more site visits where you actually get to see a program that was as robust as that. So that whatever setting we go to, I think having that opportunity to see people that are really working outside of the box and finding impressive ways to help turn around lives is very cool.

So whether that's in Alaska or California or wherever, Oklahoma, I think it's so informative.

MS. NEVINE GAHED: Excellent. I'm sure that content is going to be a priority before location. So we'll definitely do that, and I'm sure we can find some terrific places whether it's in Alaska or elsewhere. But we'll keep you informed as we do the search. And obviously, if you have any suggestions, please let me know.

MS. KANA ENOMOTO: I think along the lines of what we've all been talking about, I mean, I think what you're telling us is that we need to look at gender-responsive care certainly and also kind of what's the impact of health reform on the economy and everything else on services on the ground and the

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women and girls that are cycling through our programs.

So with that as an undercurrent, do people have thoughts on the letter that we were going to send to Administrator Hyde, as well as the set of priorities that I ran through before? I didn't hear any nays, so I'm guessing that people are okay with the priorities as they stand, although she added women veterans. I think we had kind of tucked veterans under trauma. Sounds like it might --

DR. STEPHANIE COVINGTON: Can we have the priorities brought up again?

MS. KANA ENOMOTO: Oh, Nevine is actively fiddling.

DR. STEPHANIE COVINGTON: Okay.

MS. KANA ENOMOTO: And do we also have the letter, Nevine?

MS. NEVINE GAHED: Yes. I have both of them up here.

MS. KANA ENOMOTO: I see.

MS. NEVINE GAHED: Just getting the technology to work.

MS. KANA ENOMOTO: Just so you all know,

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it’s not the same as PowerPoint. It’s not the same. That’s why it seems trickier than --

DR. STEPHANIE COVINGTON: I remember that when we were all in that room.

MS. KANA ENOMOTO: Right. It’s not exactly the same.

DR. STEPHANIE COVINGTON: It is amazing, though. Well, while we’re waiting for this, I want to go back to my other comment was about the Women’s Leadership Institute. That’s the one that was done for substance abuse that Sharon ran.

MS. KANA ENOMOTO: Right.

DR. STEPHANIE COVINGTON: And are they going to do another group of women? Are they going to --

MS. KANA ENOMOTO: I think there was some question of whether Sharon was going to do another group or she was going to take that group further.

DR. STEPHANIE COVINGTON: Okay.

MS. KANA ENOMOTO: So I don’t know where they came down on that. But again, leadership is another one that we had sort of put under consumer and peer support. But obviously, it’s not the same thing.

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DR. STEPHANIE COVINGTON: No, and I think leadership, you know, I know you came and did a brief talk at that, and I was there to do a couple of things. But afterward, it was interesting the people who have emailed me who participated in that leadership institute and said it changed their lives, that they were either feeling overwhelmed or alone or isolated and just helped them recommit to the field.

And basically, the women in that room are the leaders for this field as it moves forward, and I just wanted to really commend you on having the leadership institute and just really any opportunity to expand it or to keep it alive or whatever would be needed, I just want to put my two cents in. I think leadership is going to be critical.

MS. KANA ENOMOTO: All right. No, and I think that’s important, and some conversation about broadening it past addictions treatment.

DR. STEPHANIE COVINGTON: Exactly. It’s a piece of workforce development. I mean, we’ve got to keep the field filled with vital folks.

MS. KANA ENOMOTO: And we should be grooming

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our next generation of leaders in a more integrative way since that's how we --

DR. STEPHANIE COVINGTON: Exactly.

MS. KANA ENOMOTO: -- expect the field to evolve.

DR. STEPHANIE COVINGTON: Right. Right.

MS. KANA ENOMOTO: So I'm hearing Stephanie has been pretty vocal about leadership. You now can see the first half of the priorities up on the screen – consumer/peer support, criminal and juvenile justice. Actually, before you do that, Nevine, could you scroll up? Oh, this is trickier than it looks.

For those of you not in the room, Nevine is walking from the back of the room to the front of the room. There we go.

So this is our statement. And Gail, do you want to speak to this? Gail was our facilitator when we worked on this now a year and a half ago.

MS. GAIL HUTCHINGS: You mean to the beginning thing or the whole thing, Kana?

MS. KANA ENOMOTO: Well, the whole thing, and then -- but starting, I guess, with the preamble.

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I mean, it's a little kitchen sinkish, but at the same time, it is reflective of where we were at that time. We have different members, and they may think -- we've ratified this since then, but it's kind of talking about the process and your observations.

MS. GAIL HUTCHINGS: Yes. Just very briefly, I don't know if I have a lot of substance to add. But essentially, this is something that was done live with the at that time members of the committee, and they had some really long-time members on. So it was a really nice kind of collaboration.

And what happened, we did a brainstorming session. We came up with sort of the overall kind of values-based and context-setting statement that you'll see. I won't read it to you. You're all capable. But that was really meant to take a broad and genuine perspective of the variety of roles that women play and to sort of make the case and set the priorities for the council at work.

And then down the left column, you'll see that these were from a really dynamic conversation the kind of key topics that seemed to flow out of that

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conversation and then, with a little bit of honing down, with specific ideas people had to try to implement that. And that this really became, for lack of a better term, kind of our work plan that we wanted to achieve together with SAMHSA staff.

And so, it was sent out as draft to everyone after the meeting, everyone given ample opportunity to comment and then finalize. And I think the question now is [inaudible], but how we've been doing on these things and where do we need to go back, revisit, refine? And then are there gaps that we really need to prioritize adding in other things here?

But it was a really nice process to be involved in from my end.

DR. STEPHANIE COVINGTON: Well, I'm just wondering, for example, the issues of leadership and workforce development. I think those two things are kind of buried under consumer/peer support and cultural competence. So you know, personally, I'd like to see that become more of a major point.

I don't know what it means to change anything. I don't know whether it has value or not.

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I'm just throwing it out there.

MS. KANA ENOMOTO: Others have a --

MS. GAIL HUTCHINGS: Kana, I think part of that is a question to you. I think I share what Stephanie said. Are you looking for sort of ratification or re-ratification of this among current council members? Are you looking for a process to offer refinements or deletions or additions? What's your goal here?

MS. KANA ENOMOTO: I'm not seeking ratification, per se. I think this is an opportunity to check in and see if we are in need of redefining ourselves even if at the edges because we are going to send a message to our new Administrator, which defines who we are and where we are headed. So I think this is just kind of the basis of that. If we see there's a need to change kind of our priority list, then that should also be reflected in our letter.

So I guess we've ratified this already. So it's been moved to final. I think this is a chance to, given where we are, where we seem to get traction, where there is a need that's emerged, where we see

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potential. You know, like I think Stephanie is saying, well, this leadership academy was great, and that seems like a good role for SAMHSA. Maybe that's something to highlight more than this broad consumer/peer support since that's so big.

I mean, it's --

DR. BRITT RIOS-ELLIS: I think one thing is, given just the issues around dropout and education, I think somewhere in there, we could put literacy level appropriate. Maybe that's in the third point.

MS. KANA ENOMOTO: Literacy?

DR. BRITT RIOS-ELLIS: Where it says culturally, linguistically, and literacy levels. And maybe not "appropriate," maybe "relevant." Because we're really speaking more to -- "appropriate" denotes a certain behavior, and "relevant" just means that it works for the community.

DR. STEPHANIE COVINGTON: You want in the third box under cultural competency, do you want it to say "cultural and linguistically relevant?"

DR. BRITT RIOS-ELLIS: Yes. Especially with the issues -- I was just at a big university meeting,

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and in California, we're dealing with so much remediation, and these are kids going to college.

MS. GAIL HUTCHINGS: Kana, this is Gail. What I'm hearing is rather than us sort of editing this, what you'd like is for us to instead take a look at what's on here. For example, Stephanie's comment, say, on the first one is currently labeled consumer/peer support. We really want to focus on the aspects of leadership and maybe even a broader perspective thereof.

Moving on to the next part of the conversation, how are we going to do that with this committee make-up? Is that the model you want us to claim?

MS. KANA ENOMOTO: Well, yes. I would start on the left side, I think, and say -- I mean, there are tradeoffs. So if there is something that we want to put onto, let's say, the left side so this is really going to be a core domain, and we think leadership should be broadly a core domain or workforce should be a core domain. We can't just shift everything over to the left. So --

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MS. GAIL HUTCHINGS: Right. So take Britt's point, when we decide what might be something that we could focus on that's hopefully in the context of criminal and juvenile justice, if that's the way we do it, that has to do with cultural relevance, we want to make sure that we're adding in linguistic competencies around that, too.

So less as an edit to this and more as a how do we move forward and what way are we going to do that, with what new considerations.

DR. STEPHANIE COVINGTON: What I probably would suggest is in that first box where it says consumer/peer support, I would probably put workforce development, keep consumer and peer support, and add leadership development. You know, it's about developing the workforce, and you want to do that both through leadership and through consumer and peer. I just don't think it should be buried is all.

DR. BRITT RIOS-ELLIS: And I think on that line, and I don't know if this is something that we want to add, but just I was also really impressed by the visit that we took to the jail in Chicago. And I

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think now that community health workers are an official health occupation and there have been some funds provided for people to apply for different programs creating the health worker program, I only think that would be just such a wonderful -- but I mean it already is within the peer recovery model.

But I'm also thinking that there might be some room for that in what we're doing. So we could create along those leadership and career opportunity, that there might be some funding for something that would work together within healthcare. I'm not sure. But I know it's something that's really being taken up. It's at least in the community health worker arena.

MS. KANA ENOMOTO: And Britt, are you getting that from the visit with the Thresholds/Haymarket folks, no? From the jail?

DR. BRITT RIOS-ELLIS: From the jail. I mean, I just keep on thinking what's going to happen to the women? You know, where are they going to go from there?

MS. KANA ENOMOTO: Okay.

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DR. BRITT RIOS-ELLIS: And also, meeting all those peers that have been in that program and then come out and now are working. It just seems like there might be some opportunity for some funded positions.

MS. KANA ENOMOTO: Okay. Well, Stephanie, to get back to your point, I hear you. I think, as Gail has indicated, we probably can't get through all the wordsmithing on this call, but --

DR. STEPHANIE COVINGTON: Right. I just brought it up.

MS. KANA ENOMOTO: Right. But I hear you about moving kind of how do we feature workforce and leadership as domains, major areas in and of themselves and not bury them. And then, Britt, I hear the point about culturally and linguistically relevant services, and then literacy as an issue.

And finally, I guess on this call just today, I'm thinking that the Cook County visit was excellent, and it did highlight the unique needs. I mean, that's clearly an area where women and girls have distinctive needs, and more work could and should

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be done. And then, as Administrator Hyde just mentioned the needs of women veterans.

So in terms of kind of shifting these priorities around, I'm thinking we need to look at how we do something with leadership and workforce. And then in terms of prioritizing some activity, I'm hearing returning vets from Pam and then something on criminal justice and continuing work on workforce with core competencies and community health workers and other roles of people who are more likely to touch the lives of women and girls. Does that make sense to people?

DR. STEPHANIE COVINGTON: Yes.

MS. KANA ENOMOTO: Britt, does that capture what you were getting at?

DR. BRITT RIOS-ELLIS: Definitely. Thank you.

MS. SUSAN AYERS: There is a resource here in Massachusetts, the Blue Cross Blue Shield Foundation just released a report on workforce development, particularly around the workforce that works with children and families. And it's actually a

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nice document, and it's readily accessible if you just go to Blue Cross Blue Shield Foundation. It's the Blue Cross Blue Shield Foundation of Massachusetts.

I mean, we are all in trouble basically is what it says. The way --

DR. STEPHANIE COVINGTON: That's what every State is saying, and I think it's something we've got to pay attention to.

MS. SUSAN AYERS: Yes. I think that the reason they did the study was they felt like that sort of study hadn't been done before, and they're going to continue to sort of follow up and try and track this because everybody says, oh, there is a workforce problem. And even though there were problems with how they did the study, even the segments that they were able to capture is the tip of the iceberg, and just there are so many people leaving the field and only a quarter of them look like they will even be replaced.

MS. KANA ENOMOTO: I think the writing is on the wall that we're going to have to figure out how to do the work we need to do differently. We can't rely on the traditional methods of reaching people, which

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may be an opportunity, right? A way to think differently, approach the work differently.

We're only seeing a fraction of the people that we should be seeing.

MS. SUSAN AYERS: Right.

MS. KANA ENOMOTO: And they're not coming to use of their own accord. So --

MS. SUSAN SALASIN: One of the populations that seems to be missing in terms of not seeing a lot of the people it should be seeing -- well, there are actually two populations I don't see any reference to, and it comes up a lot on other agendas around women that I see in other departments and everything. And one is refugee women, and the other is human trafficking.

It's mostly women and girls, and it's throughout the system, and the experiences there are really pretty hideous. And even the sort of once they're kind of rescued, it gets even worse. I mean, the treatment is almost worse than the plight itself.

They do keep saying we need trauma. We need mental health. We need these kinds of perspectives on

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it.

MS. KANA ENOMOTO: I went to one of those human trafficking meetings, and they talked about a program. And it was a program that talked about their particular intervention where they forced -- they had young women because young women that are doing any sex work are automatically considered victims of human trafficking, and they would force them to recount their histories in front of the group?

MS. SUSAN SALASIN: Also they have to prove they're a victim.

MS. KANA ENOMOTO: Right.

MS. SUSAN SALASIN: That they didn't willfully enter into this, and it takes like a year or more. And until that happens, until you prove you really were a victim, you really aren't eligible for any kinds of benefits under the program. I mean, it's just -- it's barbaric. It's barbaric.

MS. KANA ENOMOTO: It's challenging. Duly noted. Thank you, Susan. So we'll add that kind of how to work that in. We'll ask Nevine to do her magic with words.

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DR. BRITT RIOS-ELLIS: You know, in Mexico, we've been seeing such a big rise in human trafficking just because of the economy and what's happened with the drug issues as well as because the drug lords are now leaning into different areas. So we're seeing -- I think that is just such a big issue.

MS. KANA ENOMOTO: They are also reporting in Guam. They are anticipating the shutdown of Okinawa as a base, military base. They're moving that base of operations to Guam, and so it's I think a 20 percent increase in the island's population, 20 or 30 percent increase. And they've already started trafficking women and girls in because of the advance work that's happening, the increase in contractors, et cetera, that are in Guam now.

So, very good. That was helpful. I think we'll work on that, and we'll get a revised draft out to folks. And I think it also helps me in terms of conceptualizing where we all are with things and giving some direction to -- ACWS doesn't have a budget in and of itself, but there are opportunities that come along on a fairly regular clip.

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And so, if I know what you all are interested in or feeling pressure around, then I can better take advantage of the opportunities before us and kind of insert myself where I might not otherwise on your behalf.

So I have asked Nevine to bring up the letter on your screens. This was -- you've had it all. All of you have had it in draft for comment. I don't think we got many comments. Nevine, how many comments did you get?

MS. NEVINE GAHED: I didn't get any.

MS. KANA ENOMOTO: No comments. So --

FEMALE SPEAKER: It's very well done.

MS. KANA ENOMOTO: It is very well done.

MS. NEVINE GAHED: We're still working on it. Thank you.

MS. KANA ENOMOTO: One thing that we do need to resolve today. A, we want to finalize this language because we're going to try to get it to Administrator Hyde quite soon. And secondly, is who would sign on behalf of the ACWS? Not me. So one of the members needs to sign, and we can do it magically

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through the beauty of technology or someone who is local and would be available to do this by Fed Ex or whatever.

So, first, on the language, as people have the opportunity to sort of scroll through --

DR. STEPHANIE COVINGTON: We can only get the first page.

MS. KANA ENOMOTO: Okay. If you have specific edits, now that this is back on your radar screen and we have an Administrator and there is a name on the “To” line, it is really going to get sent. So if you have specific edits, you can email those to Nevine.

But just in broad strokes, if there is a major gap in the content of the letter, if you think, wow, we really didn’t talk about X or Y, something that I would hesitate to insert without consulting the rest of the committee, if you would bring that up now?

I think, Nevine, did we miss scrolling down on the first page?

MS. NEVINE GAHED: No, I can go back to --

DR. STEPHANIE COVINGTON: Okay. Second page

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is up.

MS. NEVINE GAHED: Yes, I thought somebody had asked for second page.

DR. STEPHANIE COVINGTON: I have another question. It’s Stephanie. Is the women’s TIP available?

MS. KANA ENOMOTO: The bane of my life.

DR. STEPHANIE COVINGTON: I knew you’d want to hear this one.

MS. KANA ENOMOTO: Yes. The women’s TIP finally, delinked, sent to proofing, going to the printers.

DR. STEPHANIE COVINGTON: Well, this is great.

MS. KANA ENOMOTO: So it will be released independently of the men’s TIP.

DR. STEPHANIE COVINGTON: Great. Well, and I was just curious because we mentioned it in the letter. I wanted to be sure that it was still alive.

MS. KANA ENOMOTO: And we weren’t liars.

DR. STEPHANIE COVINGTON: So it’s going to be a Christmas gift.

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MS. KANA ENOMOTO: Let’s hope.

MS. GAIL HUTCHINGS: This is Gail. I think it looks really nice, and the only little, tiny thing I wonder is since she was so gracious to join us today and spend time and listen to us, I wonder if we should just reflect that as a brief thank you in the opening paragraph?

MS. KANA ENOMOTO: Excellent idea. That can be done.

All right. Have people read sufficiently the first page?

DR. STEPHANIE COVINGTON: Yes. Good letter.

MS. KANA ENOMOTO: Good letter?

DR. ROGER FALLOT: Yes.

DR. BRITT RIOS-ELLIS: So the signer, Kana, I wonder is there a person who’s been on the council for the longest that might be appropriate? Would that be the proper way to select someone?

MS. KANA ENOMOTO: You guys were all appointed at the same time. So we’re happy to go alphabetically?

MS. NEVINE GAHED: However they want to set

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it up.

MS. KANA ENOMOTO: In my family, we call it “jan ken po.” We call it scissors-paper-rock.

No, I would -- we have Susan Ayers is at the top of the list I think alphabetically.

MS. SUSAN AYERS: I will pass.

MS. KANA ENOMOTO: Did you say you’ll pass, Susan?

MS. SUSAN AYERS: I said I’ll pass. Go down the list a little further.

MS. KANA ENOMOTO: All right. Would anyone like to volunteer?

DR. BRITT RIOS-ELLIS: Well, she mentioned -- I mean, she’s extremely well read. So probably people on here who have published more than a chapter or two in a book would probably be that might be a good way to think about it.

MS. KANA ENOMOTO: Sure.

DR. BRITT RIOS-ELLIS: The other person, how about Gail?

MS. GAIL HUTCHINGS: I think because I used to be -- thank you. I’m honored to accept that. But

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I think because I used to be in SAMHSA, I can't believe -- I should sit this one out. But I'm going to punt, too. I think it should be Stephanie and Roger.

DR. BRITT RIOS-ELLIS: Yes.

MS. GAIL HUTCHINGS: That's my vote.

FEMALE SPEAKER: I'd go with them.

FEMALE SPEAKER: Me, too.

DR. STEPHANIE COVINGTON: That's okay with me.

DR. ROGER FALLOT: I still can sign my name, I think.

[Laughter.]

MS. KANA ENOMOTO: Sign while on his back. Okay. Excellent. Thank you very much.

So --

FEMALE SPEAKER: So now we're gender responsive.

MS. KANA ENOMOTO: That's right. Okay.

So we will make an adjustment to acknowledge, to thank her for her participation today, and we will have dual signatories, and we will Fed Ex

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it around so we get everyone's signatures. It will look nice.

I'm just looking about the piece on leadership.

DR. BRITT RIOS-ELLIS: Can you show the cc's again for a quick second, please, Nevine?

MS. NEVINE GAHED: Yes.

DR. BRITT RIOS-ELLIS: One question, if you're going to Fed Ex it before the break, will all of us be here? That's what I was wondering. How do you want -- when will this be leaving your office, this Fed Ex?

MS. KANA ENOMOTO: We'll work it out with Stephanie and Roger.

DR. BRITT RIOS-ELLIS: Okay.

MS. KANA ENOMOTO: So we're just going to have two people signing.

DR. BRITT RIOS-ELLIS: Oh, good.

MS. KANA ENOMOTO: And Nevine will --

MS. NEVINE GAHED: And Susan's name is on page 2, but it's there.

MS. KANA ENOMOTO: So hers is at the top of

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the list because it's alphabetical.

MS. SUSAN AYERS: Yes, that's how it ended up. You know, that A thing has traveled with me my whole life. You sit in the front of the class. You have to go first, those things.

FEMALE SPEAKER: That's funny.

FEMALE SPEAKER: I just want to make sure, Kana, is Flo Stein still the president of NASADAD's board?

MS. KANA ENOMOTO: Yes. Yes.

So the National Institutes of Health, we probably should put people there, but we'll figure that out.

FEMALE SPEAKER: And Kana, is it appropriate or reasonable for us to want to or try to integrate and collaborate with the President's Office on Women, or whatever the formal name is? Is it appropriate to "cc" them, too?

MS. KANA ENOMOTO: I'm thinking we "cc" Secretary Sebelius, who is a member of the council.

FEMALE SPEAKER: There you go.

MS. KANA ENOMOTO: So I wouldn't want to --

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FEMALE SPEAKER: Trump.

MS. KANA ENOMOTO: Yes. Wouldn't want to trump her.

Okay, well, this is much appreciated. I think we may fuss a little bit on the last bullet. It talks about interested in the future direction of HHS's Science and Service Initiative, and we believe it falls within President Obama's reform principles. I think we can just update that to be more contemporary with ARRA and the bills, the quality piece. It just makes sense. We've moved beyond his principles.

Okay, well, excellent. Thank you very much. So we'll get that done, and I think we'll -- what day is today? We can get it done by the end of the year?

MS. NEVINE GAHED: Oh, yes.

MS. KANA ENOMOTO: We'll get it done, signed, sealed, and delivered. That's the trick. Fed Ex'd and Fed Ex'd back.

Okay. So I think, finally, we were going to just talk briefly about Chicago, and then --

MS. NEVINE GAHED: We want to give an

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opportunity for public comments if there are any. So, Operator?

MS. SUSAN AYERS: I thought the whole experience was really excellent. I liked the briefings. I thought they were very informative.

MS. NEVINE GAHED: Operator? Operator, are you there?

OPERATOR: Yes, ma'am.

MS. NEVINE GAHED: We are going to open the lines now for any of the members of the public who are on mute to see if they would like to make any public comments.

OPERATOR: Okay. Those lines are open.

MS. NEVINE GAHED: Thank you.

Members of the public, if there is anybody who would like to make a comment, please indicate so, and you have about 2, 3 minutes.

[No response.]

MS. NEVINE GAHED: Okay. I guess we have no comments. Thank you very much. They can be placed back on mute. Thank you, Operator.

And I think the last thing is, yes, let's

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talk about Chicago, is the debrief.

MS. KANA ENOMOTO: The debrief, yes.

I agree, Susan, that it was an excellent visit. It was too bad we didn't get a chance -- everyone sort of splintered off and left for their plane rides at different points in time, and we didn't get to kind of reflect on the importance of what we observed for the work that we're doing here or the work that you're doing at home.

So I guess if there were thoughts that people came away with? One, I learned -- it was reinforced for me, again, that Stephanie Covington knows virtually everybody.

[Laughter.]

MS. KANA ENOMOTO: And seems to have a traveling fan club everywhere we go. That's probably the fourth city I think I've been in with Stephanie where she's like Mayor McCheese.

And that the impact of the work of Stephanie and others in the program was pretty apparent, and so I appreciated the need for the kind of gender-responsive and trauma-informed program in that

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setting. And I don't know if Susan wants to offer, since she helps direct our jail diversion program that is about trauma-informed care, but doesn't have a specific component for women. But --

MS. SUSAN SALASIN: Pardon? I didn't quite understand that.

MS. KANA ENOMOTO: The visit, which you weren't able to join us, but I think you have seen the program?

MS. SUSAN SALASIN: Right. I have, yes.

MS. KANA ENOMOTO: And kind of what relevance it has for us and programming in the future. And also for our members, if you guys had thoughts about when you went back to your programs or your work, what you carried with you?

DR. STEPHANIE COVINGTON: Well, this is Stephanie. One of the things -- well, obviously, I had been at Cook County a lot before. But one of the things that I would -- and the irony is that this is a program I suggested we visit because, quite honestly, we hadn't thought about it. But one of the things that I would suggest if we can, and I know timing is

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always an issue, is when we do a site visit like you were saying, Kana, that we allow time afterwards to debrief as a group.

Because I also think there is often what you see and then sometimes what you see or what you interpret what you see may not be how it necessarily is. Or you also see things through the lens of an hour, 2 hours on site. And I just think it would be valuable for us if we do site visits to have time together afterwards, kind of share our reflections.

DR. BRITT RIOS-ELLIS: I agree. You know, one of the things that was interesting for me, and I think his name was Dr. Gomez, the man who came in at the very -- you know, toward the end of the visit?

DR. STEPHANIE COVINGTON: Yes.

DR. BRITT RIOS-ELLIS: And I talked to him in Spanish about the lack of Spanish-speaking personnel, and it was something because I had heard that the inmates were so few who were Latino, and he said, “Oh, no, no, no. That’s a big problem.” He said, “I’m the only one.” And he said, “I’m just inundated, and I’m just really trying to get everybody

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really conscious about the need for more Spanish speaking personnel within the jail systems because we can’t meet their needs.”

And as I had heard that the inmates, there were so few who were Latino, which surprised me in Chicago because there is such a large population, but then he was reflecting very different data. He said there is about 15 percent and about 10 percent need language services.

DR. STEPHANIE COVINGTON: Yes, I mean, I think these are the things it would be important to have our debriefing.

DR. BRITT RIOS-ELLIS: Yes. Oh, yes.

DR. STEPHANIE COVINGTON: Because like any of us, someone comes to visit our house, and we clean house beforehand usually. And so, I just think it would have been helpful for you to be able to reflect on that and for everyone to sort of have their impressions and experience and be able to sort of interpret what we were seeing and what were some of the women saying and what were they not saying.

DR. BRITT RIOS-ELLIS: I mean, I was really,

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really impressed. And then I had this conversation with him, and I thought “wow.” Because he basically told me he was the only one. Interesting.

MS. SUSAN AYERS: I think the program where that really helps the participants relate to one another, kind of network with one another, and look to a positive future together, to have that kind of embodied in your alumni group. And maybe those were the only three people in the alumni group or however many people were there, but that was very exciting, it seemed like to me, because the real learning happens in the day-to-day. And if you can hold yourselves together and get outside of that program and continue to build a natural support, to keep everybody kind of intact and on track, that seemed like kind of a wonderful goal and kind of the proof in the pudding.

MS. GAIL HUTCHINGS: And they were the ones that really made me think about community health workers and recovery. Yes, it was them, interacting with them.

DR. STEPHANIE COVINGTON: Right. And then understanding for women in prison, this really can be

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problematic because most States, for example, the women in that jail, most of them were there on misdemeanors. There might be some felonies. But the State legislation says that you -- felonists cannot meet with each other after they're out of prison.

So you have to get legislation changed in order to have alumni groups after people leave an incarcerated setting.

MS. GAIL HUTCHINGS: Wow. I thought you were going to say they can't get jobs afterwards.

DR. STEPHANIE COVINGTON: Well, they can't get jobs, but they're also not supposed to meet each other.

MS. GAIL HUTCHINGS: I didn't know that.

DR. STEPHANIE COVINGTON: So it's a huge thing when we talk about having peer support once you leave one of these settings because in many jurisdictions, that's illegal.

MS. GAIL HUTCHINGS: All you have to do is bring the legislators to the --

DR. STEPHANIE COVINGTON: Yes, that's considered parole violation. So the complications are

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huge.

MS. GAIL HUTCHINGS: Yes. You've got a great strategy there, though.

DR. STEPHANIE COVINGTON: I mean, they have done a lot of work in that facility, a lot, and you know, just like any other program I've ever seen, Terrie McDermott has been in charge of this department for a number of years, and this is her passion. And because of that, when these women's programs, if they're sustained, it's because usually some woman has made it her life's goal to do it.

MS. GAIL HUTCHINGS: Right. I believe that.

DR. STEPHANIE COVINGTON: Yes.

MS. KANA ENOMOTO: Well, even this conversation really tells me how useful it is to have a chance to debrief because these are insights that I didn't have going away from the meeting, from the site visit. And there are probably some other complexities that we really didn't get to. But all in all, I think it was an excellent opportunity.

A few of us had the chance also to go visit Haymarket, who are providing -- who are partnering

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around the health services for the women, as well as providing the outpatient and inpatient addictions treatment services in Chicago. And that was an incredible -- they are partnering with Thresholds for the community healthcare, and that was really incredible to see that model of integration for the pregnant and postpartum women that they're doing.

So a lot of good work going on in Chicago, but Dan Lustig was really very heartfelt when he was describing the challenges that they're having in sustaining a 30 percent cut to their budget from the State and having to shut down outpatient treatment services, having to be in an environment where five community mental health centers have been shut down and the incredible drain that is now filtering onto homeless services, criminal justice, and the county hospital. So --

DR. STEPHANIE COVINGTON: I think it's just a microcosm of what's happening around the country.

MS. KANA ENOMOTO: Yes.

DR. STEPHANIE COVINGTON: And the services for people who need the most are being cut the most.

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MS. KANA ENOMOTO: Right. Right. So quite tragic.

And this is -- and these are the people who are doing great work.

DR. STEPHANIE COVINGTON: Right.

MS. KANA ENOMOTO: So the places we shouldn’t be cutting.

But all in all, I guess I hear agreement that it was good to get out. We had incredible attendance at the meeting. People were really diehard in terms of sitting with us for a 6-hour meeting during the day and then coming over to another hotel a cab ride away to go to another 2-hour listening session with the community health center folks. And we had them for the whole time as well.

And so, and thank you to Stephanie and Roger for doing a wonderful overview on trauma-informed care in addictions and mental health. I think that was really -- it was like a master class on trauma. And the people in our audience probably didn’t quite know what they were getting when they got it, but I did and the rest of our members did, and we’re very

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appreciative.

And it shows something that I'd like to continue doing, which is using our members and your expertise, just as we used Amanda and her amazing leadership in speaking and insight in Alaska, that we have such a rich membership that we don't need to bring in lots of outside speakers because we haven't even learned what we can learn from each other yet.

So I hope we can continue that as kind of a working principle in our meetings in the future. Speaking of which, I guess we're planning to meet in the spring at SAMHSA, where we will be doing some of that scheduling around Administrator Hyde's scheduling to try to get her at the meeting for a more lengthy dialogue with you all.

And Nevine, I don't know if you want any other thoughts, or if you all have like, gee, this week or this month or whatever really doesn't work for me?

MS. NEVINE GAHED: What I'll probably do is I will send a calendar of some days that are open for both Kana as well as Ms. Hyde and just give you the

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opportunity to get back with me and tell me what works. We are looking to meet obviously here for a day and a half. So I'll be in touch soon.

DR. STEPHANIE COVINGTON: Great. Good.

MS. KANA ENOMOTO: Maybe we could drive over for a visit to Roger? Well, actually, Roger is in Connecticut. So Roger will have to come down for a visit to Roger.

DR. ROGER FALLOT: I can do that. It would be great [inaudible].

MS. KANA ENOMOTO: It's nice to keep us all grounded in what's really going on.

DR. ROGER FALLOT: This is maybe more grounded than you want to be.

MS. SUSAN AYERS: And SAMHSA is about science to service. I just think the more you can see it in body. That's why I thought, Stephanie, it must be a real rush for you to be able to go to places where they're actually taking both your learning and life lessons and all the other input that they get to actually be implementing really some of the best practice that we understand is effective.

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DR. STEPHANIE COVINGTON: Yes, it's one of those things where I'm always kind of -- I think we all do our work. And you go and you do your work, and then you leave. And sometimes you don't know 5 years later what's happening or 10 years later what's happening. And there is, it's a real sense of I think gratitude to be able to do work where you think it's helping someone.

MS. KANA ENOMOTO: Well, it's very impressive stuff. So we're appreciative.

And Susan, I know you're having an incredible impact in Cambridge as well. So one of these days, we'll get to Massachusetts, and we'll see --

MS. SUSAN AYERS: Yes, any time.

MS. KANA ENOMOTO: I think, with that, it was a good meeting. I know it's challenging by phone. But I think we actually did get through our objectives, and I appreciate everyone's active participation. Nevine will get back to you with the links that were promised, the summary language on health reform, the revised letter. We'll work out the

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logistics on getting it signed, and the dates, dates for the next meeting.

So, with that, I'd like to adjourn this meeting of the SAMHSA Advisory Committee for Women's Services, and thank you all very much for your participation.

[Whereupon, at 5:13 p.m., the meeting was adjourned.]