Substance Abuse and Mental Health Services Administration

(SAMHSA)

Meeting of

Advisory Committee for Women's Services

March 26, 2012

SAMHSA Building
1 Choke Cherry Road
Rockville, MD

Proceedings by:

CASET Associates, Ltd.
Fairfax, Virginia 22030
(703) 266-8402

Table of Contents

PROCEEDINGS

Agenda Item: Call to Order

MS. WOOD: Good morning. Welcome to SAMHSA. It is wonderful to see you all here today. I want to take a moment to thank you for taking time out of your busy schedules to be with us today. I would like to introduce myself since I am new to SAMHSA as of November. I am the Committee Management Officer, and I joined the agency in November.

Prior to SAMHSA, I worked for 16 years at the Food and Drug Administration, six years of which I was the Director of the Advisory Committee staff for the Center for Devices and Radiological Health. And I spent about 10 years as a scientific reviewer and a designated federal officer.

I worked for eight years at the NIH in AIDS research and also the first genetic therapy project, bone marrow and stem cell process. It is a pleasure to be at SAMHSA and I look forward to getting to know each one of you. I would like to thank you, again, for taking time out of your schedules.

Before we begin the meeting I have a few brief announcements. If you are in attendance today and have not all ready done so, please sign in at the registration table, and for those in attendance, a copy of the agenda, the member roster and bios are on the table. If you wish to address this committee during the public comment session and have not registered for time in advance, please complete the comment card at the registration desk to request an opportunity to speak.

We are recording this meeting, so please state your name before speaking and use your push to talk microphones. You will push them, you will notice that they light up, and then you will need to push them to disengage. Please leave your meeting

binder at your seat when we adjourn. Our contractor will be making a few updates to the binders for tomorrow's meeting.

And finally, as a courtesy to those around you, please silence your cell phones and other electronic devices. So as the DFO of the ACWS, I officially call this meeting to order. And Chairman, we have a quorum, so we may begin.

Agenda Item: Welcome Members and Roll Call

MS. ENOMOTO: Thank you, Geretta. Good morning. Isn't she great? Geretta did just join us late last year, and she has bravely taken on the task of coordinating our many advisory councils here at SAMHSA. She is a really wonderful addition to our team in the Office of Policy, Planning and Innovation. So thank you, Geretta.

And welcome to our new member. We have one new member here today and one on her way. And so why don't we go ahead? I am Kana Enemoto, Principal Deputy Administrator of SAMHSA, also the Associate Administrator for Women's Services. Glad to be here. We will go around and let everyone introduce themselves.

DR. BRISCOE: Good morning. My name is Yolanda Briscoe and I come from Santa Fe, New Mexico and I am very excited to be here.

MS. FORMAN: Good morning, this is Harriet Forman. I just moved not half a year ago, four months ago, from Washington State back to Santa Fe, New Mexico. I am pleased to be here and be with you today.

DR. MURRY: Good morning, I am Velma McBride Murry, and I am a Professor at Vanderbilt University, and a committee member. I should say Vanderbilt

University is in Nashville, Tennessee, the music city, for anyone that is not familiar with the place. It is great to be here.

MS. AMATETTI: Good morning everyone, I am Sharon Amatetti, and I am SAMHSA's Women's Issue Coordinator.

DR. WARSHAW: Good morning. I am Carole Warshaw. I am the new member, and I am the Director of the National Center on Domestic Violence, Trauma, and Mental Health in Chicago, which is an HHS funded by the Family Bonds Prevention Services Program Center.

MS. BERGAN: Hello, I am Johanna Bergan from Iowa. And I am a National Board Member for Youth M.O.V.E. National. Our focus is on young people in the mental health system.

MS. ENOMOTO: And we have two members on the phone.

MS. BENAVENTE: This is Bobbie Benavente, with the Guam Department of Mental Health and Substance Abuse.

MS. ROBBINS: Hi, this is Starleen Scott Robbins with the North Carolina Division of Mental Health Developmental Disabilities and Substance Abuse Services. And I also am the President of the Women's Services Network for NASADAD.

MS. ENOMOTO: Ladies, we are dealing a little bit with volume control, so we don't blast away the whole building. Bobbie, what time is it in Guam?

MS. BENAVENTE: 11:06 p.m.

MS. ENOMOTO: Thank you very much for joining. We will have you with us for as long as you can stay awake, but please don't push it too hard. They need you alert and bright-eyed where you are, as well.

Just a quick note, the Administrator and I were very fortunate that Bobbie and some of her colleagues in the Pacific Behavioral Health Coordinating Council hosted us in a two-week visit to the Pacific, which was incredibly eye-opening and educational, and wonderful. So Bobbie, thank you for that and hopefully we will chat a little bit more about some of the things we observed there later.

I had a lot of ideas for what we could do for women in the Pacific, as I was traveling around. While we are doing introductions, I would like to introduce the people around the sides of the room -- Katie, Abby, Chanda, Irene. If you could say who you are and what you are doing.

(Introductions around the room)

MS. ENOMOTO: Thanks, everybody, for coming. Chanda just told me we used to have a gentleman right here who did the transcriptions for us, but he always had big headphones. I said oh, you don't have headphones, and Chanda said no, no, no, we're digital now. I said, I'm so 18 months ago. (laughter)

I can't keep up with the technology. But the point is that Chanda is recording, so we will need to turn on our mikes and turn off our mikes, and we can't have all the mikes on at once, otherwise it will drive them nuts. So if we could please think about that as we go on.

Welcome to everybody. We had a new person join us. Do you want to say who you are?

PARTICIPANT: (off microphone)

MS. ENOMOTO: Chanda has been working with Sharon, doing great things.

Agenda Item: Remarks by the Associate Administrator for Women's Services and Adoption of Minutes for the August 15, 2011 Meeting

MS. ENOMOTO: So this morning I was going to talk to you a little bit, very brief budget talking points because you will be getting the 15 minute version. I have a 40 minute version tomorrow, complete with slides and handouts and things. But we will talk about some of the key points that are most relevant to women's services.

We will also be approving our Minutes, and then we have a very exciting report that is being officially released today here at the meeting. So the press release will mention that the launch of the report will be coming from here. That is what we have scheduled for the next 20 minutes. And then I will be asking each of you to do an update on what has been going on in your corner of the world and what you have been seeing and picking up, any questions or ideas that you may have for further discussion.

Then Sharon will be doing 15 minutes. I don't know how she is going to squeeze it in because there is just so much good stuff happening. But she has practiced, I am sure. Sharon will be doing an update on what the SAMHSA Women's Coordinating Committee has been up to and has planned.

And then how many people got to watch their DVD? Bits of it at least? I got all the way to the last scene and then I realized I have seen this movie before, when is it from? 2003. And then I realized Nicky Reed was the co-screen writer. It's 2:00 a.m. and I now realize that I have already seen it. But it was a very good movie.

That was Sharon's pick and it was her idea to do something that would tie a little bit of an experiential exercise for us, to think about issues and ground us in what issues young women are facing and then how that might tie in with what schools could be doing, more or differently or better.

Then later today we have two wonderful speakers, Norma Finkelstein, Barriers to Treatment and Engaging Adolescent Girls in Behavioral Health Services. Norma is a service provider whom some of you may know, who has been a long time leader in integrated treatment for women and girls.

And then Mary Louise Kelley, a good friend of Carol's, obviously. The unit that Carol was talking about is funded, or her center is funded out of Mary Louise's unit at the Administration for Children and Families. And so Marylouise Kelley has been a leader in domestic violence for many, many years, and she is going to talk to us about counseling as it relates to last year's IOM report on preventive services for women and girls.

And then we have discussion and public comment. Do we have any public comment as of now? No one yet. So you can Twitter and text and Facebook your friends, ask them to come comment. That is what we have planned today. Any questions on that, or any additions or requests?

I see that we last met on August 16th. There have been some changes at SAMHSA, other than that Geretta has come on board. Dr. Broderick, whom some of you know, retired, and so I became Principal Deputy Administrator permanently, and Acting OPPI Director, Office of Policy, Planning and Innovations Director.

So for the last five, six months, I have been doing both jobs. Nevine has also been doing two jobs. Nevine was the Special Assistant for the OPPI Director. She is now the Special Assistant for the Principal Deputy, but really basically doing both jobs also.

And then Sharon, you were Women's Issues Coordinator at the last meeting. But Sharon has gone great guns with many parts of her work. We have a

number of other big personnel changes. Then I became Principal Deputy Administrator. Mirtha Beadle joined SAMHSA as the Deputy for Operations. I think she was at the August meeting as well, just to say hello. So she came to us from the Office of Minority Health.

Miriam Delphin-Rittmon came to us from Yale University. She is a Senior Advisor working primarily on disparities issues as well as in data and outcome. She was in the State of Connecticut as well as Yale. She was their Cultural Competence Coordinator there. So she is bringing fantastic expertise to our Office of Behavioral Health Equity as well as generally to the Office of Policy, Planning and Innovation.

One really major departure is that John O'Brien, I think some of you heard from him before, talk about health reform at the Joint Council meeting. He was really fantastic and instrumental in getting SAMHSA to the table in many of the health reform conversations going on in CMS and across the department and with our stakeholders.

And John was a special expert, he committed to SAMHSA for two years. He stayed for two years. And luckily he is not going far. He got a job as a Senior Analyst at CMS in the Medicaid side. He will be working with Barbara Edwards there. We look forward to continuing to work for John. We feel very fortunate that someone with extreme behavioral health expertise is now right in the Medicaid office.

That is very fortunate for us. We have been casting about for some time since a couple of the people that we did know who had real expertise had retired. So between Jeff Buck and John O'Brien we are in great shape. Our regional administrators have also kicked off, mostly in January. So that is another change, that Kathryn Power is now our Region One Administrator, and Paolo del Vecchio is the Acting Director of the Center for Mental Health Services. So that is very exciting.

We also have nine other regional administrators whose names I will not try to recite to you. But they are a very, very impressive group and hopefully we will get them in at some point to meet with the Council. You have a list of them in the Joint Council book.

Each and every one of them brings an expertise that altogether they form an amazing team. There is not a topic within behavioral health that they don't cover: kids and prevention and treatment and disaster and state and local and university and Medicaid and aging. They are really wonderful. And tribal, John Perez came from Indian Health Service.

We have been just buzzing. Another big loss for us was Rose Shannon from our Exec Sec. And we have Mr. Onaje Salim in OPPI doing that as an acting job. So all this to say a lot of movement, a lot of moving parts, half of us in temporary jobs, half of us in permanent jobs. So we are an evolving organization with lots to do, but it is very exciting. It is an exciting time at SAMHSA.

I think as tired as many of us are, I think we realize that there is big change right around the corner and we are really on the cusp, I think, of becoming a new kind of organization and a new kind of health care system.

And with a very different presence and feel within the Department of Health and Human Services, where we are really interacting very much with our peer agencies, and at the table in major policy discussions that we weren't at before. So it is exciting and it is important. If ever you were going to become relevant, this is probably a good time to do that.

The President's budget came out in February. Overall, the total budget requested for SAMHSA is a healthy $3.4 billion. And it represents a four percent

decrease overall across all centers and offices, so our budget goes down by four percent, or $142 million, from what it was in fiscal year 2012.

So for as much as $142 million is, it still reflects, the fact that we did that well reflects that the Administration's priorities in these tight times are still on health, and still on behavioral health. We are highlighting a commitment to supporting communities, states, territories and tribes to reduce the impact of substance abuse and mental illness in all of America's communities.

The budget does include $500 million for targeted prevention work, expanded and refocused substance abuse prevention and mental health promotion, grants to states, territories and tribes to bring evidence-based prevention strategies to scale nationwide.

So we have a substance abuse state prevention grant, a mental health state prevention grant, and a behavioral health tribal prevention grant. So we have three separate prevention grants within the substance abuse, the mental health, and our fourth appropriation.

Our appropriation has been divided into -- we actually now have four appropriations, which is mental health, substance abuse prevention, substance abuse treatment, and health surveillance and program support. So four separate appropriations. Before we had one appropriation with eight budget lines, and now it is actually in four separate appropriations.

Congress re-organized the budgets of CDC and HRSA in the same way, which presents from an accounting perspective a lot of challenges, when you are switching all your accounts in the middle of the year, when you have already started

drawing down on your old accounts with the old way, going to a new way. We will be writing our new budget in the new way.

We have two new initiatives that actually address aspects of trauma, one of them at $2.8 million or $2.9 million is grants for adult trauma screening and brief intervention. This is a small services research proposal, really to fill a gap in the knowledge base, or in practice tools that we can give to providers, with the IOM report recommending a more universal screening of women and adolescent girls for interpersonal violence, including histories of trauma and abuse.

We realize that the fantastic work that we have done already on trauma informed care and trauma screening has really been in the specialty care sector. We have not quite caught up with the work that has been on interpersonal violence. And so in order to get a comprehensive set of tools out to clinicians to do what the IOM is recommending, we need to do a little bit of work to figure out how do we get the screenings for traumatic history together with trainings for providers to respond appropriately.

So for example, I think a lot of providers know how to refer to services where there is a current subsidies problem or a current mental health problem, or obviously a current dangerous problem where a woman or a young woman is in danger. However, how do you respond to a reported history of trauma and abuse when there isn't a current problem?

There is still an opportunity for brief intervention, and psycho-education and support. And so we would like to fund a few investigators to think more about that and help us develop some tools, and have enough space for how to do that most effectively. So that will be the GATSBY program. That is our new acronym.

There is also a disaster and distress line. It is a national line that we have been operating under pilot, and that STEM trends are experienced with BP (?) 00:22:04, that when there is a disaster everyone is sort of casting about for help and assistance and support. Some regions and some states have crisis lines, and some do not.

We already fund and support a telephone system that reaches to most the crisis centers in the country, and so what we have piloted is a line that can go up during a disaster. It is actually a line that is live, all year round. But as soon as a disaster hits in a region, we can start advertising it. And then that will link people directly to a crisis center near them.

And rather than try to every time there is a disaster, stand up a line and shut down a line, and stand up a line and shut it down -- it's very costly. So we are piloting this where we have a line going year round, and we just market it in a strategic way where there is a need for people to call and get, sometimes, psychosocial support or referral to services.

And because it is hard, most disasters are local, and so there actually is a disaster almost every day of the year somewhere, or there is a state or a community under a declaration, a disaster declaration, somewhere, whether it is a man-made or a natural one. So our proposal in 2013 is to develop more permanent, ongoing support out of our budget for that.

In addition to that, in 2012 we received increases to the mental health and substance abuse prevention treatment block grants. And so on the mental health side it was a $40 million increase, on the substance abuse prevention treatment side it was a $20 million increase.

Due to some ways that we are needing to contribute to the public health service evaluation funds, the states will only realize an increase on the mental health side, whereas the rest of the money sort of gets tapped, so to speak. So we got an increase to compensate for other moneys needing to go away.

But in 2013, in recognition of the importance of those block grants, we will be continuing that same level, or we are requesting that same level of support. When you have two-thirds of your budget in big chunks of money like that, $1.9 billion or so of our budget, $2 billion, in those two lines, it is pretty hard to take the reductions that we needed to take and leave those two lines intact, which really speaks to the importance that the administrator sees in supporting the states and communities in the basic services and prevention infrastructure of the nation.

As we go on, throughout this year we continue to work with the states to think about and lead, around using block grant funds strategically. So as states prepare for the Affordable Care Act and Medicaid expansion, there will be different populations coming into the insured roles, there will be different services, especially with parity and the Affordable Care Act.

There will be behavioral health services covered by insurance that weren't covered previously. And so we have to think differently about how we use those block grant dollars so that they are not duplicative, but complementary, to either cover those people who still will not be insured, who become temporarily uninsured, or to cover those services which haven't been and probably won't ever be covered by insurance, that we know are the best to attain and sustain recovery, for the folks that we care most about.

In the budget, and actually in 2012 as well as in 2013, we are increasing our focus on trauma within some of our programs, so there is an increasing focus on

trauma in our pregnant, post-partum women program. So it remains the program that it has always been, a largely residential treatment program for women who are pregnant and parenting with substance abuse problems. And within that we recognize, the program and the grantees recognize, trauma is really central to many of these women's lives and must be a focus.

Also, within the children's mental health initiative, also known as systems of care, there is an increasing partnership with our national traumatic stress network, and looking at how to address trauma not only of young people but also of their families.

And not within our budget, but within the Administration for Children and Families, SAMHSA has been doing a lot of partnering with ACF on the child welfare side. The department has adopted a cross-cutting goal around addressing trauma for children in the foster care system. So that is a very exciting partnership, and again, another linkage between our programs and another agency's programs.

We do see a proposed reduction in the area of FASD; however, SAMHSA plans to continue strong technical assistance and educational materials and support around fetal alcohol syndrome. We have identified a number of ways that we are starting to lay the groundwork for that in '12, should the President's budget come to pass and we have a reduction in the amount of funds we have available to support our FASD program.

Overall, this is actually the first time in some time, other than PPW, that we have had a new program targeted specifically to women in the budget. So that is exciting. In conversations we have had on the Hill and elsewhere, the reception has been very positive. Lark is unfortunately not able to be here today because she is over at ACF talking with Bryan Samuels about some of the foster care support that she is leading on.

But she will be helping as our lead on Strategic Initiative for Trauma Justice, she will be bringing a group together with our agency partners and some leaders from the field, to think about if we get these funds, what would that program look like. So we are quite excited about 2013.

Any questions about the budget? Tomorrow you will get the big blue book, which will be the congressional justification, which will show you exactly what we wrote about in 2013. Sharon, you sent this out already, but just so you know we have this report from our Center for Behavioral Health Statistics and Quality, a data spotlight about women on probation or parole experiencing mental illness at a significantly higher rate, twice as likely to experience mental illness as other women.

Again, speaking to the importance of our Trauma and Justice Initiative, particularly as it pertains to women, given how prevalent our issues are for women involved in these systems. This press release will be going out today, as a report being released at this meeting. So here it is. A very short report. There it is.

PARTICIPANT: There is also a link in the report to other information.

MS. ENOMOTO: There has only been a report to the general women's section. So I will move to adopt the Minutes. All of you received the minutes in advance of this meeting and had a chance to review them. These Minutes were certified in accordance with the Federal Advisory Committee's FACA Regulations.

Members were given the opportunity to review and comment on the draft Minutes. Members also received a copy of the certified Minutes. If you have any changes or additions, they will be incorporated in this meeting's Minutes. Does anyone have any corrections, objections, comments? (None) No? If not, may I please have a motion to approve the Minutes.

MS. FORMAN: Harriet Forman, move approval.

MS. ENOMOTO: And a second?

DR. MURRY: Velma second, Velma Murry.

MS. ENOMOTO: So moved, thank you very much. And one announcement before we move to let us hear from you, which I am sure everyone is waiting for. But a piece of good news, that Susan Salasin, who is not able to be here today, but has been selected by the National Council of Community Behavioral Health as this year's winner of their National Excellence in Public Service Award for her lifetime accomplishments in recognizing and helping people who have suffered trauma and benefited from trauma informed care.

Susan will receive the award at the NCCBH celebration dinner on April 16th at their annual 2012 convention in Chicago. And Susan has been one of my personal mentors since the first day that I walked into SAMHSA, and she has really led the field. She has championed the issues of trauma, back in the days when it was not popular to do so. And so we all owe her a great debt of gratitude.

Susan, thank you very much, and congratulations on your good work. If you have a chance to see Susan, please do say it. I think she is quite proud and flattered by this recognition. With that, let me turn the mike over to you all.

Agenda Item: Updates from ACWS Members

DR. MURRY: So this is just to provide updates of what we are doing?

MS. ENOMOTO: What you are doing, and particularly as it is relevant to women and girls, obviously. But what you are doing, what you are seeing, questions that you are hearing from the field, what you are bringing as an advisor to us.

DR. MURRY: I continue to do work with rural African-American families, and my focus specifically is designed to enhance parenting and community processes that foster positive outcomes for youth. And these youth include half of them are girls and the other half are boys. And we are continuing to see positive outcomes for the continued development of the girls, the youth in the study, including girls.

And one thing that we are very proud of is the program that we have in Georgia, the girls are now, the young women, are now in emerging adulthood. And during the time of the intervention none of the girls became pregnant, which is a really positive outcome when you think of African-American girls. Seventy-five percent of them completed high school, and many of them are going on toward positive developmental trajectories.

What I am doing now is transporting that family-based human delivered program into computer technology delivery format, testing whether or not families are able to uptake program information via technology, and whether or not they are going to internalize the things that we are targeting in our interventions in a way that fosters the same kind of positive outcomes that we have seen in the program that was delivered with humans delivering the programs.

And we are seeing really positive preliminary outcomes thus far, primarily in the involvement of fathers in the program. One of our father-daughter dyads, it is a positive story, I think, of showing how important fathers are in the life and the development of their daughters. So we are hoping to be able to tease out more of that through the technology-driven format, with the increased rate of fathers being involved in the program.

On another note, what we are finding is the increased evidence of HIV diagnosis among mothers in our studies. These are mothers in rural communities, and one of the major concerns that I have is lack of services available for the treatment of HIV in rural communities, for anyone, but women in particular.

I continue to be concerned about lack of access for girls around HPV vaccine series, and just the culture of rural communities, and how might we begin to expand our thoughts about access in a way that it moves from the traditional method of thinking of providing services for these women and their daughters in particular. So I will stop there. But some of the issues that we are seeing, that I am observing, is the increased manifestation of HIV reports among the mothers of the children whom we are focused on preventing HIV among their children.

And so they are now sandwiched with the stressors are providing for their own care without access to resources in the context of trying to be protective of their daughters against the risk of HIV-AIDS. It is a worrisome process that I would like for us to think a little bit more about that, if we have the time.

MS. ENOMOTO: Can I ask you a question? You said you would like for us to think a little bit differently about responding to service delivery in that kind of rural setting. What are you thinking?

DR. MURRY: It is really a pie in the sky thought. And the reason I say think of a different strategy for addressing the needs, is that our families live so far away from mental health services, mental health servicing agencies. And right now they are depending a lot on their primary physicians to provide the care, many of whom don’t really address issues related to the needs of our mothers and their daughters.

And so to think about the expansion of care to community lay people. How might we be able to equip -- one of the most influential institutions of these rural communities is the church, because that is where they go for a lot of their servicing needs. So how might we begin to think about preparing lay people at least for some fundamental kinds of assistance?

And then they would be developing family coaches, family partners, who could then begin to help these families navigate sometimes a pretty complicated system. And also, to be able to garner the resources in order to go and seek care. And many of these mothers, when we asked them how did they know, they found out through a gynecological screening, and they decided to ask their OBGYN or their gynecologist to do an AIDS test.

Then the question is, what are you doing now? I am not doing anything, because the closest place is four hours away, and I don't have transportation. And so they are meeting the needs of their children in the context of compromising their own health, that we know eventually is going to manifest itself in a very negative way.

And we are probably dealing with a lot of known health problems in the context of this, of being diagnosed with this disease, and then having to keep it internally a secret, because you don't want people to necessarily know. So the context of rural communities is absolutely incredibly different than urban settings, and that is where I do my work.

I am seeing a lot of mental health problems that have been left untreated, and now, sandwiched with that possible increase in cervical cancer because of the lack of HPV screening and HIV among the parents. But in the context of all of that, they have

absolutely phenomenal support systems that could also be part of the way in which we go about thinking of models to address the needs of rural families.

DR. WARSHAW: It's Carole Warshaw. I was just thinking, Velma, about some studies that just came out, I think today, about the high rates of abuse and violence among women who are diagnosed with HIV, including ongoing domestic violence. And in rural areas that is even more of an issue in terms of access to resources and transportation.

So I didn't know how much you were seeing that, and how that was factoring in, and whether the kinds of resources with domestic violence programs might be available to help that link.

DR. MURRY: The reports of inter-, co-parental conflict is increasing, which is an indication, of course, of intimate violence. Again, if you look at the services available in many of these rural communities, it is the public health department that is in much larger towns than our families live. So again, the source of assistance, it is just not readily available to these families and so they go left untreated. With the exception of relying on the church as a form of treatment. And that is really through the pastor's counseling. And many of whom are not trained.

So again, it is just feeding into a system where the kind of services needed to make people well, or healthier, is just not readily available to these families.

DR. BRISCOE: Hi, I am Yolanda from New Mexico, and we are facing a lot of the same challenges that Velma is talking about. I just recruited her to be on one of our committees in New Mexico. We are doing recovery oriented systems of care. We are looking at how do we enhance best practices.

In rural communities you have behavioral health centers that are doing the matrix model, that are doing cognitive behavioral therapy, and they are doing all the evidence-based practices and doing a wonderful job of it. If you show up. How do we engage the individuals who have fear and stigma around going to a mental health or a behavioral health organization and seeking treatment?

And so we are looking at ways of engaging families and not just dealing with the individual struggling with whatever it is -- drugs, alcohol or other mental health illnesses -- depression, anxiety, so many different areas that folks are doing a great job, as long as you show up. But then what happens to the family?

And so the committee that I head is the clinical committee. And I am saying you need to just get away from the focus of all about evidence-based practices, all about evidence-based practices, when people aren't showing up and you aren't dealing with a whole family.

So you can have this wonderful program, but if you are not dealing with the whole family and you are not engaging the community, then they are going right back into the same environments that got them there in the first place. So that is really exciting, and I am thrilled that Velma has said yes. I will be the national champion for your local work.

MS. ENOMOTO: I am going to break it up a little bit and go to the phone.

MS. BENAVENTE: I am having a little trouble hearing. The voices are coming in pretty faint. The work that we are doing out in the Pacific Islands, and more specifically here on Guam is really in the focus and the prevention area, particularly with mentoring young girls and young adults, female adults.

We are just trying to encourage them to participate in leadership roles, as far as training their peers in prevention and encouraging them to speak, to be able to find adult mentors that they can turn to when they are dealing with traumatic events in their families, whether it is domestic violence, sexual assault, substance abuse among adults in their families.

Some of the successes, although we are not measuring the tool, was the youth leadership program on Guam here, getting young girls to go beyond high school and get a degree in college. And we are seeing more and more young girls doing that in the recent six years.

As far as trauma informed care, it is a new area that we are looking at. The way that they have been getting treatment is just general treatment for anyone who would come through the door, but no real specific program for training on how to deal with girls and women.

I agree with what has been shared in that it is important to go to the families, because that is what we are about. It is family-centered, and when one person in the family is hurting and is going without treatment, then the whole family pretty much suffers until that person is in recovery and the family goes through some kind of treatment process.

I think that the work that we started with SAMHSA's support for the master trainer development program for the Pacific Island, one of the things that we are looking at, that didn't come out very strong yet, is choosing a topic area for training trainers in the area of trauma-informed care. We are looking at that right now.

MS. ENOMOTO: Bobbie, this is Kana. I was wondering, because of what Velma is asking about kind of going outside the box to build capacity and role in those

areas, do you want to do a minute about what the master trainer development program is, and how we came about, why we decided to do that?

MS. BENAVENTE: Well first of all, we are quite a distance away from the US continent, from Hawaii. And the cultures of the Pacific Islands are pretty unique, if I may say so. We have had to rely on many consultants who come to the Pacific to train in a particular area on substance abuse.

It's pretty much a one-time shot. A lot of resources and time put in for a five-day training or maybe even a week and a half, and then these consultants go away and they are left with trying to figure out how did that training make some sense for us in serving the people of the Pacific.

And adapting an EBP, for example, that would truly be effective for Pacific Islander people, for the Chamorros in Guam and the Chuukese in the Island of Chuuk and so forth. And so the idea was born by the Pacific Behavioral Health Collaborating Council, to take a look at people within our Island communities who have the experience and passion and knowledge of their community and who are part of the Pacific Island community, to learn a topic that would address a priority need, and to be mentored by those experts, whether they be in this part of the world of Asian Pacificano, or just go to the US continent or Hawaii.

And so we have completed the launch of the master trainer development program about May 5th through the 11th. And each island selected two trainer candidates to go to a few days of a generic how to do trainings with an adult audience, how do you weave in, or how do you embrace the strength of your culture, and the techniques that would work. And they are going to message, to get people excited about what you are teaching, and to own it.

And so this master trainer development program is going to be piloted up through September, and we have about -- actually we were shooting for 18 trainer candidates, but we were only able to get 16. Two did not show up on two of the other islands.

It is really exciting because we will have a pool of trained trainers who are Pacific Islander people, who live and breathe and connect with the community, with the families. We have included as a trainer candidate people who represent colleges in Guam and Micronesia.

And we foresee that there will be a way in which these courses will be offered in the college setting, where students could take these trainings, these courses, this education, and maybe it will result in a certificate degree, or something that would be tied into a two-year program and maybe move up to a four-year college or university, like the University of Guam.

And so there are these pools of trainers who will be able to take an EBT and adapt it to be really culturally appropriate and effective with the different Pacific Islander groups.

MS. ENOMOTO: Thank you, Bobbie. Velma is nodding. I think one of the issues, especially in the Pacific, it is islands, so once people go off island, a lot of people don't do back to the island. And so the idea was to build the capacity out there so that they could support one another, and that the expertise that is built stays there.

MS. BENAVENTE: Yes, and one of the things that we are excited about particularly with the trainer candidates who have come from, for example, the Island of Chuuk, which is part of the Federated States of Micronesia, is that at some point down the road when we on Guam are working with the Chuukese population who have a high

rate of alcohol dependence and suicide, then I think we could partner with a trainer candidate from Chuuk, who can come to Guam, help us to learn better ways of working with the Chuukese people who reside here, who have chosen to make Guam their home.

And so we are just really, really excited and thankful that the people who have come out here, Kana and Pam, to witness for yourself, experience a little bit about living in the islands, the challenges, the strength of our people, to hear a little bit about our culture, and fly United. Kana, you can share your adventures with delayed flights and sitting on the plane waiting for clearance to take off and all that.

This is the first that this has ever happened, to really build Pacific Islander capacity, and to trust that and to invest in the skills of the people who live here, who know our community, and isn't going to relocate pretty much anywhere else. We invest in our people. We are here to stay. We are here for the long haul because this is our home.

MS. ENOMOTO: And Bobbie, how many of the people are already licensed mental health or substance abuse clinicians or prevention specialists?

MS. BENAVENTE: Most of them are not. If you work for the government -- I can only speak for the government of Guam right now -- there are a handful of licensed.

MS. ENOMOTO: I mean in the master trainers.

MS. BENAVENTE: They are not licensed at all.

MS. ENOMOTO: So we have some nurses, but they are more, not lay nurses, but they are not Masters level nurses necessarily.

MS. BENAVENTE: No, they are not.

MS. ENOMOTO: And so it is a creative approach to getting evidenced based behavioral practices into the hands of people who are going to be able to do them in their community.

MS. BENAVENTE: I think of the 18 trainer candidates, there is one RN, and she is from the Guam Community College, and she has been trained so far in two other courses, at first for site intervention, and a brief tobacco cessation program.

DR. MURRY: Hi, Bobbie, it's Velma. So the credentials of most of the individuals in the program include -- what is the training background, if at al?

MS. BENAVENTE: Professional training in nursing, in community health work. A couple have Bachelor's degrees, a couple of them are working on their Master's. It depends on which island we are speaking of. Primarily Guam, Guam has the RN and the other trainer candidates have completed their Master's degree.

But mostly it is certificate programs, high school graduates, lots of years of experience in working in a health setting. There's a health educator who has a high school degree. A lot of it is the learning from just the normal work, working with the community, learning from the community.

DR. MURRY: This is a fabulous model, Bobbie. What I thought about was, it addresses one major issue that confronts, at least for us, rural families, and that is the stigma associated with mental health, and then going to mental health centers. So if you have someone from the community that is delivering this message, it probably will be uptake at a much greater rate than going to another kind of setting, of people whom they don't trust.

And it also creates a sense of access and community empowerment. I really like the idea of developing pipelines of future community lay people to help by

establishing some kind of certification program, maybe through junior colleges. This is very appealing.

MS. BENAVENTE: It is something that we tried to develop years ago with whatever resources we had, but it was always kind of very, very short-term in its development. But we have always known that the strength of the community is in working with the lay people. It is the moms and grandmas and the grandfathers that is going to draw interest to result in the particular problem that the community is facing.

Our struggles have always been taking a look at evidence based programs, practices and policies that are developed elsewhere, and we are trying to make it fit into our Pacific communities. And it doesn't. So that is where there is the excitement that we are going to hit the ground running with people who know the community, who have credibility, who are recognizable, who can speak the language, who know the do's and don'ts of bringing together people at a community meeting or a village meeting.

And it is just acknowledging that there are people with no formal education that can really have an impact, to turn things around. So we are not saying that we are not going to support or encourage our young children to go get a college degree or anything like that. That is what we are doing also. Just trying to get people to look less at their iPhones and their iPads, and make more eye contact with their families.

MS. ENOMOTO: Thank you very much, Bobbie, that is great. It is an exciting program.

MS. ROBBINS: Hi this is Starleen. I just wanted to give an update on what is happening with the Women's Services Network. Those of you who are not familiar with the Women's Services Network, it is made up of the Women's Services coordinators that are designated for each of the states. The Women's Services

coordinators not only are the ones who are responsible for the specific prevention treatment block grants and oversee the use of those funds in their community.

Women's Services Network has four subcommittees, including the pregnant and parenting women subcommittee, and they have been focusing this year on looking at integrated behavioral health care and the different models that work in primary health care and behavioral health for pregnant and parenting women. They have looked at different screening models and brief intervention models that have been working in different states and have been sharing that information with the network.

They also had a wonderful discussion around medication and different therapies particularly with pregnant, substance-using women given the --

MS. ENOMOTO: Starleen, could we ask you to speak a little bit more into the mike of your phone? We are having a hard time hearing.

MS. ROBBINS: We have also been looking at the Medicaid assisted treatment therapies for women who are pregnant given the high rate of opiate use across the country. We have seen a marked increase of women who are coming into treatment who area busing opiates, including Vicodin, Percocet, Oxycodone, et cetera, and who have been successfully treated with Methadone and/or Buprenorphine.

So we have had a lot of discussion around that, and have shared those discussions across the network. Our recovery oriented systems, the Care subcommittee has been focusing on the different peer support, peer coach models and credentialing of peers within treatment for women, and has been looking specifically around gender responsive models of recovery oriented systems of care that are happening across the country.

Outcomes and data -- our subcommittee has been surveying the states to see the types of data that the states are collecting, and the types of outcomes that the states have at hand, and how that data is used in order to support contingent treatment and to increase access to services across their states.

We also have a Criminal Justice subcommittee that has been working on looking at the different types of services and models that are used to help transition women back into communities as they come back out of the criminal justice system.

I think that as we are preparing in June for our annual meeting, we will also be looking at the goals for 2013. We are really looking forward to the National Behavioral Health Conference for Women and Girls in July. And we will be supporting that conference as well.

In North Carolina our focus has primarily been on transition to Medicaid managed care. We have a Medicaid 1915 (b) and (c) waiver that we are transitioning over the next 12 months all of our 100 counties. And we are doing a lot of work around integrated behavioral health care, and continue to build on the women's treatment system that we have in North Carolina.

We have a preliminary study that we are doing right now, in looking at the outcomes for our perinatal and maternal programs across the state. And what we have found so far is that our low birth weight, pre-term birth and infant mortality for the programs that are specifically gender-specific programs across our states have better outcomes than the general public.

And that is something that we are very proud of, and we have worked very hard to build a system for women and their children to be able to come into a program

and receive family centered services. And we feel like we are being successful there. Thank you.

MS. ENOMOTO: Congratulations. That is great. Starleen, I just made a note to Sharon. I would love for the WSN to come in and do an update for us formally about some of the gender responses, recovery oriented systems of care work, or what is the national scan, what does that look like around the country. That would be great.

MS. BERGAN: Hello, this is Johanna. Most of my work around these fields is with Youth M.O.V.E. National, and we have offices here in DC and a Satellite office in Los Angeles. We have a small handful of staff and a dozen very active board members around the country. Our work is really done on the ground with young people. We have 30 chapters in 26 states currently. And those young people are at the heart of Youth M.O.V.E. and making things happen.

The idea is that we provide support for groups to form, and then their purpose is to help young people share their experiences in mental health, in child welfare, in special education. And by sharing their experiences, make positive change, hopefully for themselves but definitely for the young people coming up just behind them.

So my work is very hands-off. It is all on the phone and the computer with those young people. We have just been in a period of defining the word youth and young people that we are talking about, and focusing a lot on the transitional age youth, which we are arguing ourselves up to the age of 28. That is changing our scope a little bit, and changing our relationships with funding and potential funders. When we are talking about 11 year old and 28 year olds, we are in different worlds.

So we are in that process right now. And then where we are going, and this conversation has definitely inspired me to push us quickly, is in evaluating the work

of those individual chapters. So normally we are in a chapter that would consist of some sort of social function, young people getting together who have common backgrounds, and having fun, and having a place to be social with their peers. And I think every chapter has that.

But then from there, they go anywhere, and they work in different systems. And so we are trying to figure out who they are partnering with. And the big question that I have had and this conversation ties into, is are they partnering with schools, because almost all of them are in some sort of school-age setting.

And if they are doing that successfully, can we share individual groups' experiences with others. And so this year we need to get a better handle on who is partnering, and so then we can mirror those partnerships on the national level. So for sure, in the last two years, the work between mental health and foster care has been our focus.

And that is because there are state-wide organizations for the foster care system. And we have been taking their work and saying, so, can these services and these supports work for young people who are not in the foster care system, but experiencing the same challenges? So now this year we are looking to see what organizations need to be partnered with.

MS. ENOMOTO: So are you saying the youth movement is reaching out to include kids from the foster care system?

MS. BERGAN: Definitely, and in the past year those numbers have increased, both individually and in chapters just having youth included, but also there are some states that have really great foster care support networks, similar to Youth

M.O.V.E., saying can they be both. So can our foster care group expand to include youth that are struggling with high drop-out rates and with substance abuse.

They could benefit from the services our foster care children are receiving. And so in Oregon there is the Foster Care All Kids All Star Club. And so now they are kind of running parallel with Youth M.O.V.E. chapters.

DR. WARSHAW: Well there is a lot of things that we are doing. Our center in this most recent funding, moved up from a small center to one of the four special issue resource centers on domestic violence. So our FVPSA funds went on health and domestic violence, on the civil and criminal justice system, on child custody and child protection, and now one on domestic violence trauma and mental health.

So our mandate has expanded, so we have a lot of exciting work that we are doing. Part of what we have done, our last one was we had a multi-site capacity building initiative where we worked with seven states and one urban community, mostly through the domestic violence coalitions, and the other one was an organization called Transformation, to grow capacity to respond to domestic violence trauma.

And now substance abuse is in our portfolio. We just hired Patti Bland, who moved to Chicago. Kana has spoken to me about that. It was two years ago. We worked very closely with Stephanie Covington as a consultant and now we have Patti on the staff. Anyway, we will have a report coming out in the next couple of months on that.

Part of that work is partnering to build capacity, both at the state coalition level, and for all of their programs on the intersection of these issues, and to support them in partnering with their state mental health systems and substance abuse systems, and for

the programs to partner locally with mental health and substance abuse providers in their community.

A lot of the issues in rural areas come up, and particularly the lack of mental health services, and how to provide them. One of the states, Idaho, they had some supplemental funding from the FVPSA office, so it was an Doors to Safety program. They were able to hire mental health program at their DV program that depended on the funding. And then they were able to create a network of mental health counselors in the state to help support people responding to trauma and domestic violence.

In those states the domestic violence coalitions in some cases were able to play a leadership role in their state in bringing trauma and DV to their state mental health systems. So those partnerships are something we would really like to be able to foster, but from the mental health and substance abuse side as well as from the DV side.

Going forward, we are working with Alaska, New Mexico and Wisconsin, and working closely with the native coalitions as well as some of the Latino programs, and looking at some of the promotore models and some of the culturally specific adaptations in the native community.

There is a program in Espanola, New Mexico, called Tewa Women United, that is really integrated with some of the evidence-based, more science, trauma literature, with culturally specific approaches in their community, which is very exciting. So that is one way of working.

And the new FVPSA funding for state domestic violence coalitions, that is part of the Family Violence Prevention Services Act, that is a formula grant to the states. Now all 56 coalitions, states and territories have to take steps to become trauma

informed, and to survey their constituent programs and try to identify promising practices so we will be much more involved on a broader scale in doing that.

So that is one area of work. We are also starting a train the trainers program, so I am very interested in hearing more, Bobbie, from you, how you did that, to help figure out how to build capacity within states, both on training and actually being the people who are the consultants. So it not just doing trainings, but it is actually being the people who can provide the technical support.

The other areas that we are working on are, we have a stronger research mandate now. One of the things that we have just completed, it is called a focus working with the National Domestic Violence hotline on health coercion. We are just starting one on substance abuse coercion.

What happens is, when callers call the hotline, if they are not in an immediate crisis and they are willing to participate in a four-question survey at the end, they ask questions about does your partner call you crazy, does he do specifically, he or she, to drive you crazy, does he use any kind of mental health issues against you in terms of things that you want to do or custody or credibility in court. And have you ever sought help or treatment, and if you do, does he or she prevent you from accessing that or try to control it.

We will do a similar thing about substance abuse coercion. We just got the data -- it is very exciting -- to look at. We are thinking about implications for de-stigmatizing those issues for women, the implications for the legal system, when people have their legal cases jeopardized by mental health and substance abuse coercion, for mental health and substance abuse providers, to ask about how this plays out when you

are doing screening and to do safety planning around these issues as well as regular safety planning. That is one area that is exciting.

Another area that we are working on is trauma help. There is a lot of interest in trying to build an evidence base for doing trauma informed work in the context of domestic violence. There is not a lot of research. Most of the research is for women who are no longer under siege, who have been out of the relationship on an average of five years.

And so trying to work with the DV community, we are doing a formal literature review with one of our colleagues, Chris Sullivan, who is at Michigan State University, and trying to identify promising practices in the field.

And then over the next five years engage in a collaborative conversation and dialog to look at the models that exist, how would we adapt them to include issues around coercive control and safety, how to make them culturally relevant, and to start to develop some kinds of evaluation tools and to support programs and communities in beginning to evaluate things that emerge from this process.

And also we have a new website with lots of tools that we are excited about, that are both for survivors and for programs and for policy folks. And one of the things we really want to be able to do is to work with the mental health system and substance abuse system, to think about how to address these issues in the context of other trauma-related initiatives. I will stop there.

MS. ENOMOTO: Thank you, Carole. I know the work that you do is relevant nationally, and probably internationally. Because of our recency of our visit in the Pacific, it was a very consistent message that domestic violence is a major issue for

women. I think they are significantly challenged with regard to resources on how to handle it.

So the Supreme Court, just in Saipan, before we even sat down, they are like we need resources for domestic violence prevention and batterer's intervention. They don't have enough. They don't have access to the trainings and to the resources. As well as people -- they don't have money and they don't have people to do it. Across the five jurisdictions that we visited, it a major issue.

DR. WARSHAW: One of the other areas that we work on is child trauma and parenting, and one of the things that we are very excited about is, we have a curriculum for domestic violence advocates that was developed by Patricia Van Horn based on child-parent psychotherapy, that can be delivered by non-clinicians, that could be relevant to other people besides domestic violence advocates.

MS. ENOMOTO: So we are now at 10:15, to get our updates from Sharon from the Women's Coordinating Committee, about the SAMHSA Women's Conference which is coming up, which I think is going to be great.

Agenda Item: Updates from SAMHSA Women's Coordinating Committee and the SAMHSA Women's Conference

MS. AMATETTI: Thank you, Kana. It was very interesting to hear from everybody about the work that they are doing. Thank you for sharing that and hopefully we will have opportunities to talk some more.

First I wanted to tell you a little bit about what the SAMHSA Women's Coordinating Committee is doing, and to remind you this is a group that is internal to SAMHSA, it is all SAMHSA staff from all of our centers and offices, who come together

once a month really to share information about what we are doing relating to women and girls across prevention and mental health, addiction treatment. And to plan some things together as well as share information and build some collegial collaborations.

We have been engaged in a number of different meetings. First, let me tell you that there are some of my colleagues from the committee here, and I wanted to just point them out. Ruth Hertata Day(?)is here, and Jennifer Oppenheim is here, Sada Afahi(?), Mary McCann, Claudia Richards. Thank you all for coming down this morning. Linda White, my neighbor at CSAP also, and some other folks are hopefully going to be able to make it down for different parts of the day.

In December many of us attended a meeting, and Susan Salasin from CMHS was the chair for the Women and Trauma Federal Partners' Roundtable. It was the second in a series of meetings that she co-chairs with Carol Boyer from the Department of Labor.

Pam Hyde spoke, Kathryn Power spoke, Kana spoke on the program, as well as Vince Felitti, who is one of our colleagues here on this advisory committee. He provided the keynote address about the ACE study, and also how it relates to obesity and other issues that are women-specific health concerns. It was a really excellent meeting, just jam packed over a couple of days. And I think he gave us all a lot of food for thought. Carole, I believe you were there as well. Carole was there before she was an Advisory Committee member of ours.

And then in March, a couple of weeks ago, there was a meeting on the re-entry needs of women. It was a policy program sponsored by the Office on Women's Health. A former Advisory Committee member, Stephanie Covington, provided the keynote at that conference.

We are working here with the Office of Women's Health around Women's Health Week, which is an observance that they sponsor now yearly to coincide with Mother's Day, so it is the week of May 13th through May 18th. The motto this year is it's your time.

And our colleague, Sada Afahi, is helping us to put together a program here at SAMHSA which really will be more of an in service program for staff throughout the agency to become more familiar with all of the work that our SAMHSA Women's Coordinating Committee is involved in, as well as some other programs that are going on in the agency having to do with women's issues, women and girls.

And we are looking forward to hosting this as a tea, with a gender-y, feminine theme, for that week. And we are looking forward to putting that together and hopefully will get a lot of participation. So the other thing that our coordinating committee has been working hard on is the SAMHSA conference. And hopefully you all have gotten some e-mails about this.

I am going to pass around some cards for reference. But we are calling it the National Conference on Behavioral Health for Women and Girls. And some of you may have remembered our National Conference on Women, Addiction and Recovery. So we are expanding now, to be more inclusive of mental health and prevention as well as addiction issues. And this is really the branding for the conference for the future.

It is a national conference on behavioral health for women and girls. And the theme is going to be this year health, empowerment, resilience and recovery, or it's all about HERR. So health for H, empowerment, E, resilience, R, and recovery, R. And I want to shout out to Starleen Scott-Robbins for the wonderful suggestion about that

acronym, because that came from her in one of our planning meetings. So, it's all about HERR.

We have an active co-sponsor, Mental Health Systems is our co-sponsor this year, and they are in San Diego and the conference is going to be located near them. We have also a lot of our other organizational partners who are involved in planning meetings that we have had, Community Anti Drug Coalitions of America, or CADCA, National Health America, the National Council for Community Behavioral Health Care, the State Associations of Addiction Services, or SAAS, the Women's Services Network, which is part of the National Association of Alcohol and Drug Abuse Directors, NASADAD.

And also the NTN work with NASADAD, the Addiction Technology Transfer Centers, some of you know them as ATTCs, the FASD Center for Excellence, the CAPTs, which are the Collaborative for the Application of Prevention Technologies, and the Behavior Center for Trauma Informed Care has all been involved in the planning.

The process for the planning for this conference has been highly collaborative across prevention of the health and women's addiction. And I am proud to say that I think we have had more than 100 people involved in the planning of this conference so far, making recommendations for the program.

And I especially want to acknowledge Claudia Richards from CSAP, who has really worked very hard to bring more of an awareness around prevention to this conference. Because of Claudia's involvement I think it has really begun to be a very valuable conference for our prevention colleagues as well this time.

The primary speakers that we have secured to date include Kana Enomoto, Stephanie Covington, Gail Wyatt, Chic Dabby, Patrice Gaines, Rosalind Wiseman and

Sandy Bloom. We are going to have plenaries as well, many plenaries, our traditional workshops, and we will offer again this year teas or chats with experts in the field who will hold smaller group meetings with persons who sign up for these, to have the opportunity to speak with them.

And we are going to have invigorator sessions, short sessions which would be maybe one thing. We call it a session about one thing. Like if you have a curriculum, we might do one invigorator session, 40 minutes, and you hear about that curriculum.

We didn't do a call for workshops this year, but we took a different approach, because we really wanted to make sure we had a really high quality of the program. So what we did is, we created 11 different cluster groups, and they were around the eight strategic initiatives and then a couple additional areas. And we invited persons who were experts in the field to serve as co-chairs for those cluster groups.

So we had 11 cluster groups, which meant 22 co-chairs, so they were across different disciplines. And then those cluster chairs were invited to develop a committee to help inform recommendations to us about the content of the program. So a lot of people have been involved. I was amazed at the work, and people had to work very quickly and efficiently to turn this around so that we could get those invitations out.

Right now we have, I think, about 60 confirmed workshops, and others are coming together right now. So we are going to probably have around 80 different sessions, plus the plenary sessions, at the conference. Some of the sessions include Dr. Vince Felitti, who actually lives very close by to the conference venue. He is going to be talking about a study and he is also hosting a tea or a chat.

Carole Warshaw is going to be doing a session for us about the needs of women and families who have experienced domestic violence. Tomir Kane is talking

about peer-based trauma services. Charles Wilson from the Chadwick Center, which is also in San Diego, is talking about creating trauma informed services in child welfare.

Dr. Nancy Young is talking about recovery coaches in child welfare, Renie Anderson on building recovery communities. We have a panel of Semia Norrissey and Kathryn Leary from NIDA and from NIMH, doing a panel together. And we are probably also going to have a colleague from NIAAA working with them about research, having to do with women and behavioral health. And there are many more. As I said, we have about 60 right now already lined up.

We have identified some common threads across all of the sessions and all of the clusters. We will be addressing diversity, and recognizing the importance of peers and individuals in recovery in the program. And there are quite a good number of sessions that will be individuals in recovery and peers or consumers. So I am very pleased about that.

We have some other groups that will be meeting in advance of the conference -- CPPW grantees that Linda White Young oversees are going to have their grantee meeting in advance of the program. The Women's Addiction Services Leadership Institute will have their alumni, the alumni teams are coming in to meet as well. And also, the Women's Services Network from NASA, they will be there also.

In fact, we have something planned for that evening after the pre conferences, for all of them to be together in an informal way so that they can meet one another, those who don't know each other yet. So I think that is going to be a wonderful opportunity for them. And I hope maybe to have some other groups, like the FASD coordinators and trauma services coordinators from states possibly to come in, because some of those resources have been identified to help travel some of those folks.

So I hope you will all check out the conference website. It is on this little card that I passed out. This is one of the pieces that we are using to announce the conference. We have had e-blasts come out from SAMHSA. If you have signed up for information around women and girls you would have received that e-blast, so that people know that the conference is going on this summer.

Then afterwards, for people who can't come to the program, everything will be posted on our website, so that the conference, PowerPoints and program and everything will be up there, just as it has in the past. We have past conferences posted as well.

MS. BENAVENTE: When are the dates?

MS. AMATETTI: It is going to be July 17th through the 19th, in San Diego, California.

MS. WOOD: If I could call your attention to the last page of the tab Agenda, has a tentative conference schedule for your convenience. And I would also point out that there is a news release relating to health reform and the Affordable Care Act and women's health, and also some current legislation related to women's health issues.

MS. ENOMOTO: Thank you Geretta, thank you, Sharon. Did any of our partners from across the centers have any comments or updates that you wanted to add about your programs and what is going on?

MS. ENOMOTO: Thank you, Sharon. I really have to congratulate Sharon. She has done a fantastic job. You know, when she says she is happy to say that 100 people have been involved in planning a conference, you can only imagine the

learning muscles that she is developing, trying to get 100 people to plan a conference. That is a conference to plan a conference.

It is a phenomenal amount of organization, and vision, and I really appreciate, Sharon, that you had a vision for the Conference on Women, Addiction and Recovery, and you have been flexible to transform that to this conference, which is really doing a great job of representing the entire mission of SAMHSA.

Thank you very much to Sharon and to the group, the seven of you who are here, and the 93 others who are helping to plan this conference. It is going to be fantastic, so we will see what we can do to help facilitate some of the ATWS members attending. I think it will be a very, very rich educational experience for all of us. Now, that brings us to a break. Fifteen minutes.

(Brief recess)

Agenda Item: Behavioral Health and Middle School Age Girls: Facilitated Discussion of the Movie "Thirteen"

MS. WOOD: Okay, we will get started. I am going to turn it over to Sharon, to discuss the movie that we are going to view, a short clip. Do you want to make some introductory remarks, Sharon?

MS. AMATETTI: Thank you, yes, I do. In our joint advisory committee meeting we are going to be talking about behavioral health and school age youth. We wanted to use some time together to focus on the girls gender lens of this conversation. That is what we are going to be doing this morning.

It is sometimes difficult to talk abstractly, we thought, about an issue, so we wanted to pin it to something. We had the idea to send you this movie, which covers

a very broad range of issues that young women, young girls, deal with, having to do with peer pressure and family dynamics and parents' use of substances, and even just the larger community issues that are going on in the environment.

I also wanted to mention that the other day Dr. Clark sent out an email CSAP-wide having to do with that larger context of issues. I will read you his email. He says to us, the song below is number 14 on the Billboard Hot 100. I heard them on the radio and was surprised by the lyrics. The song is associated with a music video called Mac and Devin Go to High School, for those working with adolescents and young adults.

Johanna, maybe you know this song. I don't know what stations we all listen to, but I am going to read you some of the lyrics. For adults who are not tuned into the youth culture, it is shocking, and it is something that we don't realize is so prevalent. It was number 14 on the Billboard Hot 100 when he sent this out. I think it has since gotten higher on the Billboard. It's Wiz Khalifa lyrics. The song is Young, Wild and Free, and it is with Snoop Dogg and it features Bruno Mars.

And the hook goes like this: So what we get drunk, so what we smoke weed, we're just having fun, we don't care who sees. So what we go out, that's how it's supposed to be, loving young and wild and free. And then verse one is: So what I keep 'em rolled up, saggin' my pants, not caring what I show, keep it real with my -- a word I won't say -- keep it player for these hoes.

This is a very popular song referring to girls as hoes. So what we get drunk, so what we smoke weed. I went on and watched the YouTube video of it, very provocative, scantily-dressed girls and glorifying the men and the drug culture. This is the larger context in which young people are living every day.

And then there are all of the personal family things that are going on, and the peer pressure and the school pressures, and so it seems overwhelming sometimes, when you look at what we are up against. Dr. Clark said, what are your thoughts on this matter, essentially, and you almost want to go, oh my God, I don't know. Even though we are working in this field and this is our profession and this is the issues that we care about.

We are going to show the first beginning part of this video, just to kind of get you back into the mindset of what the issues were. I don't know how long ago you all watched it. Then we have asked our Advisory Committee members to help us lead a discussion about it. So Harriet Forman and Velma McBride Murry are going to help us with the discussion.

We have sent out some questions for you to think about. Hopefully it will lead us towards perhaps some ideas for SAMHSA about direction, and particularly also lead into our discussion with the Joint Advisory Committee on this conversation with a girl's gender link. Katie, if you want to start the video.

(Video is shown)

MS. FORMAN: This is Harriet Forman. I thought it was an excellent film, scary as hell, and excellent. It says here on this paper I am a retired preschool special education consultant, which I am. But back in the olden days I was Assistant Principal at a middle school for four years.

As a former school administrator, the school role in this just shocked me enormously. We didn't really see much about the school's response. All I could see was that there was no accountability to these kids at school, and that is what I found quite

amazing. And so the question is, what could the school have done better to deal, become a stronger positive influence in this case.

I frankly would feel this is Hollywood's take on schools, at least I hope. It is not my experience of schools, although schools are different all over. But just in terms of what the school could have done to be a more positive influence, I think that there has to be accountability for kids in schools. Kids have to be accountable for themselves.

The fact that the kids were not going to class, coming in late, is just clearly unacceptable. Schools really have to have clear guidelines for that. But at base it has to be clear to kids that school staff cares about them as individuals, that they are important. A friend of mine in vice work, a colleague in Milwaukee, he used to say, they don't care what you know until they know that you care.

And so the essential thing that I think is really important are the relationships. When kids get to middle school, they are taken away. Generally they go far away from where they were beforehand. They are at the most vulnerable time in their lives. So you take away supports that they are used to in a smaller school environment and put them in a huge school environment.

The parents are further away than they were when they were in lower schools. And it really is the school's responsibility to start building relationships with the families, relationships with the kids, and various school staff has responsibilities for that. There has to be a clear code of conduct and consequences for tardiness and rudeness and skipping class. That was amazing.

And I also think that at the classroom level there have to be those personal relationships built between the teachers and the students, including expectations. Good

teachers should be setting goals with their students for what they expect, and there needs to be mutual commitments.

And there has to be communication. I think the communication with the families is key, whatever ways that they can establish. At particularly the beginning of junior high, when the kids are just coming in, they are lost, they don't know how they are going to fit in. You see the young ones coming in the first year, you just see the eyes jumping out of their heads at what they are seeing.

They have to find a way to know themselves and know how to relate, and the vulnerabilities that young women face, coming into that middle school setting. You took a look at the gap in development. Many middle schools are sixth, seventh and eighth grade. And when you see, there is more variety in development in the middle school years than any other time in life.

You have boys who are four foot two and boys who are six foot, or boys who are five foot and girls who are approaching six foot. I was my full height in seventh grade. Back before I started shrinking, became the incredible shrinking woman, I was five eight and a half. I towered over my teachers and most of the boys.

And all of these hormones that are circulating, there are more changes going on with them physically, emotionally, intellectually. So they don't know what is going on with them. And so again, that makes them enormously vulnerable to whatever is going on around them as well.

My experience is that counseling staff are really, really important in helping kids make a transition to middle school and to finding ways of relating to adults and to other kids. So one of the things I think the schools can do is have counselor's visible, available, offering an ear for whatever kids are dealing with.

One of the things that concerned me in the film was quite late, I think. I have a little trouble keeping track which girl was which. It was Tracy's mom who was in -- what I found astounding was, so late in the film came Evie's reaching out to Tracy's mom, saying that she had been abused. I don't know if you remember that. And that seemed to be part of the impetus. And what we know about kids who are abused, some of these behaviors, aside from what seem like some abandonment of parents.

Was there any way for Evie's needs to be addressed at school? There certainly should have been. There should have been ways for her to reach out. As a middle school administrator, we had our counselors doing groups for kids for all kinds of reasons, where they could come and talk about any of the issues that they are facing.

As teachers got to know the kids, they would talk to the counselors, and the counselors would reach out to kids in very subtle ways. It is hard to know from a popular film what this school might have offered. It is not part of the story. But it definitely needs to be. It isn't all the school, but the school has to be working with the kids on other than academic issues, and it has to be working with families around all the issues that the kids are facing.

And really, the schools that are dealing with the myriad of issues that kids face need to be also collaborating. And we have heard people talking all day and often about the need for collaborating with other agencies, with other resources. And so within the school, when you see a pattern of children not attending, of behavioral issues, those teachers really need to have been documenting those things, meeting with the kids, early on, to say what is going on.

Because obviously these girls were really lost in finding their own way in a way that clearly wasn't healthy for them. So let me just stop now from that perspective.

DR. MURRY: If you had been in my office the day that I opened the envelope and saw these girls with studded tongues, I was a little bit taken aback. And the staff person that brought the envelope to me said, what is it? I said, it's a movie. I had never heard of the movie before.

And then when I began to watch the movie, I kept trying to make sure that I understood these were 13 year olds, junior high kids, that are being portrayed here. And it was pretty complex, is what my first reaction was. This is a really complex situation.

I immediately began to feel that whatever was happening with the inhalation of the aerosols, that these children were hurting. That was my first reaction. They are hurting and something is not quite right here. And then as the movie began to unfold, I began to think much more about the context, the early context of these children's development that then found itself manifested in a school context.

And so I began to revert back, wanting to know more about early prevention for these children. But realizing that much of the prevention work occurs when kids are much younger, and not in middle childhood. And so my thought was, if we look at family based approaches or community or school based approaches for helping children that is at this level of risk, that we aren't doing enough to design intervention strategies for that tertiary level of youth at risk.

Even the secondary level of intervention wouldn't have been enough. And so what we focus a lot is on this, the first level of primary prevention and then we address kids whom we think might be at risk in a larger context, with very little attention given to those kids that are like Evie and Tracy.

Even in almost any of the work that we have, except when they go into some type of institutional mental health setting to begin to help them. So I looked at this

in terms of what needs to happen to address this really complex situation that these girls are experiencing, and that they just highlight it, too, because there were many in the context of the film that were also at that level of risk, because they were engaging in drug use with other peers.

So that means more than just these two junior high girls were at risk. And their behavior was acting out in just an array of maladaptive behaviors -- risky sexual practices, tattooing, body piercing, skipping school, stealing. It was just an array of behaviors that probably is pretty reflective of kids who are at that level of risk.

So in thinking about the questions posed to us, I thought much more about a comprehensive approach that includes the family and the school and identifying ways to meet the needs of these children that are really hurting. I mean, they are hurting in many ways. So I was just in awe. And it is Hollywood. But I think at the same time it reflects the life of a lot of kids.

I will tell you a story that one of my graduate students shared with me on Friday. She said, I am working in a community center in Nashville that is designed to help children who are having major problems in school. These are kids that are at the fringe of dropping out of school. They are engaging in all kinds of risky behaviors. They care nothing about school. There is no school bonding, and no consequences for them by their family when they don’t go to school.

I said, but Nashville has a very strong truancy practice. She said, right, so they get written up, which oftentimes means that they are expelled. And it just falls right into the pattern that they want to see happen to them. So she said, we are left in awe of what to do about a group of kids that is living in this neighborhood that is very isolated.

And when she began to address the isolation, it reminded me of how I think about our rural families in terms of isolation. There are inner city kids living with their families in this very isolated community. And I asked her about drug trafficking and violence. She said there aren't a lot of drive by shootings and we don't have a lot of drug trafficking. But they don't care about school.

And why don't they care about school? She said, because they feel the schools don't care about them. And so we are at a time when school systems -- and Harriet mentioned this several times -- they are bombarded with a lot of state requirements. And many of the teachers' jobs are on the line to the extent that they are able to come up to the expectations around testing.

And the State of Tennessee is looking at a bill this week about grading teachers, for the purposes of them keeping their jobs. So I want all of this taken into the context of our thinking about what can schools do when schools are being required to do tests and testing. And then many of them say what you are asking us to do, should have been done by the parents. These kids, it's the parents' fault. It's the parents' fault, it's the school's fault.

So what I would like for our discussion to really center around as we look at these questions today, we know the complexity of the problem, we have a mother who is really having some boundary issues with her own children. It's almost like she wants to be a teenager herself and she would like to be her kids' friends and she is also dealing with substance problems herself. She does a lot of acting out, modeling for her daughter.

And there seem to be multiple partners in and out of the household, and so the girls have ineffective, or non-positive role models in the home. And then they go to school and the people that they gravitate toward are these early maturing girls who they

would like to look like and be like. And therefore, because of the stage of their development, which I think Harriet described a lot of the developmental issues that occur during these transitional periods, from elementary school to junior high.

So all of those developmental issues are occurring at the same time that these girls are couched in a very mal-adaptive context. And so in the midst of all of that, realizing that they are in a family that is not functioning well, that is probably not the place to expect them to get assistance. So the question is for the panel, what can schools do. And I will stop it at that place.

We can jump in at will. I think our telephone conference attendees are also on the phone. I am open to brainstorming. I think the goal would be for us to think about the movie and the discussion today, to begin to identify some ways in which we think SAMHSA might be useful in making some recommendations of addressing the issues that may emerge from our discussion today.

DR. BRISCOE: I was initially asked to run this discussion, but I don't work in the schools any more. I work with the adults, and I run a residential and several outpatient services for adults. So I was looking at it from the lens of looking at mom, because that is who I work with, moms.

And it is said that whenever you started your addiction is where you are developmentally. So if Mom started out at 14 or 12 using drugs, she is being like a 12 or 14 year old, and that is how she is parenting this child. So mom is modeling very poor boundaries from the beginning of the movie. Mom, you promised us that he wouldn't come back, and here he is.

And so she is modeling not only the poor boundaries but also the poor choices in who she is connecting with, and also who she is bringing into her home.

People just come in and out and in and out, and the daughter is saying, mom, you are just too nice.

There is nothing wrong with being nice, but having really strong boundaries so that then daughter can also have those kind of boundaries. So mom was doing the best she could. She was sober. But interestingly I had just read that announcement from SAMHSA talking about 7.5 million children live in a household with an addict. I think that is kind of conservative actually, but maybe it's just because that is the field that I work in and I think everybody is an addict of some sort or another.

So in that context, what kind of supports there were for mom, she would call her sponsor. But sponsor isn't a master trainer, or doesn't really know about how to deal with an adolescent. And so she is just kind of floundering and calls dad and says come get her, I can't deal with her. So yet more abandonment for this child, a series of patterns of abandonment and being left.

The school didn't play much of a role, but again, it's Hollywood and I don't know that they wanted to include that. Like you were saying the boundaries, people coming in late and no big deal or just go see the principal. So what I kept seeing over and over again were issues around boundaries, and mom not having those, modeling that.

DR. MURRY: I think we have the liberty of just assuming that the school might be able to play a role, even though we didn't see it, to identify ways in which it might be useful. One of the things that was very apparent to me is the increased flexibility that these children had to congregate. And so I think we can begin to design in our minds ways in which schools may have intervened, even though we didn't really see it, just some projections.

MS. AMATETTI: I just want to add something else by way of example. I don't work in schools, but I have two teenage children and one is still in high school. She is in a larger high school, and they have about 10 counselors, guidance counselors. But the role of the guidance counselor is to help them with their academics and to get them to the right classes and to make sure that they write their transcripts and send everything. So yes, it is mostly scheduling.

Something did happen when my daughter started at this high school, where she was very concerned about a friend of hers, not a close friend but a friend who she knew was having suicidal ideation and also cutting. And my daughter was very distraught about this. So I didn't tell her that I was going to do this, but I actually called the school and asked to alert them about this, and could they perhaps look after this child.

And their response was to call the girl out of class, to accuse her of cutting herself, and to call her mother in, who was pissed to get the call, and tell them that you have to voluntarily go to a mental health clinic if you would like to, this is just our legal responsibility. That was the therapeutic intervention that they provided.

I never told my daughter that I was the person who triggered this, because the girl was furious that somebody had called to out her. It was just bad all around. It had no positive effect, and that was the counseling role of the school. I think that is probably very real for a lot of schools that that is all they are prepared to do, given the huge amount of other things that they have to do, their core function.

MS. ROBBINS: This is Starleen. There are really effective school-based health programs that include mental health and substance abuse meaning and intervention, that are incorporated into the school. What struck me about the film -- and I think I have seen it before -- was mom is in early recovery.

And what an opportunity, while mom was in treatment -- I am hoping that treatment was in there somewhere for her. But if while mom was in treatment, it would have been a great opportunity to bring those kids into treatment with her and to treat that family, as opposed to just mom. Whether it had been prevention or actually for the daughter, for Tracy, it would have been prevention because she hadn't started using yet. And for the son, I wasn't quite sure whether he had been using all alone.

But I think that we talk about this chronic disease, and it is a family disease but we don't treat it like a family disease. We focus in on that individual and forget about all those people who are also impacted by the addiction and the process. And I think it is an opportunity that you allow someone, while a parent in particular, is in treatment, that we have the opportunity to bring that family in, all those people who are impacted by that addiction, into the treatment.

Also for the school based piece, I think there was just a lack of any kind of intervention at any level with the school. And I think they were pretty much be starting from scratch. It sounds like, Sharon, what you just talked about, the experience that you had, it sounds like they would have done exactly the same thing because no one was really thinking about how to help those kids, how to help them move forward and work through some of the issues that they were experiencing.

But there are interventions out there that can be done, but the school has to be committed and so does the community and the parents.

MS. FORMAN: Additionally, the school wasn't doing its most basic requirements. It seemed to me at the end there was a teacher who told Tracy that she could be held back. Well you don't tell a child three-quarters of the way in the year that they could be held back if they don't turn their assignments in. That is something that

should have been talked to that kid about in the way beginning. So sadly, that does sound like it's really a grievous failure on the part of the school.

MS. BERGAN: I think pointing out that this was a Hollywood film is beneficial. So in this film the girls portrayed many, many risks to many different people. There were neighbors, there were a community, there were family, there were school, that could have said, oh, that's a trigger, we should identify if there were a problem.

And the dad kind of saying could someone just tell me what is wrong, I think sums up the movie. Yes, there are so many things wrong that we can't tell you. So this is Hollywood saying these are all the things happening. This movie came out when I was in high school and we all watched it and laughed and said that's so funny.

So in a way this is a young people's role model. A new movie came out with hot girls on the front cover and it is rated R, so mom is probably going to say no. Let's watch it. And so this is an example of what we want to -- it can be so easy to skip class, so let's try it. So in a way, that is really hard to watch. So taking it back and seeing how that would play day to day, at least I felt and my peers felt that we were a lot better at hiding our behaviors from everyone. We would not be so blatant.

So if you steal the clothing, great, well you keep it better hidden and you change on the way to school, and you assume and know that teacher is not going to tell mom, and the neighbor is not going to rat out on you anyway. So I think that taking a step back from the movie aspect of this and staying in the reality, that you would need better communication between the community, between the parents and between the teachers.

So the teachers might notice a gradual slipping of someone who has never turned in an assignment late, who has been getting As, within four weeks of, okay, we

have missed some things, she has been late, she has never, ever been late, let's have a conversation. And that might have helped mom connect, oh yes, I have been noticing longer times in her room. I have been noticing that she has been missing curfew.

Because it doesn't necessarily all happen like it played out in the movie for us. So how early could that be identified, and that communication strand be opened. And the other thing that is not in this movie, because it was made in 2003, is the avid use of cell phones and texting and social media. And that so much of this would be played out on the computer and on our cell phones now, making it even further steps removed from teacher's eyes and mom's eyes.

So in the conversation what do schools do, do they track their students on Facebook and on their blogs to identify them for suicidal risks, for cutting. Because most of our young people are putting that out there very openly because they haven't learned that they shouldn't. So do schools have a role to track what their students are doing on the internet, and are they allowed to use cell phones, and what are those policies. More things to think about in that conversation with schools.

MS. ENOMOTO: A question I was posing back to the group, but Yolanda in particular, is what do you see could be the role of peers? I think even if you had a conference with the mom, either mom, Evie's guardian or Tracy's mom, they were lost. So how could we engage peers to help in that because those girls are already not listening to their moms.

MS. BERGAN: Peers want to help. And we know from our friends based on posts and from their blog posts and from their text messages if there is something wrong. Like Sharon's daughter experienced, what happens to our friendship if we tell,

and who do we tell that is not going to do exactly what the school guidance counselor did, which was not helpful.

So the barrier, and we will have to go back and check where this research is, but there is some research in the state, northwest Minnesota, on text message hotline. So can you text, instead of calling because they don't want to share verbally, if you are sitting next to your friend who is cutting, or you have been cutting, can you have a text message conversation with a support who you don't know except whatever their chat name is? And that sounded really hopeful to me, and that is a community partner, another person in this mix that hasn't been in this conversation.

DR. WARSHAW: I am thinking that the National Domestic Violence hotline has a teen hotline. They do texting. And I am thinking there is a lot of teen dating violence prevention programs, which they rely a lot on peers and social media and doing work in the schools and having peer to peer works. It might be worth looking at that whole arena and seeing the strategies and to start to incorporate all of these kinds of issues together around healthy relationships and how to approach that.

I am also thinking about, like the child-parent psychotherapy model for moms and young kids, it is really helping mothers understand their own responses to their kids and what gets in the way, around violence, and what the kids are bringing up. So there may be models like that for working with older kids, and thinking about that approach, not just for violence but around these other issues as well.

MS. BERGAN: The teen dating education in the schools for the domestic violence is probably one of the strongest models that exists already in schools across the country. And I feel like if I go back to what education actually happened, domestic violence and teen dating are probably the only -- a little bit of sex ed, but that is kind of

out of the door now in most schools. So those services are getting into the schools, which is a barrier for a lot of services. How do you even get into a school that has limitations on who can speak to their children, or could that model be public.

DR. MURRY: One of the approaches I was thinking about is, teachers do in service training at the beginning of the school year. That would be an incredibly great opportunity to begin to alert them about how to prepare for the first critical six weeks, month, of these children entering into middle school, and elevate their awareness of what they may be dealing with, and then increase their awareness of triggers that they need to be thoughtful about, if you see these certain kinds of things happening. And then a mechanism of addressing them.

It can occur at a school, whatever, the general assembly. There are many opportunities at the beginning of the school year where you can go through some type of preparatory activities with the kids, with the teachers, and with the parents and the initial PTO. Now everyone doesn't maybe go to PTO meetings, but we have social media, and we have rotary phone calls. That happens.

My sister said her daughter was in the rest room between classes and they immediately contacted her and said Leona isn't in her class. So she gets this call on her cell phone and she immediately says okay, what's going on here. But the school system has a monitoring system where they know immediately where all the kids are when they don't report in class.

And so there are ways, I think, at the beginning of the school year, to begin to set up structures to help navigate. One of the questions, the very critical beginning stages of the school year, there are things that people can do.

DR. WARSHAW: I am thinking about training people to do screening and assessment for domestic violence, that people need to know what to look for, what to ask, and then what to do, otherwise it is hard to raise the issue. And so having some of that guidance, or noticing things, and then having something in place where the guidance counselors can be more responsive, or that people have some training on how to respond.

I am also thinking, maybe even with the kids, something like this but maybe a different version of a video, but that can be a critical conversation, where you do the kind of critical media analysis with kids to be able to look at media, and then have some kind of critical thinking about it, and about peer pressure, and about drug and alcohol use.

There is also an article that came in my email today about caring teachers may help kids from trying alcohol and drugs. There is some data that when teachers were supportive, when kids could actually have a close relationship with them or with their mothers, then they were less likely to use. Kids with separation anxiety from their parents were less likely to try risky, experimental kinds of activities.

The other thing I was thinking about was, there is that kind of peer pressure and risk that happens when you are a teenager and have a little more separation from your parents. So it is how you help kids come back from that, or how to experiment but not have it lead them down a path that is going to put them on a whole different trajectory, and so to be able to talk about that or how to do the secondary kind of intervention.

DR. MURRY: One great thing about middle school is that kids are still at malleable developmental stages, where you really can make a difference. And so it is critical, if you are going to be protective or try to intervene, to intervene during that

developmental period. And in addition to the other constituents that we mentioned, like teachers and parents and peers, a colleague of mine did a county-wide suicidal awareness program in a county in Georgia that was experiencing, Cobb County, high levels of suicidal problems with their children.

He and his colleagues developed an intervention or a prevention that educated every person that had contact with the child, from the custodian, the bus driver, people in the cafeteria, to the teachers, to the parents. And this suicidal awareness, suicidal behavior drastically decreased in these counties.

So he was saying you need a much more systematic approach that includes the person mopping the floor, if they were in the restroom and saw a kid engaging in certain kinds of behaviors, they immediately knew what to look for, and then also what to do. So there was a system of reporting. And it seems to me that a model like that would be useful in middle school to address a lot of the things that we saw here.

MS. BERGAN: I was thinking about mental health first aid training, providing school staff and teachers a language to use, a checklist to go through, do I see any of these 10 behaviors and here is how I would verbalize this to another colleague or to a supervisor. Because if you were just a concerned person coming, what language do you use to not cause hysteria, but you don't want to under dramatize -- so giving someone a framework of a language to use, I think could be helpful.

And so in the first three days of middle school, do you go through training? Do you go through all school assemblies saying please look at your peers, do you identify these risks? And if you do, where do you go.

MS. ENOMOTO: Was someone on the phone trying to jump in?

MS. BENAVENTE: Yes, this is Bobbie. I wanted to share a couple of initiatives that were implemented in the Guam public and private schools. One was for support groups like our teens, meetings to be conducted on campus for high school students who were dealing with addiction in families, and also with their drug use. And also some programs, one in particular called (?) for our children, where school personnel, adults, whether they be cafeteria workers or school monitors, were trained in helping young people, elementary and middle school, to deal with loss.

And loss is defined as anything that hurts the child, that the child expresses as a loss, whether it be a death in the family or the family going through a divorce, or someone leaving the island to relocate somewhere else, that kind of thing. And it was an early catch to recognizing and observing the impact of loss as the child expresses it in whatever ways, for which trained people could address almost immediately. And then to involve their family members.

And also in the middle and high schools, particularly in the public schools of Guam, there is a program called enasa malik(?), which means to make good, to come together to make good. It is a peer mediation conflict resolution program where the middle school and high school students are trained as mediators.

And that has been really effective, to get ahead of a conflict that kids hear is starting to brew. Kids, their radar is up and running far quicker than the adults in a school setting. So they know what's up and they know when trouble may be starting, or when any rumor has begun, or when there is the start of bullying and harassment. And so there are trained students with the support that they made as adults would help with that kind of conflict resolution process.

MS. ENOMOTO: Thanks, Bobbie. What I am hearing, it sounds like there are -- Harriet, you were noting that there is some sort of basic chaos or disintegration of structure in the school that is portrayed. I think Nicky Reed, the girl that pays Evie, is the co screen writer of the film, so when she was 13 or 14 she helped write this story.

It is, I think, meant to be told so much from the young person's perspective, which means whether or not the school was really involved, that is how they are experiencing it. But that being said, I do think there was a teacher who came in and said you wrote one of the most brilliant things that I have ever read. And I do think that contributed to Tracy turning things around.

And Tracy turned things around after four months. So it was sort of a four month venture into bad behavior and hopefully a four month venture out of it and into recovery. There are different issues people have mentioned. So whether it is training around suicide or dating violence or general mental health, first aid, which is behavioral health literacy, the substance abuse, parents in recovery.

I think what I hear, because the schools are already overloaded, and as you mentioned, the pressure on testing to survive for the teachers themselves, the probability of us getting a lot more air time is not great. But you could weave it almost all together into a social-emotional context, that we need to just work with the educational system to understand the role of social-emotional health in the academic success of kids.

So it's not just for the sake of meeting our mission, but for meeting their mission as well. That in order for kids to matriculate successfully, in order for them to move on in their lives, they need that foundation of social-emotional health, but in themselves, in the school community and in the community at large and in their homes.

And how do we help? I think it is very easy for educators to say look, that's not my job. I was trained, I'm a math teacher, I'm a science teacher, I'm an English teacher. That's their parents' job, and I think we have to maybe try to -- I think a lot of schools are aware of this, that we are in a different place now with the role of education.

Education is part of the community, the community is part of the school. And so we need to be working together to foster the healthy environment for the kids. It is not just one thing.

DR. WARSHAW: I was thinking, Kana, when you were saying that about weaving it in, you were talking about in the literature you could talk about social-emotional health and how that comes up. Or in science, there is a lot of stuff now I have seen on line about the brain for young kids, how to make sense of that, and how to understand trauma, and how to understand how your effective woven into science.

So maybe guidelines for teachers on how to weave some of this in, as well as noticing when things come up for kids and what to do about them. So it's not just in their social-emotional health class, or phys ed.

MS. ENOMOTO: We should also watch Race to Nowhere. I don't know if any of you saw that but it is a documentary about the incredible pressure on schools to test kids and provide a lot of homework, and the lack of flexibility that a lot of teachers are experiencing in terms of adapting their classroom curriculum.

DR. WARSHAW: What about on line stuff for kids? And apps and things. They are ways to --

MS. ENOMOTO: Yes, I know.

DR. WARSHAW: Or other venues.

MS. ENOMOTO: How to capture even the online attention of children, I think, is a question that many people with great more money than us would like to know as well.

DR. WARSHAW: IDVAAC, The Institute on Domestic Violence in the African American Community, commissioned some songs, some rap songs that were very pro anti domestic violence and pro healthy relationships, that got some play. So there is that way of engaging people, too.

MS. ENOMOTO: We have been in some conversations around -- it's a youth population, not necessarily an engaged in school population. The active duty guard reserve young men that are sort of the young, invincible group of 18 to 25 year olds who are also at high risk for binge drinking and suicide and violence.

I think many folks who care about those populations are also up against a tremendous prejudice and discrimination around addressing behavioral health issues. Both institutional, like if you have one of these problems and you get kicked out, as well as just cultural. And so there are organizations like Major League Baseball, NASCAR, Home Depot, there are a lot of video games, energy drinks, sort of macho sports, Monster Truck.

How do we use those venues that they are interested in, and the technologies that are reaching people, and then translate messages that would actually resonate and not be blown off?

MS. BERGAN: I wonder if there is a role for SAMHSA to provide a language or an example of -- I will share this story with everyone. I was in college and our floor had some drinking problems, and there had been many citations for various

rooms. And our Residence Assistant got us all together for a little meeting, and she did a demonstration, and she had us take a martini glass and a beer glass and a shot glass.

She had the girls pour water in each of those, to show serving levels. So what really is one shot, what is a serving of beer, what is a serving of wine. I remember coming out of that, and we walked into the hallway and we all looked at each other, and we are like, dude, our tolerance level is so high. I thought I only had three shots last night and I really had nine.

And that's what we learned from that. And we were so proud, and we would talk. When we were at bars we were like, I wonder how many real shots. All of a sudden, that language, and what is an acceptable amount for drinking Anyway, we were going on our own, we were measuring things and thinking we're not bingeing, and then we thought we were, and we were happy about it.

And so I always want to have a cautionary message. When educating, is there support for that education going the completely wrong direction. There has been a lot of experience with sharing too much information about drug use, and the reactions to youth actually increase the desire to try them. But in any kind of education that we provide, can there be some support for that rebound effect. Just a cautionary idea.

PARTICIPANT: Involving youth in developing --

MS. BERGAN: Yes, that would be helpful. So if we say cool and our eyes light up, maybe we should have a different context for that message.

MS. AMATETTI: I just want to welcome Norma Finkelstein who has joined us and who is going to be speaking with us this afternoon on a topic that -- I know we are talking about things that Nora cares deeply about and has a lot of knowledge. Feel free to jump in, Norma, if you want to, to the conversation.

MS. FORMAN: I just want to put in a shout out for schools, though, because I know that at middle school there is a knowledge of the things, the developmental stages of the kids. And there is an emphasis on trying to set up groups, support groups for kids, student assistance programs, mentoring programs.

I think by and large middle school staff, it is so hard to teach at that level that people who choose to teach at that level have a lot of dedication to those kids and what they are going through. While schools really are asked to do an impossible task any more, I don't want to give the impression that they are not willing warriors in trying to meet the needs of those young adolescents.

DR. WARSHAW: I am just wondering about schools holding things for parents. They have conferences and various things around some of these issues that parents could think about collectively with some guidance and training and some connections with the schools, and informational materials about how to think about, how to respond, how to notice.

I was thinking about the mom in this movie. If she was more aware of some of the ways her behavior was affecting Tracy, because she obviously cared very much and had some supports to think about it differently, she probably would have.

MS. FORMAN: The only problem is, it's very hard to get parents in, at middle and high school. It is a major challenge for middle level educators.

DR. MURRY: Again, I think it is a way to think about -- I am really glad Johanna is part of the panel as a techie, and a newbie, this young spirit. But social media, it is amazing how many of even our rural families, we can reach them by texting and Facebook. So that is a medium whereby we can do some educating. Even though it is

not in person, we can really think about social media as a way of bridging parents and schools in the context of children's development.

MS. BERGAN: And it is less expensive. I have been intrigued at least in my neck of the woods, about the social media kind of ads for safe homes. So parents, can you make your homes safe, alcohol free or alcohol stored appropriately and prescription drugs stored appropriately. I have been pleased about the conversations that I have heard, when we do classic billboards.

The schools now have text messaging set up, so if something happens, if there is important information, it goes out via text message, and anyone can sign up for those. So could we add an additional kind of education component to those news blasts, and parents don't come to events.

So then sports and extra curricula's. I am sure that Bobbie is asleep. I hope Bobbie is asleep, but she had talked earlier about having young people identify mentors in the community. And I am just wondering how frequently those mentors are teachers or coaches, and if they are, if young people are identifying their mentors as people in the school system, could we then support those kind of chosen mentorees.

And thinking about the NFL and NHL and the NBA, about their power of influence, and could the media and the advertising that come with them kind of trickle down to middle school and high school sports activities. And just how we see Pepsi or Coke in our schools, could they have an add on to behavioral messaging with them.

So every time you see a Pepsi sign, you see this in a school gymnasium. We would probably get more interactions at school concession stands than we do at booths that come to share information. So can that message go hand in hand with something that is already happening.

DR. BRISCOE: I wanted to ask how people are engaging the families. That is my big thing right now, because you are working with the entire family, and how do you get them to come to the school. In the newspaper I bought on Sunday in Santa Fe, New Mexico, there were three middle schools and two of the middle schools do not have PTAs.

So how do you engage them to be part of -- because just like this mother, you know she loves her kid. She just doesn't have the skill. She doesn't know how to be with her daughter other than what she has been doing. And so how do you engage the family to come in to get treatment, and not just the young girl?

Because if there was a teacher who was telling her, are you sure that's the person you need to be hanging out with? And then she goes to Mom who is, is that the person you should be hanging out with?

PARTICIPANT: She's saying that to mom.

DR. BRISCOE: Right, she is telling that to mom. So are there any programs out there that engage mom in this situation, or dad, or whoever is a caretaker, to be part of this education?

DR. FINKELSTEIN: From my vantage point in Massachusetts, it is not necessarily a school. We do have a CSAP high risk use prevention program in the Dorchester-Roxbury area of Massachusetts. Grove Hall, which is actually the area in the Boston which has the highest rates of violence. And we have tried, and we have a number of other programs for adolescents as well as transition-age youth.

We have tried really, really hard to get parents to come in. I can't say we have been successful in any group format. I think where we have been more successful has been if we have set up something for the parents, not around their kids, but support

for parents, whether it is kind of a stress group or yoga group, just something that is not talking to them about their kids but helping, giving them support.

Schools can do that. We are not a school so we have had programs that are able to do that because we are adding onto what the school can do. And the other thing, I think, the only way we have really reached parents, we have had a couple of CSAP, using the evidence based practice, which is somewhat family focused, to engage parents and children and adolescents as well as transition aged youth in kind of a structured format.

And I would say about a third of the time we get parents to actually agree to come and sit down and do two or three sessions together with their kids. But where we have been more successful is going to the homes and meeting parents at the home, and engaging them there. I don't think that is realistic, really, necessarily for school days.

Again, I am speaking as having additional resources. But when we have worked with parents in their home, sometimes with their children, sometimes separate, again, in some of these programs the kids are in trouble so they disappear. But we stay in touch with the families. We have done some very good work with families and parents in that way, but it has been very assertive outreach, going to where they are.

DR. MURRY: We don't work in the schools. Our work is in the community centers. And that includes churches and Boys and Girls Clubs. Many of our parents have not had very good relationships with schools, and their children go to school out of the community where they live. And so there is a lack of sense of connectedness with the schools where their children are in school. And they come, 66 percent of them come to five or more of our seven sessions.

But it takes them realizing that whatever we are presenting there, is a sense of relatedness to it.

MS. AMATETTI: I want to thank everybody for really thoughtful comments and insights about this issue. We will continue the theme later this afternoon when we discuss with Norma and also over the next couple of days. This is just sort of the beginning. I thank everybody, and we will take a one-hour lunch break.

(Whereupon, a luncheon recess was taken.)

AFTERNOON SESSION

MS. WOOD: If everyone is back, I would like to call the meeting to order, and I would like to also remind you that in your briefing books is the reimbursement forms, and we would appreciate getting those within five days of your travel, so that we can get you reimbursed in a timely fashion.

MS. ENOMOTO: We have Starleen on the phone. Bobbie has gone to bed, I hope, or has moved onto other things, at least, at 2:00 in the morning. And we have joining us Administrator Hyde to say a few words.

MS. HYDE: Hello. Thank you for being here. As I said to the other two committees I went to this morning, I really appreciate the gift of your time. I know that is what you are giving us. Your advice and your counsel is important to us, and it stimulates our thinking. You may not always see the direct connection between these meetings and what we end up doing.

But believe me, it is very important and we talk about it, and we noodle on it and think about it and think about ways to use it in our work. So I really appreciate it, and I know your time is valuable, so I wanted to thank you for that. And also, just to say this is a historic week. Last week was a historic two-year anniversary of the Affordable Care Act, and this week is probably one of the most historic arguments in front of the Supreme Court in our nation's last 50 years. So the people involved in it, as you might imagine, are fairly wrapped up in it, and it is a pretty big deal, and it has been in all the newspapers and radios.

If you have heard anything about that, you know all the pundits are imagining all kinds of things, and gosh knows what will happen. But we do expect results by the end of June or the first of July. So anyway, that is going on this week and

we are looking forward to the rest of the conversations today and tomorrow with all the Council members. There is a lot of good stuff coming up.

I don't want to spend a lot of time talking to you. I am listening here. I am just going to be here until a few minutes before two, and then I will see you tomorrow. If there is anything you want from me, specifically, now is a good time.

MS. ENOMOTO: We have five members that you already know and have met before -- Dr. Carole Warshaw is joining us. She is a national leader in the area of domestic violence, and women and mental health and substance abuse. We are very, very lucky to have Carole joining us.

The way we have it set up is, there is a 30 minute presentation from Norma, sort of soup to nuts, on engaging the issues of, and how to engage and treat adolescent girls. Norma, for those of you who don't know, is a very good friend, a long time friend. She is another one of my early mentors.

She was one of the chairs of the Women, Co-Occurring Disorders and Violence steering committee back in the day, and has been a champion of gender specific services and trauma informed care for many years. I think pretty much I have seen her at every one of our SAMHSA grantee meetings -- re-entry, PPW, NITSI, homelessness. You name it, Norma has got it. She is a very effective leader and provider for women's services and for services in general. Thank you, Norma, for your presentation.

Agenda Item: Barriers to Treatment and Engaging Adolescent Girls in Behavioral Health Services

DR. FINKELSTEIN: Thank you. Welcome. I am glad to be here. I had to listen to a little bit of your discussion the end of the morning. I am going to be talking

a little bit about a population of girls who are already in trouble with alcohol and drugs as well as mental health issues and violence, of course. The issue I was asked to talk about is, how we can engage adolescent girls in behavioral health treatment.

So although these dates seem dated, this research is still pretty much what's out there on adolescent girls. And so I thought I would do a little theoretical background, and then Sharon asked me to talk more about what is happening in Massachusetts and what we have been able to do about engaging girls in behavioral health treatment. We know that the research on gender inequality, we were just talking at lunch about back in the fifties. With some of the stuff that's going on, that is what it feels like.

Certainly with gender inequality we still have lots of issues, different expectations for girls and boys, still girls expected to not be angry, not be assertive, to value appearance. And the main thing we know is that the issues for girls is left out a lot. It is pretty much left out of substance use research and literature.

And the whole issue of girls of color, which I am going to talk about because it is the population that we work a lot with in Boston as well as the Springfield area. They are often even more stereotyped as being promiscuous and are angry.

I have been basing my work for many, many years, most of my writing in the seventies and eighties was around the relational cultural model that I am sure most of you are familiar with from the Stone Center at Wellesley College, and looking at that theoretical model and how it intersects with what we know about substance use and abuse, and the development of behavioral health issues.

So essentially what that model says is, it stresses the importance of connections, that girls' and women's sense of self is organized around making and

maintaining affiliations. I think later this morning when I came in you were talking about the importance of relationships and connections.

And so this model stresses the development -- if that went through a connection, not through a kind of separation, individuation, but how important connections and relationships are to psychological health and growth for girls and women.

The flip side of connections are what the Stone Center has labeled disconnections and what we all talk about as non-mutual or abusive relationships. And this occurs in many ways when the surrounding relational context is unresponsive. And again, thinking about the discussion that I heard some of this morning around schools, so many schools, the relational context is not responsive. It is not a nurturing, responsive environment.

The extreme form of disconnection we know plays a central role in the development of behavioral health issue, is sexual abuse, incest and violence. And talking a little bit about adolescents, around the whole issue of relationships and disconnections, the work of Carol Gilligan, Janie Ward, the people who have done some really, really great work in this area.

And what they talk about is adolescence as a time of what they call relational impasse or crisis, and that girls are responding, reacting to destructive forms of relationships by developing less direct ways of relating. So that means that they are silencing themselves as a way of maintaining relationships.

So we see this of course a lot with adolescent girls. We know that girls and women develop substance use problems often because they are in a relationship with a primary person, often it is a man, it might be also another woman. But they move into

alcohol and drugs and sometimes destructive relationships, through their wanting so much to make a relationship work.

Janie Ward talks about them taking themselves out of relationships, really not having authentic relationships but taking themselves out of relationship for the sake of what they think is maintaining the relationship. And what we see is a change also -- again, Carol Gilligan talks about losing voice.

I was in Baltimore at the re-entry meeting. I have two granddaughters in the Virginia area. They are only six and eight, but my eight year old granddaughter seems to me so much like a pre-teen already. It is kind of amazing. I just look at her and I think, oh my God, she is like a teenager. And I see her as what the Stone Center and Carol Gilligan talk about, it's being very active, very direct, confident, sure of herself.

But I see a little bit already of this kind of -- not silencing, but kind of paying a lot of attention to what other people think of her, and if they agree, or if they kind of accept what she is saying. And so a lot of this people talk about.

In adolescents, this particularly happens to girls. They begin to kind of, quote, lose their voice or their authentic voice. They may be speaking or talking, but they are not really sharing who they are. And they are not sharing who they are in connection with others.

This is a quote from a Brown and Gilligan book: Really, a lot of times I am just so worried and nervous about anything in general. And people are just like, why don't you just do it, who cares? And then I feel like, well, I can't go against what I am thinking because that is not what I think. But then I don't want to sound like I am some worried person, someone who has got to always be all perfect. They don't think that.

But I just don't want it to sound, I don't know, in that situation, I feel like they probably think I'm weird. I'm almost too paranoid.

So I think that illustrates some of that. There is the whole issue of trying to be the perfect girl, not to show any anger, it's not acceptable for girls still to show anger or else they get labeled as kind of an angry person. This is particularly true for girls of color, just like the issues that we know about men of color, and we are now dealing with a pretty horrific, horrible situation that happened in Florida, with this kind of not showing authentic self.

So girls of color, coping with silencing, is based not only on their gender but also on race and ethnicity. This comes from Bell Hooks: To make my voice I had to speak, to hear myself talk. And talk I did, darting in and out of grown folks' conversations and dialogues, answering questions that were not directed at me, asking questions, making speeches.

Needless to say, the punishments for these acts of speech seemed endless. They were intended to silence me, the child, and more particularly the girl child. Had I been a boy, they might have encouraged me to speak, believing that I might someday be called to preach. There was no calling for talking girls, no legitimized reward for speech.

So girls, again, going back to the relational model, girls need for connection, for fear of disconnection, for fear of losing a relationship and losing an effective voice puts them at high risk for all we know, including substance abuse, including depression and suicide attempts, and certainly trauma. And here is an example that I just talked about, the fear of losing a boyfriend if they refuse to join in alcohol or drug use. We hear that a lot from girls. Again, it is needing to do what the boy is doing

or the man is doing, in order to stay in relationship. So it is continuing to use alcohol and drugs with the partner.

We also know that since relationships and connections are so important, we know that strong feelings of connection are a protection-resiliency factor. And that can be with parents, with teachers, as we talked about earlier, with counselors, with family members. There is a lot of research in resilience that says, one strong person in a youth's life can make an enormous difference.

And that includes for girls, really authentic relationships, again, not silencing themselves but being able to be, quote, real in a relationship with an adult woman. So there is some research that shows that an authentic relationship with an adult woman can be the best protection against disconnection and psychological distress.

There was a study called an understanding adolescence study which showed the same thing, that for at risk girls there was a relationship between whether they felt they were authentic in a relationship, that they could speak clearly, and psychological health and good outcomes.

And finally, Teresa Bernardez has identified three critical areas in working with girls. This kind of mirrors some of what you were all talking about earlier. One was, again, mutuality and responsiveness in interaction, basically being able to have mutual relationships and authentic relationships, and people responding to who you are, listening to who you are.

Knowledge of girls' experiences and listening for what she calls healthy resistance, acknowledging and valuing girls' lives as an oppressed group, and acknowledging the strength of resistance, and what she calls healthy resistance, which is the capacity to resist disease process.

You know, in the behavioral health field we often have historically used the word resistance in a very negative term. They are resisting treatment, or they are treatment resistant. I try never to use that because I think it is really the system that is not serving the person, not the person who is resisting.

But this is an issue of reframing resistance as a strength, a mark of courage, that girls are resisting inauthentic relationships, resisting disconnection from their own experiencing, resisting basically people who are not accepting them for who they authentically are. And Jamie Ward talks about this particularly for girls of color. She calls it resistance for liberation, empowering through truth telling, a confirmation of positive self concepts, strengthening connections to a broader African-American community.

A lot of these pictures that you see here are of our girls -- we have a project at CSAP, HIV minority, HIV substance abuse prevention program in the Grove Hall area of Boston. And we are working with middle school and high school girls doing some very exciting work, I think.

And then she talks about listening with a third ear. And that is just essentially basically listening, listening to what was lost, what wasn't said, what was suppressed, what doesn't fit in with traditional ways of looking.

And finally a quote from Brown and Gilligan: For girls coming of age in this culture at this time, adolescence marks a potential point of departure from life experience. Because adolescence is a time when a variety of perspectives can be held and coordinated, a time when the hypothetical and the abstract can be entertained, girls risk losing touch with the specific—with their bodies, with their feelings, with their relationships, with their experience.

And thus they are in danger of losing their ability to distinguish what is true from what is said to be true, what feels loving from what is said to be love, what feels real from what is said to be reality. Consequently, at a time of heightened physical and psychological risks in relationships, girls becoming young women are in danger of losing their ability to know the difference between true and false relationships.

Of course, those of us in the treatment field see this all the time in girls and in women. So I am going to talk then a little bit more, to kind of a little bit what we have been doing in Massachusetts to try to make the Massachusetts adolescent treatment system more gender responsive.

In 2005, a new office was created in the Bureau of Substance Abuse Services, which in Massachusetts is under the Department of Public Health, called the Office of Youth and Young Adult Services. And that office began to look at a re-design of the youth system. So prior to 2005, our bureau funded six youth residential programs. They were all for boys.

There was really basically minimal capacity for females. There was one co-ed program that had up to five female beds, and there was an adult, women's residential program which also took some adolescent girls. But essentially there was no specialized, by 2005 none of the residential programs were specifically just for adolescent girls, and of course they followed all a male and adult model of care. Then the girls, as traditionally happens, were primarily in the mental health system.

And so what happened in Massachusetts, there was the establishment of something called the Interagency Working Group, or the IWG. Basically this is a state interagency group made up of all the kind of state departments -- the Department of Mental Health, the Department of Youth Services, the Bureau of Substance Abuse

Services, Maternal and Child Health, the Department of Children and Families, including our Executive Office of Health and Human Services -- all of the major human service agencies.

I don't think at that point -- well DOC wasn't involved, but DYS was, which is really where our youth go who are in trouble with the law. And so basically what they established then, the recommendations they started to make were, there would be a standardized screening instrument, which was the CRAFFT, down at Children's Hospital in Boston.

They decided to use the GAIN as the assessment tool and wanted to base all of what they were doing on evidence-based models of care, and wanted to make sure that any programs were capable of doing co-occurring disorders that were trauma informed. Supposedly gender, racially and culturally sensitive programming, a family systems perspective, and community based after care coordination.

Now, I need to say this was the ideal. We don't have this anywhere near yet. We have some great stuff that has happened. But I can't say that we have done as much work as we need to do in families. And certainly the community-based after care coordination has not really been implemented.

So here is kind of the continuance as it was added. The first thing that was added were licensed outpatient substance abuse programs specifically for adolescents. And then what was added in 2005 was something called Central Intake & Care Coordination. That is how we got involved, because we are, IHR is the Central Intake & Care Coordination agency.

We do this for a number of projects. We do this for our family residential treatment programs, our community housing programs. So we basically establish one

phone number in this state that parents of families or referring agencies would call to basically refer an adolescent for treatment, particularly residential treatment but in lieu of residential referrals to other kinds of treatment, which not a whole lot exists, some outpatient.

So we do intake on the phone. We do all the collateral work, we get all the assessments taken care of, and we do the placement. And so in the youth residential services system which began in 2005, the system that was set up, there were some gender specific services, what were funded were short term residential programs, three months, with structured milieux, schools basically on site, family centered treatment. They do require work with families. And a developmental model for ages 13 to 17.

We also have recovery high schools that were added in fiscal year 2007, two youth stabilization programs that were added in fiscal year 2008. And these are basically medically monitored stabilization units for adolescents that can deal with detox and withdrawal, but also can deal with medication and mental health issues. So it is kind of a comprehensive up to 30-day program with blended funding.

The state pays for some of it. But mostly it is paid for now by Medicaid and private insurance. You remember in Massachusetts we have had Medicaid managed care for many, many years, and we have the model health care reform, which I guess is kind of sinking Romney. But whatever, what is on the national level we have had in Massachusetts for a number of years. All of our kids are insured one way or another, as are 98 percent of our adults.

And we also have something called the Family Engagement Projects, which I will talk about in a minute. So what exists now is, we get something like 6,000

calls a year. And only about 29 -- I checked the figures -- about 29 percent of those calls are about young women, through our central.

We have two co-ed youth stabilization units, 24 beds each. Thirty-two percent of those have been female. We have four co-ed recovery high schools. One is actually just getting off the ground. One-third of the students in the recovery high schools are girls. We are nowhere near a 50/50 percentage of girls and boys in any of our programs.

Interestingly enough, what I was told by the recovery high schools is that most of the girls who come to the recovery high schools -- and they are scattered in four different sites in the state -- come from treatment programs. They rarely come directly from the community. Boys come much more from direct community referrals. We can talk about what the issues are.

In terms of outpatient programs for adolescents, they are very, very small. We have only a couple in the state really that have financially survived. And they serve very few girls. For our population, whether it is in Boston or it is rural Western Massachusetts, it is very difficult to get teens to get to outpatient treatment. They don't drive, they don't have their own transportation, they rely on parents who don't want to take them. So getting them into outpatient treatment is pretty difficult.

And I say even in Boston because urban communities also have all kinds of turf issues and lots of OUs that will not cross turf boundaries to go to say we had a program in Grove Hall - for them to go to the Dimock Community Health Center, which is in Roxbury, they just won't go. They don't consider it safe.

We now have four residents. An interesting thing happened with our residential programs. We started with five residential programs of 15 beds each. There

were three boys and two girls. And that started in 2005, 2006, and again, ages 13 to 17. We worked for years and years, and we did a lot of the outreach and the advertising and training and talking to treatment providers.

They could not film those girls' programs. One was in Worcester, central Massachusetts, and one was in Northeast Massachusetts. And so they reduced just last year, they changed one of the girls' programs to a program for 18 to 24 year old girls. So we really only have one adolescent girls' program.

Now both programs are totally full with huge wait lists. I don't know if it was premature, but all I know is that the one adolescent girls' program at this point I think has eight or 10 girls on a wait list. I don't know if it was just a matter of taking much more time, or whatever. But both girls' programs are totally full, where the boys go in and out.

They are usually full, but they have some vacancies. The girls' have, since they did this change, both programs, the adolescent and the transition age youth girls' programs have been totally full to capacity with long wait lists.

In addition to the three boys' adolescent programs, we have two recovery homes which are a little less treatment oriented, for boys. That is supposed to be from 16 to 24, but as you can see most of them are 18 to 24 year olds. One boys' and one girls' for older kids.

What are the challenges we ran into? I kind of talked about them already. From the very beginning, for the girls' program, we had many, many fewer referrals. So the initial referrals were low. We had less follow through on referrals.

In other words, we get a referral and of course we had parental permission. We either couldn't get the girl to follow through, we couldn't get the parents to follow through, we couldn't get consent, the girls didn't want to go.

And then we had always, and less so now, issues of girls remaining in treatment. They really left much faster than the boys. They stayed a couple of days, maybe a week, and then they left. So the residential programs which meet every month with our Director of Youth and Young Adult Services as well as from the Bureau of Substantive Services, Jen Tracey, they began reviewing reasons the girls were not staying in treatment.

They started initiating all kinds of trainings, particularly on co-occurring mental health issues, which were clearly prominent for the girls, on trauma, on cutting, on eating disorders, on relationship violence and sexuality, and they continue to do this training.

They brought Stephanie Covington in, who did days of training on the Voices curriculum, which some of the programs are using. But trying to help the staff be able to do a better job hopefully with the girls so that we could retain them more in treatment.

One of the things that we did, then, we got a small grant. Again, in this effort, since we really are the coordinating agency for a lot of these youth substance abuse, the girls particularly, we got a small grant to fund something called the Old Daughters Project, which was really specifically to find out why girls, try to find out some of the reasons that girls were not accessing substance use treatment.

We did nine focus groups with 62 girls, ages 14 to 20, a diverse racial and ethnic background. We also interviewed 19 substance abuse adolescent treatment providers. So I will give you some of the highlights of what girls let us know.

Basically they said their primary concern was for safety. No surprise there. They were worried about their safety, whether that was accessing an outpatient program somewhere or going to a residential program. They said adolescent males get more attention for their substance use problems because they run into legal issues, but we have problems, too.

We are embarrassed about our substance use because it is seen as more acceptable for boys to struggle with this issue. We are afraid of what our families are going to say. We need more targeted outreach, community and school meetings. And the girls, interestingly enough, which you will see a little later on, also talked about that their parents needed more help. The parents needed parenting skills, the parents needed support groups, and the parents needed treatment.

The other thing we ran into, and the girls let us know, going far away from home isn't an option. So our two adolescent girls programs, remember, one was in the middle part of the state and one was in the Northeast. So particularly our Boston girls, and this still is an issue, which I will talk about later, which really has to do with urban girls of color not accessing our system still.

We want programs in the community to reduce stigma so we can remain with our families and friends. We often have responsibilities in our home. We have run into this time and time again. A million years ago it seems like, Hortensia Amaro and I had a CSAP girls' prevention project, also in the same area, Roxbury and Dorchester, called Girls on the Move.

We did everything. We transported girls, we did a lot to get them there. We consistently managed this issue, which if you talk to girls in adolescent treatment you hear it again. They are often the caretakers of other children in the home. They have responsibilities at the home and their parents don't want them to go. The parents want them at home.

There are a lot of reasons their parents want them home. They are worried about safety. They don't want them to go so far from home, they keep the girls, they don't want the girls to go out of the home. But it is also true that the girls often -- like in Girls on the Move, or in our Grove Hall project, they don't make it because they have responsibilities at home.

They also let us know if our homes are not safe. If we have unsafe homes and we do want to go to residential treatment as opposed to home based treatment, but we still want it closer to us and the community. They want care that is safe and nurturing. We like counselors coming to where we are -- our homes, our schools, our community centers.

They were saying we want it in the community, we want you to be assertively outreaching to us. We are not really that interested in going far away from home into residential treatment. If we do go to residential treatment, we want to feel safe and work with staff who really want to work with us.

Some of the girls felt, and these were coming from the two residential girls' programs, that the staff there really didn't like girls, they didn't really want to work with them. That is not a great place to be. I hope those staff are no longer there. But it is true that there is not a lot of adolescent providers aren't that interested in working with girls. They can be difficult, from their perspective.

We didn't know there were any programs for us, and the ones we knew of appeared to be frightening and scary places. And they said very clearly, we want to see what the programs look like. Because they envision residential being like an institution. The staff said some of the very same thing. The staff said family responsibilities prevent girls from leaving home. Shame and stigma keep girls from getting help. The families are not willing to send their daughters to treatment. The programs are too far out of the community, the stigma is too great.

The lack of attention given to substance use in girls differs -- it mirrors what the girl said, in other words. It is difficult to find staff interested in working with girls. Girls are embarrassed, they are not comfortable seeking treatment, they are concerned what family members will say, they fear being judged by others.

The need for dual diagnosis programs is the language that they used, that the girls as we know were more likely to present with co-occurring mental health problems, and there was a need for more of those kinds of programs.

So this is one of the brochures we designed, which was an attempt to address specific girls, youth services, you need help or know someone who does help, with some pictures of what the programs look like, and some pictures of girls.

But also you can see pictures of the houses. What we did was put it on our website, on the bureau website, so that parents and girls could actually look at the houses and see, these are beautiful houses, they don't look like an institution, they don't look like a prison. And this has helped, I think. They do go for an interview, but to get them to go first was, I think, the picture is in letting them see what the program is. There is more on the site. You can look inside and see more of what the pictures are.

So what are some of the other things that we have tried to do other than residential and outpatient, that reach out to girls? One has been kind of looking at some home visiting models. It is still true that our residential programs have been more successful. The boys programs are mostly full. The girls programs, as I said, are full with wait list.

The recovery schools, most of them, are full. A couple are just starting up. But it is still really true that none of those programs are serving -- they are serving predominantly white kids. Even our recovery school in Boston, which is an Irving School.

It is not getting kids of color, by and large. There are a sprinkling, but the majority of the kids that are being served in the residential programs, in the recovery homes, are white.

One of the other models that has been funded have been more home visiting models. We had a program called SAFE, which we still do, the SAFE Project. Our project first started actually with the CSAP Adolescent Community Reinforcement Approach grant, which was a home visiting program in Boston. That grant did serve mainly Latina and African-American girls, girls and boys, but 36 percent more female. So a little better than our residential programs.

But we did serve a very ethnically and racially diverse population. And that project has been expanded to the Bureau of Substance Abuse Services, so we still have that safe project and we are doing it also in greater Boston as well as in the Northeast and metro West. That is now known as the family engagement project.

The Bureau has funded three new families. So what basically happened, which was very nice, the three A-CRA projects that were funded in Massachusetts were

picked up by the Bureau of Substance Use Services, and they are focused on youth and ours is one of them.

We also have a project that is working with transition ages, down in Southeastern Massachusetts, which is working with young people who have been civilly committed to treatment. That project is also a home based project. And that is reaching 57 percent female. So we have been much more successful with our home visiting models, much more successful in reaching young women and their families when we go out to the community and when we go out to basically their homes.

I asked our staff, our youth staff -- we have about 16 or 20 youth staff -- what their summaries were and what they found. And basically it mirrors pretty much what we said. They did say -- and this is true, that we know this is true for women -- we have known this for years and we have talked about how women end up getting into substance abuse treatment at later ages, and then it is certainly true for girls. The girls who come to treatment are usually older and have more acuity.

So it has taken longer for them to basically be identified, I think. It has taken the families don't want them to go, the families shelter them more, they are sheltered more in the community, people don't assess, the questions aren't asked. And so they come to treatment with more acuity, not only of substance use but certainly there are mental health problems, and at older ages.

And again, here we have significantly more mental health diagnoses, including the ones we always talk about, depression, PTSD and anxiety disorders. The residential programs were also saying that in the transition age, more of the older girls than boys were using heroin and needles, which I found interesting. In Massachusetts,

our big drug of choice is opiates. We have a huge opiate problem in Massachusetts including heroin and Oxycontin, et cetera.

What they were saying is, in the residential programs they were finding that the girls were more likely to be needle users and heroin users than the boys. They thought this was true because the girls were a lot involved with older men who again, back to the relationship, they were introduced to opiates, heroin and needle use in relationship with older men. No surprise there.

Early trauma histories, complex trauma. And we talked about the lack of gender specific trauma curriculum for adolescent girls. We have a grant through the National Child Traumatic Stress Network, so there are quite a number of adolescent trauma curriculums.

And there are adult trauma curriculums, but none of the adolescent trauma curriculums are gender specific. It doesn't mean they are not used with girls, but they are not gender specific, which I thought was interesting.

The only curriculum that people have been using has been VOICES, which is really not a trauma curriculum but it is kind of a girls relationship support. Unhealthy, unsafe relationships, lots of body image and eating disorders.

This is a summary which I have already said. After years of outreach, starting since 2005, and marketing, we are starting to see more girls in the treatment system, particularly in the home based models but also in our residential treatment system. Again, still few girls of color are in any of the systems except in the home based family engagement projects. And the recommendation is that we need more community and home treatment.

And the staff thought it was really important that the programs need to address the barriers, to recognize the concrete barriers with the girls -- transportation, girls as babysitters in families. Again, addressing trauma, we are working a lot with our adolescent programs to address trauma, but to address it up front.

The question about what happened to you, monitor safety. It is very important with kids, and certainly girls, to be flexible about scheduling. So that is why the home based or community based model. We have a recovery center for transition age youth in South Boston, another CSAP project. There are all these great projects, most of which are about to end.

This drop in center, it is a recovery center with some treatment attached to it, because it is a ROSC, a Recovery Oriented System of Care. We have had the most difficult time getting these young people to come in for scheduled groups. They say they want to come, they say they want this, but they do not come. They come, they drop in any time in the day, they want you to be available when they are available.

But for scheduled activities -- and in fact, we have a whole mental health system for kids in Massachusetts called CBHI, Child Behavioral Health Initiative. It is very completely to go into it, as a result of a lawsuit. But there are all these mental health services including in-home treatment and home therapy that have been set up for young people with mental health problems.

They have had the same problem in engaging adolescents or transition-age people in any structured kinds of activities. They kind of walk with their feet. And in a recovery center, they walk with their feet. They come when they want to come, they come, they want to see you but they don’t want to be scheduled. It is part of, I guess, youth independence.

The staff recommended that we use practices such as A-CRA/ACC. Those aren't the only practices, but the focus, again, the focus being on what the adolescents want, building on their strengths, what their goals are. Not so much the kind of treatment deficit model of care. And of course more focus on the parents. That is what we talked about right before lunch, more sort of outreach for parents, more supports, more services.

You can't, as you saw from the film, I don't believe -- some girls are probably out of the house, but most adolescents and certainly adolescent girls, you cannot be successful in doing work, I don't believe, unless you somehow engage the parents. That's it. Thank you very much.

Agenda Item: ACWS Discussion and Recommendations

MS. ENOMOTO: Thank you. That was great. I appreciate the broad overview of what is happening with girls as well as well as the specific case of what is happening in Massachusetts. We normally don't use the administrator's time to do presentations, but I think this one was very helpful to give us a time and space in what we are dealing with, with respect to women's services and in this case adolescent treatment. So with that, I would like to open to floor to Pam and to others for quick reactions, questions.

MS. HYDE: I am always struck when we ask people their voices, it is not always what we think. So the data you have about the number of young women who come, or young girls who come with substance abuse and mental health issues, and yet we get a lot of pressure here to keep those things separate.

And then we have tried very hard to think about alternatives in the community, and then we get a fair amount of pushback about how we hate residential services. Which isn't true, but we keep trying to say, but there are other things we have to make available to people -- not to the exclusion of that.

But I was curious that the kids are telling you that. And I also thought, I didn't get a chance to talk with you all about the movie, but I did watch it last night as well, and I was struck by a lot of that, the parent's issues. It's not like the parent wasn't engaged. She was very engaged. But essentially didn't know what to do and frankly had some of her own issues going on. Anyway, I appreciated it. It was very helpful.

DR. BRISCOE: I just wanted to say that again, all morning we have been saying how important it is to engage the family, and this is saying the same thing, that you just don't work with the adolescent, you work with the family. In Santa Fe I am part of a pilot project between a youth organization that is offering the matrix model for the adolescents, and then the Santa Fe Mountain Center is offering the experiential component.

And so they come into residential and get fired up about recovery. We start seeing clients 18 and over. That is youth, 18 to 25. We engage them in to treat them, get them fired about being part of Youth NA, and then we transition them to the outpatient where they do the Matrix model. And then they go do experiential training.

So they get really bonded as a group, in making their own new families as youth versus looking for other families. They are making their own families and supporting each other.

That has been very helpful, because getting the kids to do Matrix model at our place, in our outpatient, who wants to sit there and listen to, this is the brain on drugs

and this is what happens to the brain. But you get them out there doing stuff and they want to come back. So that is how we have engaged them to actually want to come back to treatment and stay engaged in treatment, is the experiential component.

It has only been five months, but we are hoping that this can continue.

PARTICIPANT: What is the experiential?

DR. BRISCOE: It is ropes courses, and team building, being out in the outdoors, going camping. And then including moms on Saturdays, or a parent, in part of that team building with their kids. It is very exciting.

DR. MURRY: It seems that what you are describing is just an extension of this relational building. And so that relational building in the group work is facilitating increased likelihood of staying in treatment. That seems to be a common thread as well that we have been talking about.

Can you talk a little bit more, Norma, about what do you think is working with the girls of color?

DR. FINKELSTEIN: Well I think as I said, what has worked for us has been more community home based models. It is not clear why. They have told us some why they are not accessing residential. Again, remember the two girls residential programs are not in the urban areas. Well, Worcester is an urban area so they should be accessing that. There are plenty of Worcester young girls of color who need residential treatment.

So what has worked for us mostly has really been the kind of very assertive outreach, working in the community, meeting them where they are at. Sometimes it is at the home, sometimes it is not the home because they don’t want to

meet in the home. Basically with the adolescents and also the transition age youth, following their lead, listening to what they want.

With the A-CRA model, which is also a very good model for that, it really basically asks you what do you want to work on, what is important to you, what are your goals. I think also we have a diverse staff. The residential programs have some diversity, but probably not enough diversity. Probably the same thing for the recovery schools.

So our staff is much more reflective of the population that we are serving. This is a battle for us as we continue, because the requirements for our managed care right now, as we move to an insurance reimbursable system, has its problems. We have grown our substance abuse system tremendously through the use of Medicaid dollars.

However, what has come with that is a kind of a much more professional -- it's the wrong use of the word, but we have basically now, in order to get reimbursed, we can only have LSCWs and LMHCs. We cannot reimburse people without it. And it is a problem in terms of designing certain programs that will be more community based.

But what has worked so far is the staff that we have who are either from the community or look more like the community that they are serving, more basically being in people's homes, or we have a staff member actually cited at the recovery high school in Gloucester.

So he is actually in the high school and he goes to the three schools where he gets referrals. So he meets them at school, he will meet them at Dunkin Donuts, he will meet him at a park. Those two things seem to be -- plus listening to what they want.

MS. BERGAN: Norma, how many students are in each of the recovery schools?

DR. FINKELSTEIN: There are supposed to be 50. So Boston came on first. Boston I think is at 50. So is the Northeast and Gloucester. Springfield is newer, and so I don't think they are at that. We have just added a fourth school in Brockton, in the Southeast, which is just opening. There are supposed to be 50 each.

They are all very different, just like all programs, even it's a system they are very different. They have their share of problems with the community and the Department of Education. They have to be part of -- even though they are funded they are part of the education system, which means they, quote, take money away from schools. So there are battles about it.

MS. ROBBINS: Hi Norma, this is Starleen. I have two questions. One is, when you are doing the in home services, are you able to engage the parents in the treatment? And two, are you using peer coaches or mentors when you have those young women who go through treatment?

DR. FINKELSTEIN: Great questions. Starleen. Yes, I should say that first of all, with the adolescents, we have to engage the parents because we need parental consent. So I think earlier I said in our A-CRA program, A-CRA has two or three sessions where you are supposed to formally sit down with a family member or members, and the youth, and work on certain sessions together.

What I can say about that is, we have about one-third of our parents who agree to do that. However, we are in touch with all of the parents of the youth that we see, even our transition age youth. So it may be that they won't come to see us, or they won't do a formal session in the home but they will call.

We are in touch with them on the phone. Sometimes -- not many but certainly numerous times -- we have had kids disappear, run away, end up in DYS or

whatever, and we still work with the parents. So we have been able to engage them. But again, not necessarily always in kind of a formal counseling, but in a more informal, in touch, let us know what is happening, et cetera.

I think we have been successful in the in home. The residential programs all require some form of parental -- in fact, there are a couple that I think for the older kids in South Boston, the recovery home, 18 to 24 year olds, I don't think they will take kids, which I think is a little unfortunate, unless their parents agree to be active participants.

The other programs don't require that, and they have a family, something on the weekend for the families. But I don't know how effective they have been in the residential programs, engaging the families. We are hoping to do something more, engage the families when they are in residential treatment, but stay in touch with them in after care.

What happens is, the system doesn't have the resources to follow the families after their kids leave residential treatment. Of course that is a problem because the kids are going back home. What was your second question, Starleen?

MS. ROBBINS: Peer.

DR. FINKELSTEIN: We have our recovery center in South Boston which is for transition aged youth. It is a peer model. It is a recovery center that we are using peers. We have our project in Grove Hall. Grove Hall getting healthier is a prevention project which uses peer mentors.

And we try to engage all of our youth and young adults in peer activities. Some of the things you mentioned, social activities as well as peer mentoring. But not all of the projects have a formal peer program, but some of them do.

I think with the transition age, the recovery project we have in South Boston, the recovery center, is for 18 to 24 year olds. And when we envisioned that center being more based on recovery, certainly treatment but also having some kids with some recovery. But what we are finding, partly where we are located -- we are in South Boston, huge drug problem, we are dealing again with opiates, needle use, heroin. A lot of overdoses.

The kids that we are seeing by and large -- I am calling them kids but we are talking 18 to 24 year old here. They are in serious trouble. And they are in and out and some of them have some recovery. But we have to get some older people involved because we don't have enough stable recovery at that age to really be effective peer mentors. That has been something we are struggling with.

MS. ENOMOTO: The administrator has to leave, so I want to make sure she gets to ask you her last question.

MS. HYDE: This is a question for all of you, so you can discuss it, Kana can let me know what you say. But you are advisors, so you mentioned the problem of grants going away. We have spent a lot of time thinking about how we sustain issues. I don't mean just a grant having a sustainability plan. Frankly, getting our money out differently, which may not be as satisfactory but in some ways may sustain things better or not. I don't know.

We had less money, and we expect to have less going forward. So given what you know, and given the vagaries of managed care and other kinds of things, if you have advice for us about what we can do, I am a big one on saying while we make grants, it is not the only thing SAMHSA does.

So if you have advice for us about other things that we could do around adolescent treatment, I would be glad to hear that. We have got just a few minutes. I'm sorry, I have to go back upstairs.

DR. FINKELSTEIN: In some ways, we are quite lucky in Massachusetts because we have been able to do some sustaining through the block grant. And we are hoping that we have a system of recovery centers, and we are hoping that will broaden. I don't know what the solution is because I understand the issues of more money going directly to the states in terms of block grant.

I'll be frank. I have seen programs funded that I think should never have been funded because they write a good grant but we know on the local level that they are not that great of a program. I know that for Massachusetts because we know the programs. And those are true for women's and youth programs.

MS. HYDE: I know that is a problem. I know the states struggle with that because I know they feel like nobody is checking with us, because of the peer review system. ON the other hand, I know from a million years ago, I got my first women's grant from NIAAA in 1975. So I am dating myself.

If there hadn't been that money for women, just like if there hadn't been the money for the child, for the woman, much of the stuff -- I just think what has come from the WCVVS(?) study is to me amazing, all the trauma stuff. I don't think that would have happened at the state level.

To me it is really difficult. I think you need both. So you need the stimulation that can happen from innovation, which is really hard to get sometimes at the state level because they are concentrated on just the same day to day funding.

We can write, which we do or don't, like creative RFAs, but once a grant has come in it is who writes the best grant. And there is really not much we can do about that. In fact, having worked at all three levels -- local, state and federal -- there is even less we can do about it here than at the state level.

Which is not to say, that states are the right place to go, it is to say managed care companies have two goals. They have to increasingly get good outcomes, and they have to save money. So going to a managed care company and saying, hey.

And then you have flexibility. The whole point of managed care is they have flexibility the government doesn't have. So being able to go to them and say pay me for a successful young person, and let me figure out how to do it.

There are some managed care companies who have been willing to try those kind of pilots. It might be worth -- but I didn't think about that until just discussing it with you.

DR. FINKELSTEIN: Well I know there is a pay for performance and I noticed it was somewhere that was just out from Stanford. We might want to try to engage those new companies who are getting more and more of this business to try to do some of that kind of stuff.

DR. HYDE: Well keep talking about that. Tell Kana what you think and she will tell me. Thank you.

DR. BRISCOE: In talking about just even earlier, again, in the collaboration, working with other organizations and working with churches and community, the whole task of our committee is low cost, no cost. How are you going to engage kids into treatment without pouring money into it? That is where we are trying to be creative.

Also, New Mexico, I think it is number one now in opioid in overdoses for youth. And so there is a lot of impetus to really go out there and try to look at something different, because what has been working in the past actually isn't working. We are losing more and more youth. The other day I went with my daughter to go see 21 Jump Street. It was really funny, and I go with my daughter because she said, hey mom, let's go see something dumb and stupid and have a good time.

The premise of it is police officers going into the high school acting like youth so that they can infiltrate undercover. There is one very poignant statement that the Sergeant says to the two cops, and this is happening in New Mexico right now. He said a couple of white kids died and now people give a shit.

That is happening in New Mexico. Heroin is a new, emerging population of upper middle class kids who are dying of overdoses. And now the governor is calling mandates and there are some at Memorial 56. And that is kind of what it took unfortunately, for there to be some movement and some more focus on heroin overdoses. So that is why we have this new project, this pilot program, because of the interest of middle and upper middle class populations.

MS. ENOMOTO: Norma, I was wondering what proportion of the kids coming through are Criminal Justice referred or JJ referred.

DR. FINKELSTEIN: We have a lot of kids from DYS. We, IHR, did the regional substance abuse contract within DYS in the state. So we do get a lot of DY, which is where our youth are, under 18 anyhow. They are in the DYS system, Department of Youth Services.

So yes, there are a lot of referrals from DYS to the residential programs. And I would say in our SAFE project, our home visiting project, in Boston as well as the

Northeast, we see a lot of DYS kids, both in the community as well as kids who are in residential or locked up.

Just to mention the thing about parents. We have a parenting program, as some of you know. It is called the Nurturing Program for Families in Substance Abuse Treatment and Recovery. The third edition just came out. It is on NRAP.

We also developed as part of this youth services, a whole other program called "Parent Time", which we actually developed with the Bureau of Substance Abuse Services, which is an eight-week support group for parents of kids who have alcohol and drug problems. It has been very effective. DYS liked it so much that we have a DYS version for parents.

So pretty much that is what we are doing. We are doing groups for parents in different regions of the state. And the DYS parents basically said nobody talks from us from DYS. The kids get locked up or they get into some community place, and nobody has reached out to the parents from the Department of Youth Services.

The parents who have come, the most of important thing for them has been the networking. That is what I have found with all parents' groups. It is not even so much the information, although the information is clearly important. It is really the chance to talk to other parents. So we have been doing that in a juvenile justice setting.

MS. ENOMOTO: So even though their daughters might have sanctioned, the parents aren't supportive of sending their girls to treatment? For residential, or even intensive outpatient.

DR. FINKELSTEIN: Let me just say, we don't have a lot of intensive outpatient. We have just few programs. Some of that, it's hard to talk about that without

talking about the system. But our outpatient system is a mess. And managed care was partly responsible for that.

It is very problematic, without going into all the permutations about why it is a problem, why the rates are a problem, why the requirements are a problem. The outpatient system, other than our CBHI, our Child Behavioral Health, which has gotten more money, basically the programs are dying, or they are becoming these large conglomerates.

So we don't have a lot for youth and outpatient, specialized. Do the DYS? Yes, DYS kids do end up in residential treatment, and then of course the parents are somewhat involved. They have to agree. They may agree to have their child there. That doesn't mean that they are actively involved in the treatment.

MS. ENOMOTO: We did see the precursor of health reform in Massachusetts with our good friend, Susan Ayers, who was on ACWS. She was Executive Director of Cambridge Child Guidance and her last presentation at ACWS was about how she had decided to merge Cambridge Child Guidance into a larger --

DR. FINKELSTEIN: A very large system. I sit on the Board with a director of that system. It's not a bad system, but it is becoming these big conglomerates.

MS. ENOMOTO: One of my questions is, we are looking at doing a program focusing on teen courts. So moving up stream a little bit. Because other than in Massachusetts, many places where kids and parents who want treatment can't afford treatment, they will have access to services.

Even though they might like to get them, they have to wait until the kid gets into bigger trouble, gets kicked out of school, gets arrested, and then has a sanction over their head before they get forced into treatment.

We are looking at offering teen court systems, access to treatment dollars, as well as screening support so that they could, for those kids that meet criteria and have need of treatment, they could do that earlier, from a teen court setting rather than a criminal court setting. I don't know if you have thoughts about that, whether that would be effective, if kids would or wouldn't follow through.

DR. FINKELSTEIN: I think it is great. I think I heard something like that at the re-entry meeting that I was just coming from. We don't have in Massachusetts really also much in the way of family drug court. We haven't been one of those states that has done it.

We keep on thinking, struggling with, do we really want to get some judges involved, whether it is teen court or family court, and out of the adult criminal court. I think it would be terrific. It seems to work well, when it works well.

MS. ENOMOTO: Other comments or reactions? Or do people want to take a five-minute, one thing break? Then we have Marylouise Kelley, who has already joined us. Thank you very much, Norma. That was a great presentation, a great overview, and fascinating stuff that you are doing, so thank you for that.

(Break)

MS. WOOD: Let's call the meeting back to order, and I will turn it over to Kana.

MS. ENOMOTO: I am pleased to introduce Marylouise Kelley from the Administration of Children, Youth and Families, Family Youth Services Bureau. Marylouise is a very important person, particularly for the field of domestic violence, as that interacts with the field of behavioral health. She has been overseeing their family

violence prevention services program for some time and has been in the fields since 1983, so coming up on 30 years.

Thank you, Marylouise. She is a tremendous leader at the federal level, as well as nationally on domestic violence issues. And so we are just very happy to have her here and we look forward to partnering in the future, as we have our GASPI proposal in the present budget. Thank you.

Agenda Item: Screening and Counseling for Women and Adolescent Girls for Interpersonal and Domestic Violence

DR. KELLEY: I want to thank you and also Sharon for inviting me to be here today. We have been building a lot of bridges, I think, between the Administration on Children, Youth and Families and SAMHSA, with our commissioner Brian Samuels. I know we are working very hard with Kana and with Pam Hyde.

Sharon and I bump into each other at meetings all the time, with the Coordinating Committee on Women's Health, the Violence Against Women Steering Committee. And some people think that the federal government doesn't work together. I tell you, we are starting to spend an awful lot of time doing a better job I think, building those bridges.

Before I start with this slide, I just want to say I so admire this. I don't know if it is your strategic plan in a snapshot, but it is so positive. I love the focus on people recover, people do and can recover. And I just want to compliment you on all that it conveys in one snapshot. A very nice vision.

As you can tell, I am going to try and cover a lot of ground. And I will warn you, I am just going to flip through some information. We wanted to convey

several things an thought it might be handy for you to have in hand some of the statistics that convey the importance of addressing domestic violence in a behavioral health setting.

But we also wanted to just cover the activities that are going on within the department today around screening of domestic violence, particularly in light of the Institute of Medicine's recent recommendation, and the department's adoption of a guideline to screen for domestic violence in health care settings.

So I am going to give a quick background of my program, and some of the co currents of behavioral health and domestic violence, statistics, talk about screening, give you an example of screening activities and resources, and talk about connecting to domestic violence service providers in the work that you do or in the work around health screening.

And also, talk about the coordinated effort within the Department, with the Coordinating Committee on Women's Health, trying to move the agenda along for domestic violence screening.

What we know -- some statistics that have been updated for the first time in 15 years, from the National Intimate Partner and Sexual Violence Survey conducted by CDC, give us a picture of a huge problem across this nation, with one in four women experiencing severe domestic violence at some point in their lifetime.

Severe domestic violence is frightening levels of violence, being strangled, hit with items, and so seriously severe domestic violence. We are very grateful that CDC will on an annual basis be tracking the incidence and prevalence data.

My program, the FVPSA program, just to give you an idea, it is the Department of Health and Human Services, Domestic Violence Services Program. So it

supports across the nation about 2,500 local domestic violence programs through states and Native American tribes. It reaches over 1.2 million survivors and their children, and does a lot of prevention, outreach and community education on prevention of domestic violence.

The other resource that we make available, a series of nine national resource centers on domestic violence. They do wonderful work. But I want to focus on two of them today. It is the work of two of them because they are really very pertinent to the issues I will be talking about today. One is our National Health Resource Center on Domestic Violence.

We have been supporting their work for 16 years. And they have been educating health care providers on the health consequences of domestic violence and how health providers can do a better job intervening in domestic violence. I am going to pass around a couple of their resources as a sample for you of their work.

The other national center on domestic violence that I want you to know about is led by Dr. Carole Warshaw, who is part of your advisory committee. Carole has for a dozen years now been working with the FVPSA program, and has really taken the domestic violence field and made a real shift around a fear of addressing domestic violence and substance abuse, because of the fear that it would start victim blaming and wouldn't keep the responsibility on the perpetrator's behavior.

Carole has really helped the field come along to understand that a trauma informed response is critical. People suffer a lifetime history of abuse, and if we don't address that we are not helping people to recover from that history. And she has done some incredible work. Included in the very thick handout that you have we included a

presentation that Carole has done for other audiences. We found it so incredibly valuable that we couldn't get rid of a page of it.

So we included the entire presentation. We ask you to take a look at it, and ask you to consider having Carole present it for this group at some point. It is almost a manualized intervention on what should assessment look like to address domestic violence.

FVPSA programs are reaching, as I said, over a million survivors every year. We are measuring some short term outcomes, because many people are only involved in these interventions for a couple of weeks. But we know that the improved access in community resources and safety planning is leading to longer term safety involved being.

However, we also know that domestic violence programs, I am not able to keep up with all the requests for services. This is not a service where we are trying to drag people in and fill up the rooms for education programs. Instead, programs are turning people away every day. And the pace at which people are being turned away is increasing in recent years.

Another aspect of our work is that we support the National Domestic Violence Hotline. I think this is the one thing that if any service provider needs to know something about domestic violence, they should at least know the Domestic Violence Hotline. Because it is a place where you can do a connection, where somebody can be connected to an advocate who can talk them through disclosures, identifying resources, and getting help.

Available 24 hours a day, and since September of 2011, available by chats and texts, and over 10,000 chats and texts have been used, and youth are starting to

access this service to a huge extent, not that that is happening. So I am here because, as we all know, there are some immediate health consequences of domestic violence, and health care providers need to know to look for those.

There is some emerging information that Jackie Campbell from Johns Hopkins has shared about some new research that is finding that traumatic brain injury in women is caused to a frightening extent by choking and by the abuse they experience. So some of these health issues that people are being treated for, if you scratch under the surface, there is a cause related to their history of domestic violence.

We also know that there are long term health consequences. The data on this is growing to a frightening extent. We know that people with a history of abuse, their frequency of using health care services is doubled, either two times to 2.5 times as often they will use health care services if they have a history of abuse, for all of these different illnesses and disorders.

There is a connection, we know, to the rates of PTSD. Abused women are far more likely to come to the emergency room with symptoms of PTSD. And suicide -- how often have we seen training on suicide address the fact that suicide risk is five times higher among abused women who are sexually assaulted by their partner. And sexual assault by a partner is one of those actions that is considered among the serious abuse by a partner.

In culturally diverse populations, digging a little deeper, there has been some investigation of the rates of depression, significantly higher among Latinos when there is a history of abuse, and that black women with a lifetime history of abuse are 9.3 times more likely to report depression. So that link between rates of behavioral health problems and histories of intimate partner violence.

We also know from the recent NYSPS survey that the rates of abuse are far higher for women of color, particularly for Native American and Alaskan Native women, and for women who respond as multi-racial. The mental health co-morbidities are extensive. As an example, a Dienemann 2000 study reported that the prevalence of lifetime intimate partner violence among women diagnosed with depression was 61 percent. So approximately twice that of the general population.

The link between domestic violence and substance abuse. We see that spouse abuse scores are the strongest predictor of alcoholism in women. And a couple of notes to unpack that. It is important to identify and assess the co-existence of intimate partner violence and substance abuse, to help victims be safer and to help them with their sobriety.

So substance abuse treatment that is not addressing this co-occurrence is going to leave a victim with this underlying problem that will only interfere with recovery. Patti Bland, who also now is working with Dr. Warshaw and has done a lot of work on domestic violence and substance abuse, notes that while most battered women are not chemically dependent, substance abuse occurs as a coping method for many, many women who are abused.

Fifty-nine percent of women who screen positive for drinking problems experienced intimate partner violence in the past year. The link between pregnancy and substance abuse, linked once again to being physically abused. So the evidence goes on and on. So this raises the question of how do we distinguish between a lifetime trauma history and assessing for current intimate partner violence? We have had a lot of conversation, I believe, on trauma informed care, the need to address a lifetime history of abuse.

But what we are finding and hearing from many practitioners in the field is that screening for current domestic violence is not necessarily a part of that assessment. And there are differences between asking about current domestic violence in the context of the lifetime history, and really addressing that, because it has to be treated differently. It requires different responses.

And that is why screening for current abuse is so important. And when you screen for current abuse, you realize that you have to address these immediate safety risks. You see it in the context of all the other lifetime history of abuse, but screening for current abuse can help break the cycle of violence and prevent future harm. So that's why it is so critical.

The support for screening has grown. Studies are showing that women's support screening, there is not harm to those who have been screened, that there is some evidence that interventions can improve health and safety. And there is a growing course of national medical associations supporting widespread screening.

The key findings from the Institute of Medicine in their review was that asking about domestic violence could help prevent future abuse and could improve future functioning, that women may not disclose abuse unless directly questioned under safe and respectful conditions. And so that under safe and respectful conditions, doing it right was critically important.

Victims have frequent encounters with health care services because they are of poorer health, and higher rates of health services utilization. So the health setting is a great setting to address this issue. And most women will never reach out to a domestic violence service provider on their own. That is, it cannot be the only place where we address domestic violence.

Physicians are in a unique position. Health care providers of all sorts are in a unique position to identify abuse. But they are rarely screening. And those that do screen, some studies have shown, don't do anything with that information. They are uncomfortable with it, they may bring to this work a history of their own trauma, they don't know what to do next, and so they are hesitant to ask, or may do nothing with that information.

So those barriers to screening are critically important to understand and overcome. The preventive measures recommended by the Institute of Medicine, when they were looking at preventive services for women, considering whether to include intimate partner violence screening, they based their recommendation to do screening on purity of studies, federal and international guidelines, and the clinical professional guidelines that the various medical associations had developed.

And this is the recommendation, which is further than the recommendation now. It has actually been adopted by the Department and it is the guideline for the Department, around screening and counseling for interpersonal and domestic violence. And believe me, we have all been doing some background information to understand how those terms were used and we are digging into that a little more deeply.

Screening and counseling, they were talking about elicitation of information from women and adolescents about current and past violence and abuse in a culturally sensitive and supportive manner, to address current health concerns about safety, and other current or future health problems.

So it is comprehensive, it is a wide population, it asks not only for screening -- so in other words, just saying have you been abused is not enough. It is

screening and counseling, and the counseling goes with it. And I will talk a little bit further about what they had in mind in counseling, not necessarily mental health counseling.

On August 1st, Secretary Sibelius approved this guideline. It is now a guideline for the Department and we are in the implementation process. This will be effective for all new health plans starting on August 1st, 2012. Other health plans will be grandfathered in. However, any time they make a change in coverage they become a new health plan. So we can expect that this will be very pervasive, after August 1st.

Now let's talk a little bit about unpacking the screening versus brief counseling. Screening is generally short. It can be one to five questions. There are some good examples, like the abuse assessment screening, some of these done by computer assisted programs which some are finding very helpful to gain disclosure.

I also welcome you to take a look at the presentation that is attached to mine in your packet from Carole Warshaw, where she talks about screening questions that include questions to frame the issue, some initial questions, more direct questions to unpack it, and what an assessment for safety needs to include.

So the screening process can really range. There have been several studies on different types of screening, but not widespread screening studies. It is probably one of the areas the Department needs to move toward, toward testing out various screening protocols. There are several that can be recommended and I will be giving you resources that you can refer to.

Even if victims don't disclose, the understanding is that by raising the issue, by calling it their attention and making that link between domestic violence and

health, victims have some new information that may change decisions. The counseling was about providing very basic information, connecting the health concerns to violence.

The definition that the Institute of Medicine used was that counseling refers to a discussion between clinician and patient about ways that changes in personal behavior can reduce the risk of illness or injury. The goal of counseling is for clinicians to educate patients about their health risks, as well as to provide them with the skills, motivation and knowledge they need to address their risk behaviors.

So this is counseling related to a disclosure of abuse and what some of the next steps might be. The goal is also to create opportunities for education and action. Thinking of in a setting, for instance, a behavioral treatment setting, how keeping domestic violence in the picture might change practice, is another consideration that we would like to raise.

Carole Warshaw calls this being domestic violence informed, not only trauma informed but domestic violence informed. She also adds in, culture informed, if we are going to be comprehensive. So assessing for domestic violence is not the same as assessing for mental health or substance abuse. Some of the concerns are the same. We need to use a trauma framework.

But in this case, prioritizing immediate safety may be the biggest difference and the overriding concern. So that new focus on safety, as a priority. There is also the need to focus on empowerment, remembering always that the survivor is not responsible for the abuse, is not to be held responsible for stopping the abuse, and needs to make choices. So survivor driven choices, so that it doesn't become her responsibility to end the abuse in her life.

And it also needs to remain her responsibility, not only what will she do next, but who needs to know about it. Does she want to disclose, and to keep that information within her power. There is a need for continuing use of a trauma framework, a need to pay attention to culture and context, because of course that changes everything, including the options, how people see things, how they understand it.

And what is also new, and what we are thinking is very critical to intimate partner violence screening, is the essential step of working in partnership with domestic violence programs and advocates. Because a comprehensive screening, and some of the work that has been developed over these many years -- and I talked with you about the health resource center on domestic violence -- one of the products they sent around was consensus guidelines that were developed with advisory committees like these, made up of people from the American Medical Association and ACOG and behavioral health providers, health care professionals talking with domestic violence advocates about what are appropriate responses to domestic violence in a health setting.

And these consensus guidelines come to the conclusion that it is inappropriate and unsafe to ask simple questions about screening. It has to be done with a comprehensive response. So the intervention elements that these consensus guidelines include, include health care providers providing a whole health setting for asking the question, when you are at home has your partner ever hit, struck or hurt you?

You have to be able to deal with that by knowing who will ask the question. Everybody who may ask the question or get the response needs to know what an appropriate response is. So preparing everybody in that practice, including information that is shared within the setting, pamphlets, posters, all of that.

It needs to begin with reviewing the limits of confidentiality, so it is very clear who will get this information if somebody opens their mouth and discloses that they are a victim of domestic violence. It needs to include an assessment for domestic violence, using things like the safety card, which I will talk a little bit more about.

A next step would be saying I am so sorry to hear that you were abused, and let's talk about how that might be connected to the migraine headaches you have been experiencing, making that connection to healthcare. Responding in a supportive way, and doing a supportive referral, not a, that's too bad, here, call this number, but making a connection. I will talk a little bit more about that. And if reporting is necessary, doing that in a trauma informed way.

I also want to refer you to some of the materials that are attached to my slides, include a summary of an article that Kaiser Permanente did. They have established a really wonderful comprehensive model of responding to domestic violence, and it gives you a sense of the comprehensive response that they have put into place.

Let's talk about how this might work in a real world. You all have a copy of the little palm cards. The idea with these palm cards is not that you leave them out, or hand them to somebody and don't say anything. Always thinking safety first, talk through with someone whether or not it is safe for her to have this in her purse, or to take it home, or would that just trigger somebody's violence, as a first step.

These are all steps that would be important for health care professionals to be aware of. So this process, as I mentioned, begins with disclosing the limits of confidentiality prior to any assessment. So, if you are really wanting to have the survivor have the autonomy, to make the decision about whether or not she is ready to disclose domestic violence.

Before she makes that disclosure it is important for her to know that I will need to share that information if you disclose, for instance, child abuse. In some states, such as the State of California, a disclosure of domestic violence may require a mandatory report to the police. If that survivor is not ready to report to the police, or it becomes more dangerous for her to leave the doctor's office having her partner know that she has reported this, it may be in her best interest and her children's best interest to not disclose to you. And she should know that.

So this is just respectful prior consent. The other consideration is for some immigrant victims of domestic violence, they face fears of deportation. So there are those fears, and people deserve the information up front. And then, the little palm cards include some questions, sort of like a magazine quiz kind of questions. It says to the survivor, ask yourself some of these questions.

These can also be a tool for health care professionals, so if the health care professional wanted to just rephrase these questions and use them as an assessment tool, they could say, does your partner make you have sex when you don't want to? Rather than the question being turned to the survivor.

So it turns into a staff prompt, just by changing the wording, and they can be helpful to have a provider know the words to say if they want to ask those difficult questions.

Harm reduction. Some of the requirements of a health care professional learning this information are to reduce the harm to the survivor by making that link to how the domestic violence is affecting their health, and talking about safe ways to follow up so that they don't place her in any more danger.

And then what happens if you get a positive disclosure? People need to practice saying these words sometimes. They fumble. As I mentioned, a very comprehensive review of health care screening found that half of the health professionals who received a positive response stuck that in the file and never said a word about it. Talk about dangerous. How many years do you think it will be before she will disclose the next time? Probably many, because it wasn't safe to say it.

So people need help and training. This is the concern this raises. We are really thinking about what is the scope of training that is going to be required if health care professionals across the country will feel able to do an effective job of screening for domestic violence?

And then safety planning is a critical piece. Yes, there are some tips around safety planning here. But safety planning is not a checklist, it is a process. So sometimes we simplify safety planning, tell people to get together their birth certificate and figure out who they are going to call.

But safety planning is much more complex. It involves looking at that whole range of risks that somebody faces. There are risks from the abuser, there are risks from life, if they walk out of the door and don't have a home, don't have a place to send their children. So this is why we feel that it is critically important that as the Department implements and promotes this guideline about screening for intimate partner violence, it is going to be critically important to make sure that there is a strong connection to domestic violence service providers who can help in those next steps.

When domestic violence is disclosed, it is really important to make a warm referral. And some of the consensus guidelines have been around any provider who is going to ask that question should be prepared to either refer to in house advocates

or counselors, or to know very well that I can call the crisis center, and at the crisis center Kim is the advocate on call. May I refer to you Kim, or can I give Kim a call so that she can meet with you? That kind of warm referral, so that people know exactly what they are going to get. The provider should know what that program actually offers.

The Futures Without Violence, which runs the Health Resource Center on Domestic Violence, talks about every provider should make that sample call to the Domestic Violence Hotline to find out what happens when you disclose, so they can say, let me tell you, this is a good number. Here is what happens if you call. The warm referral.

These sound a bit like simple steps. But I just want to say that Dr. Liz Miller, with a National Institute of Mental Health grant, did a study of using safety card screening with an adolescent population in the San Francisco area. And so they provided some information. The prevention was actually just talking about the issue, saying you know, this issue happens so commonly that I talk to everybody who comes to my practice. And we ask some questions about this. So it normalizes this conversation. People know why they are being asked, not because they suspect.

And she did some screening with the adolescents who came into this clinic, and was surprised by the finding that first of all, they were finding all kinds of coercion around sabotaging birth control and that some of the adolescents coming into this pregnancy clinic were there because their abusive partner had sabotaged their birth control.

But following this intervention, there was a 71 percent reduction in the odds for pregnancy coercion compared to the control group, and that women receiving

the intervention were 60 percent more likely to end the relationship because they thought it unsafe.

Now very interesting. They weren't told that you have to end this relationship because it is unsafe. They were asked a few questions and told that it is very common among women, and they were given a little bit of information. And based on somebody just opening that door, these adolescents were far more likely to end the relationship because they found it to be not safe. It was pretty fascinating, amazing results.

So I want to get back to the whole idea of what is the role of the domestic violence advocate. People, and I think health care providers, probably need to understand better that the domestic violence programs are not beds and a hot meal, that the role of the domestic violence advocate is actually to talk through the safety planning, option planning. When victims of domestic violence come to a program, the number one thing that they request is help with thinking about what their options will be, and that is the role of the advocate.

So an advocate with a good relationship -- and I think there is going to be a lot of bridge building that needs to happen -- is going to feel as though they should respond to these referrals from health care professionals. They can provide a range of help, which I think takes the load off the health care professional, that boy, if I ask her about domestic violence then all of a sudden she and the kids don't have a home. What am I going to do?

The idea is that she should be linked to an advocate whose responsibility it is to work on that issue. And then there are also, there can be ongoing services. Nobody

has to leave their home that day. They may choose to go to a support group for a month or two and think about it. And that is a resource that can be made available to them.

So contacting that nearest domestic violence program, probably asking about a training, would be that normal step that would need to be in place, if a practice wants to start addressing domestic violence. A caveat, though. We suspect that increased screening in the health care setting will probably raise the number of referrals to domestic violence programs.

So there is going to be that need to ensure that there is some kind of capacity to respond to all those calls. We do know that there is a one-day census of domestic violence services every year. And the number goes up each year, the number of victims served. In a single day in domestic violence programs, over 67,000 victims are served, over 22,000 hotline calls are answered. And there are over 10,000 unmet requests for services, because programs can't always respond.

So looking at what needs to take place in those programs, in these partnerships, to ensure those services can be there, it may be that a large practice would need advocacy services available in house in order to respond appropriately. The Kaiser model, for instance, is one option.

Speaking of which, the Kaiser model. I just briefly want to talk about Kaiser Permanente in Northern California has been working on this model for several years now, and they are looking at this coordinated approach. And so the way they are doing this in their health care setting is this comprehensive model.

It includes onsite services for mental health clinicians, a simplified inquiry and referral, so that front line clinicians are prompted to ask questions in a simple way, and they know what to do next. Materials throughout the practice, so people know that

this is a safe place to talk about domestic violence. And they have made those linkages to community resources, so the community resources are able to respond.

Their identification of intimate partner violence has increased six times the rates. And it is very interesting to note that the departments that are providing most of those referrals, it is not the Emergency Room. It is mental health, and primary health care.

Kaiser of Northern California, not across the country, is providing this as part of everyday care, as part of their screening for depression, their prenatal care, teen clinics, and their chronic condition management programs. For example, part of their depression screening are these three questions around intimate partner violence.

In their clinical decision support assists, in their electronic records, questions about next steps, prompts come up for physicians and other health care providers. So it prompts them to ask these questions, and gives them a quick, on the spot advice about what to do, if they get a yes.

And I just want to say thank you to Bridget McCullough at Kaiser Permanente, who shared this information with the Coordinating Committee for Women's Health at the Department and also shared the use of her beautiful slides.

I wanted to speak a little bit about another group, like yours, a coordinating council focused on women's health. It has representatives from across the department. So we have NIH at the table, Office of Women's Health offices from around the country, CDC, all of the agencies and offices and the Department of Health and Human Services. And the coordinating committee has taken this on.

We have got Howard Koh, the Assistant Secretary's blessing, to make this a top priority for this year. Just recognizing that the new recommendations around

preventive services have a major impact on women's health. And he specifically encouraged the Coordinating Committee, and the Coordinating Committee enthusiastically adopted it, to focus on this issue of screening for intimate partner violence.

Because of the huge impact it has on health, and because of the need to do additional work, to develop the research on this, to develop tools and models and training for health care professionals around the country. And to also just look at how this needs to be integrated into health care systems across the department.

A few challenges and issues I think it is critical that we keep in mind. And this is a concern that will certainly be raised by domestic violence advocates -- the issue of mandatory reporting. One of the first tools we want to have in a toolkit is the reporting laws for every state. So providers know what needs to be reported, we will be able to follow the law, and we will be able to give that guidance to survivors before asking them questions.

In states with mandatory reporting, there are alternatives to asking questions or asking people to disclose. There is universal education and prevention, talking to people about saying we share this information on domestic violence with everybody we serve, to make sure the information gets to people without requiring them to step forward with a disclosure they are not ready to make.

So be very thoughtful about this in places where there is mandatory reporting. I also just want to mention, the State of Tennessee is looking at a new mandatory reporting law which has a different twist, which wouldn't require individuals to be disclosed. They are looking at a law that would require health care professionals to

report aggregate data about the number of disclosures of violence rather than reporting names and numbers.

So we can keep tabs on the scope of the problem without sharing personally identifying information. The other thing about mandatory reporting, and placing this information in electronic health records, is that insurance discrimination, which is one of the concerns that has always been out there around screening for domestic violence, the concern that if this becomes a pre-existing condition, it could be held against the survivor, and might change the rates for her health insurance and so forth.

With the passage of the Affordable Care Act, we were encouraged that the pre-existing condition would not be a problem. But that doesn't go into place until 2014. And as we all know, the law is being considered by the Supreme Court this week. So that is a powerful impact, and something that we really need to think about in terms of recommendations around what should be in health records.

Some of the other challenges, as I mentioned -- there is reporting to Child Protective Services, concerns from immigrants about deportation or disclosure. And there is also the issue of addressing all forms of interpersonal violence. The guideline, the screening guideline, reads interpersonal and domestic violence. In looking at the background, it appears that there is a concern about people from age 10 to 64, 65, that we need to be figuring out to what extent this also needs to cover child abuse, elder abuse.

But I am speaking today specifically around domestic violence, because there has been this 16-year history of developing screening tools and procedures and consensus, and we still have a long way to go. But we need to also look at exploring this further around other types of interpersonal violence.

There is a huge body of work out there, what has been done, documenting the need, developing the solutions, evaluating some of these outcomes. And we are fortunate that we can build on what has been created. So all of these organizations have developed, as I have mentioned, some wonderful tools. I am going to give you some links to websites where you can access any of those that are of interest.

It is important to take the next steps without reinventing the wheel. There is a lot of work to be done as we try to scale up and include these interventions more broadly, as recommended by this guideline on screening.

Some other opportunities for SAMHSA, as we came here we considered what are some of the resources and tools that SAMHSA supports, in which addressing domestic violence could be inserted into current and existing tools. Just insuring that our trauma informed work includes domestic violence informed activities, including safety planning and others, we have just identified some of the tools on the SAMHSA website that might be a great place to expand this work and attention to domestic violence.

That is my contact information for further information. Also, a few websites. I just want to tell you what they are. The first one has a summary of assessment tools shared by Dr. Jackie Campbell, a real expert in this field out of Johns Hopkins. And it includes some of the many assessment tools that have been investigated to date.

The other two websites are the Futures Without Violence Health Resource Center on Domestic Violence. You looked at many of their tools. And Carol Warshaw's National Center on Domestic Violence, Trauma and Mental Health. And one final thank you to all of those fine and smart people who shared their slides and information, some of which I shared with you today.

MS. ENOMOTO: Thank you, Mary Louise, that was great. We did go a little bit over, but I think that was well worth it, and gives us a lot of fodder for our conversation. I know we have got Marylouise times three, because there are several PowerPoint presentations in your booklets, so you get not only what she spoke to directly as well as some of the other materials from Carole, who I know is a big support in the presentation as well.

Do folks have immediate reactions, comments, questions?

DR. WARSHAW: Quickly, one of the things that is really critical is how people ask the questions. It is not just the screening tools, which seems very obvious. But in doing training with health care providers early on, people would say, no one hit they, did they? So in addition to not responding, when somebody says something, or whether someone else in the practice sees what is in the record and then the person feels like they are looked at differently.

So there are lots and lots of factors. And some of the barriers that we face in training physicians, it is not just the time and constraints and how medical training trains those capacities out of you. But it is whether your own personal experiences get involved.

Typically health care providers don't get training on being psychologically aware. And their own responses get in the way. And then medical training compounds that. And so there is a lot of work. There are always going to be people who are really great at this, and other people who you actually might not want to ask.

In the beginning I was sort of resistant to the computer generated questions, because I thought health care providers should be doing this. But often it ends

up being a way that people can get information and disclose what is going on in a way that is helpful to them, that bypasses someone who is not that empathic.

The other thing we learned in doing this at Cook County Hospital back starting in the eighties, was that often people won't disclose. It may take -- it was -- what's her name? the doc who did a study back – that women might be asked seven times before they disclose. And it was when it felt right to them, when it was the right person, when it was the right time.

It might be the person who was selling newspapers in the lobby or the taxi driver who brought them into the hospital. So it's thinking about all of the factors, and that people don't feel like I'm a detective, I have to get someone to disclose. Rather than creating a safe place for people to get the kind of universal information and make choices about what they do with that.

The other issue is around the electronic health records, and thinking about confidentiality. And also thinking, as those are developed for behavioral health practices, how to make sure that some of this is in there, and that the kinds of prompts that guide people are available.

MS. ENOMOTO: Are there modules that you know of being developed for screening and recording domestic violence in EHRs?

DR. KELLEY: There are a couple of models that we have actually been doing a little digging. It is not comprehensive. And as far as I know there are not federal standards. But there is, actually, a notice for NPRM, proposed rulemaking we currently had around electronic health records and what needs to be included in them and an opportunity to develop them.

But apparently there are hundreds of developers and some are developing modules around this. But the quality of those, or the guidance for the development of those, has not been federally driven.

DR. WARSHAW: One of the things that we may be working on with -- the National Network to End Domestic Violence has a Safety Technology group that looks at cyber stalking, but they are also looking at medical records and some of the confidentiality issues. So we may be partnering with them to look at some of that. There may be others.

DR. FINKELSTEIN: In the behavioral health electronic medical world I am not seeing a lot of domestic violence integrated into the EHRs right now. Our Alcohol and Drug Abuse Association, which is very strong, ADAA, in Massachusetts, has an actual certification process certifying the EHRs. I don't know if this has been given much thought. I don't see it in much of what I am looking at right now.

But the other thing, continuing on the kind of behavioral health issue, not the health but specific screening for DV. I think what you said is what we all know, at least in my experience, our providers have become much more comfortable, and I think some of this has been the WCVVS and all the trauma informed training of asking past history. But they are still not very comfortable at asking current safety questions.

And so I think it is a really huge need. It's training, but also attitudinal. And then there is the issue of what we learned years ago, with alcohol and drugs. It is not just enough to screen. They have to know what to do, because it is current. And I think that is really what stops them, because they ask the question and they have to worry about it, they have to do something.

Carole and I were talking about this earlier. We have a pilot project going on right now with our Batterers Intervention Program in the Department of Public Health. We have a certified Batterers Intervention in Massachusetts. We have been trying to work for years now with the Batterers Intervention, with Larry Bennett, and around screening within substance abuse of perpetrators, perpetration.

And there have been a lot of issues around that, a lot of controversy around it, the safety issues. It is clearly a missing link, and we have decided to do it a little bit through the back door by using Stephanie Griffith's Helping Men Recover. They have a new curriculum called Helping Men Recover, and there is a number of chapters on relationships.

And they do kind of get to power and control issues and relationship and violence through that backdoor of recovery. And so we are kind of piloting that while training the staff to recognize signs of perpetration in men's programs. We are doing it in men's substance abuse treatment programs. I just don't know if this has been anything that you have --

DR. KELLEY: It hasn't been part of the scope of what we are looking at. Very interesting. Talk about keeping the accountability where it belongs. But you are talking about screening for perpetration and then having responses?

DR. FINKELSTEIN: Yes. Well, it is complicated. It is a very complicated discussion between us and substance abuse and the batterers' intervention, because Carrie Pressman, who is basically the woman's person here in our Bureau of Substance Services, wants very much for this to happen and wants it to be a kind of treatment response.

But her batterers' intervention, there is that whole issue about the legal response. Which is why we have decided to go this more educational route, and maybe do something like that, and have the staff be more sensitive to identification.

It is a huge problem, because in the field of substance abuse, whether you believe alcohol and drugs exacerbates the situation or not, or pre-exists that, we have a lot of men in our treatment programs who are perpetrators.

DR. KELLEY: And we are assuming too, of course, in the domestic violence field, that many of their partners want to remain with them. And the problem needs to be solved by having them get treatment. I feel this, so it is a very pervasive problem across the country, that we don't have dedicated national programs or interventions for people who are abusive.

A major concern -- it is a different problem, but a very serious problem that affects all of us -- one of the other issues is, again, like we were talking about screening and assessment for domestic violence, you have to know what to do. And the same thing with batterers.

One of the issues that has come up around screening for perpetration in health care settings, it is very hard that an individual, if you are not really grounded in that, to either not collude, because you are trying to form a bond, or to not get judgmental and have the person go back and take it out on their partner.

And so it takes a lot for people to do that well, and have the safety pieces in place. Because you have confidentiality arrangements where you can't report to the partner about what is going on, or check in with them, which you can in batterer programs. And that is why individual treatment isn't really great for that.

So it is really having to really be grounded in that. And that is why the safety is first, to always be thinking about that, and the potential consequences. Then you could do it. And then there has been a lot of controversy around the trauma interventions, the more psychological interventions for batterers, and that don't hold them accountable. And yet if trauma is part of a history -- we always talk about that batterers have both the psychological need and the social permission. And it is not one or the other. So you have to have a way to respond that integrates and holds all of that.

Some of the interventions in communities of color have actually been dealing with that in a better way, because there is a sense of community, there is a sense that people want to stay connected to a community, there is a sense of shared oppression, that you can then make those connections. So there is a lot of thinking that goes in.

And having the support. Just like when you were saying about having those connections to DV advocates, having those connections to batterer intervention programs. Because you can't hold all of that, and it is a different relationship sometimes.

DR. FINKELSTEIN: The problem with the batterers intervention, which we have had this struggle, is why can't we get insurance. Is there the treatment approach which insurance won't pay for. This is a legal approach. It is complicated.

We are working on that, but we are also just trying to raise awareness. There is that, but there is also then the general awareness of victims, awareness of perpetration, and it links to substance use.

DR. WARSHAW: One of the things that I have learned from Patti Bland was, sometimes when a perpetrator is in recovery and is sober, he may be more dangerous than when he is more out of it. It sometimes doesn't work that way, but sometimes it does. And it is less safe than it was. There are lots of complicated things.

DR. FINKELSTEIN: That is what I meant to say. Part of the argument is that shouldn't this be part of recovery. The fact of the matter is, the definition of recovery should include nonviolence, it should include healthy relationships.

DR. WARSHAW: And the harms that you create.

DR. FINKELSTEIN: So isn't that part of the work that we should be doing for everyone, both perpetrators or survivors -- recovery. And this is the argument actually from the head of our Batterers Intervention Program in Massachusetts, saying hey wait a minute, shouldn't you be dealing with this issue. Because is somebody really in recovery if they are still continuing to batter? Not by the definitions of recovery that SAMHSA is using, or we are using, right? That is not really recovery.

DR. WARSHAW: There is another issue that you raise, and it is about mental health treatment. We used to say that in the health care system people didn't want to ask, but when they do, they would ask, they would have a response and then they would refer to a DV program. But in mental health treatment, there are all kinds of treatment modalities that are actually counterproductive and do harm.

And that was part of the resistance for wanting to go near the mental health system, like couples therapy, which isn't safe. Or things that are looking at the psychologically why did you keep choosing abusive partners instead of helping someone think about safety and hold the perpetrator accountable.

So that a lot of re-thinking or flooding exposure therapy when someone is still under siege for trauma. So of the ways people do treatment and their theoretical orientations, they also have to be part of the behavioral health side.

MS. ENOMOTO: I am going to check in with our other members. It is a lively discussion, an important one. I want to check in with other folks.

DR. BRISCOE: I am just listening and taking a lot of notes because that is not my area. Although, when you work in substance abuse treatment you are working with grief, loss, domestic violence, child abuse, you are working with all of that. But most importantly, I guess, first, do no harm, and getting individuals to get the help that they need without making it worse. Disclosure -- who to report to? When to report? How to ask the question so that somebody feels safe?

I like what you mentioned, saying this is kind of what I ask everybody. That is what I do in my assessment. I am going to be asking you questions that I ask everybody. I hope I don't offend you or scare you off in any way, and you are welcome to at any time say I would rather not answer that question, that's okay too. Just to put somebody at ease before I even start to ask the questions.

DR. KELLEY: I think your point about do no harm is very important. And I really think we need to be thoughtful across the department as we roll out the guideline, and promote its use. If a system is not ready to respond, do you even suggest that they open a can of worms?

An example of unintended consequences, about 15 years ago there was a real focus on raising visibility, the fact that children exposed to domestic violence are harmed. And the information about that became widespread, and systems not knowing how to respond, responded with the only tools they had.

So the child welfare system started taking children out of homes so that they would be safer. And just using whatever tools they had. It was actually more damaging, and some children were removed from protective parents because of that. So I think of that, and think through what it is going to take to prepare health care providers so that if they do open that can of worms, it will be able to close again.

DR. MURRY: I really like the idea of normalizing it in a way that it is part of a screening or a routine screening process. And as you were going through those questions, it is a normative part of the screening for all of the medical places that I go in Nashville. And it is asked in more than one context.

So when you first enter the practice, you are asked a set of questions -- how are you feeling, yada yada yada, in the context of that someone will read off the screen, and it's computerized, it's a medical electronic -- they will ask you this set of questions. Then you leave there and you go to the next station. Now they ask you the same questions over again.

But it is asked in multiple contexts. And it is just like asking me, when did you last have headaches about -- so it is all in that normative screening intake information context. I asked the woman one day that was the nurse, I said do you really think that this is working? She said yes, and then I said what if I had said yes. And she showed me on the screen what would have happened.

She would have been triggered to do something else that then would have led me to another place in the medical setting for something else to happen.

DR. KELLEY: One other thing I think, talking about normalizing, I think health care providers, too, it needs to be normalized. It is pertinent health information. If you are being hurt, punched, there may be a connection to those headaches, those migraines, that stomach pain, which will be misdiagnosed if the question isn't there. It is pertinent to the health.

MS. ENOMOTO: I think we need to keep reminding ourselves that it is a balance of risks, so I think do no harm is sometimes an excuse for, well we are not going

to ask because we are not ready, and we don't want to open the can of worms and we don't want to harm people, and children can get removed from families, et cetera.

That is a very convenient shield to not becoming informed and changing your system and introducing the trainings and the support that you need to, to be able to do it responsibly. Because it is also harmful not to ask. And it is also harmful to have a woman go back home to a violent situation without being given resources that might have saved her life. So I think we have to keep in mind the balance of risks with maintaining an impetus toward taking action and being informed and competent, and responsible to the population of women and children and men that need services.

DR. FINKELSTEIN: I was just going to add, because I agree with you totally, as you know. I remember, I have been doing trauma work for a long time. At the beginning of the WCVVS study, people were so terribly concerned that if we asked the questions about trauma, that we were going to do harm, that we were going to trigger. And in fact, what we all found, I know on our side and all of the sides, and we are talking over 2,000 women across the country. People more than thanked us for finally asking them the question that nobody had ever asked them.

And so I think sometimes it is used as an excuse, and sometimes it is used out of fear, because people think you are asking these questions and we are not going to know how to handle it. I have never had, in all the years we have been doing these questions we have not had that response for the most part, any harm coming from asking those questions.

DR. WARSHAW: I think the issue is more when people aren't trained to do it well and they don't know what to do, so they do something that actually is harmful.

In the study that was part of people were trained and there was an intervention to do. And I just think it has to be thoughtful. It is labor intensive to help.

We used to have people role play, and with medical students who hadn't solidified their interviewing skills it was easier for them. They seemed to have language. When we were training interns back in the Institute of Medicine, videotape was part of their interviewing skills. He was trying to ask her.

You could watch it afterwards and see how awkward he was, and when he said something that the woman he was talking to could actually connect with him, and when she totally disengaged because he was saying totally bizarre things that came into his head, because he didn't know what to say because he was uncomfortable. So anyway, there is a lot of work involved. But it is really important.

MS. ENOMOTO: Marylouise, you had in your slides just basic three sentences. I am so sorry this is happening in your life. You don't deserve this, it is not your fault. I am worried about your safety. Dr. Felitti had talked about what they trained their preventive medicine specialists to say in response to the ACE score is, and how has this affected you later in life?

Having a script of something to say, or having a decision tree that then helps you, if they say yes you don't have to freak out and it is not all on you. The system will support you in directing that person to a safe and responsible place that has competency to deal with their issues.

And I think that really most health care providers or other types of providers want to do the right thing and they are in human services because they want to help people. And the fear of doing harm and the fear of not being able to help people is, I think, what holds them back more.

DR. WARSHAW: I think having the video vignettes where they can actually see someone doing it helps a lot. Because some people just don't have a comfortable way of talking. In mental health you are more comfortable asking about a lot of those kinds of issues. In medicine, not necessarily. So I think it helps that if Futures had some online models.

DR. KELLEY: I did just want to mention this curriculum that went around. There is some very basic training. This one focused on home visitation settings, for Futures Without Bounds is doing some online curriculum. And this comes with video vignettes so people can see that modeling.

And the Future materials, also. That is part of the toolkit that we are developing in support of this work and the promotion of a guideline. So I agree. Those visuals, the online training. ACOG has also done online training on screening for domestic violence. It is available through them and some of the other medical associations are developing and doing medical education units around it.

I also wanted to mention, I was so struck by Dr. Felitti at the Women and Trauma Roundtable several people attended in December. He spoke, and he was talking about the ACE study, and sort of saying, people have known about this for 15 years. Why isn't it more widespread?

And he as a physician, he said -- his thinking, and I know he is a member of this Committee and I wish he were here -- he mentioned that whole issue of people having personal trauma histories and therefore being very uncomfortable with it. I really thought it was a very compelling reason, why it was interfering with peer professionals asking. That is another big issue.

MS. ENOMOTO: So how do you envision it? I was looking at the Happy Moms, Happy Babies, and just skimming it, I didn't see a lot in there. It said something about, now if we were asking why a person would stay in a relationship if this were child abuse, it is a different set of circumstances.

But it didn't really get into that many of the moms you will be visiting who are high risk moms may also have histories of other kinds of trauma and abuse, other than domestic violence. So how are you guys integrating that? I notice you had trauma informed, but I don't know if you were using trauma to be domestic violence informed, versus the other types of trauma. I know it is a challenge.

DR. KELLEY: A lot broader than that, and I would also welcome Carole to talk further about that -- it has been a process in developing truly trauma informed work in domestic violence programs. Carol is working with HHS now and broadening that initiative, working with state domestic violence coalitions around training capacity building for programs.

And it has been, as some of the people who have been involved in this work are saying, this trauma informed work is transformative. They are finding that doing a trauma informed lens on their work is not only changing interventions, but it is changing how they approach their work.

And it has included things like doing an entire review of the rules that are in a program. If we have this congregate living setting where we have all kinds of rules and don't understand how that might affect a survivor who has been controlled in the past, are we truly trauma informed.

So the domestic violence programs who have been engaged in this process have been really changing their practice. But it has required a real process of reflective

supervision, changing rules. We have some of the coalitions that are changing their standards to make sure that the programs statewide are doing trauma informed approaches.

It is spreading, and the openness to this trauma informed approach across domestic violence programs, from what I am seeing we are having people very accepting and excited about the approach, and it has been a real transition. So it is broader. But it takes a lot of process and training. You have been doing a lot of that.

DR. WARSHAW: I think when we started doing this work, part of the issues, a lot of programs didn't take in women who had any kind of mental health history, if they were taking Prozac. That has really changed. But I think part of what would come up was when women were having responses to trauma in a collective living situation and it affected their interactions with staff.

So it is the awareness of complex trauma and lifetime trauma and how that affects survivors and how it affects them in that situation, how it affects staff whose own responses are being affected, whether it is from their own trauma history or from just their reactions to what people bring, as they manage their own experiences.

So it is meant, training people about all of that, so the other half of the equation of being trauma informed is our own responses and our own organizations, and what the organizational structure supports, staff, and being reflective and empathic and aware of your own reactions so you are not managing them at the expense of yourself or other people.

So it means working at all those levels in order to have people be able to be professional and respond more effectively and provide the kind of normative information that helps survivors make sense of their own experience.

So that has been part of it within the DV world, is bringing in that whole context of lifetime trauma and social-political, cultural trauma, historical trauma, immigration-related trauma. So people really have a sense of how not only are the women who come in as survivors affected, but also how staff and organizations are affected as well.

A kind of parallel process, understanding counter transference and how that works. We don't talk about it that way, and vicarious trauma. So it is how you find the balance to be able to do the work well, as opposed to the bubble bath version of self care.

DR. KELLEY: In addition to the training and technical assistance that you are offering, just at a federal level, part of our role, too, is guidance around priorities and accountability. We have this year included as part of our process of funding state domestic violence coalitions and the state funding that goes to programs, asked each of the coalitions to do an assessment of their capacity, to provide training and technical assistance around trauma informed services so that we can get a gauge of where we are nationally, and what some of the next steps are going to be.

So it is something that we are really working on very strongly, and are addressing across the domestic violence programs across the nation.

DR. WARSHAW: One of the other issues is people not having access to trauma treatment that is affordable. So part of what we are trying to think about, again, what are other models that maybe don't need a professional to deliver them, or the same thing with substance treatment.

I think that is one of the areas where working together is going to be really critical. In a community, how do you provide the resources? What is the level that

someone who is not a clinician, a domestic violence advocate could learn and do and create in a program

What is the kind of baseline do no harm? What is the enhanced services? Using some of Stephanie's curricula in a DV setting. Or our advocacy curriculum that is based on child-parent psychotherapy, and what do you need a clinician for and what do you need partnerships.

So the other half of our work is always partnering the mental health and substance abuse providers, and thinking at the state level as well, how could you come together and figure that out. So some of what we do in some states is trauma training for mental health folks so that then they have more capacity to partner. It is all wrapped together.

MS. ENOMOTO: I do think there is a lot of room for collaboration in the future, where we have talked about different types of trauma and different systems. As you said, the Kaiser referrals, we are really talking about a lot of the same people, the same women going to primary care, going to mental health, going to domestic violence. So that we can start speaking the same language, and having access to some of the same tools and systems will be a good thing, I think, for women and kids.

I want to thank both of our speakers, both Marylouise and Norma for their great presentations. Norma is running to the airport. For the committee members, we are at a time for a break, although we do have an option either to continue our conversation and try to end a little bit early. We can take a break or we can keep going, but we will excuse our speakers, who are anxious to go. (Applause)

(Housekeeping details)

Agenda Item: ACWA Discussion and Recommendations continued

MS. ENOMOTO: We are going to move ahead to the 3:45 ACWS discussion, continued. So we can continue to discuss issues around the intersection of being able to help domestic violence and trauma, or you may also revisit any other subject or introduce a subject.

MS. ROBBINS: In listening to the discussion around domestic violence, generally treatment is exactly kind of that comprehensive systemic care look at the family, seeing those who come through the door. It is that need that our substance abuse programs, or our mental health programs, or the domestic violence programs, don't have to do it on their own, that they can partner and collaborate and coordinate services together because we all have our own niche in this.

And the fact that we can actually get farther along if we can figure out how to work together in a comprehensive manner, I think that is what we have tried to do with the PPW programs, with the advisory committees that we have asked them to build over the years, with all of our women and children's programs. So it was great to hear the conversation going in that direction.

DR. WARSHAW: One other thing. When we were starting to do this mental health coalition study with the National and Domestic Violence Hotline, one of the issues that came up was referral sources around the country. And they referred people to the SAMHSA website.

We thought about were there peer support resources around the country. I talked to a bunch of people, including Mary Blake was involved, and Kathy Carroway and Renie(?). And there wasn't a national kind of resource of trauma informed or DV

informed peer support, and we talked about maybe trying to do something about that as well, just to think about what are the resources and supports.

One of the things that we are doing, and actually it was an OBW Ending Violence Against Women with Disabilities project in Illinois. It was a partnership with a community DV program, state psychiatric hospitals and a big conference of community mental health centers, psycho-social rehab organization.

Our idea was to build support with the recovery support specialists who could then be cross trained and provide supports in whatever setting women turned up. And part of that worked and part of it didn't, because of funding cuts and people losing positions and then not rehiring. But as a model we were thinking about trying to do some of that. It is something to think about going forward.

MS. ENOMOTO: I think we have been looking at our locators. We currently serve two separate locators, a subsidies treatment locator and a mental health locator. The subsidies treatment locator is much more expansive than the mental health one at this time, just different levels of investment over time. But we are looking to bring those closer together.

I know that the substance abuse one does indicate whether or not an agency provides trauma informed care. Whether or not it is peer based, recovery oriented, or peer led, it doesn't get into that level of detail? They are generally, I think, state recognized treatment providers on both sides.

So again, for a recovery organization to be recognized it would have to be one where it got through the certified peer specialists, or some other kind of licensed, credentialed provider. But it would certainly be a thing to look forward to as we go,

moving as the block grants evolve to supporting more of those services that are not the third party payer reimburse services.

We will need to keep a better track of the kinds of wrap around supports that people really need and want.

DR. BRISCOE: When I mentioned earlier first do no harm, that doesn't mean we don't ask the questions. We do ask the questions. But as most therapists, and as a psychologist you are trained for years and years on how to set the tone so that people feel comfortable answering questions.

So if they have gotten through me and it still hasn't come out, then we do the ACE scores. And then after that if it still hasn't come up the nurse meets with them. And so they have many opportunities to meet with somebody who maybe they feel more comfortable disclosing with, because not everybody has that essence, that aura, or whatever it is.

But just asking the question, and maybe they may not answer it at the time, but at least it sends up an, okay, I am being asked, maybe it is not such a scary thing, maybe it is not so embarrassing, but how to do it in a non-judgmental way.

I wanted to ask you a question about validate and support. I am so sorry this is happening in your life, you don't deserve this. That sounds kind of judgmental. So you could help me with that. Help me out with that. You don't deserve this.

DR. WARSHAW: The things that are scripted sound scripted unless you are actually having interaction. But a lot of times abusers say I am doing this because it is your fault, and blame the victim for the abuse. And so it is to counteract that, that no one deserves to be treated this way.

DR. BRISCOE: Where I am going with that is that you don't deserve this, they know that, but you telling them makes them feel like, I think, that something must be wrong with me.

MS. ENOMOTO: Something is wrong with you that you are letting this happen when it shouldn't be happening?

DR. BRISCOE: Right.

DR. WARSHAW: I think it is saying it in a way that is kind of attuned to the person, as opposed to just scripted. It sounds really weird when you just say it like --

DR. BRISCOE: You don't deserve this?

MS. ENOMOTO: Yes. I think there are many people that get convinced that it is exactly what they deserve.

DR. BRISCOE: I totally agree with that. What I am saying is that by saying you don't deserve this, are you then putting on the person what is wrong with you because you continue to be in a relationship that you don't deserve this?

MS. ENOMOTO: I think it is probably meeting the person where they are. For someone who has already recognized that they don't deserve this, and yet they are stuck and they can't get out, that is probably not a very helpful thing to say. But for someone who says, well he does this, because I don't clean up, because I got home late, because dinner wasn't ready, because if I didn't mouth off so much.

I think it is even trying to get that first light bulb to go off, that actually no, this isn't really an okay way for anybody to treat another person.

DR. BRISCOE: But I think that they have some kind of understanding, women have some sense that yes, this isn't probably a good thing that somebody is slapping me around.

DR. WARSHAW: I think a lot of people are convinced it is my fault because I did this, or because I did that, or because I was drinking or because I didn't do this. And so it is a way of engaging with someone around that, as opposed to just a statement that you say. If you say, you don't deserve to be treated that way, what are you doing there, that is totally different than when you engage someone and say you don't deserve that, nobody does.

But you have to acknowledge -- there is a whole thing that we didn't talk about that comes from, it was called Safety Planning with Battered Women, by Jill Davies and Eleanor Lyon. They are writing a new version of it right now.

And they do this whole kind of risk analysis with women about why women make the choices they do and how complicated it is, and all the things that you have to weigh in making choices and being safe, protecting your kids, dealing with economic issues, is it more dangerous to leave or to stay.

So it really acknowledges that women are thinking all the time, what is the best choice within the range of things that they have room to even think about. Sometimes just creating that space where someone can think a little bit opens that out. But then they have to deal with, okay, then what do I do. Because the critical mass of what makes it possible to make a shift isn't there.

And then they are alone with that when they have to go back to that situation. We found, when we were at Cook County Hospital, maybe 10 percent of women wanted a shelter. We had on site advocates. And mostly people wanted information, they wanted other kind of resources. They were kind of figuring out for themselves, this was input in a way that supported them, created a little space where they felt differently, had a different kind of experience.

And then at some point, they might make a different choice, depending on the balance of power in their lives. If it is just saying that without any context, it could be done badly. I don't think anything without some training and maybe even role plays, being able to talk about what comes up and hearing yourself.

Some of the controversies about routine screening that came from Canada and England and Australia, because people were starting to implement without training. And women had bad experiences. That is why hearing that is so critical.

DR. MURRY: How prevalent is this kind of training in medical schools?

DR. WARSHAW: I don't know the answer now. I was doing health care and domestic violence a long time ago, and at that time there wasn't a lot, although people would have maybe one little thing, which doesn't necessarily teach you how to do that. We did a course at University of Chicago for a couple of years. It was an elective.

People got eight, 10 weeks, they went to the shelter, they went to courts, they did a lot of role playing, a lot of thinking. But that didn't last. I also think that even when people get their training, a lot of it gets trained out of you in medical training. And it is not valued, it is not reinforced on your rotations.

We had someone who was another ER doc, who did training with judges before she came there. She was a real activist, and she didn't even ask routinely because her role was so different. So there has to be a lot of support and reinforcement, and that's why I think the work that Rich has done at Kaiser where they put a lot of supports in place in the whole system.

And they bring people together and there is a champion in each site. Is there someone there who can be the person who carries it and can have those hard conversations? It can be the person someone calls, especially a colleague, when they are

over their heads. It is that kind of mentoring that really helps it take hold, someone who keeps reminding people and helps them get over whatever barriers are there for them. And there are different ones, depending on where they are working.

DR. MURRY: It has such major implications for people's health and wellness. It would be great, if that was just one of the core courses, because it will help them understand better how to treat. With the prevalence of these situations, it would just be incredibly asset to a medical intern.

DR. WARSHAW: I think when the US Preventive Health Task Force downgraded screening for domestic violence to a C, that there wasn't evidence, it was partly because we had originally wanted screening to be like how people thought of health care screening, like PAP smears or colonoscopies. And it didn't meet those criteria.

It was so silly, because why wouldn't you want to know what is going on in someone's life that is affecting their health and mental health? That includes trauma, it includes economics, the social history of medicine is like do you smoke and do you drink. It is not what is going on in your life or what happened that is affecting you now.

And so it is that kind of training that integrates all of that, I think, that would be a whole sea change in medicine.

MS. ENOMOTO: I think the good news is with the IOM recommendations and the HHS endorsement as clinical preventive services for women, this does put a foothold in the awareness of academic medicine, that this is endorsed. And it is also a reimbursed service, it will be a reimbursed service, which also helps to make things happen. Although screening and brief intervention for alcohol is a reimbursed service, and not everybody does that either.

DR. WARSHAW: It is like when people were really uncomfortable asking about sexual histories when HIV first started. People had to get over it.

MS. ENOMOTO: So I appreciate today's conversations. I think we had a very rich start to our day. It was Sharon's idea to do the film, to help ground us, because we are not all working with young people. Also, for the eye opening opportunity, to see what could be happening with young people at risk. I think that was a good conversation, about what we could do with schools, with what schools could, should be, are already doing, what young people can do for each other and what SAMHSA can do.

And then with Norma's presentation, I thought that was really exciting to see what one state and one provider group is doing, very innovative stuff to reach young women in their state, and being adaptive to changing health care contexts as well as to the different populations that they are trying to serve. And finding ways to weave and dodge through all the complex financing, to reach the girls that are hardest to reach.

And then Marylouise and Carole, really giving us a great overview of this area of domestic violence screening and brief intervention where ACWS really hasn't gone before, and where there is room both for SAMHSA to grow as well as the DV field, bringing our mutual interests together and serving people as whole people. These things probably travel in packs. These issues probably travel in clusters.

And so to the degree that we can get our shared set of providers and systems speaking fluently in both languages or all the different languages or the different parlances and access to the shared set of resources, I think the more efficient we will be as communities. I thank you all for participating in those conversations and for your insights with your different individual perspectives. We have a great group here.

Geretta has a couple of things looking forward already, because today is our first meeting of fiscal year 2012, and we will have one more meeting within this fiscal year, and talking about the date and those topics.

MS. WOOD: We have scheduled our next series of meetings August 8th, 9th and 10th. It is not definite, but tentatively the ACWS will meet on Wednesday, August 8th, and not potentially the joint committee would be August 9th. That is tentative, but the dates are 8, 9 and 10. If you can work your calendars around that in advance that would be helpful to all of us. Thank you again for participating today. I have enjoyed meeting all of you.

We wanted to throw out the idea of topics for the next meeting, some things you would like to hear discussed. Do any of you have some ideas? Anything specific to women and girls that you think would be a good area to explore in the fall?

MS. ROBBINS: I was wondering if we could talk a bit about medication assisted therapy and pregnant women.

MS. WOOD: Okay.

MS. ROBBINS: I have some suggestions around speakers as well.

MS. WOOD: Could you email those to me, please.

MS. ROBBINS: I sure could.

DR. WARSHAW: HRSA has an initiative on post partum depression and intimate partner violence that Chandelle(?) has been involved with, and it is connected with the home visitation. I don't know if you have talked about that before.

MS. ENOMOTO: Possibly the home visitation program in general we haven't really talked about. Home visitation and MAT for pregnant women may tie

nicely together. We could do a panel looking at sets of perinatal services. We might bring in PPW as well.

DR. WARSHAW: Last August we talked about gender responsive mental health services. I don't know if anything moved forward with that or if there are ways to just do updates on where things are. For things we have already talked about, is there some kind of agenda that could help move that forward rather than just being a topic.

I don't know what fits in with what you can do now, or what you are interested in, priorities, with the peer support work and trauma and gender and what is going on there.

MS. ENOMOTO: We are limited in the number of new programs and new initiatives that we can do. But I think we might have mentioned before, we have looked at the background applications and for the first time asked folks to, on the mental health side, requested information, did not require it but requested that they describe how they are providing services to women, which for many years it has been a requirement on the substance abuse side and has not been a requirement on the mental health side.

And so it is still not a requirement, because we didn't change the law. But we did do a joint application where we gave the states an opportunity and encouraged them to report on both sides. Many states actually did tell us what they were doing around women. So we could maybe get the report out on what states indicated in their block grant applications that they were doing.

DR. WARSHAW: Are there any models with people doing something really great that would be worth other people hearing about?

MS. ENOMOTO: We will have to see how much there is there. We are just trying to start the ball rolling. I appreciate it, that's very good.

DR. WARSHAW: I was thinking about the whole system that is in place, Starleen, that you are involved with around substance abuse. I know there is not funding to do the same kind of thing, of women's services and mental health. But I wonder if there are any lessons from that model, that states could at least start to think about.

Or, if they already have someone doing that on the substance abuse side, to encourage someone to kind of learn from how they are doing things, if there is some way to parlay that to help with re-thinking mental health services, even if there is not that much funding attached to it.

MS. ROBBINS: You mean in terms of the women's services coordinators and kind of coordinating the gender-specific services?

DR. WARSHAW: Yes.

MS. ROBBINS: I think for most of the states who actually did choose to do the combined block grants, many of the women's coordinators probably were the folks who were spearheading the mental health side as well. So I can actually put some feelers out as well to see if we have any folks who have programs or have curricula set up already in their states that are doing some of the things that we are interested in hearing about.

MS. ENOMOTO: That sounds great. One other topic that I had thought of that was inspired somewhat by Velma's questions and Norma's presentation, is some of the revisiting. We have done this at different times, but revisiting the needs of specific, either ethnic and racial minority groups, or other subgroups of women.

So looking at what are the specific needs of African-American and Latina women, how do they differ from women in Indian country or Alaskan natives or women in the Pacific or other Asian-Americans? Just looking at some of those different

subpopulations. Women are not a monolith, girls are not a monolith. What are the different needs for different kinds of programs.

DR. MURRY: Do we address women in military issues? Military related issues and their needs?

MS. ENOMOTO: This committee hasn't. Another thing is that we started getting into the salad bowl of ideas, which it is tempting. I am contributing as well -- to have a priority setting conversation. Just to be in full disclosure, it is not like it is then going to translate into lots of money or a big new program.

However, if this set of advisors can -- we have had now a few meetings where you have had a chance to hear different things, go to the joint advisory council meetings, and to say given the lay of the land we think as SAMHSA does focus on women, these one, two, three, five issues, would really be the top priorities for when there are opportunities. So when we are shaping the new block grant application we add in the joint planning for women type of thing.

But is that more important than domestic violence screening or trauma screening? Or is criminal justice, or is it the military family, military sexual violence, is it early childhood prevention, aging? That does help us as we do the work that we do. Often when there is an opportunity to advance a particular topic or a particular population or to address the needs of a population, because someone else is doing something on women and we can sneak a sentence or a few words in there.

If we have some of the priorities from this group we can have that at the ready in a more proactive way. So that could be another opportunity we have done in the past, which is get a facilitator and do some pre work, and then get the group to spend time

saying, of all the issues these are the ones we think, or this is how we define these terms and these are the ones we think should be a priority, or we would like to hear about later.

DR. WARSHAW: Another thought based on what you were talking about earlier this morning, about are there community based models that are responding to trauma or the needs of women and girls that aren't necessarily delivered by the mental health or substance abuse systems that are worth knowing about, that could be supported or communicated?

I am just thinking about what SAMHSA's priorities are, and then what are resources out there that could be at least shared with SAMHSA grantees, even if they are not funded to do it. People always want to know about things, if they have other resources that they can at least be creative about.

Agenda Item: Public Comment

MS. ENOMOTO: Others? Everyone's good? So at this point I would like to see if there are any public comment. We did not have anyone scheduled. And Katie, we don't have anyone? (None) These are all our staff, so I am sorry you don't get to make public comments. (Laughter) Thank you for being here.

Agenda Item: Closing Remarks/Adjourn

With that, I think it was a fantastic day. It was really a very rich conversation, spurred some new thinking. Pam, generally we don't have her sit through presentations. I think that was a good one for her to hear and see, the unique needs of adolescent girls and some creative ways of trying to get to them. Which is helpful, as we

prioritize our programs in the macro sense, to have some reminder of how all that plays out, or one particular slice of all the many populations we are trying to serve.

So I thank all of you for your great comments, your insights, your facilitation and your collegiality. Again, I look forward to meeting with you again August 8th and 9th. Hold the date and fill it in. And with that, by the power vested in me, I adjourn this meeting.

MS. WOOD: Maybe we could have a discussion about that, that the role of this committee is to provide advice and recommendations to the agency, and we are trying to move more in that realm. Do you want to add anything?

MS. ENOMOTO: Yes. I think we already adjourned the meeting.

[Whereupon, at 4:00 p.m., the meeting was adjourned.]