SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

ADVISORY COMMITTEE FOR WOMEN'S SERVICES MEETING

9:05 a.m.

Monday, August 15, 2011

1 Choke Cherry Road

Rockville, Maryland 20857

PROCEEDINGS

MS. GRAHAM: Good morning. This meeting of the SAMHSA Women's Advisory Committee is now called to order. Ms. Kana Enomoto is the Chair.

Kana?

MS. ENOMOTO: Thank you very much. Okay. Thank you very much. Good morning.

FEMALE SPEAKER: Good morning.

MS. ENOMOTO: I am pleased to be here with this convening of the Advisory Committee for Women's Services. We have five members in the room and one member on the phone. So let's start with just going around and introducing ourselves. We also have a new addition to our team at this table, and we'll talk about that in a little bit.

So we'll start with Bobby.

MS. BENAVENTE: Huffadey. My name is Barbara Benavente. I go by Bobby. And I'm with the Guam Department of Mental Health and Substance Abuse. and good afternoon.

FEMALE SPEAKER: You were the disembodied voice on the phone.

MS. BENAVENTE: Yes, that was me.

FEMALE SPEAKER: Welcome.

MS. FORMAN: Hi. I'm Harriet Forman, retired preschool consultant with an educational background. Nice to be here.

MS. SCOTT-ROBBINS: And I'm Starleen Scott-Robbins. I'm with the North Carolina Division of Mental Health Developmental Disabilities and Substance Abuse Services.

DR. CAMPBELL: I'm Jean Campbell. Sorry. I'm somewhat discombobulated this morning. So I'm Jean Campbell. I'm from the Missouri Institute of Mental Health, where I direct the Program in Consumer Studies and Training. And today I have two meetings going on simultaneously, so I apologize for not getting in here when it started.

MS. BRISCOE: My name's Yolanda Briscoe. I'm a psychologist and also an educator. And I work and live in Santa Fe, New Mexico. I'm very happy to be here.

MS. ENOMOTO: And we'd like to go to the phone to our mom-to-be.

MS. BERGEN: Hello. This is Johanna Bergen. And I serve on East -- National as a board member. Happy to be with you via phone today.

MS. ENOMOTO: How are you doing, Johanna?

MS. BERGEN: I'm all right. I have allergies, so I sound a little stuffed up. But I'm about six days from a baby, so doing okay, I think.

MS. ENOMOTO: Great. Great. Well, we are excited with you. Thank you. Thank you for being on the phone. We appreciate it.

We'll go around the room as well. But I want to acknowledge our additions to the ACWS team that will be -- I think you've been introduced by e-mail and by phone. But now it is in person. We are happy to welcome in the Office of Policy, Planning and Innovation, Planning and Planning and Innovation, OPI, Cynthia Graham is on detail from the Center for Substance Abuse Treatment. She is our Committee Management Officer for all of SAMHSA. And in addition to managing the NAC, the Joint NAC, and shepherding the other Center Council, she is also the designated federal official for the ACWS. And she's replacing

Nevine Gahed, who is actually newly the Special Assistant to the Director of OPI. So we have a number of transitions going on.

And we are also welcoming in person Sharon Amatetti, who is the Administrator's fantastic choice and my choice also, to be SAMHSA's Women's Issues Coordinator. So I'll just let you both say a few words of greeting.

MS. GRAHAM: I'm very delighted to have this opportunity to work with you. I think I probably have spoken with either of you via phone or e-mail. And we hope that we were able to accommodate you and that your stay here has been good thus far, in spite of the weather and perhaps travel conditions. But, as we work with you and you with us, we hope to make things better. Thank you for coming.

MS. AMATETTI: And I'd also like to welcome everybody in person. I am Sharon Amatetti. I'm a long-time SAMHSA employee. We're getting ready to celebrate the 20th anniversary of SAMHSA, and I was here at the beginning. So I'm proud of that. And I'm very passionate about issues having to do with women

and families. And looking forward to working more closely with you. Thank you.

MS. ENOMOTO: And let's, if we could, go around the room also, starting with Abby. If folks would just introduce themselves and, sort of, say -- tell us what you're doing.

MS. SMITH: Abby Smith, [inaudible] Group [inaudible].

FEMALE SPEAKER: [Inaudible] with [inaudible] Group.

FEMALE SPEAKER: I'm Irene [inaudible]. And I'd like to [inaudible].

COURT REPORTER: My name's Greg Altham. I'm [inaudible].

FEMALE SPEAKER: I'm [inaudible]. I'm the State Project Officer for the Center for Substance Abuse Treatment at SAMHSA. And I'm a member of the team that overseas the Substance Abuse Prevention and Treatment block grant that goes to all the [inaudible].

FEMALE SPEAKER: [Inaudible]. I previously worked for the state of Colorado, where I was the

[inaudible] of treatment. And previous to that, I directed from [inaudible] Colorado Substance Abuse Treatment [inaudible].

MS. WORSBURG: I'm Sarah Worsburg. I work for [inaudible] Women's Service Network [inaudible].

MS. RICHARDS: Good morning. I'm Claudia Richards, Senior Advisor to the Office of the Director for the Center for Sex Abuse Prevention. And currently, I'm working [inaudible] and also a new member of the ACWS [inaudible]. Happy to be a part of this really [inaudible].

FEMALE SPEAKER: Hi, I'm [inaudible].

FEMALE SPEAKER: And I'm Marissa Delign. I'm with [inaudible] Associates. And I'm a contractor, and I work with Cynthia [inaudible].

MS. ENOMOTO: All right, thank you. I always think it's helpful to know who's in the room, for everyone's comfort and enjoyment.

I want to acknowledge that Dr. Covington, Stephanie Covington and Amanda Manbeck are not with us today. Stephanie is on travel. And I hope that Amanda is well, but productively occupied. Both of

them are leaving the ACWS. This would have been their last meeting, had they been able to attend. So we're sorry that we're not able to present them with their beautiful ACWS pink plaques in person. But they will be getting them. And we will miss them dearly. They've both made really incredible contributions to the group.

DR. CAMPBELL: We get plaques? Wow.

[Laughter.]

DR. CAMPBELL: Membership benefit.

MS. ENOMOTO: You're right. Right, right. And, you know, 10 percent off at Safeway would be nice.

[Laughter.]

MS. ENOMOTO: Yeah, right. Sorry, that's just a joke.

[Laughter.]

MS. ENOMOTO: But, yes, we will miss them for their terms. Each of them made a unique and rich contribution to our conversations and to the direction of activities at SAMHSA. So we were lucky to have them for the period that we did.

We also will be having Dr. Felitti and Dr.

McBride Murry join us shortly. They are on their way, but delayed due to travel difficulties. And I understand that some others of you have had long trips and rigorous challenges along the way. And we appreciate you being here. I know it was some bad weather yesterday. But we will forge on.

And we have now a few days of meetings. And, again, I appreciate -- I realize that this is a big chunk of time people are taking out. It's, you know, four days and all the traveling -- or four and-a-half or five days, for some others of you who are coming all the way from the Pacific. But, you know, I think the direction that we're taking, as you can see now, on a regular basis, of having the Advisory Committee for Women meeting together at the same time as the Joint National Advisory Committee and the other Centers is really -- I mean, it's really signaling a new direction for SAMHSA and an incredible opportunity for everyone to be in the same place at the same time to hear the same messages, and at the same time, provide their specific expertise and guidance to us.

I think we did a Joint National Advisory

Committee as an experiment, but found that it was so rich in the dialogue and people were so engaged in speaking with one another, that, I think, we're going to continue this strategy, probably a little bit to Cynthia's dismay, because it is a Herculean effort to do all this logistics for seven committees at once, the staff, the NAC, the Center NACs, and ACWS. So it's a lot. If we'd just add the Drug Testing Advisory Board, you'd really have a party.

[Laughter.]

MS. ENOMOTO: But, no, we're going to let them stay separate for now. But, you know, the benefit is -- and so, you know, I appreciate -- I know it's a big chunk of time for everybody. It's a commitment. And poor Jean now has this conflict with the Center Subcommittee. But the benefit really, if you think about where we're headed, if you look at the SAMHSA vision where behavioral health and sexual health, prevention works. Treatment is effective. People recover. These things need to work together.

And our committees and our centers -- our centers need to be working together. They need to, not only

be working together within SAMHSA, but we need to be working together with the field and not within behavioral health field, but within health care, and not just within health care, but within human services with education, with Justice, with Child Welfare.

And, Jean?

DR. CAMPBELL: I was just going to say, because I'm looking at two agendas right now, that one way to work together would be to make sure that key issues on one agenda also appear on the other. For example, in the Consumer Subcommittee, they're going to have a discussion about the new definition of recovery. Now, we have an issue about recovery, critical issues in recovery. But it would have been good to have, I mean, other things as well that -- and I would say with the other committees and stuff, too, similar things on the agenda so we're considering these.

And then, have some way to be able to report out what this committee said on that, what this committee -- I mean, I would be very interested in that, like, to know what the tribes are responding to on the definition of recovery and --

MS. ENOMOTO: Well, actually, you will have that opportunity at the Joint National Advisory Committee meeting, because we are going to have that conversation with all the committees at once.

DR. CAMPBELL: But that's not the same thing as internal to our meeting having a discussion and then bringing that perspective and sharing that with the consumers and the --

MS. ENOMOTO: Right. Right. Well --

DR. CAMPBELL: -- then moving forward.

MS. ENOMOTO: Yeah. That's a good input. I think scheduling would be tricky. And then, you'd have to put the Joint NAC at the end in order to allow everybody, sort of, that caucus time on the front side. But, certainly, it's something to think about. We've tried to arrange it so that we could have enough space and room that we have half the people coming in a day early and then the other half of the people staying, sort of, the days later.

DR. CAMPBELL: Well, it doesn't have to be a perfect approach.

MS. ENOMOTO: Yeah.

DR. CAMPBELL: But I think it would be helpful because one group could inform another. And it's also another way for -- like, I had never thought, in all the years being on the Consumer Subcommittee -- I mean, we don't deal with identity politics. So it's the broader issue of mental health consumers rather than thinking about women and girls. But now, I'm thinking that that is an important understanding to bring to that subcommittee. And I think it also works the other way. Because I do a presentation this afternoon, and I was thinking -- on recovery -- and I was thinking, "Well, what may they not know about that in this group focusing on women and girls"? So, I mean, I think that that could serve a broader benefit.

MS. ENOMOTO: Right, right. Yeah. Well, I definitely think we can take that back and look at how do we integrate agendas with one another in a really productive way. Thank you.

Harriet?

MS. FORMAN: Yeah, I think what you're saying, kind of, is it helps to raise consciousness of, you know, issues in each place. It spreads the

consciousness by, you know, sharing that.

MS. ENOMOTO: Right. Yeah. Okay, great. Well, I appreciate that input. And we will definitely put our heads together on how we can use the different committees and their meetings in strategic ways to provide -- to bring perspective to the larger ones. Because I don't know that -- and we can actually still talk about that today. I mean, it's not like the day is gone. We can talk about it today. You know, let's look at the agenda for the Joint National Advisory Committee meeting and see about are there some key messages that you all would like to bring to that.

We do have a session focused on women's and girls' issues in the Joint National Advisory Committee meeting, which is -- I mean, that was, sort of, some of the intent that the Administrator had heard this committee loud and clear about where are women and girls in the strategic initiatives, how are they playing in across SAMHSA's programmatic activity. And so, she's decided to bring that to all the groups to think about.

And so, within that, as Starleen's presenting,

Sharon's presenting -- Jean, you'll be presenting on the --

DR. CAMPBELL: Workforce.

MS. ENOMOTO: -- workforce piece. So, I mean, we've done -- okay. We've done some -- we put some effort into trying to bring the ACWS perspective to the main part of the meeting. And so, if there are key messages that we, as a group, think, you know, Jean, could you bring this up at the workforce session, you know, Starleen, could you bring this up in the women's and girls session or --

DR. CAMPBELL: That would be really helpful because I hadn't even thought about it in the context of women and girls' issues.

MS. ENOMOTO: Right, right.

DR. CAMPBELL: The workforce.

MS. ENOMOTO: Right, right. So that's -- I mean, that's good. I mean, that's great. That's how we should be using this group in ways to advance the issues as the collective rather than as just individuals working independently.

Okay. So I have some remarks prepared for you

all about our exciting budget debt ceiling future and what the implications are for SAMHSA, as much as we know, which are distil at best, but still some insight, which some of you may not have gotten out of the news, per say.

So we know that the president and Congress reached agreement on the Budget Control Act of 2011, which is a combination of budget reductions over the next decade to increase the debt ceiling. First, there was a big chunk that was agreed to. It's $900 billion increase in the debt ceiling, which is then offset by a $900 billion decrease in discretionary spending over the next nine years, from 2012 to 2021. So the president and Congress agreed, $900 billion increase in the debt ceiling, $900 billion decrease in discretionary. And that's scored off of an OMB developed baseline.

The new 2012 spending cap is .7 percent below the fiscal year 2011 enacted level. I know that's a lot of words. But, so, we have a budget for 2011. The best we could do next year is .7 percent below what we have now. Now, that's not necessarily -- and that's

for federal government discretionary spending overall. So that doesn't necessarily mean it's a haircut across all agencies. It may be 10 percent from here, and this agency goes up 8 percent. But overall, it will have to equal .7 percent less.

So this is the spending level the Appropriations Committees are working from in passing 2012. And so, the Congress has the president's budget proposal for 2012, which is not .7 percent below the 2011 level. So they'll have some distance to go.

Do we have a question from someone online?

Okay. We do have just -- so folks know, we do have about 12 people joining us from outside on the phone and online. So that's great.

So welcome to all of you to our Advisory Committee for Women's Services. Thank you for joining us.

So we already anticipate that we are going to start 2012 without an enacted budget, but with a continuing resolution. And it's not clear whether or not they will -- generally, the continuing resolution is just an extension of the past year's budget and,

sort of, allocated on a quarterly basis, or on a time-limited basis. It's not clear yet whether they're going to go ahead and even just do that by the .7 percent, as a new baseline.

In addition to the $900 billion of discretionary spending cuts, there is a Super Committee. Probably people heard about the Super Committee. It's 12 members, House, Senate, Republican and Democrat. And they are charged with coming up with the big chunk, which is 1.2 to $1.5 trillion. We're now seeing the t next to stuff, which is really wild. So there's 1.2 to $1.5 trillion, which is going to come out for the next 10 years.

And they need to get agreement on what these savings are by November 23rd of this year. So they have about three months to figure that out. And they will go -- it must come to a vote by December 23rd. And if they can't agree, then it's going to be sequestration. Sequestration -- new word for me. But it's really going to be across-the-board reductions. They're going to say, okay, well, we have to take $1.2 trillion somehow. If you all can't agree, we're just

going to do a haircut of $1.2 trillion across discretionary and mandatory spending, which will be triggered in 2013, which would be -- that would be quite something.

I mean, there are many that believe we need to get our mandatory spending under control. But mandatory spending, for those of you that may not be familiar with all these terms, I mean, those are entitlement programs. So that's Medicaid. That's Medicare. That's Social Security. That's TANF. So these are -- those would mean cutting benefits that people are currently getting on a formula basis. And until now, all the focus has been exclusively on discretionary spending.

So that is -- any questions on the budget or what implication that may have for SAMHSA? I'm sorry. It's a little bit distil.

Harriet?

MS. FORMAN: I just have a question. Where do any possible revenue increases fall under this 1.2 to $1.5 trillion? Are these --

MS. ENOMOTO: I think they need to find spending

cuts, because I don't think it can be -- I don't think this is spending -- I don't think it's a net reduction as a result of revenue increase plus cut. I think it is -- these are just cuts. And if there's revenue increases, that's elsewhere. But I could be wrong. Does that make sense? So if there's new taxes, that's a separate discussion than where we're going to have spending reductions. But, yeah. No?

Starleen?

MS. SCOTT-ROBBINS: So are there any, kind of, projections on what impact that has on the substance abuse and mental health block grants for the 2012?

MS. ENOMOTO: Right. You know, no. I mean, I think it would be -- it's one of those any loss is unacceptable. And yet, we will probably have to deal with it. We already know that there have been, in different proposals -- even for the 2011 continuing resolution, there were proposed -- or there were reductions in the block grant. And so, I think with that being such a substantial part of SAMHSA's budget, taking any kind of cut would be very difficult to not take it out of the block grants somehow. But we'll

see. I mean, I think .7 percent -- if we were only to get a .7 percent cut, that would be good news. So I think we're anticipating more significant cuts than that, not necessarily to the block grant, but to SAMHSA overall. So we shall see.

I mean, certainly, the projections, the numbers that we were asked to provide for 2013 are much more dramatic than that, present much more dramatic reductions than .7 percent. So I would take that as a floor to the cuts, not a ceiling to the cuts. But how they get distributed is really -- you know, your guess is as good as mine, whether they were going to eradicate, you know, whole discretionary grant programs or take a big chunk out of the block grants to maintain favorite programs on the discretionary side. You know, at this point, it's not for us to decide. It's the Congress will work out what the continuing resolution looks like and then, what the final enacted budget will look like.

Thanks.

I would like to welcome -- a new member has joined us, Dr. McBride Murry.

Would you like to introduce yourself to the group?

DR. McBRIDE MURRY: Coming in late, I'm not sure what the key anchor introductory comments were. But I'm Velma McBride Murry. I'm a professor at Vanderbilt University and hold an [inaudible] Chair position there as well and so research on rural African-American families, including children, girls, and women.

Anything else I need to say? I'm happy to be here. Sorry to be late. You know what the traffic is like on the beltway.

[Laughter.]

MS. ENOMOTO: We are just happy that you are here. I think, actually, we're delighted -- this is your first in-person meeting. We've been lucky to have you by phone earlier.

DR. McBRIDE MURRY: Yeah, I was on phone in June. And so, it's my first in-person meeting.

MS. ENOMOTO: Yeah. So welcome. Nice to put a face to the voice.

DR. McBRIDE MURRY: Thank you.

MS. ENOMOTO: And, just for your information, we do have about a dozen people joining us online and by phone. And we have one member, Johanna Bergen, who is also on by phone today.

Let me just finish a few of my updates for you all, just to get you up to speed with what's been happening around town. On July 19th, the White House Office of Management and Budget approved SAMHSA's uniform block grant applications. These had gone out for 60-day and 30-day review and public comment. In the process of finalizing the applications for the mental health block grant and the substance abuse prevention and treatment block grant, we have received and addressed over 1,000 comments from almost 600 individuals and organizations.

And we turned this around -- I think they -- in something, like, 102 days. I mean, it was a 60-day comment period, a 30-day comment period. And we got it done in an incredibly truncated time period. And so, the center staff worked incredibly hard together -- or under the leadership of John O'Brien and our center directors to try to be as responsive as we

could be to the field, to OMB, to the Department, and to others who were making comments.

The goal is to have uniform block grant applications, so not a single block grant application, but a common format to both block grants and giving the states the option to have a combined application. So it's not a requirement to have a single application. But for efficiency purposes or planning purposes, to get more integrated and to prepare for, you know, Medicaid expansion and other things that will be happening in the future, we're giving the states the option to do a combined application and to do every two-year application.

So they could potentially be going from four applications to one application every two years. How many states will avail themselves of that opportunity, we're not sure. But certainly, we were happy to provide that flexibility. We'll continually update you on the progress and the adaption of the applications.

And maybe Starleen can speak to some of it, being one of the appliers.

But, you know, I think what the effort of the application -- some of it, welcome, some of it, less well-understood or welcome -- is really to help the states -- or, not just the states -- along in preparing for the implementation of certain provisions of the Affordable Care Act, specifically Medicaid expansion, to eligibility to 133 percent of federal poverty level, including single childless adults, which we think will really have a major impact on our populations and who is -- many of our -- the number of people who are uninsured in the public substance abuse treatment and mental health systems will dramatically shift.

And so, you know, helping -- we need to collect information to help CMS and the nation plan for how this is going to impact financing. And we think that states also need to be preparing on their ends. And so, that is the direction of the application. And we hope that by doing this, we'll all be better off when 2014 gets here.

Another announcement, which we were really pleased to send you earlier, is that the Institute of

Medicine recommended preventive services of women, which HHS has moved forward in also recommending -- or endorsing -- comprehensive guidelines for clinical preventive services for women, that the Department has adopted and for which we are recommending -- the Department is recommending no insurance co-pays. And they will -- these requirements will be applied to insurance products starting on or after August 1st, 2012, taking effect in January 2013 for insurance plans that operate on calendar-year basis.

The services include eight categories, including contraceptive methods as well as wellness screening and counseling. Recommendation 5.7, which you have in front of you, is -- importantly, if you look at Recommendation 5.7, screening and counseling for interpersonal and domestic violence, screening and counseling involving 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. We think that will have major implications for women and girls

in our systems.

And hopefully, as we -- unfortunately, Dr. Felitti is not here, but as we think about what the A-Study has told us, the need for this kind of screening and helping women and girls get services or attention earlier, I think this will be a very important step towards that. So you can see that there's other -- the other eight recommendations here. And we're just very pleased to have been able to share that with you.

I'm sorry. I think -- then, finally, I would like to acknowledge the recent passing of two leaders in the field of behavioral health with a specific focus on women. One of them was Bernadine Healy, the first woman Director of the National Institutes of Health from 1991 to 1993. She championed studies that overturned false assumptions about women's health. And she also served as the first physician to lead the American Red Cross. So she passed recently.

As well as, many of you probably saw in the news, that Betty Ford, you know, world-famous advocate for women's rights, as well as for the treatment of chemical dependency, passed away this year. And she

was such a wonderful spokesperson about the efficacy of treatment and the importance of recovery. So both legends in our field who will be missed.

And thank you to Sharon for bringing that to our attention.

So now, we have one, two, three, four, five, six, seven members present. I'd like to call for a motion for formal consideration and approval of the minutes for the March in-person meeting and the June phone meetings. All right? So if all of you can see in your folders, you have -- I don't know what their folders look like, but we do have the minutes from our past two meetings.

Can you tell them where they are in [inaudible]?

MS. GRAHAM: [Inaudible] after the Advisory Committee.

MS. ENOMOTO: So after the agenda and the bios --

MS. GRAHAM: After the agenda --

MS. ENOMOTO: -- you'll have the minutes for both --

MS. GRAHAM: -- and minutes.

MS. ENOMOTO: -- meetings.

MS. GRAHAM: Uh-huh.

MS. ENOMOTO: Were they sent out in advance, or they're just getting them?

MS. GRAHAM: We sent them out for [inaudible].

MS. ENOMOTO: Right. Okay. So we've sent these out, received comments, finalized them. And so, these are the --

MS. GRAHAM: The ones that have been certified in-house. So we [inaudible].

MS. ENOMOTO: Great. Okay. So these minutes were certified in accordance with the Federal Advisory Committee's Act, 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.

So does anyone have any questions or concerns about these minutes?

[No response.]

No? If not, may I have a motion to approve the March/June minutes?

FEMALE SPEAKER: So moved.
MS. ENOMOTO: Thank you, Velma.
And may I, please, have a second?
MS. SCOTT-ROBBINS: Second.
MS. ENOMOTO: Thank you, Starleen. So moved. Wonderful. So we are keeping close to on time with our business. Thank you very much.
And now, I'd like to turn the -- enough talking for me. I apologize. I'd like to turn it back over to you folks and get some updates from you. We have 50 minutes for this session. But, you know, as always, this group tends to get into some lively discussions. So if you guys could keep it to, sort of, three minutes, two to three minutes of highlighting the issues and things that you're working on right now, particularly relevant that you'd like to bring to this table.
I mean, Jean, you sort of mentioned, "Gee, I'm thinking about how does recovery apply to women, or what are the workforce issues for women," or, you know, something that is going on. The benefit of this group for me, and I think for one another, is that

you're going to keep your pulse on stuff that's -- before it gets into the journals and before it gets into the newsletters and the shared consciousness. You guys are on the edge. So we'll start -- Velma, would you like to start?
DR. McBRIDE MURRY: and I'll be looking for guidance in case I'm a little bit off-track. As I mentioned earlier, I do research with rural African-American families. And I currently have a preventive intervention that's ongoing in six counties in Western Regional Tennessee that's focused on HIV-AIDS prevention. And it tests a technology-driven, family-based format for exposing families to this curriculum. It's a tip-off from a program that I had for 10 years at the University of Georgia before moving to Vanderbilt University.
So we wanted to look at whether or not rural families would have greater access to HIV-preventive interventions through the use of DVD-interactive technology format for exposing families to programs. In the process of collecting data on those things that we were targeting in the intervention, we decided to

also ask mothers and their daughters and sons about the receptivity to the HPV vaccine series and to find out whether or not they were actually taken the vaccine, and if not, why. And we found that many -- only -- I guess, less than 10 percent of our sample of 412 families, half of whom were girls -- we targeted girls, and we targeted boys. But only 10 percent -- less than 10 percent of them had begun the series with their daughters.
And then, from the mothers who were young mothers in their twenties, none of them had begun the series. And we asked them why. And, not surprising to any of you, it was lack of access, uninformed about whether or not our 10-Care Insurance Program would pay for that, unsure of where to go in order to be able to get the vaccine series started with their daughters.
And then, we asked if they knew about it. Eighty-five percent of them were aware. We asked where was their source of knowledge about the vaccine. And most of them indicated from magazines. So they had seen it in Essence. They had seen it in Ebony. But other than that, they had not been informed by

their primary --, their child's primary care about the importance of beginning these series.
And we asked to whom would they seek if they really wanted to do that. And they said that their child's pediatrician. So the pediatrician serves a major role in helping these mothers understand the importance of this vaccine for cervical cancer prevention, which African-American women rate very high in the contraction of cervical cancer. And, you know, and so, what we began to think about were ways in which we might increase access to, not only knowledge, but the implementation of these vaccines in isolated rural communities where people don't really have great access to health care.
And so, that, in a nutshell, is some of the things that I'm working on now. The other issue is the increased diagnosis of new cases of HIV-AIDS among our young mothers in these rural communities, many of whom have been diagnosed with the disease, but they are not in any kind of treatment. And the question around treatment, again, centers around the stigma associated with the disease and just not really

knowing what to do now that they've been diagnosed with this disease, because they aren't having symptoms right now. It's almost like having diabetes with no symptoms. But they are infected.

So I should stop now because I'm probably way over my moment of needing to talk about my work. But don't ask a researcher to talk about their work.

[Laughter.]

DR. McBRIDE MURRY: But I'll be more than happy to share other things with you. But there's some critical issues facing mothers and children in rural communities, and particularly the disenfranchised communities. And we're just not finding ways to do more than just finding out that they're in trouble. And so, my role is -- in my work that I do -- is to find ways to empower these communities to really promote their health in ways that they're able to manage it, based on the scarce resources available to them.

MS. ENOMOTO: Great, thank you. I think you're allowed more than two or three minutes. This is your first time to be with us in person, so I think it's

good for everyone to have some frame on what it is that you do and what's really important to you. So thank you.

MS. BRISCOE: I am currently part of a pilot program that has been initiated in New Mexico, where we are -- the marriage of experiential education and the matrix model for intensive outpatient for youth and adolescents. Having kids sit through an IOP of the matrix model cycle educational -- kids starting to fall asleep, and including experiential education into that piece so that, as you all know, kids learn in different ways, not just being lectured.

And so, having that team effort and finding the community and progressing from whether it be detox, transitioning them to intensive outpatient and being part of this experiential education, we're hoping that we can address the rising opioid addition in youth and adolescents. There is an emerging population. In New Mexico, there was historically an inter-generational opioid dependence. But this emerging population of young people starting out with prescription drugs and then transferring to heroin because it's cheaper and

easier to get, is an emerging population. So in order to address that, trying to think of different ways of how to treat youngsters and getting them engaged in treatment.

MS. ENOMOTO: How are you seeing that play out for girls or girls and their moms?

MS. BRISCOE: Including moms, because the matrix model does include the family. And so, team-building activities and going out into the Santa Fe Mountain Center to -- there's a lot of analogies that are used in the experiential treatment that are analogous to the challenges in life and how you address them, which is more powerful than just sitting and listening to a lecture or talked to about the dangers of drugs and alcohol.

MS. ENOMOTO: But are you [inaudible]?

MS. BRISCOE: Yes, including mothers and daughters and sons and mothers, all inclusive. But, yes, definitely, women and girls. Thank you.

MS. SCOTT-ROBBINS: Yolanda, we're actually -- in North Carolina, as a part of our Administration for Children and Families grant, we utilized the matrix

model as a part of a continuum that we put in place in a very rural county in North Carolina. We have 100 counties. And one of our counties that is actually probably one of our most diverse counties in terms of race, it's one-third Lumbee Indian, one-third African-American, and a third Caucasian. And we put in place the Strengthening Families Program with Carol Kumfer.

We put the matrix model with a gender-specific component to it, because it didn't actually have a very gender-specific piece for adults, and then, seeking safety. And that has worked really well, because we've been able to address also the cultural issues within that model. And so, we've worked with the matrix folks to, kind of, look at what that looks like in a community that has that level of diversity, particularly with women and families. So I'd love to hear more about what you're doing with the kids and the families.

You mentioned the uniform block grant. And we are currently in the midst of completing the first phase of that block grant. And it's interesting, because for the very first time, it's asking for

information regarding pregnant women with a substance use or mental health disorder. And historically, it's only been specific to pregnant women with a substance use disorder. And so, we are looking through our outcomes.

We actually do track outcomes on pregnant women with a primary mental illness. So we have information. And, I have to say, it is pretty enlightening in terms of the number of women that we have in our system currently who are pregnant with a primary mental illness who are getting treatment. But the type of treatment they're getting in terms of the content is -- I have no idea at this point. So it is actually opening up a new avenue for us to look at whether they're receiving gender-specific services, which, you know, who knows at this point, and what those services look like, and what additional supports they need in order to be successful in their recovery.

And also, the other interesting part of the uniform block grant is that they ask about -- instead of just women with dependent children, they ask about parents with dependent children who have a substance

use or mental disorder. So that is also a stretch in terms of how we have had to respond to the block grant in the past.

And through one of our initiatives around TANF, we actually do have some pretty good information on parents who are receiving TANF funding, but not in the broader system that we have. So we're looking at how we can expand on collecting information on parents throughout the system. So that's been quite interesting.

Also, I don't know if I shared, when I was here last. I had the opportunity to participate in the SAMHSA Women's Addiction Leadership Institute over the last six months. And the graduation was in May. And I was a coach as a part of that process. And I have to say that it was one of the most enriching experiences I've had in a very long time in my professional career.

It's a six-month process, where coaches actually work with women in the field who are working on their leadership skills. And I have to say, the coaches walk away with quite a bit of learning and

introspection themselves in terms of how they're working within the field. And I really appreciate SAMHSA's support of the WASLI Institute. It is something that you will get the benefits from at SAMHSA at many years to come.

I was also just recently reelected as the President of the National Association of Substance Abuse Directors Women's Services Network, which is made up of the states and territories and the women's services coordinators across the country. And I'm very proud to say that the four subcommittees of the network are continuing to work on issues around women and girls as it relates to pregnant and parenting women, criminal justice, data and the use of outcomes, as well as recovery-oriented systems of care. Thank you.

MS. ENOMOTO: Congratulations.

MS. SCOTT-ROBBINS: Thank you.

MS. ENOMOTO: President Scott-Robbins.

[Laughter.]

MS. ENOMOTO: And thank you for the nod to Sharon and her fantastic work on the WASLI group. It really

is a wonderful program. And I hope we -- I agree that SAMHSA and the field will reap benefits from that program for years to come. And I hope that we can think about how to apply that leadership model across behavior health and, you know, how does that mesh with what we're doing in prevention. How does that mesh with what we're doing in mental health?

I know that you had people who did both already in this WASLI group. But, you know, it is a nice model and very productive. So thank you, and congratulations to you.

MS. SCOTT-ROBBINS: Thank you.

MS. ENOMOTO: I just want to touch on the point that you brought up about the -- which I forgot to mention earlier. And I apologize. But that in the uniform block grant applications, it has been a statutory requirement to have states report on their services to women who are pregnant and parenting. But it has not been a -- it's not a legal requirement for states to report the same data on the mental health side.

But with the uniform block grant application, we

are requesting that information. There is no penalty to a state who doesn't have the data. And the point really is not to penalize or catch people, but to give us an opportunity to plan for the future. And I think it will open some doors for us to talk about, I think, the conversation we have later today about gender-specific services across behavioral health. So what are we doing around gender-specific services in mental health for women who are pregnant and have a primary diagnosis of a mental illness? What are we doing around prevention for girls?

And so, I appreciate you bringing that up. Thank you.

Sharon?

MS. AMATETTI: I just wanted to make one additional comment based on Yolanda and Starleen's reporting. About two years ago, we commissioned Gene Obert from the Matrix Institute to help us develop a women's-specific add-on to the matrix model program materials. And we just recently have gotten the deliverable on this, which is nine additional sessions of recovery support sessions on women's issues that

she also pilot tested and got really very positive feedback on that. So that's going to be another tool that we're going to have available. And it should be, you know, ready for other communities to use before too long. So I'm glad that you're interested in that and that you're trying to put together pieces. And we saw a need for that as well.

MS. ENOMOTO: All right. Well, we appreciate Dr. Felitti making the long trek here. I know it was a journey that started somewhere on Saturday afternoon, and it's culminated in his arrival mid-morning in D.C. on Monday.

So we appreciate your trials and tribulations of the journey. But your presence is valuable to us. So if you would like to give us an update on what's happening with you.

DR. FELITTI: I'm Vincent Felitti. I'm an internist. I've been at Kaiser Permanente in Southern California since 1968, and for the past 30 or 35 years, been running a large preventive medicine operation there.

I suppose I'm here because of the ACE Study, the

Adverse Childhood Experiences Study. Robert Anda and I at the CDC and I are the co-principal investigators of a study of 17,000 people that's been going on for the past 16 years or so, matching 10 categories of adverse life experience in childhood against the large array of biomedical, mental health, social malfunction outcomes in life, on average, about 50 years later. I suppose I could summarize the several interests that I have by saying that they would all fit into the idea of trying to move primary care medical practice from its current symptom-reactive mode to the more comprehensive style it was always conceived for it, but never attained.

MS. BENAVENTE: Good morning. I've been working in the field of prevention for about 28 plus years, primarily with the Department of Mental Health and Substance Abuse on Guam, and also with a private firm that worked with Headstart families and children. The interest that has been developing over the past five, six years for the region, for the Pacific Islands, is around the work that was initiated with the funding that came with specific dollars. And we've come to

learn how useful the process is for helping us to truly hone in on what's important in the community, based on data and what the community is telling us and how we can truly empower community people to deal with the issues that children, families, girls, and women are faced with on a daily basis.

I was elected as the Vice President for the Pacific Behavioral Health Collaborating Council, which just means more work on top of my primary job. But it's all exciting work, because as Pacific Islander people, we have a lot of strengths culturally that we want to enhance. And we want to learn from our traditional practices, such as dealing with the high rate of non-communicable diseases and what does this mean with behavioral health care work.

And things like going back to letting young women or moms, new moms know that breastfeeding, for example, is okay, and bottle feeding with formula doesn't necessarily mean a status of wealth, for example, which is a lot of misperception that if you move into purchased formula, then that means that you're probably more well-off than the woman who

decides to breastfeed.

So in thinking about women and girls' issues and cultural practices, the work that we have is to take a look at how you collect real data as told to us by our community and make it make sense and make sure that the funding that may be available to help us achieve our goals and objectives for healthier Pacific Island community is really done well and done quickly. So we are still struggling with collecting data, building relationships with our community folks, and seeing that the data that you send to us will be used to improve lives.

And it's not because researchers just want to publish about it, and then we don't do anything about the information provided. So the Pacific Island Region is probably more united now in terms of developing strategic plans and approaches to serve the broader Pacific Region in Micronesia, American Samoa, and the Marshall Islands and so forth. So thank you.

MS. ENOMOTO: Bobby, do you have any thoughts about -- are you part of the team that works on the block grant applications?

MS. BENAVENTE: Yes.

MS. ENOMOTO: I know Kiti also, sort of -- well, she used to have a role. I don't know that she has a role anymore. But I know that we had a sense that, sort of, the same people working on the different applications in some of the places.

MS. BENAVENTE: We're the same people working on everything.

MS. ENOMOTO: Yeah.

MS. BENAVENTE: We're just wearing different hats.

MS. ENOMOTO: How is the uniform application working for folks?

MS. BENAVENTE: I think it makes a whole lot of sense, that we need to start putting in writing applications that reflect true collaboration and integration of services so that we're maximizing on the funds and we're all focused together, whether it be, you know, the CMH portion or SAPT. It's the technical writing and the division of labor and how the government is set up. So we're trying to take care of local policies and protocols in order to make

sure it supports a uniform application that doesn't cancel each other out, but really makes it a solid approach to deal with all the issues.

I know for Guam, we've opted not to do a joint application this coming year and plan better for next year. I'm a prevention person. I work the SAPT block grant, and I don't want CMH's to hold me up, truthfully.

[Laughter.]

MS. BENAVENTE: Don't tell them I said that. Take that off the minutes.

[Laughter.]

MS. BENAVENTE: But, you know, sometimes it's, kind of, like, cut-throat. You know, like, you just get it together, because prevention is really on fire. And, you know, you're slowing us down. But, no. But I'm really excited. The whole region is really excited about prevention being a top priority in the SAMHSA initiatives. Some of the things that are talked about with integrating and talking and sharing knowledge and identifying that, you know, top one, two, three priorities that serves the broader

community in very targeted ways. Women and girls -- in our culture, we have a very special role and responsibility on top of having to deal with a lot of, you know, recovery issues and trauma issues in order to get better ourselves in order to help our families.

And so, one of the things that we're looking at that the community has said to us is with addressing non-communicable diseases in the islands, breastfeeding is important. Let's get back to basics. We have herb doctors that are specialists in treating babies and women. And we've, sort of, put that on the wayside and gone with traditional Western doctors in clinics and all that. But now, young women, young mothers are seeing the value of taking their two-week-old baby or one-month-old baby to an herb doctor for traditional herbs to be, you know, given the child and then the massages with oils and all that.

We had healthy babies then, and we're not having as healthy babies now that rely on, you know, antibiotics so quickly for treating a cold as opposed to herbs and massages. So those are some things that we're looking at for creating a balance, for choices

and options that women and girls could look at.

MS. ENOMOTO: I'd like to give Jean a chance to step out, but I'd like to give you a chance to give an update on what you're working on and thinking about, if you want to talk about the presentations for today or tomorrow, that would be great, too.

DR. CAMPBELL: Great. I'm going to be apologizing for ducking in and out, I think, for the next three days. But I'll do my best here.

When I left the room, I was giving an update to the Consumer Subcommittee on a major conclusion of the research I've been conducting for over a decade, that one of the documents, the Consumer Operated Service Evidence-Based Practices Kit, has been released by SAMHSA and is now on their Web site. And we're beginning a dialogue with SAMHSA about how that document's more like a tome -- it's this thick -- will be disseminated in the field.

And I was just quickly looking here over some of our findings from the -- the toolkit came out of a multi-site study that began in 1996. And I was the principal investigator of the Coordinating Center.

There were eight sites throughout the United States of consumer operated service programs, which are programs that are administratively administered -- they are administered by mental health consumers themselves. They have self-help [inaudible] as their prime philosophical approach.

And this was over a $20 million study. It was very rigorous. It was randomized control trial, too. What our investigation led to a study of these programs in terms of their effectiveness to promote well-being amongst participants when offered as an adjunct to traditional mental health services. And our findings showed that, indeed, they do significantly improve the well-being of the participants who attended consumer operated service programs as an adjunct to traditional mental health services. And the more they participated in consumer operated services, the higher their well-being was.

And our end for that study was 1,827, so it was the largest study ever done of these programs. And not only was it the largest, but it was the most rigorously conducted. And interestingly, along with

this finding, which led to the recognition that these are evidence-based practices, was a greater understanding and contribution to the scientific field about recovery and the role of the components of recovery. And I'm going to address a little of that this afternoon when we talk about it.

But I was looking at -- I happen to have the draft for site services on the well-being construct. And we looked at covariates. And so, we had some mention of women. I mean, we did do demographics. And there was some interesting findings. But, as I mentioned before, the focus within consumer studies is much more on the identity of being a mental health consumer rather than of being a person of color, being a younger person. You know, that those issues of gender, age, status, income have been found consistently to not be as significant.

They've overwhelmed by the identity of being a mental health consumer. But I thought I would share these. And it would be interesting to start to get some feedback of what you would make of these. As I said, I mean, the number one thing we found, that the

well-being construct was negatively related to being discriminated against and positively related to being connected and accepted within a social network. So those were some of the -- that was one of the key findings.

On average, men had a higher well-being score than women. But this gender difference seemed to be due to marital status. That's what we found, that well-being scores tended to be higher for people who had never been married, which were more likely to be men.

FEMALE SPEAKER: Say that again.

DR. McBRIDE MURRY: That goes a little bit counter to studies of marriage and being beneficial to men.

DR. CAMPBELL: Yes, exactly.

MS. ENOMOTO: Jean, could you repeat that?

DR. CAMPBELL: On average, men had a higher well-being score than women. But this gender difference seemed to be due to marital status. Well-being scores tended to be higher for people who had never been married, most likely to be men. The men in the COS

MRI sample were also less likely than women to have children. Since approximately 70 percent of men and women who had ever been married were not married any longer at the time of the COS MRI, which, I think, begins to explain -- and when I'm -- this is, like, one of our major populations. When I say consumer, it's people with mental illness.

Since approximately 75 percent of the men and the women who had ever been married were not married any longer at the time of the COS MRI, it seems that well-being scores were lower for women in the COS MRI sample because more women than men were single parents. Now, this may not seem to be a startling, but it begins to tease out some of the issues. And I just started reading this more carefully. I mean, that's what the data showed, and we just reported that with -- but how complex this concept of recovery and the role that well-being plays within it, and that we can't just go on what the general population -- because there are different life narratives for persons with mental illness.

And one of them is being a single parent. And

when you think about being a single parent and so that married thing suggest, since most of the people who had been married and were no longer married, that that may have been a difficult time, during marriage. Marriage wasn't seen as a comfort, but was a complication, a complication in life.

MS. ENOMOTO: Jean, I remember when we did COS, I was in the Division of Services Systems Improvement.

DR. CAMPBELL: Yeah, you were just a newbie coming out.

MS. ENOMOTO: I was. I was a kid straight out of clinical psych. program coming to SAMHSA and a whole new world of thinking. But I was an evaluator on the Women in Violence Study.

DR. CAMPBELL: Yes.

MS. ENOMOTO: And that was going on simultaneously with the COS. So I'm wondering if you guys had trauma measures in the COS. But [inaudible] –

DR. CAMPBELL: No, no. I don't even think the word trauma ever, ever came up.

MS. ENOMOTO: Yeah.

DR. CAMPBELL: In fact, trauma-informed care and the concept of trauma is just like a whole new world opening up for me. I was going to share that with people, because Missouri Institute of Mental Health has an expert grant from SAMHSA for alcohol. And that's the brief screening and -- I forget what all the --

MS. ENOMOTO: Screening, brief intervention referral and treatment.

DR. CAMPBELL: Brief intervention -- and what's the --

MS. ENOMOTO: Referral and treatment.

DR. CAMPBELL: Treatment.

MS. ENOMOTO: Brief intervention, treatment, and referral.

DR. CAMPBELL: Thank you. We applied for that. And I was part of the team that was going to help develop the trauma module, as a mental health consumer expert. And I began more and more to learn about the trauma field.

Particularly, Vincent, your work was key in doing that. And also, that, from our last face-to-face

meeting, I read carefully the trauma guidebook that was present about how trauma could be offered within peer-run programs. That I found a little wanting, because when I went -- I hope people here study that and give some feedback, because I tried to use that guidebook. I thought it was I had a step up. But it really wasn't a how-to or clearly discriminated against normal peer services and what a trauma program would be.

And I think it got all mushed together. So, really, we were starting -- I was starting to try to break some new ground within our proposal. Unfortunately, SAMHSA didn't have the money to fund that, so it was withdrawn. But the benefit for me was being able to learn a lot about trauma. And I was particularly excited because we had integrated within that -- I found some short measures. And I had suggested that we study -- we had this scale of well-being. And then, we had -- and I know it's very simplistic -- but a community coping scale. And we were going to look at those relationships in terms of trauma within that study.

Those sort of things were not even available when we did COS.

MS. ENOMOTO: Right. They were parallel programs. Right? So we didn't have good measures of –

DR. CAMPBELL: So did you use the word trauma when you were doing the Women in Violence?

MS. ENOMOTO: It was WCDB, so it was Women Co-Occurring Disorders and Violence. It was –

DR. CAMPBELL: But, I mean, the concept hadn't really –

MS. ENOMOTO: You know, we actually – we had some of the early A-Study papers. And so, we had started – I mean, Susan Salasin was talking – has been talking about trauma for decades.

DR. CAMPBELL: Yeah.

MS. ENOMOTO: And so, we were talking and thinking about it. But I think it was that study, which was in the same cohort of demonstration programs that SAMHSA did with the COS study and the support employment studies and the aging Prism-E Study.

DR. CAMPBELL: Yeah.

MS. ENOMOTO: I think all four of those programs that we did during that time really -- each of them advanced the fields in their specific domain. We are still at the point of having -- we still have an opportunity to benefit from cross-fertilization of those different studies. So COS was coming out with its, you know, very important findings about the importance and the value of consumer operated services. You know, Judith Cook and the Support Employment Study had similar findings.

DR. CAMPBELL: Yeah.

MS. ENOMOTO: How do we then – and the Women in Violence Study was also incredible and has really been a game-changer in terms of the field and trauma-informed care. How we get those things to cross over, I think, is our next challenge. So how do we bring the consumer operated piece over to the trauma-informed care piece? How do we bring support and employment and, you know, to consumer operated? I mean, all that, I think, is quite an opportunity.

DR. CAMPBELL: Well, you know, in the mix of doing all those multi-site studies, at the very

beginning – or, I guess, it was mid-stream, because our study was one of the last -- that they brought together researchers and P.I.s from the different studies and had this giant meeting. I mean, I still have the binder for that.

And people talked about their results. There might be some consideration in the future to think about bringing those people together again to talk about the cross-fertilization.

MS. ENOMOTO: Yeah, yeah, yeah, yeah.

DR. CAMPBELL: But this piece -- you're right, I think, does have an implication in terms of trauma. I mean, we can't totally, outside of saying trauma is a national epidemic -- but we can say that life is not easy for people with psychiatric conditions on top of -- that's why I read the discrimination. Just one example of how difficult it is for people with psychiatric problems and their life narrative within the community and what stresses and how that affects some of the other, what we think, are things that help sustain one's well-being and create resilience within the community.

MS. ENOMOTO: Right. Well, thank you very much for that. I mean, I think those are really important findings. And I think we'd all benefit from talking more about that in the future.

DR. CAMPBELL: Just one other thing. So could we just take a couple minutes for people to provide some feedback on workforce and development from the perspective of this group?

MS. ENOMOTO: Okay. Or perhaps we can also caucus a little bit at lunch.

DR. CAMPBELL: Okay.

MS. ENOMOTO: And have some conversation about that. People would be willing to have some conversation. Okay?

All right. Thank you very much, Jean.

And to our members for giving updates. Okay.

Johanna, do you have an update for us?

MS. BERGEN: Thanks, Kana.

Well, I had some things I'll share later this afternoon. But the thing that I have been working on or able to present at a conference recently this summer was [inaudible] alternative study done at the

Portland State University on young adults with mental health illness and their use of the Internet. And I grew up in a really rural community and have always, kind of, been speaking out and looking for how do we reach consumers whose, maybe, only contact with doctors is their primary care physician once a year. And part of that conversation and the answer has become ever more frequently, the Internet and how can we use video conferencing and how can we -- anyways, on and on about the Internet.

And so, we did this survey of young adults and asked them to use the Internet and to then to better figure out where they found the information from. And it was very apparent early on that everyone in the study was not good at finding healthy information or information from an accredited source. And maybe 20 percent of the people were finding results that were well-rated.

But something like 87 percent of the participants believed that you could find everything you needed to know somewhere on the Internet. And the disconnect between those numbers have, kind of, been what I've

been focusing on, looking on recently. So just a thought as we think about solutions to reach out to, particularly, rural communities.

MS. ENOMOTO: Well, it sounds like there's a nexus of the work that all of you [inaudible] information and rural and consumer and getting folks good and accurate data and guidance that they need. So that's great.

Thank you, Johanna.

All right. So I'd like to turn it over to Sharon Amatetti, who is going to lead our SAMHSA Women's Coordinating Committee in giving you all an update on what is happening internally with respect to women and girls.

MS. AMATETTI: Okay, thank you very much, Kana.

I just wanted to refresh the memories of this committee about what the SAMHSA Women's Coordinating Committee is and does. We call ourselves SWCC, and it's a SAMHSA-only membership. So it's just persons from throughout all of our centers and offices that participate in the committee. It's been around for about 12 years now. Really, the function is to do the

cross-center and office coordination, to collaborate so we infuse information about what's going on throughout the agency into our work. And, really, hopefully that enriches our work and what we're able to do with the communities that we work with.

So we've made an effort in the past three months now, partly at the urging of this committee, to really revitalize this group to get more energy and enthusiasm around the committee. And, as a result, over the past couple of months, we have increased our membership. We now have about 12 people who are actively participating in our group. And you can see from our folks over here that, you know, many people are now participating.

And one of the functions of the group is to support this committee. So by coming to the committee meetings -- for those who can't come to committee meetings, to read the minutes of what was discussed and to bring what you all say to us about what's important to the work that we do as a committee. So I'm very glad that so many of them were able to be here with us today. And each of them in a minute are

going to tell you a little bit about what they do and who they are.

We wanted you to know who we are so that you have a better sense of resources within the agency that you might reach out to, also just to know that there are people working on shared interests. And so, we have a lot of interest in women's issues here at the agency.

Sometimes we do joint activities. We might confer around a subject like trauma. We worked together to develop core competencies for women and girls in behavioral health a year ago. We all will be working together on our next national conference on women across behavioral health. So it's a wonderful internal resource, and colleagues with shared interests have an opportunity to meet. We will meet monthly. And so, that's a little bit about the group, just so you know that this is also a resource for you all as well.

So I have quite a lot of colleagues here with us today. And I asked each of them if they would just share a minute or two, sort of, just what they do here at SAMHSA, if they have any interests that they'd like

you to know about their interests or work that they're doing, just a little tidbit so that you have a flavor of who's participating in this group.

And I don't know if -- can we have them come up to the table, maybe as I call their name.

And, Velma Montgomery, you're up already. Would you like to be the first person to join us at the table?

MS. MONTGOMERY: [Inaudible] where did you want me to go?

MS. AMATETTI: Just at the microphone.

MS. MONTGOMERY: Okay. At the microphone?

MS. AMATETTI: Yeah, thank you.

MS. MONTGOMERY: This is what I get for introducing myself first at our first meeting. Thank you. I'm Velma Montgomery. Good morning. I'm in CSAP in the Division of Development Systems -- System Development. But that branch division focuses a great deal on research for all of CSAP, whereas there are five of us that are the Materials Development Group team. And we do a lot of different kinds of things, including a really important program on under-age

drinking prevention as well as working with states doing all sorts of speeches, writing blogs, publications through the print process. So we're kept really busy.

I am the -- I don't know the formal title -- the Project Manager for the Publications and the Web for FASD. And our Web is really -- if you haven't been to it -- something that is extraordinary because the database is so huge. And we have magazine. We have journals as well as newspaper articles, both pro and con, on drinking. And we have just an amazing amount of information.

I will add a handout to the handout table, because it has the information about the Web. And you'll have all the information there that you need for the addresses and the kinds of materials we've developed and the amount. One of the things we have found is that our materials are gaining in popularity as the interest in the subject goes up. So we have trouble sometimes keeping them plenished up there. But everything that we do is downloadable, so you have access to everything we have.

We also sponsor trainings across the country on FASD. We have two really top-notch trainers as well as support research of programs that work with both people who have FASD and their families. So we're proud of the whole range of things that we do, in addition to having the Center for Excellence and a variety of other things that people are doing.

I'm sure you already know the stats. I'm concerned about giving those again, particularly because you have another speaker today at 2:30. So I'll just do the COS a little bit.

It's an estimated $6 billion a year to provide services for people with FASD. And it's $2 million a lifetime for somebody who has FASD. One percent of the population -- and it outranks the combination of autism and Downs Syndrome. So there's so much heartbreak around this. The strength of these people is amazing. They're caring, creative, determined, eager to please, which is one of the problems, because they can get talked into getting into trouble because they're eager to please friends and people.

I think the main thing to remember is that FASD

is 100 percent preventable. And that is the saddest thing that I know about. And leaving with the saddest thing, I'll turn it back.

MS. AMATETTI: Okay, thank you very much, Velma.

So all things Fetal Alcohol Spectrum Disorder, if you need a resource person, Velma will help you or find somebody who can, if she's not the right person.

But thank you very much, Velma.

Now I'd like to turn it over to Claudia Richards.

MS. RICHARDS: Hi. I'm with the Center for Substance Abuse Prevention. And I've been with the center for about six years as the Branch Chief for the Minority AIDS Initiative, which provides substance abuse and HIV prevention services across the country, working with community-based organizations. We have at CSAP approximately 148 grantees across the country that receive funding from CSAP.

Specifically, we have gender-specific programs. There are not a large number of gender-specific, but we do have a few gender-specific programs that focus on girls, youth, and adults. In addition, prior to me coming to CSAP, I was the Women's Coordinator for the

block grant, the Substance Abuse Prevention and Treatment block grant. And in that capacity, we were quite instrumental in terms of having presence in this work group as well as participate in a number of national events and conferences and also in working with state alcohol and drug abuse directors across the country to ensure that they were in compliance with the woman's set-aside requirements, as Starleen knows.

I was their project officer before for North Carolina. And that was a very good effort on the part of working with the block grants since 1991. I was one of the first project officers hired at SAMHSA. And when we launched a woman's set-aside, it was very enlightening to see a transformation or movement in the field. Because, as you know, previously there were very little to no gender-specific services relative for substance abuse and targeting specifically women, pregnant women, and women of dependent children.

So I have a passion for this work, as you know. I'm a social worker, licensed independent chemical social worker by profession. And I have worked with

many, many providers across the country that provide gender-specific services over the past 20 years at SAMHSA.

Again, my interest is to help this group be cognizant of the health disparities, looking at HIV disease burden, not just in the urban setting, but also in the rural setting. Coming across and doing site visits, it's very obvious that we need to begin to think outside the box in terms of how we're going to deal disparities of care when it come to access for HIV testing services, early diagnosis of minority and persons who are at risk for substance abuse and mental illness to ensure that these individuals are access to care and services and testing.

So I'm just going to stop there, because I can just go on and on.

MS. AMATETTI: Okay. All right. All right. Well, you know, why don't we move along.

Bev, do you want to step up to this mike?

MS. FALIK: That one over there?

MS. AMATETTI: Yeah, we'll just find one [inaudible] in the way.

And, maybe, Mary, you can join her up at the mike.

So, Bev?

Bev is another CSAP colleague who, actually, I think you met the last time we met in person.

MS. FALIK: Yes.

MS. AMATETTI: You gave a report. And Bev's here today, too. Okay.

MS. FALIK: So I'll be brief, because you heard me last time. But I'm really glad to be here. And you've already impacted something we're going to do this year just from sitting here this morning. So thank you in advance.

As I said, I'm the Project Officer, AKA, COTAR. That's our new term. Contracting Officer Technical Representative is the new term for Project Officer of a contract. And so, I'm the COTAR of the data analysis contract at CSAP.

And the short version of what we do is -- we do many things. But the short version is that we look at national and state trends in different prevention-related factors. And we examine our program

effectiveness. And we do special reports. Those are the types of analyses we do, as well as ad hoc analyses. And I think I mentioned to you last time -- and it is continuing -- that you do find gender differences in national trends related to substance abuse and related risk and protective factors.

Not all of them, but, for example, this year, I noticed, particularly related to under-age drinking, heavy drinking, binge drinking, we're finding that the males are improving, but the females are not. And so, you know, that's of a concern. And that provides information to CSAP and SAMHSA about, well, what should we do about it, what could we do about it, what could we share with the states to do about it. So that's one of the important things that we do.

It's kind of like the step one in a SIP. It's our needs assessment for the nation, you know, what's going on. And we look at -- and Charlene may actually talk about it when she comes. We look at NSDUH, but we also look at other data sources like Honoring the Future and Wire B.S. and BRFSS and stuff, because sometimes they're not totally aligned. So that's also

very interesting. So that's the first thing we do is we do this needs assessment and look at gender differences there.

Then we look at program effectiveness. And what I showed you last time was the differences in program effectiveness that we found in some cases. And it was consistent every year. And so, that precipitated something on our part about, you know, what should we be doing differently. And we feed this information back to the programs.

Now, interestingly, I just got this year's analysis of our program effectiveness. And it is not so blatant. So there are very few gender differences this year that I could see. So I don't know if this year's an aberration or if programs have used this information and improved the targeting of, you know, different kinds of gender approaches. I don't know. We have to look into it. So that was kind of interesting to me.

And the other thing that we do is we do special reports. And this year, we are doing special reports on gender differences in program effectiveness,

because we are going to be looking at this in-depth. Right now, we have only been able to see a difference. But we haven't had enough resources to examine why what was going on. Did this work, and this not work? Or, you know?

So this is the year that we're able to do that. And I'm very excited about it. And the reason I'm saying you helped guide our work is that we hadn't been thinking of looking at in terms of rural and urban. But I wonder if that's a factor. You know? I wonder if there are not enough resources in rural areas to do that kind of work. I don't know. But maybe that's one of the ways we should do the analysis. So thank you. And any other, you know, recommendations you have -- we're early on, we haven't actually begun. So I'd be delighted to hear.

MS. AMATETTI: Okay. Thank you so much, Bev. Jen is over there, Jen Oppenheim.

MS. OPPENHEIM: Okay. Good morning. My name is Jennifer Oppenheim. I am new to the committee as of about a month ago. But I am -- in the Women's Committee at SAMHSA. I'm very excited to have joined.

And I have to apologize. I would love to be here all day today. My grantees are all coming together tomorrow, so I'm in a frenzy. So I did want to be here for a little bit. But I look forward to being here for the entire time in the future.

FEMALE SPEAKER: [Off-mike.]

MS. OPPENHEIM: Yes. I certainly will.

I am in the Center for Mental Health Services in the Mental Health Promotion Branch. And I'm Coordinator for a program called Project Launch, which is focused on young children and promoting the healthy development of young children and their families and communities, focusing particularly on kids from birth or prenatally through age eight and with the ultimate goal of kids really entering school ready to learn and able to succeed and trying to prevent some of the behavioral health and health issues that other people at SAMHSA are struggling with.

I did want to say, actually, my background is as a clinical psychologist. And I have a long-standing interest in women's issues. I've done a lot of work with both child and adult sexual abuse survivors. I

don't think I mentioned this in the committee. My dissertation was on women and courage. So I bring a lot of interest in women's issues.

But on the committee, I think, I hope to bring expertise on child and family issues and the perspective of thinking, in terms of my program, about particularly parenting and women's health and well-being and the impact of that on young kids. Because I think the research is definitely there in terms of, you know, with maternal depression, for example, and the impact of that on children's functioning and healthy development and all kinds of -- there's a lot we know about attachment and the outcomes for that for young kids.

So Project Launch has five core strategies that we focus on. And I'm not going to go through each of them, but they really -- the idea is really to be looking across all the systems that serve young kids and families and to be increasing awareness about social, emotional and healthy development in those systems. And I think there's a lot of focus for me and for our program on women's health and women's

issues in those settings as well. So just, for example, we do a lot of work in primary care around educating pediatricians in particular about screening and understanding and identifying and making appropriate referrals for children's social, emotional, and behavioral issues, but also trying to broaden that lens to think about when maternal and family issues as well. So being more comfortable identifying, talking about, referring women who are depressed.

Or if there's domestic violence or substance abuse, we also do a lot of work and training in childcare settings, you know, with a similar focus on really attending to children's social and emotional development, but also family functioning and working with families around some of these issues. And we also -- we do a lot of coordination with other -- in collaboration with other federal agencies, working particularly with HRSA and ACF and CDC and with HRSA on the new home visiting initiative, HRSA and ACF.

And we have a big focus on infusing some of these behavioral health issues into these -- as this home

visiting initiative really ramps up and there's a lot of money going there, thinking about home visitors are trained and how mental health consultants and behavioral health consultants can work with home visitors to also address some of these issues when they encounter them and that are beyond, in a lot of cases, the training they have. So dealing with a maternal depression is a big one, substance abuse, domestic violence.

So I think that, you know, there are lots of issues around women's health that are relevant to my program. And I know I'm already, just through being on the committee, have connected with other folks across the agency and look forward to also learning from all of your work.

MS. AMATETTI: Thank you very much, Jennifer.

Mary McCann?

MS. McCANN: Good morning. I'm Mary McCann. I'm a State Project Officer for the SAPT block grant. And I'd like to tell you a little bit about the block grant. As you may know, a large percentage of SAMHSA's funding for grants is in the form of the

block grant. I believe the block grants are around 70 percent of SAMHSA's grant funding.

And the Substance Abuse Prevention and Treatment block grant allocates a minimum of 20 percent of the funds to prevention. They come right off the top. And then, the remaining funds go to treatment, with no more than 5 percent to administration.

The thing that I am very excited about regarding the block grant is that it requires every state and every territory to have specialized services for pregnant women and for women with dependent children. And it goes -- the regulations go into some detail about what those services must include. And first of all, they require for the family to be treated as a unit, and, if at all possible, for children to be admitted to treatment at the same time as the mother.

They require that certain ancillary services are provided in addition to treatment. And these include either providing or arranging and referring to the women for primary medical care, which, of course, includes a referral for prenatal care for pregnant women, primary pediatric care for the children,

including immunizations, gender-specific substance abuse treatment, and other therapeutic interventions for women, which may address issues of particular interest to women such as relationships, sexual and physical abuse, and parenting. And the providers are required to provide childcare while the women are receiving these services.

Further, they're required to provide or link to the children to therapeutic interventions that may address things such their developmental needs and their issues regarding sexual and physical abuse and possibly neglect. And the providers also must provide case management and transportation to ensure that the children and the women have access to these services.

This is a very exciting program. This is not a short-term funding. This is funding that occurs year after year after year. The ADAMHA was the predecessor of SAMHSA. And there was at that time a requirement of a minimum of 10 percent being spent on women's services. And at this point in time, the basic percentage that's being spent on women's services of the block grant right now is around 14 percent. And

the entire block grant each year is $1.8 billion. And so, that percentage of dollars is around 200 to $250 million going to specialized services for pregnant women and women with dependent children. And this is throughout the country.

The states are also required to publicize the fact that this treatment services, specialized services are available for pregnant women. They can do outreach. They can use public service announcements. There are a variety of methods that they can use. But the block grant requires them to publicize the availability of treatment.

And pregnant women are also given priority of mission. So pregnant women are either admitted immediately to treatment, or, if there's not a treatment slot available, the state gets involved to see if there is a treatment slot elsewhere in the state for that woman to be placed into. And if she does have to wait for admission to treatment, then there is a requirement that interim services are provided. And interim services include counseling the woman about the impact of alcohol or drugs on her

fetus.

I am the Project Officer for the New England states. We have reorganized in our division according to the Health and Human Services 10 regions. And so, I happen to have six states in New England. And I have the opportunity to visit each of the states on an annual basis. And that means I get to visit the women's programs on an annual basis.

There is a lot of very exciting programming going on in the states for women and children. And I have a handout that I'll leave on the back table. And I'm happy to be of help to you at any time. Feel free to call me. And be happy to talk with you about the block grant.

MS. AMATETTI: Thank you very much, Mary. I don't think we've had an opportunity to really go over the block grants. So I've been wondering for some time, so it was very helpful. And thank you.

And now, I'd like to introduce Margaret Matson from our Center for Behavioral Health [inaudible] Statistics, or something like that.

MS. MATSON: Center for Behavioral Health

Statistics and Quality, formerly OSA. I'm not going to say very much about the center because in juts about 15 minutes, Charlene Lewis, our Deputy Director, is going to give you a detailed presentation on what the center does.

I just wanted to say how thrilled I am that Sharon invited me to be on this committee, especially since I'm a real newbie to SAMHSA. I came here in February after 33 years at NIH, where I was, among other things, at the Alcoholism and Alcohol Abuse Institute for 22 of those years, where I was very involved in adolescent programs and also in FASD as well. So those are two big interests of mine. And certainly, both are very gender-relevant.

So since we are running short in time, I think that's all I'll say.

MS. AMATETTI: Yeah, okay. Thank you very much, Margaret.

Thank you to all of my colleagues for coming and telling you all a little bit about what they do.

Also, in the committee who are not here today, Linda White-Young, a colleague at CSAT who manages

pregnant, post-partum women's grants and is working very hard right now to award a 19 to 20 additional PPW grants; Ruth Hurtado-Day, who is in the CSAT, Homeless and Co-Occurring Disorders Branch and also manages a women's work group in that portfolio of grants.

Susan Salasin and Mary Blake from CMHS are not here, but I think most of you know them from their work on trauma and managing the National Child -- no, the National Center on Trauma-Informed Care. And, actually, Mary will be here this afternoon, and perhaps Susan as well; Onaje Salim, who has been working on medication assistance issues in our Office of Pharmacological Therapies; and Anrea Harris, another colleague from CSAP.

So we have quite a little, you know, widespread of representation from across the agency. And people are very interested in hearing from you. And we're coming up against a break right now. And we will take a break. But please feel free to talk to colleagues now. And if you want to follow-up with anything, to get their e-mail address so that they can converse with you. And thank you again, very much, to all my

colleagues for coming down this morning and saying just a few words. And I think with that, we'll go to a 15-minute break and come back at 11.

[Break.]

MS. ENOMOTO: All right. We're going to try to get started. We are very fortunate to have today the newly-anointed Deputy Director of the Center for Behavioral Health Statistics and Quality, Dr. Charlene Lewis. I think it came to Sharon's attention that CBHSQ actually does a lot of really wonderful work, as has been mentioned before, in looking at gender differences across the rich data sets that SAMHSA possesses. And so, Charlene has agreed to do a little bit of a highlight or an overview of some of the multiple surveys that we manage and the analysis and what we've learned about the behavioral health of women and girls.

So I think she's going to start -- you're going to start with doing an overview of what our national surveys are, so you have a sense of where we're getting our data and then, what the data are telling us. So with that, we'll let Dr. Lewis start.

DR. LEWIS: Can you all hear me if I don't use this?

MALE SPEAKER: No, you need to use that.

DR. LEWIS: I need to use it? All right. I can take direction.

First of all, I want to thank you all for inviting me today. This is -- I don't get to go out a whole lot these days. We're very busy trying to build our center, which is a full-time job in and of itself. So, for me, this is a real treat to get to talk to people in the field. And I'm hoping that you all will talk more than I do. I have very few slides, and I want to go through them relatively quickly. But I'm very interested in the kinds of things that you would find most interesting and the forms in which you would find them to be the most interesting.

Not everybody has the leisure to read the peer review, the literature, and divine from it some useful nugget to apply to their own particular circumstances. So I hope you'll keep that in mind as we go along here.

And, thanks to Katy, I have this remote control thingy, which works perfectly. A quick review of our major studies -- and before I start, I just want to mention that every one of our major surveys is currently under some degree of being redesigned for a variety of reasons. NSDUH is a survey that most people are familiar with. It's an annual survey. It's in the field 51 weeks out of every 52. It is a face-to-face interview of 67,000 people conducted annually.

The people in the survey are selected on the basis of several characteristics. One is their ability to represent the state in which they reside. The second is their ability to represent the country in which they reside. The third is to represent their age groups.

One-third of those 67,000 respondents are between the ages of 12 and 17. Another third are 18 to 25. And the remaining one-third are 26 and older. The survey covers everything you can squeeze into one hour. An hour is about as long as you can expect anybody to sit still and answer questions.

We have a fairly high response rate because we have instituted incentives for people to sit down and let an interviewer into their home. The survey is both anonymous and confidential. It's done using an audio cassette technique where the respondent gets earphones and a laptop. The interviewer never sees the answers to any of the questions. So the data are as objective as we can make them.

The second major survey activity is TEDS, our Treatment Episode Data Set, which is an annual compilation of state administrative records on who is entering treatment. TEDS data are admissions-based, meaning they are tagged to a person, but they are -- there are more admissions than there are people, because a person may be admitted to treatment multiple times over the course of a year.

We collect currently just under 2 million records a year in TEDS for admissions and a near comparable number for discharges. We then take those two sets of information and wed them to each other so we have a complete episode of care from admission to discharge.

N-SSATS is one of my personal favorite surveys. It is an annual census of all of the known and

approved, accredited, or otherwise recognized substance abuse treatment services facilities in the country. There are over 17,000 of them. And they respond to a -- I think of it as a relatively brief questionnaire, which covers the kinds of people that they treat, the kind of services that they offer, the kinds of payments that they accept from their clients.

And it's used as the background to the substance abuse treatment locator. All the information that you see on that locator when you go in to look for a facility that's appropriate for a client comes from this survey and from the weekly updates that get done to the locator.

Those of you in either substance abuse or mental health know that there are changes all the time. There's a particular turbulence, whether it's just a phone and a fax number or a new project director or a facility is merging or splitting. There's a lot of information that needs to be transferred in order to keep the locator running and to be as accurate as possible. That survey is the core behind that locator.

Finally, we have the drug abuse warning network, which is a bit of a misnomer. This is a survey in a nationally-representative set of hospitals in their emergency departments. The hospitals are selected, again, for two reasons: one, for their ability to represent the metropolitan area in which they are found, and there is another panel that runs with these metropolitan samples, which gives us a national perspective on who's showing up in emergency rooms, what kind of people they are and what drugs are on-board when they come to the emergency room.

And we have a very specific protocol for how we collect drug-related emergency events, which I'm not going to go into. I'm just going to give you some of the results from what we've found.

With that in mind, when we sit down to plan analytic work, we like to focus on the heterogeneity of women. Women are not some amorphous planned group of folks. They come in various ages. And the age state of people is, not only important for the substances that they might use or the mental health disorders that they might experience, it also has

important physiologic implications for the intersection of behavioral health and physical health.

Women occupy a variety of societal roles. We'll talk a little about two of those roles as I get into this. We look at racial and ethnic differences. And when we can, we delve more deeply into the geographic differences that might feed into some of these other differences.

I was very privileged a few years ago to sit in a presentation by a social demographer from the state of Washington. And she had done a very, very careful analysis of urban and rural Mexican women in the state of Washington and the different substances they used and the different pathways that they chose to get into treatment for their addictions.

I was absolutely fascinated. I'm dying to continue to expand on ideas like that of how geography feeds into the services that are available, the substances that are available, what the intersection is between distance and accessibility, whether it's mental health treatment or substance abuse treatment.

We also sometimes get a chance to deal with some

special topics. And I see that the Administrator is going to talk later this afternoon about women and her strategic initiatives. So I'm going to let her do that. I'm going to focus on just a couple of really quick things.

Questions -- everybody's looking a little overwhelmed.

MS. BRISCOE: I just wanted to [inaudible] N-SSATS?

DR. LEWIS: Uh-huh.

MALE SPEAKER: Microphone.

MS. BRISCOE: N-SSATS surveys -- I have to fill out three for our facility. They will hunt you down if you don't.

[Laughter.]

MS. BRISCOE: They run a tight ship. Telephone calls, e-mails -- and they are not going to let you get away with not filling out that survey. So I think that's great.

DR. LEWIS: It's a good thing.

MS. BRISCOE: It's a good thing.

DR. LEWIS: If you want to be on the treatment

locator -- and people call up all the time, "How do I get on the treatment locator"? The only way to get there is by filling out that survey. You must fill it out, and you must be approved by your state authority, whatever that authority is, so that we know that the facilities that we are putting on there are actual facilities fun by people of whom your state approves.

So thank you very much.

MS. BRISCOE: You're welcome.

DR. LEWIS: Appreciate that.

Yeah? I'm sorry. I can't see your name from here, because -- Bobby.

MS. BENAVENTE: I'm Bobby Benavente from Guam.

DR. LEWIS: Hi.

MS. BENAVENTE: Guam and the other Pacific Islands are not -- have never been included in the NSDUH survey. And I was wondering if there would be a time soon that the Pacific Islanders would be included in some fashion. And also, I was wondering, with the other three surveys you described, are there numbers in there that reflect Pacific Island countries.

DR. LEWIS: Pacific Island heritage, yes.

Countries, per say -- I don't think we have a big enough sample to get down to the various countries. I suspect that the reason we don't have interviewers in the field in the Pacific Island is more monetary than anything else. But I will check on that and get back to you about that, because you're right. That's a lack in the coverage that we have.

Bobby. Okay.

MS. BENAVENTE: Just one other thing.

DR. LEWIS: Sure.

MS. BENAVENTE: How long has NSDUH been conducted?

DR. LEWIS: Running? Okay. It used to be the NHSDA, the National Household Survey on Drug Abuse. And that started back in 1979. It was biannual for a while. It's been annual since, I think, the mid-'80s. However, we've had several breaks in trends across time. Most recently, 2004 was the -- or 2002 was the last break. So we have comparable data from 2002 through what will be released next month, 2010. We've been at it for a while.

MS. BENAVENTE: And back when it first started,

it was the same reason for not including Pacific Islanders, is that the cost factor, the numbers were small. And I'm just hoping that there'll be a time when we are included in surveys like this so we can be represented as part of this nation's survey.

DR. LEWIS: I think that's something we can certainly look into. When it first started, it was a very much smaller survey. It was not designed to give state estimates, for example. It had, I think, 17,000 respondents instead of 67,000. Just to give you an idea of the magnitude of what goes on in NSDUH, there are more people employed as NSDUH field staff than work here at SAMHSA. So there are 700 people in the field engaging and persuading people to answer questions for us. It's a big deal. It's a big undertaking. But let me look into your question, and I'll get back to you.

MS. SCOTT-ROBBINS: I was wondering if there is a -- has been or is a possibility of including sexual orientation as well.

DR. LEWIS: That's --

MS. SCOTT-ROBBINS: The issues of gay and

lesbian, bisexual, transgender folks, particularly related to substance abuse are huge. And, you know, this is the first year --

DR. LEWIS: That's exactly right.

MS. SCOTT-ROBBINS: This is the first year that the census counted, at least partnered, same-gendered couples. And what's counted counts. We know that.

DR. LEWIS: Here's what's going on. I mentioned that each of these surveys is under some amount of being redesigned. In NSDUH, we're looking at a variety of methods changing, including how we enumerate households at all, because that also has undergone some changes. Drugs come and go in popularity, so we're looking at how to redo the drug modules.

We're looking at adding issues around LGBT -- hello -- issues. We're also looking at military families and how to identify military families. And, again, I think the Administrator will be addressing some of these issues.

MS. ENOMOTO: Yeah. One of the challenges, Harriet -- I think SAMHSA's actually led the

department in some of our surveys in terms of asking LGBT questions and identifiers within some of our performance measures as well as in the surveys. But the issue now is, kind of, getting some consistency across our surveys and how that's being done and then, with other folks in the department. So there is the work group at the departmental level looking at that measurement and then, across government looking at the military families issue, how to assess that.

Because there's lots of different ways to define a military family member. So both of those things -- we're, I think, leading the pack in terms of being interested and having collected some of that data already. But now, we're just trying to, I think, synchronize with -- or harmonize with others.

DR. LEWIS: I've got two or three slides coming up -- and I guess they're in your book -- of things that we've looked at recently analytically that have taken me by surprise. And I've been in the substance abuse field for a long time. And I'm still surprised by some of the things that we find and the different ways that we find things.

Young women -- I have recently become very concerned about the state of adolescents in the country. We've found that more than a quarter of all girls between the ages of 12 to 17 engaged in at least one violent act in the past year. And by violent act, we're talking a group-on-group fight, i.e., a gang fight. We're talking attacking someone with a weapon with the intent to harm them, or getting into some kind of serious fight at school or at work.

There is a correlation, as you might expect, between the number of acts in which one has participated and the prevalence of certain use of substances, principally alcohol and marijuana. However, when you look at what happens on the treatment end, we had only 132,000 girls admitted to treatment, principally for alcohol or marijuana, which is a small proportion of those who might perhaps benefit from some kind of therapeutic intervention.

What I found surprising was that a quarter of them were not in treatment for the first time. They were coming back for the second and third time. There's a message there for those of you who are in

prevention, for everyone in prevention, and for folks in treatment. One would hope that there would be less cycling through at such an early age for these young women.

Another finding that came out of our DAWN data -- yes?

DR. McBRIDE-MURRY: What is the source of referral? So how do they get into treatment? Do you know?

DR. LEWIS: I believe, for most adolescents, the source of referral is somewhere in the criminal justice system. Specifically, I couldn't tell you because I don't have that one with me just this moment. But it's usually the criminal justice system for kids.

Suicide, as -- oh, my word. I can't spell. Oh, dear. I am so sorry.

DR. McBRIDE-MURRY: We know exactly what it's supposed to say.

DR. LEWIS: Thank you so much for being so generous.

Three out of four adolescent drug-related

admissions for attempted suicide were made by young girls between the ages of 12 and 17. I was absolutely staggered by that. We looked deeper into those data. Ninety-five of those admissions involved some kind of pharmaceutical. And the most popular pharmaceuticals -- want to guess? Ibuprofen, Acetaminophen, aspirin.

FEMALE SPEAKER: I have a question.

MS. SCOTT-ROBBINS: The sources of suicide?

DR. LEWIS: It was attempted suicide. And that's what they had on-board when they came into the emergency department.

DR. McBRIDE MURRY: I'm assuming that these data primarily represent white girls. Because the data show the drug use among African-American youth is very, very small and even more so among girls, but that there is an age cross-over effect that occurs in emerging adulthood with increased drug use, illicit drug use among males.

DR. LEWIS: Right.

DR. McBRIDE-MURRY: And then, alcohol use among females. So I'm assuming that -- I don't know that, but I'm assuming that these are for white girls.

DR. LEWIS: I can't confirm or deny that at this moment. I'll go take a look and –

MS. ENOMOTO: But they would not have been only on European-Americans; right?

DR. LEWIS: Right.

MS. ENOMOTO: They would have been for all girls.

DR. LEWIS: This is all young girls.

DR. McBRIDE MURRY: And so, we don't know how it breaks down by race?

DR. LEWIS: By racially? No.

DR. McBRIDE MURRY: Okay.

DR. LEWIS: What astonished me was the difference between the boys and the girls.

DR. McBRIDE MURRY: Yes.

DR. LEWIS: That somehow the girls end up in the emergency rooms. We don't know what the attempted suicide rate is for each of the genders in adolescents. But whatever it is, even if it's not quite equal, the girls are ending up in the emergency department far more often than the boys are.

DR. McBRIDE MURRY: You're familiar with Shawn Joe's work on suicide rates among African-Americans?

DR. LEWIS: No.

DR. McBRIDE MURRY: He's done some pretty remarkable work and was actually in Science. Five hundred percent, I think, increase over the past five years among African-American males. So that may be -- but also increasing rates among African-American girls. And so, that may be something to just look at to capture a context for the work you have here.

DR. LEWIS: And this would be something that would be of interest to you, if we were able to get more deeply involved?

DR. McBRIDE MURRY: Yes. Yes.

DR. LEWIS: Okay. Good. This is exactly what I need to know, is what is of interest.

DR. FELITTI: Is it of interest to anyone other than me, perhaps, that what is being studied is apparently the mechanism for attempting suicide as opposed to the reason for attempting suicide?

DR. LEWIS: We don't collect information on why.

DR. FELITTI: Well, I understand that. I mean, I see that as a huge flaw, since they're -- studying the mechanism is certainly comfortable, and it's

meaningless.

DR. McBRIDE MURRY: I agree with Vincent, because not knowing why, it's difficult then to target an intervention or a prevention to address the why.

DR. FELITTI: Putting it a different way -- you know, and I realize these phrasings are annoying. Putting it a different way, suicide is not the problem for the person involved. It's their attempted solution. It may be a problem for other people. You know, it's disturbing, et cetera. Not everyone wishes to serve out a full life sentence.

DR. LEWIS: Fair enough.

DR. FELITTI: And the question is why is that.

DR. LEWIS: The only -- well, there is a legal issue involved in looking at the whys of suicide for people who have attempted suicide, at least from our perspective.

DR. FELITTI: Could you explain that? Because it certainly doesn't strike me as evident.

DR. LEWIS: If it were part of the medical record, which is how the E.D. data are collected –

DR. FELITTI: No, sure.

DR. LEWIS: -- we could pick that up.

DR. FELITTI: Yeah.

DR. LEWIS: And we haven't looked at what else, other than the actual quantifiable data, shows up to look at what reasons might be posted in the records.

DR. FELITTI: Yeah, well, I mean, medical records are notably vacuous in that regard, because it's quite uncomfortable to all sorts of people to pursue that line of questioning, including physicians. And it's avoided.

DR. LEWIS: If you have some suggestions for improving what gets into medical records around this that we could then pick up on, that would be great. Right now, because of the way we collect the data, we will, in the future -- again, DAWN is another one of the surveys that's under revision. We'll be picking up a lot more mental health data. So we'll know if, for example, these young ladies are diagnosed with depression, an anxiety disorder, a bipolar disorder.

DR. FELITTI: And that would be as a result of what?

MS. ENOMOTO: I think we are also working on

testing on a module around trauma.
DR. LEWIS: Yes, we are.
MS. ENOMOTO: Right. Which we don't have a systematic way of collecting across any of our surveys, any of the national surveys right now. So we are CBHSQ has been leading the charge for SAMHSA on that. And it's part of the trauma and [inaudible) --
DR. FELITTI: I mean, the remarkable thing about the A-Study was how willing 17,500 middle-class adults were to speak openly about their own traumatic experiences and how overwhelmingly my colleagues assured me, "No, you're crazy. You can't ask questions like that. Patients will be furious. And nobody'll tell you the truth."
DR. LEWIS: That's what they say about drug abuse. And --
DR. FELITTI: Well, all right. Let me pick up on that.
DR. LEWIS: We have to say --
DR. FELITTI: Once you use the phrase, "drug abuse," you have slanted one's thinking on the subject as opposed to drug use.

MS. ENOMOTO: Okay. Well, it is the national survey on drug use and health. I mean, I think we're there on that. And I think we are trying to get to being able to collect data around trauma. One of the things about this particular survey -- this is about drug-related admissions to an E.D. This isn't all suicides. So CDC has lead responsibility around the epidemiology of suicides nationwide. And I think we can also have conversations with them in terms of their growing understanding of what are the causal routes to suicide attempts and completed suicides.
DR. FELITTI: Okay. Let me just lay out an idea that perhaps will stick in people's minds. Everyone is aware about crystal meth, you know, the demonized crystal meth and its problems. No one remembers -- and this is a remarkable oversight -- that the first prescription anti-depressant introduced in sale in the United States by Barrows Welcome in 1940 was methamphetamine. The brand name was methadrine.
MS. ENOMOTO: Interesting.
DR. FELITTI: And if you doubt that, anyone can look, you know, at a bound journal of the Journal of

the American Medical Association 1941 and see full-page ads for this. And methamphetamine -- it retained the position as the major prescription anti-depressant for roughly the next 20 years until the advent of tricyclic anti-depressants.
DR. LEWIS: We should get together and talk about some of these things.
DR. FELITTI: So the question is does it mean anything that the most commonly-sold street drug, you know, that people speak of, has potent anti-depressant activity.
DR. LEWIS: Thank you. Maybe we could chat afterwards.
DR. FELITTI: Sure.
DR. LEWIS: That'd be great.
Let me go back to my young girls here.
Oh, I'm sorry.
Bobby?
MS. BENAVENTE: Again, these findings don't reflect Pacific Islanders. And one of the -- well, I just wanted to quickly share that Guam is one of the first Pacific Island that received a Garrett Lee Smith

memorial grant two years ago. And the work that we've done in such a short time frame -- it ends next month -- in terms of this funding is we were able to learn that we have one of the highest rates of suicide in our part of the world, one every two weeks. So it's about 30 deaths a year in a population of about 170,000 plus people, with the expected increase of population about 25 percent over a 10-year span with the military build-up.
You know, the Marines are leaving Japan and choosing Guam as their home by order of the Department of Defense, and not at our invitation. That's a sideline. It doesn't go in the minutes, again.
But it is important to not just put our energies or concentration on how many deaths and by what means, but what is going on in these young people's lives that they think life isn't worth living. And the work that we've seen so far in the first profile on suicide for the island that we published last year show personal relationships and just inability to cope with whatever challenges, whether it be relationships or failure to meet up to the expectations of their

teacher or their parents or just changes in cultural expectations for young people and adults.

But the 30 plus individuals that die by suicide every year for the past 10 years, we've learned, are under the age of 30 and mostly males and mostly by hanging. But there is a growing increase of females that use more lethal means like hanging as opposed to some gestures of cutting and trying to overdose on medications like over-the-counter drugs.

DR. LEWIS: One of the things we do notice in some of our surveys is that -- when I was growing up in this field, there was always a timeline between the boys and the girls in terms of initiating various kinds of behaviors. And it was generally two years. And it was generally attributed to the fact that older boys date younger girls, which worked very well as an explanation, that boyfriends would introduce their girlfriends to whatever their favorite pastime was.

That's no longer true. Girls are, in fact, exceeding boys in the initiation of some behaviors. And I can point you to the data, and I can tell you what the data said.

The context -- and Bobby and Vincent as well, both talking about the context for why it is my numbers look the way they do. It's critically important. I can tell you, again, that 75 percent of these drug-related suicide attempts occur in girls. I don't know why. But I can give you that and say this is something that clinicians, epidemiologists and other folks need to be looking at. And I'll keep you pointed in the right direction, because I put these statistics out, generally speaking, once a week. We try to get something out the door that's new and a little different.

Before I use up every single bit of your lunch hour, let me just move on. Women work. During this economic downturn, more jobs have been lost by men than by women. However, I was a little astonished to discover that one out of every five women working full-time engage in binge drinking and that 3.2 million of them are using illicit drugs. But when you look at the treatment data, less than a quarter of them are getting into treatment.

So three-quarters of the females who come into

treatment have either lost their jobs or never had jobs or are no longer employed full-time, for whatever reason. I also thought it was kind of interesting that employed women tend to be referred to treatment through the criminal justice system. And when I looked at the detailed categories of criminal justice that we collect, it was not through DUI or DWI programs. Yeah, that -- yes.

DR. McBRIDE MURRY: That's [inaudible].

DR. LEWIS: That's what I would have thought, too. And it's not. It's through parole and probation. Again, I don't know quite what to make of that. But I can tell you that this seems to be true. And it shows up in our data.

Do I need to go back? I can do the back button.

MS. SCOTT-ROBBINS: Just like the changes that, I think, you were seeing with girls and how soon they're coming into substance use and how they're getting into treatment, I think we're seeing the same kinds of trends with women. And when you look at what's happening with economically and with folks losing jobs, et cetera, I mean, women right now are still,

even with the women set-aside in place and everything else, are still an underserved population within our treatment system.

DR. LEWIS: I have the perfect fact about two slides from now that's going to speak exactly to that point, which I thought you all would be really interested in and might want to spend some time advocating about. Hold that thought.

We talked about women. Another important role for women -- women are mothers. And I had the folks who actually run data look at young women who were mothers and living with one child. This, to me, is over half a million teenage moms living with their kids -- that in and of itself is a public health societal concern, because we all know what the poverty rates are. The long-term prospects for many of these women are not that good.

Their children, however, are of particular concern. If you look at the fact that more than one-third of the women are smoking cigarettes, using alcohol, using marijuana, whether you believe it or not as a mother -- and believe me, there are days when

I didn't believe it at all. Not only do our kids listen to us, but they do as we do. They are -- we are role models for our children.

So in looking at a statistic like 528,000 women, we'd also need to be looking at 528,000 kids who are growing up with these young women as mothers. And, again, I can point you to the statistic. I'm not entirely sure of what to recommend, but I would depend on you to make recommendations about this.

MS. ENOMOTO: And past year MDE is major depressive episodes.

DR. LEWIS: I'm going to get to that.

MS. ENOMOTO: Okay.

DR. LEWIS: Okay. We mostly know that women who smoke are highly correlated with women who have depression. And we measure a past-year major depressive episode as more than just feeling a little blue once in a while. This is a clinical diagnosis.

If, as a mom, I have no experience with the past-year major depressive episode and I don't smoke, the probability that my child is going to smoke is very, very small. It's 6 percent. However, if I have both

a past-year major depressive episode and I smoke, the probability that one or more of my children will smoke jumps all the way up to 25 percent. There are multiple possible points of intervention there for people who design programs: smoking cessation programs, depression treatment programs, parenting classes, all kinds of things.

Let me -- what happened to my slide on -- huh. Well, let me talk a little bit about racial and ethnic differences. Because of the size of some of our databases, we are able to look very closely, for example, within -- Hispanic women are not all the same. I talked a little bit earlier about the analysis I saw that was so brilliant on Mexican women living in rural and urban settings and the differences in their behavioral health.

We can look at levels of acculturation, how long someone has been in the country. We can distinguish Mexican, Puerto Rican, Cuban women, because we have power in the database. We can look at American Indian, Alaska Native women, for whom we do not have such a large sample. We know something about the fact

that they don't use -- as a group, they don't use alcohol as much as other women in other ethnic or racial groups. But when they do, they tend to binge drink as opposed to just having a glass of wine with dinner.

Asian women have the lowest rates of past-month alcohol, binge alcohol, and illicit drug use. Eventually, I'm going to be able to look within that Asian category and sort out various cultural groups within the Asian label and see if there are differences among them that might -- I don't know. Is anybody here from a California treatment program?

DR. FELITTI: I'm from California.

DR. LEWIS: You are?

I was in one a while ago. And they had, I believe, 17 different Asian cultures represented within their treatment program and needed more than 17 different interpreters because of the language difficulties that their own staff had in trying to help their clients. Again, I can point you to where the problems appear to be, statistically. The context for them, the solutions are in different -- are

different from different folks.

MS. ENOMOTO: I think, Charlene, I know on youth, you're able to pull out Native Hawaiian and other Pacific Islander --

DR. LEWIS: Yes.

MS. ENOMOTO: So it's possible that she could do an Hopi run on women across years.

DR. LEWIS: Possibly.

MS. ENOMOTO: But again, it's -- first of all, I want to say that there's a hyphen-American on all of these.

DR. LEWIS: Yes.

MS. ENOMOTO: All right? These are not international data. And that Native Hawaiian and other Pacific Islander women who live either in Hawaii or the mainland United States do have different rates, I think.

DR. McBRIDE MURRY: I have a question, Charlene. For the African descendants, do you collect data on heritage, their ethnic differences as well --

DR. LEWIS: No.

DR. McBRIDE MURRY: -- within -- no? Okay.

DR. LEWIS: We collect the information on nativity.
DR. McBRIDE MURRY: Okay.
DR. LEWIS: Were you born here, or were you born elsewhere? And if you were born elsewhere, where you born?
DR. McBRIDE MURRY: Okay.
DR. LEWIS: But that would get me only to country of origin, not to whether it's tribal or other affiliations within --
DR. McBRIDE MURRY: Okay. Because the folks in Michigan are finding some interesting patterns with Caribbean-born kids and their engagement in risky behaviors. So I just wondered.
DR. LEWIS: We've looked at something similar with Hispanics, whether the nativity was here or elsewhere. And oddly enough, the people of Hispanic descent who were born here behaved just like everybody else. And the newly-arrived -- those who are considered still to be immigrants, whether legal or illegal, or whatever their status, they behaved quite differently. And it seems to have something to do

with the level of acculturation. I was raised as an anthropologist, so I like acculturation.
Let me just very, very quickly get to the very last slide, because I want to get to Starleen's point. And it's down at the bottom. It's the very last bullet. We look at treatment facilities fairly closely. Eighty-seven percent of substance abuse treatment facilities accept women as clients, which is good. But only half of them have special groups or programs for women, which, again, in picking out things that I found surprising, there was one of them.
That means, you know, only 40 percent of the substance abuse treatment programs in the country have programs or special groups just for women. And everybody sitting in this room knows that women's issues and treatment are different from other issues. So there you go.
MS. SCOTT-ROBBINS: And I even question the half that say they have special programs --
DR. LEWIS: Well, they tell us they do.
MS. SCOTT-ROBBINS: -- and what that means. I know, because we did a very light study in North

Carolina years ago. And the programs that came back and said, "Oh, we have gender-specific services," -- and when we asked them what that meant to them, then you, kind of, get that they don't get it. So that's --
DR. LEWIS: And of the many things we are hoping to do in the future, one is to do exactly what you're talking about, which is to take a representative sample of these programs and find out what they mean when they click off the box that says, "Yep, I've got groups for adolescents, I've got groups for women, I've got groups for the newly diagnosed. I've got all of this stuff, and aren't I wonderful?" Because they know it shows up in the locator. So we would like to just do a little trust, but verify.
I think, Kana, I have run over. And I apologize.
MS. ENOMOTO: No. Okay. Thank you.
DR. LEWIS: I hope that all of you will take to heart two things from this. One is that in order to keep looking at the endless possibilities that an hour-long interview, 2 million records, 100,000 records on treatment, on admissions to emergency

departments -- there are endless analytic possibilities in all of this. We like to do things that people want to read and need to know. And the more you can help us to focus what we're doing, to tell us what you need, the more we'll be able to get to those needs.
The other thing that's important and that we spend a lot of time thinking about is in what format: one page, one fact, two facts, for you, for your professional staff, for your clients, for whom, three pages, four pages, a poster. What will help to get this kind of information across to the people whom you feel need it most? And I am more than open for suggestions.
Please feel free to e-mail me, if not Sharon or Kana, any of the staff that are here, because it doesn't do me a whole lot of good to sit in my office and think of things and write lovely articles for the Journal of the American Medical Association if none of you have the leisure to sit and read it. So thank you very much for having me. I really appreciate it.
Bobby, you want to say something. I can see it.

MS. BENAVENTE: While I still remember it, maybe, Kana, you can answer this. The CMHS block grant -- are there requirements, as with SAPT, for serving women and girls right away, pregnant women and child -- -

MS. ENOMOTO: No. No.

MS. BENAVENTE: There isn't?

MS. ENOMOTO: No, there's not a statutory requirement, as there is on the SAPT side.

MS. BENAVENTE: Because on Guam -- and it may be true in the other Pacific Islands -- there is a need to, kind of, force that. I learned a couple of weeks ago from our treatment folks from mental health services that there are over 300 some people wait-listed for service. And they couldn't even give me a breakdown with, well, who are they and how do you know who to treat first, if you've not even done a fairly decent assessment of their critical needs. And so, I think having that kind of language in CMHS block grant funding would help to improve timely service for women and girls.

MS. ENOMOTO: I think the changing languages of

the requirements of the block grant would necessitate a reauthorization of SAMHSA and of the block grants, which is a whole legal process that goes through Congress and is fraught with a number of political difficulties at the moment. However, I think, by adding the language in the uniform block grant application where we're just asking the states and territories to even look at the data, I think, in that way, we're not forcing it, but we are strongly encouraging people to start paying attention.

I think sometimes shining the light of day on an issue and actually collecting the data will help people understand what issues there are. But, you know, I mean, I hear what you're saying. There's a lot of things people would like to get into the block grant requirements. And, you know, we're not anticipating changes to that anytime soon. It's, sort of, something that's a little bit outside of our hands at the moment. But thank you.

I want to thank Charlene and Center for Behavioral Health Statistics and Quality. They are -- I think it is a very sincere offer. They have been

extremely responsive to our stakeholders, to internal SAMHSA customers in terms of doing data runs, because this is not your grandfather's OAS.

DR. LEWIS: There you go.

MS. ENOMOTO: This is a brand newly-minted center, which has really become an integral part of the fabric of SAMHSA, how we operate. And so, to the degree this group could take advantage of the incredible resources they have -- it's not everything in the world that we'd like, but it really is a lot, and it's more than we're taking advantage of at the moment.

So thank you, Charlene.

DR. LEWIS: Thank you for having me.

MS. ENOMOTO: Thank you.

DR. LEWIS: And, please, take us up on our offer, because, as Kana said, we really do mean it.

MS. ENOMOTO: Yep. Thank you. Thank you.

So I'm going to let Cynthia talk a little bit about the logistics for our lunch here. And then, for anyone who would like to stay, Jean is back with us. And so, for folks who want to stay around the table

and chat a little about what we're going to be doing at the joint NAC conversations around workforce or women, we can do that before the Administrator gets here at 1:00.

So, Cynthia, you want to talk about that?

MS. GRAHAM: For those of you that ordered lunch for today -- and I've spoken with some of you already there on the table and back -- I think you're going to go to the café down the hall.

Yolanda, so you can go there.

And, Jean, you brought your own snacks.

DR. CAMPBELL: Yes.

MS. GRAHAM: Right. We have the others. So if you want to stay here and be a part of the discussion that Kana mentioned [inaudible] Jean talked about workforce development, or if you're too crowded in here, we do have tables set up in the Sugar Loft Room, where we could take the group there, if you'd rather stretch your legs and go someplace else. It's your call.

MS. ENOMOTO: You guys want to take it out to the different setting, sit around a table? That's fine.

DR. CAMPBELL: Down at the other end of the hallway.
MS. GRAHAM: Yes, uh-huh. There are tables.
DR. CAMPBELL: They have windows there.
FEMALE SPEAKER: Yes.
[Lunch break.]
MS. GRAHAM: This meeting is now reconvened, please. Thank you.
MS. ENOMOTO: All right. Thank you, folks, for coming back promptly from our lunch.
We actually had a very energetic lunchtime conversation, which I appreciate greatly. We have such a good and interesting, smart, and passionate group today. We had a special guest at lunch, who is now carrying on into our afternoon session.
Administrator Pam Hyde is here with us today as a follow-up to a conversation -- several conversations -- a couple of conversations now we had in the meeting in March together, which was relatively short, where we had a first opportunity to go introduce you to the strategic initiative paper and review what was in there. And then, at a request of the group, we had a

subsequent conversation by phone in June, where Sharon had put together a really excellent summary of activities within the strategic initiatives that are addressing the needs and interests of women and girls.
And that was really an overview of that. And it was by phone, so we didn't have as much opportunity for conversation about what next, what are the implications of those things, how does that intersect with what our budget picture looks like for the coming years, and what are the opportunities outside of the current women and girls-specific portfolio. But beyond that, how do we stay within the strategic initiatives advancing the interests of a population that we care very much about?
So with that, I would like to call your attention -- there is the conversation guide in your binder.
If someone could point me to it. Oh, this is actually for tomorrow's.
FEMALE SPEAKER: Oh, for tomorrow's?
MS. ENOMOTO: Is it for tomorrow's or for today's?
FEMALE SPEAKER: This one right here is today.

MS. ENOMOTO: It's in today's.
FEMALE SPEAKER: It's in today.
MS. ENOMOTO: I didn't get tabs on mine. Okay.
I don't know if yours looks like mine, but mine's behind the first piece of beige paper.
Yes, strategic initiative discussion guide. So that just -- it just gives you a summary. We're not going to represent the slides to you, but it does give you a nice table -- some reminders of things that were done that we talked to you about that are ongoing or are already planned within the strategic initiative.
Now, we're also going through a process of refining and focusing our work. We realize that we have about 18 months left within the first Obama administration. And so, we're trying to channel our energies productively on a select set of priority projects and activities.
I think, Yolanda, you have it. There you.
And so, that means, in general, focusing energy on a little bit less rather than expanding. So I think that's the jumping off point for where we're going to go today.

Sharon, did you want to add something before Pam leads off?
MS. AMATETTI: No. The members might have some questions in terms of refreshing their memories from our last conversations. Before we get started, I think that would be totally appropriate. But I didn't plan to add anything else.
MS. HYDE: I spent the morning with the Tribal Advisory Council. And I'm actually quite looking forward to tomorrow as well. There's lots of things to discuss. So you're going to hear things tomorrow that I won't repeat today about things that Kana, sort of, alluded to about budgets and priorities and in a tight time where we're having to do less rather than more and all that good stuff.
And I didn't really prepare particular remarks here, because I'd really rather spend the time in dialogue. So last time we met, I was running in and out and had gotten pulled to go downtown or wherever it was that I had gotten pulled to go.
FEMALE SPEAKER: [Off-mike.]
MS. HYDE: Yeah, White House. Oh, yeah, that

thing. Oh, yeah, that one.

So I think it was really helpful for you all to raise the issues so that we could go back and actually put in our minds and in your minds and on paper some of the ways in which each of the strategic initiative addressed women and girls. I think I said to some of you -- maybe it was Stephanie -- that when I speak about our behavioral health equities issue, I always talk about racial and ethnic minorities. I talk about LGBT populations. I talk about American-Indian and Alaskan Native populations, and women and girls. Those are the four groups. Now, there could be others, but those are the ones we have chosen to think about in terms of disparity issues and things that we need to pay particular attention to.

And in each one of the initiatives, there are clearly issues that address -- or that affect women and girls and things in each of those. So I think what I'm interested in today is, given what you heard that we presented on the Webinar or the phone call that we did with you all and given now that you've had an opportunity to look at the strategic initiatives,

we're in the process of priority setting. So what I said to the tribal group this morning is we need you to tell us what are the most important things in each of those strategic initiatives that you think, from your perspective, we should be paying attention to. Because we're going to have to choose to set some of them aside for a while. It doesn't mean we're not going to do them, but set them aside for a while while we prioritize other things for the next 15, 16 months.

So I think that's all I really want to say. I just want to open it up. And this is, really, hopefully, a dialogue. I want to listen to you and see what you've got to suggest to us about how we think about this.

And the other thing I might say -- I said it again this morning to the tribal group, but I'll say it tomorrow as well and on Wednesday as well, which is I really value -- I really look forward to these meetings. I think the staff can tell you I get, kind of, into them, because I think the chance to step back and think and to have people who don't, sort of, sit every day and do exactly the same thing we do to, kind

of, look at this in a different way and give us a way to think about it a little differently. And I always learn things from these meetings. It really does impact the way we think about stuff.

So I just want you to know that advice is a product that we value highly. So that's what we're looking for from you. So with that, let me just open it up to you, or turn it back to Kana to facilitate.

MS. SCOTT-ROBBINS: So thank you so much for this opportunity for us to have this discussion again. When I look at the first strategic initiative around prevention, I think it was Charlene who presented to us earlier about young women and girls and the impact that substance use is having with that, you know, 12 to 17 population and how those numbers keep rising.

And we're, kind of, not quite sure why or how or what. But the fact that it's happening -- we need to get a hold on what is happening with those girls and what works in terms of preventing them from getting to that point, and when they've gotten to that point, how we can be effective in helping to give them a path to recovery.

And so, I think, also Fetal Alcohol Syndrome, spectrum disorders, like the presentation earlier, it is preventable. And we don't, I don't think -- even with all the money that's out there, kind of, in the campaigns, you don't hear it, I think, in the right places where women are. I think we've got to get that message out in a different way.

Because, you know, when I'm on the airplane -- and there was a woman, you know, drinking on the airplane. And I'm saying to myself, "Oh, my goodness." And her husband's saying, "Just one, okay"?

But so, it's nice that the airlines -- actually, Southwest did pick up the message, and they actually have it in their pamphlet now. You know, when you go to look at the drinks, it says, you know, drinking while pregnant is not a good thing. But prevention is our first line. And so, I am advocating that we make sure that we can put the message out there to girls that they don't have to make that choice, that there are other choices out there.

MS. MONTGOMERY: But it seems that, yes, young

girls -- but particularly --
MALE SPEAKER: [Inaudible.]
MS. MONTGOMERY: Thank you. Yes, young girls need to learn more about prevention of FASD. But in addition, there's a huge problem among women who are drinking heavily or who are addicted. And we find that, particularly women who have more money, if their doctors asked them if they drink, they don't go back to that doctor. So there's two populations we really need to be reaching out to.
DR. McBRIDE MURRY: I have a question, a follow-up for Starleen. You mentioned being that information needs to be in places where women are more likely to get that information. Any thoughts about any particular strategies for where you're thinking about, in terms of the context?
MS. SCOTT-ROBBINS: Where are women? They're in the beauty parlor. They're in the nail salon. They're in the laundromat.
DR. McBRIDE MURRY: At church.
MS. SCOTT-ROBBINS: They're at church. They're in all those places that I -- yeah. I never see a

poster. I never see an 800 number. And it may be different in other places. But that is certainly how we, over the years, have gotten the word out about gender-specific treatment services being available, is going where people are.
DR. McBRIDE MURRY: And the other thing that I thought about, with the girls being as young as they are, how are we effectively using social media as a way of advertising about prevention. I mean, that's where they -- that's their line of communication. Yeah.
MS. ENOMOTO: Velma, while the Administrator is here, do you want to bring up a little bit about what you were finding around HPV awareness and access to services?
DR. McBRIDE MURRY: The work that I do, Administrator Hyde, is in rural Tennessee and specifically, in rural African-American communities. And I've been involved in an alcohol substance use prevention and HIV AIDS prevention for testing a randomized control trial that we've shown to be efficacious 10 years in a group of rural kids in

Georgia. And I'm moving that program into rural Tennessee. What we decided to do with the sample of families in rural Tennessee was to ask mothers and their daughters about HPV vaccine series and whether or not they had actually begun those series with their daughters, and if not, why.
And what we found, out of a sample of 412 families, less than 10 percent of the mothers had begun the HPV series with their daughters. Both mothers and daughters and sons were aware of this. But the reason that they weren't doing it is because they weren't sure where to go. And they also were not sure if they would have to pay for it, if they did go.
And then, we asked them who would be your source to encourage you to do this, if you did do that. And they said that their child's pediatrician, who had not said anything to them, according to the moms, about the HPV series, and that most of them were thinking of it more in terms of a sexually-transmitted disease rather than cervical cancer prevention. They just didn't seem to make the link.
And so, we began to think about the importance of

public awareness, education, and then, access, because they're not doing it. And most of them talked about it in the context of not knowing or if they did know, not knowing where to go to get them and what it would cost for them, if they did start the series. And even the mothers who were young, in their twenties, had not begun the series as well.
MS. ENOMOTO: And my point of asking you to bring that up is not that we would start an HPV cervical cancer prevention campaign.
DR. McBRIDE MURRY: No.
MS. ENOMOTO: But there is certainly -- there's just -- I think it's a pattern of weakness in our ability to get good health information out to people, particularly in rural, underserved areas.
DR. McBRIDE MURRY: Yes. Right.
MS. ENOMOTO: And our need to piggyback on that. Like, we don't want a separate, you know, HPV vaccine campaign and a substance abuse treatment campaign and a depression-awareness campaign.
DR. McBRIDE MURRY: Right.
MS. ENOMOTO: I mean, we need to figure out what

are the economies of scale that we can get for reaching folks with good, accurate, meaningful health information.

DR. McBRIDE MURRY: Right. And the context of this program is alcohol, drugs, sex, risk prevention. But in the context of that, we're talking about other kinds of healthy sexual promotive behaviors. And part of that is the preventiveness of cervical cancer through these series. So it provides an opportunity to do more than just HIV prevention or HIV-related risk prevention, but other ways that we can then begin to inform.

Because what happened as a consequence of asking those questions -- we inserted in those questions information that will say HPV is for this, are you aware of this. And what the families said to us afterwards, after the data collection, is that it was an awareness for them to even be engaged in answering the questions about this, because it triggered for them ways in which they need to really begin to think seriously about this for their daughters and their sons.

MS. BENAVENTE: Administrator Hyde, I'm Bobby Benavente. And it's my first face-to-face meeting with you. I'm in awe of you. I just need to say that, for the record.

[Applause.]

MS. BENAVENTE: I really am.

MS. HYDE: I haven't said anything yet. How –

MS. BENAVENTE: No, but you have. Since you came into office, I've read the stuff. I've been participating online in the Webinars. And you're real. And that is so important to us, to all of us. But especially for me on Guam, prevention has been my passion for over 25 years. I've been working for the government of Guam for about 33 years now. So I don't want to retire, because prevention is one of your top initiatives.

[Laughter.]

MS. HYDE: Hey, if that keeps you in the game, then this is a good thing.

MS. BENAVENTE: I'm in the game for as long as God allows me to keep on working.

I wanted to, first of all, thank you, thank

SAMHSA.

Kana, you're my heroine, too, and Larke. I just love you women. I want to be just like you in my next life, because I'm older than both of you put together.

[Laughter.]

MS. BENAVENTE: But from the perspective and from the experience of Pacific Islander people and women, we do have our share of challenges. But we really do learn a lot from what SAMHSA has to offer and from all the people at this table. The resources that we've been able to get for the Pacific Islands like the SPIFF-SIG funding and the Garrett Lee Smith funding, they've all been put to really good use in our learnings about strategic prevention framework processes has certainly benefited Guam as part of cohort one.

And we're looking and helping out the other islands as they engage in their processes as well. I think they're cohort three, four. Is there a five? Maybe it's three, four.

But I just wanted to thank you for the attention and the commitment that's been provided the Pacific

Islands, because we've always felt very removed, far removed and not even known in terms of, you know, the challenges that we have geographically and culturally because of the vastness of the different cultures in the Western Pacific and Micronesia. Some of the things that we do with addressing the needs of girls and women is just making sure that they're represented and included in all that we do with prevention and helping to develop policy for the Pacific governments.

Getting the word out to where women are at -- one of the things that we did was partnering with our phone company so that every phone -- every household that had a land line and got their phone books delivered, there were phone labels that they could put on the instrument so they could see numbers, they could call for help. And so, little things like that we've been able to do.

The young people that we train in prevention in our youth leadership initiative for the past 23 years we've worked with them, especially recently, for us old folks who aren't quite sure how FaceBook and all that stuff works. Someone's relating, I can tell.

And so, they're teaching us a lot about how to set up attractive Web sites that would really draw a crowd to link onto the FaceBook. It's Youth For Youth Live. They helped us, the youth, develop our one-nation campaign. We were successful in raising Guam's legal drinking age to 21 just last year. And that was as a result of the SPIFF-SIG work, working with communities and really helping them to work with the power they possess to make some changes, policy-wise.

And my next goal, before I retire -- the government of Guam -- and this doesn't have to go on the record, but I just need to say it. There is a Bureau of Women's Services out of the government of Guam. And I really need to help them to understand that programs like Dress For Success is really not what that should be about. You know? It goes beyond all that. And it really should be led by a man -- I mean, not by a man, but by a woman.

So I'm learning a lot. Thank you so much for your leadership.

MS. HYDE: I probably shouldn't do this, because I'm going to put Kana on the spot. But she and I

don't travel together very much, because we need to have one of us be here all the time. But we actually committed that we were going to come together out to see you guys. So sometime in 2012, you may be the only recipient of a joint visit from the Administrator and the Principal Deputy when we get out there. So maybe you can set up a meeting with us with your Office of Women's Services and we can help you deliver some messages.

MS. BENAVENTE: Is it calendar year 2012 or fiscal year 2012? Because the Collaborating Council is holding the next meeting in Palau first week in December. And we extend the invitation to both of you.

MS. HYDE: In 2012?

MS. BENAVENTE: December '11.

MS. HYDE: December '11?

MS. BENAVENTE: FY 2012, which would mean December. That counts.

[Laughter.]

MS. HYDE: Well, we'll talk.

[Laughter.]

DR. CAMPBELL: I was curious when you began to talk. And you were asking us about considering priorities in this time of fiscal retraction. And my first question was were you thinking of delayed implementation of some initiatives or some projects within initiatives or the combination of those approaches. That was one question. And then, I was thinking in terms of principals, if you were thinking about setting priorities that -- just off the top of my head, I was thinking those initiatives that successfully address health inequities might be, you know, having some way of looking at these programs so you could actually create within this retraction an agenda.

And then, I was thinking of also prevention-focused and recovery-based, that those three things. And it could be others. But the strategy of creating agenda within the initiatives themselves to stage your overall plan might be a good approach.

MS. HYDE: We'll probably talk about this a little bit more tomorrow. I think there's a little, tiny spot on the agenda tomorrow about what we're

doing with strategic initiatives. But to answer your first question, which I think goes to your second one a little bit, is within the eight initiatives, there are probably 400 -- I've forgotten the exact number -- 427 or something activities that we've committed to.

DR. CAMPBELL: Yeah.

MS. HYDE: It is a four-year plan, not a one-year plan or a two-year plan, but a four-year plan. And even at that, some of the activities are written so broadly that it would take a lifetime to do. You know? So sometimes there's just more there than we can possibly do.

So what we're trying to do is it took the first 18 months or so that I was here to, sort of, get clear about what those eight strategies or strategic initiatives were going to be and what those 427 activities we were going to commit to. And we've been doing a lot. We've done a lot of stuff.

But now, we're, sort of, looking at the next 16 months and saying, "What could we get done in those 16 months"? So it's not saying we're not going to do some of the things. It is more to say where do we

need to focus our attention for the next 16 months. And then, 16 months from now, we'll say where do we need to focus our attention the next 18 months. So it's sort of a right now, given this situation, given we don't know what Congress is going to do with 2012, given that some things have to go before another thing, even if this thing is more important or what we're trying to get at. You have to do this before you can get there. So sometimes it's an order-type priority.

Sometimes it's literally we can't do everything. We have less staff, less money, less whatever. So what should we focus on? So if there are 16 things in these eight initiatives that are really going to push women's services for girls ahead, but we can only do four of them, what would that be? You know, what do you think are the most important of those? So that's what we -- for right now, what are the most important things for right now as opposed to three from now, for example. So that's what we mean by prioritizing.

DR. CAMPBELL: Thank you. That's helpful.

MS. ENOMOTO: I realize that folks don't actually

have the strategic initiative paper in front of them. They do have the summary of –

DR. CAMPBELL: We've all memorized it.

MS. ENOMOTO: Yes. You have the – okay. So we do have it? Okay. Okay. I have no idea what's in my book. Okay.

MS. HYDE: But you do have on the – whatever you're calling it – a conversation piece.

MS. ENOMOTO: Right.

MS. HYDE: You do have at least what the eight initiatives are. So –

MS. ENOMOTO: Right. Right.

MS. AMATETTI: I might add that tomorrow morning at the Joint NAC, we're going to be doing a presentation, sort of, a shortened version of the how women and girls are handled throughout the strategic initiatives. And we're going to be soliciting feedback from the Joint NAC about what we're doing, about what they think we could be doing, maybe – again, what areas would they emphasize, strengthen, some new ideas for us.

And so, if there is anything that you would want

as a council to say, that these -- as a committee, what you think the priorities are. And so, it'd be good to think about that a little bit right now. You'll have an opportunity to be respondents as well tomorrow to share, sort of, what the conversation was here, if you want to share that as a group, or even just individually about your thoughts. For instance, you know, Starleen's recommendation looking at the issue of younger women or girls, how that really needs to be addressed, given what the trends are. I mean, that would be the type of thing that we could bring up to the Joint NAC.

We've had the benefit of hearing Dr. Lewis this morning talking about some trends. We've been talking about that sort of thing. So just to, sort of, help focus your thoughts today for the conversation tomorrow as well. I just wanted to let you know that was coming up.

MS. ENOMOTO: Okay. I see that Bobby has her leading change book. And to the degree -- if we could get copies for any of the members who would like to take a look at it, because it has the action steps in

there and the objectives. And I think that's what would be -- that's some of the sorting process that we're going through right now. So of the 375 plus action steps that we've committed to, which of those are going to come first? Because we can only split -- I mean, we can't assign, you know, 500 people, each person gets an action step to do by themselves.

And we have to put these things in order. So to the degree you take a look and say, well, if I were the administrator and I wanted to really make sure that, along with all these other things, I also advanced the health of women and girls, I would do these five things in the first cohort of activity. And here's why.

I mean, I think that would be a good -- and, obviously, for other populations of interest, et cetera, you can do that. But that is some of the process that we're going through, just, you know, in parallel with these meetings right now. People are doing that and, sort of, doing that sort of a has to come before b, comes before c. Or if I have to choose between a and b, I'm doing a now and b later. So is

someone getting them copies? Okay.

So for those of you who need them, we'll have copies of that for you to look at.

Okay, Starleen?

MS. SCOTT-ROBBINS: Just to give you an idea what the Women's Services Network -- the pregnant -- we have four different subcommittees. And the Pregnant and Parenting Subcommittee right now -- they're, kind of, focusing on ESPER and ensuring that you are able to identify women early, particularly in their pregnancy so that you can have a larger impact on the birth outcome.

They are also looking at parenting skills and the need for evidence-based practice to ensure that women, particularly because a lot of the women who come into treatment get their children back and have not had them in their custody for such a long time, that you want to ensure that they can be as successful as possible when they are getting reunified with their children.

Our Criminal Justice Subcommittee has been looking at how you can ensure that women who are

transitioning from the criminal justice environment can transition back into the community with the right supports to prevent them from going back into that situation. Our Data and Outcomes -- they're looking at how you can utilize the data and outcomes from the programs to build on the successes and to help support better outcomes for our programs and also to use that data to also sustain programs, to be able to make the argument that treatment works and that this is a way for, not just the federal government, but foundations and private dollars to help support the programs.

So I think all of those are things that, you know, kind of, fit into the strategic initiatives, one way or the other. And so, I would just like to make a bid for the block grant. I think it's absolutely wonderful that the women's set-aside is there and available to states. And as we, kind of, broaden that look into the mental health arena, how can we ensure that the services that pregnant women and women with children who have a mental disorder actually are getting gender-specific treatment services?

I was sharing earlier that as we're doing the

uniform block grant, that we actually have data that shows the number of women who have a primary mental illness. But we don't know what type of treatment they're getting. And so, we're going to use this as an opportunity to understand better what it is they're getting and how we can help enhance and enrich what they're receiving when they're in treatment.

The block grant, as we move forward in health care reform, is also extremely important because of the residential services that are currently supported -- that aren't supported through Medicaid. We have a long history of working with Child Welfare and helping families get reunified. And for Child Welfare, that means in a safe, structured environment, at least initially.

And I would like to just put out there that without those services, we have a lot of families that would never get back together. So I just want to advocate for us to be looking for effective residential supports within our community to make sure that those are available for families so that they can either remain together or to be reunified.

Also, recovery-oriented systems of care -- we talk about that all the time. But are those gender-specific?

And you talked a bit about that this morning, Jean.

DR. CAMPBELL: Well, I was just thinking that the results of --

MALE SPEAKER: Microphone.

DR. CAMPBELL: -- that just what you were saying about unifying the families and bringing them back together, those covariant data suggest that that would be a successful program for increasing the well-being of those individuals and their resilience in the community.

MS. SCOTT-ROBBINS: So I think there's a lot of things that we could be looking at that don't take a lot of money, but -- and, certainly, are on the agendas of the states right now, but how SAMHSA can help support, you know, those activities would be, kind of, the way that, I think, this committee could help figure out how we could support states in moving forward with those agendas.

MS. BRISCOE: I agree. And as far as advocacy and in the states and looking at legislation, last month, in Yes Magazine, the whole magazine was about prisons and women in prison and people of color in prison. And it was astounding that whole generations are being lost. And there's racism involved in it, because if you look at who's being incarcerated, even though in the general population, it's more the white population that abuses drugs and alcohol, that prisons are filled with people of color.

And why isn't anybody saying anything about that? That was infuriating to read that and see that 85 percent of the women were in there for non-violent crimes. And it was for drugs.

In New Mexico, there was an initiative for treatment versus incarceration in which our governor vetoed. But those are the kind of things that need to -- I think, as advocates, that SAMHSA may be a greater role in advocating. That information -- I feel like I'm very learned. I read a lot. And I study a lot. And I look at research. But still, in one magazine, what came out in that magazine was I wanted to cry.

It's modern-day slavery, is what it is.

MS. ENOMOTO: I think we actually have just started talking with -- can I talk about MacArthur?

We're talking with MacArthur Foundation as well as Office of Justice Programs, juvenile justice delinquency programs, about -- and I think RWJ as well -- but something that looks at disproportionate minority youth in juvenile justice in collaborating and getting states together with some folks that have best practices and the research base that shows that there are alternatives to incarceration, ways to prevent kids getting there as well as to divert them from that juvenile justice involvement at an earlier age. So we're certainly looking at that, both on the substance abuse and on mental health sides for young people.

Bobby, you had asked a question similar to what Starleen's statement was about on the mental health block grant and women. Did you want to bring that up, just to hear your point of view no that?

MS. BENAVENTE: Yes, my question earlier this morning was around whether the CMHS block grant has a

requirement for ensuring that women and pregnant women and women with children were served without delay, as the requirement is in place for SAPT. And one of the things I shared was, learning from our treatment folks, the CMHS side of the house of the Guam Department of Mental Health and Substance Abuse, was that there were 300 individuals on a wait list for service.

And my question to the treatment providers and the intake workers is, well, who are they. How many of them are women? How many of them are girls? And what is it that they need? And how do you determine who comes in for service quickly as opposed to who can truly afford to wait until the next appointment book opens up?

So I was thinking about ways in which we could influence, through block grant language, for CMHS something that states women can't wait or girls can't wait, or maybe just write it for Guam's requirement. I don't know.

[Laughter.]

MS. HYDE: The answer to your question is a

frustratingly no, there isn't a requirement in the mental health block grant, in the same way that there is in the substance abuse one. We actually tried to see what we could do about introducing that kind of a requirement for, especially women, pregnant women to have priority. And we couldn't get the legal authority to do that.

So what we basically did is called it out as a population that needs to be addressed. And the best that does is give those of you at the state and territory level some advocacy capacity. So that and other populations, frankly, that we called out a little bit in the block grant, but that we can't require states and territories to address. We're very much encouraging them to do that.

We're trying to explain to them that even if they will say, yes, there's a huge issue, and we have no resources to deal with it, that in and of itself is an important thing to have that we can compile across all the states and territories and say, look, look at the need and the lack of resources. But we got a fair amount of push-back, mostly, frankly, on the substance

abuse side more than the mental health side, about, "You can't make us do anything that's not in the law." So the best we could do is put it in there as a population that we encourage them to address.

MS. BENAVENTE: Would it be as difficult or more difficult to raise the minimum 20 percent set-aside for prevention to, you know, half and half, 50 maybe?

MS. HYDE: Well --

[Laughter.]

MS. HYDE: Any of those require congressional action. Now, if you've watched the newspapers lately, you would know that the concept of congressional action is a strange concept.

[Laughter.]

MS. HYDE: Right? It's a paralyzing concept at the moment. So it's a little frustrating, because we are left with a 20-year-old law that we have to try to live within. And the world is very different today than it was in 1992.

However, what we have tried to do -- and we're getting push-back about this as well -- we have tried to pull prevention out, the 20 percent set-aside out,

and combine it with some other prevention funds, because we have a plethora of prevention programs and tried to put it together into a state, which would mean tribes as well -- I mean, territories as well -- state, a substance abuse state prevention grant and a separate mental health state prevention grant. There are individuals -- and there's some public positions, so I assume it's okay to say. The state substance abuse directors, along with some other substance abuse advocates, have taken the position they don't want us to pull that out and put it that way.

What we were trying to do was protect the prevention dollars, because we know there are going to be cuts. And when it's 20 percent of a hundred, and the 100 drops down to 70, then it's less money. So what we were trying to do is pull the 20 percent out and hold it harmless from some of those cuts. And we haven't been able to get very far with that at this point.

So it is our number one priority. Prevention is our number one priority. I think we have an opportunity here in a way that we haven't ever had

before to both get the prevention science for both substance abuse and mental illness in front of people and also, because there is such a push for prevention in the health reform bill. But we're having a hard time getting traction on doing that.

And what we also did, though, is when we proposed that pull-out, that set-aside pull-out, that would require language that says, "notwithstanding the language in the law." Because I don't know if you know how Congress works, but there is, like, authorizers, and there's appropriators. And they don't like you messing with each other's authority.

So if the appropriators pull out language and says, "notwithstanding what those guys over there did, we want to use the money this way," they don't, kind of, like it so much. So we were trying with that, kind of, notwithstanding language to pull prevention out, and at the same time, let states and territories continue to spend -- in some cases, they do spend more than 20 percent of their block grant for prevention. So we were trying to preserve their right to spend some of the treatment dollars for prevention, if they

wanted to do so.

So we're on the same side here, I think. We're just -- our hands are tied a little bit by some of the congressional constraints. And I'm not, sort of, doing that to try to dump on Congress, but rather to say there is a role for the legislative branch. And they haven't acted for a while on that side. So until they do, we are stuck with the language that's there.

MS. BENAVENTE: Just one last thing for now is, again, just restating the importance of being a part of national surveys. None of the Pacific Islands are included in the NSDUH. We are struggling with understanding a way in which we could gather data that may or may not be comparable to other Pacific Islanders and Asians that live away from the Western Pacific and American Samoa. Because a lot of -- you know, being in the field for such a long time doesn't mean I know a whole lot. I still wonder what it is that I know.

So you've got this healthy people 20 -- what year is that? 2020, which is reflective of information that has been gathered from these surveys; right? So

these surveys don't include Pacific Islanders who live off this continent and Hawaii. And so, it's really hard to pay attention to that when there's so much data-gathering needs that needs to occur on a government level and a community or village level in all the islands that make up the Pacific nations who are affiliated with the United States.

So again, just stating the importance and the desire for us to be a part of this whole movement to get the data, to understand what that means, and to have that information drive the priorities that would serve Pacific Islanders and Asians across the nation beyond this continent and Hawaii.

MS. HYDE: Can I react, also, to something, Starleen, that you said earlier, a couple things? And actually, several of you did. Whether it's about people in prisons, or whether it's about immunizations, HPV immunizations, or whether it's about Fetal Alcohol Syndrome or anything else, those are issues that are not uniquely SAMHSA's responsibility. And, in fact, in some cases, we barely touch them, if at all.

We might touch them by being on a work group. Or we might touch them in maybe a small grant program or something. But one of the things that we're having to do in this difficult budget times is to step back and look at those things that may be the purview of other agencies like CDC, like HRSA. You're going to hear something about that tomorrow.

And I think we've got tremendous collaboration opportunities. And if there's anything that women know how to do, it's collaborate. So we have tremendous opportunities to collaborate against these other -- or with these other agencies. And we're really trying to think about -- let's use under-age drinking for a minute here as an example.

If we've got NIDA and CDC and us and ONDCP -- all these acronyms, but bunches of different agencies all doing separate programs for under-age drinking, that may not be the best use of limited dollars. Unfortunately, our stakeholders tend to look at just our budget or just the line item in our budget they care about or whatever and then think we don't care about a particular issue because we can't continue to

fund it in the way that we're doing in these tight budget times.

So my question about all that is what role do you think -- SAMHSA certainly can do what I laughingly call leadership by nuisance, which is we're constantly at the table saying, "Don't forget about behavioral health, don't forget about substance abuse, don't forget about mental illness," at these other tables. And our partners are very much listening to us.

We're doing a lot of work with the Department of Justice. We're doing a lot of work with CDC. And the issue of immunizations and its role in prevention is clearly on everybody's mind. But I think we tend to think about immunizations of babies for measles more than we think about something else.

So anyway, what advice would you give us about things that we could work -- Fetal Alcohol Syndrome, for example. CDC does work in that. NIAA does work on that. Lots of folks are touching it. So how can we best move any of these issues forward, in your mind, if we don't have a program or we have a program and it's going away?

Things that come to a natural end in a budget cycle are pretty dangerously up for grabs when they come to natural ends. And if it happens to hit in the year you got a cut, they're going to get cut. So what is it that you would recommend to us or advise to us about working on some of these issues that go far beyond SAMHSA's four walls? How can we be an appropriate player?

DR. FELITTI: Several books have been written about the remarkable effectiveness of soap operas as a way of disseminating public health information in African and in South America, particularly related to condom use and HIV prevention. I don't know what constraints you would have to use that tool. But the audiences are vast. And I think the opportunities are really major in terms of using serial theater as a way of getting information across in a way that is not instructional, et cetera, but rather uses story-telling. And besides which, many cultures have a long history of using story-telling as a way of getting information across.

MS. HYDE: So we could start a soap opera on --

DR. FELITTI: Well, I don't know what sort of limitations you -- I mean, basically, it would be to try to influence a soap opera and, obviously, would not cost very much money --

MS. HYDE: Yeah.

DR. FELITTI: -- if you were skillful at --

MS. HYDE: I was actually teasing a little. But we do actually have a program where we reward TV and entertainment programs for doing the right thing by our topics. So I can't remember if there's been soap operas --

DR. FELITTI: Is it Hollywood Health and Society Program?

MS. HYDE: No, it's called the Voice Awards. We have two of them right now.

DR. FELITTI: Okay.

MS. HYDE: The Voice Awards that we do in the fall, and then, we support -- it's not our program, but the Entertainment Industry Council does a Prism Awards that we provide a little funding to.

DR. FELITTI: Yes, okay.

MS. HYDE: But it more calls out good programs

that -- whether it's TV or movies or whatever that are sending the right message. So there may be ways that we can -- last year, we focused on military families. And it was amazing how many military-themed programs there were dealing with PTSD, substance abuse, even trauma issues and other kinds of things. So sometimes maybe by calling it out, we can get some attention to it. So it's a good point.

MS. ENOMOTO: We also did some developmental activities through some of the guild organizations, trying to reach the Writer's Guild and some producers and directors in the L.A. entertainment industry, community to talk to them about women's health issues. And we worked with Hollywood Health in Society on a consultant basis as well. So, I mean, you know, there's -- we can -- I think we said you can lead the horse to -- what was it?

MALE SPEAKER: [Inaudible.]

MS. ENOMOTO: No. She said --

MS. FORMAN: You can lead a horse to drink, but you can't make it water.

MS. ENOMOTO: Yes.

[Laughter.]

MS. ENOMOTO: Yes. So, you know, I mean, I think we are, as aggressively as we can, putting the information and the opportunity for consultation out there. And it's really just a matter of getting that kind of pick-up. But, yeah.

Yolanda?

MS. BRISCOE: I do appreciate you saying that you were doing more collaboration, because, as providers, doing more with less -- we're called to do that. With the SAPT grant, where it says that women and pregnant women are a priority -- but if you're waiting for the phone to ring for a pregnant woman to call you, it's not going to happen. You have to go to the health care for the homeless. You have to go to the Welfare Department. You have to -- because there's so much fear in education around, no, we will not call the police when you come get treatment here, and this is confidential, and there are laws to protect you.

And so, really our wait list, when we first started it, was predominantly men. And yet, we're asked to address women and HIV and injection users in

a population that isn't likely to say, "Hi, how do I get into your treatment facility? My OBGYN recommended that I come see you." It's women who haven't even gone to an OBGYN. So clinics -- going to clinics and getting -- formulating really strong relationships with those kind of clinics has been very helpful for us. And I share this because one of the wonderful things that I enjoy about being on this committee is that I learn so much, and then, I go back and then, try to implement some of the things such as ACE and doing training around that and doing it around trauma-informed services.

So I offer that as something that -- for wait lists, that going after the population is it takes a lot of outreach. You don't get reimbursed for that. But it's just the right thing to do. Thank you.

MS. ENOMOTO: I'll go to Bobby in a second. But I do -- Johanna, I'm just going to give you a heads up that if you want to comment, I'll give you a second to think about it. And then, we'll come back to you, if you're still on the line.

Okay, all right.

So, Bobby, go ahead. And we'll get back to Johanna if she has a comment.

MS. BENAVENTE: I know what that's like to try to participate online when I couldn't travel.

It took over 18 hours to fly over, just the flying time from Guam. So if you would indulge me, I'll ask just one more -- or make one more statement, please.

The question I have is what can we ask SAMHSA to do to help us with dialogue with the Department of Defense or the Department of Interior to change things up for the island where we are one island community, even though there are military bases that take up one-third of the island and with a different set of policies. The reason why I bring that up is we are expected to figure out in our strategic plan for the territory how to serve the military population, the military personnel, their dependents, and the contractors that are coming to Guam because of the shut-down of the base in Japan and the Marines coming to our island.

But there's only so much we can do if we don't

even have enough to serve our own civilian population. And there's only so much that we will have access to if we can't get on the military bases without being sponsored by someone who has the I.D. to go in there. We are provided free services to military personnel and their families when they leave the base for mental health and substance abuse treatment services, because they want to keep things under wrap from their command. So we can't say, "Guess what, Rear Admiral So and So, we need you to compensate the local government because we're providing all of this value of services to your people."

And so, I mean, I'm not sure I'm presenting this clearly enough. It's just that it is policy issue, and it's something we've all agreed when we leave the island is just to keep voicing it, that there is a need to be -- to set up some policies around how does the civilian community work with the military community.

MS. HYDE: You know, I don't know that we have a way to fix that particular issue, although we'd be happy to sit offline and talk about it and maybe get

Kathryn Power, who's our military families lead, to talk with you about it. But interestingly enough, while it is writ large in Guam, for all the reasons you said, these are very similar issues anytime there is a grouping of military personnel anywhere in the United States and then, the civilian service delivery system is getting a lot of people who don't want to use, for whatever reason, don't want to use the military-based health care delivery, whether it's a base or whether it's TRICARE, or whether it's, for veterans, the V.A., or it's -- maybe it's because they don't live close or whatever. So we've had lots of conversations with them about that.

And it is one of the priorities for our military families initiative is to try to, again, we've already begun to try to influence a little bit making that military population more able to get services where they want and getting our civilian service delivery systems culturally geared up. Because a lot of times, they don't understand military culture, either. So it's some of both.

So it is something we're working on. But I think

it's -- we're working on it this much compared to the problem. So I think it would be worth -- and she'll be here tomorrow. So I think it would be worth to have a conversation with Kathryn Power about that. We've got memorandums of agreement with the V.A. and with the Department of Defense Center of Excellence.

And so, there are some mechanisms or some avenues for us to have these conversations. We've been having the conversations with TRICARE. So I think it just bears more discussion.

MS. ENOMOTO: Johanna?

MS. BERGEN: Thanks. I got bumped off for a minute, but I'm back on.

I guess my question, as I'm listening to this, is how can we -- and how can SAMHSA encourage these same kind of conversations and collaborations between the different departments on a state level, on a more local level. It seems like -- I don't know. We just need to be told -- as we work in this field, we just need to be told SAMHSA just didn't stop this priority. Now they're in conversations and making sure it's continued with another department.

How can we -- just letting us know that, I think, is really important. But then, how do we also bring that level of collaboration and, kind of, [inaudible] happening on the federal government level to our state conversations? Because just knowing that it's happening on both levels makes it a more powerful and meaningful conversation. So I guess I'm just thinking about, you know, how to take that conversation back home.

MS. HYDE: I would actually ask you back, sort of, what would you suggest we do. So we've been doing a ton of things, everything from in the block grant application -- we've been putting explicit language about bringing in education authorities, Justice authorities, Child Welfare authorities. And we haven't probably been explicit, because not every sate has, I think, a separate women's services office. A lot of them do, but not all of them do.

We have been asking them to bring in public health authorities. These are, again, things we can't actually demand or require. But we can strongly encourage. And then, we've been doing some regional

meetings around specific topics. I suppose if we could figure out -- and scare up the staff, we could figure out a way to do some regional meetings around women and girls or around behavioral health equities issues, disparity issues, if we could figure out how to do that.

These have been really effective. What we do is go out and ask the state mental health authorities and the state substance abuse authorities -- and in the case of health reform, the state Medicaid authorities, so those three groups. For our regional HIT, we've asked the state health information technology lead and the state mental health and substance abuse authority to come to the table. And then, we had some regional meetings around under-age drinking as well.

So sometimes, frankly, we've been thinking about the fact that as grant dollars get shorter and shorter, that our convening power may be the one thing that we can do. So that's rambling a bit, but I guess to say back to you, what is it that you think would be useful to try to get that kind of relationship going at the state.

We understand -- I came out of a state environment. I've worked at every level. I've worked at the city level and the county level, and the state level, provider level and now, at the federal level. And they're all different. But the states are really key right now as they're rethinking their health delivery systems, and they're rethinking their budgets, and they're rethinking their priorities. So if you have a thought about how we can do that or use our authority to do that, I'm open to that conversation.

Have you ever had Larke here to talk about just the behavioral disparities issue? Maybe we should do that. She's with tribal.

MS. ENOMOTO: Yeah, we did it with the -- we did the MAC.

MS. HYDE: Okay.

MS. ENOMOTO: One of the tools that we use frequently, Johanna, is the state policy academy. And so, we've done that on a number of different topics. And I think the strategic initiative paper probably proposes three or four more topics of doing state

policy academies. But, certainly, that would be one of the ways where we encourage a parallel process of collaboration to happen at the state level where they bring in their teams to formulate a plan around a specific topic or activity.

MS. HYDE: You know, the other thing I usually saying and forgot to is that we're about to -- we're in the process of trying to create some regional presence in the 10 regional offices. It's only going to be one human being. But everybody -- all of our sister and brother operating divisions, CDC and HRSA and ACF and CMS and all the acronym family have presence there.

They actually have staff, you know, whole groups of staff there. We're just going to try to have one person in each of those areas. But they're really calling on us to help with behavioral health issues, because they're just getting barraged with behavioral health concerns. And they don't have the ways to respond to them.

So I, sort of, both pity and think it's going to be exciting for that person to be there. They're

going to be deluged. And yet, so this is another area, because there's women's services offices that have a focus there at the regional areas as well. So maybe there's some things that can be done that way as well.

MS. ENOMOTO: We have time for one more comment. Actually, one in a quarter people in the regional offices.

MS. HYDE: Oh, cool. They just upped it by a [inaudible].

MS. ENOMOTO: Harriet?

MS. FORMAN: I have learned so much these last couple of sessions. And I'm so particularly impressed with Vincent's work in ACE. Coming from a school and young child perspective, I am enormously impressed with strategic initiative two and how important and how pervasive the effects of trauma and violence.

We see it in schools so enormously. And I would just say whatever push-back you're getting from moving this initiative forward is worth piling on all that you can, because I think it really does underlie so much of the problem, behavior -- the mental health and

substance and learning problems that our kids are facing. And I just want to encourage that. If there is anything that you emphasizes, that that would definitely be something that receives extraordinarily high priority.

MS. HYDE: Thanks for that comment. I actually am a relative newcomer to the science of trauma as well. I've learned a lot about it from Kana and from the people working on it the last few years. And, certainly, I've become a big fan of the A-Study. I've taken it to my colleagues at our senior staff meeting. I've taken it to the Secretary on a one-on-one. She's also a very big fan now. She's really taken with it as well.

So we are trying to just get the word out. And we're also, as we think about -- you're going to hear about it some -- well, I guess it's actually Wednesday. The National Advisory Council's going to hear a little bit about some of our thinking about what we call the national dialogue, for lack of a better term at the moment.

And, sort of, a piece of that is an understanding

how communities can understand that the role of trauma and the way our kids are exposed from a very young age and what that does to the health of community, not just the health of individuals, but the health of the community. So it is a big issue and a growing issue. And I think, sort of, people are glomming onto it.

We do get push-back, Harriet. We got -- it's one of those wonderful things, you know. Congress wants us to do it in the way that Congress does it. So they appropriated money in a certain way, and we tried to braid the funding in a certain way to do some work around trauma. And that didn't fly. So we're backing up and trying it a slightly different way. But that's good validation that we should keep pushing on that. So thank you.

And if there's any of these initiatives -- they all have issues for women and girls. But if there's any of these initiatives that have a particular relevance, I think, for women and girls, it's that one.

So I also -- just, actually, Starleen, I remembered I wanted to say -- this is probably jumping

from the fire into the frying pan. But on the residential treatment issue, it's interesting. You make comments and raise questions, and then, positions get assumed in many ways. So there's been, sort of, an assumption. I've actually had people ask me are we completely going to stop funding residential services. And no matter how many times I've said I never said that, it keeps coming back to me as, "You don't like residential services."

It's not that. And, in fact, the one place I said that absolutely we need residential services is for women, especially women with children. And I'll put my own personal history in service delivery systems and what I've supported getting done about that.

But there is a tough, tough issue. There is no question that residential services for some people for certain types of things is part of the continuum that needs to be addressed. The problem is there's just less and less dollars. So we've got to figure out where's the right balance. And we could spend every dollar we have on residential services just for women,

and we still wouldn't be anywhere near meeting needs. So the question is what's the right balance, and where do we -- my own experience also tends to be that people will develop residential programs.

And because there isn't anything else, then everybody gets put in there. And they get put in there for way longer than they should because there's nothing to let them help them once they get out, which is why we're trying to develop the recovery supports and all of these other kinds of efforts.

I know in New Mexico -- and, Yolanda, you may remember this. And we were told, because there was a court program who wanted to deal with men coming out of the court system. And as we started developing the facility -- it was supposed to be a residential treatment facility. And we started developing it. And we said, you know, the first group that needs this is women with children. So we designed it as women with children.

We, frankly, never got even that far with it because the budget only let us do the first anchor building. But the design of that program now is an

anchor building for women, men, and children that's outpatient, intensive outpatient, and then, women with girls residential next. And then, if we ever have time -- pardon?

MS. FORMAN: Women with children?

MS. HYDE: Women with children. What did I say?

MS. FORMAN: Girls.

MS. HYDE: Oh, women with children. Sorry.

So the point here is often, it is -- frankly, it's often courts. And that's a good thing. It's often courts and law enforcement that are driving the we need services discussion. And the people that are in front of them may or may not be women and girls, for the reason -- children, for the reason that you said. And yet, when you step back and look at what the design needs to be first for the limited dollars that you have. You know, that's where you go.

But this is going to be -- continue to be a hard one, because there's just not enough dollars. And it's -- even in things like a program where you've got -- like our pregnant, parenting women program where it has been traditionally a lot of residential, we're

having to think, well, are there other ways we can serve pregnant and parenting women short of residential, because you can serve so many more women if you don't do it in a residential setting. So it's not about thinking that residential is somehow awful. It is a matter of what's the right balance with very limited dollars, and where do you try to stretch those dollars the best way you can. So, yeah.

MS. SCOTT-ROBBINS: And I believe that residential is one of those situations, though, where the collaboration and coordination with all of those other agencies that help support that family make the difference in terms of the funding. Because when you're working with Child Welfare and public health and domestic violence and with the criminal justice system, I think all of them share a piece of supporting that family, because they're all the ones who -- and child mental health and the system of care, who are all going to help make that family successful.

And so, that's one of the things that we look at when we do an RFP, is what is the support of all the other partners who have the same, exact families, who

want the same, exact outcomes. And that's why I think, you know, the discussion that you had earlier about, you know, it's not always SAMHSA's, you know, number one priority, because it's six other people's priority, too.

I think we have to have those partnerships at the state level to help maintain those things that we know actually help families recover and be healthy. And so, you know, I wasn't actually putting the residential piece out there because of what I've heard you say in the past. I think that it is a key piece for some families in order to stay together or to get reunified. And if we don't have that as a part of the continuum, I think we will see a lot more moms in jail. I think we'll see a lot more kids in foster care, et cetera. But I think that it is a part of the continuum. So I was just putting it out there.

MS. HYDE: Yeah, no, I agree with you. And we've had some really good relationships with the Administration on Children and Families, especially Bryan Samuels and that Children, Youth and Families Group. And actually, Larke and I and a couple of

other people just went over and met with them. They're doing some terrific stuff around trauma issues and around service delivery issues.

And I really liked the way Bryan talked about it, which is just because you take a child out of a dangerous or a negative situation, doesn't mean all of a sudden, they're okay. I mean, the way -- just the way he described that was a good way to think of it, because I think that's the way society thinks. We'll just get them out of that bad situation, then they'll be okay.

And, you know, the trauma that's remaining, the separation that's remaining and all of those -- huge issues. So they're really doing a lot of data driven, trying to look at the data that tells them about their kids and the families that are behind those kids and what they can do about it differently. And we're very much a partner with them about that. So I appreciate your input.

MS. ENOMOTO: All right. Thank you.

Yolanda, make the last comment, and then, we're going to break. So go ahead.

MS. BRISCOE: I completely agree about residential [inaudible] --

MALE SPEAKER: Microphone.

MS. BRISCOE: The residential piece is just a small, tiny piece. We get individuals for 30 days. The community gets them for a lifetime. But if you don't have that support of housing or employment afterwards, it's just a revolving door. And so, those supports have to be built in.

MS. ENOMOTO: All right. Thank you, everybody, for a robust discussion. And we will be back here in 10 minutes. Thanks.

[Break.]

MS. GRAHAM: The meeting is now called to order. Thank you, Sharon.

MS. AMATETTI: Thank you.

Okay, we wanted to spend hour, hour and-a-half or so on a subject that actually was brought to us by Stephanie Covington. Although she is not here with us today, she did influence the agenda for this meeting. So, as you'll see in your agenda, we're talking about gender specificity across behavioral health. And we

wanted to really spend some time looking at what gender specificity and responsiveness means across the different domains of substance abuse treatment, substance abuse prevention, mental health prevention and treatment, because we know that when we talk about being gender responsive in those different domains, that we're not always talking about one in the same thing.

Our work really has been influenced by many different things, sometimes by science, sometimes by politics, advocacy, also the way that services are organized. The way they're organized in treatment and the way they're organized in prevention and mental health services are not necessarily one in the same.

Okay, so that was what really prompted us wanting to look at. But we know that there are differences. We are trying to do more across behavioral health now. And we thought it was important for us to spend some time talking about what that means.

In SAMHSA, we have a paper, the Good and Modern Paper, which I think most of you have heard about. And it states that the goal of a good and modern

system of care is to provide a full range of high-quality services to meet the range of age, gender, cultural, and other needs presented. And interventions that are used in a good system should reflect the knowledge and technology that are available as part of modern medicine and include evidence-informed practice. So we think of services that are good and modern as services that do attend to gender differences.

So I wanted to set the stage for this discussion by highlighting the work that has been done in SAMHSA's Center for Substance Abuse Treatment, the center that I'm most familiar with. I've asked my colleague, Mary Blake, to talk about what our Center for Mental Health Services has done, the work that they've done around gender-responsive services.

I've asked Patricia Getty to talk a little bit about what the Center for Substance Prevention has done, the history of that work there. And then, we've invited two guests to help lead this conversation, Dr. Carole Warshaw and Dr. Hortensia Amaro, who we are expecting to come in shortly. And I'll introduce them

a little bit more in a few minutes.

But so to begin with, I wanted to really talk about, you know, what we've been doing in the Center for Substance Abuse Treatment around being gender responsive and the way that we approach our work. When SAMHSA was created, we had a body of work that we were able to build on from the National Institute of Drug Abuse and the National Institute of Alcohol Abuse and Alcoholism that looked at specific addiction treatment concerns of women.

Our first discretionary portfolios included large residential women and children programs as well as our pregnant and post-partum women's grants, which we're continuing today under the leadership of Linda White-Young, who was here earlier. I'm not sure she -- she'll be back, though, I'm sure.

We also have been talking this morning about the block grant and the block grant set-aside. The first block grant set-aside was in 1984, which at that time, 5 percent of the funds were supposed to be set aside for women's services. It increased in 1988 to 10 percent. And then with the subsidies prevention

treatment block grant, there was much greater definition about what those services should look like. What was the money intended to be spent on was defined in a much more prescriptive way by Congress, because there was a feeling that the money wasn't really being spent on services that were intended for women and women and their children.

Over time, we've also documented our approaches and lessons learned. The very first effort to document at CSAT what women's services should look like was in what we call the Purple Book. I think I have the last remaining copy. Practical approaches to the treatment of women was our very first effort in the early 1990s. And at that time, we just got together in an advisory group, and this is what they thought should include best practices. And that's what went into the book.

As we started having more experience with our residential treatment grants, the large-scale, comprehensive programs I told you about, we tried to document that work as well. And we did it through a lessons learned document, telling their stories, which

was the grant program's words about what they thought was effective services for women and women with children.

As we moved along, we thought it was important to try and really articulate in a more prescriptive way what it was -- what they were trying to tell us when they were telling their stories. And so, a group put together the CSAT model for comprehensive services for women and women's programs. And at that time, we talked about clinical treatment services for women, clinical support services for women, and community support services for women in a model.

And then, we went and did the same thing for the children. What would clinical services look like for children as well as clinical support and community support services for children? That ended up being documented and finally published in the SAMHSA Tip for Women. This is our Treatment Improvement Protocol, which I know you all know about the TIP Series. Actually, it just came out a year ago, this TIP on women. Although it was under development for quite some time.

As our field has grown, we've appreciated the fact that women do not exist in isolation, certainly, and that, not only are our children important, but family is important as a concept that needs to be part of treatment and recovery. We developed a paper on family-centered treatment for women with substance abuse disorders, history, key elements, and challenges. It was developed by a working group, including the Rebecca Project for Human Rights that was helping to promote the model of residential care for women and children, but to also look at, sort of, a continuum of what does family. And so, we have tried to articulate that for the field in this paper.

And, of course, people said, well, that's nice to have family-centered treatment, but how are we going to pay for it. So then, we developed funding family-centered treatment for women with substance abuse disorders. You can see it's a longer document than the actual model. And that is now going to become dated, actually, as we move into health care reform and changes that are going to be taking place. There's probably going to be a need for updates to how

to fund family-centered treatment for women and children.

The state women's services coordinators, who are part of state network, are the women in the states who usually are the managers of the state block grant money for women's programs. And they had worked together and realized that they independently were trying to develop treatment standards that they could share with the providers that they were managing. And they found that some of them were really developing some areas well, and some areas not so well.

So they got together, and with our help, they developed treatment standards for women with substance abuse disorders, which looks at 25 different parts of practice and what a treatment standard might be that a program could be, kind of, reviewed against. So we published that.

More recently, we've been talking about core competencies. In addressing the needs of women and girls, we've developed these core competencies for mental health and substance abuse professionals to really look at the knowledge, skills, attitudes, and

attributes that the workforce would benefit from having and working with women and girls. I think that's the end of my visual aids. So it's a big body of work.

And so, we have this body of work. And we've obviously done a lot of thinking about what it means to be gender responsive in addiction treatment. You know, I think that some of the key concepts over the years that we've talked about are things like comprehensiveness, the role of mothering, family, women's groups, violence and trauma, of course, persons in recovery and working, you know, in treatment programs. And mutual self-help groups is all part of the gender-responsive approach to working with women and other issues as well.

In terms of, you know, the future and what some of the gaps are, certainly, bringing services to scale is part of the issue. We've talked a little bit this morning -- Dr. Lewis was talking about do facilities even report that they have services for women. Starleen mentioned, you know, what they report and what they have don't necessarily line up in terms of

being really best practices for women.

We know from similar -- from that same survey that 8 percent of programs report that they have childcare for clients who have children that they're responsible for and that 4 percent of programs have residential beds for children. So it really is a modest effort. And so, you know, the issue of bringing services to scale for women who need them is certainly one that's important.

And them, some of the key questions as we move forward -- you know, how do services that have been described as evidence-based and, say, that are fitting into a changing environment impacted by health care reform as well as just the state and federal budgets. And I think that's something that we're all going to be looking at and trying to answer those questions in years to come.

So I offer that to you as a, sort of, background, a little bit about the history of what SAMHSA's Center for Substance Abuse Treatment has done in terms of trying to think about what it means to deliver gender-responsive services to women. And now, I've asked my

colleagues to, sort of, go a little bit in the same direction in terms of what the other centers have done around their thinking.

I'm going to turn to Mary Blake now to do that for us.

MS. BLAKE: Thanks, Sharon, very much.

I'm actually going to speak a little bit, actually, about gender responsiveness in the context of what we've done around trauma within the Center for Mental Health Services. And just to say that historically, I think, gender-specific or gender-responsive services have not really been the hallmark of mental health treatment, per say. But in the early 1990s, I think there was a growing recognition that many of the people served through mental health services had experiences of abuse, neglect, violence, and other, kind of, traumatic experiences that was seriously under-addressed, under-reported, under-diagnosed, under-asked.

And SAMHSA held a seminal meeting called -- sorry.

FEMALE SPEAKER: Dare to Vision.

MS. BLAKE: Dare to Vision in 1994. And it was at this particular forum where people who had lived experience. So people who had experienced trauma and who were receiving treatment through mental health services really started to put their experiences on the table, their experiences of abuse in childhood, of bullying, of neglect, of abuse as adults. And it really was a seminal event in terms of bringing together the understanding of mental health, mental health challenges, mental illness, and the experience of trauma through the stories of the people who spoke at this meeting.

And that really started to galvanize us in terms of looking at how we might best move forward and, kind of, respond to the issues. In particular, what the people at this meeting talked about was their experiences in a residential or an in-patient settings and how some of the practices that were commonly used were actually experiences retraumatizing or revictimizing. And that really started us really looking at the issue of addressing coercive practices, seclusion, and restraint and what not.

One of the -- what happened next was that we had -- sorry. We put together a study called the Women with Co-Occurring Disorders and Violence Study. And this was a study that involved partnerships between the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment, and the Center for Mental Health Services. And it was a five-year study to really look at the interrelationship between violence, trauma, and co-occurring mental health and substance abuse disorders among women.

Again, there were a number of seminal things that came out of this study. One was reestablishing the fact that prevalence rates were very high among women of abuse -- among women with co-occurring disorders, and second, that the recommendation for trauma-integrated services counseling for these women also started to look at development of guiding principles for a positive change, including the principle that providers should be mindful of the ways that they interact with clients. Apart from just the treatment intervention, the whole way of interacting and engaging with women really had a powerful impact on

their ability to move forward in recovery and to discuss their experiences and to engage in treatment.

In 2004, we hosted a seminal meeting called Dare to Act. And here was really -- the focus was really looking at understanding and addressing the needs of survivors, especially in terms of trauma-specific services, strategies for implementing trauma-informed care, and also, kind of, again, exploring how the use of the personal stories of trauma and recovery could provide a basis for empowerment, if you will. So really starting to look at the trauma healing story.

Through all of these -- through this whole period of activity, really starting to, kind of, understand more deeply the issues of women in mental health services and women with co-occurring disorders and women with trauma experiences, there started to emerge some very effective trauma-specific, gender-specific treatments. Some of those include the target model, seeking safety, TREM, Trauma Recovery Empowerment Model.

And all of these have really been, kind of, established with ENREP, as ENREP practices. But there

was other gender-specific work that has emerged over the years, including work from Stephanie Covington, who has now rotating off of this committee; Sandy Blume, the Tamar Project, Risking Connections, Boston-based recovery model, and Atrium. And Atrium is really a peer-to-peer model that emerged out of the Women with Co-Occurring Disorders and Violence Study.

That said, I mean, I don't think in the broader sense of things that there's been a lot of activity out in the field to really look at what is mental health treatment look like when it's gender responsive, more broadly speaking. And these are some of the questions that we have to start looking at through some of the work that we've been doing around peer empowerment and really building, kind of, trauma-informed peer support approaches.

We're also hearing from men that there's a real need for gender-responsive support and services for men, especially given some of the concerns that they have around issues of shame, especially having been victimized sexually or whatever, that, you know, they really need safe places to really address their

issues. And they need a provider base that really is understanding of the impact of trauma and how difficult it is to, kind of, put that on the table in the first place.

The other thing that we've learned from the mental health side is that many of the practitioners, many of the provider workforce don't ask about trauma often because they're not really sure where to send people who are experienced or specialized in addressing trauma. And there's been, you know, historically, kind of, a de facto, don't ask, don't tell, kind of, approach in mental health treatment around violence abuse and putting that on the table.

We're also learning through our work through the National Center for Trauma-Informed Care that many people in the provider workforce have also experienced their own abuse, domestic violence, neglect, or whatever. And their needs are also not being attended to. And they don't know how to get their concerns taken care of, which poses a dilemma for them if they're trying to provide services to people who themselves are trauma survivors.

And we've started to work with the National Council for Community Behavior Health Care, first, to develop their capacity to support community mental health agencies and addressing trauma within the services that they provide in community mental health, and also, to look at where does gender responsiveness fit in this paradigm of service, but also, to take a look at how they can be more responsive or provide better avenues of support for the workforce that's providing treatment.

Some of the things that we're doing through the Center for Mental Health Services right now in terms of looking at issues around gender responsiveness -- we are participating on a federal partners committee on women, girls and trauma. This is a committee that was established about a year-and-half, two years ago and is really a cross-agency -- I think we have over 35, 40 agencies and sub-agencies represented on this federal inter-governmental committee, really looking at what are the issues for women and girls in particular as it relates to violence across the spectrum of the various ways that they access services

or support. It could be through health. It could be through employment. It could be through social services.

We held a roundtable in March of 2010 that was very, very successful. Really, the goal of that roundtable was to establish a common body, a common understanding across the federal partners in terms of what some of the issues were. And we're now planning for a follow-up meeting in December that's going to really be looking at where the pockets of excellence in terms of addressing the needs of women and girls in particular areas.

So we'll be looking at women in the workforce or employment settings. We'll be looking at screening and assessment from different perspectives, depending on which agency, you know, perspective we're looking at, looking at issues around disparities, diversity issues, under-represented issues, LBGTQI. And then, also, there will be a session that's really looking at veterans, and women in particular who are veterans.

So we're also developing a number of products to address this issue of gender specificity. But I think

that there is a lot of work to be done in the area of mental health in terms of addressing these needs. Some of the questions would be, you know, does the field really understand fully how gender responsiveness can be helpful, especially in the context of trauma, addressing the needs of trauma. We're seeing a groundswell of interest from -- we have over 45 states that are now really looking at implementing trauma-informed care in multiple different settings.

The other thing that we have to look at is, you know, how are we looking at screening and assessment. In particular, are there, you know, differences that arise in terms of looking at women's issues versus men's issues or how they respond to the questions? And also, looking at, you know, how in the recovery communities -- you know, how are we looking at gender-responsive peer support, things like that? These are some of the questions that we could put on the table. Thank you.

MS. AMATETTI: Thank you very much, Mary. I would ask you to turn off your little -- and Mary

actually was on leave today, so I really appreciate that you came in to be with us. Thank you again.

And, Patricia, if you would share a few minutes about CSAP perspective.

MS. GETTY: Thank you, Sharon.

I'm going to talk specifically about a topic that, as I've been listening today, has popped up a number of times. And that is around the Fetal Alcohol Spectrum Disorder. We have within prevention a contract specifically to address those issues.

But to give you a little bit of background, how we got to this point was in 2001, there was a congressional earmark specifically for providing services around FASD. And it works on several levels. For example, NIH is focusing specifically on research around FASD. The Center for Disease Control is looking at the surveillance component. And what fell to SAMHSA was specifically looking at what kinds of programs can we implement on a prevention level that would make a difference in reducing the number of incidences of FASD births.

As you know, Fetal Alcohol Spectrum Disorder is a

100 percent preventable problem that we have in our country. So we wanted to take a look at, specifically in SAMHSA, how do we develop, implement, and disseminate information and innovative techniques that produce effective strategies for reducing, preventing, and eliminating FASD.

It has, out of that, developed a collaborative effort. It's called – I love acronyms – ICCFASD. It's the Interagency Coordinating Committee on FASD. And it brings together all of the federal agencies, SAMHSA, NIH, HRSA, CDC. NIAAA heads it up. And we meet on a regular basis to really make sure that we effectively collaborate all of our varied interests. And, as you can tell, each of the agencies have a role in that process.

Before I go into more specifics on what we're doing here in SAMHSA with the FASD Center for Excellence, I want to interrupt this program and bring you some good news. I think we talk about all the issues and the problems, but there are a couple of things that I wanted to bring to your attention. And that is in 1998, SAMHSA began to establish programs in

the state of Alaska around preventing FASD. And we have been working with them through a multi-media process, through ESPERT and intervention programs within agencies in the state of Alaska. And I am so excited about this, I can't contain myself.

New prevalence data indicates the overall FAS birth prevalence rate in the state of Alaska decreased from 19.9 to 13.5 per 10,000 live births. In a period of 10 years, we have made an impact. What we need to do is to learn the lessons from that experiment and apply it to other agencies.

However, that's not the best part. The best part is we truly focused on Native American populations. And in the state of Alaska, there has been a decline in Alaska Native populations with a 49 percent decline from 63.1 to 32.4 per 10,000 live births. Think about it, folks. A 49 percent decrease because we're focusing on prevention programs of a totally preventable problem. That so excites me.

The thing you have to put into perspective is it's only a beginning. But we know we can do it. And we know that our efforts make a difference. It's how

do we now take what we have learned in the state of Alaska and expand it to all of our different agencies.

So what we wanted to look at is we always think in terms of prevention programs. Let's put placards in bars, drinking during pregnancy may cause damage to your child. We have put in birth test kits -- you know, the little pregnancy test -- warnings. So if a woman thinks that she might be pregnant, we've put warning labels. Southwest Airlines now has -- when they serve alcohol, they now have messages that basically say that drinking during pregnancy may cause a problem to your child.

So in looking at that, we went back and took a look at the NSDUH data, which is produced here at SAMHSA. And we did a survey of what we call women of child-bearing age. And that's the 18 to 44-year-old. And we ask, in the past month, questions around binge drinking. And what we discovered is that 32 percent of women of child-bearing age, 18 to 44, in the past month, report an incidence of binge drinking.

So we looked at what is our efforts, what differences have we made since that time, as far as

women, once they discover they're pregnant. If we have college women, women of child-bearing age that are binge drinking at that rate, it's very much a concern.

So we looked at, in the first trimester, as a result of our efforts around the prevention message. It dropped to 8 percent, which means once a woman begins to discover or is planning on becoming pregnant, we are getting the message across to some women that if you're going to be pregnant, you don't drink.

In the second trimester, it drops to 1.8 percent; third percent [sic], 1 percent. Now, that sounds wonderful. But when you think of 1 percent of a large number of women, that's still a lot of women that are drinking in the second and third trimesters. The concern we have is once they deliver, those numbers go up again.

But what we wanted to look at is, obviously, women are getting the message that once they become pregnant, many of them quit drinking. But who are these women that continue to drink while they're

pregnant? Where can we reach out to them? Where can we find them and help them?

One of the problems that we've run into is many -- there is a stigma associated with a woman who drinks during pregnancy or gives birth to a child with an FASD. We have many states that have passed legislation that makes it punitive for a woman to drink during pregnancy. We talked earlier today about the problem with women hesitant to go into treatment programs, even though their OBGYN doctor may recommend it. We still run into problems with that woman.

So where are these women? And how can we help them? They are in treatment programs. They are in WIC programs. They are seen in health care units. So what we've began to do with the FASD Center for Excellence is develop programs that target those high-risk women.

And through sub-recipients with the FASD Center for Excellence, we have worked collaboratively with the Center for Disease Control to develop a -- it's called Program Choices. And we are implementing that in many of the WIC programs in the health care units

to begin to identify these women, help them understand the dangers that they are looking at with alcohol-exposed pregnancies.

We are using -- it's not the S-BERT, as you normally would see it, because we don't refer for treatment. But it is a brief intervention for many of these women. And that's the direction that we're going. We are continuing with the overall prevention message, but we're also looking at targeting high-risk women in high-risk settings so that we can decrease even further those small amounts of women that are drinking in their second and third trimesters.

Very exciting that we're making inroads, but also very concerned that we still have a large number of women, as we were talking about the woman who is sitting on an airplane and her husband's saying, "Come on, Honey, just one or two more drinks." Those are the values, those are the attitudes that we still have to work on.

So we're working at multiple levels: number one, the general population, changing the environment, changing the policies, but also looking at those women

in targeted high-risk population areas, moving to where we can find them. And one of the things that's very important within SAMHSA is many of them are found in treatment programs. They're found in mental health programs. And so, a lot of this effort is that collaborative movement between multiple federal agencies working to make a difference around the FASD project. Thank you.

MS. AMATETTI: Thank you.

DR. FELITTI: About eight minutes ago, you mentioned --

MALE SPEAKER: Microphone.

DR. FELITTI: About eight minutes ago, you mentioned that the success in Alaska was attributable to a multi-media approach. Could you specify what the multi-media approach was?

MS. GETTY: That was one of the techniques that they used. And they were provided funding --

DR. FELITTI: Yes. What does the word mean in that one of the techniques?

MS. GETTY: They were using media campaigns. They were using brochures. They were using

information within the tribal communities, Webinars. That's why they said multi-media is many different ways, instead of just a pamphlet or a spot on a TV, that they were using -- and I'd be more than happy to share with you the specifics in it. But they were focusing on varied levels to make sure that they reach people, both auditory, visual within the stories, within the communities, but as many ways as they possibly could to reach that population.

And in closing, one of the things I'd like to share is on the back table is a hand-out with some of the specific SAMHSA publications and materials that are out there that can be accessible. Also, on the SAMHSA Web site, if you go to FASD, it has a link that you can also download many of the trainings, the materials, the information about the programs that we've developed.

MS. AMATETTI: Okay, thank you very much, Patricia.

So I hope that from this you've gotten a sense of, sort of, how the issue of gender responsiveness has been approached across our different centers and

with some distinct differences in trauma as a bridge and looking at Fetal Alcohol Spectrum Disorder as, sort of, development of a model at CSAT.

But now, I want to turn to our invited guests. We're very fortunate that we have two women here today to help us with this conversation and really, kind of, give us a better perspective about some of the thinking in the field about what it means to be gender responsive. We have Dr. Carole Warshaw. And we also have Dr. Hortensia Amaro.

And welcome, Hortensia. Glad that you could make it. And thank you for rearranging your schedule on our behalf.

So I think we're going first turn to Dr. Warshaw.

And you can either advance your slides from here, if you like? Would that work for you?

DR. WARSHAW: Yes.

MS. AMATETTI: So let me introduce you a little bit and tell folks about you, Carole.

Carole is the Director of the National Center on Domestic Violence, Trauma, and Mental Health, which is a project of the Chicago-based domestic violence and

mental health policy initiative, which Dr. Warshaw is the Executive Director. The center develops comprehensive, accessible, and culturally-relevant responses to trauma and mental health-related issues to enhance the capacity of local, state, and national service providers to delivery mental health services for survivors of domestic violence and their children.

Dr. Warshaw is an adjunct faculty member in the Department of Psychiatry at the University of Illinois and has provided consultation to a number of federal agencies and national advisory boards, including the Surgeon General's workshop on women's mental health and the Council of State Government's workshop on violence against women and mental illness. And I've been talking with Dr. Warshaw over the past weeks now or so, and also with Dr. Covington.

And I really appreciate that you're here to help us, sort of, think about what this means to be gender responsive in mental health systems.

DR. WARSHAW: Thanks.

Part of this conversation really comes from my talking with Stephanie for over the years, over many

years about gender responsiveness and how impressed I am at what's been happening in the substance abuse field and how that doesn't happen in the same way in mental health services. And there are a couple things. I think this is stuff that you all know because it came from the Surgeon General's report on women's mental health.

But just to, kind of, refocus on, you know, looking at the disorders that are more prevalent among women that are often the same disorders that are associated with women and trauma, that looking at gender-specific risk factors for women around unequal power and status in society and economic disparities, so thinking about all the things that go into stressors that may impact on women's mental health, including depression, which is often a trauma-related diagnosis, work overload that women experience when they're working and care-giving at the same time and gender-based violence.

So, I mean, just looking at all of those things as well as, you know, biological risk factors. Also, gender-specific medication issues -- there's a lot of

work around peri-partum medication and the peri-partum period. But the work that Margaret Gensfald and Gene Hamilton did quite some time ago about fluctuations in drug metabolism and drug levels for women around the menstrual cycle -- I haven't seen much about that since then. So, again, looking at some of the things that have dropped off the radar.

The other thing that came up and I'm going to talk about in a little more detail from a needs assessment we did in Illinois for an OVW, Office on Violence Against Women-sponsored disabilities -- Violence Against Women with Disabilities project -- was the importance of gender-specific services and environments as well as gender-responsive treatments. So we're talking about what happens in the service environment as well as the treatment and services that women are receiving. So part of what this conversation really is about -- and I think it links what we're all talking about -- is part of being trauma-informed, and because there's such a big push to be trauma-informed, means attending to gender-specific concerns, particularly around gender-based

violence and gender-based trauma.

So we know that gender-based violence can have significant medical consequences. I put this in because it just came out in JAMA two weeks ago. It was an Australian study. You can see the AN is pretty small. But they looked at close to 4,500 women. And for the women who'd experienced three to four types of gender-based violence, you can see the prevalence rates of a range of psychiatric disorders as well as substance abuse disorder. And again, looking at the links between those issues is really important.

One of the recommendations they make at the end in their discussion is the importance of considering gender-specific services in mental health settings, particularly in residential, drop-in, and in-patient settings. And we know that women who receive mental health services are at higher risk for abuse. It's been a big piece of the work that Center for Mental Health Services has been doing for a long time.

But one of the things we bring into the picture from the D.V. perspective -- and I think it's important for thinking about what you're doing with

Fetal Alcohol Spectrum -- I'm talking too fast -- is that there's the impact, the psychological, psycho-physiological impact of trauma, and then, there's the coercive control that's going on in a woman's life. And we always talk about looking at both of those together.

So we know that batterers use mental health issues to control their partners. They control medications. They coerce women to overdose. They control treatment. They keep women up all night. They don't let them take their meds. If they coerce women into taking an overdose, and they have them committed, and then, she's at risk for losing custody of her kids.

They actively undermine sanity and her credibility. They say she was out of control. And I had to restrain her because she was out of control.

And we know this is a particularly lethal -- potentially lethal form of domestic violence. So the same thing with substance abuse. There's the women who use drugs and alcohol as a form of self-medication and then women who are coerced into using or prevented

from seeking treatment or maintaining treatment. And so, it's always looking at those two together. So when we're talking about gender-responsive services, we're looking at both of those, not just the symptoms that someone's coming in for. And the reason that works is because of stigma and discrimination and other conditions that women experience.

And again, this is, you know, the work that you've been doing around women being misdiagnosed in the mental health system, men, too, where things that were really related to trauma were not seen as such and that people were revictimized in the system. So again, if you --

MS. FORMAN: Excuse me?

DR. WARSHAW: Yes?

MS. FORMAN: What does M.I. mean?

DR. WARSHAW: Mental illness. And M.H. is mental health. It's to fit on the PowerPoint slide. Sorry about that.

I just want to make sure that that's part of what we're thinking about. And also, trauma can affect survivors' responses to services. Some of the

outreach work that we do is -- for example, if someone has a legal case, if her credibility is undermined in court -- we've done some work with judges, the National Council on Juvenile and Family Court Judges.

They assume that if a woman has any mental health diagnosis, any mental health symptoms, that she's going to be an unfit parent and the abuser is going to be a better parent, because he's going to look more put-together than the woman that he's been abusing for years. So there's a lot of work to be done on those issues.

I believe the Bazelon Center for Mental Health Law has done a case where using the ADA, the Americans with Disabilities Act, to say that a reasonable accommodation for parenting is to provide, you know, personal assistance to a woman that will allow her to then do the things she needs to do or reduce other stressors in her life so she can a good parent. And one of the ways this comes out is the retraumatization in mixed-gender settings. And we'll talk about what women had to say about that from a needs assessment.

So this was done, you know, as part of a -- it's

not a formal research study, so I wasn't sure whether I could present this or not. It was really an internal needs assessment. And this was a collaboration with a peer support advocacy program, Lucy Sajak's Growing Place Empowerment Organization, Illinois Coalition Against Domestic Violence, the Illinois Department of Human Services Division of Mental Health, a large D.V. agency, a large mental healthy psycho-social rehab agency, and us and our consultant in writing the grant.

So what women said -- we did focus groups of women who were in in-patient state psychiatric hospitals and in out-patient mental health settings. And they said that safety and security in the service environment was really critical and that women -- the heart of this is that women did not feel safe in mixed-gender settings.

They talked about times when they felt unsafe because of other program participants, mostly men, whether they were an in-patient, drop-in, or residential settings, the lack of emotional safety when it was noisy and chaotic, loud, arguing -- people

who were loud and arguing or aggressive behaviors made them feel frightened and triggered previous trauma. And they also talked about the literal lack of safety they experienced, like, actual assaults and harassment and stalking in residential settings.

And we also -- this is -- some of this comes from T.A. requests we received, that women who worked in, kind of peer support programs and drop-in centers, that often an abusive partner was using the same services. And nobody knew how to address those issues of safety. So it was another whole, kind of, layer of, you know, both people have a right to receive services versus how do we address safety issues in settings where you want to make sure that everyone receives services.

Women said that they looked to staff to set limits about aggression in the programs, but not all staff are equipped to meet these needs. And women also were very aware of their risk of abuse and violence from being female. It was they experienced that as gendered. But they didn't see the systems where they received services as paying attention to

that. There were individual people who did, but it wasn't a priority issue.

I mean, one of the things we were able to do with the Chicago Department of Public Health where we were working for many years with -- to have them change their intake screening so they didn't just ask, are you a danger to yourself or someone else, but are you in danger from another person, which led to a whole other set of questions. And because that cost so much money to add that question, they couldn't afford to add the next question, which was, what's a safe number that I could contact you so that maybe if you have a partner who you don't want to know about this, when we call, you won't be in danger.

So it's, like, just very simple things, like asking about collateral information and when someone's in an emergency room and who you're asking that information from. Is it someone's who's abusive.

Now, my colleague, Denise Markum, who's a lawyer, said, ask that information and document it, because people will say things that they don't even realize what they're doing is abusive. And it might help a

woman in her custody battle if you actually have documented what an abusive partner has said.

Now, this is what some of the staff said, was, because you're open to a range of people, some can be aggressive and loud, or that there's a two to one male to female ratio in some of the settings so that it's an intimidating environment for them. So it's just little things that we might want to think about.

And again, this was women saying when they felt safe, how important it was when the program practices really took that into consideration. And again, SAMHSA -- Illinois had one of the reducing coercive practices grants. And that made a big difference of doing safety planning -- personal safety planning for these women.

One of the things that staff talked about is, like, we have an empty unit. We could make a gender-specific unit. But we don't have the funds to do it. Or we can't have a separate unit because we have more male patients. Or how do we actually do that?

And these were some of the things that people came up with: some segregation, keeping the woman

closer to the nurse's station if they were feeling unsafe. But again, it's really thinking about how do we structure those settings. You know, coming from working on the domestic violence world, that's not an issue. You're in gender-specific settings. And then, when we're partnering with the mental health system where we want to refer women into that system, it doesn't necessarily feel safe.

Again, not involving a family member in treatment who may be an abuser, making sure that you do safety planning on discharge -- are some very specific, easy things that can happen. But they weren't happening. So that's part of the work we're doing in this project, is making sure that attention to both trauma and domestic violence are embedded in every level of what's happening in those systems.

Mostly what would happen is there might be an individual staff member who had their own personal experience or training, and they would become the local -- the expert in their agency. But it wasn't systematic. So again, this is more of a summary. But it's very clear that when we're talking about trauma

informed, it's the physical safety and the emotional safety.

One of the things that, I think, that you mentioned, Mary, was that we did have the programs in this project do what we called a CDVTI self-assessment accultured D.V. trauma-informed assessment -- self-assessment. And it included, you know, the physical environment, the relational environment, and the programmatic environment as well as policies and procedures and collaboration and how are staff supported to be able to be emotionally present and not reacting in ways that end up being retraumatizing.

And again, this isn't about gender-specific services. But it is gender informed about what women said would make them feel safe and welcomed in their environment, so just the physical -- that it's cheerful, that there aren't unpleasant surprises, that flexibility -- the sensory environment is really important. But they were -- women were very clear about the need to have women-only spaces.

And the second part was that women were very aware of abuse and violence in their lives. They said

nobody asked them about it and that it needed to be addressed. And there were a number of ways this played out.

One is wanting women's groups that deal with abuse and power and control and trauma, sort of, like, okay, how do we learn what to do, you know, having the resources, but also, to hear how other women deal with those experiences, so we don't have a chance to hear from other women about their own experiences and how they deal with these issues. And women were also concerned about confidentiality, and particularly in residential settings.

And some of the other issues that came up was the lack of therapeutic staff. And so, one of the disparities is for people who were in the -- received private mental health services or private, not-for-profit where they can get higher-end trauma treatment that is often gender responsive because it evolved from the experiences of women as survivors.

So some of the complex trauma treatment models really came from working with adult survivors of childhood sexual abuse. And some of the treatments

around post-partum depression -- so that are gender-specific kinds of concerns -- there's treatment that reflects that. But for other women who are in the public sector who have, you know, diagnosed mental illness, there is nothing that's gender-responsive.

Okay? So there's a disparity in who gets what kinds of treatment and what kinds of treatment is more gender responsive versus what people get who are getting served in the public sector.

Okay. So how do reconfigure, how do you create, you know, gender-specific settings? How do you access resources in the community? How do we create respite? You know, if a woman is in danger physically and is having a mental health crisis, what are the safe places where women could go?

Some of the outreach workers in one of the settings said for women who are living in the streets who -- coming inside is very frightening. Could there be a safe place where women could come in without a lot of requirements, where they could just come in and get what they need and not have to be part of a program that felt safe, unlike most shelters that

women who are homeless go to that are literally not safe.

So what kind of recommendations? Gender-specific settings or spaces, attending to physical and emotional safety in mental health settings, which means the relational part. With the budget cuts in Illinois, there's no time for supervision.

There's psych. techs who have, you know, a high school degree who have no -- some people are wonderful, and some people aren't. And there's just nothing -- the kinds of supports that people need to be trauma informed aren't there. And it's heart-wrenching because there are people who are so committed and want to be able to do that, and they just don't have the resources.

Having gender-specific programming and groups -- so there's not a lot of evidence-based research on gender-specific, gender-responsive treatment in mental health. So that needs to happen. The do no harm level around safety -- when we're talking about enhanced services, we're also talking about supporting parenting and supporting the parenting capacity. And

often, in substance abuse, you have combined services. In mental health, you often don't. It's very siloed. And when we're talking about child development and how do we move forward, there are a number of models that really support the parenting capacity of the non-abusive parent for a woman who's also under siege who's also been traumatized.

And the community partnerships -- we're doing a lot of work with the domestic violence programs around the country, the 17, 1,900 programs and all the 56 coalitions. And what they're finding is that when they need mental health services, that they don't exist in their communities, often in rural communities. And because services are free, they're often the place of last resort. And they want to serve women who are dealing with a range of needs. And they need those resources in place that are gender-responsive.

One of the things we were thinking about is using tele-medicine or tele-psychiatry in developing, kind of, specific models for serving women in rural areas that are gender responsive and trauma informed.

And the last thing I was thinking about was the post-partum depression. HRSA has an initiative that family violence prevention services program has also been involved with on post-partum depression and intimate partner violence. And there aren't a lot of models of how do you address both -- how do you serve a woman who isn't safe, who is really struggling and instead of having a supportive family, actually has a family that is abusive and controlling and undermining and may be one of the major risk factors for post-partum depression. So how do we create a new level of services and supports in the community that don't exist?

So that's --

MS. AMATETTI: Thank you very much, Dr. Warshaw. Our whole session [inaudible] just, you know, [inaudible] we will have time for just a few questions at the end.

DR. WARSHAW: I had just one other point I wanted to make. One of the things we were able to do in Illinois was change the state Medicaid rule to include questions about current and past abuse and ongoing

safety. But with the training dollars disappearing, then people don't know how to and, because they don't know what to do. And so, again, there's that whole other level, so, on this subject.

MS. AMATETTI: System issues -- internal.

Let me go ahead and introduce Dr. Amaro. She's the distinguished professor of Health Sciences at the Bouve College of Health Sciences at Northeastern University. She's developed two national model substance abuse treatment programs targeted to Latina and African-American women. One of her community-based interventions with pregnant [inaudible] women, the Moms Project, received national recognition by our Department of Health and Human Services.

Dr. Amaro also developed the Boston Consortium model, trauma-informed substance abuse treatment for women, which is included in SAMHSA national registry of effective programs and practices. The Massachusetts Department of Public Health has recognized her work as the founder of Unthri Familia and the Moms Project has received a citation from the governor's office for its unique contribution to the

health of mothers and children. And Dr. Amaro's also a member of the SAMHSA National Advisory Committee, and we're very happy to hear her talk a little bit from the perspective of addiction treatment.

DR. AMARO: Thank you.

I seem to have gotten very different instructions. I was told one or two slides, so I didn't prepare any. So otherwise, I would be happy to provide a more formal presentation.

But what Sharon asked me to talk about is to share my thinking on some of the observations, you know, for the over 30 years that I've been working this field, both from a research perspective, but also from a, you know, community-based perspective, because all of my work has been very community-based. And you also asked me to think about why is it that in substance abuse treatment, we have seen more gender-specific approaches compared to mental health. And so, I'm going to comment on those issues.

So first, just to tell you that I started work in this area. A little bit about, sort of, where I'm coming from and my history, I started doing work with

Linda Backman at the Neuro-Psychiatric Institute at UCLA when I was a graduate student on a study funded by NIAAA on women's barriers to alcoholism treatment. And later on, I went on to work on a NIDA-funded study on drug use during pregnancy with people like Barry Zuckerman and Ralph Henksin. And we published findings on, not only infant outcomes and pregnancy outcomes, but luckily, because I was one of the few social scientists, I was able to get in measures on depression, on violence, on social support, and things like that. And so, we published a number of papers on that as well.

We noted early on the impact of trauma and mental health and women's addiction disorders in some of those early studies, which were pretty descriptive. And the AIDS epidemic hit, and I really was interviewing women in the field, for some of those studies, who were just being diagnosed. And I realized that I really wanted to do something that really was about providing services in some kind of new model.

And so, I started work with the Moms Project,

which was initially funded by NIDA and then, by CSAP and then, by CSAT, eventually. Those projects were really serving injection-drug-using women who were pregnant who were also sex workers and/or partners of injection drug users. And we went on to develop a number -- also a residential program and some intensive out-patient programs, et cetera. So that's, kind of, my history in the field.

And we also were part of the Women with Co-Occurring Disorders and Violence Study and developed the Boston Consortium model. We developed manuals, treatment manuals that are available as well as the case-based manual for training providers on how to think about both mental health, trauma, and addiction together. So those are available, if you think they would be useful to you.

You know, sometimes we -- when you called me about this question, I thought I had a déjà vu, because, you know, starting in the late '60s and '70s, we were talking about all these issues. And then, it sort of went away. But I remember having SAMHSA-sponsored meetings in the '70s, not then called

SAMHSA. I guess it was called OSAP -- where we got together for several days to actually outline what was gender specific, what did we mean by that, and what were the implications for treatment.

So there's a huge literature on gender differences every year, pretty much, a lot of what Carole just covered, that's been there describing what are the differences in psychological profile. Linda Backman and Cheryl Wolsnak did a lot of that early work as well as specific needs of women in treatment. And then, Chris Grella and a lot of other people have gone on to add to that literature.

So I don't think we have to reinvent the wheel. In fact, there are a number of SAMHSA tips and texts that actually review that literature. And tip 23 -- I was just looking at it before I came. And it's got a great summary of all of that.

But anyway, so we saw this great interest in the '70s and then a waning of this interest in the '80s. And then, in '92 again, the women's program set aside 10 percent of the discretionary funding to states for gender-specific programming. I don't know if that's

still there. I just looked at one of the latest reports, and I don't see that set-aside. It's there for prevention.

Is it there for women?

MS. AMATETTI: Yeah. Yeah.

DR. AMARO: Okay, I just couldn't find it.

MS. AMATETTI: [Off-mike.]

DR. AMARO: Okay, great. So I'm glad. I'm happy to hear that it's still there, because I was searching for it, and I couldn't find it.

But that made a huge difference at the state level. Although there are people like Chris Grella who has looked more closely at what states are actually doing with that money. And she feels that there's been slippage in what's being -- how that money's being used. So I think a good look at whether, in fact, the funds are being used for that purpose or not would be a good thing to do.

So then, there was a shift in SAMHSA. I served on the SAMHSA Women's Advisory Committee, the first one. And there was a shift from focus on women to then focus on pregnant women to then focus on women

and their families. And I think that's actually a very good thing, as long as we don't really lose sight of the very gender-specific issues that women face in treatment, and instead, focus only on the parenting part, which is very important and part of women-specific issues. But it's not the whole thing.

The other thing I wanted -- so, you know, I refer you to that tip 23, because I think it's really good. One of the conclusions in that tip is that adding special services to male treatment models is really not sufficient, that that's just not going to do it.

But the interesting thing is that, while there is a lot of literature that describes the nature of substance abuse disorders in women and gender differences, there really is -- the literature is quite sparse in terms of any credible, real solid randomized clinical trials on gender-specific approaches to treatment, even in terms of trauma seeking safety, which was -- went through a randomized clinical trial, did not show a significant group by time interaction in terms of it being more efficacious than a health education group -- I think, was their

comparison group.

I think that might be because they limited to 12 sessions, which is not what the original seeking safety is. And in my experience, in working with this population, there's no way that you're going to deal with a whole history of trauma. It's not one event. It's multiple events from the time of childhood to the day they walked in. Or maybe if they're an out-patient, 'til last night right before they came in.

So you're really going to need a more intensive than 12 sessions. You know, and my concern is that we're always looking for the quick, easy fix, the Band-Aid. And there are -- like I say, you know, when you go into -- you have a trauma in the E.R., you don't try to put a Band-Aid on it. You know, there are some conditions that just are going to require more intensive and longer term approaches.

So I would encourage SAMHSA to really think about that in looking at models. You know, different stages of treatment, not just a quick fix, because I think we're going to end up paying for it in lots of other ways, as, you know, we already know and has been well-

documented.

Let's see. How am I doing on time? Okay.

So SAMHSA has an incredible history of attending to these issues, as I mentioned, from the '70s 'til today. The tips, the taps that look at specific gender-specific issues are examples of that, the Women with Co-Occurring Disorders and Violence Study is another great example.

In our experience, in developing and implementing and evaluating integrated models of treatment, there is a huge up-front work that has to be done around preparing staff, training staff, and setting up supervision mechanisms and resources. Because our experience was that substance abuse treatment staff really were not trained in mental health. They were not trained in trauma. And they even had resistance around it, because they weren't equipped to do it until they felt more competent. They really resisted that.

But once they got the skills, it made a lot of sense to them. But that takes resources and effort. And it takes a lot of, like, local -- you know, they

can go to conferences, but they have to have this training and the supervision locally at their site.

There are, as I mentioned, few studies on gender-specific treatment for women with co-occurring disorders. Plenty of evidence describing the epidemiology, a number of quasi-experimental studies looking at effectiveness. But, as I mentioned, you know, it's amazing we still don't have a good randomized clinical trial or a number of them. We shouldn't just have one looking at different approaches.

The other point I wanted to make is treatment of co-occurring disorders in our client population, mostly Latina, African-American women, but also poor, white women, is not just about treating addiction. It is, obviously, about treating the trauma and mental illness. But it's also about a whole set of socio-economic disadvantages that these women have that have huge implications for their -- how quickly they're able to gain benefits from treatment and what they're able to do or not do when they leave treatment.

And that we haven't paid a lot of attention to.

It's the parenting role, but it's also the low socio-economic, less education, less employment experience, fewer programs that accommodate training -- job training programs that can accommodate the needs of this population.

Another point that I wanted to make is that in the treatment literature, in the substance abuse treatment literature, there has been quite a bit written about the importance of family involvement and as a factor that improves treatment outcomes. But when you're talking about women who have a history of abuse from family members and from partners, this gets to be a very difficult and challenging issue. And it has to be -- you have to really discern this very carefully, because it can actually introduce risks for the women: physical risks, emotional risks, and also risk of relapsing.

So I just wanted to say that, because we do tend to think, well, if we involve the families and we involve the partners -- well, it's not always appropriate. Sometimes it's going to be a risk factor for relapse or for abuse.

The issue of having children in treatment is something, you know, we fought a lot for in the '70s. And as we've implemented this, all of our residential programs have that women can have their kids. But it's really a double-edged sword. And I don't think we have a lot of good research on this.

We tried to collaborate with Child Protective Services, but it's very challenging. Depending on what their budget looks like or what the latest court cases have been against them, they want to just get -- you know, they want to get their caseload down. They want to get the kids out the door.

So they could return two or three children at a time to a woman who's in residential treatment. That makes it very challenging for her to be able to manage the stress and the challenge of parenting kids, who themselves have a series of problems. So I think we really need to look at that more carefully.

I haven't seen a lot of research on that. And clinically, I think you have to be very thoughtful about it. I think we need more research about when it is beneficial, how, and what really are the services

you have to provide to support the mother and the children.

The last thing I wanted to mention is that most approaches to trauma treatment do not integrate historical trauma or migration or immigration trauma and minority stress-related trauma. And this has, kind of, been, I think, under the heading of my experience.

I was telling Sharon, you know, over 30 years, I have gone to the gender-specific groups that work on whatever, you know, gender issues. And I go to the race and ethnicity and culture groups. And the two groups shall never meet. It's so frustrating. So you get studies that address the cultural or race differences in terms of efficacy of a treatment protocol, for example. But they don't look at gender within race or the other way around.

You've got studies, a whole literature, that looks at gender, but does not look at, well, how do women of different ethnic groups -- so I think that goes for both treatment programs as well as the research literature. There's really the need to look

at that intersectionality.

The last comment has to do with why has, perhaps, the mental health field been so different from substance abuse. And so, this is just a wild stab at that question.

I think, you know, obviously, the representation of women in the mental health treatment system is very different and has historically been very different than in substance abuse treatment where it's been primarily men. So I think that may have had -- may have more readily brought up the disparity and the, kind of, discomfort that women experience in those clinical settings.

Also, the psychiatric basis of mental health treatment versus community-based substance abuse treatment and the involvement of persons in recovery in each of those systems has been very different. And I think the voices of, you know, consumers, persons in recovery, whatever the term is you want to use, has helped to inform substance abuse treatment programs in terms of gender.

The exception, I think, in psychiatry was the

work by Elaine Hiberman early on, and Pat Reeker, on the use of medication and physical restraints. You know, we all remember that from the '70s. And then, the work of Jean Baker Miller on the psychology of women and Nancy Shuderow, et cetera, who really looked at the relational aspects of girls and women's development, not in relation to addiction, but it then got used in our field.

But really, I think that some of it has to do with the disciplinary perspective and the fact that most -- and especially then, psychiatry was primarily a male-dominated discipline, and so, perhaps less inclination to look at issues of gender. So I'll be quiet now.

MS. AMATETTI: Okay. Thank you very much, Dr. Amaro.

And what a rich discussion we've had here. And we can go a little bit longer. We're going to go just 10 minutes longer so that we have a chance to get some reactions and thoughts about the comments.

But really, I few could, sort of, frame them in, to the extent that what do we need to think about in

terms of really being more holistic in our approach for working with women, you know, across addiction treatment, mental health, gender, race. I think that's, sort of, you know, what the need is for us to understand and to really think about what we could do and proceed.

And did you want to add one thing?

DR. AMARO: I did want to add one thing. I did want to add the observation that as SAMHSA has moved -- and you know, I'm very delighted to have seen that move -- into doing more work around children, like Project Launch, et cetera.

And I'm working on a Project Launch with Massachusetts -- that I think there's really a need to really look at these issues and within all of those programs, including screening of moms and screening of women in various service settings, not just in substance abuse treatments, so that we can -- because it's a very small minority who walk into treatment facilities.

MS. AMATETTI: Right. And you missed -- Jen Oppenheimer [sic] was here this morning from Project

Launch. And she's part of our SAMHSA Women's Coordinating Committee as well. So, yes, that's absolutely right.

And, Dr. Warshaw, do you like to –

DR. WARSHAW: Hortensia, you made me think about, you know, part of what may have happened in mental health and psychiatry is because there's been such a push for psychiatrists to be biological in the focus on medication, partly for managed care and partly from pharma, that therapy is more conducted by women, and it's devalued.

DR. AMARO: Yeah.

DR. WARSHAW: And there's this disparity. And there's so many different approaches. There isn't like a treatment protocol like the SAMHSA tips in mental health. There are just so many different approaches. So if you're lucky enough to choose, you may get what you want. But if you don't have a choice, then it's very different.

MS. AMATETTI: So let me turn it out to our Advisory Committee.

Yes, Dr. Felitti?

DR. FELITTI: One thing that occurs to me that hasn't been mentioned, obviously, is a meaningful antecedent to any approach or treatment, one would need to know a person's developmental and experiential history. And no one speaks about how one gets that information. I mean, there's intense resistance to getting that information, for all sorts of reasons, most particularly, uncertainty about what to do with it.

I mean, I remember vividly an internist colleague of mine saying to me, but what would I do if I asked and someone said yes.

DR. WARSHAW: But that's a big question. I mean, at Kaiser, you have resources. And often, in many settings, many people don't. And then --

DR. FELITTI: Wait, wait, wait, wait. What are you talking about, at Kaiser, we have resources? That's, kind of -- you know, it's certainly a nice compliment.

[Laughter.]

DR. FELITTI: It's misleadingly vague.

DR. WARSHAW: Well, I think -- one of the things

we talk about in settings, intake settings, is asking people about trauma. Is there any things that have occurred in your past that may be affecting how you're feeling now or what's going on with you now as an opening before doing the detailed trauma history, when you don't have that relationship and people -- I guess what I want to say is what you were saying, Hortensia, is that it's a very labor-intensive process to prepare staff and to have the supervision that people can respond appropriately and helpfully. And so, that's a really critical piece to have in place before you start screening.

DR. FELITTI: Let me make a pitch for a different approach.

DR. WARSHAW: Okay.

DR. FELITTI: Because over an eight-year period, we have gotten detailed trauma-based histories on 440,000 adults by questionnaire. And a skillfully-devised questionnaire, which is, you know, an important idea, skillfully-devised, filled out at home -- was an invaluable tool because it enables a person to walk into a room, meet a stranger, and know ahead

of time where you need to go and where you don't need to go.

DR. AMARO: Yeah. I totally agree with you.

You know, when we did that first NIDA-funded study on women's drug use during pregnancy, which was primarily focused, actually, on, you know, infant outcomes and labor and delivery outcomes, but I added questions on history of abuse. I had to really argue with my team. They said, well, what if they say yes, you know, what do we do. And that's what the staff in our treatment program said. Well, so there are different answers in those two situations.

For the study in the prenatal clinic at Boston City Hospital, I said I will put together a list of resources. And all you have to do is give the women these, you know, resources, or we will give the women the resources. In the treatment facility, obviously, because we were arguing that treatment of trauma and childhood experiences, adverse experiences, is an integral part of healing and recovery. Then, you know, the training had to be more in-depth.

There are studies that have looked at whether

there are adverse consequences of asking people about trauma history. And it depends, you know, how you ask it. But a lot of times in studies, people say, "Thank you so much for talking to me." You know? Because just being able to name it and to talk about, even if you cannot provide the treatment, for some people experience that as therapeutic.

You also have to know when to stop. You know? I mean, you do have to have some level of training, you know. But I agree. And I think that continuing to not ask -- I asked myself, with what other kind of medical history situation would we say, no, we shouldn't ask because, you know, we don't have -- we would not do that.

DR. FELITTI: You shouldn't ask, you know, do you cough up blood, because you might not know what to do.

[Laughter.]

DR. AMARO: Well, I'm not going to take your blood pressure, because I can't give you the medication.

DR. FELITTI: Sure. Yeah.

DR. AMARO: I don't know.

DR. FELITTI: A very useful response to a yes answer -- I mean, probably the one that was most commonly used by the staff was the simple sentence, "Tell me how that's affected you later in your life." It doesn't open Pandora's Box, you know, a statement that's another mode of resisting all of this. The answers typically were a minute, minute and-a-half, two minutes long.

MS. AMATETTI: Yes, Jean?

DR. CAMPBELL: Just a quick question for Hortensia.

You mentioned that there's a lack of research in the intersection of gender and race. And I was wondering if you found that due to studies that aren't powered enough and also, research instruments that aren't responsive to change, which is the other problem. I mean, that's an overall problem, particularly the power issue, because you end up with all those missing cells, you know, with nothing in it.

DR. AMARO: Right. So I think that SAMHSA --

MALE SPEAKER: Use the microphone.

DR. AMARO: Oh, I'm sorry. I think that there

are methodological reasons such as sampling approaches, you know, that don't -- where studies aren't powered, number one. But, two, sometimes even when studies are powered, they don't do the analysis. And, three, you could still do preliminary analysis and at least get, you know, effect-size estimates looking at race and ethnic interactions. And those studies are, like, you can count them, you know, in one hand, probably, or two hands, that have done that.

So I think it's a -- among investigators, researchers, it's probably lack of their own training. When you think about, you know, what's the generation that's getting the grants, probably the younger generation are integrating these things more. That's just a hunch. But lack of training, sense of discomfort with different populations, feeling like it's too complicated -- you know, they don't have people on their teams, generally, that would be able to outreach to certain populations to get them in the study.

FEMALE SPEAKER: Recruitment.

DR. AMARO: Recruitment -- you know, the NIDA CTN

-- the sites -- the studies that have done best in recruiting minorities have been ones that had partnerships with community agencies where minorities got the services. And the studies were done in those sites. And that's, like, a no-brainer. You know -- and other ones that use more creative approaches to sampling -- so I think it is the issue of [inaudible] and being powered.

But even when you don't have the power, there are things you can do. And so, I think that, while the NIH guidelines on, you know, inclusion, that everybody has to write up and say they're going to do, from the analysis I've seen of those is that the majority of people fall short of their minority recruitment.

But people know they have to say that they're going to recruit a certain number, or they won't get funded. But that doesn't mean they're able to. And then, when they do collect the data, they don't analyze it. And they do need to have some kind of understanding of what does it mean if you find differences. So they have to have some kind of understanding of the content to be able to then

interpret or even know what questions to ask and what analysis might be useful.

MS. AMATETTI: Okay. I am going to wrap us, because I have extended our time already.

I just, again, want to thank our panel for participating.

Thank you very much, everybody. And we're now going to take a five-minute stretch. That means you can do one thing. You can go to the restroom. You can make a call. You can get a drink of water. But you can't do all three. So, please, just five minutes. And we'll come back.

[Applause.]

[Break.]

MS. GRAHAM: This meeting is now reconvened, please.

MS. ENOMOTO: All right. So, well, I thank you all for your patience. I think that was a rich discussion and a rich set of presentations on the last one and something that, as a group, we probably need to continue as a conversation about how we move the ball down the field in terms of broadening gender-

specific services through mental health and substance abuse prevention in a way similar to the way it's been done in the substance abuse treatment side.

For this next session, just for your information, we have two speakers. We have Johanna Bergen and Jean Campbell. Amanda Manbeck is not joining us. And we don't have anyone scheduled for public comment, so we do have a little bit of extra time. So that's why we were able to take a little extension on the last session.

So with that, as I mentioned yesterday -- or this morning, we are going to have a session tomorrow about the principles of recovery. SAMHSA is working towards a shared definition of recovery across mental health and substance abuse. This has been an interesting process of consulting with the field and consulting with our internal experts.

And tomorrow will be our opportunity to consult with the councils. So I thought before we go into that meeting, we might talk a little bit about what does recovery mean for women and girls. And while I asked Jean and Johanna both to speak, both from their

personal and professional experiences, I hope that the rest of you will join in and speak to your experiences and observations as well.

So with that, Jean?

DR. CAMPBELL: First of all, I'm cold and tired. And I assume many of you are since we've had such a -- I wouldn't say draining, but intellectually-stimulated session -- it's kind of worn me down here. So apologies for I may ramble at points here.

But I thought it was fortuitous that we were able to talk about recovery in this group, with SAMHSA beginning yet another initiative to continue the discussion on how to define recovery, which is a consensus-building process of looking at the attitudes of the different stakeholders and validating the lived experience of people that have been in recovery, and basically started by SAMHSA in 2004 with over 150 experts were brought together or stakeholders were brought together to come up with a definition of recovery in mental health.

And then, the next year, a similar process occurred in substance abuse. And now, SAMHSA is

moving toward,a unified theory of recovery that would be considered behavioral health. And I think -- and they're going to start taking public comments, I believe -- is it next Friday, August 12th? So they're already --

FEMALE SPEAKER: [Off-mike.]

DR. CAMPBELL: Yeah. Until August 26th. So, hopefully, this conversation and our conversation tomorrow will stimulate people to provide input on their perceptions of recovery and the principles of recovery. What I thought I would do, since there -- I will tell you there isn't much that has been done looking at gender-specific issues around the concept of recovery. But I did find some in the research. And I thought what might be important is to provide some information about recovery that you probably will not hear any other place, you know, sort of, like, from my work and my experience.

The other fortuitous part is is that the multi-site study that I mentioned in the morning that looked at the promotion of well-being in these peer-run centers and found that, indeed, when -- when these

programs did offer their services as an adjunct to traditional mental health services, that there was a significant rise in well-being, which, within my field, is another way to conceptualize the concept of recovery, because recovery itself is and will continue to be a moving target.

So one of the things -- I thought I would address two basic issues. One is to give you, sort of, a sociological narrative of where the concept came from, and then, second, to share what are some of the scientific conceptions of what recovery would be from positive psychology. And I don't think that either one of those -- in the initiatives to define recovery, neither one of those things have actually been considered, looking at the history of the development of the concept or the science of recovery. It's been more of a perceptual process from people's lived experiences.

So the first thing I wanted to do is in terms of a sociological narrative, I'm going to use this draft paper that we're submitting to psychiatric services. And you can just gaze upon that -- I thought that was

a very tranquil picture -- while I'm talking -- is that -- I mean, when you -- most people, when they're looking at positive psychological states really look back to the work of the humanistic psychologists such as Maslow and Seleckman. But there is a rich history of promoting what we would call well-being in consumer-operated services, which I defined this morning as those services that are administered and delivered by mental health consumers themselves, based on the philosophy of self-help.

And so, it really came from around the 1970s where large numbers of psychiatric patients were released from the large mental health institutions into the communities where they were really -- found themselves alone and powerless in most situations. And it was during the next two decades that they banded together to form these self-help groups for mutual support and advocate for social justice.

And in that process, they developed empathic and empowering practices as alternatives to the treatments offered in the traditional mental health system. And one person, Sally Zinman, wrote, "Self-help groups

demystify our emotional life, giving back to us the knowledge and tools to help ourselves. Our emotional life is no longer somebody else's. We are the experts." And Sue Bud, another consumer, described these groups as, "A place to feel useful, to affirm your self-respect."

Another project, which I was the principal investigator of, was the Well-Being Project, which was 1986, where, in California, we looked at what promoted and deterred well-being of mental health consumers. And consumers in that case, developed the instruments. They conducted the survey themself and analyzed the data and came to some interesting conclusions about well-being, particularly that it was a positive, empowering, life-affirming process. And analysis of the survey data revealed this dynamic search for well-being by persons with mental illness, a dynamic search, and particularly to form acceptable identities, acceptable to themselves and to others.

And, as researchers, we concluded that in order to get inside that dynamic, the researchers called for a social scientist -- I'm, by the way, also a social

scientist -- that could capture the fullness of experience and the richness of living. And this is very different from what was going on in traditional mental health services and research in the field itself. Over the years, by the 1990s, mental health consumers formed this movement called, Nothing About Us Without Us, and began to gain a national voice.

And they saw science and research as a way to articulate their perspectives in public policy, services research, and service provision. And SAMHSA, particularly the Center for Mental Health Services, provided quite a bit of funding for those efforts, including a series of focus groups to define what kind of outcomes should be measured in state mental health authorities. And consumers utilized this approach called concept mapping, where you brainstorm ideas, and then, you sort and rank those ideas to develop these concepts.

And they identified positive, subjective dimensions such as recovery, personhood, well-being, and empowerment as those outcomes that were the most valued by mental health consumers. It was at that

time also that CMHS, through the Mental Health Statistics Improvement Program, developed a report card to measure mental health services and had consumers as participants in that effort. And they utilized these focus group findings to develop some of the first inquiries into things like satisfaction, particularly satisfaction and treating people with respect in services.

So at this time, there was, like, a robust or abundant effort in beginning to develop positive psychological measures by consumers in collaboration with scientists of hope, meaning of life, self-efficacy, goal attainment, and social inclusion in the research protocols. Consumers were involved in the protocols.

So they began to ask questions that took one out of looking at recidivism, for example, or bed use in hospitalization. Those were the types of things that people looked at before. Biomedical measures -- that consumers were really pushing, looking at these psychological measures.

So about the turn of the century, in about the

year 2000, that there -- with this national movement, particularly with consumers involved in research, public policy, and service delivery, many of the service centers banded together to provide these more integrated programs, which we now call consumer-operated service programs. And research of those programs continued. And again, what they tended to measure or to find were that these programs improved psychological and social adjustment and goal advancements.

And by the late -- during this period, the Surgeon General's report on mental health came out. And it included peer services and talked about much of that research.

MS. ENOMOTO: [Off-mike.]

DR. CAMPBELL: What? I only get three more minutes?

MS. ENOMOTO: [Off-mike.] Go ahead.

DR. CAMPBELL: Oh, I thought because there were only two of us, that we got more time.

MS. ENOMOTO: [Off-mike.]

DR. CAMPBELL: Oh. Okay. So this all led to the

development of definitions of recovery and to the funding of the large, multi-site study, which we're now producing findings about.

So I wanted to talk about, conceptually -- about recovery and what consumers, based on their focus on recovery-type measures, have looked at over -- which I would say is -- 30 some years of investigation and service provision to build practices that promote recover. So when people are confronted with mental illness -- and this goes to a definition of recovery -- I mean, they continue -- recovery could mean that they continue to function, but in an impaired fashion. That's survival. And it's basically been -- we were very concerned that early on, that chronicity would be included within a definition of recovery, even though there was increasingly impaired function.

It can also mean returning to your previous state of functioning, which means -- I mean, you don't get worse, but you don't get better. And then, there was this concept out of the consumer movement of thriving, growing beyond the original level of -- to add value to life. Being -- recovery provided the opportunity

to grow and become greater and to move on with your life as opposed to staying back in this homeostatic equilibrium. And this, sort of, helps look at that concept, when faced with a challenge, the basic choices.

So a lot of studies, when you look at positive psychology, have shown that the treatment of illness and the promotion of wellness are different. They're not on the same continuum. They have parallel processes, but they're not on the same continuum. That's why, in our multi-site study, it was interesting to find that the promotion of wellness plus the treatment of illness produced these positive effects, by combining services that were parallel.

People went to traditional mental health programs. They also participated in a consumer-operated program. I mean, the common thing is to see it on a continuum.

Noting also that research has shown -- I mean, in research, traditional mental health programs primarily treat mental illness, focusing on the remediation of deficits, and even in prevention, focus on reduction

of the risk factors. But peer support and those concepts coming out of positive psychology primarily promote mental wellness. They nurture positive, subjective human strengths. As positive, subjective human strengths are engendered, the model would go, the consumer develops protective factors and begins to thrive. So those are two different things.

So you could have a lack of positive promotion of mental wellness, and that would not be the same thing as an absence of mental illness. Those are two separate things.

So the one study I wanted to share, and one of the leaders in the positive psychology movement, is Carol Ryff. And she wrote this outstanding article really investigating the dynamics of recovery, based on these assumptions: first of all, that adversity and its accumulation over time has negative mental health consequences. And I think we could all agree with that, particularly after our conversations about trauma.

Advantage, positive things occurring in one's life and its accumulation over time have positive

mental health consequences. Reactions to adversity and advantage can heighten or reduce the impact of life experiences. And position in social hierarchies through time has consequences for mental health. And social relationships can heighten or reduce the impact of life experiences and enduring conditions.

And these, you know, taken separately, I think we basically would agree with those. But what they did was they looked at variations in well-being through studies of discrete life events and enduring human experiences of this group of women. They collected these life histories of psychologically-vulnerable and resilient people. And these were particularly women.

They separated the study by males and females and then looked at the cross-classification with depression. And the goal of this study was to understand how a given outcome, that is depression or resilience, can come about.

And they ended up looking at four groups. First of all was the depressed or unwell, were those with prior episodes of major depression and who also lacked high psychological well-being. The healthy were those

with high levels of well-being who had no history of depression. And then, the last two, which are more interesting -- the resilient were individuals with prior history of depression, but also reported high current well-being. And the vulnerable were those with no history of depression who had low levels of well-being.

And they found out that resilient women -- this is just one of the descriptions, which I thought was really interesting -- resilient women had lives that included aversity, typically growing up with alcohol parents or experiencing early family death. They also possessed important factors of advantage, like high I.Q., high grades in high school, good physical health.

They also had good social relationships. And the researchers suggested that the presence of these factors and the relational experiences contributed to their high profiles of life purpose, mastery growth, and quality connections to others. And they predicted that such features of well-being offer important protective resources as these women confront the

vicissitudes of growing old. So, I mean, this really argues for the importance of well-being and begins to understand what are the factors that would promote resilience, for example, in the communities.'

And, as a conclusion, recovery from mental illness requires more than adequate access to quality clinical services, medication, and rehabilitation. Recovery also depends on the well-being of the mental health consumers, their capacities to have hope, be empowered, attain their goals, have meaning and purpose in life, and be connected to others, and sustain a sense of self-efficacy.

MS. ENOMOTO: Thank you, Jean. I apologize for rushing you. But I think this was very helpful to get through. And your thought is vigorous on this. And so, that's appreciated.

Johanna, I don't know if she has -- if you have slides. But if you -- are you available on the line?

MS. BERGEN: Yes, I'm here. I don't have slides.

MS. ENOMOTO: Okay, great.

MS. BERGEN: Okay.

MS. ENOMOTO: Do you want to take it away?

MS. BERGEN: Sure. So I was thinking, in preparing to share a few comments with you, that I should steer away from my personal experience, which is what I am apt to do when I am in awe of the rest of the people around the table. But maybe with Kana's introduction, I don't have to do that as much. So I, kind of, will share a little bit throughout.

Because of my personal experience, I think that when I think about recovery or when I think about any of this work with women and girls, my focus and priority will always align with teenage mothers and the fact that there are so many of us, and the whys and the hows may vary. But I am very shocked that my journey, my personal journey to recovery, started by becoming a mother. And I feel like there are a lot of -- I have a lot of peers who are trying to recover because they became mothers.

But it was different for me and that becoming a mom and having a child pulled me away and allowed me to start this process. And my mom is probably one of the few moms who when she was being embraced by her community and her co-workers and her church saying,

How can we help your daughter, and how does your family find yourself where they are. She would come home and say, "I can't tell them that it's a good thing that you had a baby, because they can't tell their 18-year-olds that." But it was how she was feeling.

And because of the journey of motherhood got me to where I am today, and because when I'm feeling as if I'm being pushed off the road of recovery by this constant process -- because you never get to the end. You're always in it. And that's an idea, I think, that should remain in the definition and how we talk about recovery is that you don't ever get there. You're always doing it.

But because of the things, the worries and the fears and the anxiety that would push me away from staying on the recovery path have to do mostly with my child and soon-to-be children. I would like to have us think about keeping the role of women as mothers in our mind as we're looking to redefine and we have this conversation about recovery, particularly as I've been reading studies about the number of mothers who are

making choices to stop receiving services or treatment or to avoid seeking services for themselves because they have children who they see as having higher needs than their own.

And so, if we are making a decision to help our children and take our children to services and to help with mental health disorders and to provide treatment for them, will they be able to succeed and find a path to recovery if the closest family members aren't receiving treatment and aren't receiving the care that they need to be in a, kind of, mode of recovery with them?

And so, throughout today, I've been thinking a lot about how can programs -- it seems, at least where I'm from, that there is more funding and there's more referral places for the youth in our community. And so, how can we connect those services, the idea that they could help the family and help the mother, particularly, as a part of the service to our young people?

And the other thought that I really have around recovery and looking at the guiding principles of

recovery as they stand now -- probably the most important to remain there and stay is something to address trauma. And I have been amazed throughout today's conversation about how long trauma has been part of the conversation, a part of [inaudible] the research and evaluation component of this conversation in the mental health and substance abuse field.

Yet, if you asked me if I had a traumatic experience, or if you asked the woman next to me or my younger sister, I think we would all say no. And what I'm discovering is that there's a different definition of trauma out there that means a lot -- many more women and girls have experienced a traumatic experience some time in their lives. But they know to define it as such.

And so, while we should use that word trauma as we're thinking about recovery, also working to provide a redefinition of that, kind of, to the general public. And then, after we understand and, kind of, self-identify traumatic experiences, understanding the fact that we will always respond differently to treatments and to services because of that experience

of trauma. And that is something just like how we're unique individuals on our path to recovery. This is just going to be another effect that we need to be thinking about as we figure out what works for us and what doesn't.

So I think -- I just wanted to share with everyone that I don't think that we can think about recovery for women and girls without thinking about their whole family units and their decisions they make because of the obligations we feel we have, and then, to just make sure that we keep the idea of trauma within that language in a way that everyone can understand and work to use that.

MS. ENOMOTO: Thank you, Johanna.

I was just looking to see if we actually have the principles of recovery today. We don't have those?

It sounds like, Johanna, you've seen them.

MS. BERGEN: Uh-huh, yes.

MS. ENOMOTO: I don't know if Jean's worked on them. But have other people seen the principles of recovery that have been sent out for comment? Is it --

DR. CAMPBELL: I have it here.

MS. ENOMOTO: Okay. I'm sorry.

DR. CAMPBELL: I don't know if it's in there. I got it in the other meeting.

MS. ENOMOTO: Okay.

Okay. So are you all looking at it?

[No response.]

MS. ENOMOTO: No. Because I know that being trauma informed is one of the principles. I don't know if gender specific is one of them.

MS. BERGEN: It's not specifically addressed. That might be something we would want to share tomorrow, or a suggestion.

DR. CAMPBELL: I can read those.

MS. ENOMOTO: Okay. Yeah, go ahead.

DR. CAMPBELL: They're really short. Guiding principles of recovery -- recovery is person driven. Recovery occurs via many pathways. Recovery is holistic. Recovery is supported by peers and allies. Recovery is supported through relationships and social networks. Recovery is culturally-based and influenced. Recovery is supported by addressing

trauma. Recovery involves individual, family, and community strengths and responsibility. Recovery is based on respect. Recovery emerges from hope.

And this is a consensus-building process that has come up with these guiding principles from stakeholders over the last decade, basically. This isn't necessarily research. So the --

MS. ENOMOTO: Right, right. This has been a consensus-driven process. And again, in recent rounds, we've had some conversation about adding resilience language to that, because it's both to address the -- some of it is to get to the thrive and it's moving past just recovery to the next step and building people up for the next phase of their life as well as to address the issues, the developmental issues, that kids are not necessarily recovering a past or former state, that kids are developing as they go. And so, they may be overcoming challenges of addiction or mental illness, but moving toward a new state of development rather than recovering a past one.

DR. CAMPBELL: Well, if you notice, when that

brief, like, whirlwind tour of efforts by mental health consumers, they actually chose the term right from the very beginning of well-being. Recovery wasn't a term that was commonly used until SAMHSA supported the focus on recovery, which I have to say we said, okay, we'll go with that. But it wasn't -- like we didn't have recovery measures. We had measures of empowerment and well-being, those types of things as opposed to recovery.

MS. ENOMOTO: Okay.

Vincent?

DR. FELITTI: And is there any effort to define who would draw those conclusions?

DR. CAMPBELL: The conclusions that I read?

DR. FELITTI: Yeah.

DR. CAMPBELL: Well, those conclusions represent the feedback of the people who participated in the --

DR. FELITTI: Well, I understand.

DR. CAMPBELL: And so, I mean, there are lists of who those are. You know, consumers --

DR. FELITTI: No, no, no, no, no.

DR. CAMPBELL: Oh --

DR. FELITTI: I mean, in an individual case, who draws the conclusions leading to the concept of recovery or no recovery?

MS. ENOMOTO: Right. I mean, I think there's been some question about measuring. How do you measure recoveries that you can say, okay, have we tipped the balance here, recovered or not? You qualify recovery support services, or you don't.

DR. FELITTI: It would seem to me that one could argue that there would be three different sources of assessment: the individual, him or herself; family members or friends; and someone who's been therapeutically involved with that individual and has a fair understanding of what's been going on with them.

DR. CAMPBELL: Well, actually, mental health consumers resist using the concept of recovery to determine the types of services that people should have or to impose a definition on them, to be assessed or to impose a definition. And the emphasis is on the dynamic process of recovery, recovering at one's own necessary speed, recovering in some areas and not in

other areas.

I mean, so that's why I was confused when you asked that, because, I mean, that's normally -- although there have been efforts to assess people and then say, okay, you can go to this recovery center, and then, after so many times, reassess them. But it's not like doing a GAF or, you know, looking at -- in biomedical measures, you can say the person is recovered based on Colorado's symptom checklist or the GAF or something like that.

DR. FELITTI: Yeah, my point is that I wouldn't trust any single one of those. It's too easy for people to delude themselves or to fool their families or to have some inept or mistaken person, other person, you know, draw a conclusion about that. That's why I'm proposing that there would be three different viewpoints. Obviously, you'd like to have conformance between them.

DR. CAMPBELL: The concept of recovery isn't assessment or to be used within the traditional mental health services to necessarily assign services. It's more of a political or policy concept to try to

develop supports for people so they can achieve well-being in their life. It's more voluntary. Those that work with people to achieve recovery are usually peers. It isn't within the -- some recovery occurs -- some well-being occurs within the traditional mental health services. It just isn't significant, because traditional mental health services treat illness. This is a promotion of wellness concept where the end point, if you believe in self-actualization, can't clearly be defined.

MS. ENOMOTO: I think one of the issues there, Jean, is that that may be the history of the definition of recovery or the use of the term recovery. But we are now moving into this age of health reform, where we're encouraging systems to pay for helping people achieve recovery and to pay for recovery support services and to continue to wrap around people past the remediation of illness towards the achievement of recovery and wellness. And so, you know, I mean, systems being as they are, they, sort of, want measures. And how do we know --

DR. CAMPBELL: But there are measures of

services. And, I mean, looking at participants, the outcomes of services -- I mean, that's what our multi-site was about. And so, we found significant improvement in well-being.

We had positive measures of hope, goal attainment, empowerment, meaning in life. Those were the measures. What was measured was the effectiveness of the program to produce that in the participants, not as an individual assessment tool to rank somebody on a recovery-type scale.

MS. ENOMOTO: But now that you're moving into an era of third-party payment, right, that's the challenge. That's the struggle that we're going to have to grapple with.

DR. CAMPBELL: Yes, indeed.

MS. ENOMOTO: Yeah.

MS. FORMAN: Can I say something?

MS. ENOMOTO: Go ahead.

MS. FORMAN: What I thought I heard both Jean and Johanna saying is that recovery is a process, not an end point. Did I hear --

DR. CAMPBELL: Well, it's both an outcome and a

process.
MS. FORMAN: Yeah, but --
DR. CAMPBELL: I mean, because the outcomes can be hope, increased hope, you know, increased goal attainment, increased empowerment. So it can be an outcome, in that case. But it also can be a process.
MS. FORMAN: And it sounds, kind of, like, what you're saying is that it needs, for pragmatic purposes and for SAMHSA, for the new health care systems and everything else -- it needs to be a goal that can be more quantified and --
FEMALE SPEAKER: Operationalized?
MS. ENOMOTO: Yeah, I mean, I don't know that we're saying it has to be. But I think we have to be careful what we're asking for. So if we're saying, pay for recovery support services, pay for performance, don't pay for the absence of symptoms, but pay for wellness, pay for -- we're going to have to be able to say, and here's how you know you've gotten what you paid for. And here's how you know who gets these services and who gets those services, because they will ask. It can't be -- you know, it's

not going to be sufficient for us to say --
DR. CAMPBELL: But the approaches normally have been, in looking at outcomes and looking at the effectiveness of services individually determining where an individual are you -- hasn't been the approach. So, I mean, it can be rigorously defined and measured as outcomes. I mean, and most of those scales are recognized sound, psychometric scales that can be used, but not used to tell a person where they fit on a recovery-type scale.
I mean, I could see where that maybe CMS would want that in terms of coming up with reimbursements. That, I can -- because then they are looking at the individual as opposed -- but SAMHSA has always had the focus on the services component, looking at evidence-based practices. Evidence-based practices -- most of them are assessed through studies that look at the effectiveness of the services for the individuals.
MS. ENOMOTO: Right. Well, even how we're looking at evidence-based practices -- and when you've been dealing with a population that's 39 percent uninsured, with significant funding coming from state

general funds and block grant funding to a population that's going to be predominantly insured -- on the substance abuse side, it's 69 percent uninsured, which is going to become predominantly insured. It's just a paradigm shift in how we have to think about being disciplined and being very explicit about what we're paying for, what we're trying to achieve, how we're measuring it, how we're billing for it, how we're describing it.
And so, you're right. We've always done it this way. And we're going to have to do it differently. And that's part of the purpose of having this conversation in a very explicit way.
You know, it's fine to have a really nice poster on the wall, and we can feel good about it. But at this point, the rubber's hitting the road. You know, and people are saying, okay, so is this what you want to pay for. All right. So if this is what we're going to hold providers as a standard to, how should we measure it, and then, what are the thresholds so people have achieved this, then they don't get the benefit any more?

I mean, at a certain point, you don't keep treating somebody for their recovery from X disease. You know? You're, sort of, okay, you're done. You're done with treatment. You're good. Come back in six months. Come back in a year, and we'll do a checkup. So at what point do we reach that with some of these things? Do we reach it, do we not reach it?
I mean, it's not set what we have to do. But I think in terms of it's a six-month timeframe or a 12-month timeframe. But what is determined is people are going to want to know. And it's our opportunity as a field to say, and this is what we think it should be.
DR. CAMPBELL: But, you know, I don't understand, Kana, that -- I mean, you're mentioning the principles, and you're saying that. But those are not scientific. That's a survey of attitudes. So people think. People believe. So, I mean, that point is not scientific at all. And I see no rigor there. But the rigor is in the science who really establishes that a recovery is based in respect. I mean, you can do a study of that and come up with that.
I think that we're one -- we're willing to skip

over the science of what actually recovery is. But then, all of a sudden, begin to measure it on an individual level before understanding the psychological dynamics of recovery.

MS. ENOMOTO: I don't think I'm suggesting we should skip scientific rigor. I'm saying, this is what we have. If we have other things, we should bring that to the table. This is an opportunity. Right? So I don't necessarily have the answer, and I'm not pushing an answer.

I'm saying, if you think we need to bring more scientific rigor to this, then tomorrow is a chance to talk about it. And as we are -- and so, to have that lens that as the system is -- as we are pushing the system to embrace, again, not just the medical model, treat disorder, treat addiction, you know, abstinence, we're done. Okay? You're abstinent, you're cured. See you later. Right?

We're not -- we're past that now. We're promoting a different model. We're promoting recovery. We're promoting wrap-around, you know, recovery supports. So if that's the case, what is the

science that we have? How should we measure that? How are we going to communicate that? How are we going to create thresholds for treatment for service provision, for reimbursement? And I think you're right. We do want to be as rigorous as possible in doing that process.

So probably, principles alone are not enough. But that's the conversation we need to have. So, I mean, you're right. You know, SAMHSA has been going this way.

And I think people didn't realize that health reform was going to come so quickly, that we needed to be getting beyond ourselves and having all these nice conversations and getting agreement on a poster. Because, just around the corner, CMS said, okay, well, just tell us what we should be paying for, and we'll do it.

So that's, I guess, some of the thinking that I encourage folks to bring to the table tomorrow, because this is a serious conversation now. Not that it wasn't before, but it's got different implications than it did in the past. And it's not about feeling

good. It's not about building a bridge between substance abuse and mental health. It's really about how are we going to get our populations that will be newly insured the kind of services that we think that they deserve and that they will benefit most from.

All right. So we have -- I want to thank Jean and Johanna both for sharing their thoughts and their perspectives on this. I think it'll be helpful as we walk into the conversation tomorrow.

Cynthia just shared with me that 56 people viewed the Webcast today. Seven folks joined us by phone, including Johanna. So though we didn't have the video Webcast, for which I'm grateful --

[Laughter.]

DR. CAMPBELL: I like that from when I'm sitting in front of my computer to see, like, Pam and --

MS. ENOMOTO: Yeah. It is. It's good. It's just better when you're on the other side.

[Laughter.]

MS. ENOMOTO: Than eight hours of vigilance.

But I thank all of you for participating actively and contributing mightily. I want to just bring your

attention to what we are doing for the next couple of days so you have some sense of what to expect.

Tomorrow we're starting at 8:30. We will be here on the first floor. It's going to be in the big room, Sugar Loaf, with all of the National Advisory Councils. So it'll be -- I think we have -- how many, folks coming, 60?

MS. GRAHAM: Sixty-five, 49 council members, 49 council members.

MS. ENOMOTO: And then, 65 with all the SAMHSA people?

MS. GRAHAM: And plus 120 plus SAMHSA staff --

MS. ENOMOTO: Wow. Okay.

MS. GRAHAM: -- that have registered online.

MS. ENOMOTO: Okay. All right. So we're expecting a very full house tomorrow. The Administrator will do her remarks. I think she's going to make some announcements on personnel changes that are happening. And then, she's going to walk us through our budget situation, which is also exciting.

Starting at 10:15, we will have a women and girls conversation for an hour. Sharon's going to be doing

the overview – a truncated version of the overview she did for you all in June. And then, we'll have someone from the HHS Office on Women's Health and Flo Stein pinch hitting for Starleen Scott-Robbins and Elizabeth Neptune, who is from Maine.

And she is one of our Tribal Technical Advisory Committee members. So those will be our respondents. And all council members will be invited to join the conversation.

Then, again, the principles of recovery conversation – Kathryn's going to present where we are and the future of the principles and their definitions. So I think bringing up some of the issues around women and girls and their roles as mothers and where gender is in that – as you look at the definitions, perhaps we can make sure that that's in there.

Workforce development – Jean is – first, Dr. Clark and Linda Kaplan are going to be doing an overview of some of our collaborations that we have on workforce development, both across the centers and with HRSA and other agencies. And we'll have a number

of reactors to that. So Marsha Brand from HRSA; Shirley Beckett Mikell from NAADAC; Leighton Huey, who is the CSAT NAC member; Ruth Satterfield, who is from the MPN. And Jean will be there representing ACWS.

And finally, we're going to talk about the National Behavioral Health Quality framework. I see a word missing on my agenda. But we have been working very, very busily with the departments and ARC and Richard Frank and Q.F. on developing a quality framework for behavioral health, which we think will be helpful as we, again, are moving into a different way of thinking about and paying for health care. So that will be tomorrow.

And then, I suppose most of you will be going back after tomorrow. And then, we'll have – that'll be the Joint NAC. And then, on Wednesday, we have the SAMHSA National Advisory Committee meeting, where we're going to focus on a national dialogue conversation.

And Administrator Hyde has noted that there is a level of public sentiment which needs to get harnessed in order to truly move behavioral health beyond where

it's been, that we've been talking to the choir quite a bit. And so, many of us are on the same page about how important our issues are and how critical we are -- and how critical we are to overall community health and to individuals' general health. And yet, somewhere that has not made it into the national consciousness.

So, you know, as soon as you see somebody, for example, with the Tucson shooting, I mean, people went very quickly to very stigmatizing and negative attitudes towards people with mental illness. They went to, gee, if we could just control guns better or identify those people earlier or lock them away or not let them get guns or something, which would be inefficient and doesn't -- you know, it's not borne out by data that would tell us they're less likely to be violent and be -- they're more likely to be victimized than to be victimizers.

But that's just where people's thinking is. And so, they don't say, let's do more prevention, let's do early intervention with young kids, let's do, you know, more screening and get people help. It's so we

want to turn the tide. How do we harness public sentiment to turn the tide on that?

And finally, we've been very active with the National Action Alliance on Suicide Prevention, which Secretary Sebelius, Secretary Gates – former Secretary – well, Secretary McHugh of the Army and former Senator Greg Smith are co-chairing our National Action Alliance for Suicide Prevention. We're going to be doing an update on what our activities are there.

So that is the rest of this week, although I know some of you won't be there on Wednesday. But I look forward to seeing you tomorrow, and I hope you all are able to participate actively.

MS. BENAVENTE: [Off-mike.]

MS. ENOMOTO: Yes.

MS. BENAVENTE: [Off-mike.]

MS. ENOMOTO: Yes. You are welcome to attend the NAC meeting.

FEMALE SPEAKER: [Off-mike.]

MS. ENOMOTO: We'll get that to you, yeah. Okay?

MS. GRAHAM: Would you just please leave your

notebooks on the tables along with your badges, except the one that has visitor on it. You need to take that badge with you so that you have access to the building tomorrow. But if you will leave your notebooks on the table, we do have some updates that we need to insert in your notebooks, please.

MS. ENOMOTO: Great. Okay, great.

MS. GRAHAM: Yes. Take the visitor's badge with you.

MS. ENOMOTO: Okay. All right. With that, thank you. We are adjourned.

[Whereupon, at 5:03 p.m., the meeting was adjourned.]

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