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7           SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

8                           ADMINISTRATION (SAMHSA)

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10          ADVISORY COMMITTEE FOR WOMEN'S SERVICES MEETING

11

12

13                                   9:05 a.m.

14                                   Monday, August 15, 2011

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18                                   1 Choke Cherry Road

19                                   Rockville, Maryland 20857

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1 PROCEEDINGS  
2 MS. GRAHAM: Good morning. This meeting of the  
3 SAMHSA Women's Advisory Committee is now called to  
4 order. Ms. Kana Enomoto is the Chair.  
5 Kana?  
6 MS. ENOMOTO: Thank you very much. Okay. Thank  
7 you very much. Good morning.  
8 FEMALE SPEAKER: Good morning.  
9 MS. ENOMOTO: I am pleased to be here with this  
10 convening of the Advisory Committee for Women's  
11 Services. We have five members in the room and one  
12 member on the phone. So let's start with just going  
13 around and introducing ourselves. We also have a new  
14 addition to our team at this table, and we'll talk  
15 about that in a little bit.  
16 So we'll start with Bobby.  
17 MS. BENAVENTE: Huffadey. My name is Barbara  
18 Benavente. I go by Bobby. And I'm with the Guam  
19 Department of Mental Health and Substance Abuse.  
20 and good afternoon.  
21 FEMALE SPEAKER: You were the disembodied voice  
22 on the phone.

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1 MS. BENAVENTE: Yes, that was me.  
2 FEMALE SPEAKER: Welcome.  
3 MS. FORMAN: Hi. I'm Harriet Forman, retired  
4 preschool consultant with an educational background.  
5 Nice to be here.  
6 MS. SCOTT-ROBBINS: And I'm Starleen Scott-  
7 Robbins. I'm with the North Carolina Division of  
8 Mental Health Developmental Disabilities and Substance  
9 Abuse Services.  
10 DR. CAMPBELL: I'm Jean Campbell. Sorry. I'm  
11 somewhat discombobulated this morning. So I'm Jean  
12 Campbell. I'm from the Missouri Institute of Mental  
13 Health, where I direct the Program in Consumer Studies  
14 and Training. And today I have two meetings going on  
15 simultaneously, so I apologize for not getting in here  
16 when it started.  
17 MS. BRISCOE: My name's Yolanda Briscoe. I'm a  
18 psychologist and also an educator. And I work and  
19 live in Santa Fe, New Mexico. I'm very happy to be  
20 here.  
21 MS. ENOMOTO: And we'd like to go to the phone to  
22 our mom-to-be.

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1 MS. BERGEN: Hello. This is Johanna Bergen. And  
2 I serve on East -- National as a board member. Happy  
3 to be with you via phone today.  
4 MS. ENOMOTO: How are you doing, Johanna?  
5 MS. BERGEN: I'm all right. I have allergies, so  
6 I sound a little stuffed up. But I'm about six days  
7 from a baby, so doing okay, I think.  
8 MS. ENOMOTO: Great. Great. Well, we are  
9 excited with you. Thank you. Thank you for being on  
10 the phone. We appreciate it.  
11 We'll go around the room as well. But I want to  
12 acknowledge our additions to the ACWS team that will  
13 be -- I think you've been introduced by e-mail and by  
14 phone. But now it is in person. We are happy to  
15 welcome in the Office of Policy, Planning and  
16 Innovation, Planning and Planning and Innovation, OPI,  
17 Cynthia Graham is on detail from the Center for  
18 Substance Abuse Treatment. She is our Committee  
19 Management Officer for all of SAMHSA. And in addition  
20 to managing the NAC, the Joint NAC, and shepherding  
21 the other Center Council, she is also the designated  
22 federal official for the ACWS. And she's replacing

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1 Nevine Gahed, who is actually newly the Special  
2 Assistant to the Director of OPI. So we have a number  
3 of transitions going on.  
4 And we are also welcoming in person Sharon  
5 Amatetti, who is the Administrator's fantastic choice  
6 and my choice also, to be SAMHSA's Women's Issues  
7 Coordinator. So I'll just let you both say a few  
8 words of greeting.  
9 MS. GRAHAM: I'm very delighted to have this  
10 opportunity to work with you. I think I probably have  
11 spoken with either of you via phone or e-mail. And we  
12 hope that we were able to accommodate you and that  
13 your stay here has been good thus far, in spite of the  
14 weather and perhaps travel conditions. But, as we  
15 work with you and you with us, we hope to make things  
16 better. Thank you for coming.  
17 MS. AMATETTI: And I'd also like to welcome  
18 everybody in person. I am Sharon Amatetti. I'm a  
19 long-time SAMHSA employee. We're getting ready to  
20 celebrate the 20th anniversary of SAMHSA, and I was  
21 here at the beginning. So I'm proud of that. And I'm  
22 very passionate about issues having to do with women

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 DR. CAMPBELL: We get plaques? Wow.  
9 [Laughter.]

10 DR. CAMPBELL: Membership benefit.

11 MS. ENOMOTO: You're right. Right, right. And,  
12 you know, 10 percent off at Safeway would be nice.  
13 [Laughter.]

14 MS. ENOMOTO: Yeah, right. Sorry, that's just a  
15 joke.  
16 [Laughter.]

17 MS. ENOMOTO: But, yes, we will miss them for  
18 their terms. Each of them made a unique and rich  
19 contribution to our conversations and to the direction  
20 of activities at SAMHSA. So we were lucky to have  
21 them for the period that we did.  
22 We also will be having Dr. Felitti and Dr.

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

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

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1 Committee as an experiment, but found that it was so  
2 rich in the dialogue and people were so engaged in  
3 speaking with one another, that, I think, we're going  
4 to continue this strategy, probably a little bit to  
5 Cynthia's dismay, because it is a Herculean effort to  
6 do all this logistics for seven committees at once,  
7 the staff, the NAC, the Center NACs, and ACWS. So  
8 it's a lot. If we'd just add the Drug Testing  
9 Advisory Board, you'd really have a party.  
10 [Laughter.]  
11 MS. ENOMOTO: But, no, we're going to let them  
12 stay separate for now. But, you know, the benefit is  
13 -- and so, you know, I appreciate -- I know it's a big  
14 chunk of time for everybody. It's a commitment. And  
15 poor Jean now has this conflict with the Center  
16 Subcommittee. But the benefit really, if you think  
17 about where we're headed, if you look at the SAMHSA  
18 vision where behavioral health and sexual health,  
19 prevention works. Treatment is effective. People  
20 recover. These things need to work together.  
21 And our committees and our centers -- our centers  
22 need to be working together. They need to, not only

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1 be working together within SAMHSA, but we need to be  
2 working together with the field and not within  
3 behavioral health field, but within health care, and  
4 not just within health care, but within human services  
5 with education, with Justice, with Child Welfare.  
6 And, Jean?  
7 DR. CAMPBELL: I was just going to say, because  
8 I'm looking at two agendas right now, that one way to  
9 work together would be to make sure that key issues on  
10 one agenda also appear on the other. For example, in  
11 the Consumer Subcommittee, they're going to have a  
12 discussion about the new definition of recovery. Now,  
13 we have an issue about recovery, critical issues in  
14 recovery. But it would have been good to have, I  
15 mean, other things as well that -- and I would say  
16 with the other committees and stuff, too, similar  
17 things on the agenda so we're considering these.  
18 And then, have some way to be able to report out  
19 what this committee said on that, what this committee  
20 -- I mean, I would be very interested in that, like,  
21 to know what the tribes are responding to on the  
22 definition of recovery and --

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1 MS. ENOMOTO: Well, actually, you will have that  
2 opportunity at the Joint National Advisory Committee  
3 meeting, because we are going to have that  
4 conversation with all the committees at once.  
5 DR. CAMPBELL: But that's not the same thing as  
6 internal to our meeting having a discussion and then  
7 bringing that perspective and sharing that with the  
8 consumers and the --  
9 MS. ENOMOTO: Right. Right. Well --  
10 DR. CAMPBELL: -- then moving forward.  
11 MS. ENOMOTO: Yeah. That's a good input. I  
12 think scheduling would be tricky. And then, you'd  
13 have to put the Joint NAC at the end in order to allow  
14 everybody, sort of, that caucus time on the front  
15 side. But, certainly, it's something to think about.  
16 We've tried to arrange it so that we could have  
17 enough space and room that we have half the people  
18 coming in a day early and then the other half of the  
19 people staying, sort of, the days later.  
20 DR. CAMPBELL: Well, it doesn't have to be a  
21 perfect approach.  
22 MS. ENOMOTO: Yeah.

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1 DR. CAMPBELL: But I think it would be helpful  
2 because one group could inform another. And it's also  
3 another way for -- like, I had never thought, in all  
4 the years being on the Consumer Subcommittee -- I  
5 mean, we don't deal with identity politics. So it's  
6 the broader issue of mental health consumers rather  
7 than thinking about women and girls. But now, I'm  
8 thinking that that is an important understanding to  
9 bring to that subcommittee. And I think it also works  
10 the other way. Because I do a presentation this  
11 afternoon, and I was thinking -- on recovery -- and I  
12 was thinking, "Well, what may they not know about that  
13 in this group focusing on women and girls"? So, I  
14 mean, I think that that could serve a broader benefit.  
15 MS. ENOMOTO: Right, right. Yeah. Well, I  
16 definitely think we can take that back and look at how  
17 do we integrate agendas with one another in a really  
18 productive way. Thank you.  
19 Harriet?  
20 MS. FORMAN: Yeah, I think what you're saying,  
21 kind of, is it helps to raise consciousness of, you  
22 know, issues in each place. It spreads the

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1 consciousness by, you know, sharing that.  
2 MS. ENOMOTO: Right. Yeah. Okay, great. Well,  
3 I appreciate that input. And we will definitely put  
4 our heads together on how we can use the different  
5 committees and their meetings in strategic ways to  
6 provide -- to bring perspective to the larger ones.  
7 Because I don't know that -- and we can actually still  
8 talk about that today. I mean, it's not like the day  
9 is gone. We can talk about it today. You know, let's  
10 look at the agenda for the Joint National Advisory  
11 Committee meeting and see about are there some key  
12 messages that you all would like to bring to that.  
13 We do have a session focused on women's and  
14 girls' issues in the Joint National Advisory Committee  
15 meeting, which is -- I mean, that was, sort of, some  
16 of the intent that the Administrator had heard this  
17 committee loud and clear about where are women and  
18 girls in the strategic initiatives, how are they  
19 playing in across SAMHSA's programmatic activity. And  
20 so, she's decided to bring that to all the groups to  
21 think about.  
22 And so, within that, as Starleen's presenting,

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1 Sharon's presenting -- Jean, you'll be presenting on  
2 the --  
3 DR. CAMPBELL: Workforce.  
4 MS. ENOMOTO: -- workforce piece. So, I mean,  
5 we've done -- okay. We've done some -- we put some  
6 effort into trying to bring the ACWS perspective to  
7 the main part of the meeting. And so, if there are  
8 key messages that we, as a group, think, you know,  
9 Jean, could you bring this up at the workforce  
10 session, you know, Starleen, could you bring this up  
11 in the women's and girls session or --  
12 DR. CAMPBELL: That would be really helpful  
13 because I hadn't even thought about it in the context  
14 of women and girls' issues.  
15 MS. ENOMOTO: Right, right.  
16 DR. CAMPBELL: The workforce.  
17 MS. ENOMOTO: Right, right. So that's -- I mean,  
18 that's good. I mean, that's great. That's how we  
19 should be using this group in ways to advance the  
20 issues as the collective rather than as just  
21 individuals working independently.  
22 Okay. So I have some remarks prepared for you

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1 all about our exciting budget debt ceiling future and  
2 what the implications are for SAMHSA, as much as we  
3 know, which are distil at best, but still some  
4 insight, which some of you may not have gotten out of  
5 the news, per say.  
6 So we know that the president and Congress  
7 reached agreement on the Budget Control Act of 2011,  
8 which is a combination of budget reductions over the  
9 next decade to increase the debt ceiling. First,  
10 there was a big chunk that was agreed to. It's \$900  
11 billion increase in the debt ceiling, which is then  
12 offset by a \$900 billion decrease in discretionary  
13 spending over the next nine years, from 2012 to 2021.  
14 So the president and Congress agreed, \$900 billion  
15 increase in the debt ceiling, \$900 billion decrease in  
16 discretionary. And that's scored off of an OMB  
17 developed baseline.  
18 The new 2012 spending cap is .7 percent below the  
19 fiscal year 2011 enacted level. I know that's a lot  
20 of words. But, so, we have a budget for 2011. The  
21 best we could do next year is .7 percent below what we  
22 have now. Now, that's not necessarily -- and that's

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1 for federal government discretionary spending overall.  
2 So that doesn't necessarily mean it's a haircut  
3 across all agencies. It may be 10 percent from here,  
4 and this agency goes up 8 percent. But overall, it  
5 will have to equal .7 percent less.  
6 So this is the spending level the Appropriations  
7 Committees are working from in passing 2012. And so,  
8 the Congress has the president's budget proposal for  
9 2012, which is not .7 percent below the 2011 level.  
10 So they'll have some distance to go.  
11 Do we have a question from someone online?  
12 Okay. We do have just -- so folks know, we do  
13 have about 12 people joining us from outside on the  
14 phone and online. So that's great.  
15 So welcome to all of you to our Advisory  
16 Committee for Women's Services. Thank you for joining  
17 us.  
18 So we already anticipate that we are going to  
19 start 2012 without an enacted budget, but with a  
20 continuing resolution. And it's not clear whether or  
21 not they will -- generally, the continuing resolution  
22 is just an extension of the past year's budget and,

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

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

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

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

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

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

18 Harriet?

19 MS. FORMAN: I just have a question. Where do  
20 any possible revenue increases fall under this 1.2 to  
21 \$1.5 trillion? Are these --

22 MS. ENOMOTO: I think they need to find spending

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

9 Starleen?

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

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

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

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

20 Thanks.

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

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1 Would you like to introduce yourself to the  
 2 group?

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

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

13 [Laughter.]

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

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

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

22 DR. McBRIDE MURRY: Thank you.

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

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

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

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

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

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

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

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

14 And so, you know, helping -- we need to collect  
 15 information to help CMS and the nation plan for how  
 16 this is going to impact financing. And we think that  
 17 states also need to be preparing on their ends. And  
 18 so, that is the direction of the application. And we  
 19 hope that by doing this, we'll all be better off when  
 20 2014 gets here.

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

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<p>1 Medicine recommended preventive services of women,  2 which HHS has moved forward in also recommending -- or  3 endorsing -- comprehensive guidelines for clinical  4 preventive services for women, that the Department has  5 adopted and for which we are recommending -- the  6 Department is recommending no insurance co-pays. And  7 they will -- these requirements will be applied to  8 insurance products starting on or after August 1st,  9 2012, taking effect in January 2013 for insurance  10 plans that operate on calendar-year basis.</p> <p>11 The services include eight categories, including  12 contraceptive methods as well as wellness screening  13 and counseling. Recommendation 5.7, which you have in  14 front of you, is -- importantly, if you look at  15 Recommendation 5.7, screening and counseling for  16 interpersonal and domestic violence, screening and  17 counseling involving elicitation of information from  18 women and adolescents about current and past violence  19 and abuse in a culturally-sensitive and supportive  20 manner to address current health concerns about safety  21 and other current or future health problems. We think  22 that will have major implications for women and girls</p>	<p>1 was such a wonderful spokesperson about the efficacy  2 of treatment and the importance of recovery. So both  3 legends in our field who will be missed.</p> <p>4 And thank you to Sharon for bringing that to our  5 attention.</p> <p>6 So now, we have one, two, three, four, five, six,  7 seven members present. I'd like to call for a motion  8 for formal consideration and approval of the minutes  9 for the March in-person meeting and the June phone  10 meetings. All right? So if all of you can see in  11 your folders, you have -- I don't know what their  12 folders look like, but we do have the minutes from our  13 past two meetings.</p> <p>14 Can you tell them where they are in [inaudible]?</p> <p>15 MS. GRAHAM: [Inaudible] after the Advisory  16 Committee.</p> <p>17 MS. ENOMOTO: So after the agenda and the bios --</p> <p>18 MS. GRAHAM: After the agenda --</p> <p>19 MS. ENOMOTO: -- you'll have the minutes for both  20 --</p> <p>21 MS. GRAHAM: -- and minutes.</p> <p>22 MS. ENOMOTO: -- meetings.</p>
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<p>1 in our systems.</p> <p>2 And hopefully, as we -- unfortunately, Dr.  3 Felitti is not here, but as we think about what the A-  4 Study has told us, the need for this kind of screening  5 and helping women and girls get services or attention  6 earlier, I think this will be a very important step  7 towards that. So you can see that there's other --  8 the other eight recommendations here. And we're just  9 very pleased to have been able to share that with you.</p> <p>10 I'm sorry. I think -- then, finally, I would  11 like to acknowledge the recent passing of two leaders  12 in the field of behavioral health with a specific  13 focus on women. One of them was Bernadine Healy, the  14 first woman Director of the National Institutes of  15 Health from 1991 to 1993. She championed studies that  16 overturned false assumptions about women's health.  17 And she also served as the first physician to lead the  18 American Red Cross. So she passed recently.</p> <p>19 As well as, many of you probably saw in the news,  20 that Betty Ford, you know, world-famous advocate for  21 women's rights, as well as for the treatment of  22 chemical dependency, passed away this year. And she</p>	<p>1 MS. GRAHAM: Uh-huh.</p> <p>2 MS. ENOMOTO: Were they sent out in advance, or  3 they're just getting them?</p> <p>4 MS. GRAHAM: We sent them out for [inaudible].</p> <p>5 MS. ENOMOTO: Right. Okay. So we've sent these  6 out, received comments, finalized them. And so, these  7 are the --</p> <p>8 MS. GRAHAM: The ones that have been certified  9 in-house. So we [inaudible].</p> <p>10 MS. ENOMOTO: Great. Okay. So these minutes  11 were certified in accordance with the Federal Advisory  12 Committee's Act, FACA, regulations. Members were  13 given the opportunity to review and comment on the  14 draft minutes. Members also received a copy of the  15 certified minutes. If you have any changes or  16 additions, they will be incorporated in this meeting's  17 minutes.</p> <p>18 So does anyone have any questions or concerns  19 about these minutes?</p> <p>20 [No response.]</p> <p>21 No? If not, may I have a motion to approve the  22 March/June minutes?</p>



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1 FEMALE SPEAKER: So moved.  
2 MS. ENOMOTO: Thank you, Velma.  
3 And may I, please, have a second?  
4 MS. SCOTT-ROBBINS: Second.  
5 MS. ENOMOTO: Thank you, Starleen. So moved.  
6 Wonderful. So we are keeping close to on time with  
7 our business. Thank you very much.  
8 And now, I'd like to turn the -- enough talking  
9 for me. I apologize. I'd like to turn it back over  
10 to you folks and get some updates from you. We have  
11 50 minutes for this session. But, you know, as  
12 always, this group tends to get into some lively  
13 discussions. So if you guys could keep it to, sort  
14 of, three minutes, two to three minutes of  
15 highlighting the issues and things that you're working  
16 on right now, particularly relevant that you'd like to  
17 bring to this table.  
18 I mean, Jean, you sort of mentioned, "Gee, I'm  
19 thinking about how does recovery apply to women, or  
20 what are the workforce issues for women," or, you  
21 know, something that is going on. The benefit of this  
22 group for me, and I think for one another, is that

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

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1 also ask mothers and their daughters and sons about  
2 the receptivity to the HPV vaccine series and to find  
3 out whether or not they were actually taken the  
4 vaccine, and if not, why. And we found that many --  
5 only -- I guess, less than 10 percent of our sample of  
6 412 families, half of whom were girls -- we targeted  
7 girls, and we targeted boys. But only 10 percent --  
8 less than 10 percent of them had begun the series with  
9 their daughters.  
10 And then, from the mothers who were young mothers  
11 in their twenties, none of them had begun the series.  
12 And we asked them why. And, not surprising to any of  
13 you, it was lack of access, uninformed about whether  
14 or not our 10-Care Insurance Program would pay for  
15 that, unsure of where to go in order to be able to get  
16 the vaccine series started with their daughters.  
17 And then, we asked if they knew about it.  
18 Eighty-five percent of them were aware. We asked  
19 where was their source of knowledge about the vaccine.  
20 And most of them indicated from magazines. So they  
21 had seen it in Essence. They had seen it in Ebony.  
22 But other than that, they had not been informed by

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

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1 knowing what to do now that they've been diagnosed  
2 with this disease, because they aren't having symptoms  
3 right now. It's almost like having diabetes with no  
4 symptoms. But they are infected.  
5 So I should stop now because I'm probably way  
6 over my moment of needing to talk about my work. But  
7 don't ask a researcher to talk about their work.  
8 [Laughter.]  
9 DR. McBRIDE MURRY: But I'll be more than happy  
10 to share other things with you. But there's some  
11 critical issues facing mothers and children in rural  
12 communities, and particularly the disenfranchised  
13 communities. And we're just not finding ways to do  
14 more than just finding out that they're in trouble.  
15 And so, my role is -- in my work that I do -- is to  
16 find ways to empower these communities to really  
17 promote their health in ways that they're able to  
18 manage it, based on the scarce resources available to  
19 them.  
20 MS. ENOMOTO: Great, thank you. I think you're  
21 allowed more than two or three minutes. This is your  
22 first time to be with us in person, so I think it's

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1 good for everyone to have some frame on what it is  
2 that you do and what's really important to you. So  
3 thank you.  
4 MS. BRISCOE: I am currently part of a pilot  
5 program that has been initiated in New Mexico, where  
6 we are -- the marriage of experiential education and  
7 the matrix model for intensive outpatient for youth  
8 and adolescents. Having kids sit through an IOP of  
9 the matrix model cycle educational -- kids starting to  
10 fall asleep, and including experiential education into  
11 that piece so that, as you all know, kids learn in  
12 different ways, not just being lectured.  
13 And so, having that team effort and finding the  
14 community and progressing from whether it be detox,  
15 transitioning them to intensive outpatient and being  
16 part of this experiential education, we're hoping that  
17 we can address the rising opioid addiction in youth and  
18 adolescents. There is an emerging population. In New  
19 Mexico, there was historically an inter-generational  
20 opioid dependence. But this emerging population of  
21 young people starting out with prescription drugs and  
22 then transferring to heroin because it's cheaper and

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1 easier to get, is an emerging population. So in order  
2 to address that, trying to think of different ways of  
3 how to treat youngsters and getting them engaged in  
4 treatment.  
5 MS. ENOMOTO: How are you seeing that play out  
6 for girls or girls and their moms?  
7 MS. BRISCOE: Including moms, because the matrix  
8 model does include the family. And so, team-building  
9 activities and going out into the Santa Fe Mountain  
10 Center to -- there's a lot of analogies that are used  
11 in the experiential treatment that are analogous to  
12 the challenges in life and how you address them, which  
13 is more powerful than just sitting and listening to a  
14 lecture or talked to about the dangers of drugs and  
15 alcohol.  
16 MS. ENOMOTO: But are you [inaudible]?  
17 MS. BRISCOE: Yes, including mothers and  
18 daughters and sons and mothers, all inclusive. But,  
19 yes, definitely, women and girls. Thank you.  
20 MS. SCOTT-ROBBINS: Yolanda, we're actually -- in  
21 North Carolina, as a part of our Administration for  
22 Children and Families grant, we utilized the matrix

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1 model as a part of a continuum that we put in place in  
2 a very rural county in North Carolina. We have 100  
3 counties. And one of our counties that is actually  
4 probably one of our most diverse counties in terms of  
5 race, it's one-third Lumbee Indian, one-third African-  
6 American, and a third Caucasian. And we put in place  
7 the Strengthening Families Program with Carol Kumfer.  
8 We put the matrix model with a gender-specific  
9 component to it, because it didn't actually have a  
10 very gender-specific piece for adults, and then,  
11 seeking safety. And that has worked really well,  
12 because we've been able to address also the cultural  
13 issues within that model. And so, we've worked with  
14 the matrix folks to, kind of, look at what that looks  
15 like in a community that has that level of diversity,  
16 particularly with women and families. So I'd love to  
17 hear more about what you're doing with the kids and  
18 the families.  
19 You mentioned the uniform block grant. And we  
20 are currently in the midst of completing the first  
21 phase of that block grant. And it's interesting,  
22 because for the very first time, it's asking for

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

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

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

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

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

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

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

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

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

17 MS. ENOMOTO: Congratulations.  
18 MS. SCOTT-ROBBINS: Thank you.  
19 MS. ENOMOTO: President Scott-Robbins.  
20 [Laughter.]  
21 MS. ENOMOTO: And thank you for the nod to Sharon  
22 and her fantastic work on the WASLI group. It really

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

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

12 MS. SCOTT-ROBBINS: Thank you.  
13 MS. ENOMOTO: I just want to touch on the point  
14 that you brought up about the -- which I forgot to  
15 mention earlier. And I apologize. But that in the  
16 uniform block grant applications, it has been a  
17 statutory requirement to have states report on their  
18 services to women who are pregnant and parenting. But  
19 it has not been a -- it's not a legal requirement for  
20 states to report the same data on the mental health  
21 side.  
22 But with the uniform block grant application, we

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1 are requesting that information. There is no penalty  
2 to a state who doesn't have the data. And the point  
3 really is not to penalize or catch people, but to give  
4 us an opportunity to plan for the future. And I think  
5 it will open some doors for us to talk about, I think,  
6 the conversation we have later today about gender-  
7 specific services across behavioral health. So what  
8 are we doing around gender-specific services in mental  
9 health for women who are pregnant and have a primary  
10 diagnosis of a mental illness? What are we doing  
11 around prevention for girls?  
12 And so, I appreciate you bringing that up. Thank  
13 you.  
14 Sharon?  
15 MS. AMATETTI: I just wanted to make one  
16 additional comment based on Yolanda and Starleen's  
17 reporting. About two years ago, we commissioned Gene  
18 Obert from the Matrix Institute to help us develop a  
19 women's-specific add-on to the matrix model program  
20 materials. And we just recently have gotten the  
21 deliverable on this, which is nine additional sessions  
22 of recovery support sessions on women's issues that

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1 she also pilot tested and got really very positive  
2 feedback on that. So that's going to be another tool  
3 that we're going to have available. And it should be,  
4 you know, ready for other communities to use before  
5 too long. So I'm glad that you're interested in that  
6 and that you're trying to put together pieces. And we  
7 saw a need for that as well.  
8 MS. ENOMOTO: All right. Well, we appreciate Dr.  
9 Felitti making the long trek here. I know it was a  
10 journey that started somewhere on Saturday afternoon,  
11 and it's culminated in his arrival mid-morning in D.C.  
12 on Monday.  
13 So we appreciate your trials and tribulations of  
14 the journey. But your presence is valuable to us. So  
15 if you would like to give us an update on what's  
16 happening with you.  
17 DR. FELITTI: I'm Vincent Felitti. I'm an  
18 internist. I've been at Kaiser Permanente in Southern  
19 California since 1968, and for the past 30 or 35  
20 years, been running a large preventive medicine  
21 operation there.  
22 I suppose I'm here because of the ACE Study, the

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1 Adverse Childhood Experiences Study. Robert Anda and  
2 I at the CDC and I are the co-principal investigators  
3 of a study of 17,000 people that's been going on for  
4 the past 16 years or so, matching 10 categories of  
5 adverse life experience in childhood against the large  
6 array of biomedical, mental health, social malfunction  
7 outcomes in life, on average, about 50 years later. I  
8 suppose I could summarize the several interests that I  
9 have by saying that they would all fit into the idea  
10 of trying to move primary care medical practice from  
11 its current symptom-reactive mode to the more  
12 comprehensive style it was always conceived for it,  
13 but never attained.  
14 MS. BENAVENTE: Good morning. I've been working  
15 in the field of prevention for about 28 plus years,  
16 primarily with the Department of Mental Health and  
17 Substance Abuse on Guam, and also with a private firm  
18 that worked with Headstart families and children. The  
19 interest that has been developing over the past five,  
20 six years for the region, for the Pacific Islands, is  
21 around the work that was initiated with the funding  
22 that came with specific dollars. And we've come to

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1 learn how useful the process is for helping us to  
2 truly hone in on what's important in the community,  
3 based on data and what the community is telling us and  
4 how we can truly empower community people to deal with  
5 the issues that children, families, girls, and women  
6 are faced with on a daily basis.  
7 I was elected as the Vice President for the  
8 Pacific Behavioral Health Collaborating Council, which  
9 just means more work on top of my primary job. But  
10 it's all exciting work, because as Pacific Islander  
11 people, we have a lot of strengths culturally that we  
12 want to enhance. And we want to learn from our  
13 traditional practices, such as dealing with the high  
14 rate of non-communicable diseases and what does this  
15 mean with behavioral health care work.  
16 And things like going back to letting young women  
17 or moms, new moms know that breastfeeding, for  
18 example, is okay, and bottle feeding with formula  
19 doesn't necessarily mean a status of wealth, for  
20 example, which is a lot of misperception that if you  
21 move into purchased formula, then that means that  
22 you're probably more well-off than the woman who

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1 decides to breastfeed.  
2 So in thinking about women and girls' issues and  
3 cultural practices, the work that we have is to take a  
4 look at how you collect real data as told to us by our  
5 community and make it make sense and make sure that  
6 the funding that may be available to help us achieve  
7 our goals and objectives for healthier Pacific Island  
8 community is really done well and done quickly. So we  
9 are still struggling with collecting data, building  
10 relationships with our community folks, and seeing  
11 that the data that you send to us will be used to  
12 improve lives.  
13 And it's not because researchers just want to  
14 publish about it, and then we don't do anything about  
15 the information provided. So the Pacific Island  
16 Region is probably more united now in terms of  
17 developing strategic plans and approaches to serve the  
18 broader Pacific Region in Micronesia, American Samoa,  
19 and the Marshall Islands and so forth. So thank you.  
20 MS. ENOMOTO: Bobby, do you have any thoughts  
21 about -- are you part of the team that works on the  
22 block grant applications?

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1 MS. BENAVENTE: Yes.  
2 MS. ENOMOTO: I know Kiti also, sort of -- well,  
3 she used to have a role. I don't know that she has a  
4 role anymore. But I know that we had a sense that,  
5 sort of, the same people working on the different  
6 applications in some of the places.  
7 MS. BENAVENTE: We're the same people working on  
8 everything.  
9 MS. ENOMOTO: Yeah.  
10 MS. BENAVENTE: We're just wearing different  
11 hats.  
12 MS. ENOMOTO: How is the uniform application  
13 working for folks?  
14 MS. BENAVENTE: I think it makes a whole lot of  
15 sense, that we need to start putting in writing  
16 applications that reflect true collaboration and  
17 integration of services so that we're maximizing on  
18 the funds and we're all focused together, whether it  
19 be, you know, the CMH portion or SAPT. It's the  
20 technical writing and the division of labor and how  
21 the government is set up. So we're trying to take  
22 care of local policies and protocols in order to make

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1 sure it supports a uniform application that doesn't  
2 cancel each other out, but really makes it a solid  
3 approach to deal with all the issues.  
4 I know for Guam, we've opted not to do a joint  
5 application this coming year and plan better for next  
6 year. I'm a prevention person. I work the SAPT block  
7 grant, and I don't want CMH's to hold me up,  
8 truthfully.  
9 [Laughter.]  
10 MS. BENAVENTE: Don't tell them I said that.  
11 Take that off the minutes.  
12 [Laughter.]  
13 MS. BENAVENTE: But, you know, sometimes it's,  
14 kind of, like, cut-throat. You know, like, you just  
15 get it together, because prevention is really on fire.  
16 And, you know, you're slowing us down. But, no. But  
17 I'm really excited. The whole region is really  
18 excited about prevention being a top priority in the  
19 SAMHSA initiatives. Some of the things that are  
20 talked about with integrating and talking and sharing  
21 knowledge and identifying that, you know, top one,  
22 two, three priorities that serves the broader

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1 community in very targeted ways. Women and girls --  
2 in our culture, we have a very special role and  
3 responsibility on top of having to deal with a lot of,  
4 you know, recovery issues and trauma issues in order  
5 to get better ourselves in order to help our families.  
6 And so, one of the things that we're looking at  
7 that the community has said to us is with addressing  
8 non-communicable diseases in the islands,  
9 breastfeeding is important. Let's get back to basics.  
10 We have herb doctors that are specialists in treating  
11 babies and women. And we've, sort of, put that on the  
12 wayside and gone with traditional Western doctors in  
13 clinics and all that. But now, young women, young  
14 mothers are seeing the value of taking their two-week-  
15 old baby or one-month-old baby to an herb doctor for  
16 traditional herbs to be, you know, given the child and  
17 then the massages with oils and all that.  
18 We had healthy babies then, and we're not having  
19 as healthy babies now that rely on, you know,  
20 antibiotics so quickly for treating a cold as opposed  
21 to herbs and massages. So those are some things that  
22 we're looking at for creating a balance, for choices

<p style="text-align: right;">Page 50</p> <p>1 and options that women and girls could look at.</p> <p>2 MS. ENOMOTO: I'd like to give Jean a chance to</p> <p>3 step out, but I'd like to give you a chance to give an</p> <p>4 update on what you're working on and thinking about,</p> <p>5 if you want to talk about the presentations for today</p> <p>6 or tomorrow, that would be great, too.</p> <p>7 DR. CAMPBELL: Great. I'm going to be</p> <p>8 apologizing for ducking in and out, I think, for the</p> <p>9 next three days. But I'll do my best here.</p> <p>10 When I left the room, I was giving an update to</p> <p>11 the Consumer Subcommittee on a major conclusion of the</p> <p>12 research I've been conducting for over a decade, that</p> <p>13 one of the documents, the Consumer Operated Service</p> <p>14 Evidence-Based Practices Kit, has been released by</p> <p>15 SAMHSA and is now on their Web site. And we're</p> <p>16 beginning a dialogue with SAMHSA about how that</p> <p>17 document's more like a tome -- it's this thick -- will</p> <p>18 be disseminated in the field.</p> <p>19 And I was just quickly looking here over some of</p> <p>20 our findings from the -- the toolkit came out of a</p> <p>21 multi-site study that began in 1996. And I was the</p> <p>22 principal investigator of the Coordinating Center.</p>	<p style="text-align: right;">Page 52</p> <p>1 this finding, which led to the recognition that these</p> <p>2 are evidence-based practices, was a greater</p> <p>3 understanding and contribution to the scientific field</p> <p>4 about recovery and the role of the components of</p> <p>5 recovery. And I'm going to address a little of that</p> <p>6 this afternoon when we talk about it.</p> <p>7 But I was looking at -- I happen to have the</p> <p>8 draft for site services on the well-being construct.</p> <p>9 And we looked at covariates. And so, we had some</p> <p>10 mention of women. I mean, we did do demographics. And</p> <p>11 there was some interesting findings. But, as I</p> <p>12 mentioned before, the focus within consumer studies is</p> <p>13 much more on the identity of being a mental health</p> <p>14 consumer rather than of being a person of color, being</p> <p>15 a younger person. You know, that those issues of</p> <p>16 gender, age, status, income have been found</p> <p>17 consistently to not be as significant.</p> <p>18 They've overwhelmed by the identity of being a</p> <p>19 mental health consumer. But I thought I would share</p> <p>20 these. And it would be interesting to start to get</p> <p>21 some feedback of what you would make of these. As I</p> <p>22 said, I mean, the number one thing we found, that the</p>
<p style="text-align: right;">Page 51</p> <p>1 There were eight sites throughout the United States of</p> <p>2 consumer operated service programs, which are programs</p> <p>3 that are administratively administered -- they are</p> <p>4 administered by mental health consumers themselves.</p> <p>5 They have self-help [inaudible] as their prime</p> <p>6 philosophical approach.</p> <p>7 And this was over a \$20 million study. It was</p> <p>8 very rigorous. It was randomized control trial, too.</p> <p>9 What our investigation led to a study of these</p> <p>10 programs in terms of their effectiveness to promote</p> <p>11 well-being amongst participants when offered as an</p> <p>12 adjunct to traditional mental health services. And</p> <p>13 our findings showed that, indeed, they do</p> <p>14 significantly improve the well-being of the</p> <p>15 participants who attended consumer operated service</p> <p>16 programs as an adjunct to traditional mental health</p> <p>17 services. And the more they participated in consumer</p> <p>18 operated services, the higher their well-being was.</p> <p>19 And our end for that study was 1,827, so it was</p> <p>20 the largest study ever done of these programs. And</p> <p>21 not only was it the largest, but it was the most</p> <p>22 rigorously conducted. And interestingly, along with</p>	<p style="text-align: right;">Page 53</p> <p>1 well-being construct was negatively related to being</p> <p>2 discriminated against and positively related to being</p> <p>3 connected and accepted within a social network. So</p> <p>4 those were some of the -- that was one of the key</p> <p>5 findings.</p> <p>6 On average, men had a higher well-being score</p> <p>7 than women. But this gender difference seemed to be</p> <p>8 due to marital status. That's what we found, that</p> <p>9 well-being scores tended to be higher for people who</p> <p>10 had never been married, which were more likely to be</p> <p>11 men.</p> <p>12 FEMALE SPEAKER: Say that again.</p> <p>13 DR. McBRIDE MURRY: That goes a little bit</p> <p>14 counter to studies of marriage and being beneficial to</p> <p>15 men.</p> <p>16 DR. CAMPBELL: Yes, exactly.</p> <p>17 MS. ENOMOTO: Jean, could you repeat that?</p> <p>18 DR. CAMPBELL: On average, men had a higher well-</p> <p>19 being score than women. But this gender difference</p> <p>20 seemed to be due to marital status. Well-being scores</p> <p>21 tended to be higher for people who had never been</p> <p>22 married, most likely to be men. The men in the COS</p>

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

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

22 And one of them is being a single parent. And

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1 when you think about being a single parent and so that  
2 married thing suggest, since most of the people who  
3 had been married and were no longer married, that that  
4 may have been a difficult time, during marriage.

5 Marriage wasn't seen as a comfort, but was a  
6 complication, a complication in life.

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

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

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

15 DR. CAMPBELL: Yes.

16 MS. ENOMOTO: And that was going on  
17 simultaneously with the COS. So I'm wondering if you  
18 guys had trauma measures in the COS. But [inaudible]  
19 --

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

22 MS. ENOMOTO: Yeah.

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

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

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

12 MS. ENOMOTO: Referral and treatment.

13 DR. CAMPBELL: Treatment.

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

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

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

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

10 And I think it got all mushed together. So,  
11 really, we were starting -- I was starting to try to  
12 break some new ground within our proposal.

13 Unfortunately, SAMHSA didn't have the money to fund  
14 that, so it was withdrawn. But the benefit for me was  
15 being able to learn a lot about trauma. And I was  
16 particularly excited because we had integrated within  
17 that -- I found some short measures. And I had  
18 suggested that we study -- we had this scale of well-  
19 being. And then, we had -- and I know it's very  
20 simplistic -- but a community coping scale. And we  
21 were going to look at those relationships in terms of  
22 trauma within that study.

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1 Those sort of things were not even available when  
 2 we did COS.  
 3 MS. ENOMOTO: Right. They were parallel  
 4 programs. Right? So we didn't have good measures of  
 5 --  
 6 DR. CAMPBELL: So did you use the word trauma  
 7 when you were doing the Women in Violence?  
 8 MS. ENOMOTO: It was WCDB, so it was Women Co-  
 9 Occurring Disorders and Violence. It was --  
 10 DR. CAMPBELL: But, I mean, the concept hadn't  
 11 really --  
 12 MS. ENOMOTO: You know, we actually -- we had  
 13 some of the early A-Study papers. And so, we had  
 14 started -- I mean, Susan Salasin was talking -- has  
 15 been talking about trauma for decades.  
 16 DR. CAMPBELL: Yeah.  
 17 MS. ENOMOTO: And so, we were talking and  
 18 thinking about it. But I think it was that study,  
 19 which was in the same cohort of demonstration programs  
 20 that SAMHSA did with the COS study and the support  
 21 employment studies and the aging Prism-E Study.  
 22 DR. CAMPBELL: Yeah.

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1 MS. ENOMOTO: I think all four of those programs  
 2 that we did during that time really -- each of them  
 3 advanced the fields in their specific domain. We are  
 4 still at the point of having -- we still have an  
 5 opportunity to benefit from cross-fertilization of  
 6 those different studies. So COS was coming out with  
 7 its, you know, very important findings about the  
 8 importance and the value of consumer operated  
 9 services. You know, Judith Cook and the Support  
 10 Employment Study had similar findings.  
 11 DR. CAMPBELL: Yeah.  
 12 MS. ENOMOTO: How do we then -- and the  
 13 Women in Violence Study was also incredible and has  
 14 really been a game-changer in terms of the field and  
 15 trauma-informed care. How we get those things to  
 16 cross over, I think, is our next challenge. So how do  
 17 we bring the consumer operated piece over to the  
 18 trauma-informed care piece? How do we bring support  
 19 and employment and, you know, to consumer operated? I  
 20 mean, all that, I think, is quite an opportunity.  
 21 DR. CAMPBELL: Well, you know, in the mix of  
 22 doing all those multi-site studies, at the very

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1 beginning -- or, I guess, it was mid-stream, because  
 2 our study was one of the last -- that they brought  
 3 together researchers and P.I.s from the different  
 4 studies and had this giant meeting. I mean, I still  
 5 have the binder for that.  
 6 And people talked about their results. There  
 7 might be some consideration in the future to think  
 8 about bringing those people together again to talk  
 9 about the cross-fertilization.  
 10 MS. ENOMOTO: Yeah, yeah, yeah, yeah.  
 11 DR. CAMPBELL: But this piece -- you're right, I  
 12 think, does have an implication in terms of trauma. I  
 13 mean, we can't totally, outside of saying trauma is a  
 14 national epidemic -- but we can say that life is not  
 15 easy for people with psychiatric conditions on top of  
 16 -- that's why I read the discrimination. Just one  
 17 example of how difficult it is for people with  
 18 psychiatric problems and their life narrative within  
 19 the community and what stresses and how that affects  
 20 some of the other, what we think, are things that help  
 21 sustain one's well-being and create resilience within  
 22 the community.

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1 MS. ENOMOTO: Right. Well, thank you very much  
 2 for that. I mean, I think those are really important  
 3 findings. And I think we'd all benefit from talking  
 4 more about that in the future.  
 5 DR. CAMPBELL: Just one other thing. So could we  
 6 just take a couple minutes for people to provide some  
 7 feedback on workforce and development from the  
 8 perspective of this group?  
 9 MS. ENOMOTO: Okay. Or perhaps we can also  
 10 caucus a little bit at lunch.  
 11 DR. CAMPBELL: Okay.  
 12 MS. ENOMOTO: And have some conversation about  
 13 that. People would be willing to have some  
 14 conversation. Okay?  
 15 All right. Thank you very much, Jean.  
 16 And to our members for giving updates. Okay.  
 17 Johanna, do you have an update for us?  
 18 MS. BERGEN: Thanks, Kana.  
 19 Well, I had some things I'll share later this  
 20 afternoon. But the thing that I have been working on  
 21 or able to present at a conference recently this  
 22 summer was [inaudible] alternative study done at the



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

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

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

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

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

9 Thank you, Johanna.

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

15 MS. AMATETTI: Okay, thank you very much, Kana.  
16 I just wanted to refresh the memories of this  
17 committee about what the SAMHSA Women's Coordinating  
18 Committee is and does. We call ourselves SWCC, and  
19 it's a SAMHSA-only membership. So it's just persons  
20 from throughout all of our centers and offices that  
21 participate in the committee. It's been around for  
22 about 12 years now. Really, the function is to do the

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

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

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

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

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

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

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

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1 you to know about their interests or work that they're  
 2 doing, just a little tidbit so that you have a flavor  
 3 of who's participating in this group.  
 4 And I don't know if -- can we have them come up  
 5 to the table, maybe as I call their name.  
 6 And, Velma Montgomery, you're up already. Would  
 7 you like to be the first person to join us at the  
 8 table?  
 9 MS. MONTGOMERY: [Inaudible] where did you want  
 10 me to go?  
 11 MS. AMATETTI: Just at the microphone.  
 12 MS. MONTGOMERY: Okay. At the microphone?  
 13 MS. AMATETTI: Yeah, thank you.  
 14 MS. MONTGOMERY: This is what I get for  
 15 introducing myself first at our first meeting. Thank  
 16 you. I'm Velma Montgomery. Good morning. I'm in  
 17 CSAP in the Division of Development Systems -- System  
 18 Development. But that branch division focuses a great  
 19 deal on research for all of CSAP, whereas there are  
 20 five of us that are the Materials Development Group  
 21 team. And we do a lot of different kinds of things,  
 22 including a really important program on under-age

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1 drinking prevention as well as working with states  
 2 doing all sorts of speeches, writing blogs,  
 3 publications through the print process. So we're kept  
 4 really busy.  
 5 I am the -- I don't know the formal title -- the  
 6 Project Manager for the Publications and the Web for  
 7 FASD. And our Web is really -- if you haven't been to  
 8 it -- something that is extraordinary because the  
 9 database is so huge. And we have magazine. We have  
 10 journals as well as newspaper articles, both pro and  
 11 con, on drinking. And we have just an amazing amount  
 12 of information.  
 13 I will add a handout to the handout table,  
 14 because it has the information about the Web. And  
 15 you'll have all the information there that you need  
 16 for the addresses and the kinds of materials we've  
 17 developed and the amount. One of the things we have  
 18 found is that our materials are gaining in popularity  
 19 as the interest in the subject goes up. So we have  
 20 trouble sometimes keeping them plished up there.  
 21 But everything that we do is downloadable, so you have  
 22 access to everything we have.

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1 We also sponsor trainings across the country on  
 2 FASD. We have two really top-notch trainers as well  
 3 as support research of programs that work with both  
 4 people who have FASD and their families. So we're  
 5 proud of the whole range of things that we do, in  
 6 addition to having the Center for Excellence and a  
 7 variety of other things that people are doing.  
 8 I'm sure you already know the stats. I'm  
 9 concerned about giving those again, particularly  
 10 because you have another speaker today at 2:30. So  
 11 I'll just do the COS a little bit.  
 12 It's an estimated \$6 billion a year to provide  
 13 services for people with FASD. And it's \$2 million a  
 14 lifetime for somebody who has FASD. One percent of  
 15 the population -- and it outranks the combination of  
 16 autism and Downs Syndrome. So there's so much  
 17 heartbreak around this. The strength of these people  
 18 is amazing. They're caring, creative, determined,  
 19 eager to please, which is one of the problems, because  
 20 they can get talked into getting into trouble because  
 21 they're eager to please friends and people.  
 22 I think the main thing to remember is that FASD

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1 is 100 percent preventable. And that is the saddest  
 2 thing that I know about. And leaving with the saddest  
 3 thing, I'll turn it back.  
 4 MS. AMATETTI: Okay, thank you very much, Velma.  
 5 So all things Fetal Alcohol Spectrum Disorder, if  
 6 you need a resource person, Velma will help you or  
 7 find somebody who can, if she's not the right person.  
 8 But thank you very much, Velma.  
 9 Now I'd like to turn it over to Claudia Richards.  
 10 MS. RICHARDS: Hi. I'm with the Center for  
 11 Substance Abuse Prevention. And I've been with the  
 12 center for about six years as the Branch Chief for the  
 13 Minority AIDS Initiative, which provides substance  
 14 abuse and HIV prevention services across the country,  
 15 working with community-based organizations. We have  
 16 at CSAP approximately 148 grantees across the country  
 17 that receive funding from CSAP.  
 18 Specifically, we have gender-specific programs.  
 19 There are not a large number of gender-specific, but  
 20 we do have a few gender-specific programs that focus  
 21 on girls, youth, and adults. In addition, prior to me  
 22 coming to CSAP, I was the Women's Coordinator for the

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1 block grant, the Substance Abuse Prevention and  
2 Treatment block grant. And in that capacity, we were  
3 quite instrumental in terms of having presence in this  
4 work group as well as participate in a number of  
5 national events and conferences and also in working  
6 with state alcohol and drug abuse directors across the  
7 country to ensure that they were in compliance with  
8 the woman's set-aside requirements, as Starleen knows.  
9 I was their project officer before for North  
10 Carolina. And that was a very good effort on the part  
11 of working with the block grants since 1991. I was  
12 one of the first project officers hired at SAMHSA.  
13 And when we launched a woman's set-aside, it was very  
14 enlightening to see a transformation or movement in  
15 the field. Because, as you know, previously there  
16 were very little to no gender-specific services  
17 relative for substance abuse and targeting  
18 specifically women, pregnant women, and women of  
19 dependent children.  
20 So I have a passion for this work, as you know.  
21 I'm a social worker, licensed independent chemical  
22 social worker by profession. And I have worked with

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1 many, many providers across the country that provide  
2 gender-specific services over the past 20 years at  
3 SAMHSA.  
4 Again, my interest is to help this group be  
5 cognizant of the health disparities, looking at HIV  
6 disease burden, not just in the urban setting, but  
7 also in the rural setting. Coming across and doing  
8 site visits, it's very obvious that we need to begin  
9 to think outside the box in terms of how we're going  
10 to deal disparities of care when it come to access for  
11 HIV testing services, early diagnosis of minority and  
12 persons who are at risk for substance abuse and mental  
13 illness to ensure that these individuals are access to  
14 care and services and testing.  
15 So I'm just going to stop there, because I can  
16 just go on and on.  
17 MS. AMATETTI: Okay. All right. All right.  
18 Well, you know, why don't we move along.  
19 Bev, do you want to step up to this mike?  
20 MS. FALIK: That one over there?  
21 MS. AMATETTI: Yeah, we'll just find one  
22 [inaudible] in the way.

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1 And, maybe, Mary, you can join her up at the  
2 mike.  
3 So, Bev?  
4 Bev is another CSAP colleague who, actually, I  
5 think you met the last time we met in person.  
6 MS. FALIK: Yes.  
7 MS. AMATETTI: You gave a report. And Bev's here  
8 today, too. Okay.  
9 MS. FALIK: So I'll be brief, because you heard  
10 me last time. But I'm really glad to be here. And  
11 you've already impacted something we're going to do  
12 this year just from sitting here this morning. So  
13 thank you in advance.  
14 As I said, I'm the Project Officer, AKA, COTAR.  
15 That's our new term. Contracting Officer Technical  
16 Representative is the new term for Project Officer of  
17 a contract. And so, I'm the COTAR of the data  
18 analysis contract at CSAP.  
19 And the short version of what we do is -- we do  
20 many things. But the short version is that we look at  
21 national and state trends in different prevention-  
22 related factors. And we examine our program

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1 effectiveness. And we do special reports. Those are  
2 the types of analyses we do, as well as ad hoc  
3 analyses. And I think I mentioned to you last time --  
4 and it is continuing -- that you do find gender  
5 differences in national trends related to substance  
6 abuse and related risk and protective factors.  
7 Not all of them, but, for example, this year, I  
8 noticed, particularly related to under-age drinking,  
9 heavy drinking, binge drinking, we're finding that the  
10 males are improving, but the females are not. And so,  
11 you know, that's of a concern. And that provides  
12 information to CSAP and SAMHSA about, well, what  
13 should we do about it, what could we do about it, what  
14 could we share with the states to do about it. So  
15 that's one of the important things that we do.  
16 It's kind of like the step one in a SIP. It's  
17 our needs assessment for the nation, you know, what's  
18 going on. And we look at -- and Charlene may actually  
19 talk about it when she comes. We look at NSDUH, but  
20 we also look at other data sources like Honoring the  
21 Future and Wire B.S. and BRFSS and stuff, because  
22 sometimes they're not totally aligned. So that's also

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1 very interesting. So that's the first thing we do is  
2 we do this needs assessment and look at gender  
3 differences there.  
4 Then we look at program effectiveness. And what  
5 I showed you last time was the differences in program  
6 effectiveness that we found in some cases. And it was  
7 consistent every year. And so, that precipitated  
8 something on our part about, you know, what should we  
9 be doing differently. And we feed this information  
10 back to the programs.  
11 Now, interestingly, I just got this year's  
12 analysis of our program effectiveness. And it is not  
13 so blatant. So there are very few gender differences  
14 this year that I could see. So I don't know if this  
15 year's an aberration or if programs have used this  
16 information and improved the targeting of, you know,  
17 different kinds of gender approaches. I don't know.  
18 We have to look into it. So that was kind of  
19 interesting to me.  
20 And the other thing that we do is we do special  
21 reports. And this year, we are doing special reports  
22 on gender differences in program effectiveness,

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1 because we are going to be looking at this in-depth.  
2 Right now, we have only been able to see a difference.  
3 But we haven't had enough resources to examine why  
4 what was going on. Did this work, and this not work?  
5 Or, you know?  
6 So this is the year that we're able to do that.  
7 And I'm very excited about it. And the reason I'm  
8 saying you helped guide our work is that we hadn't  
9 been thinking of looking at in terms of rural and  
10 urban. But I wonder if that's a factor. You know? I  
11 wonder if there are not enough resources in rural  
12 areas to do that kind of work. I don't know. But  
13 maybe that's one of the ways we should do the  
14 analysis. So thank you. And any other, you know,  
15 recommendations you have -- we're early on, we haven't  
16 actually begun. So I'd be delighted to hear.  
17 MS. AMATETTI: Okay. Thank you so much, Bev.  
18 Jen is over there, Jen Oppenheim.  
19 MS. OPPENHEIM: Okay. Good morning. My name is  
20 Jennifer Oppenheim. I am new to the committee as of  
21 about a month ago. But I am -- in the Women's  
22 Committee at SAMHSA. I'm very excited to have joined.

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1 And I have to apologize. I would love to be here all  
2 day today. My grantees are all coming together  
3 tomorrow, so I'm in a frenzy. So I did want to be  
4 here for a little bit. But I look forward to being  
5 here for the entire time in the future.  
6 FEMALE SPEAKER: [Off-mike.]  
7 MS. OPPENHEIM: Yes. I certainly will.  
8 I am in the Center for Mental Health Services in  
9 the Mental Health Promotion Branch. And I'm  
10 Coordinator for a program called Project Launch, which  
11 is focused on young children and promoting the healthy  
12 development of young children and their families and  
13 communities, focusing particularly on kids from birth  
14 or prenatally through age eight and with the ultimate  
15 goal of kids really entering school ready to learn and  
16 able to succeed and trying to prevent some of the  
17 behavioral health and health issues that other people  
18 at SAMHSA are struggling with.  
19 I did want to say, actually, my background is as  
20 a clinical psychologist. And I have a long-standing  
21 interest in women's issues. I've done a lot of work  
22 with both child and adult sexual abuse survivors. I

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1 don't think I mentioned this in the committee. My  
2 dissertation was on women and courage. So I bring a  
3 lot of interest in women's issues.  
4 But on the committee, I think, I hope to bring  
5 expertise on child and family issues and the  
6 perspective of thinking, in terms of my program, about  
7 particularly parenting and women's health and well-  
8 being and the impact of that on young kids. Because I  
9 think the research is definitely there in terms of,  
10 you know, with maternal depression, for example, and  
11 the impact of that on children's functioning and  
12 healthy development and all kinds of -- there's a lot  
13 we know about attachment and the outcomes for that for  
14 young kids.  
15 So Project Launch has five core strategies that  
16 we focus on. And I'm not going to go through each of  
17 them, but they really -- the idea is really to be  
18 looking across all the systems that serve young kids  
19 and families and to be increasing awareness about  
20 social, emotional and healthy development in those  
21 systems. And I think there's a lot of focus for me  
22 and for our program on women's health and women's

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

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

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

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

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

16 MS. AMATETTI: Thank you very much, Jennifer.  
17 Mary McCann?

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

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

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

8 The thing that I am very excited about regarding  
9 the block grant is that it requires every state and  
10 every territory to have specialized services for  
11 pregnant women and for women with dependent children.

12 And it goes -- the regulations go into some detail  
13 about what those services must include. And first of  
14 all, they require for the family to be treated as a  
15 unit, and, if at all possible, for children to be  
16 admitted to treatment at the same time as the mother.

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

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

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

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

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

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

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

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1 fetus.

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

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

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

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

22 MS. MATSON: Center for Behavioral Health

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

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

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

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

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

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

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

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

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

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1 colleagues for coming down this morning and saying  
 2 just a few words. And I think with that, we'll go to  
 3 a 15-minute break and come back at 11.  
 4 [Break.]  
 5 MS. ENOMOTO: All right. We're going to try to  
 6 get started. We are very fortunate to have today the  
 7 newly-anointed Deputy Director of the Center for  
 8 Behavioral Health Statistics and Quality, Dr. Charlene  
 9 Lewis. I think it came to Sharon's attention that  
 10 CBHSQ actually does a lot of really wonderful work, as  
 11 has been mentioned before, in looking at gender  
 12 differences across the rich data sets that SAMHSA  
 13 possesses. And so, Charlene has agreed to do a little  
 14 bit of a highlight or an overview of some of the  
 15 multiple surveys that we manage and the analysis and  
 16 what we've learned about the behavioral health of  
 17 women and girls.  
 18 So I think she's going to start -- you're going  
 19 to start with doing an overview of what our national  
 20 surveys are, so you have a sense of where we're  
 21 getting our data and then, what the data are telling  
 22 us. So with that, we'll let Dr. Lewis start.

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1 DR. LEWIS: Can you all hear me if I don't use  
 2 this?  
 3 MALE SPEAKER: No, you need to use that.  
 4 DR. LEWIS: I need to use it? All right. I can  
 5 take direction.  
 6 First of all, I want to thank you all for  
 7 inviting me today. This is -- I don't get to go out a  
 8 whole lot these days. We're very busy trying to build  
 9 our center, which is a full-time job in and of itself.  
 10 So, for me, this is a real treat to get to talk to  
 11 people in the field. And I'm hoping that you all will  
 12 talk more than I do. I have very few slides, and I  
 13 want to go through them relatively quickly. But I'm  
 14 very interested in the kinds of things that you would  
 15 find most interesting and the forms in which you would  
 16 find them to be the most interesting.  
 17 Not everybody has the leisure to read the peer  
 18 review, the literature, and divine from it some useful  
 19 nugget to apply to their own particular circumstances.  
 20 So I hope you'll keep that in mind as we go along  
 21 here.  
 22 And, thanks to Katy, I have this remote control

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1 thing, which works perfectly. A quick review of our  
 2 major studies -- and before I start, I just want to  
 3 mention that every one of our major surveys is  
 4 currently under some degree of being redesigned for a  
 5 variety of reasons. NSDUH is a survey that most  
 6 people are familiar with. It's an annual survey.  
 7 It's in the field 51 weeks out of every 52. It is a  
 8 face-to-face interview of 67,000 people conducted  
 9 annually.  
 10 The people in the survey are selected on the  
 11 basis of several characteristics. One is their  
 12 ability to represent the state in which they reside.  
 13 The second is their ability to represent the country  
 14 in which they reside. The third is to represent their  
 15 age groups.  
 16 One-third of those 67,000 respondents are between  
 17 the ages of 12 and 17. Another third are 18 to 25.  
 18 And the remaining one-third are 26 and older. The  
 19 survey covers everything you can squeeze into one  
 20 hour. An hour is about as long as you can expect  
 21 anybody to sit still and answer questions.  
 22 We have a fairly high response rate because we

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1 have instituted incentives for people to sit down and  
 2 let an interviewer into their home. The survey is  
 3 both anonymous and confidential. It's done using an  
 4 audio cassette technique where the respondent gets  
 5 earphones and a laptop. The interviewer never sees  
 6 the answers to any of the questions. So the data are  
 7 as objective as we can make them.  
 8 The second major survey activity is TEDS, our  
 9 Treatment Episode Data Set, which is an annual  
 10 compilation of state administrative records on who is  
 11 entering treatment. TEDS data are admissions-based,  
 12 meaning they are tagged to a person, but they are --  
 13 there are more admissions than there are people,  
 14 because a person may be admitted to treatment multiple  
 15 times over the course of a year.  
 16 We collect currently just under 2 million records  
 17 a year in TEDS for admissions and a near comparable  
 18 number for discharges. We then take those two sets of  
 19 information and wed them to each other so we have a  
 20 complete episode of care from admission to discharge.  
 21 N-SSATS is one of my personal favorite surveys.  
 22 It is an annual census of all of the known and

<p style="text-align: right;">Page 90</p> <p>1 approved, accredited, or otherwise recognized  2 substance abuse treatment services facilities in the  3 country. There are over 17,000 of them. And they  4 respond to a -- I think of it as a relatively brief  5 questionnaire, which covers the kinds of people that  6 they treat, the kind of services that they offer, the  7 kinds of payments that they accept from their clients.  8 And it's used as the background to the substance  9 abuse treatment locator. All the information that you  10 see on that locator when you go in to look for a  11 facility that's appropriate for a client comes from  12 this survey and from the weekly updates that get done  13 to the locator.  14 Those of you in either substance abuse or mental  15 health know that there are changes all the time.  16 There's a particular turbulence, whether it's just a  17 phone and a fax number or a new project director or a  18 facility is merging or splitting. There's a lot of  19 information that needs to be transferred in order to  20 keep the locator running and to be as accurate as  21 possible. That survey is the core behind that  22 locator.</p>	<p style="text-align: right;">Page 92</p> <p>1 important physiologic implications for the  2 intersection of behavioral health and physical health.  3 Women occupy a variety of societal roles. We'll  4 talk a little about two of those roles as I get into  5 this. We look at racial and ethnic differences. And  6 when we can, we delve more deeply into the geographic  7 differences that might feed into some of these other  8 differences.  9 I was very privileged a few years ago to sit in a  10 presentation by a social demographer from the state of  11 Washington. And she had done a very, very careful  12 analysis of urban and rural Mexican women in the state  13 of Washington and the different substances they used  14 and the different pathways that they chose to get into  15 treatment for their addictions.  16 I was absolutely fascinated. I'm dying to  17 continue to expand on ideas like that of how geography  18 feeds into the services that are available, the  19 substances that are available, what the intersection  20 is between distance and accessibility, whether it's  21 mental health treatment or substance abuse treatment.  22 We also sometimes get a chance to deal with some</p>
<p style="text-align: right;">Page 91</p> <p>1 Finally, we have the drug abuse warning network,  2 which is a bit of a misnomer. This is a survey in a  3 nationally-representative set of hospitals in their  4 emergency departments. The hospitals are selected,  5 again, for two reasons: one, for their ability to  6 represent the metropolitan area in which they are  7 found, and there is another panel that runs with these  8 metropolitan samples, which gives us a national  9 perspective on who's showing up in emergency rooms,  10 what kind of people they are and what drugs are on-  11 board when they come to the emergency room.  12 And we have a very specific protocol for how we  13 collect drug-related emergency events, which I'm not  14 going to go into. I'm just going to give you some of  15 the results from what we've found.  16 With that in mind, when we sit down to plan  17 analytic work, we like to focus on the heterogeneity  18 of women. Women are not some amorphous planned group  19 of folks. They come in various ages. And the age  20 state of people is, not only important for the  21 substances that they might use or the mental health  22 disorders that they might experience, it also has</p>	<p style="text-align: right;">Page 93</p> <p>1 special topics. .And I see that the Administrator is  2 going to talk later this afternoon about women and her  3 strategic initiatives. So I'm going to let her do  4 that. I'm going to focus on just a couple of really  5 quick things.  6 Questions -- everybody's looking a little  7 overwhelmed.  8 MS. BRISCOE: I just wanted to [inaudible] N-  9 SSATS?  10 DR. LEWIS: Uh-huh.  11 MALE SPEAKER: Microphone.  12 MS. BRISCOE: N-SSATS surveys -- I have to fill  13 out three for our facility. They will hunt you down  14 if you don't.  15 [Laughter.]  16 MS. BRISCOE: They run a tight ship. Telephone  17 calls, e-mails -- and they are not going to let you  18 get away with not filling out that survey. So I think  19 that's great.  20 DR. LEWIS: It's a good thing.  21 MS. BRISCOE: It's a good thing.  22 DR. LEWIS: If you want to be on the treatment</p>



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1 locator -- and people call up all the time, "How do I  
2 get on the treatment locator"? The only way to get  
3 there is by filling out that survey. You must fill it  
4 out, and you must be approved by your state authority,  
5 whatever that authority is, so that we know that the  
6 facilities that we are putting on there are actual  
7 facilities fun by people of whom your state approves.  
8 So thank you very much.  
9 MS. BRISCOE: You're welcome.  
10 DR. LEWIS: Appreciate that.  
11 Yeah? I'm sorry. I can't see your name from  
12 here, because -- Bobby.  
13 MS. BENAVENTE: I'm Bobby Benavente from Guam.  
14 DR. LEWIS: Hi.  
15 MS. BENAVENTE: Guam and the other Pacific  
16 Islands are not -- have never been included in the  
17 NSDUH survey. And I was wondering if there would be a  
18 time soon that the Pacific Islanders would be included  
19 in some fashion. And also, I was wondering, with the  
20 other three surveys you described, are there numbers  
21 in there that reflect Pacific Island countries.  
22 DR. LEWIS: Pacific Island heritage, yes.

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1 Countries, per say -- I don't think we have a big  
2 enough sample to get down to the various countries. I  
3 suspect that the reason we don't have interviewers in  
4 the field in the Pacific Island is more monetary than  
5 anything else. But I will check on that and get back  
6 to you about that, because you're right. That's a  
7 lack in the coverage that we have.  
8 Bobby. Okay.  
9 MS. BENAVENTE: Just one other thing.  
10 DR. LEWIS: Sure.  
11 MS. BENAVENTE: How long has NSDUH been  
12 conducted?  
13 DR. LEWIS: Running? Okay. It used to be the  
14 NHSDA, the National Household Survey on Drug Abuse.  
15 And that started back in 1979. It was biannual for a  
16 while. It's been annual since, I think, the mid-'80s.  
17 However, we've had several breaks in trends across  
18 time. Most recently, 2004 was the -- or 2002 was the  
19 last break. So we have comparable data from 2002  
20 through what will be released next month, 2010. We've  
21 been at it for a while.  
22 MS. BENAVENTE: And back when it first started,

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1 it was the same reason for not including Pacific  
2 Islanders, is that the cost factor, the numbers were  
3 small. And I'm just hoping that there'll be a time  
4 when we are included in surveys like this so we can be  
5 represented as part of this nation's survey.  
6 DR. LEWIS: I think that's something we can  
7 certainly look into. When it first started, it was a  
8 very much smaller survey. It was not designed to give  
9 state estimates, for example. It had, I think, 17,000  
10 respondents instead of 67,000. Just to give you an  
11 idea of the magnitude of what goes on in NSDUH, there  
12 are more people employed as NSDUH field staff than  
13 work here at SAMHSA. So there are 700 people in the  
14 field engaging and persuading people to answer  
15 questions for us. It's a big deal. It's a big  
16 undertaking. But let me look into your question, and  
17 I'll get back to you.  
18 MS. SCOTT-ROBBINS: I was wondering if there is a  
19 -- has been or is a possibility of including sexual  
20 orientation as well.  
21 DR. LEWIS: That's --  
22 MS. SCOTT-ROBBINS: The issues of gay and

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1 lesbian, bisexual, transgender folks, particularly  
2 related to substance abuse are huge. And, you know,  
3 this is the first year --  
4 DR. LEWIS: That's exactly right.  
5 MS. SCOTT-ROBBINS: This is the first year that  
6 the census counted, at least partnered, same-gendered  
7 couples. And what's counted counts. We know that.  
8 DR. LEWIS: Here's what's going on. I mentioned  
9 that each of these surveys is under some amount of  
10 being redesigned. In NSDUH, we're looking at a  
11 variety of methods changing, including how we  
12 enumerate households at all, because that also has  
13 undergone some changes. Drugs come and go in  
14 popularity, so we're looking at how to redo the drug  
15 modules.  
16 We're looking at adding issues around LGBT --  
17 hello -- issues. We're also looking at military  
18 families and how to identify military families. And,  
19 again, I think the Administrator will be addressing  
20 some of these issues.  
21 MS. ENOMOTO: Yeah. One of the challenges,  
22 Harriet -- I think SAMHSA's actually led the

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

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

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

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

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

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

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

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

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

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

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

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

20 DR. LEWIS: Thank you so much for being so  
21 generous.  
22 Three out of four adolescent drug-related

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

7 FEMALE SPEAKER: I have a question.

8 MS. SCOTT-ROBBINS: The sources of suicide?

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

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

19 DR. LEWIS: Right.

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

1 DR. LEWIS: I can't confirm or deny that at this  
 2 moment. I'll go take a look and --  
 3 MS. ENOMOTO: But they would not have been only  
 4 on European-Americans; right?  
 5 DR. LEWIS: Right.  
 6 MS. ENOMOTO: They would have been for all girls.  
 7 DR. LEWIS: This is all young girls.  
 8 DR. McBRIDE MURRY: And so, we don't know how it  
 9 breaks down by race?  
 10 DR. LEWIS: By racially? No.  
 11 DR. McBRIDE MURRY: Okay.  
 12 DR. LEWIS: What astonished me was the difference  
 13 between the boys and the girls.  
 14 DR. McBRIDE MURRY: Yes.  
 15 DR. LEWIS: That somehow the girls end up in the  
 16 emergency rooms. We don't know what the attempted  
 17 suicide rate is for each of the genders in  
 18 adolescents. But whatever it is, even if it's not  
 19 quite equal, the girls are ending up in the emergency  
 20 department far more often than the boys are.  
 21 DR. McBRIDE MURRY: You're familiar with Shawn  
 22 Joe's work on suicide rates among African-Americans?

1 DR. LEWIS: No.  
 2 DR. McBRIDE MURRY: He's done some pretty  
 3 remarkable work and was actually in Science. Five  
 4 hundred percent, I think, increase over the past five  
 5 years among African-American males. So that may be --  
 6 but also increasing rates among African-American  
 7 girls. And so, that may be something to just look at  
 8 to capture a context for the work you have here.  
 9 DR. LEWIS: And this would be something that  
 10 would be of interest to you, if we were able to get  
 11 more deeply involved?  
 12 DR. McBRIDE MURRY: Yes. Yes.  
 13 DR. LEWIS: Okay. Good. This is exactly what I  
 14 need to know, is what is of interest.  
 15 DR. FELITTI: Is it of interest to anyone other  
 16 than me, perhaps, that what is being studied is  
 17 apparently the mechanism for attempting suicide as  
 18 opposed to the reason for attempting suicide?  
 19 DR. LEWIS: We don't collect information on why.  
 20 DR. FELITTI: Well, I understand that. I mean, I  
 21 see that as a huge flaw, since they're -- studying the  
 22 mechanism is certainly comfortable, and it's

1 meaningless.  
 2 DR. McBRIDE MURRY: I agree with Vincent, because  
 3 not knowing why, it's difficult then to target an  
 4 intervention or a prevention to address the why.  
 5 DR. FELITTI: Putting it a different way -- you  
 6 know, and I realize these phrasings are annoying.  
 7 Putting it a different way, suicide is not the problem  
 8 for the person involved. It's their attempted  
 9 solution. It may be a problem for other people. You  
 10 know, it's disturbing, et cetera. Not everyone wishes  
 11 to serve out a full life sentence.  
 12 DR. LEWIS: Fair enough.  
 13 DR. FELITTI: And the question is why is that.  
 14 DR. LEWIS: The only -- well, there is a legal  
 15 issue involved in looking at the whys of suicide for  
 16 people who have attempted suicide, at least from our  
 17 perspective.  
 18 DR. FELITTI: Could you explain that? Because it  
 19 certainly doesn't strike me as evident.  
 20 DR. LEWIS: If it were part of the medical  
 21 record, which is how the E.D. data are collected --  
 22 DR. FELITTI: No, sure.

1 DR. LEWIS: -- we could pick that up.  
 2 DR. FELITTI: Yeah.  
 3 DR. LEWIS: And we haven't looked at what else,  
 4 other than the actual quantifiable data, shows up to  
 5 look at what reasons might be posted in the records.  
 6 DR. FELITTI: Yeah, well, I mean, medical records  
 7 are notably vacuous in that regard, because it's quite  
 8 uncomfortable to all sorts of people to pursue that  
 9 line of questioning, including physicians. And it's  
 10 avoided.  
 11 DR. LEWIS: If you have some suggestions for  
 12 improving what gets into medical records around this  
 13 that we could then pick up on, that would be great.  
 14 Right now, because of the way we collect the data, we  
 15 will, in the future -- again, DAWN is another one of  
 16 the surveys that's under revision. We'll be picking  
 17 up a lot more mental health data. So we'll know if,  
 18 for example, these young ladies are diagnosed with  
 19 depression, an anxiety disorder, a bipolar disorder.  
 20 DR. FELITTI: And that would be as a result of  
 21 what?  
 22 MS. ENOMOTO: I think we are also working on

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

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

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

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1 memorial grant two years ago. And the work that we've  
2 done in such a short time frame -- it ends next month  
3 -- in terms of this funding is we were able to learn  
4 that we have one of the highest rates of suicide in  
5 our part of the world, one every two weeks. So it's  
6 about 30 deaths a year in a population of about  
7 170,000 plus people, with the expected increase of  
8 population about 25 percent over a 10-year span with  
9 the military build-up.  
10 You know, the Marines are leaving Japan and  
11 choosing Guam as their home by order of the Department  
12 of Defense, and not at our invitation. That's a  
13 sideline. It doesn't go in the minutes, again.  
14 But it is important to not just put our energies  
15 or concentration on how many deaths and by what means,  
16 but what is going on in these young people's lives  
17 that they think life isn't worth living. And the work  
18 that we've seen so far in the first profile on suicide  
19 for the island that we published last year show  
20 personal relationships and just inability to cope with  
21 whatever challenges, whether it be relationships or  
22 failure to meet up to the expectations of their

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1 teacher or their parents or just changes in cultural  
2 expectations for young people and adults.  
3 But the 30 plus individuals that die by suicide  
4 every year for the past 10 years, we've learned, are  
5 under the age of 30 and mostly males and mostly by  
6 hanging. But there is a growing increase of females  
7 that use more lethal means like hanging as opposed to  
8 some gestures of cutting and trying to overdose on  
9 medications like over-the-counter drugs.  
10 DR. LEWIS: One of the things we do notice in  
11 some of our surveys is that -- when I was growing up  
12 in this field, there was always a timeline between the  
13 boys and the girls in terms of initiating various  
14 kinds of behaviors. And it was generally two years.  
15 And it was generally attributed to the fact that older  
16 boys date younger girls, which worked very well as an  
17 explanation, that boyfriends would introduce their  
18 girlfriends to whatever their favorite pastime was.  
19 That's no longer true. Girls are, in fact,  
20 exceeding boys in the initiation of some behaviors.  
21 And I can point you to the data, and I can tell you  
22 what the data said.

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1 The context -- and Bobby and Vincent as well,  
2 both talking about the context for why it is my  
3 numbers look the way they do. It's critically  
4 important. I can tell you, again, that 75 percent of  
5 these drug-related suicide attempts occur in girls. I  
6 don't know why. But I can give you that and say this  
7 is something that clinicians, epidemiologists and  
8 other folks need to be looking at. And I'll keep you  
9 pointed in the right direction, because I put these  
10 statistics out, generally speaking, once a week. We  
11 try to get something out the door that's new and a  
12 little different.  
13 Before I use up every single bit of your lunch  
14 hour, let me just move on. Women work. During this  
15 economic downturn, more jobs have been lost by men  
16 than by women. However, I was a little astonished to  
17 discover that one out of every five women working  
18 full-time engage in binge drinking and that 3.2  
19 million of them are using illicit drugs. But when you  
20 look at the treatment data, less than a quarter of  
21 them are getting into treatment.  
22 So three-quarters of the females who come into

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1 treatment have either lost their jobs or never had  
2 jobs or are no longer employed full-time, for whatever  
3 reason. I also thought it was kind of interesting  
4 that employed women tend to be referred to treatment  
5 through the criminal justice system. And when I  
6 looked at the detailed categories of criminal justice  
7 that we collect, it was not through DUI or DWI  
8 programs. Yeah, that -- yes.  
9 DR. McBRIDE MURRY: That's [inaudible].  
10 DR. LEWIS: That's what I would have thought,  
11 too. And it's not. It's through parole and  
12 probation. Again, I don't know quite what to make of  
13 that. But I can tell you that this seems to be true.  
14 And it shows up in our data.  
15 Do I need to go back? I can do the back button.  
16 MS. SCOTT-ROBBINS: Just like the changes that, I  
17 think, you were seeing with girls and how soon they're  
18 coming into substance use and how they're getting into  
19 treatment, I think we're seeing the same kinds of  
20 trends with women. And when you look at what's  
21 happening with economically and with folks losing  
22 jobs, et cetera, I mean, women right now are still,

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1 even with the women set-aside in place and everything  
2 else, are still an underserved population within our  
3 treatment system.  
4 DR. LEWIS: I have the perfect fact about two  
5 slides from now that's going to speak exactly to that  
6 point, which I thought you all would be really  
7 interested in and might want to spend some time  
8 advocating about. Hold that thought.  
9 We talked about women. Another important role  
10 for women -- women are mothers. And I had the folks  
11 who actually run data look at young women who were  
12 mothers and living with one child. This, to me, is  
13 over half a million teenage moms living with their  
14 kids -- that in and of itself is a public health  
15 societal concern, because we all know what the poverty  
16 rates are. The long-term prospects for many of these  
17 women are not that good.  
18 Their children, however, are of particular  
19 concern. If you look at the fact that more than one-  
20 third of the women are smoking cigarettes, using  
21 alcohol, using marijuana, whether you believe it or  
22 not as a mother -- and believe me, there are days when

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1 I didn't believe it at all. Not only do our kids  
 2 listen to us, but they do as we do. They are -- we  
 3 are role models for our children.  
 4 So in looking at a statistic like 528,000 women,  
 5 we'd also need to be looking at 528,000 kids who are  
 6 growing up with these young women as mothers. And,  
 7 again, I can point you to the statistic. I'm not  
 8 entirely sure of what to recommend, but I would depend  
 9 on you to make recommendations about this.  
 10 MS. ENOMOTO: And past year MDE is major  
 11 depressive episodes.  
 12 DR. LEWIS: I'm going to get to that.  
 13 MS. ENOMOTO: Okay.  
 14 DR. LEWIS: Okay. We mostly know that women who  
 15 smoke are highly correlated with women who have  
 16 depression. And we measure a past-year major  
 17 depressive episode as more than just feeling a little  
 18 blue once in a while. This is a clinical diagnosis.  
 19 If, as a mom, I have no experience with the past-  
 20 year major depressive episode and I don't smoke, the  
 21 probability that my child is going to smoke is very,  
 22 very small. It's 6 percent. However, if I have both

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1 a past-year major depressive episode and I smoke, the  
 2 probability that one or more of my children will smoke  
 3 jumps all the way up to 25 percent. There are  
 4 multiple possible points of intervention there for  
 5 people who design programs: smoking cessation  
 6 programs, depression treatment programs, parenting  
 7 classes, all kinds of things.  
 8 Let me -- what happened to my slide on -- huh.  
 9 Well, let me talk a little bit about racial and ethnic  
 10 differences. Because of the size of some of our  
 11 databases, we are able to look very closely, for  
 12 example, within -- Hispanic women are not all the  
 13 same. I talked a little bit earlier about the  
 14 analysis I saw that was so brilliant on Mexican women  
 15 living in rural and urban settings and the differences  
 16 in their behavioral health.  
 17 We can look at levels of acculturation, how long  
 18 someone has been in the country. We can distinguish  
 19 Mexican, Puerto Rican, Cuban women, because we have  
 20 power in the database. We can look at American  
 21 Indian, Alaska Native women, for whom we do not have  
 22 such a large sample. We know something about the fact

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1 that they don't use -- as a group, they don't use  
 2 alcohol as much as other women in other ethnic or  
 3 racial groups. But when they do, they tend to binge  
 4 drink as opposed to just having a glass of wine with  
 5 dinner.  
 6 Asian women have the lowest rates of past-month  
 7 alcohol, binge alcohol, and illicit drug use.  
 8 Eventually, I'm going to be able to look within that  
 9 Asian category and sort out various cultural groups  
 10 within the Asian label and see if there are  
 11 differences among them that might -- I don't know. Is  
 12 anybody here from a California treatment program?  
 13 DR. FELITTI: I'm from California.  
 14 DR. LEWIS: You are?  
 15 I was in one a while ago. And they had, I  
 16 believe, 17 different Asian cultures represented  
 17 within their treatment program and needed more than 17  
 18 different interpreters because of the language  
 19 difficulties that their own staff had in trying to  
 20 help their clients. Again, I can point you to where  
 21 the problems appear to be, statistically. The context  
 22 for them, the solutions are in different -- are

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1 different from different folks.  
 2 MS. ENOMOTO: I think, Charlene, I know on youth,  
 3 you're able to pull out Native Hawaiian and other  
 4 Pacific Islander --  
 5 DR. LEWIS: Yes.  
 6 MS. ENOMOTO: So it's possible that she could do  
 7 an Hopi run on women across years.  
 8 DR. LEWIS: Possibly.  
 9 MS. ENOMOTO: But again, it's -- first of all, I  
 10 want to say that there's a hyphen-American on all of  
 11 these.  
 12 DR. LEWIS: Yes.  
 13 MS. ENOMOTO: All right? These are not  
 14 international data. And that Native Hawaiian and  
 15 other Pacific Islander women who live either in Hawaii  
 16 or the mainland United States do have different rates,  
 17 I think.  
 18 DR. McBRIDE MURRY: I have a question, Charlene.  
 19 For the African descendants, do you collect data on  
 20 heritage, their ethnic differences as well --  
 21 DR. LEWIS: No.  
 22 DR. McBRIDE MURRY: -- within -- no? Okay.

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

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

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1 Carolina years ago. And the programs that came back  
 2 and said, "Oh, we have gender-specific services," --  
 3 and when we asked them what that meant to them, then  
 4 you, kind of, get that they don't get it. So that's -  
 5 -  
 6 DR. LEWIS: And of the many things we are hoping  
 7 to do in the future, one is to do exactly what you're  
 8 talking about, which is to take a representative  
 9 sample of these programs and find out what they mean  
 10 when they click off the box that says, "Yep, I've got  
 11 groups for adolescents, I've got groups for women,  
 12 I've got groups for the newly diagnosed. I've got all  
 13 of this stuff, and aren't I wonderful?" Because they  
 14 know it shows up in the locator. So we would like to  
 15 just do a little trust, but verify.  
 16 I think, Kana, I have run over. And I apologize.  
 17 MS. ENOMOTO: No. Okay. Thank you.  
 18 DR. LEWIS: I hope that all of you will take to  
 19 heart two things from this. One is that in order to  
 20 keep looking at the endless possibilities that an  
 21 hour-long interview, 2 million records, 100,000  
 22 records on treatment, on admissions to emergency

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

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1 MS. BENAVENTE: While I still remember it, maybe,  
 2 Kana, you can answer this. The CMHS block grant --  
 3 are there requirements, as with SAPT, for serving  
 4 women and girls right away, pregnant women and child -  
 5 -  
 6 MS. ENOMOTO: No. No.  
 7 MS. BENAVENTE: There isn't?  
 8 MS. ENOMOTO: No, there's not a statutory  
 9 requirement, as there is on the SAPT side.  
 10 MS. BENAVENTE: Because on Guam -- and it may be  
 11 true in the other Pacific Islands -- there is a need  
 12 to, kind of, force that. I learned a couple of weeks  
 13 ago from our treatment folks from mental health  
 14 services that there are over 300 some people wait-  
 15 listed for service. And they couldn't even give me a  
 16 breakdown with, well, who are they and how do you know  
 17 who to treat first, if you've not even done a fairly  
 18 decent assessment of their critical needs. And so, I  
 19 think having that kind of language in CMHS block grant  
 20 funding would help to improve timely service for women  
 21 and girls.  
 22 MS. ENOMOTO: I think the changing languages of

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1 the requirements of the block grant would necessitate  
 2 a reauthorization of SAMHSA and of the block grants,  
 3 which is a whole legal process that goes through  
 4 Congress and is fraught with a number of political  
 5 difficulties at the moment. However, I think, by  
 6 adding the language in the uniform block grant  
 7 application where we're just asking the states and  
 8 territories to even look at the data, I think, in that  
 9 way, we're not forcing it, but we are strongly  
 10 encouraging people to start paying attention.  
 11 I think sometimes shining the light of day on an  
 12 issue and actually collecting the data will help  
 13 people understand what issues there are. But, you  
 14 know, I mean, I hear what you're saying. There's a  
 15 lot of things people would like to get into the block  
 16 grant requirements. And, you know, we're not  
 17 anticipating changes to that anytime soon. It's, sort  
 18 of, something that's a little bit outside of our hands  
 19 at the moment. But thank you.  
 20 I want to thank Charlene and Center for  
 21 Behavioral Health Statistics and Quality. They are --  
 22 I think it is a very sincere offer. They have been

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1 extremely responsive to our stakeholders, to internal  
 2 SAMHSA customers in terms of doing data runs, because  
 3 this is not your grandfather's OAS.  
 4 DR. LEWIS: There you go.  
 5 MS. ENOMOTO: This is a brand newly-minted  
 6 center, which has really become an integral part of  
 7 the fabric of SAMHSA, how we operate. And so, to the  
 8 degree this group could take advantage of the  
 9 incredible resources they have -- it's not everything  
 10 in the world that we'd like, but it really is a lot,  
 11 and it's more than we're taking advantage of at the  
 12 moment.  
 13 So thank you, Charlene.  
 14 DR. LEWIS: Thank you for having me.  
 15 MS. ENOMOTO: Thank you.  
 16 DR. LEWIS: And, please, take us up on our offer,  
 17 because, as Kana said, we really do mean it.  
 18 MS. ENOMOTO: Yep. Thank you. Thank you.  
 19 So I'm going to let Cynthia talk a little bit  
 20 about the logistics for our lunch here. And then, for  
 21 anyone who would like to stay, Jean is back with us.  
 22 And so, for folks who want to stay around the table

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1 and chat a little about what we're going to be doing  
 2 at the joint NAC conversations around workforce or  
 3 women, we can do that before the Administrator gets  
 4 here at 1:00.  
 5 So, Cynthia, you want to talk about that?  
 6 MS. GRAHAM: For those of you that ordered lunch  
 7 for today -- and I've spoken with some of you already  
 8 there on the table and back -- I think you're going to  
 9 go to the café down the hall.  
 10 Yolanda, so you can go there.  
 11 And, Jean, you brought your own snacks.  
 12 DR. CAMPBELL: Yes.  
 13 MS. GRAHAM: Right. We have the others. So if  
 14 you want to stay here and be a part of the discussion  
 15 that Kana mentioned [inaudible] Jean talked about  
 16 workforce development, or if you're too crowded in  
 17 here, we do have tables set up in the Sugar Loft Room,  
 18 where we could take the group there, if you'd rather  
 19 stretch your legs and go someplace else. It's your  
 20 call.  
 21 MS. ENOMOTO: You guys want to take it out to the  
 22 different setting, sit around a table? That's fine.



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

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

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

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

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1 thing. Oh, yeah, that one.  
2 So I think it was really helpful for you all to  
3 raise the issues so that we could go back and actually  
4 put in our minds and in your minds and on paper some  
5 of the ways in which each of the strategic initiative  
6 addressed women and girls. I think I said to some of  
7 you -- maybe it was Stephanie -- that when I speak  
8 about our behavioral health equities issue, I always  
9 talk about racial and ethnic minorities. I talk about  
10 LGBT populations. I talk about American-Indian and  
11 Alaskan Native populations, and women and girls.  
12 Those are the four groups. Now, there could be  
13 others, but those are the ones we have chosen to think  
14 about in terms of disparity issues and things that we  
15 need to pay particular attention to.  
16 And in each one of the initiatives, there are  
17 clearly issues that address -- or that affect women  
18 and girls and things in each of those. So I think  
19 what I'm interested in today is, given what you heard  
20 that we presented on the Webinar or the phone call  
21 that we did with you all and given now that you've had  
22 an opportunity to look at the strategic initiatives,

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1 we're in the process of priority setting. So what I  
2 said to the tribal group this morning is we need you  
3 to tell us what are the most important things in each  
4 of those strategic initiatives that you think, from  
5 your perspective, we should be paying attention to.  
6 Because we're going to have to choose to set some of  
7 them aside for a while. It doesn't mean we're not  
8 going to do them, but set them aside for a while while  
9 we prioritize other things for the next 15, 16 months.  
10 So I think that's all I really want to say. I  
11 just want to open it up. And this is, really,  
12 hopefully, a dialogue. I want to listen to you and  
13 see what you've got to suggest to us about how we  
14 think about this.  
15 And the other thing I might say -- I said it  
16 again this morning to the tribal group, but I'll say  
17 it tomorrow as well and on Wednesday as well, which is  
18 I really value -- I really look forward to these  
19 meetings. I think the staff can tell you I get, kind  
20 of, into them, because I think the chance to step back  
21 and think and to have people who don't, sort of, sit  
22 every day and do exactly the same thing we do to, kind

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1 of, look at this in a different way and give us a way  
2 to think about it a little differently. And I always  
3 learn things from these meetings. It really does  
4 impact the way we think about stuff.  
5 So I just want you to know that advice is a  
6 product that we value highly. So that's what we're  
7 looking for from you. So with that, let me just open  
8 it up to you, or turn it back to Kana to facilitate.  
9 MS. SCOTT-ROBBINS: So thank you so much for this  
10 opportunity for us to have this discussion again.  
11 When I look at the first strategic initiative around  
12 prevention, I think it was Charlene who presented to  
13 us earlier about young women and girls and the impact  
14 that substance use is having with that, you know, 12  
15 to 17 population and how those numbers keep rising.  
16 And we're, kind of, not quite sure why or how or  
17 what. But the fact that it's happening -- we need to  
18 get a hold on what is happening with those girls and  
19 what works in terms of preventing them from getting to  
20 that point, and when they've gotten to that point, how  
21 we can be effective in helping to give them a path to  
22 recovery.

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1 And so, I think, also Fetal Alcohol Syndrome,  
2 spectrum disorders, like the presentation earlier, it  
3 is preventable. And we don't, I don't think -- even  
4 with all the money that's out there, kind of, in the  
5 campaigns, you don't hear it, I think, in the right  
6 places where women are. I think we've got to get that  
7 message out in a different way.  
8 Because, you know, when I'm on the airplane --  
9 and there was a woman, you know, drinking on the  
10 airplane. And I'm saying to myself, "Oh, my  
11 goodness." And her husband's saying, "Just one,  
12 okay"?  
13 But so, it's nice that the airlines -- actually,  
14 Southwest did pick up the message, and they actually  
15 have it in their pamphlet now. You know, when you go  
16 to look at the drinks, it says, you know, drinking  
17 while pregnant is not a good thing. But prevention is  
18 our first line. And so, I am advocating that we make  
19 sure that we can put the message out there to girls  
20 that they don't have to make that choice, that there  
21 are other choices out there.  
22 MS. MONTGOMERY: But it seems that, yes, young

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

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

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

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

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1 are the economies of scale that we can get for  
 2 reaching folks with good, accurate, meaningful health  
 3 information.  
 4 DR. McBRIDE MURRY: Right. And the context of  
 5 this program is alcohol, drugs, sex, risk prevention.  
 6 But in the context of that, we're talking about other  
 7 kinds of healthy sexual promotive behaviors. And part  
 8 of that is the preventiveness of cervical cancer  
 9 through these series. So it provides an opportunity  
 10 to do more than just HIV prevention or HIV-related  
 11 risk prevention, but other ways that we can then begin  
 12 to inform.  
 13 Because what happened as a consequence of asking  
 14 those questions -- we inserted in those questions  
 15 information that will say HPV is for this, are you  
 16 aware of this. And what the families said to us  
 17 afterwards, after the data collection, is that it was  
 18 an awareness for them to even be engaged in answering  
 19 the questions about this, because it triggered for  
 20 them ways in which they need to really begin to think  
 21 seriously about this for their daughters and their  
 22 sons.

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1 MS. BENAVENTE: Administrator Hyde, I'm Bobby  
 2 Benavente. And it's my first face-to-face meeting  
 3 with you. I'm in awe of you. I just need to say  
 4 that, for the record.  
 5 [Applause.]  
 6 MS. BENAVENTE: I really am.  
 7 MS. HYDE: I haven't said anything yet. How --  
 8 MS. BENAVENTE: No, but you have. Since you came  
 9 into office, I've read the stuff. I've been  
 10 participating online in the Webinars. And you're  
 11 real. And that is so important to us, to all of us.  
 12 But especially for me on Guam, prevention has been my  
 13 passion for over 25 years. I've been working for the  
 14 government of Guam for about 33 years now. So I don't  
 15 want to retire, because prevention is one of your top  
 16 initiatives.  
 17 [Laughter.]  
 18 MS. HYDE: Hey, if that keeps you in the game,  
 19 then this is a good thing.  
 20 MS. BENAVENTE: I'm in the game for as long as  
 21 God allows me to keep on working.  
 22 I wanted to, first of all, thank you, thank

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1 SAMHSA.  
 2 Kana, you're my heroine, too, and Larke. I just  
 3 love you women. I want to be just like you in my next  
 4 life, because I'm older than both of you put together.  
 5 [Laughter.]  
 6 MS. BENAVENTE: But from the perspective and from  
 7 the experience of Pacific Islander people and women,  
 8 we do have our share of challenges. But we really do  
 9 learn a lot from what SAMHSA has to offer and from all  
 10 the people at this table. The resources that we've  
 11 been able to get for the Pacific Islands like the  
 12 SPIFF-SIG funding and the Garrett Lee Smith funding,  
 13 they've all been put to really good use in our  
 14 learnings about strategic prevention framework  
 15 processes has certainly benefited Guam as part of  
 16 cohort one.  
 17 And we're looking and helping out the other  
 18 islands as they engage in their processes as well. I  
 19 think they're cohort three, four. Is there a five?  
 20 Maybe it's three, four.  
 21 But I just wanted to thank you for the attention  
 22 and the commitment that's been provided the Pacific

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1 Islands, because we've always felt very removed, far  
 2 removed and not even known in terms of, you know, the  
 3 challenges that we have geographically and culturally  
 4 because of the vastness of the different cultures in  
 5 the Western Pacific and Micronesia. Some of the  
 6 things that we do with addressing the needs of girls  
 7 and women is just making sure that they're represented  
 8 and included in all that we do with prevention and  
 9 helping to develop policy for the Pacific governments.  
 10 Getting the word out to where women are at -- one  
 11 of the things that we did was partnering with our  
 12 phone company so that every phone -- every household  
 13 that had a land line and got their phone books  
 14 delivered, there were phone labels that they could put  
 15 on the instrument so they could see numbers, they  
 16 could call for help. And so, little things like that  
 17 we've been able to do.  
 18 The young people that we train in prevention in  
 19 our youth leadership initiative for the past 23 years  
 20 we've worked with them, especially recently, for us  
 21 old folks who aren't quite sure how FaceBook and all  
 22 that stuff works. Someone's relating, I can tell.

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1 And so, they're teaching us a lot about how to set up  
 2 attractive Web sites that would really draw a crowd to  
 3 link onto the FaceBook. It's Youth For Youth Live.  
 4 They helped us, the youth, develop our one-nation  
 5 campaign. We were successful in raising Guam's legal  
 6 drinking age to 21 just last year. And that was as a  
 7 result of the SPIFF-SIG work, working with communities  
 8 and really helping them to work with the power they  
 9 possess to make some changes, policy-wise.  
 10 And my next goal, before I retire -- the  
 11 government of Guam -- and this doesn't have to go on  
 12 the record, but I just need to say it. There is a  
 13 Bureau of Women's Services out of the government of  
 14 Guam. And I really need to help them to understand  
 15 that programs like Dress For Success is really not  
 16 what that should be about. You know? It goes beyond  
 17 all that. And it really should be led by a man -- I  
 18 mean, not by a man, but by a woman.  
 19 So I'm learning a lot. Thank you so much for  
 20 your leadership.  
 21 MS. HYDE: I probably shouldn't do this, because  
 22 I'm going to put Kana on the spot. But she and I

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1 don't travel together very much, because we need to  
 2 have one of us be here all the time. But we actually  
 3 committed that we were going to come together out to  
 4 see you guys. So sometime in 2012, you may be the  
 5 only recipient of a joint visit from the Administrator  
 6 and the Principal Deputy when we get out there. So  
 7 maybe you can set up a meeting with us with your  
 8 Office of Women's Services and we can help you deliver  
 9 some messages.  
 10 MS. BENAVENTE: Is it calendar year 2012 or  
 11 fiscal year 2012? Because the Collaborating Council  
 12 is holding the next meeting in Palau first week in  
 13 December. And we extend the invitation to both of  
 14 you.  
 15 MS. HYDE: In 2012?  
 16 MS. BENAVENTE: December '11.  
 17 MS. HYDE: December '11?  
 18 MS. BENAVENTE: FY 2012, which would mean  
 19 December. That counts.  
 20 [Laughter.]  
 21 MS. HYDE: Well, we'll talk.  
 22 [Laughter.]

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1 DR. CAMPBELL: I was curious when you began to  
 2 talk. And you were asking us about considering  
 3 priorities in this time of fiscal retraction. And my  
 4 first question was were you thinking of delayed  
 5 implementation of some initiatives or some projects  
 6 within initiatives or the combination of those  
 7 approaches. That was one question. And then, I was  
 8 thinking in terms of principals, if you were thinking  
 9 about setting priorities that -- just off the top of  
 10 my head, I was thinking those initiatives that  
 11 successfully address health inequities might be, you  
 12 know, having some way of looking at these programs so  
 13 you could actually create within this retraction an  
 14 agenda.  
 15 And then, I was thinking of also prevention-  
 16 focused and recovery-based, that those three things.  
 17 And it could be others. But the strategy of creating  
 18 agenda within the initiatives themselves to stage your  
 19 overall plan might be a good approach.  
 20 MS. HYDE: We'll probably talk about this a  
 21 little bit more tomorrow. I think there's a little,  
 22 tiny spot on the agenda tomorrow about what we're

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1 doing with strategic initiatives. But to answer your  
 2 first question, which I think goes to your second one  
 3 a little bit, is within the eight initiatives, there  
 4 are probably 400 -- I've forgotten the exact number --  
 5 427 or something activities that we've committed to.  
 6 DR. CAMPBELL: Yeah.  
 7 MS. HYDE: It is a four-year plan, not a one-year  
 8 plan or a two-year plan, but a four-year plan. And  
 9 even at that, some of the activities are written so  
 10 broadly that it would take a lifetime to do. You  
 11 know? So sometimes there's just more there than we  
 12 can possibly do.  
 13 So what we're trying to do is it took the first  
 14 18 months or so that I was here to, sort of, get clear  
 15 about what those eight strategies or strategic  
 16 initiatives were going to be and what those 427  
 17 activities we were going to commit to. And we've been  
 18 doing a lot. We've done a lot of stuff.  
 19 But now, we're, sort of, looking at the next 16  
 20 months and saying, "What could we get done in those 16  
 21 months"? So it's not saying we're not going to do  
 22 some of the things. It is more to say where do we

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1 need to focus our attention for the next 16 months.  
2 And then, 16 months from now, we'll say where do we  
3 need to focus our attention the next 18 months. So  
4 it's sort of a right now, given this situation, given  
5 we don't know what Congress is going to do with 2012,  
6 given that some things have to go before another  
7 thing, even if this thing is more important or what  
8 we're trying to get at. You have to do this before  
9 you can get there. So sometimes it's an order-type  
10 priority.  
11 Sometimes it's literally we can't do everything.  
12 We have less staff, less money, less whatever. So  
13 what should we focus on? So if there are 16 things in  
14 these eight initiatives that are really going to push  
15 women's services for girls ahead, but we can only do  
16 four of them, what would that be? You know, what do  
17 you think are the most important of those? So that's  
18 what we -- for right now, what are the most important  
19 things for right now as opposed to three from now, for  
20 example. So that's what we mean by prioritizing.  
21 DR. CAMPBELL: Thank you. That's helpful.  
22 MS. ENOMOTO: I realize that folks don't actually

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1 have the strategic initiative paper in front of them.  
2 They do have the summary of --  
3 DR. CAMPBELL: We've all memorized it.  
4 MS. ENOMOTO: Yes. You have the -- okay. So we  
5 do have it? Okay. Okay. I have no idea what's in my  
6 book. Okay.  
7 MS. HYDE: But you do have on the -- whatever  
8 you're calling it -- a conversation piece.  
9 MS. ENOMOTO: Right.  
10 MS. HYDE: You do have at least what the eight  
11 initiatives are. So --  
12 MS. ENOMOTO: Right. Right.  
13 MS. AMATETTI: I might add that tomorrow morning  
14 at the Joint NAC, we're going to be doing a  
15 presentation, sort of, a shortened version of the how  
16 women and girls are handled throughout the strategic  
17 initiatives. And we're going to be soliciting  
18 feedback from the Joint NAC about what we're doing  
19 about what they think we could be doing, maybe --  
20 again, what areas would they emphasize, strengthen,  
21 some new ideas for us.  
22 And so, if there is anything that you would want

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1 as a council to say, that these -- as a committee,  
2 what you think the priorities are. And so, it'd be  
3 good to think about that a little bit right now.  
4 You'll have an opportunity to be respondents as well  
5 tomorrow to share, sort of, what the conversation was  
6 here, if you want to share that as a group, or even  
7 just individually about your thoughts. For instance,  
8 you know, Starleen's recommendation looking at the  
9 issue of younger women or girls, how that really needs  
10 to be addressed, given what the trends are. I mean,  
11 that would be the type of thing that we could bring up  
12 to the Joint NAC.  
13 We've had the benefit of hearing Dr. Lewis this  
14 morning talking about some trends. We've been talking  
15 about that sort of thing. So just to, sort of, help  
16 focus your thoughts today for the conversation  
17 tomorrow as well. I just wanted to let you know that  
18 was coming up.  
19 MS. ENOMOTO: Okay. I see that Bobby has her  
20 leading change book. And to the degree -- if we could  
21 get copies for any of the members who would like to  
22 take a look at it, because it has the action steps in

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1 there and the objectives. And I think that's what  
2 would be -- that's some of the sorting process that  
3 we're going through right now. So of the 375 plus  
4 action steps that we've committed to, which of those  
5 are going to come first? Because we can only split --  
6 I mean, we can't assign, you know, 500 people, each  
7 person gets an action step to do by themselves.  
8 And we have to put these things in order. So to  
9 the degree you take a look and say, well, if I were  
10 the administrator and I wanted to really make sure  
11 that, along with all these other things, I also  
12 advanced the health of women and girls, I would do  
13 these five things in the first cohort of activity.  
14 And here's why.  
15 I mean, I think that would be a good -- and,  
16 obviously, for other populations of interest, et  
17 cetera, you can do that. But that is some of the  
18 process that we're going through, just, you know, in  
19 parallel with these meetings right now. People are  
20 doing that and, sort of, doing that sort of a has to  
21 come before b, comes before c. Or if I have to choose  
22 between a and b, I'm doing a now and b later. So is

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1 someone getting them copies? Okay.

2 So for those of you who need them, we'll have

3 copies of that for you to look at.

4 Okay, Starleen?

5 MS. SCOTT-ROBBINS: Just to give you an idea what

6 the Women's Services Network -- the pregnant -- we

7 have four different subcommittees. And the Pregnant

8 and Parenting Subcommittee right now -- they're, kind

9 of, focusing on ESPER and ensuring that you are able

10 to identify women early, particularly in their

11 pregnancy so that you can have a larger impact on the

12 birth outcome.

13 They are also looking at parenting skills and the

14 need for evidence-based practice to ensure that women,

15 particularly because a lot of the women who come into

16 treatment get their children back and have not had

17 them in their custody for such a long time, that you

18 want to ensure that they can be as successful as

19 possible when they are getting reunified with their

20 children.

21 Our Criminal Justice Subcommittee has been

22 looking at how you can ensure that women who are

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1 transitioning from the criminal justice environment

2 can transition back into the community with the right

3 supports to prevent them from going back into that

4 situation. Our Data and Outcomes -- they're looking

5 at how you can utilize the data and outcomes from the

6 programs to build on the successes and to help support

7 better outcomes for our programs and also to use that

8 data to also sustain programs, to be able to make the

9 argument that treatment works and that this is a way

10 for, not just the federal government, but foundations

11 and private dollars to help support the programs.

12 So I think all of those are things that, you

13 know, kind of, fit into the strategic initiatives, one

14 way or the other. And so, I would just like to make a

15 bid for the block grant. I think it's absolutely

16 wonderful that the women's set-aside is there and

17 available to states. And as we, kind of, broaden that

18 look into the mental health arena, how can we ensure

19 that the services that pregnant women and women with

20 children who have a mental disorder actually are

21 getting gender-specific treatment services?

22 I was sharing earlier that as we're doing the

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1 uniform block grant, that we actually have data that

2 shows the number of women who have a primary mental

3 illness. But we don't know what type of treatment

4 they're getting. And so, we're going to use this as

5 an opportunity to understand better what it is they're

6 getting and how we can help enhance and enrich what

7 they're receiving when they're in treatment.

8 The block grant, as we move forward in health

9 care reform, is also extremely important because of

10 the residential services that are currently supported

11 -- that aren't supported through Medicaid. We have a

12 long history of working with Child Welfare and helping

13 families get reunified. And for Child Welfare, that

14 means in a safe, structured environment, at least

15 initially.

16 And I would like to just put out there that

17 without those services, we have a lot of families that

18 would never get back together. So I just want to

19 advocate for us to be looking for effective

20 residential supports within our community to make sure

21 that those are available for families so that they can

22 either remain together or to be reunified.

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1 Also, recovery-oriented systems of care -- we

2 talk about that all the time. But are those gender-

3 specific?

4 And you talked a bit about that this morning,

5 Jean.

6 DR. CAMPBELL: Well, I was just thinking that the

7 results of --

8 MALE SPEAKER: Microphone.

9 DR. CAMPBELL: -- that just what you were saying

10 about unifying the families and bringing them back

11 together, those covariant data suggest that that would

12 be a successful program for increasing the well-being

13 of those individuals and their resilience in the

14 community.

15 MS. SCOTT-ROBBINS: So I think there's a lot of

16 things that we could be looking at that don't take a

17 lot of money, but -- and, certainly, are on the

18 agendas of the states right now, but how SAMHSA can

19 help support, you know, those activities would be,

20 kind of, the way that, I think, this committee could

21 help figure out how we could support states in moving

22 forward with those agendas.

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

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

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

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

2 MS. ENOMOTO: I think we actually have just  
 3 started talking with -- can I talk about MacArthur?  
 4 We're talking with MacArthur Foundation as well  
 5 as Office of Justice Programs, juvenile justice  
 6 delinquency programs, about -- and I think RWJ as well  
 7 -- but something that looks at disproportionate  
 8 minority youth in juvenile justice in collaborating  
 9 and getting states together with some folks that have  
 10 best practices and the research base that shows that  
 11 there are alternatives to incarceration, ways to  
 12 prevent kids getting there as well as to divert them  
 13 from that juvenile justice involvement at an earlier  
 14 age. So we're certainly looking at that, both on the  
 15 substance abuse and on mental health sides for young  
 16 people.

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

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

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

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

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

21 [Laughter.]  
 22 MS. HYDE: The answer to your question is a

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

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

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



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1 abuse side more than the mental health side, about,  
2 "You can't make us do anything that's not in the law."  
3 So the best we could do is put it in there as a  
4 population that we encourage them to address.  
5 MS. BENAVENTE: Would it be as difficult or more  
6 difficult to raise the minimum 20 percent set-aside  
7 for prevention to, you know, half and half, 50 maybe?  
8 MS. HYDE: Well --  
9 [Laughter.]  
10 MS. HYDE: Any of those require congressional  
11 action. Now, if you've watched the newspapers lately,  
12 you would know that the concept of congressional  
13 action is a strange concept.  
14 [Laughter.]  
15 MS. HYDE: Right? It's a paralyzing concept at  
16 the moment. So it's a little frustrating, because we  
17 are left with a 20-year-old law that we have to try to  
18 live within. And the world is very different today  
19 than it was in 1992.  
20 However, what we have tried to do -- and we're  
21 getting push-back about this as well -- we have tried  
22 to pull prevention out, the 20 percent set-aside out,

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1 and combine it with some other prevention funds,  
2 because we have a plethora of prevention programs and  
3 tried to put it together into a state, which would  
4 mean tribes as well -- I mean, territories as well --  
5 state, a substance abuse state prevention grant and a  
6 separate mental health state prevention grant. There  
7 are individuals -- and there's some public positions,  
8 so I assume it's okay to say. The state substance  
9 abuse directors, along with some other substance abuse  
10 advocates, have taken the position they don't want us  
11 to pull that out and put it that way.  
12 What we were trying to do was protect the  
13 prevention dollars, because we know there are going to  
14 be cuts. And when it's 20 percent of a hundred, and  
15 the 100 drops down to 70, then it's less money. So  
16 what we were trying to do is pull the 20 percent out  
17 and hold it harmless from some of those cuts. And we  
18 haven't been able to get very far with that at this  
19 point.  
20 So it is our number one priority. Prevention is  
21 our number one priority. I think we have an  
22 opportunity here in a way that we haven't ever had

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1 before to both get the prevention science for both  
2 substance abuse and mental illness in front of people  
3 and also, because there is such a push for prevention  
4 in the health reform bill. But we're having a hard  
5 time getting traction on doing that.  
6 And what we also did, though, is when we proposed  
7 that pull-out, that set-aside pull-out, that would  
8 require language that says, "notwithstanding the  
9 language in the law." Because I don't know if you  
10 know how Congress works, but there is, like,  
11 authorizers, and there's appropriators. And they  
12 don't like you messing with each other's authority.  
13 So if the appropriators pull out language and  
14 says, "notwithstanding what those guys over there did,  
15 we want to use the money this way," they don't, kind  
16 of, like it so much. So we were trying with that,  
17 kind of, notwithstanding language to pull prevention  
18 out, and at the same time, let states and territories  
19 continue to spend -- in some cases, they do spend more  
20 than 20 percent of their block grant for prevention.  
21 So we were trying to preserve their right to spend  
22 some of the treatment dollars for prevention, if they

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1 wanted to do so.  
2 So we're on the same side here, I think. We're  
3 just -- our hands are tied a little bit by some of the  
4 congressional constraints. And I'm not, sort of,  
5 doing that to try to dump on Congress, but rather to  
6 say there is a role for the legislative branch. And  
7 they haven't acted for a while on that side. So until  
8 they do, we are stuck with the language that's there.  
9 MS. BENAVENTE: Just one last thing for now is,  
10 again, just restating the importance of being a part  
11 of national surveys. None of the Pacific Islands are  
12 included in the NSDUH. We are struggling with  
13 understanding a way in which we could gather data that  
14 may or may not be comparable to other Pacific  
15 Islanders and Asians that live away from the Western  
16 Pacific and American Samoa. Because a lot of -- you  
17 know, being in the field for such a long time doesn't  
18 mean I know a whole lot. I still wonder what it is  
19 that I know.  
20 So you've got this healthy people 20 -- what year  
21 is that? 2020, which is reflective of information  
22 that has been gathered from these surveys; right? So

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

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

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

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

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

15 If we've got NIDA and CDC and us and ONDCP -- all  
16 these acronyms, but bunches of different agencies all  
17 doing separate programs for under-age drinking, that  
18 may not be the best use of limited dollars.

19 Unfortunately, our stakeholders tend to look at just  
20 our budget or just the line item in our budget they  
21 care about or whatever and then think we don't care  
22 about a particular issue because we can't continue to

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

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

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

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

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

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

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

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1 DR. FELITTI: Well, I don't know what sort of  
2 limitations you -- I mean, basically, it would be to  
3 try to influence a soap opera and, obviously, would  
4 not cost very much money --  
5 MS. HYDE: Yeah.  
6 DR. FELITTI: -- if you were skillful at --  
7 MS. HYDE: I was actually teasing a little. But  
8 we do actually have a program where we reward TV and  
9 entertainment programs for doing the right thing by  
10 our topics. So I can't remember if there's been soap  
11 operas --  
12 DR. FELITTI: Is it Hollywood Health and Society  
13 Program?  
14 MS. HYDE: No, it's called the Voice Awards. We  
15 have two of them right now.  
16 DR. FELITTI: Okay.  
17 MS. HYDE: The Voice Awards that we do in the  
18 fall, and then, we support -- it's not our program,  
19 but the Entertainment Industry Council does a Prism  
20 Awards that we provide a little funding to.  
21 DR. FELITTI: Yes, okay.  
22 MS. HYDE: But it more calls out good programs

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1 that -- whether it's TV or movies or whatever that are  
2 sending the right message. So there may be ways that  
3 we can -- last year, we focused on military families.  
4 And it was amazing how many military-themed programs  
5 there were dealing with PTSD, substance abuse, even  
6 trauma issues and other kinds of things. So sometimes  
7 maybe by calling it out, we can get some attention to  
8 it. So it's a good point.  
9 MS. ENOMOTO: We also did some developmental  
10 activities through some of the guild organizations,  
11 trying to reach the Writer's Guild and some producers  
12 and directors in the L.A. entertainment industry,  
13 community to talk to them about women's health issues.  
14 And we worked with Hollywood Health in Society on a  
15 consultant basis as well. So, I mean, you know,  
16 there's -- we can -- I think we said you can lead the  
17 horse to -- what was it?  
18 MALE SPEAKER: [Inaudible.]  
19 MS. ENOMOTO: No. She said --  
20 MS. FORMAN: You can lead a horse to drink, but  
21 you can't make it water.  
22 MS. ENOMOTO: Yes.

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1 [Laughter.]  
2 MS. ENOMOTO: Yes. So, you know, I mean, I think  
3 we are, as aggressively as we can, putting the  
4 information and the opportunity for consultation out  
5 there. And it's really just a matter of getting that  
6 kind of pick-up. But, yeah.  
7 Yolanda?  
8 MS. BRISCOE: I do appreciate you saying that you  
9 were doing more collaboration, because, as providers,  
10 doing more with less -- we're called to do that. With  
11 the SAPT grant, where it says that women and pregnant  
12 women are a priority -- but if you're waiting for the  
13 phone to ring for a pregnant woman to call you, it's  
14 not going to happen. You have to go to the health  
15 care for the homeless. You have to go to the Welfare  
16 Department. You have to -- because there's so much  
17 fear in education around, no, we will not call the  
18 police when you come get treatment here, and this is  
19 confidential, and there are laws to protect you.  
20 And so, really our wait list, when we first  
21 started it, was predominantly men. And yet, we're  
22 asked to address women and HIV and injection users in

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1 a population that isn't likely to say, "Hi, how do I  
2 get into your treatment facility? My OBGYN  
3 recommended that I come see you." It's women who  
4 haven't even gone to an OBGYN. So clinics -- going to  
5 clinics and getting -- formulating really strong  
6 relationships with those kind of clinics has been very  
7 helpful for us. And I share this because one of the  
8 wonderful things that I enjoy about being on this  
9 committee is that I learn so much, and then, I go back  
10 and then, try to implement some of the things such as  
11 ACE and doing training around that and doing it around  
12 trauma-informed services.  
13 So I offer that as something that -- for wait  
14 lists, that going after the population is it takes a  
15 lot of outreach. You don't get reimbursed for that.  
16 But it's just the right thing to do. Thank you.  
17 MS. ENOMOTO: I'll go to Bobby in a second. But  
18 I do -- Johanna, I'm just going to give you a heads up  
19 that if you want to comment, I'll give you a second to  
20 think about it. And then, we'll come back to you, if  
21 you're still on the line.  
22 Okay, all right.

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

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

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

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

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

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1 even have enough to serve our own civilian population.  
2 And there's only so much that we will have access to  
3 if we can't get on the military bases without being  
4 sponsored by someone who has the I.D. to go in there.

5 We are provided free services to military personnel  
6 and their families when they leave the base for mental  
7 health and substance abuse treatment services, because  
8 they want to keep things under wrap from their  
9 command. So we can't say, "Guess what, Rear Admiral  
10 So and So, we need you to compensate the local  
11 government because we're providing all of this value  
12 of services to your people."

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

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

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

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

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

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1 it's -- we're working on it this much compared to the  
2 problem. So I think it would be worth -- and she'll  
3 be here tomorrow. So I think it would be worth to  
4 have a conversation with Kathryn Power about that.

5 We've got memorandums of agreement with the V.A. and  
6 with the Department of Defense Center of Excellence.

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

11 MS. ENOMOTO: Johanna?

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

14 I guess my question, as I'm listening to this, is  
15 how can we -- and how can SAMHSA encourage these same  
16 kind of conversations and collaborations between the  
17 different departments on a state level, on a more  
18 local level. It seems like -- I don't know. We just  
19 need to be told -- as we work in this field, we just  
20 need to be told SAMHSA just didn't stop this priority.

21 Now they're in conversations and making sure it's  
22 continued with another department.

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

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

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

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

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

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

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

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

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

17 MS. HYDE: Okay.

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

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

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

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

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

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

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

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

11 MS. ENOMOTO: Harriet?

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 and we still wouldn't be anywhere near meeting needs.  
2 So the question is what's the right balance, and  
3 where do we -- my own experience also tends to be that  
4 people will develop residential programs.  
5 And because there isn't anything else, then  
6 everybody gets put in there. And they get put in  
7 there for way longer than they should because there's  
8 nothing to let them help them once they get out, which  
9 is why we're trying to develop the recovery supports  
10 and all of these other kinds of efforts.  
11 I know in New Mexico -- and, Yolanda, you may  
12 remember this. And we were told, because there was a  
13 court program who wanted to deal with men coming out  
14 of the court system. And as we started developing the  
15 facility -- it was supposed to be a residential  
16 treatment facility. And we started developing it.  
17 And we said, you know, the first group that needs this  
18 is women with children. So we designed it as women  
19 with children.  
20 We, frankly, never got even that far with it  
21 because the budget only let us do the first anchor  
22 building. But the design of that program now is an

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1 anchor building for women, men, and children that's  
2 outpatient, intensive outpatient, and then, women with  
3 girls residential next. And then, if we ever have  
4 time -- pardon?  
5 MS. FORMAN: Women with children?  
6 MS. HYDE: Women with children. What did I say?  
7 MS. FORMAN: Girls.  
8 MS. HYDE: Oh, women with children. Sorry.  
9 So the point here is often, it is -- frankly,  
10 it's often courts. And that's a good thing. It's  
11 often courts and law enforcement that are driving the  
12 we need services discussion. And the people that are  
13 in front of them may or may not be women and girls,  
14 for the reason -- children, for the reason that you  
15 said. And yet, when you step back and look at what  
16 the design needs to be first for the limited dollars  
17 that you have. You know, that's where you go.  
18 But this is going to be -- continue to be a hard  
19 one, because there's just not enough dollars. And  
20 it's -- even in things like a program where you've got  
21 -- like our pregnant, parenting women program where it  
22 has been traditionally a lot of residential, we're

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1 having to think, well, are there other ways we can  
2 serve pregnant and parenting women short of  
3 residential, because you can serve so many more women  
4 if you don't do it in a residential setting. So it's  
5 not about thinking that residential is somehow awful.  
6 It is a matter of what's the right balance with very  
7 limited dollars, and where do you try to stretch those  
8 dollars the best way you can. So, yeah.  
9 MS. SCOTT-ROBBINS: And I believe that  
10 residential is one of those situations, though, where  
11 the collaboration and coordination with all of those  
12 other agencies that help support that family make the  
13 difference in terms of the funding. Because when  
14 you're working with Child Welfare and public health  
15 and domestic violence and with the criminal justice  
16 system, I think all of them share a piece of  
17 supporting that family, because they're all the ones  
18 who -- and child mental health and the system of care,  
19 who are all going to help make that family successful.  
20 And so, that's one of the things that we look at  
21 when we do an RFP, is what is the support of all the  
22 other partners who have the same, exact families, who

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1 want the same, exact outcomes. And that's why I  
2 think, you know, the discussion that you had earlier  
3 about, you know, it's not always SAMHSA's, you know,  
4 number one priority, because it's six other people's  
5 priority, too.  
6 I think we have to have those partnerships at the  
7 state level to help maintain those things that we know  
8 actually help families recover and be healthy. And  
9 so, you know, I wasn't actually putting the  
10 residential piece out there because of what I've heard  
11 you say in the past. I think that it is a key piece  
12 for some families in order to stay together or to get  
13 reunified. And if we don't have that as a part of the  
14 continuum, I think we will see a lot more moms in  
15 jail. I think we'll see a lot more kids in foster  
16 care, et cetera. But I think that it is a part of the  
17 continuum. So I was just putting it out there.  
18 MS. HYDE: Yeah, no, I agree with you. And we've  
19 had some really good relationships with the  
20 Administration on Children and Families, especially  
21 Bryan Samuels and that Children, Youth and Families  
22 Group. And actually, Larke and I and a couple of

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1 other people just went over and met with them.  
2 They're doing some terrific stuff around trauma issues  
3 and around service delivery issues.  
4 And I really liked the way Bryan talked about it,  
5 which is just because you take a child out of a  
6 dangerous or a negative situation, doesn't mean all of  
7 a sudden, they're okay. I mean, the way -- just the  
8 way he described that was a good way to think of it,  
9 because I think that's the way society thinks. We'll  
10 just get them out of that bad situation, then they'll  
11 be okay.  
12 And, you know, the trauma that's remaining, the  
13 separation that's remaining and all of those -- huge  
14 issues. So they're really doing a lot of data driven,  
15 trying to look at the data that tells them about their  
16 kids and the families that are behind those kids and  
17 what they can do about it differently. And we're very  
18 much a partner with them about that. So I appreciate  
19 your input.  
20 MS. ENOMOTO: All right. Thank you.  
21 Yolanda, make the last comment, and then, we're  
22 going to break. So go ahead.

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1 MS. BRISCOE: I completely agree about  
2 residential [inaudible] --  
3 MALE SPEAKER: Microphone.  
4 MS. BRISCOE: The residential piece is just a  
5 small, tiny piece. We get individuals for 30 days.  
6 The community gets them for a lifetime. But if you  
7 don't have that support of housing or employment  
8 afterwards, it's just a revolving door. And so, those  
9 supports have to be built in.  
10 MS. ENOMOTO: All right. Thank you, everybody,  
11 for a robust discussion. And we will be back here in  
12 10 minutes. Thanks.  
13 [Break.]  
14 MS. GRAHAM: The meeting is now called to order.  
15 Thank you, Sharon.  
16 MS. AMATETTI: Thank you.  
17 Okay, we wanted to spend hour, hour and-a-half or  
18 so on a subject that actually was brought to us by  
19 Stephanie Covington. Although she is not here with us  
20 today, she did influence the agenda for this meeting.  
21 So, as you'll see in your agenda, we're talking about  
22 gender specificity across behavioral health. And we

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1 wanted to really spend some time looking at what  
2 gender specificity and responsiveness means across the  
3 different domains of substance abuse treatment,  
4 substance abuse prevention, mental health prevention  
5 and treatment, because we know that when we talk about  
6 being gender responsive in those different domains,  
7 that we're not always talking about one in the same  
8 thing.  
9 Our work really has been influenced by many  
10 different things, sometimes by science, sometimes by  
11 politics, advocacy, also the way that services are  
12 organized. The way they're organized in treatment and  
13 the way they're organized in prevention and mental  
14 health services are not necessarily one in the same.  
15 Okay, so that was what really prompted us wanting  
16 to look at. But we know that there are differences.  
17 We are trying to do more across behavioral health now.  
18 And we thought it was important for us to spend some  
19 time talking about what that means.  
20 In SAMHSA, we have a paper, the Good and Modern  
21 Paper, which I think most of you have heard about.  
22 And it states that the goal of a good and modern

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1 system of care is to provide a full range of high-  
2 quality services to meet the range of age, gender,  
3 cultural, and other needs presented. And  
4 interventions that are used in a good system should  
5 reflect the knowledge and technology that are  
6 available as part of modern medicine and include  
7 evidence-informed practice. So we think of services  
8 that are good and modern as services that do attend to  
9 gender differences.  
10 So I wanted to set the stage for this discussion  
11 by highlighting the work that has been done in  
12 SAMHSA's Center for Substance Abuse Treatment, the  
13 center that I'm most familiar with. I've asked my  
14 colleague, Mary Blake, to talk about what our Center  
15 for Mental Health Services has done, the work that  
16 they've done around gender-responsive services.  
17 I've asked Patricia Getty to talk a little bit  
18 about what the Center for Substance Prevention has  
19 done, the history of that work there. And then, we've  
20 invited two guests to help lead this conversation, Dr.  
21 Carole Warshaw and Dr. Hortensia Amaro, who we are  
22 expecting to come in shortly. And I'll introduce them



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1 a little bit more in a few minutes.  
2 But so to begin with, I wanted to really talk  
3 about, you know, what we've been doing in the Center  
4 for Substance Abuse Treatment around being gender  
5 responsive and the way that we approach our work.  
6 When SAMHSA was created, we had a body of work that we  
7 were able to build on from the National Institute of  
8 Drug Abuse and the National Institute of Alcohol Abuse  
9 and Alcoholism that looked at specific addiction  
10 treatment concerns of women.  
11 Our first discretionary portfolios included large  
12 residential women and children programs as well as our  
13 pregnant and post-partum women's grants, which we're  
14 continuing today under the leadership of Linda White-  
15 Young, who was here earlier. I'm not sure she --  
16 she'll be back, though, I'm sure.  
17 We also have been talking this morning about the  
18 block grant and the block grant set-aside. The first  
19 block grant set-aside was in 1984, which at that time,  
20 5 percent of the funds were supposed to be set aside  
21 for women's services. It increased in 1988 to 10  
22 percent. And then with the subsidies prevention

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1 treatment block grant, there was much greater  
2 definition about what those services should look like.  
3 What was the money intended to be spent on was  
4 defined in a much more prescriptive way by Congress,  
5 because there was a feeling that the money wasn't  
6 really being spent on services that were intended for  
7 women and women and their children.  
8 Over time, we've also documented our approaches  
9 and lessons learned. The very first effort to  
10 document at CSAT what women's services should look  
11 like was in what we call the Purple Book. I think I  
12 have the last remaining copy. Practical approaches to  
13 the treatment of women was our very first effort in  
14 the early 1990s. And at that time, we just got  
15 together in an advisory group, and this is what they  
16 thought should include best practices. And that's  
17 what went into the book.  
18 As we started having more experience with our  
19 residential treatment grants, the large-scale,  
20 comprehensive programs I told you about, we tried to  
21 document that work as well. And we did it through a  
22 lessons learned document, telling their stories, which

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1 was the grant program's words about what they thought  
2 was effective services for women and women with  
3 children.  
4 As we moved along, we thought it was important to  
5 try and really articulate in a more prescriptive way  
6 what it was -- what they were trying to tell us when  
7 they were telling their stories. And so, a group put  
8 together the CSAT model for comprehensive services for  
9 women and women's programs. And at that time, we  
10 talked about clinical treatment services for women,  
11 clinical support services for women, and community  
12 support services for women in a model.  
13 And then, we went and did the same thing for the  
14 children. What would clinical services look like for  
15 children as well as clinical support and community  
16 support services for children? That ended up being  
17 documented and finally published in the SAMHSA Tip for  
18 Women. This is our Treatment Improvement Protocol,  
19 which I know you all know about the TIP Series.  
20 Actually, it just came out a year ago, this TIP on  
21 women. Although it was under development for quite  
22 some time.

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1 As our field has grown, we've appreciated the  
2 fact that women do not exist in isolation, certainly,  
3 and that, not only are our children important, but  
4 family is important as a concept that needs to be part  
5 of treatment and recovery. We developed a paper on  
6 family-centered treatment for women with substance  
7 abuse disorders, history, key elements, and  
8 challenges. It was developed by a working group,  
9 including the Rebecca Project for Human Rights that  
10 was helping to promote the model of residential care  
11 for women and children, but to also look at, sort of,  
12 a continuum of what does family. And so, we have  
13 tried to articulate that for the field in this paper.  
14 And, of course, people said, well, that's nice to  
15 have family-centered treatment, but how are we going  
16 to pay for it. So then, we developed funding family-  
17 centered treatment for women with substance abuse  
18 disorders. You can see it's a longer document than  
19 the actual model. And that is now going to become  
20 dated, actually, as we move into health care reform  
21 and changes that are going to be taking place.  
22 There's probably going to be a need for updates to how

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1 to fund family-centered treatment for women and  
2 children.

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

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

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

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

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

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

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1 being really best practices for women.

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

10 And then, some of the key questions as we move  
11 forward -- you know, how do services that have been  
12 described as evidence-based and, say, that are fitting  
13 into a changing environment impacted by health care  
14 reform as well as just the state and federal budgets.

15 And I think that's something that we're all going to  
16 be looking at and trying to answer those questions in  
17 years to come.

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

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

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

6 MS. BLAKE: Thanks, Sharon, very much.

7 I'm actually going to speak a little bit,  
8 actually, about gender responsiveness in the context  
9 of what we've done around trauma within the Center for  
10 Mental Health Services. And just to say that  
11 historically, I think, gender-specific or gender-  
12 responsive services have not really been the hallmark  
13 of mental health treatment, per say. But in the early  
14 1990s, I think there was a growing recognition that  
15 many of the people served through mental health  
16 services had experiences of abuse, neglect, violence,  
17 and other, kind of, traumatic experiences that was  
18 seriously under-addressed, under-reported, under-  
19 diagnosed, under-asked.

20 And SAMHSA held a seminal meeting called --  
21 sorry.

22 FEMALE SPEAKER: Dare to Vision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 Some of the things that we're doing through the  
12 Center for Mental Health Services right now in terms  
13 of looking at issues around gender responsiveness --  
14 we are participating on a federal partners committee  
15 on women, girls and trauma. This is a committee that  
16 was established about a year-and-a-half, two years ago  
17 and is really a cross-agency -- I think we have over  
18 35, 40 agencies and sub-agencies represented on this  
19 federal inter-governmental committee, really looking  
20 at what are the issues for women and girls in  
21 particular as it relates to violence across the  
22 spectrum of the various ways that they access services

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1 or support. It could be through health. It could be  
2 through employment. It could be through social  
3 services.

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

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

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

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

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

20 Thank you.

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

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1 actually was on leave today, so I really appreciate  
2 that you came in to be with us. Thank you again.  
3 And, Patricia, if you would share a few minutes  
4 about CSAP perspective.  
5 MS. GETTY: Thank you, Sharon.  
6 I'm going to talk specifically about a topic  
7 that, as I've been listening today, has popped up a  
8 number of times. And that is around the Fetal Alcohol  
9 Spectrum Disorder. We have within prevention a  
10 contract specifically to address those issues.  
11 But to give you a little bit of background, how  
12 we got to this point was in 2001, there was a  
13 congressional earmark specifically for providing  
14 services around FASD. And it works on several levels.  
15 For example, NIH is focusing specifically on research  
16 around FASD. The Center for Disease Control is  
17 looking at the surveillance component. And what fell  
18 to SAMHSA was specifically looking at what kinds of  
19 programs can we implement on a prevention level that  
20 would make a difference in reducing the number of  
21 incidences of FASD births.  
22 As you know, Fetal Alcohol Spectrum Disorder is a

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1 100 percent preventable problem that we have in our  
2 country. So we wanted to take a look at, specifically  
3 in SAMHSA, how do we develop, implement, and  
4 disseminate information and innovative techniques that  
5 produce effective strategies for reducing, preventing,  
6 and eliminating FASD.  
7 It has, out of that, developed a collaborative  
8 effort. It's called -- I love acronyms -- ICCFASD.  
9 It's the Interagency Coordinating Committee on FASD.  
10 And it brings together all of the federal agencies,  
11 SAMHSA, NIH, HRSA, CDC. NIAAA heads it up. And we  
12 meet on a regular basis to really make sure that we  
13 effectively collaborate all of our varied interests.  
14 And, as you can tell, each of the agencies have a role  
15 in that process.  
16 Before I go into more specifics on what we're  
17 doing here in SAMHSA with the FASD Center for  
18 Excellence, I want to interrupt this program and bring  
19 you some good news. I think we talk about all the  
20 issues and the problems, but there are a couple of  
21 things that I wanted to bring to your attention. And  
22 that is in 1998, SAMHSA began to establish programs in

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1 the state of Alaska around preventing FASD. And we  
2 have been working with them through a multi-media  
3 process, through ESPERT and intervention programs  
4 within agencies in the state of Alaska. And I am so  
5 excited about this, I can't contain myself.  
6 New prevalence data indicates the overall FAS  
7 birth prevalence rate in the state of Alaska decreased  
8 from 19.9 to 13.5 per 10,000 live births. In a period  
9 of 10 years, we have made an impact. What we need to  
10 do is to learn the lessons from that experiment and  
11 apply it to other agencies.  
12 However, that's not the best part. The best part  
13 is we truly focused on Native American populations.  
14 And in the state of Alaska, there has been a decline  
15 in Alaska Native populations with a 49 percent decline  
16 from 63.1 to 32.4 per 10,000 live births. Think about  
17 it, folks. A 49 percent decrease because we're  
18 focusing on prevention programs of a totally  
19 preventable problem. That so excites me.  
20 The thing you have to put into perspective is  
21 it's only a beginning. But we know we can do it. And  
22 we know that our efforts make a difference. It's how

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1 do we now take what we have learned in the state of  
2 Alaska and expand it to all of our different agencies.  
3 So what we wanted to look at is we always think  
4 in terms of prevention programs. Let's put placards  
5 in bars, drinking during pregnancy may cause damage to  
6 your child. We have put in birth test kits -- you  
7 know, the little pregnancy test -- warnings. So if a  
8 woman thinks that she might be pregnant, we've put  
9 warning labels. Southwest Airlines now has -- when  
10 they serve alcohol, they now have messages that  
11 basically say that drinking during pregnancy may cause  
12 a problem to your child.  
13 So in looking at that, we went back and took a  
14 look at the NSDUH data, which is produced here at  
15 SAMHSA. And we did a survey of what we call women of  
16 child-bearing age. And that's the 18 to 44-year-old.  
17 And we ask, in the past month, questions around binge  
18 drinking. And what we discovered is that 32 percent  
19 of women of child-bearing age, 18 to 44, in the past  
20 month, report an incidence of binge drinking.  
21 So we looked at what is our efforts, what  
22 differences have we made since that time, as far as

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1 women, once they discover they're pregnant. If we  
 2 have college women, women of child-bearing age that  
 3 are binge drinking at that rate, it's very much a  
 4 concern.  
 5 So we looked at, in the first trimester, as a  
 6 result of our efforts around the prevention message.  
 7 It dropped to 8 percent, which means once a woman  
 8 begins to discover or is planning on becoming  
 9 pregnant, we are getting the message across to some  
 10 women that if you're going to be pregnant, you don't  
 11 drink.  
 12 In the second trimester, it drops to 1.8 percent;  
 13 third percent [sic], 1 percent. Now, that sounds  
 14 wonderful. But when you think of 1 percent of a large  
 15 number of women, that's still a lot of women that are  
 16 drinking in the second and third trimesters. The  
 17 concern we have is once they deliver, those numbers go  
 18 up again.  
 19 But what we wanted to look at is, obviously,  
 20 women are getting the message that once they become  
 21 pregnant, many of them quit drinking. But who are  
 22 these women that continue to drink while they're

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1 pregnant? Where can we reach out to them? Where can  
 2 we find them and help them?  
 3 One of the problems that we've run into is many -  
 4 - there is a stigma associated with a woman who drinks  
 5 during pregnancy or gives birth to a child with an  
 6 FASD. We have many states that have passed  
 7 legislation that makes it punitive for a woman to  
 8 drink during pregnancy. We talked earlier today about  
 9 the problem with women hesitant to go into treatment  
 10 programs, even though their OBGYN doctor may recommend  
 11 it. We still run into problems with that woman.  
 12 So where are these women? And how can we help  
 13 them? They are in treatment programs. They are in  
 14 WIC programs. They are seen in health care units. So  
 15 what we've began to do with the FASD Center for  
 16 Excellence is develop programs that target those high-  
 17 risk women.  
 18 And through sub-recipients with the FASD Center  
 19 for Excellence, we have worked collaboratively with  
 20 the Center for Disease Control to develop a - it's  
 21 called Program Choices. And we are implementing that  
 22 in many of the WIC programs in the health care units

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1 to begin to identify these women, help them understand  
 2 the dangers that they are looking at with alcohol-  
 3 exposed pregnancies.  
 4 We are using -- it's not the S-BERT, as you  
 5 normally would see it, because we don't refer for  
 6 treatment. But it is a brief intervention for many of  
 7 these women. And that's the direction that we're  
 8 going. We are continuing with the overall prevention  
 9 message, but we're also looking at targeting high-risk  
 10 women in high-risk settings so that we can decrease  
 11 even further those small amounts of women that are  
 12 drinking in their second and third trimesters.  
 13 Very exciting that we're making inroads, but also  
 14 very concerned that we still have a large number of  
 15 women, as we were talking about the woman who is  
 16 sitting on an airplane and her husband's saying, "Come  
 17 on, Honey, just one or two more drinks." Those are  
 18 the values, those are the attitudes that we still have  
 19 to work on.  
 20 So we're working at multiple levels: number one,  
 21 the general population, changing the environment,  
 22 changing the policies, but also looking at those women

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1 in targeted high-risk population areas, moving to  
 2 where we can find them. And one of the things that's  
 3 very important within SAMHSA is many of them are found  
 4 in treatment programs. They're found in mental health  
 5 programs. And so, a lot of this effort is that  
 6 collaborative movement between multiple federal  
 7 agencies working to make a difference around the FASD  
 8 project. Thank you.  
 9 MS. AMATETTI: Thank you.  
 10 DR. FELITTI: About eight minutes ago, you  
 11 mentioned -  
 12 MALE SPEAKER: Microphone.  
 13 DR. FELITTI: About eight minutes ago, you  
 14 mentioned that the success in Alaska was attributable  
 15 to a multi-media approach. Could you specify what the  
 16 multi-media approach was?  
 17 MS. GETTY: That was one of the techniques that  
 18 they used. And they were provided funding -  
 19 DR. FELITTI: Yes. What does the word mean in  
 20 that one of the techniques?  
 21 MS. GETTY: They were using media campaigns.  
 22 They were using brochures. They were using

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

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

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

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

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

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

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

14 So I think we're going first turn to Dr. Warshaw.  
 15 And you can either advance your slides from here,  
 16 if you like? Would that work for you?

17 DR. WARSHAW: Yes.

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

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

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

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

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

20 DR. WARSHAW: Thanks.

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

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

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

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

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

8 The other thing that came up and I'm going to  
9 talk about in a little more detail from a needs  
10 assessment we did in Illinois for an OVW, Office on  
11 Violence Against Women-sponsored disabilities --  
12 Violence Against Women with Disabilities project --  
13 was the importance of gender-specific services and  
14 environments as well as gender-responsive treatments.

15 So we're talking about what happens in the service  
16 environment as well as the treatment and services that  
17 women are receiving. So part of what this  
18 conversation really is about -- and I think it links  
19 what we're all talking about -- is part of being  
20 trauma-informed, and because there's such a big push  
21 to be trauma-informed, means attending to gender-  
22 specific concerns, particularly around gender-based

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1 violence and gender-based trauma.

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

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

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

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

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

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

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

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

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

14 MS. FORMAN: Excuse me?

15 DR. WARSHAW: Yes?

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

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

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



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1 outreach work that we do is -- for example, if someone  
2 has a legal case, if her credibility is undermined in  
3 court -- we've done some work with judges, the  
4 National Council on Juvenile and Family Court Judges.  
5 They assume that if a woman has any mental health  
6 diagnosis, any mental health symptoms, that she's  
7 going to be an unfit parent and the abuser is going to  
8 be a better parent, because he's going to look more  
9 put-together than the woman that he's been abusing for  
10 years. So there's a lot of work to be done on those  
11 issues.  
12 I believe the Bazelon Center for Mental Health  
13 Law has done a case where using the ADA, the Americans  
14 with Disabilities Act, to say that a reasonable  
15 accommodation for parenting is to provide, you know,  
16 personal assistance to a woman that will allow her to  
17 then do the things she needs to do or reduce other  
18 stressors in her life so she can a good parent. And  
19 one of the ways this comes out is the retraumatization  
20 in mixed-gender settings. And we'll talk about what  
21 women had to say about that from a needs assessment.  
22 So this was done, you know, as part of a -- it's

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1 not a formal research study, so I wasn't sure whether  
2 I could present this or not. It was really an  
3 internal needs assessment. And this was a  
4 collaboration with a peer support advocacy program,  
5 Lucy Sajak's Growing Place Empowerment Organization,  
6 Illinois Coalition Against Domestic Violence, the  
7 Illinois Department of Human Services Division of  
8 Mental Health, a large D.V. agency, a large mental  
9 healthy psycho-social rehab agency, and us and our  
10 consultant in writing the grant.  
11 So what women said -- we did focus groups of  
12 women who were in in-patient state psychiatric  
13 hospitals and in out-patient mental health settings.  
14 And they said that safety and security in the service  
15 environment was really critical and that women -- the  
16 heart of this is that women did not feel safe in  
17 mixed-gender settings.  
18 They talked about times when they felt unsafe  
19 because of other program participants, mostly men,  
20 whether they were an in-patient, drop-in, or  
21 residential settings, the lack of emotional safety  
22 when it was noisy and chaotic, loud, arguing -- people

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1 who were loud and arguing or aggressive behaviors made  
2 them feel frightened and triggered previous trauma.  
3 And they also talked about the literal lack of safety  
4 they experienced, like, actual assaults and harassment  
5 and stalking in residential settings.  
6 And we also -- this is -- some of this comes from  
7 T.A. requests we received, that women who worked in,  
8 kind of peer support programs and drop-in centers,  
9 that often an abusive partner was using the same  
10 services. And nobody knew how to address those issues  
11 of safety. So it was another whole, kind of, layer  
12 of, you know, both people have a right to receive  
13 services versus how do we address safety issues in  
14 settings where you want to make sure that everyone  
15 receives services.  
16 Women said that they looked to staff to set  
17 limits about aggression in the programs, but not all  
18 staff are equipped to meet these needs. And women  
19 also were very aware of their risk of abuse and  
20 violence from being female. It was they experienced  
21 that as gendered. But they didn't see the systems  
22 where they received services as paying attention to

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1 that. There were individual people who did, but it  
2 wasn't a priority issue.  
3 I mean, one of the things we were able to do with  
4 the Chicago Department of Public Health where we were  
5 working for many years with -- to have them change  
6 their intake screening so they didn't just ask, are  
7 you a danger to yourself or someone else, but are you  
8 in danger from another person, which led to a whole  
9 other set of questions. And because that cost so much  
10 money to add that question, they couldn't afford to  
11 add the next question, which was, what's a safe number  
12 that I could contact you so that maybe if you have a  
13 partner who you don't want to know about this, when we  
14 call, you won't be in danger.  
15 So it's, like, just very simple things, like  
16 asking about collateral information and when someone's  
17 in an emergency room and who you're asking that  
18 information from. Is it someone's who's abusive.  
19 Now, my colleague, Denise Markum, who's a lawyer,  
20 said, ask that information and document it, because  
21 people will say things that they don't even realize  
22 what they're doing is abusive. And it might help a

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1 woman in her custody battle if you actually have  
2 documented what an abusive partner has said.  
3 Now, this is what some of the staff said, was,  
4 because you're open to a range of people, some can be  
5 aggressive and loud, or that there's a two to one male  
6 to female ratio in some of the settings so that it's  
7 an intimidating environment for them. So it's just  
8 little things that we might want to think about.  
9 And again, this was women saying when they felt  
10 safe, how important it was when the program practices  
11 really took that into consideration. And again,  
12 SAMHSA -- Illinois had one of the reducing coercive  
13 practices grants. And that made a big difference of  
14 doing safety planning -- personal safety planning for  
15 these women.  
16 One of the things that staff talked about is,  
17 like, we have an empty unit. We could make a gender-  
18 specific unit. But we don't have the funds to do it.  
19 Or we can't have a separate unit because we have more  
20 male patients. Or how do we actually do that?  
21 And these were some of the things that people  
22 came up with: some segregation, keeping the woman

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1 closer to the nurse's station if they were feeling  
2 unsafe. But again, it's really thinking about how do  
3 we structure those settings. You know, coming from  
4 working on the domestic violence world, that's not an  
5 issue. You're in gender-specific settings. And then,  
6 when we're partnering with the mental health system  
7 where we want to refer women into that system, it  
8 doesn't necessarily feel safe.  
9 Again, not involving a family member in treatment  
10 who may be an abuser, making sure that you do safety  
11 planning on discharge -- are some very specific, easy  
12 things that can happen. But they weren't happening.  
13 So that's part of the work we're doing in this  
14 project, is making sure that attention to both trauma  
15 and domestic violence are embedded in every level of  
16 what's happening in those systems.  
17 Mostly what would happen is there might be an  
18 individual staff member who had their own personal  
19 experience or training, and they would become the  
20 local -- the expert in their agency. But it wasn't  
21 systematic. So again, this is more of a summary. But  
22 it's very clear that when we're talking about trauma

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1 informed, it's the physical safety and the emotional  
2 safety.  
3 One of the things that, I think, that you  
4 mentioned, Mary, was that we did have the programs in  
5 this project do what we called a CDVTI self-assessment  
6 accultured D.V. trauma-informed assessment -- self-  
7 assessment. And it included, you know, the physical  
8 environment, the relational environment, and the  
9 programmatic environment as well as policies and  
10 procedures and collaboration and how are staff  
11 supported to be able to be emotionally present and not  
12 reacting in ways that end up being retraumatizing.  
13 And again, this isn't about gender-specific  
14 services. But it is gender informed about what women  
15 said would make them feel safe and welcomed in their  
16 environment, so just the physical -- that it's  
17 cheerful, that there aren't unpleasant surprises, that  
18 flexibility -- the sensory environment is really  
19 important. But they were -- women were very clear  
20 about the need to have women-only spaces.  
21 And the second part was that women were very  
22 aware of abuse and violence in their lives. They said

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1 nobody asked them about it and that it needed to be  
2 addressed. And there were a number of ways this  
3 played out.  
4 One is wanting women's groups that deal with  
5 abuse and power and control and trauma, sort of, like,  
6 okay, how do we learn what to do, you know, having the  
7 resources, but also, to hear how other women deal with  
8 those experiences, so we don't have a chance to hear  
9 from other women about their own experiences and how  
10 they deal with these issues. And women were also  
11 concerned about confidentiality, and particularly in  
12 residential settings.  
13 And some of the other issues that came up was the  
14 lack of therapeutic staff. And so, one of the  
15 disparities is for people who were in the -- received  
16 private mental health services or private, not-for-  
17 profit where they can get higher-end trauma treatment  
18 that is often gender responsive because it evolved  
19 from the experiences of women as survivors.  
20 So some of the complex trauma treatment models  
21 really came from working with adult survivors of  
22 childhood sexual abuse. And some of the treatments

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1 around post-partum depression -- so that are gender-  
2 specific kinds of concerns -- there's treatment that  
3 reflects that. But for other women who are in the  
4 public sector who have, you know, diagnosed mental  
5 illness, there is nothing that's gender-responsive.  
6 Okay? So there's a disparity in who gets what  
7 kinds of treatment and what kinds of treatment is more  
8 gender responsive versus what people get who are  
9 getting served in the public sector.  
10 Okay. So how do reconfigure, how do you create,  
11 you know, gender-specific settings? How do you access  
12 resources in the community? How do we create respite?  
13 You know, if a woman is in danger physically and is  
14 having a mental health crisis, what are the safe  
15 places where women could go?  
16 Some of the outreach workers in one of the  
17 settings said for women who are living in the streets  
18 who -- coming inside is very frightening. Could there  
19 be a safe place where women could come in without a  
20 lot of requirements, where they could just come in and  
21 get what they need and not have to be part of a  
22 program that felt safe, unlike most shelters that

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1 women who are homeless go to that are literally not  
2 safe.  
3 So what kind of recommendations? Gender-specific  
4 settings or spaces, attending to physical and  
5 emotional safety in mental health settings, which  
6 means the relational part. With the budget cuts in  
7 Illinois, there's no time for supervision.  
8 There's psych. techs who have, you know, a high  
9 school degree who have no -- some people are  
10 wonderful, and some people aren't. And there's just  
11 nothing -- the kinds of supports that people need to  
12 be trauma informed aren't there. And it's heart-  
13 wrenching because there are people who are so  
14 committed and want to be able to do that, and they  
15 just don't have the resources.  
16 Having gender-specific programming and groups --  
17 so there's not a lot of evidence-based research on  
18 gender-specific, gender-responsive treatment in mental  
19 health. So that needs to happen. The do no harm  
20 level around safety -- when we're talking about  
21 enhanced services, we're also talking about supporting  
22 parenting and supporting the parenting capacity. And

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1 often, in substance abuse, you have combined services.  
2 In mental health, you often don't. It's very siloed.  
3 And when we're talking about child development and  
4 how do we move forward, there are a number of models  
5 that really support the parenting capacity of the non-  
6 abusive parent for a woman who's also under siege  
7 who's also been traumatized.  
8 And the community partnerships -- we're doing a  
9 lot of work with the domestic violence programs around  
10 the country, the 17, 1,900 programs and all the 56  
11 coalitions. And what they're finding is that when  
12 they need mental health services, that they don't  
13 exist in their communities, often in rural  
14 communities. And because services are free, they're  
15 often the place of last resort. And they want to  
16 serve women who are dealing with a range of needs.  
17 And they need those resources in place that are  
18 gender-responsive.  
19 One of the things we were thinking about is using  
20 tele-medicine or tele-psychiatry in developing, kind  
21 of, specific models for serving women in rural areas  
22 that are gender responsive and trauma informed.

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1 And the last thing I was thinking about was the  
2 post-partum depression. HRSA has an initiative that  
3 family violence prevention services program has also  
4 been involved with on post-partum depression and  
5 intimate partner violence. And there aren't a lot of  
6 models of how do you address both -- how do you serve  
7 a woman who isn't safe, who is really struggling and  
8 instead of having a supportive family, actually has a  
9 family that is abusive and controlling and undermining  
10 and may be one of the major risk factors for post-  
11 partum depression. So how do we create a new level of  
12 services and supports in the community that don't  
13 exist?  
14 So that's --  
15 MS. AMATETTI: Thank you very much, Dr. Warshaw.  
16 Our whole session [inaudible] just, you know,  
17 [inaudible] we will have time for just a few questions  
18 at the end.  
19 DR. WARSHAW: I had just one other point I wanted  
20 to make. One of the things we were able to do in  
21 Illinois was change the state Medicaid rule to include  
22 questions about current and past abuse and ongoing

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1 safety. But with the training dollars disappearing,  
 2 then people don't know how to and, because they don't  
 3 know what to do. And so, again, there's that whole  
 4 other level, so, on this subject.

5 MS. AMATETTI: System issues -- internal.

6 Let me go ahead and introduce Dr. Amaro. She's  
 7 the distinguished professor of Health Sciences at the  
 8 Bouve College of Health Sciences at Northeastern  
 9 University. She's developed two national model  
 10 substance abuse treatment programs targeted to Latina  
 11 and African-American women. One of her community-  
 12 based interventions with pregnant [inaudible] women,  
 13 the Moms Project, received national recognition by our  
 14 Department of Health and Human Services.

15 Dr. Amaro also developed the Boston Consortium  
 16 model, trauma-informed substance abuse treatment for  
 17 women, which is included in SAMHSA national registry  
 18 of effective programs and practices. The  
 19 Massachusetts Department of Public Health has  
 20 recognized her work as the founder of Unthri Familia  
 21 and the Moms Project has received a citation from the  
 22 governor's office for its unique contribution to the

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1 health of mothers and children. And Dr. Amaro's also  
 2 a member of the SAMHSA National Advisory Committee,  
 3 and we're very happy to hear her talk a little bit  
 4 from the perspective of addiction treatment.

5 DR. AMARO: Thank you.

6 I seem to have gotten very different  
 7 instructions. I was told one or two slides, so I  
 8 didn't prepare any. So otherwise, I would be happy to  
 9 provide a more formal presentation.

10 But what Sharon asked me to talk about is to  
 11 share my thinking on some of the observations, you  
 12 know, for the over 30 years that I've been working  
 13 this field, both from a research perspective, but also  
 14 from a, you know, community-based perspective, because  
 15 all of my work has been very community-based. And you  
 16 also asked me to think about why is it that in  
 17 substance abuse treatment, we have seen more gender-  
 18 specific approaches compared to mental health. And  
 19 so, I'm going to comment on those issues.

20 So first, just to tell you that I started work in  
 21 this area. A little bit about, sort of, where I'm  
 22 coming from and my history, I started doing work with

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1 Linda Backman at the Neuro-Psychiatric Institute at  
 2 UCLA when I was a graduate student on a study funded  
 3 by NIAAA on women's barriers to alcoholism treatment.  
 4 And later on, I went on to work on a NIDA-funded  
 5 study on drug use during pregnancy with people like  
 6 Bary Zuckerman and Ralph Henksin. And we published  
 7 findings on, not only infant outcomes and pregnancy  
 8 outcomes, but luckily, because I was one of the few  
 9 social scientists, I was able to get in measures on  
 10 depression, on violence, on social support, and things  
 11 like that. And so, we published a number of papers on  
 12 that as well.

13 We noted early on the impact of trauma and mental  
 14 health and women's addiction disorders in some of  
 15 those early studies, which were pretty descriptive.  
 16 And the AIDS epidemic hit, and I really was  
 17 interviewing women in the field, for some of those  
 18 studies, who were just being diagnosed. And I  
 19 realized that I really wanted to do something that  
 20 really was about providing services in some kind of  
 21 new model.

22 And so, I started work with the Moms Project,

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1 which was initially funded by NIDA and then, by CSAP  
 2 and then, by CSAT, eventually. Those projects were  
 3 really serving injection-drug-using women who were  
 4 pregnant who were also sex workers and/or partners of  
 5 injection drug users. And we went on to develop a  
 6 number -- also a residential program and some  
 7 intensive out-patient programs, et cetera. So that's,  
 8 kind of, my history in the field.

9 And we also were part of the Women with Co-  
 10 Occurring Disorders and Violence Study and developed  
 11 the Boston Consortium model. We developed manuals,  
 12 treatment manuals that are available as well as the  
 13 case-based manual for training providers on how to  
 14 think about both mental health, trauma, and addiction  
 15 together. So those are available, if you think they  
 16 would be useful to you.

17 You know, sometimes we -- when you called me  
 18 about this question, I thought I had a déjà vu,  
 19 because, you know, starting in the late '60s and '70s,  
 20 we were talking about all these issues. And then, it  
 21 sort of went away. But I remember having SAMHSA-  
 22 sponsored meetings in the '70s, not then called

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1 SAMHSA. I guess it was called OSAP -- where we got  
2 together for several days to actually outline what was  
3 gender specific, what did we mean by that, and what  
4 were the implications for treatment.  
5 So there's a huge literature on gender  
6 differences every year, pretty much, a lot of what  
7 Carole just covered, that's been there describing what  
8 are the differences in psychological profile. Linda  
9 Backman and Cheryl Wolsnak did a lot of that early  
10 work as well as specific needs of women in treatment.  
11 And then, Chris Grella and a lot of other people have  
12 gone on to add to that literature.  
13 So I don't think we have to reinvent the wheel.  
14 In fact, there are a number of SAMHSA tips and texts  
15 that actually review that literature. And tip 23 -- I  
16 was just looking at it before I came. And it's got a  
17 great summary of all of that.  
18 But anyway, so we saw this great interest in the  
19 '70s and then a waning of this interest in the '80s.  
20 And then, in '92 again, the women's program set aside  
21 10 percent of the discretionary funding to states for  
22 gender-specific programming. I don't know if that's

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1 still there. I just looked at one of the latest  
2 reports, and I don't see that set-aside. It's there  
3 for prevention.  
4 Is it there for women?  
5 MS. AMATETTI: Yeah. Yeah.  
6 DR. AMARO: Okay, I just couldn't find it.  
7 MS. AMATETTI: [Off-mike.]  
8 DR. AMARO: Okay, great. So I'm glad. I'm happy  
9 to hear that it's still there, because I was searching  
10 for it, and I couldn't find it.  
11 But that made a huge difference at the state  
12 level. Although there are people like Chris Grella  
13 who has looked more closely at what states are  
14 actually doing with that money. And she feels that  
15 there's been slippage in what's being -- how that  
16 money's being used. So I think a good look at  
17 whether, in fact, the funds are being used for that  
18 purpose or not would be a good thing to do.  
19 So then, there was a shift in SAMHSA. I served  
20 on the SAMHSA Women's Advisory Committee, the first  
21 one. And there was a shift from focus on women to  
22 then focus on pregnant women to then focus on women

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1 and their families. And I think that's actually a  
2 very good thing, as long as we don't really lose sight  
3 of the very gender-specific issues that women face in  
4 treatment, and instead, focus only on the parenting  
5 part, which is very important and part of women-  
6 specific issues. But it's not the whole thing.  
7 The other thing I wanted -- so, you know, I refer  
8 you to that tip 23, because I think it's really good.  
9 One of the conclusions in that tip is that adding  
10 special services to male treatment models is really  
11 not sufficient, that that's just not going to do it.  
12 But the interesting thing is that, while there is  
13 a lot of literature that describes the nature of  
14 substance abuse disorders in women and gender  
15 differences, there really is -- the literature is  
16 quite sparse in terms of any credible, real solid  
17 randomized clinical trials on gender-specific  
18 approaches to treatment, even in terms of trauma  
19 seeking safety, which was -- went through a randomized  
20 clinical trial, did not show a significant group by  
21 time interaction in terms of it being more efficacious  
22 than a health education group -- I think, was their

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1 comparison group.  
2 I think that might be because they limited to 12  
3 sessions, which is not what the original seeking  
4 safety is. And in my experience, in working with this  
5 population, there's no way that you're going to deal  
6 with a whole history of trauma. It's not one event.  
7 It's multiple events from the time of childhood to the  
8 day they walked in. Or maybe if they're an out-  
9 patient, 'til last night right before they came in.  
10 So you're really going to need a more intensive  
11 than 12 sessions. You know, and my concern is that  
12 we're always looking for the quick, easy fix, the  
13 Band-Aid. And there are -- like I say, you know, when  
14 you go into -- you have a trauma in the E.R., you  
15 don't try to put a Band-Aid on it. You know, there  
16 are some conditions that just are going to require  
17 more intensive and longer term approaches.  
18 So I would encourage SAMHSA to really think about  
19 that in looking at models. You know, different stages  
20 of treatment, not just a quick fix, because I think  
21 we're going to end up paying for it in lots of other  
22 ways, as, you know, we already know and has been well-

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1 documented.

2 Let's see. How am I doing on time? Okay.

3 So SAMHSA has an incredible history of attending

4 to these issues, as I mentioned, from the '70s 'til

5 today. The tips, the taps that look at specific

6 gender-specific issues are examples of that, the Women

7 with Co-Occurring Disorders and Violence Study is

8 another great example.

9 In our experience, in developing and implementing

10 and evaluating integrated models of treatment, there

11 is a huge up-front work that has to be done around

12 preparing staff, training staff, and setting up

13 supervision mechanisms and resources. Because our

14 experience was that substance abuse treatment staff

15 really were not trained in mental health. They were

16 not trained in trauma. And they even had resistance

17 around it, because they weren't equipped to do it

18 until they felt more competent. They really resisted

19 that.

20 But once they got the skills, it made a lot of

21 sense to them. But that takes resources and effort.

22 And it takes a lot of, like, local -- you know, they

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1 can go to conferences, but they have to have this

2 training and the supervision locally at their site.

3 There are, as I mentioned, few studies on gender-

4 specific treatment for women with co-occurring

5 disorders. Plenty of evidence describing the

6 epidemiology, a number of quasi-experimental studies

7 looking at effectiveness. But, as I mentioned, you

8 know, it's amazing we still don't have a good

9 randomized clinical trial or a number of them. We

10 shouldn't just have one looking at different

11 approaches.

12 The other point I wanted to make is treatment of

13 co-occurring disorders in our client population,

14 mostly Latina, African-American women, but also poor,

15 white women, is not just about treating addiction. It

16 is, obviously, about treating the trauma and mental

17 illness. But it's also about a whole set of socio-

18 economic disadvantages that these women have that have

19 huge implications for their -- how quickly they're

20 able to gain benefits from treatment and what they're

21 able to do or not do when they leave treatment.

22 And that we haven't paid a lot of attention to.

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1 It's the parenting role, but it's also the low socio-

2 economic, less education, less employment experience,

3 fewer programs that accommodate training -- job

4 training programs that can accommodate the needs of

5 this population.

6 Another point that I wanted to make is that in

7 the treatment literature, in the substance abuse

8 treatment literature, there has been quite a bit

9 written about the importance of family involvement and

10 as a factor that improves treatment outcomes. But

11 when you're talking about women who have a history of

12 abuse from family members and from partners, this gets

13 to be a very difficult and challenging issue. And it

14 has to be -- you have to really discern this very

15 carefully, because it can actually introduce risks for

16 the women: physical risks, emotional risks, and also

17 risk of relapsing.

18 So I just wanted to say that, because we do tend

19 to think, well, if we involve the families and we

20 involve the partners -- well, it's not always

21 appropriate. Sometimes it's going to be a risk factor

22 for relapse or for abuse.

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1 The issue of having children in treatment is

2 something, you know, we fought a lot for in the '70s.

3 And as we've implemented this, all of our residential

4 programs have that women can have their kids. But

5 it's really a double-edged sword. And I don't think

6 we have a lot of good research on this.

7 We tried to collaborate with Child Protective

8 Services, but it's very challenging. Depending on

9 what their budget looks like or what the latest court

10 cases have been against them, they want to just get --

11 you know, they want to get their caseload down. They

12 want to get the kids out the door.

13 So they could return two or three children at a

14 time to a woman who's in residential treatment. That

15 makes it very challenging for her to be able to manage

16 the stress and the challenge of parenting kids, who

17 themselves have a series of problems. So I think we

18 really need to look at that more carefully.

19 I haven't seen a lot of research on that. And

20 clinically, I think you have to be very thoughtful

21 about it. I think we need more research about when it

22 is beneficial, how, and what really are the services

<p style="text-align: right;">Page 246</p> <p>1 you have to provide to support the mother and the 2 children.</p> <p>3 The last thing I wanted to mention is that most 4 approaches to trauma treatment do not integrate 5 historical trauma or migration or immigration trauma 6 and minority stress-related trauma. And this has, 7 kind of, been, I think, under the heading of my 8 experience.</p> <p>9 I was telling Sharon, you know, over 30 years, I 10 have gone to the gender-specific groups that work on 11 whatever, you know, gender issues. And I go to the 12 race and ethnicity and culture groups. And the two 13 groups shall never meet. It's so frustrating. So you 14 get studies that address the cultural or race 15 differences in terms of efficacy of a treatment 16 protocol, for example. But they don't look at gender 17 within race or the other way around.</p> <p>18 You've got studies, a whole literature, that 19 looks at gender, but does not look at, well, how do 20 women of different ethnic groups -- so I think that 21 goes for both treatment programs as well as the 22 research literature. There's really the need to look</p>	<p style="text-align: right;">Page 248</p> <p>1 work by Elaine Hiberman early on, and Pat Reeker, on 2 the use of medication and physical restraints. You 3 know, we all remember that from the '70s. And then, 4 the work of Jean Baker Miller on the psychology of 5 women and Nancy Shuderow, et cetera, who really looked 6 at the relational aspects of girls and women's 7 development, not in relation to addiction, but it then 8 got used in our field.</p> <p>9 But really, I think that some of it has to do 10 with the disciplinary perspective and the fact that 11 most -- and especially then, psychiatry was primarily 12 a male-dominated discipline, and so, perhaps less 13 inclination to look at issues of gender. So I'll be 14 quiet now.</p> <p>15 MS. AMATETTI: Okay. Thank you very much, Dr. 16 Amaro.</p> <p>17 And what a rich discussion we've had here. And 18 we can go a little bit longer. We're going to go just 19 10 minutes longer so that we have a chance to get some 20 reactions and thoughts about the comments.</p> <p>21 But really, I few could, sort of, frame them in, 22 to the extent that what do we need to think about in</p>
<p style="text-align: right;">Page 247</p> <p>1 at that intersectionality.</p> <p>2 The last comment has to do with why has, perhaps, 3 the mental health field been so different from 4 substance abuse. And so, this is just a wild stab at 5 that question.</p> <p>6 I think, you know, obviously, the representation 7 of women in the mental health treatment system is very 8 different and has historically been very different 9 than in substance abuse treatment where it's been 10 primarily men. So I think that may have had -- may 11 have more readily brought up the disparity and the, 12 kind of, discomfort that women experience in those 13 clinical settings.</p> <p>14 Also, the psychiatric basis of mental health 15 treatment versus community-based substance abuse 16 treatment and the involvement of persons in recovery 17 in each of those systems has been very different. And 18 I think the voices of, you know, consumers, persons in 19 recovery, whatever the term is you want to use, has 20 helped to inform substance abuse treatment programs in 21 terms of gender.</p> <p>22 The exception, I think, in psychiatry was the</p>	<p style="text-align: right;">Page 249</p> <p>1 terms of really being more holistic in our approach 2 for working with women, you know, across addiction 3 treatment, mental health, gender, race. I think 4 that's, sort of, you know, what the need is for us to 5 understand and to really think about what we could do 6 and proceed.</p> <p>7 And did you want to add one thing?</p> <p>8 DR. AMARO: I did want to add one thing. I did 9 want to add the observation that as SAMHSA has moved - 10 - and you know, I'm very delighted to have seen that 11 move -- into doing more work around children, like 12 Project Launch, et cetera.</p> <p>13 And I'm working on a Project Launch with 14 Massachusetts -- that I think there's really a need to 15 really look at these issues and within all of those 16 programs, including screening of moms and screening of 17 women in various service settings, not just in 18 substance abuse treatments, so that we can -- because 19 it's a very small minority who walk into treatment 20 facilities.</p> <p>21 MS. AMATETTI: Right. And you missed -- Jen 22 Oppenheimer [sic] was here this morning from Project</p>

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1 Launch. And she's part of our SAMHSA Women's  
2 Coordinating Committee as well. So, yes, that's  
3 absolutely right.

4 And, Dr. Warshaw, do you like to --

5 DR. WARSHAW: Hortensia, you made me think about,  
6 you know, part of what may have happened in mental  
7 health and psychiatry is because there's been such a  
8 push for psychiatrists to be biological in the focus  
9 on medication, partly for managed care and partly from  
10 pharma, that therapy is more conducted by women, and  
11 it's devalued.

12 DR. AMARO: Yeah.

13 DR. WARSHAW: And there's this disparity. And  
14 there's so many different approaches. There isn't  
15 like a treatment protocol like the SAMHSA tips in  
16 mental health. There are just so many different  
17 approaches. So if you're lucky enough to choose, you  
18 may get what you want. But if you don't have a  
19 choice, then it's very different.

20 MS. AMATETTI: So let me turn it out to our  
21 Advisory Committee.

22 Yes, Dr. Felitti?

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1 DR. FELITTI: One thing that occurs to me that  
2 hasn't been mentioned, obviously, is a meaningful  
3 antecedent to any approach or treatment, one would  
4 need to know a person's developmental and experiential  
5 history. And no one speaks about how one gets that  
6 information. I mean, there's intense resistance to  
7 getting that information, for all sorts of reasons,  
8 most particularly, uncertainty about what to do with  
9 it.

10 I mean, I remember vividly an internist colleague  
11 of mine saying to me, but what would I do if I asked  
12 and someone said yes.

13 DR. WARSHAW: But that's a big question. I mean,  
14 at Kaiser, you have resources. And often, in many  
15 settings, many people don't. And then --

16 DR. FELITTI: Wait, wait, wait, wait. What are  
17 you talking about, at Kaiser, we have resources?  
18 That's, kind of -- you know, it's certainly a nice  
19 compliment.

20 [Laughter.]

21 DR. FELITTI: It's misleadingly vague.

22 DR. WARSHAW: Well, I think -- one of the things

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1 we talk about in settings, intake settings, is asking  
2 people about trauma. Is there any things that have  
3 occurred in your past that may be affecting how you're  
4 feeling now or what's going on with you now as an  
5 opening before doing the detailed trauma history, when  
6 you don't have that relationship and people -- I guess  
7 what I want to say is what you were saying, Hortensia,  
8 is that it's a very labor-intensive process to prepare  
9 staff and to have the supervision that people can  
10 respond appropriately and helpfully. And so, that's a  
11 really critical piece to have in place before you  
12 start screening.

13 DR. FELITTI: Let me make a pitch for a different  
14 approach.

15 DR. WARSHAW: Okay.

16 DR. FELITTI: Because over an eight-year period,  
17 we have gotten detailed trauma-based histories on  
18 440,000 adults by questionnaire. And a skillfully-  
19 devised questionnaire, which is, you know, an  
20 important idea, skillfully-devised, filled out at home  
21 -- was an invaluable tool because it enables a person  
22 to walk into a room, meet a stranger, and know ahead

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1 of time where you need to go and where you don't need  
2 to go.

3 DR. AMARO: Yeah. I totally agree with you.

4 You know, when we did that first NIDA-funded  
5 study on women's drug use during pregnancy, which was  
6 primarily focused, actually, on, you know, infant  
7 outcomes and labor and delivery outcomes, but I added  
8 questions on history of abuse. I had to really argue  
9 with my team. They said, well, what if they say yes,  
10 you know, what do we do. And that's what the staff in  
11 our treatment program said. Well, so there are  
12 different answers in those two situations.

13 For the study in the prenatal clinic at Boston  
14 City Hospital, I said I will put together a list of  
15 resources. And all you have to do is give the women  
16 these, you know, resources, or we will give the women  
17 the resources. In the treatment facility, obviously,  
18 because we were arguing that treatment of trauma and  
19 childhood experiences, adverse experiences, is an  
20 integral part of healing and recovery. Then, you  
21 know, the training had to be more in-depth.

22 There are studies that have looked at whether



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1 there are adverse consequences of asking people about  
 2 trauma history. And it depends, you know, how you ask  
 3 it. But a lot of times in studies, people say, "Thank  
 4 you so much for talking to me." You know? Because  
 5 just being able to name it and to talk about, even if  
 6 you cannot provide the treatment, for some people  
 7 experience that as therapeutic.

8 You also have to know when to stop. You know? I  
 9 mean, you do have to have some level of training, you  
 10 know. But I agree. And I think that continuing to  
 11 not ask -- I asked myself, with what other kind of  
 12 medical history situation would we say, no, we  
 13 shouldn't ask because, you know, we don't have -- we  
 14 would not do that.

15 DR. FELITTI: You shouldn't ask, you know, do you  
 16 cough up blood, because you might not know what to do.  
 17 [Laughter.]

18 DR. AMARO: Well, I'm not going to take your  
 19 blood pressure, because I can't give you the  
 20 medication.

21 DR. FELITTI: Sure. Yeah.

22 DR. AMARO: I don't know.

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1 DR. FELITTI: A very useful response to a yes  
 2 answer -- I mean, probably the one that was most  
 3 commonly used by the staff was the simple sentence,  
 4 "Tell me how that's affected you later in your life."  
 5 It doesn't open Pandora's Box, you know, a statement  
 6 that's another mode of resisting all of this. The  
 7 answers typically were a minute, minute and-a-half,  
 8 two minutes long.

9 MS. AMATETTI: Yes, Jean?

10 DR. CAMPBELL: Just a quick question for  
 11 Hortensia.

12 You mentioned that there's a lack of research in  
 13 the intersection of gender and race. And I was  
 14 wondering if you found that due to studies that aren't  
 15 powered enough and also, research instruments that  
 16 aren't responsive to change, which is the other  
 17 problem. I mean, that's an overall problem,  
 18 particularly the power issue, because you end up with  
 19 all those missing cells, you know, with nothing in it.

20 DR. AMARO: Right. So I think that SAMHSA --  
 21 MALE SPEAKER: Use the microphone.  
 22 DR. AMARO: Oh, I'm sorry. I think that there

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1 are methodological reasons such as sampling  
 2 approaches, you know, that don't -- where studies  
 3 aren't powered, number one. But, two, sometimes even  
 4 when studies are powered, they don't do the analysis.  
 5 And, three, you could still do preliminary analysis  
 6 and at least get, you know, effect-size estimates  
 7 looking at race and ethnic interactions. And those  
 8 studies are, like, you can count them, you know, in  
 9 one hand, probably, or two hands, that have done that.

10 So I think it's a -- among investigators,  
 11 researchers, it's probably lack of their own training.

12 When you think about, you know, what's the generation  
 13 that's getting the grants, probably the younger  
 14 generation are integrating these things more. That's  
 15 just a hunch. But lack of training, sense of  
 16 discomfort with different populations, feeling like  
 17 it's too complicated -- you know, they don't have  
 18 people on their teams, generally, that would be able  
 19 to outreach to certain populations to get them in the  
 20 study.

21 FEMALE SPEAKER: Recruitment.

22 DR. AMARO: Recruitment -- you know, the NIDA CTN

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1 -- the sites -- the studies that have done best in  
 2 recruiting minorities have been ones that had  
 3 partnerships with community agencies where minorities  
 4 got the services. And the studies were done in those  
 5 sites. And that's, like, a no-brainer. You know --  
 6 and other ones that use more creative approaches to  
 7 sampling -- so I think it is the issue of [inaudible]  
 8 and being powered.

9 But even when you don't have the power, there are  
 10 things you can do. And so, I think that, while the  
 11 NIH guidelines on, you know, inclusion, that everybody  
 12 has to write up and say they're going to do, from the  
 13 analysis I've seen of those is that the majority of  
 14 people fall short of their minority recruitment.

15 But people know they have to say that they're  
 16 going to recruit a certain number, or they won't get  
 17 funded. But that doesn't mean they're able to. And  
 18 then, when they do collect the data, they don't  
 19 analyze it. And they do need to have some kind of  
 20 understanding of what does it mean if you find  
 21 differences. So they have to have some kind of  
 22 understanding of the content to be able to then

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1 interpret or even know what questions to ask and what  
2 analysis might be useful.

3 MS. AMATETTI: Okay. I am going to wrap up,  
4 because I have extended our time already.

5 I just, again, want to thank our panel for  
6 participating.

7 Thank you very much, everybody. And we're now  
8 going to take a five-minute stretch. That means you  
9 can do one thing. You can go to the restroom. You  
10 can make a call. You can get a drink of water. But  
11 you can't do all three. So, please, just five  
12 minutes. And we'll come back.

13 [Applause.]  
14 [Break.]

15 MS. GRAHAM: This meeting is now reconvened,  
16 please.

17 MS. ENOMOTO: All right. So, well, I thank you  
18 all for your patience. I think that was a rich  
19 discussion and a rich set of presentations on the last  
20 one and something that, as a group, we probably need  
21 to continue as a conversation about how we move the  
22 ball down the field in terms of broadening gender-

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1 specific services through mental health and substance  
2 abuse prevention in a way similar to the way it's been  
3 done in the substance abuse treatment side.

4 For this next session, just for your information,  
5 we have two speakers. We have Johanna Bergen and Jean  
6 Campbell. Amanda Manbeck is not joining us. And we  
7 don't have anyone scheduled for public comment, so we  
8 do have a little bit of extra time. So that's why we  
9 were able to take a little extension on the last  
10 session.

11 So with that, as I mentioned yesterday -- or this  
12 morning, we are going to have a session tomorrow about  
13 the principles of recovery. SAMHSA is working towards  
14 a shared definition of recovery across mental health  
15 and substance abuse. This has been an interesting  
16 process of consulting with the field and consulting  
17 with our internal experts.

18 And tomorrow will be our opportunity to consult  
19 with the councils. So I thought before we go into  
20 that meeting, we might talk a little bit about what  
21 does recovery mean for women and girls. And while I  
22 asked Jean and Johanna both to speak, both from their

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1 personal and professional experiences, I hope that the  
2 rest of you will join in and speak to your experiences  
3 and observations as well.

4 So with that, Jean?

5 DR. CAMPBELL: First of all, I'm cold and tired.  
6 And I assume many of you are since we've had such a -  
7 - I wouldn't say draining, but intellectually-  
8 stimulated session -- it's kind of worn me down here.  
9 So apologies for I may ramble at points here.

10 But I thought it was fortuitous that we were able  
11 to talk about recovery in this group, with SAMHSA  
12 beginning yet another initiative to continue the  
13 discussion on how to define recovery, which is a  
14 consensus-building process of looking at the attitudes  
15 of the different stakeholders and validating the lived  
16 experience of people that have been in recovery, and  
17 basically started by SAMHSA in 2004 with over 150  
18 experts were brought together or stakeholders were  
19 brought together to come up with a definition of  
20 recovery in mental health.

21 And then, the next year, a similar process  
22 occurred in substance abuse. And now, SAMHSA is

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1 moving toward, a unified theory of recovery that would  
2 be considered behavioral health. And I think -- and  
3 they're going to start taking public comments, I  
4 believe -- is it next Friday, August 12th? So they're  
5 already --

6 FEMALE SPEAKER: [Off-mike.]

7 DR. CAMPBELL: Yeah. Until August 26th. So,  
8 hopefully, this conversation and our conversation  
9 tomorrow will stimulate people to provide input on  
10 their perceptions of recovery and the principles of  
11 recovery. What I thought I would do, since there -- I  
12 will tell you there isn't much that has been done  
13 looking at gender-specific issues around the concept  
14 of recovery. But I did find some in the research.  
15 And I thought what might be important is to provide  
16 some information about recovery that you probably will  
17 not hear any other place, you know, sort of, like,  
18 from my work and my experience.

19 The other fortuitous part is is that the multi-  
20 site study that I mentioned in the morning that looked  
21 at the promotion of well-being in these peer-run  
22 centers and found that, indeed, when -- when these

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1 programs did offer their services as an adjunct to  
2 traditional mental health services, that there was a  
3 significant rise in well-being, which, within my  
4 field, is another way to conceptualize the concept of  
5 recovery, because recovery itself is and will continue  
6 to be a moving target.

7 So one of the things -- I thought I would address  
8 two basic issues. One is to give you, sort of, a  
9 sociological narrative of where the concept came from,  
10 and then, second, to share what are some of the  
11 scientific conceptions of what recovery would be from  
12 positive psychology. And I don't think that either  
13 one of those -- in the initiatives to define recovery,  
14 neither one of those things have actually been  
15 considered, looking at the history of the development  
16 of the concept or the science of recovery. It's been  
17 more of a perceptual process from people's lived  
18 experiences.

19 So the first thing I wanted to do is in terms of  
20 a sociological narrative, I'm going to use this draft  
21 paper that we're submitting to psychiatric services.  
22 And you can just gaze upon that -- I thought that was

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1 a very tranquil picture -- while I'm talking -- is  
2 that -- I mean, when you -- most people, when they're  
3 looking at positive psychological states really look  
4 back to the work of the humanistic psychologists such  
5 as Maslow and Seleckman. But there is a rich history  
6 of promoting what we would call well-being in  
7 consumer-operated services, which I defined this  
8 morning as those services that are administered and  
9 delivered by mental health consumers themselves, based  
10 on the philosophy of self-help.

11 And so, it really came from around the 1970s  
12 where large numbers of psychiatric patients were  
13 released from the large mental health institutions  
14 into the communities where they were really -- found  
15 themselves alone and powerless in most situations.  
16 And it was during the next two decades that they  
17 banded together to form these self-help groups for  
18 mutual support and advocate for social justice.

19 And in that process, they developed empathic and  
20 empowering practices as alternatives to the treatments  
21 offered in the traditional mental health system. And  
22 one person, Sally Zinman, wrote, "Self-help groups

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1 demystify our emotional life, giving back to us the  
2 knowledge and tools to help ourselves. Our emotional  
3 life is no longer somebody else's. We are the  
4 experts." And Sue Bud, another consumer, described  
5 these groups as, "A place to feel useful, to affirm  
6 your self-respect."

7 Another project, which I was the principal  
8 investigator of, was the Well-Being Project, which was  
9 1986, where, in California, we looked at what promoted  
10 and deterred well-being of mental health consumers.  
11 And consumers in that case, developed the instruments.  
12 They conducted the survey themselves and analyzed the  
13 data and came to some interesting conclusions about  
14 well-being, particularly that it was a positive,  
15 empowering, life-affirming process. And analysis of  
16 the survey data revealed this dynamic search for well-  
17 being by persons with mental illness, a dynamic  
18 search, and particularly to form acceptable  
19 identities, acceptable to themselves and to others.

20 And, as researchers, we concluded that in order  
21 to get inside that dynamic, the researchers called for  
22 a social scientist -- I'm, by the way, also a social

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1 scientist -- that could capture the fullness of  
2 experience and the richness of living. And this is  
3 very different from what was going on in traditional  
4 mental health services and research in the field  
5 itself. Over the years, by the 1990s, mental health  
6 consumers formed this movement called, Nothing About  
7 Us Without Us, and began to gain a national voice.

8 And they saw science and research as a way to  
9 articulate their perspectives in public policy,  
10 services research, and service provision. And SAMHSA,  
11 particularly the Center for Mental Health Services,  
12 provided quite a bit of funding for those efforts,  
13 including a series of focus groups to define what kind  
14 of outcomes should be measured in state mental health  
15 authorities. And consumers utilized this approach  
16 called concept mapping, where you brainstorm ideas,  
17 and then, you sort and rank those ideas to develop  
18 these concepts.

19 And they identified positive, subjective  
20 dimensions such as recovery, personhood, well-being,  
21 and empowerment as those outcomes that were the most  
22 valued by mental health consumers. It was at that

<p style="text-align: right;">Page 266</p> <p>1 time also that CMHS, through the Mental Health  2 Statistics Improvement Program, developed a report  3 card to measure mental health services and had  4 consumers as participants in that effort. And they  5 utilized these focus group findings to develop some of  6 the first inquiries into things like satisfaction,  7 particularly satisfaction and treating people with  8 respect in services.</p> <p>9 So at this time, there was, like, a robust or  10 abundant effort in beginning to develop positive  11 psychological measures by consumers in collaboration  12 with scientists of hope, meaning of life, self-  13 efficacy, goal attainment, and social inclusion in the  14 research protocols. Consumers were involved in the  15 protocols.</p> <p>16 So they began to ask questions that took one out  17 of looking at recidivism, for example, or bed use in  18 hospitalization. Those were the types of things that  19 people looked at before. Biomedical measures -- that  20 consumers were really pushing, looking at these  21 psychological measures.</p> <p>22 So about the turn of the century, in about the</p>	<p style="text-align: right;">Page 268</p> <p>1 development of definitions of recovery and to the  2 funding of the large, multi-site study, which we're  3 now producing findings about.</p> <p>4 So I wanted to talk about, conceptually -- about  5 recovery and what consumers, based on their focus on  6 recovery-type measures, have looked at over -- which I  7 would say is -- 30 some years of investigation and  8 service provision to build practices that promote  9 recover. So when people are confronted with mental  10 illness -- and this goes to a definition of recovery -  11 - I mean, they continue -- recovery could mean that  12 they continue to function, but in an impaired fashion.  13 That's survival. And it's basically been -- we were  14 very concerned that early on, that chronicity would be  15 included within a definition of recovery, even though  16 there was increasingly impaired function.</p> <p>17 It can also mean returning to your previous state  18 of functioning, which means -- I mean, you don't get  19 worse, but you don't get better. And then, there was  20 this concept out of the consumer movement of thriving,  21 growing beyond the original level of -- to add value  22 to life. Being -- recovery provided the opportunity</p>
<p style="text-align: right;">Page 267</p> <p>1 year 2000, that there -- with this national movement,  2 particularly with consumers involved in research,  3 public policy, and service delivery, many of the  4 service centers banded together to provide these more  5 integrated programs, which we now call consumer-  6 operated service programs. And research of those  7 programs continued. And again, what they tended to  8 measure or to find were that these programs improved  9 psychological and social adjustment and goal  10 advancements.</p> <p>11 And by the late -- during this period, the  12 Surgeon General's report on mental health came out.  13 And it included peer services and talked about much of  14 that research.</p> <p>15 MS. ENOMOTO: [Off-mike.]</p> <p>16 DR. CAMPBELL: What? I only get three more  17 minutes?</p> <p>18 MS. ENOMOTO: [Off-mike.] Go ahead.</p> <p>19 DR. CAMPBELL: Oh, I thought because there were  20 only two of us, that we got more time.</p> <p>21 MS. ENOMOTO: [Off-mike.]</p> <p>22 DR. CAMPBELL: Oh. Okay. So this all led to the</p>	<p style="text-align: right;">Page 269</p> <p>1 to grow and become greater and to move on with your  2 life as opposed to staying back in this homeostatic  3 equilibrium. And this, sort of, helps look at that  4 concept, when faced with a challenge, the basic  5 choices.</p> <p>6 So a lot of studies, when you look at positive  7 psychology, have shown that the treatment of illness  8 and the promotion of wellness are different. They're  9 not on the same continuum. They have parallel  10 processes, but they're not on the same continuum.  11 That's why, in our multi-site study, it was  12 interesting to find that the promotion of wellness  13 plus the treatment of illness produced these positive  14 effects, by combining services that were parallel.</p> <p>15 People went to traditional mental health  16 programs. They also participated in a consumer-  17 operated program. I mean, the common thing is to see  18 it on a continuum.</p> <p>19 Noting also that research has shown -- I mean, in  20 research, traditional mental health programs primarily  21 treat mental illness, focusing on the remediation of  22 deficits, and even in prevention, focus on reduction</p>

<p style="text-align: right;">Page 270</p> <p>1 of the risk factors. But peer support and those  2 concepts coming out of positive psychology primarily  3 promote mental wellness. They nurture positive,  4 subjective human strengths. As positive, subjective  5 human strengths are engendered, the model would go,  6 the consumer develops protective factors and begins to  7 thrive. So those are two different things.  8 So you could have a lack of positive promotion of  9 mental wellness, and that would not be the same thing  10 as an absence of mental illness. Those are two  11 separate things.  12 So the one study I wanted to share, and one of  13 the leaders in the positive psychology movement, is  14 Carol Ryff. And she wrote this outstanding article  15 really investigating the dynamics of recovery, based  16 on these assumptions: first of all, that adversity  17 and its accumulation over time has negative mental  18 health consequences. And I think we could all agree  19 with that, particularly after our conversations about  20 trauma.  21 Advantage, positive things occurring in one's  22 life and its accumulation over time have positive</p>	<p style="text-align: right;">Page 272</p> <p>1 with high levels of well-being who had no history of  2 depression. And then, the last two, which are more  3 interesting -- the resilient were individuals with  4 prior history of depression, but also reported high  5 current well-being. And the vulnerable were those  6 with no history of depression who had low levels of  7 well-being.  8 And they found out that resilient women -- this  9 is just one of the descriptions, which I thought was  10 really interesting -- resilient women had lives that  11 included adversity, typically growing up with alcohol  12 parents or experiencing early family death. They also  13 possessed important factors of advantage, like high  14 I.Q., high grades in high school, good physical  15 health.  16 They also had good social relationships. And the  17 researchers suggested that the presence of these  18 factors and the relational experiences contributed to  19 their high profiles of life purpose, mastery growth,  20 and quality connections to others. And they predicted  21 that such features of well-being offer important  22 protective resources as these women confront the</p>
<p style="text-align: right;">Page 271</p> <p>1 mental health consequences. Reactions to adversity  2 and advantage can heighten or reduce the impact of  3 life experiences. And position in social hierarchies  4 through time has consequences for mental health. And  5 social relationships can heighten or reduce the impact  6 of life experiences and enduring conditions.  7 And these, you know, taken separately, I think we  8 basically would agree with those. But what they did  9 was they looked at variations in well-being through  10 studies of discrete life events and enduring human  11 experiences of this group of women. They collected  12 these life histories of psychologically-vulnerable and  13 resilient people. And these were particularly women.  14 They separated the study by males and females and  15 then looked at the cross-classification with  16 depression. And the goal of this study was to  17 understand how a given outcome, that is depression or  18 resilience, can come about.  19 And they ended up looking at four groups. First  20 of all was the depressed or unwell, were those with  21 prior episodes of major depression and who also lacked  22 high psychological well-being. The healthy were those</p>	<p style="text-align: right;">Page 273</p> <p>1 vicissitudes of growing old. So, I mean, this really  2 argues for the importance of well-being and begins to  3 understand what are the factors that would promote  4 resilience, for example, in the communities.'  5 And, as a conclusion, recovery from mental  6 illness requires more than adequate access to quality  7 clinical services, medication, and rehabilitation.  8 Recovery also depends on the well-being of the mental  9 health consumers, their capacities to have hope, be  10 empowered, attain their goals, have meaning and  11 purpose in life, and be connected to others, and  12 sustain a sense of self-efficacy.  13 MS. ENOMOTO: Thank you, Jean. I apologize for  14 rushing you. But I think this was very helpful to get  15 through. And your thought is vigorous on this. And  16 so, that's appreciated.  17 Johanna, I don't know if she has -- if you have  18 slides. But if you -- are you available on the line?  19 MS. BERGEN: Yes, I'm here. I don't have slides.  20 MS. ENOMOTO: Okay, great.  21 MS. BERGEN: Okay.  22 MS. ENOMOTO: Do you want to take it away?</p>

1 MS. BERGEN: Sure. So I was thinking, in  
2 preparing to share a few comments with you, that I  
3 should steer away from my personal experience, which  
4 is what I am apt to do when I am in awe of the rest of  
5 the people around the table. But maybe with Kana's  
6 introduction, I don't have to do that as much. So I,  
7 kind of, will share a little bit throughout.

8 Because of my personal experience, I think that  
9 when I think about recovery or when I think about any  
10 of this work with women and girls, my focus and  
11 priority will always align with teenage mothers and  
12 the fact that there are so many of us, and the whys  
13 and the hows may vary. But I am very shocked that my  
14 journey, my personal journey to recovery, started by  
15 becoming a mother. And I feel like there are a lot of  
16 -- I have a lot of peers who are trying to recover  
17 because they became mothers.

18 But it was different for me and that becoming a  
19 mom and having a child pulled me away and allowed me  
20 to start this process. And my mom is probably one of  
21 the few moms who when she was being embraced by her  
22 community and her co-workers and her church saying,

1 How can we help your daughter, and how does your  
2 family find yourself where they are. She would come  
3 home and say, "I can't tell them that it's a good  
4 thing that you had a baby, because they can't tell  
5 their 18-year-olds that." But it was how she was  
6 feeling.

7 And because of the journey of motherhood got me  
8 to where I am today, and because when I'm feeling as  
9 if I'm being pushed off the road of recovery by this  
10 constant process -- because you never get to the end.

11 You're always in it. And that's an idea, I think,  
12 that should remain in the definition and how we talk  
13 about recovery is that you don't ever get there.  
14 You're always doing it.

15 But because of the things, the worries and the  
16 fears and the anxiety that would push me away from  
17 staying on the recovery path have to do mostly with my  
18 child and soon-to-be children. I would like to have  
19 us think about keeping the role of women as mothers in  
20 our mind as we're looking to redefine and we have this  
21 conversation about recovery, particularly as I've been  
22 reading studies about the number of mothers who are

1 making choices to stop receiving services or treatment  
2 or to avoid seeking services for themselves because  
3 they have children who they see as having higher needs  
4 than their own.

5 And so, if we are making a decision to help our  
6 children and take our children to services and to help  
7 with mental health disorders and to provide treatment  
8 for them, will they be able to succeed and find a path  
9 to recovery if the closest family members aren't  
10 receiving treatment and aren't receiving the care that  
11 they need to be in a, kind of, mode of recovery with  
12 them?

13 And so, throughout today, I've been thinking a  
14 lot about how can programs -- it seems, at least where  
15 I'm from, that there is more funding and there's more  
16 referral places for the youth in our community. And  
17 so, how can we connect those services, the idea that  
18 they could help the family and help the mother,  
19 particularly, as a part of the service to our young  
20 people?

21 And the other thought that I really have around  
22 recovery and looking at the guiding principles of

1 recovery as they stand now -- probably the most  
2 important to remain there and stay is something to  
3 address trauma. And I have been amazed throughout  
4 today's conversation about how long trauma has been  
5 part of the conversation, a part of [inaudible] the  
6 research and evaluation component of this conversation  
7 in the mental health and substance abuse field.

8 Yet, if you asked me if I had a traumatic  
9 experience, or if you asked the woman next to me or my  
10 younger sister, I think we would all say no. And what  
11 I'm discovering is that there's a different definition  
12 of trauma out there that means a lot -- many more  
13 women and girls have experienced a traumatic  
14 experience some time in their lives. But they know to  
15 define it as such.

16 And so, while we should use that word trauma as  
17 we're thinking about recovery, also working to provide  
18 a redefinition of that, kind of, to the general  
19 public. And then, after we understand and, kind of,  
20 self-identify traumatic experiences, understanding the  
21 fact that we will always respond differently to  
22 treatments and to services because of that experience

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1 of trauma. And that is something just like how we're  
2 unique individuals on our path to recovery. This is  
3 just going to be another effect that we need to be  
4 thinking about as we figure out what works for us and  
5 what doesn't.

6 So I think -- I just wanted to share with  
7 everyone that I don't think that we can think about  
8 recovery for women and girls without thinking about  
9 their whole family units and their decisions they make  
10 because of the obligations we feel we have, and then,  
11 to just make sure that we keep the idea of trauma  
12 within that language in a way that everyone can  
13 understand and work to use that.

14 MS. ENOMOTO: Thank you, Johanna.

15 I was just looking to see if we actually have the  
16 principles of recovery today. We don't have those?

17 It sounds like, Johanna, you've seen them.

18 MS. BERGEN: Uh-huh, yes.

19 MS. ENOMOTO: I don't know if Jean's worked on  
20 them. But have other people seen the principles of  
21 recovery that have been sent out for comment? Is it -  
22 -

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1 DR. CAMPBELL: I have it here.

2 MS. ENOMOTO: Okay. I'm sorry.

3 DR. CAMPBELL: I don't know if it's in there. I  
4 got it in the other meeting.

5 MS. ENOMOTO: Okay.

6 Okay. So are you all looking at it?  
7 [No response.]

8 MS. ENOMOTO: No. Because I know that being  
9 trauma informed is one of the principles. I don't  
10 know if gender specific is one of them.

11 MS. BERGEN: It's not specifically addressed.  
12 That might be something we would want to share  
13 tomorrow, or a suggestion.

14 DR. CAMPBELL: I can read those.

15 MS. ENOMOTO: Okay. Yeah, go ahead.

16 DR. CAMPBELL: They're really short. Guiding  
17 principles of recovery -- recovery is person driven.  
18 Recovery occurs via many pathways. Recovery is  
19 holistic. Recovery is supported by peers and allies.  
20 Recovery is supported through relationships and  
21 social networks. Recovery is culturally-based and  
22 influenced. Recovery is supported by addressing

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1 trauma. Recovery involves individual, family, and  
2 community strengths and responsibility. Recovery is  
3 based on respect. Recovery emerges from hope.

4 And this is a consensus-building process that has  
5 come up with these guiding principles from  
6 stakeholders over the last decade, basically. This  
7 isn't necessarily research. So the --

8 MS. ENOMOTO: Right, right. This has been a  
9 consensus-driven process. And again, in recent  
10 rounds, we've had some conversation about adding  
11 resilience language to that, because it's both to  
12 address the -- some of it is to get to the thrive and  
13 it's moving past just recovery to the next step and  
14 building people up for the next phase of their life as  
15 well as to address the issues, the developmental  
16 issues, that kids are not necessarily recovering a  
17 past or former state, that kids are developing as they  
18 go. And so, they may be overcoming challenges of  
19 addiction or mental illness, but moving toward a new  
20 state of development rather than recovering a past  
21 one.

22 DR. CAMPBELL: Well, if you notice, when that

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1 brief, like, whirlwind tour of efforts by mental  
2 health consumers, they actually chose the term right  
3 from the very beginning of well-being. Recovery  
4 wasn't a term that was commonly used until SAMHSA  
5 supported the focus on recovery, which I have to say  
6 we said, okay, we'll go with that. But it wasn't --  
7 like we didn't have recovery measures. We had  
8 measures of empowerment and well-being, those types of  
9 things as opposed to recovery.

10 MS. ENOMOTO: Okay.

11 Vincent?

12 DR. FELITTI: And is there any effort to define  
13 who would draw those conclusions?

14 DR. CAMPBELL: The conclusions that I read?

15 DR. FELITTI: Yeah.

16 DR. CAMPBELL: Well, those conclusions represent  
17 the feedback of the people who participated in the --

18 DR. FELITTI: Well, I understand.

19 DR. CAMPBELL: And so, I mean, there are lists of  
20 who those are. You know, consumers --

21 DR. FELITTI: No, no, no, no, no.

22 DR. CAMPBELL: Oh --

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1 DR. FELITTI: I mean, in an individual case, who  
2 draws the conclusions leading to the concept of  
3 recovery or no recovery?  
4 MS. ENOMOTO: Right. I mean, I think there's  
5 been some question about measuring. How do you  
6 measure recoveries that you can say, okay, have we  
7 tipped the balance here, recovered or not? You  
8 qualify recovery support services, or you don't.  
9 DR. FELITTI: It would seem to me that one could  
10 argue that there would be three different sources of  
11 assessment: the individual, him or herself; family  
12 members or friends; and someone who's been  
13 therapeutically involved with that individual and has  
14 a fair understanding of what's been going on with  
15 them.  
16 DR. CAMPBELL: Well, actually, mental health  
17 consumers resist using the concept of recovery to  
18 determine the types of services that people should  
19 have or to impose a definition on them, to be assessed  
20 or to impose a definition. And the emphasis is on the  
21 dynamic process of recovery, recovering at one's own  
22 necessary speed, recovering in some areas and not in

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1 other areas.  
2 I mean, so that's why I was confused when you  
3 asked that, because, I mean, that's normally --  
4 although there have been efforts to assess people and  
5 then say, okay, you can go to this recovery center,  
6 and then, after so many times, reassess them. But  
7 it's not like doing a GAF or, you know, looking at --  
8 in biomedical measures, you can say the person is  
9 recovered based on Colorado's symptom checklist or the  
10 GAF or something like that.  
11 DR. FELITTI: Yeah, my point is that I wouldn't  
12 trust any single one of those. It's too easy for  
13 people to delude themselves or to fool their families  
14 or to have some inept or mistaken person, other  
15 person, you know, draw a conclusion about that.  
16 That's why I'm proposing that there would be three  
17 different viewpoints. Obviously, you'd like to have  
18 conformance between them.  
19 DR. CAMPBELL: The concept of recovery isn't  
20 assessment or to be used within the traditional mental  
21 health services to necessarily assign services. It's  
22 more of a political or policy concept to try to

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1 develop supports for people so they can achieve well-  
2 being in their life. It's more voluntary. Those that  
3 work with people to achieve recovery are usually  
4 peers. It isn't within the -- some recovery occurs --  
5 some well-being occurs within the traditional mental  
6 health services. It just isn't significant, because  
7 traditional mental health services treat illness.  
8 This is a promotion of wellness concept where the end  
9 point, if you believe in self-actualization, can't  
10 clearly be defined.  
11 MS. ENOMOTO: I think one of the issues there,  
12 Jean, is that that may be the history of the  
13 definition of recovery or the use of the term  
14 recovery. But we are now moving into this age of  
15 health reform, where we're encouraging systems to pay  
16 for helping people achieve recovery and to pay for  
17 recovery support services and to continue to wrap  
18 around people past the remediation of illness towards  
19 the achievement of recovery and wellness. And so, you  
20 know, I mean, systems being as they are, they, sort  
21 of, want measures. And how do we know --  
22 DR. CAMPBELL: But there are measures of

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1 services. And, I mean, looking at participants, the  
2 outcomes of services -- I mean, that's what our multi-  
3 site was about. And so, we found significant  
4 improvement in well-being.  
5 We had positive measures of hope, goal  
6 attainment, empowerment, meaning in life. Those were  
7 the measures. What was measured was the effectiveness  
8 of the program to produce that in the participants,  
9 not as an individual assessment tool to rank somebody  
10 on a recovery-type scale.  
11 MS. ENOMOTO: But now that you're moving into an  
12 era of third-party payment, right, that's the  
13 challenge. That's the struggle that we're going to  
14 have to grapple with.  
15 DR. CAMPBELL: Yes, indeed.  
16 MS. ENOMOTO: Yeah.  
17 MS. FORMAN: Can I say something?  
18 MS. ENOMOTO: Go ahead.  
19 MS. FORMAN: What I thought I heard both Jean and  
20 Johanna saying is that recovery is a process, not an  
21 end point. Did I hear --  
22 DR. CAMPBELL: Well, it's both an outcome and a



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1 process.

2 MS. FORMAN: Yeah, but --

3 DR. CAMPBELL: I mean, because the outcomes can

4 be hope, increased hope, you know, increased goal

5 attainment, increased empowerment. So it can be an

6 outcome, in that case. But it also can be a process.

7 MS. FORMAN: And it sounds, kind of, like, what

8 you're saying is that it needs, for pragmatic purposes

9 and for SAMHSA, for the new health care systems and

10 everything else -- it needs to be a goal that can be

11 more quantified and --

12 FEMALE SPEAKER: Operationalized?

13 MS. ENOMOTO: Yeah, I mean, I don't know that

14 we're saying it has to be. But I think we have to be

15 careful what we're asking for. So if we're saying,

16 pay for recovery support services, pay for

17 performance, don't pay for the absence of symptoms,

18 but pay for wellness, pay for -- we're going to have

19 to be able to say, and here's how you know you've

20 gotten what you paid for. And here's how you know who

21 gets these services and who gets those services,

22 because they will ask. It can't be -- you know, it's

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1 not going to be sufficient for us to say --

2 DR. CAMPBELL: But the approaches normally have

3 been, in looking at outcomes and looking at the

4 effectiveness of services individually determining

5 where an individual are you -- hasn't been the

6 approach. So, I mean, it can be rigorously defined

7 and measured as outcomes. I mean, and most of those

8 scales are recognized sound, psychometric scales that

9 can be used, but not used to tell a person where they

10 fit on a recovery-type scale.

11 I mean, I could see where that maybe CMS would

12 want that in terms of coming up with reimbursements.

13 That, I can -- because then they are looking at the

14 individual as opposed -- but SAMHSA has always had the

15 focus on the services component, looking at evidence-

16 based practices. Evidence-based practices -- most of

17 them are assessed through studies that look at the

18 effectiveness of the services for the individuals.

19 MS. ENOMOTO: Right. Well, even how we're

20 looking at evidence-based practices -- and when you've

21 been dealing with a population that's 39 percent

22 uninsured, with significant funding coming from state

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1 general funds and block grant funding to a population

2 that's going to be predominantly insured -- on the

3 substance abuse side, it's 69 percent uninsured, which

4 is going to become predominantly insured. It's just a

5 paradigm shift in how we have to think about being

6 disciplined and being very explicit about what we're

7 paying for, what we're trying to achieve, how we're

8 measuring it, how we're billing for it, how we're

9 describing it.

10 And so, you're right. We've always done it this

11 way. And we're going to have to do it differently.

12 And that's part of the purpose of having this

13 conversation in a very explicit way.

14 You know, it's fine to have a really nice poster

15 on the wall, and we can feel good about it. But at

16 this point, the rubber's hitting the road. You know,

17 and people are saying, okay, so is this what you want

18 to pay for. All right. So if this is what we're

19 going to hold providers as a standard to, how should

20 we measure it, and then, what are the thresholds so

21 people have achieved this, then they don't get the

22 benefit any more?

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1 I mean, at a certain point, you don't keep

2 treating somebody for their recovery from X disease.

3 You know? You're, sort of, okay, you're done. You're

4 done with treatment. You're good. Come back in six

5 months. Come back in a year, and we'll do a checkup.

6 So at what point do we reach that with some of these

7 things? Do we reach it, do we not reach it?

8 I mean, it's not set what we have to do. But I

9 think in terms of it's a six-month timeframe or a 12-

10 month timeframe. But what is determined is people are

11 going to want to know. And it's our opportunity as a

12 field to say, and this is what we think it should be.

13 DR. CAMPBELL: But, you know, I don't understand,

14 Kana, that -- I mean, you're mentioning the

15 principles, and you're saying that. But those are not

16 scientific. That's a survey of attitudes. So people

17 think. People believe. So, I mean, that point is not

18 scientific at all. And I see no rigor there. But the

19 rigor is in the science who really establishes that a

20 recovery is based in respect. I mean, you can do a

21 study of that and come up with that.

22 I think that we're one -- we're willing to skip

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1 over the science of what actually recovery is. But  
2 then, all of a sudden, begin to measure it on an  
3 individual level before understanding the  
4 psychological dynamics of recovery.  
5 MS. ENOMOTO: I don't think I'm suggesting we  
6 should skip scientific rigor. I'm saying, this is  
7 what we have. If we have other things, we should  
8 bring that to the table. This is an opportunity.  
9 Right? So I don't necessarily have the answer, and  
10 I'm not pushing an answer.  
11 I'm saying, if you think we need to bring more  
12 scientific rigor to this, then tomorrow is a chance to  
13 talk about it. And as we are -- and so, to have that  
14 lens that as the system is -- as we are pushing the  
15 system to embrace, again, not just the medical model,  
16 treat disorder, treat addiction, you know, abstinence,  
17 we're done. Okay? You're abstinent, you're cured.  
18 See you later. Right?  
19 We're not -- we're past that now. We're  
20 promoting a different model. We're promoting  
21 recovery. We're promoting wrap-around, you know,  
22 recovery supports. So if that's the case, what is the

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1 science that we have? How should we measure that?  
2 How are we going to communicate that? How are we  
3 going to create thresholds for treatment for service  
4 provision, for reimbursement? And I think you're  
5 right. We do want to be as rigorous as possible in  
6 doing that process.  
7 So probably, principles alone are not enough.  
8 But that's the conversation we need to have. So, I  
9 mean, you're right. You know, SAMHSA has been going  
10 this way.  
11 And I think people didn't realize that health  
12 reform was going to come so quickly, that we needed to  
13 be getting beyond ourselves and having all these nice  
14 conversations and getting agreement on a poster.  
15 Because, just around the corner, CMS said, okay, well,  
16 just tell us what we should be paying for, and we'll  
17 do it.  
18 So that's, I guess, some of the thinking that I  
19 encourage folks to bring to the table tomorrow,  
20 because this is a serious conversation now. Not that  
21 it wasn't before, but it's got different implications  
22 than it did in the past. And it's not about feeling

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1 good. It's not about building a bridge between  
2 substance abuse and mental health. It's really about  
3 how are we going to get our populations that will be  
4 newly insured the kind of services that we think that  
5 they deserve and that they will benefit most from.  
6 All right. So we have -- I want to thank Jean  
7 and Johanna both for sharing their thoughts and their  
8 perspectives on this. I think it'll be helpful as we  
9 walk into the conversation tomorrow.  
10 Cynthia just shared with me that 56 people viewed  
11 the Webcast today. Seven folks joined us by phone,  
12 including Johanna. So though we didn't have the video  
13 Webcast, for which I'm grateful --  
14 [Laughter.]  
15 DR. CAMPBELL: I like that from when I'm sitting  
16 in front of my computer to see, like, Pam and --  
17 MS. ENOMOTO: Yeah. It is. It's good. It's  
18 just better when you're on the other side.  
19 [Laughter.]  
20 MS. ENOMOTO: Than eight hours of vigilance.  
21 But I thank all of you for participating actively  
22 and contributing mightily. I want to just bring your

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1 attention to what we are doing for the next couple of  
2 days so you have some sense of what to expect.  
3 Tomorrow we're starting at 8:30. We will be here  
4 on the first floor. It's going to be in the big room,  
5 Sugar Loaf, with all of the National Advisory  
6 Councils. So it'll be -- I think we have -- how many,  
7 folks coming, 60?  
8 MS. GRAHAM: Sixty-five, 49 council members, 49  
9 council members.  
10 MS. ENOMOTO: And then, 65 with all the SAMHSA  
11 people?  
12 MS. GRAHAM: And plus 120 plus SAMHSA staff --  
13 MS. ENOMOTO: Wow. Okay.  
14 MS. GRAHAM: -- that have registered online.  
15 MS. ENOMOTO: Okay. All right. So we're  
16 expecting a very full house tomorrow. The  
17 Administrator will do her remarks. I think she's  
18 going to make some announcements on personnel changes  
19 that are happening. And then, she's going to walk us  
20 through our budget situation, which is also exciting.  
21 Starting at 10:15, we will have a women and girls  
22 conversation for an hour. Sharon's going to be doing

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1 the overview – a truncated version of the overview  
2 she did for you all in June. And then, we'll have  
3 someone from the HHS Office on Women's Health and Flo  
4 Stein pinch hitting for Starleen Scott-Robbins and  
5 Elizabeth Neptune, who is from Maine.  
6 And she is one of our Tribal Technical Advisory  
7 Committee members. So those will be our respondents.  
8 And all council members will be invited to join the  
9 conversation.  
10 Then, again, the principles of recovery  
11 conversation -- Kathryn's going to present where we  
12 are and the future of the principles and their  
13 definitions. So I think bringing up some of the  
14 issues around women and girls and their roles as  
15 mothers and where gender is in that -- as you look at  
16 the definitions, perhaps we can make sure that that's  
17 in there.  
18 Workforce development -- Jean is -- first, Dr.  
19 Clark and Linda Kaplan are going to be doing an  
20 overview of some of our collaborations that we have on  
21 workforce development, both across the centers and  
22 with HRSA and other agencies. And we'll have a number

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1 of reactors to that. So Marsha Brand from HRSA;  
2 Shirley Beckett Mikell from NAADAC; Leighton Huey, who  
3 is the CSAT NAC member; Ruth Satterfield, who is from  
4 the MPN. And Jean will be there representing ACWS.  
5 And finally, we're going to talk about the  
6 National Behavioral Health Quality framework. I see a  
7 word missing on my agenda. But we have been working  
8 very, very busily with the departments and ARC and  
9 Richard Frank and Q.F. on developing a quality  
10 framework for behavioral health, which we think will  
11 be helpful as we, again, are moving into a different  
12 way of thinking about and paying for health care. So  
13 that will be tomorrow.  
14 And then, I suppose most of you will be going  
15 back after tomorrow. And then, we'll have -- that'll  
16 be the Joint NAC. And then, on Wednesday, we have the  
17 SAMHSA National Advisory Committee meeting, where  
18 we're going to focus on a national dialogue  
19 conversation.  
20 And Administrator Hyde has noted that there is a  
21 level of public sentiment which needs to get harnessed  
22 in order to truly move behavioral health beyond where

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1 it's been, that we've been talking to the choir quite  
2 a bit. And so, many of us are on the same page about  
3 how important our issues are and how critical we are -  
4 - and how critical we are to overall community health  
5 and to individuals' general health. And yet,  
6 somewhere that has not made it into the national  
7 consciousness.  
8 So, you know, as soon as you see somebody, for  
9 example, with the Tucson shooting, I mean, people went  
10 very quickly to very stigmatizing and negative  
11 attitudes towards people with mental illness. They  
12 went to, gee, if we could just control guns better or  
13 identify those people earlier or lock them away or not  
14 let them get guns or something, which would be  
15 inefficient and doesn't -- you know, it's not borne  
16 out by data that would tell us they're less likely to  
17 be violent and be -- they're more likely to be  
18 victimized than to be victimizers.  
19 But that's just where people's thinking is. And  
20 so, they don't say, let's do more prevention, let's do  
21 early intervention with young kids, let's do, you  
22 know, more screening and get people help. It's so we

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1 want to turn the tide. How do we harness public  
2 sentiment to turn the tide on that?  
3 And finally, we've been very active with the  
4 National Action Alliance on Suicide Prevention, which  
5 Secretary Sebelius, Secretary Gates -- former  
6 Secretary -- well, Secretary McHugh of the Army and  
7 former Senator Greg Smith are co-chairing our National  
8 Action Alliance for Suicide Prevention. We're going  
9 to be doing an update on what our activities are  
10 there.  
11 So that is the rest of this week, although I know  
12 some of you won't be there on Wednesday. But I look  
13 forward to seeing you tomorrow, and I hope you all are  
14 able to participate actively.  
15 MS. BENAVENTE: [Off-mike.]  
16 MS. ENOMOTO: Yes.  
17 MS. BENAVENTE: [Off-mike.]  
18 MS. ENOMOTO: Yes. You are welcome to attend the  
19 NAC meeting.  
20 FEMALE SPEAKER: [Off-mike.]  
21 MS. ENOMOTO: We'll get that to you, yeah. Okay?  
22 MS. GRAHAM: Would you just please leave your

1 notebooks on the tables along with your badges, except  
2 the one that has visitor on it. You need to take that  
3 badge with you so that you have access to the building  
4 tomorrow. But if you will leave your notebooks on the  
5 table, we do have some updates that we need to insert  
6 in your notebooks, please.

7 MS. ENOMOTO: Great. Okay, great.

8 MS. GRAHAM: Yes. Take the visitor's badge with  
9 you.

10 MS. ENOMOTO: Okay. All right. With that, thank  
11 you. We are adjourned.

12 [Whereupon, at 5:03 p.m., the meeting was  
13 adjourned.]

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