

**U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration**

Advisory Committee for Women's Services (ACWS)

**April 15, 2015
Rock Creek Conference Room
1 Choke Cherry Road
Rockville, MD**

**Transcribed by:
Alderson Court Reporting
Washington, D.C. 20036
(202) 289-2260**

Table of Contents

PROCEEDINGS.....	4
Agenda Item: Call to Order.....	4
Agenda Item: Welcome Members and Roll Call.....	4
Agenda Item: Remarks and Adoption of Minutes for the April 2, 2014, and August 26, 2014, Meetings.....	7
Agenda Item: Updates from ACWS and the SAMHSA Women's Coordinating Committee Members.....	10
Agenda Item: Impact of IPV on Lesbian, Bisexual, and Transgender Women.....	31
Agenda Item: ACWS Future Priorities – A Conversation with the Administrator.....	47
Agenda Item: Supporting Women in Co-Ed Settings – Core Competencies, Practices, and Strategies.....	71
Agenda Item: Pregnant and Postpartum Women (PPW) Grant Program – Future Direction.....	88
Agenda Item: High-Risk/High-Need Girls and Young Women.....	106
Agenda Item: Review and Discussion of Joint NAC Questions.....	123
Agenda Item: Public Comment.....	143
Agenda Item: Closing Remarks/Adjourn.....	143

Committee Members Present:

Nadine Benton, DFO
Kana Enomoto, Chair
Sharon Amatetti
Anita Fineday
Shelly F. Greenfield
Dan Lustig
Karen Mooney
Sarah Nerad [on telephone]
Jeannette Pai-Espinosa
Carole Warshaw
Rosalind Wiseman

Other Participants:

Mary Blake
John Campbell
June Crenshaw
Kathy Crowley
Nevine Gahed
Irene Goldstein
Judy Grill
Kim Harris
Pamela S. Hyde, SAMHSA Administrator
Andre Johnson
Elliott Kennedy [on telephone]
Andrea Kopstein
Indira Palaria
Rachel Ratel
Arthur Schut
Josh Shapiro
Steve White
Linda White-Young

PROCEEDINGS

Agenda Item: Call to Order

MS. NADINE BENTON: This meeting is now called to order. And I will now turn the meeting over to Ms. Kana Enomoto, Principal Deputy Administrator and Associate Administrator for Women's Services.

Agenda Item: Welcome Members and Roll Call

MS. KANA ENOMOTO: All right. Good morning, everyone, and welcome to the SAMHSA Advisory Committee for Women's Services meeting.

We are thrilled to be welcoming any listeners on the phone as well as the new members and returning members for what promises to be a very stimulating few days of discussion. That is, today's discussion for the ACWS and tomorrow joining with the Joint National Advisory Committees for all of SAMHSA.

I'd like to start out with quick introductions around the room and on the phone for our members, just to let folks know who is here, and then we'll also do the staff and the folks recording the meeting.

So I'm Kana Enomoto. I am the Principal Deputy Administrator of SAMHSA, and I'm the chair of the SAMHSA Advisory Committee for Women's Services.

MS. NADINE BENTON: I'm Nadine Benton. I am the Acting Designated Official -- Officer for the Committee for Women's Services.

MS. KANA ENOMOTO: For those of you who are new, you can say -- or even those who aren't, just say a couple of sentences about who are and what you do and why you're here today.

DR. DAN LUSTIG: My name is Dan Lustig. I'm the vice president of clinical services at Haymarket Center in Chicago. We are a residential and outpatient treatment facility, about a 450-bed residential complex in which we see 16,000 clients a year come through our system.

And I'm really excited. I'm new to the committee, but I am excited to be able to participate and talk about the experiences we've had with women and addictions.

MS. JEANNETTE PAI-ESPINOSA: I'm Jeannette Pai-Espinosa. I'm president of the National Crittenton Foundation, and we're the national umbrella for the Crittenton family of agencies, which includes 26 agencies providing direct

services in 32 States and the District of Columbia. And we see about 18,000 young women a month.

And I'm also co-director of the National Girls Initiative for the Office of Juvenile Justice and Delinquency Prevention.

DR. CAROLE WARSHAW: Good morning. I'm Carole Warshaw. I'm the director of the National Center on Domestic Violence, Trauma, and Mental Health, which is an HHS ACYF Family Violence and Prevention Services program, a Special Issue Resource Center on the intersection of domestic violence, trauma, mental health and substance abuse, actually. And we provide training and technical assistance and do research and policy work on these issues, both through the DV field and through the mental health and substance abuse fields.

MS. JUDY GRILL: I'm sorry. I am Judy Grill. I am the court reporter for today, and I'm with Alderson Reporting in D.C. Thank you.

MS. IRENE GOLDSTEIN: I'm Irene Goldstein, and I write the minutes.

MS. ROSALIND WISEMAN: I'm -- oh, thanks. I'm Rosalind Wiseman. I am an educator and researcher that works with thousands of kids in large settings and small settings to try and figure out how to be relevant to young people about the issues that they are often lectured to, but do not often engage in -- on issues of abusive relationships, domestic bullying, their "not-favorite" favorite topic.

Anything to do with young people, elementary school through high school, I am working with students, teachers, parents, and administrators to create bridges between those people to be able to create cultures of -- real cultures of dignity in school.

MS. KAREN MOONEY: Hello. I'm Karen Mooney, and I'm the women's treatment coordinator for the State of Colorado. I'm also the president of the Women's Services Network, which is a component group of NASADAD, the National Association of State Alcohol and Drug Abuse Directors.

MS. SHARON AMATETTI: Good morning. I'm Sharon Amatetti, and I am the SAMHSA women's issue coordinator. I also manage our SAMHSA Women's Coordinating Committee, and several of our members are here this morning.

MS. KANA ENOMOTO: Do you want to go around the room? Or let's get to Sarah. Is Sarah able -- is there a line open? So, Sarah, would you like to introduce yourself?

MS. SARAH NERAD: [on telephone] Yes. Hi, everyone. This is Sarah Nerad. I'm the co-founder of PTR Associates, and I'm also the program manager for The

Ohio State University's Collegiate Recovery Community and serve as the director of recovery for our Higher Education Center. And I'm also a woman in long-term recovery.

Happy to be here. Thanks, you all.

MS. KANA ENOMOTO. Thank you, Sarah. So I think one of the things, it wasn't totally clear, you're a co-founder of Young People in Recovery?

MS. SARAH NERAD: Well, I did help to do that, but currently, I have my own consulting company, which is PTR Associates.

MS. KANA ENOMOTO: PTR. Okay, thank you.

All right. So just going around the room quickly for the SAMHSA staff. And Josh?

MR. JOSH SHAPIRO: Josh Shapiro, Capital Consulting. I'm the logistics coordinator for ACWS.

MS. RACHEL RATEL: Rachel Ratel, Cabezon Group, project manager for the contract that services this meeting.

MS. LINDA WHITE-YOUNG: Linda White-Young, CSAT.

MS. NEVINE GAHED: Nevine Gahed, special assistant to Kana Enomoto.

MS. KIM HARRIS: Kim Harris, CMHS. I'm new, new monitor for the block grant. But I come with about 10 years of experience working with interpersonal violence, as well as combating women trafficking in Rhode Island and Massachusetts.

MS. KATHY CROWLEY: Kathy Crowley. I'm a project officer on the mental health block grant.

MR. STEVE WHITE: Steve White from OP, admin assistant.

MS. MARY BLAKE: Mary Blake from the Center for Mental Health Services.

MS. KANA ENOMOTO: So thank you to everyone for being here this morning, and we have a few people who are going to be joining us late. One of them is Shelly Greenfield, who we know is in a taxi on her way here. She flew in this morning from Massachusetts.

And Anita Fineday is a new member. She's managing director of Indian Child Welfare Programs for the Casey Foundation, Casey Family Programs. And she

previously was chief judge for the White Earth Tribal Nation for 14 years and served as associate judge for the Leech Lake Band of Ojibwe and the Grand Portage Band of Chippewa. So we're excited to have Anita joining us and the viewpoints that she'll be bringing.

And Hendree Jones is not able to join us today, but she's also a new member who's bringing -- from UNC, and she is bringing us some fantastic expertise on pharmacologic treatments for pregnant women and their children in risky life situations. So I think it's a very nice fit for our group.

And unfortunately, we're not able to have Brenda Smith here today, as Dr. Smith --

MS. NADINE BENTON: She'll join by phone this afternoon.

MS. KANA ENOMOTO: She'll join by phone this afternoon. She had some scheduling conflicts with her teaching schedule today.

Agenda Item: Remarks and Adoption of Minutes for the April 2, 2014, and August 26, 2014, Meetings

MS. KANA ENOMOTO: So, with that, I'd like to get us started with the adoption of minutes. We have two sets of minutes to adopt for this meeting. Those of you who are able to reach back a year ago to our April 2, 2014, meeting, we didn't have a quorum in our August meeting this past August. So we were not able to adopt the April minutes.

So for the minutes of the April meeting, these were certified in accordance with the Federal Advisory Committees Act regulations. Members were given the opportunity to review and comment on the draft minutes. Members also received a copy of the certified minutes.

Does anyone have any changes or additions that should be incorporated into this meeting's minutes?

[No response.]

MS. KANA ENOMOTO: Hearing none, if not, may I have a motion to approve the minutes?

MS. ROSALIND WISEMAN: Yes.

MS. KANA ENOMOTO. Rosalind Wiseman has moved to approve. A second?

MS. JEANNETTE PAI-ESPINOSA: Second.

MS. KANA ENOMOTO: And Jeannette Pai-Espinosa has moved to second. Minutes are approved.

For the minutes of the August meeting, these were also certified in accordance with FACA regulations. Members were given the opportunity to review and comment on the draft minutes. Members also received a copy of the certified minutes.

If you have any changes or additions, they will be incorporated into this meeting's minutes. Do I have any changes or additions?

[No response.]

MS. KANA ENOMOTO: Hearing none, may I please have a motion to approve the minutes?

MS. KAREN MOONEY: Yes.

MS. KANA ENOMOTO: Karen Mooney moves to approve the minutes. May I have a second?

MS. ROSALIND WISEMAN: Second. Second.

MS. KANA ENOMOTO: And Rosalind Wiseman seconds that motion. Great. The minutes are approved. So thank you.

All right. So I am just going to take a few more minutes to bring folks a little bit up to date with where SAMHSA is, and then we'll do updates from the members and from the SAMHSA folks here, who are here working on issues of women and girls.

For SAMHSA, just so you know, Congress has enacted a \$3.6 billion budget for SAMHSA in FY '15. We did very well. We're \$494,000 less -- so less than half a million dollars off of what we had in FY '14. So we see that actually as a victory.

We saw some increases in certain programs. We saw \$12 million for medication-assisted treatment for prescription drug and opioid addiction, to expand and enhance the availability of MAT and other clinically appropriate services for persons with opioid use disorders, and we will be giving 11 -- grants to 11 States who are seeing high increases in their rates of admissions for opioid use disorder.

The President's Now is the Time initiative also received an increase to provide support for approximately 3,500 new behavioral health professionals. So that will be para-professionals and mid-level professionals, and we're very excited about

that, as well as advanced degree folks. And we have enacted a \$1 million agreement with the Health Resources and Services Administration to expand our work on the behavioral health workforce data so we can better understand who and where our workforce are.

So we'll be discussing tomorrow and doing a fuller presentation on our 2016 proposal. That's with Congress right now in the President's budget, but the broad strokes are that we're requesting \$3.7 billion, or a 1.2 percent increase from FY '15. And we've got a focus on four initiatives.

One is strengthening crisis systems in our country. So we're proposing a new \$10 million program to mitigate the demand for in-patient beds for those with serious mental illnesses and substance use disorders. So we want to prevent crises from happening.

We want to better understand how to bring communities together to de-escalate crises and, very importantly, how do you connect folks with the services, those supports that they need in the community to prevent future need for crisis care? And that's where we probably see sort of the system falling apart, where people aren't getting what they need after a crisis so that it gets into this revolving cycle. So that will be both a mental health and a substance abuse program.

We want to take clear steps to address the public health crisis of prescription drug and opioid abuse. So we're proposing an increase in funding to prevent the misuse of opioids and expand MAT, as well as increasing the use of naloxone, which is a life-saving intervention to reverse the effects of opioid overdose.

We are prioritizing workforce development with a request of an additional \$31 million for two workforce programs, our Peer Professional Workforce Program, as well as an additional \$21 million for our work with HRSA on behavioral health workforce education and training. So that's the mid-level and para-professional training. We would expect to train about 6,800 new professionals with those programs, as well as our total with our Minority Fellowship Program, we will have almost 8,000 new professionals added to the workforce.

And fourth, we are reaffirming the President's and HHS's and SAMHSA's commitment to tribal communities that we know bear a disproportionate burden from mental and substance use disorders by requesting \$25 million to expand our tribal behavioral health grants to prevent substance use and suicide, as well as address trauma for Native young people and address the behavioral health issues that we know are affecting their performance in school, as well as their lives and their communities.

So we're thrilled with a very positive President's budget for behavioral health and a lot of support that we're receiving from the administration and the Secretary at all levels.

In the news, we know that there are some important legislative things happening with respect to our issues, both on the mental health side and the substance abuse side. SAMHSA is actively involved in conversations with the field and with the Hill about the efforts to improve services for people with serious mental illness, as well as efforts to protect -- well, to address prenatal opioid abuse and infants who experience opioid withdrawal. And so, there's the Protecting Our Infants Act.

So we -- without getting into too much detail about what is in that act, there's also another piece looking at opioid use and medication-assisted treatment. So we're across the board very involved in conversations. And the good news is, is that there is a lot of interest on the Hill about our issues. And I mean, that also brings some challenges in terms of channeling the energy that's there toward things that we know are evidence based and have the best chance of preventing these illnesses from having an effect on our communities as well as to sustain recovery for people in ways that we know work.

Another piece of great news is that ACWS member Shelly Greenfield was honored yesterday, which is why she's late this morning, with the A. Clifford Barger Excellence in Mentoring Award from the Harvard Medical School. So Shelly will be joining us after receiving this recognition of the value of her mentoring relationships and impact that they've had on the development and career and advancement of other physicians in basic clinical medicine, research, teaching, and administration.

So we're congratulating -- when Shelly gets here, we'll congratulate her on this well-deserved recognition.

So I want to recognize Anita Fineday, who has entered the room, and allow her to introduce herself. And then we'll go around to some of the SAMHSA committee members and ask for their updates, and then we'll go to the committee.

So, Anita?

MS. ANITA FINEDAY: Good morning, everyone. My name is Anita Fineday, and I'm here -- I'm the managing director of the Indian Child Welfare Program for Casey Family Programs in Seattle and new to the committee. So I look forward to figuring out everything that's going on. It looks like there's a lot, a lot to take in.

So, thank you.

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

MS. KANA ENOMOTO: So why don't I -- should we start with -- maybe I will first. I'm going to start with staff. So, Sharon, do you mind giving a quick update on things that you've been doing, and then we'll go to some other members. And Mary, you might want to -- if you know you're going to talk, please come to the table.

MS. SHARON AMATETTI: Thank you, Kana.

So for the new members, I just want to explain that SAMHSA has a Women's Coordinating Committee with staff that is drawn from all of the centers in the agency, who come together monthly to share information about what we're doing around women's issues and family issues. And sometimes we do joint projects. Sometimes we just share what we're doing so that we can collaborate on them.

And several of the participating members are here this morning -- Mary Blake, Linda White-Young, Kathy Crowley, new member Kim Harris. And others should be coming throughout the day to hear your discussions because they are interested in what this committee is thinking about and advising the agency on.

So I just wanted to give a few updates pertaining to some of the work that we're doing around women's issues. I hope that some of you are aware that we're running a webinar series right now called Women Matter, which is a five-part really more of an introductory webinar series on women's addiction treatment and co-occurring mental health concerns. You may know that last year, we did a Girls Matter webinar series. So this really builds off of the Girls Matter series.

SAMHSA used to be in the business of hosting large women's conferences. We haven't been able to do that for a while. So we're using the webinar series as a technical assistance venue for us to get information out to the field about best practices for working with girls and now women.

In March, we had our first webinar, and there were 975 participants on that webinar. April 9th, we had our second one with 600 participants. So we have very good participation and strong evaluations.

The next webinar will be in May, it's the 9th, which is Introduction to Women's Substance Use Disorders and Health. And Hendree Jones is actually one of the speakers. Our ACWS member is one of the speakers on that webinar.

So if you want more information about those webinars, if you just go to the SAMHSA Web page and in the search field type in "Women Matter," it'll get you right to the information about what we're doing on that.

So there's the webinar series. SAMHSA is also continuing to support the Women's Addiction Services Leadership Institute, which is a leadership training

for women working in behavioral health. We're on our fourth round of what we call the acronym WASLI. We just had the immersion training for the new associates who are somewhat younger, emerging leaders, which just was a really wonderful meeting. And it's really a way for us to develop continuing leadership around addiction treatment and for women's services. So that's going on.

We also sponsor every year with National Women's Health Week an event. This is something that HHS, the Coordinating Committee on Women's Health at HHS has really been behind the past 5 years or so, and this year will be again we're doing a webinar. And Hendree Jones is going to be helping us and talking about medications to treat opioid-dependent pregnant women, and then we have two physicians who are going to be on that webinar as well talking about neonatal abstinence syndrome.

So it's really -- it started as an in-service for SAMHSA and HHS staff, but we're going to make it more broadly available this year because of the high interest in that topic, and it'll be archived as well so other people can access it.

I want to turn, actually, to John Campbell, who we invited to come speak about what's happening with the substance abuse treatment grant and block grant around the women's set-aside. So, John, if you want to say hello?

MR. JOHN CAMPBELL: Good morning, everybody. And I understand I have very limited time. So instead of spending 2 hours telling you about the women's set-aside, I'll spend 2 minutes. You don't have to take any notes because I brought down a little folder that has an excerpt from the draft uniform application that's currently out for public comment, and it shows you what we're asking the States to provide in terms of their plan.

There is also a screen shot of the uniform application Web site, of SAMHSA's Web site, that includes a lot of the other resources' fact sheets, including a fact sheet about the women's set-aside, fact sheets about the block grant in general, the statute, the reg, all those wonderful things.

Some of you I've probably addressed before. So I'll make this very sweet and short. The women's set-aside predates the current substance abuse prevention and treatment block grant. It was part of the alcohol, drug abuse, and mental health services block grant. It started out as a 5 percent set-aside, went to a 10 percent set-aside, and then the General Accountability Office issued a report in 1991, where they looked in 7 States who -- and how they were carrying out this 10 percent set-aside for women, and it was discovered that everybody was serving women. Most of the States were not serving pregnant women.

So when the statute was changed in '92, it was much more explicit to say this set-aside is for -- designed to serve pregnant women and women with dependent

children, no more parenthetical phrases, and another very important piece of it was called the rule of construction that basically said the States no longer had the flexibility to interpret the statute as they saw fit. Only the Federal Government could.

So long story short, there is a fairly substantial set-aside that is now becoming --

FEMALE SPEAKER: How much is it?

MR. JOHN CAMPBELL: -- performance requirement.

FEMALE SPEAKER: How much is it total?

MR. JOHN CAMPBELL: Well, the history is it started out with 5 percent of your '93 allotment and 5 percent of your '94 allotment, and it was to build upon what had previously existed. So it was 5 percent of your allotment in '93 to increase relative to the prior year. So it included some of the ADMS block grant dollars.

After '94, the amount of money could be from the block grant, could be State general revenue dollars, it could be Medicaid dollars. The floor, the aggregate floor is just under \$200 million, but I think we're in the roughly \$450 million, \$480 million. I was going to print out a spreadsheet, and I'll try to bring it down here later so you can see State by State what's being spent currently.

And there is another way to demonstrate that in certain States, the floor has been maintained. In other words, they haven't really moved beyond the '94 floor, where other States may have increased it 200 or 300 or 400 percent. So it has not only been a priority in terms of the extended term, now they're also a priority in admissions to treatment.

So there's two statutory citations relating to pregnant women and women with dependent children. Then we took that further to say what do we mean by services? So we went to Sharon's group, the Women and Children Branch in the early '90s. Yes, Sharon, I've been around a long time. We said what would be the gold standard?

Now the gold standard probably had a laundry list of things, and we were able to get a few into the regulation. And basically, what it says is in the regulation we talked about primary -- access to primary care, including prenatal care for pregnant women, access to primary care, including pediatric care for women and children in the custody of those women, gender-specific treatment, case management, transportation. So we got at least a core group of things.

Now there are States that are doing much more than that, and then some are just, you know, addressing the core requirements. But then, additionally, we say that any program receiving block grant funds, you know, a pregnant woman has

priority over anyone else. So, and States have worked out their own mechanisms for how they do that. It wouldn't necessarily be appropriate to admit a pregnant woman to a program that's really not designed to suit their needs. So they have the flexibility of maybe calling the State and trying to identify an open capacity somewhere where there is an appropriate treatment provider.

I don't know if I have more time?

MS. KANA ENOMOTO: Just quickly, what's the quick update of what has changed?

MR. JOHN CAMPBELL: Oh, so the quick update is that there's a very detailed description in here of what we're asking new States to provide in terms of their plan. We also ask them to say what type of technical assistance do you need?

And technical assistance is not just limited to when they're submitting their plan. A State can contact one of my staff at any time to request technical assistance for this population. A lot of times we work with Sharon's group as well, Children and Family Futures. We're doing stuff with four States now.

But generally speaking, there is resources available for any State who's seeking, you know, guidance or just wants to just be a little innovative with their targeted population.

MS. KANA ENOMOTO: Thank you.

And the difference between this application that's out for comment and the previous one is that there was a uniform application 2 years ago that had taken a more streamlined approach to what it was requesting on the substance abuse side about women's treatment. We had -- because there isn't such a requirement on the mental health side that when we went to a uniform application, we took a more minimalist approach to the women's data request.

As a result, I think some States, probably they didn't need to monitor things that carefully, and that was a problem. So we have gone back and, thanks to some feedback from some colleagues, from the States, we have gone back to having a more expansive list of data requirements on that side. So that's the change.

DR. CAROLE WARSHAW: And what about on the mental health side? So back to --

MS. KANA ENOMOTO: It is not -- right. There is no -- there is still a disparity because the statute does not require that for the mental health side. There is more regulation on the side of the substance abuse side that does. So that's why we've gone back. That permits us to require it versus on the mental side we don't have that.

Is that correct, John?

MR. JOHN CAMPBELL: Yes.

MS. KANA ENOMOTO: Yeah, okay. Thank you.

MR. JOHN CAMPBELL: I'm going to leave these here, and I'll bring back the spreadsheet later.

MS. KANA ENOMOTO: Thank you.

And this is particularly relevant for some of our conversations later in that this is at \$400 million. That's a lot of money going into women's treatment, and we can influence that.

And so, part of the value of the ACWS and part of the importance of your role on the ACWS is that you can advise us, not more things we can require because that sort of requires laws and regulations, but things that we can advise, things that we can offer, directions that we can guide people toward to influence a very large chunk of the public substance abuse system that affects women and girls.

MS. SHARON AMATETTI: Thank you very much.

MR. JOHN CAMPBELL: You're welcome.

MS. KANA ENOMOTO: Mary?

MS. MARY BLAKE: Hi, everyone. I'm going to be brief. I'm going to just highlight some key things that we think you might be interested in, and my comments are going to focus on some of our work with the administration and with some of our Federal partners.

So the first thing I wanted to mention is that SAMHSA was asked to work with an HHS working group to address the intersection of HIV/AIDS, violence against women, and gender-related health disparities. And in particular, we brought our portfolio on the targeted capacity expansion grants for minority women and HIV/AIDS. So we're working collaboratively with the Center for Substance Abuse Treatment, and we brought to the table our trauma work that we've done. In particular, SAMHSA's concept paper on trauma and guidance for a trauma-informed approach.

So those two perspectives were brought to the table, and we've now been incorporated into the White House working group, and we're very pleased. We seem to be having some really good impact with our Federal partners. So we've done a number of things internally in SAMHSA -- training of grantees on

SAMHSA's concept paper, training of project officers, working with the minority, AIDS, and women grant program.

But we've also now started doing education and training with our fellow partners on the concept paper. In particular, the guidance about how you implement a trauma-informed approach and the various domains and why that matters to providing gender-specific, gender-responsive, culturally competent, and trauma-informed services for women. So that work has gone extremely well.

We've been asked by the White House to provide some technical consulting to the Department of Homeland Security in regards to the detention of women and girls and children. As you know, there was an influx of children crossing the border last year, and so we've been providing some consultation with Homeland Security, as well as providing some education and consultation to the White House Council on Women and Girls. And a lot of this is related to SAMHSA's concept paper.

I was very pleased in a meeting with the White House about a month ago to hear -- to hear them say that trauma and addressing trauma-informed approaches is now a priority of the administration, and they're really trying to integrate it into the work that they are doing related to women and girls. And I would say that there's a lot of great work that's happening with some of our partner Federal agencies, but collectively, we feel that SAMHSA, working with our Federal partners, has had a good impact. So that's something very exciting.

And then the other thing I just wanted to mention is that SAMHSA co-chairs a committee, a Federal interagency committee called the Federal -- the Women and Trauma Federal Partners Committee. Actually, SAMHSA actually founded the committee back in 2009, and we now co-chair it with Department of Labor. And we have done some really significant things.

We have 14 Federal agencies and over 34 operating divisions in offices across the Federal Government who participate regularly in our monthly meetings. So we are now preparing for our third major meeting. We've held two. We have identified the dates of September 28th and 29th, and the Department of Labor will be sponsoring the meeting this time.

The purpose of this meeting will really to be to gather information about what's happening in States and communities to move a trauma-informed approach forward, and we'll be looking at how that -- specifically looking at issues related to women and girls. And this is going to be very exciting because we see it as a broader effort to create a national agenda for addressing trauma in the lives of women and girls.

So stay tuned. We'll be getting more information to you on that. And in the meantime, this summer we are hosting a training event for our Federal

colleagues on trauma and trauma-informed approach. In the morning, we will have a basic overview provided by our colleagues in the Office of Women's Health, and in the afternoon, we'll be spotlighting initiatives in different agencies, including SAMHSA, the Peace Corps, the Bureau of Prisons, and some other Federal agencies that are doing some really great work to implement a trauma-informed approach. And this is to bring us all in alignment and coordinate our efforts.

Thank you very much.

MS. KANA ENOMOTO: Thank you, Mary.

So do we have -- Linda, did we have any other SAMHSA staff wanted to add anything?

So instead of me reading out everything that everyone else is doing, I thought I would let you hear it from the folks who are actually doing the really exciting and important work across the agency. There is just really good stuff happening here, and we don't have a lot of money dedicated to -- well, we don't have a lot of programs. There is a lot of money in the block grant set-aside, and it leverages a lot of other money.

But, Mary, you don't have a women's program that you're the project officer of, for example, but this is a piece of her work that she does. And while trauma and work is -- has its origins, I think, in our work with women, it's not only women. And some of our grant programs, like the National Child Traumatic Stress Initiative, isn't just focused on girls. It's focused on girls and boys. But obviously, trauma, we know it's an issue that profoundly affects the lives of women, and so it's been a great entree.

Has everyone here seen our trauma concept paper? We had a presentation on it the last meeting. So, Anita, you haven't seen it. It's just we could make sure that the new members all have it. Dan, have you seen it? No? Okay.

We've been referring to it, but I just want to make sure people know that we're all on the same playing field, and one of the things that I think SAMHSA has really contributed in the process with our colleagues across the field is putting a definition on trauma in a very -- in I think a very useful way. And if there is an event which has -- which a person has an experience of, and it has an effect. And all three of those variables are very important because you have the same event that people experience differently and will then lead to different effects.

Or you can have the same event which people experience in the same way, but then they have different effects. They know what they've experienced previously. And so, those are -- those -- I think it's a very useful way of defining trauma rather than getting a really just a glimmer of types of events. You know, whether

it's a chemical spill or combat, you know, military combat or a sexual assault. I mean, just you could sort of go on and on and on about what is a trauma.

But I think the three Es really helps us put a frame on what is trauma and depend on some fairly predictable variables, and we put them together, then you have a trauma or you don't have a trauma. And that gets us away from the hair-splitting of whether or not a car accident is a trauma or whether or not a medical procedure is a trauma. It just depends on a number of things. But at the end of the day, what is the experience? What is the effect on the individual?

So thank you to the staff. I want to just review the agenda quickly after this, and then I'll let everyone go and tell us what you're doing. Today, we're going to talk about IPV, the impact of IPV on lesbian, bisexual, and transgender women. I think this was an issue that's been -- was brought to us, was a high priority to address, both IPV and LBT issues for the administration, the Secretary, and the Administrator. So this was suggested as a hot topic that we might look at.

We're going to have the Administrator joining us at 11:30 a.m. That will be another opportunity -- you advise me all day long and all year long, but it will be a chance to ask her questions about what she sees as key priorities and for you to offer to her advice. She loves advice.

She does. She really does. She often says that the committee sometimes want things to do, like what is their charge? What are they supposed to be producing? And she emphasizes consistently what you are producing is your advice to us. I don't want you to do a project.

And many people are project people, right? That's sort of what we do in our regular lives is we sort of set a goal to accomplish something, and then like then you can look at that.

But for her, it's we're bringing together this collective of very experienced, very wise people to hear what we're doing and say maybe you should do it this way, or maybe you should look at this thing on the horizon. Or you're in D.C., but we're out in the field and here's what we're hearing, and you're not getting that yet.

And so, that's what you're bringing to us. So that's, I think, if you can bring that to her, she will be -- she will find that extremely valuable.

We are going to look at some of the fantastic work that's been happening looking at women in co-ed settings. While we absolutely think gender-based treatment is important, we think that not everyone can be gender -- not every treatment setting can be entirely gender specific, and so what do you do about all the others? And this is just great, important work.

Then we're going to look at the PPW program and future directions with Linda. I always refer to her, she's like the mother of the PPW program. But Andrea Kopstein is one of her bosses, and she'll be doing a presentation for us. And we have a longstanding PPW grantee and folks who have experience with this. Karen, who's dealing with the set-aside.

I think it'll be a really rich discussion in terms of advancing what we refer to commonly as our theory of change is that in the past, SAMHSA sort of got a program and kept in one place and kept doing it the same way for like 18 years. And what we worry about was whether or not we were doing that program well and getting good outcomes from that program. It's like, you know, there's \$18 million, there's \$30 million that is well spent. You know, good for us.

On the other hand, you know, of the -- of the 20,000 women experiencing this issue, we're treating 1,000 a year. So the question now is, yes, we have done this 1,000 women or this feeds 2,000 women and their babies, you know, well. How are we going to get to the other 98,000 or however many of thousands there are. And that sort of getting that multiplier effect and what do we need to get there -- do to get there?

And then Jeannette will be presenting to us about high-risk/high-need girls and young women. And that will be a presentation that we missed due to like weather and airplanes in the past, but I think this will be a great -- another great conversation, with Rosalind as the discussant.

So, and then we'll talking about the Joint NAC questions. And I would like you to all think about that as we go through the day today. SAMHSA has been encouraged in many ways, and SAMHSA wants to think about what our role is in the treatment arena. And even for prevention folks, the prevention council is also being asked to think about how does prevention relate to treatment?

For this group, it's how do we want to advance our work in the sphere of treatment for women and girls? And we're going to bring that perspective to the Joint Council tomorrow because it is absolutely a priority for us. While we have placed a lot of emphasis on prevention, we know that treatment is the backbone of what we do, and it's important to the Nation that we step up and we offer the leadership and voice and some of the resources to get people the most and best treatment that they -- that they need and can get.

So, with that, any questions about the agenda?

[No response.]

MS. KANA ENOMOTO: Great. All right. So, with that, I will let Shelly, whom we congratulated already for the great honor that has been bestowed on you for your role in mentoring other rising professionals. But I'll let you introduce yourself, and

then why don't you go ahead, start with an update on what's been going on with you and from your perspective. Then we'll go around to our other members.

DR. SHELLY F. GREENFIELD: Thank you very much.

So I'm Shelly Greenfield. I am a professor at Harvard Medical School, and I am at McLean Hospital, where I am the chief academic officer. I also am the chief of a relatively new Division of Women's Mental Health, where we treat girls and women through the full age spectrum, with both psychiatric disorders and co-occurring substance use disorders.

I'm also an addiction researcher. My focus has been on women and addiction, and in particular, I'm -- I have piloted a group therapy for women with substance use disorders called Women's Recovery Group. And that is something that we are excited to have moved into standard practice at the hospital and in some of our other programs.

In terms of things that have been happening in that sphere and that arena, I would say that this new division has been working together to do cross-collaborations. We were very excited that Carole Warshaw came and spent a day with us and talked about interpersonal violence and domestic violence and prevention of those things at the hospital. And we're also very excited to be piloting some co-occurring eating and substance use disorders treatment for girls and women.

So those are my updates.

MS. KANA ENOMOTO: Jeannette or Dan or anyone?

MS. JEANNETTE PAI-ESPINOSA: So a couple things that we've been working on. Remember when I did my intro, I said we served 18,000 girls and young women a month. It's actually 140,000 a year. Eighteen thousand is the number of employees.

So I'm going to talk later about the work we did with ACE a couple years ago. So when I do that, I'll fill you in. We're in the middle of our second administration. We've done it differently, and we've seen some interesting trends. So I'll share that then.

We are -- in about 2 weeks, we're going to launch an app, which is called The Society. It's a closed, secure app. It's not -- you can't just go and download it. But it was designed to serve as a bridge for young women leaving our agencies. So they may be in residential treatment. They may be in after school programs. It's a variety of different settings.

So they would come into The Society, and they would be able to, you know, have

conversations, find support from not only other women who've come through our agencies over the last -- we're 132 years old. So for that many years. But they'll also be brought together with -- so they're called sisters. It's a very complicated thing that's up in the air.

So they're called sisters, and then we have friends, who are women who have not come through our agencies that we're going to invite to be a part of that secure community. And it's designed to really bolster their health, as well as build their social capital and provide the kind of support that they felt like they were missing when they left, you know, these really substantive programs. So it was designed by a group of eight women from the ages of 17 to 35 who had left our agencies over the last about 15 to 20 years.

So we're pretty excited and very nervous about that. All I've seen are wire diagrams so far. So that will launch in May in five cities, five States, and then a second cohort will go up for a pilot in October. So we're using different kind of formulas and different relationships and different sort of recruitment mechanisms. So by the next time we're together, I should have some real information about how it went. So we're very excited about that.

On the National Girls Initiative side that is part of the Office of Juvenile Justice and Delinquency Prevention, we just announced the award -- three Innovation Awards to three different States to do policy reform focused on girls and young women, which really focuses on, you know, what is effective policy, continuum of service, and showing that girls receive gender and trauma-informed, culturally appropriate, developmentally appropriate services. So we're really excited about that.

And we're going to be hosting roundtables in the future on girls' needs in tribal communities and also most likely will be looking at the impact of the mandatory arrest requirements for domestic violence. We're seeing a lot of girls get swept into that, and doing some State-by-State analysis, it's becoming more and more clear that the numbers are pretty large.

So I think, short and sweet, that's it for me. You must be next?

DR. CAROLE WARSHAW: I guess so. Well, so our center, which is actually very tiny, we lost one of our key staff this year, Patti Bland, who was our substance abuse training director. And so, we're down to like five full-time staff. But in the last year, we responded to nearly 1,800 TA requests and did over 100 trainings with teaching over 10,000 people in 25 States, including D.C. In our online presence, we had over 15,000 downloads of materials on substance abuse and trauma.

We are doing a final revision of our core capacity building curriculum for creating trauma-informed DV services and organizations and a revision of our accessible

culture DV and trauma-informed agency self-assessment tool that makes it more standalone. We originally developed it to be in conjunction with trainings and TA, and so we want to kind of bolster that.

We're also working closely with Gwendolyn Packard at the National Indigenous Women's Resource Center on developing more integrated approaches in culturally relevant approaches to trauma and domestic violence, and we are also in the process of developing -- we're piloting a curriculum on child trauma in DV for child welfare workers and creating a -- trying to develop an online presence for our trauma curriculum for DV advocates that builds on the principles of childcare and psychotherapy.

We also were recently brought into the White House Committee on Violence against Women and HIV/AIDS, and we're going to be working on the tip sheet on trauma and violence against women with Naina Khanna from Positive Women's Network. Our paper on alcohol and substance use coercion is finally out. We did a webinar on that, and we had a tremendous number of cases for the mental health and substance use field around, you know, women being coerced into using and their recovery being sabotaged by abusive partners.

And we're working as a TA provider as part of a FVPSA-funded project on developing culturally specific domestic violence and trauma-informed interventions, and we are working specifically with the GLBTQ DV project in Boston and a group in Hawaii that's trying to develop a Native Hawaiian culturally specific approach to healing.

And, but one of the things that we're really excited about is work that we've been doing with a number of people, including Mary Ann Dutton, on thinking about complex trauma and both individual and collective trauma and looking at the, you know, not only the legacies of historical trauma, but also the sexual violence and trying to think about more integrated approaches where it's not just individual and what that means and how to build evidence around things that are much more complicated in our survivor center or community center, not just for a culture. But how do you manage all of that, create that discourse?

MS. ROSALIND WISEMAN: Are you done, Carole? Can I ask a question about the -- can you say again the report that you were so excited about? That you just said so much information that I'm -- now I'm trying to remember what I wanted to ask you. Now I can't remember what it is, but it was --

DR. CAROLE WARSHAW: It was the substance use coercion?

MS. ROSALIND WISEMAN: Yes. Can you just talk a little bit how -- you know?

DR. CAROLE WARSHAW: Okay. This is something that the National Domestic Violence Hotline did, and we helped kind of support and both report and analyze

the data. And at the end of a hotline call, if the person is not in crisis and they want to participate, you can ask -- they do these focus surveys with up to five questions.

And the first one -- both surveys were over 6 weeks. The first one had over 2,000 participants. The second one had over 3,000. We asked about, you know, does your partner call you crazy? So over 83 percent said yes. Or does your partner deliberately do things to make you feel like you're going crazy or losing your mind? Over 73 percent said yes.

So for people who over 50 percent sought help or treatment, of those, over half said their partner tried to control their treatment or prevent them from accessing treatment. This is on the mental health side. And then their partner would then use that against them in court around custody and credibility.

So, first, they'd undermine -- they have this traumatic effect of use. Then they undermine their sanity and sobriety. Then they interfere with treatment, and then they use it against them.

So on the substance abuse side, there were over 3,000 people. The numbers were lower, but some of it may be because people were less comfortable disclosing over 25 percent of their partners coerced or forced them to use. Not as many said they sought treatment, but of those, over 60 percent said their partners tried to sabotage their treatment.

There was lots of anecdotal, you know, people -- the advocates would write down the kinds of things that people said about, you know, "I'd come out of, you know, a treatment program. He'd have alcohol around. Of course, we'd use." It was indicated in coerced sex as well.

And so, it's really, when you think about the implications for mental health and substance abuse treatment, and we're creating a tip sheet for guidance for both mental health and substance abuse providers on what questions to ask and how to respond when these kinds of things come up.

You think about the courts. Judges think that if, you know, there's any mental health or substance abuse issues that are brought up by an abusive partner in a custody battle, that they'd rather give custody to the person who's the abuser rather than the person who's creating, you know, who's being undermined.

And so, we are trying to get judges to think that if someone brings that up, that should be a red flag. Because if someone has a mental illness and their partner is supportive, they're not going to say, "Okay, we should get custody," and having to bring it to court.

One of our young staff who's an attorney is talking about thinking about ways of

using the ADA, Americans with Disability Act, as a way of supporting people and as an accommodation providing support to someone's needs when there is trauma, mental health, substance abuse to that they can maintain custody. She's working on a paper on that. So does that --

MS. ROSALIND WISEMAN: Yeah. First of all, incredibly important. And second, really helpful. And it's out, or it will be?

DR. CAROLE WARSHAW: Yeah, it's on our Web site.

MS. ROSALIND WISEMAN: Right. Okay. That's what I thought. Okay. Thank you.

DR. CAROLE WARSHAW: And we're going to write an academic paper also. That would be in 2 weeks for our next report.

[Laughter.]

MS. ROSALIND WISEMAN: Wow. That's incredible. Where are you trying -- can I ask one more question? Where are you trying to get it published? Like, where can we look for it, or do you know when?

DR. CAROLE WARSHAW: Our research colleague said she was going to write a draft in the next 2 weeks. So we have to say that we have it done by --

[Laughter.]

MS. KANA ENOMOTO: In an academic journal. So you have a -- you have a report for the public that's on the Web site --

DR. CAROLE WARSHAW: Yeah, I think it'll get that, and then we also --

MS. KANA ENOMOTO: Right. Got it to academic.

DR. CAROLE WARSHAW: Yes.

MS. ROSALIND WISEMAN: Thank you. Thank you for indulging me. Thank you.

Okay. Well, the work I've been doing is really on three things. One is, and I think I've spoken to this with other meetings, that we just have such a huge -- there is so much money in all different kinds of ways going into bullying, and kids hate it, and they think it's a waste of time. And most of the -- it's just there are so many campaigns about it. There is so much information about it, and most of the work that I do with young people is just trying to get their credibility back if they think that I am there or anybody representing what we do is about bullying.

It's particularly children who have high social status, and they're not necessarily abusing it, but just have -- want nothing to do with the entire subject. And I think that they have good reason for it. One is that is the way in which it's presented to young people is incredibly simplified and not very realistic to their experiences. So you have one person who's like 100 percent evil and one person who is 100 percent innocent, and kids know that maybe that's a case at some point, but that's not what they see in their interactions with people.

Because people might fail to -- also don't like to talk about the provocative target, the kid that is hard to like, who doesn't get social cues, who -- who doesn't get social cues, and it looks to young people, like to the people that might be on the receiving end of that, that they're not listening to really obvious social cues.

So it is also the case in going through the presentations or work of any kind, none of -- very few, if any, of the curricula that I see addresses or even acknowledges that bullying and abuse of power occurs between adult to student. And that's another reason -- and then we say to kids that you should tell an adult if you have a problem, and that's a really big problem because not only are adults abusing their power, but well-meaning adults see abusing adults do things to kids, but those well-meaning adults don't say anything.

So we have a serious lack of credibility in our education, and they're spending a lot of -- some amount of time on this. And it really goes to disengagement of young people, and it goes to disengagement of seeking help from counselors when they're having mental health problems. So this is -- to me is a really challenging problem.

And on top of that, some of the schools and some of them were -- some of the schools also believe that it's useful to bring in an adult who has gone through the experience of having a child that they have defined as killing themselves through bullying or because they were bullied killed themselves, and so they bring an adult, a parent, who's had this incredible experience. And usually, these experiences are much more complicated than they have been bullied to death.

And the kids sit there and are like, okay, this is a sad story, but -- right? And that adult is really ill-equipped to be able to also address issues in concrete ways. So we have a pretty significant issue with this.

And the problem also is that schools are doing a lot of stuff around it, and I would rather it be about -- I'm trying to redefine and have been for a long time -- how to redefine this in terms of conflicts that's going to happen. Abuse of power is going to happen. And how do we have skills around that that where young people and adults jointly collaborate to figure out these issues, and then we don't silo them?

And then the last thing about bullying is that it really doesn't address what these

issues are about, right? Abusive relationships, racism, homophobia. I mean, so it's really -- we have lost, I think, some of the substance of what the issues are about. So that's something that I'm really struggling with and continue to struggle with.

To that end, too, I think the thing that I'm -- the two things I'm working on to be in a more positive direction is we've been doing a lot of work on girls and gaming and boys and gaming and how boys see girls in gaming. And we just did a conference at the Game Developers Conference, where we had a survey of over 1,400 -- an exploratory survey of over 1,400 students through 6th through 12th graders. And one of the most amazing things about it was their responses were completely opposite of what the gaming industry says.

So 82 percent of our boys who identified themselves as gamers want girls to participate in games. They think that, for example, vast majority of them think that gaming is way overly sexualizing women. That they want girls and they want strong female heroes in their games, and if they were given female heroes in their games, they would play as women. They have no problem with it. They actually want to do it.

So it's way more progressive than what we hear in the gaming industry. In fact, actually, one of our most interesting findings was that boys wanted to -- were much more willing to want to play female characters than girls, as they got older, wanted to play more female characters, but did not want to play boys, male characters.

So it's -- why this matters is because for so many young people who are disengaged in school, games can be an extraordinary part of their social lives and an outlet when they're having mental health issues or when their families are falling apart, that the relationships that they create online are really important to them. And unfortunately, adults usually think of that is if you're playing games, there's a problem with you.

So I've been going a lot to how do we work with games as a way to reach out to young people? And so, the third part of that is that I'm just in the beginning stages with the Association of Middle Level Educators, AMLE, to be able to create a curricula that would address these issues for middle school people and to collaborate with them to be able to do that.

So I don't like being optimistic, but I have like a couple of moments of feeling optimistic in the last couple of weeks getting ready to work with the AMLE because these issues are so politicized at schools that you need an association like AMLE to be behind it to give you the safety to -- I talk to a lot of school board members, super politicized councils, administrators, superintendents so they can provide safety for everybody.

So those are the ways in which I'm trying on my ongoing efforts to try and shift the conversation that we have for young people so that they have a sense of taking us seriously on these issues that are so important. And also, they also really do have these issues and really do need access to all of the things that we do around the table. But it's so difficult for them to do it because adults make it so much harder for them in general to be able to reach out to the services that they need.

MS. KANA ENOMOTO: Thank you.

MS. KAREN MOONEY: You guys are all doing really amazing things. Carole, thank you for the citation of that article. I will be grabbing it and passing it out to the women's treatment providers in my State. I think that's stuff that we've known has been going on for a long time, but has never been quantified or documented anywhere. So that will be really, really helpful to have.

And thank you to SAMHSA for adding the requirement around reporting the women's set-aside back into that application. That's huge, and so that's -- really grateful for that.

The Women's Services Network continues to do its work around supporting the women's treatment coordinators. We're called a variety of different things, but women's treatment coordinators, the old name that is still stuck in my head. But we're continuing to work on issues related to our roles, our kind of unique roles in the State of being responsible for some portion of the block grant, but not always being directly given the authority to enforce the pieces of the block grant that are requirements that are needed.

We've been working on updating our mission statement to reflect a little bit more active participation in the issues that are taking place throughout the treatment field. We are also hearing from a variety of expert speakers on our topic calls, and those have been very helpful. Dr. Jones was one. She spoke about neonatal abstinence syndrome and opioid treatment.

We are in the process now of through my role with the WSN, I also participated in development of the co-ed document that we'll be discussing a little bit later. I think this is going to be really critical for the women's services coordinators to be able to try to bring some of these principles of gender-responsive treatment into our contracts and into our licensing roles in our States to make things, the treatment that's available for women a little bit more relevant regardless of the setting.

And thank you for allowing us to be represented here in this committee. This is great.

MS. KANA ENOMOTO. Thank you.

MS. ANITA FINEDAY: Thank you.

I gave a very brief introduction. So I'll just give you a little bit more of an introduction about what I do. This is my first committee meeting. So it's kind of like opening the spigot and trying to take all this information in.

So, as I said, I currently work for Casey Family Programs, which is a multibillion dollar foundation based in Seattle, Washington, that focuses on youth in foster care. And that's really the focus of Casey's work. I'm in charge of the tribal work at Casey. I have 13 people in my team who work in Indian Country. And so, we focus on working with tribes, building capacity to provide services to children who are in foster care or who have been in foster care and assisting tribes in building their mostly social services programs, accessing best practices, and spreading what we believe are best practices for Indian Country.

And so, before I came to Casey, I worked as a tribal judge for my tribe. I was the chief judge for the White Earth Tribal Nation in northwest Minnesota for 14 years. And one of the programs that we developed that I remain very proud of was funded by SAMHSA, and that was a fetal alcohol spectrum disorder program that allowed the tribal court to screen every child that came through the court for FASD.

And the White Earth Tribe was eventually able to take on development of its own FASD clinic that was self-sustaining after the FASD, the 5-year FASD grant was completed. So that program is still in existence at White Earth and continues to screen every child that goes through the court system, and so it was a big success.

So that's just a little bit about what I've done. Thank you.

MS. KANA ENOMOTO: Dan and then Sarah. Or do you feel like you've updated?

DR. DAN LUSTIG: Yeah, I think I pretty much updated on my previous speech, but I do -- I will mention just briefly some of the work that we've done at Haymarket Center on women's services. About 51 percent of our beds, of our 450 beds are women's programming. And through the years, the last 40 years of women's services, we've really developed evidence-based programming around the corrections populations for women.

The one thing, if anything was to stand out, that I was really, really excited about was 4 years ago, Cook County had a policy that every pregnant woman part of the criminal justice system, whether they were out on bond or not, was shackled prior to giving delivery. And when I asked the question why were they shackled because I couldn't envision that a woman in the middle of labor was going to be

running down the hallway to escape. But I could be wrong.

[Laughter.]

DR. DAN LUSTIG: And so, there was no theme or common sense to that, and so we led a class action lawsuit against Cook County and won that. And today it is policy now that women that are part of the correction system are not shackled during childbirth, which is a big thing for us specifically in providing decent treatment to women and children.

And so, Haymarket was several years ago a recipient of a PPW grant that really helped us to change and enhance and hone a lot of the programming that we do for women and children. And so, it's been a good time, and also right now we're entering a pretty challenging time in our State.

But, so thank you.

MS. KANA ENOMOTO: Sarah, would you like to give us an update?

[No response.]

MR. JOSH SHAPIRO: She's gone. She's no longer on the line.

MS. KANA ENOMOTO: Okay. All right. So we lost Sarah.

So it is, I think, Karen, you said it well. Everyone is doing some great stuff. We have, I think, a very stellar assembly of folks who are touching the behavioral health of women and girls in different ways. I think that's also very exciting to bring such unique perspectives, and collectively, I think we can get some very rich discussions happening and some great advice to us.

It's not all treatment. It's not all prevention. It's not all behavioral health specific. It's not all adults. It's not all kids. So I think this is we have achieved -- we have reached a new high in terms of diversity and yet evolution of the perspectives here because it's also possible to be quite diverse, but also fairly irrelevant.

[Laughter.]

MS. KANA ENOMOTO: So we've done that, too. So I'm excited. So thank you very much.

Nadine, is -- I think we were going to hand out the joint committee review agenda also? The joint -- you all have the joint committee agenda in your binders. So -- it's in my binder.

You have a tab, a beige tab that says -- looks like this. SAMHSA's Joint Advisory

Committee meeting.

MS. ROSALIND WISEMAN: For tomorrow?

MS. KANA ENOMOTO: For tomorrow.

MR. JOSH SHAPIRO: Yes.

MS. ROSALIND WISEMAN: Yeah, I've seen it.

MS. KANA ENOMOTO: Mid way through. Well, the tab page.

MS. NADINE BENTON: You do. You have it. They have it.

MS. KANA ENOMOTO: All right. Just so you know, you have tomorrow's agenda. If you don't have it, let us know, and we will get you tomorrow's agenda so that -- I just -- and I raise that because I want you to think through today's discussion and be thinking through who are you going to nominate to represent today's discussion to tomorrow's meeting of the 70 or so members of our joint -- of our joint committees.

And then just for some of you who may be staying through Friday the 17th or would like to join us by phone, the SAMHSA National Advisory Council is going to have a special presentation where the Acting Assistant Secretary for Health, Karen DeSalvo, is coming, and the Deputy Administrator for Innovation and Quality from CMS, the CMO is also coming to talk to SAMHSA. So this is part of our ongoing effort to engage our colleagues from across HHS.

Two very high-level people who are leading for the Secretary around important initiatives like delivery system reform and the ACA implementation coming to talk to the SAMHSA NAC. So you are also all welcome to join us for that.

So, with that, I'm going to take a quick break. And yes, if you don't have it, I have it. I wanted to hand it back. We're going to take a quick break, and we're going to ask people to come back in 10 minutes, if you would.

Thank you. So we will be back online at 10:30 a.m.

[Off the record at 10:21 a.m.]

[On the record at 10:35 a.m.]

MS. KANA ENOMOTO: All right. Great. Thank you very much to everyone for getting back on time. We are -- we have our lines open?

MR. JOSH SHAPIRO: Yes.

Agenda Item: Impact of IPV on Lesbian, Bisexual, and Transgender Women

MS. KANA ENOMOTO: Great. Okay. So this is the Advisory Committee for Women's Services. We are reconvening for our session on the Impact of IPV on Lesbian, Bisexual, and Transgender Women. Carole Warshaw is going to open us up, and then we have June Crenshaw to be our speaker and a presentation.

Thank you.

DR. CAROLE WARSHAW: Thanks, Kana.

So welcome to -- I've been asked to introduce you and to facilitate the conversation afterwards. SAMHSA is especially interested in mental health and personal challenges for lesbian, bi, and trans women, including the challenges of interpersonal violence. And in this session, we'll hear from you, June Crenshaw, advisory board member to the D.C. Mayor's GLBT Advisory Board and the ACWS members about how SAMHSA could provide additional support to the lesbian/bi/trans community through our work and programs.

June Crenshaw is the longest standing member of the advisory board of the Mayor's Office of LGBT Affairs, where she is chair of the Public Safety Committee. The advisory board provides insight and guidance to the Mayor's Office of LGBT Affairs on programs, services, and support mostly in the LGBT community.

During her time on the board, June has been an actively present face in the expansion of services that includes all components of primary medical care, and she is particularly proud of the improved services offered to women such as gynecologic services and prenatal care in the merger with the Mautner Project, which provides support and services for residents with cancer and other chronic illnesses.

June is also the chair and one of the original founders of the all-volunteer board of Rainbow Response Coalition, whose members identify resources and provide education and outreach to victims and survivors of intimate partner violence in the LGBTQ communities.

So I'll stop there. There's a lot more to say, but in the interest of time, we'd rather hear from you.

MS. JUNE CRENSHAW: Absolutely. Thank you. Thank you, Carole, for the introduction.

I am June Crenshaw. I'm very excited to be here. And as Carole mentioned, I

am the chair of the Board of Directors for Rainbow Response and one of the founding members. Very excited to be a part of this discussion on intimate partner violence and its impact on lesbian, bisexual, trans women, and other individuals in the community.

So the agenda that I will be following today is a brief introduction of Rainbow Response and some of the work that we've done in the community. A definition of intimate partner violence just to level that to make sure that we're talking from the same perspective. Some of the abusive behaviors that we've identified that occur not only in heterosexual relationships, but LGBT relationships as well.

We will briefly talk about some myths and the problem, as it presents itself in the LGBTQ community. In addition, we'll talk about some statistical information around the prevalence of intimate partner violence and some of the obstacles to seeking care. And then, finally, we'll talk about what we can do together and some of the work again that Rainbow Response is doing in the community.

So Rainbow Response is an all-volunteer organization. This is a -- it was a coalition that was started in 2007, and it was started by a group of individual that were mainly in the DV community, but it was also other agencies and organizations and individuals that were just purely concerned about the lack of services and resources and outreach to victims and survivors of intimate partner violence in the LGBTQ community.

We had heard for -- let me start back. There were activists that were in the community at the time that were hearing anecdotal information around the prevalence of intimate partner violence. In fact, in September, one month before this organization was founded, there was a case of a lesbian being shot in front of Safeway in Adams Morgan. And in this particular case, this individual had followed all the typical routes, getting a protective order, staying away, doing all of the things that she should have done, and still she was attacked by her ex-lover in front of her place of business.

This, I think, was the flashpoint for the LGBTQ community to say we need to do something differently. We need to be talking about healthy relationships. We need to be talking about services and support to our community, and we need to come together to make sure that we're addressing this issue differently.

So Rainbow Response's mission, one of our major missions, is to raise awareness around the prevalence of partner violence in our community with the hope of responding to this collectively, finding creative ways to address this crisis in our community. We also work to identify organizations that provide culturally competent, supportive, and respectful services to victims and survivors of intimate partner violence in our community.

So the definition that I am working from today regarding intimate partner violence

is intimate partner violence, also known as domestic violence -- and I use these, and most individuals in the community use these interchangeably -- is a pattern of behavior where one partner coerces, dominates, or isolates another partner to maintain power and control over the relationship.

So some of the abusive behaviors that occur in intimate partner violence is around physical violence, and this could be hitting, slapping, shoving, choking, kicking, and in the case of the Safeway situation, actually killing.

Sexual violence, including forcing sex or forcing a particular type of sex or forcing a partner to have sex with someone else or refusing to practice safe sex.

The emotional threats and intimidation, which is criticism and insults and name-calling and degrading behavior, to really impact the self-esteem of the victim or survivor in intimate partner violence.

Also controlling a person's finances, creating debt or stealing credit cards or cash. Or if a person has a particular economic advantage over their other partner, forcing certain decisions to be followed because they have the economic advantage in the situation.

Isolation of controlling access to friends and family and to community. Refusing to allow them to have freedom. Controlling access to medical care and medicine. Threats to harm the children, animals, or destroy property.

Also controlling technology. Sometimes repeated text messages or access to phone or, you know, tracking their activity through technology is an issue as well.

But some of the abusive behaviors that are really unique to the LGBTQ community is threats of outing to family, work, landlord, school, et cetera. So not everybody in the community is out. Not everyone lives openly. And so, the threat of having to out yourself to police officers or out yourself to first responders, or if your partner says, "Listen, if you don't do the things that I want you to do or if you report this, I'm going to out you to your workplace" is a threat that is unique to our community.

Also threats to take children away due to sexual orientation. In D.C., Maryland, and Virginia, we have some of the most progressive laws in the Nation. However, the lived experience and the legal experience is not always the same. Sometimes there is a gap in that situation.

Controlling a person's gender expression. And so, the way that this shows up in our community is that if a person likes to present or dress in a, for example, masculine way, there may be a partner that prevents that expression and prevents that person from comfortably dressing in the manner in which they feel the most comfortable.

So some of the myths that our community deals with around domestic violence is particularly in the lesbian, bi, and trans community where some of our couples present in more of a role presentation. So there may be a masculine partner and a feminine partner. That's not always the case, but that's sometimes the way our relationships present themselves. So sometimes it's considered that a "butch" or masculine partner must be the perpetrator to abuse. Well, we know that this is false.

Butch or masculine women are not always the primary aggressor in a relationship. But when reporting crimes to -- reporting DV incidents to police officers that are trained to look for DV in a particular type of way that, you know, the masculine -- more times than not, the masculine partner is the one that is causing the abuse, this is another stigma that our community has to sometimes overcome.

Another myth is physically smaller or weaker people cannot be aggressive toward a larger partner. We also know that this is not true. And some of the ways in which domestic violence shows up is not about size or weight or personality or any of those things.

Another myth that we deal with pretty regularly is with our transgender women. Transgender people are more likely to be perpetrators of abuse. Well, I think that sometimes there is fear and hatred of trans individuals that feeds this particular bias. The truth is, is that trans women are more often the victim of crime, the victim of hate crime, and the victim of DV than any other LGBT individuals.

Victims are always feminine. Not true.

An intimate partner violence cannot occur in a relationship between lesbian, bisexual, or trans women because a "cat fight" is normal. Well, again, if we refer back to the incident that occurred in front of the Safeway where this "cat fight" turned deadly.

So the problem is for our community, as in all communities, but specifically for our community, intimate partner violence is a devastating and deadly problem facing LGBTQ communities. We know that intimate partner violence is all too common and way too hidden in our community. In fact, it's nearly invisible.

And with the focus of LGBT individuals on fight for -- on our fight for full equality and marriage equality, there are even national organizations that refuse to focus on the problem of intimate partner violence in our relationships because that sort of airs our dirty laundry and takes away the focus from our fight for full equality around marriage and other rights.

Most domestic violence research, programs, and outreach frame the issue of

intimate partner violence as something that really only happens in heterosexual relationships. So all of the outreach that's done by agencies and organizations really don't include the underserved community, the underserved LGBTQ community.

[Laughter from adjacent room.]

MS. JUNE CRENSHAW: They're having a lot more fun over there, right?

[Laughter.]

MS. JUNE CRENSHAW: Talking about less serious things.

So here are some of the numbers. Rainbow Response conducted a survey in 2009 and again in 2013, and we found that 33 percent of LGBT respondents reported having been in an abusive relationship. This rate really is on par with the best academic research available on LGBT partner relationship violence, and it's very comparable to partner violence experienced in heterosexual relationships.

However, another study was conducted by the Centers for Disease Control in 2010, and it found that 44 percent -- that's nearly half, 44 percent of lesbian and bisexual, trans women reported being victims of domestic violence. That's an astonishing number to really think about. It's just -- it's 11 percent above the already-high number. And every time I think about the fact that 44 percent of our relationships are unhealthy or are abusive, it is just overwhelming.

Our research also found that of the individuals that responded to our survey and reported being in an abusive relationship, only 16 percent of them reported it, reported being abused or sought help from individuals. Only 16 percent.

So we also know that lesbian and trans women victims are more likely to experience certain types of intimate partner violence. So the physical violence that we talked about were the slapping and the kicking and the hitting and the choking and the killing. Lesbian and trans women experience that particular type of violence 1.5 times higher than anyone else in the community.

Lesbian and trans women experience violence in the workplace nearly 2.5 times more than other individuals. And violence that occurs at shelters is nearly 5 times higher. Trans women were also 5.2 times more likely to experience police violence when interacting with the police after an intimate partner violence incident.

So let's talk about some of the obstacles to seeking care that individuals, victims, survivors of intimate partner violence in our community experience. Some of the most common reasons LGBT people report not leaving an abusive relationship is

that they don't know or realize it was abusive and was not aware resources were available to them.

Since in our relationships we typically can't look to our own parents or family members or media to reflect the types of relationships that we are in, it's really hard to have a support system or guidance on what a healthy relationship is. And so, this creates this -- this void of really knowing what is healthy and what isn't healthy and what are appropriate boundaries and what -- what should be done if there is not, you know, a healthy -- if you're not in a healthy relationship.

You know, again, if I refer back to the case of the lady that was shot in front of Safeway, some -- anecdotally, some of her friends were saying, you know, we didn't even know that this was a problem for her. We were close to her. We had conversations and interacted all the time and didn't see the relationship as problematic.

Our survey results also indicate that 60 percent of respondents are not even sure that local laws protect LGBT victims. That's 60 percent, right? So in an area in which the most progressive laws exist, within the LGBTQ community, we don't know that. So, again, our lived experience of having support, having supportive laws and supportive programs and systems is not trickling down and translating directly to the community that really needs it the most.

Victims of LGBT partner violence may remain silent, fearing that they will be denied protection by law enforcement, by judges who believe in antiquated gender roles and stereotypes. So we know that there is stigma and there is shame around intimate partner violence.

Combine that with the stigma and shame that some folks feel around their sexual orientation or being in a same-gender loving relationship or the loss of family and friends because of the fact that they're LGBT. All of this causes survivors to remain silent and prevents them from seeking much-needed help. And the trauma of intimate partner violence affects a victim's mental health, self-esteem, their medical health, and increases the likelihood of depression.

Again, there is a big gap between the lived experience and the legal experience, especially in people of color in the LGBTQ community. We know that there are the jobless rate and the homeless rate and healthcare disparities all are very big issues in our community.

There is also, you know, again, this code of silence. There is so much hate and violence that's directed at us from society. It feels wrong to report LGBT folks to that same system that's suppressing them, that's denying them rights, that is not supporting the relationships that they have. We are sometimes, you know, again, without the support of our family, our friends, and our community.

And sometimes, as women, we are desperate, particularly as people of -- women of color, we are desperate to be strong under any circumstances. And so, to seek help or to ask for help or to say "I've gotten myself into this relationship, and I don't really know how to get out of it" is not a skill that some of us have. And there is the shame and secrecy and social taboo that keeps us -- keeps us silent.

So what are some of the things that -- that we can do? It's really having discussions like this, having dialogue around the prevalence of intimate partner violence and talking about the existence of the problem in our community, which really propels us all forward.

I would personally like to see more coordinated response to intimate partner violence and the public safety of LGBT communities. We need to talk holistically with assessment, treatment, program, and planning. This is programs that provide DV services to the community have to think outside their typical box on how to connect with our underserved, under represented community.

It's imperative that we provide culturally specific services and support to this community and the marginalized community. We want to encourage a trauma-informed approach to interacting with LGBT folks. Just sometimes existing in the world as a woman, as a person of color, as lesbian, just brings on so much strife and trauma to some of the members of our community.

Obviously, we encourage sharing and partnership with medical care providers and really having a holistic approach to caring for individuals. And one of the big things regarding programming and services is that there is a real lack of data around the prevalence of intimate partner violence. There is a lack of data that is collected for LGBT folks across the board. And so, whenever there is an opportunity to collect data on sexual orientation or gender identity that helps with the research and the programs that could be created to support that community, that is absolutely always a plus.

And we know that supporting the victims is only one fraction of the issue, that there really has to be batterers intervention programs to fully address this issue. So one of the things that Rainbow Response has done in collaboration with the Mayor's Office of the LGBT Affairs and with several other local LGBT organizations, Rainbow Response is one, which I mentioned. SMYAL, which does outreach to LGBT youth and really has a focus on LGBT homelessness. DCTC, which is a trans coalition organization that tries to advance rights to trans folks. And GLOV, which is the Gays and Lesbians Opposing Violence.

We all came together to create this collaborative community response to violence as a whole in the community, but particularly around hate crime and intimate partner violence because of the prevalence. And unfortunately, in D.C., hate

crime to LGBT individuals is probably pretty high and very high in the Nation as a whole.

So this coalition comes together on a monthly basis. We have worked with MPD to get reports directly from them when there are incidents of hate crime or incidents of domestic violence in the community. And what that does is allows us to come together and plan around training officers, for example, how to -- how to properly investigate and properly address domestic violence calls that they're responding to.

One of the other problems that's occurring in D.C. is that we've got a very high dual arrest rate, and that means that an officer will show up after a DV call is made, and because the training around how to deal with our relationships will be -- not occur, so they'll just arrest both parties because there is a mandatory requirement to arrest if there is evidence of intimate partner violence. So instead of figuring out who the primary aggressor is and who really is the abuser in the situation, they'll just arrest both individuals, revictimizing the victim.

And so, we have worked with MPD since 2009 to try to make sure that officers are trained. And then we go to roll calls, and we talk about ways in which to interact with the community and build trust and build collaboration around addressing these issues.

We also have a rapid community response. So in the case of, you know, a number of incidents occurring in a particular ward, for example, then we will come together and we will do ride-alongs and we will go to the libraries in that particular ward, or we will go to the barber shop and the beauty shops to make sure that information around domestic violence and hate crimes and the resources that are available to the community are in those spaces in which DV is on the rise.

And it allows us to talk about trends and talk about intervention and talk about creative ways for these DV organizations that really don't have a whole lot of outreach to the LGBTQ community, how they could do things differently.

So thank you very much for allowing me to come and speak to you about this issue, and I welcome any questions or comments or suggestions on how we can work together and do things differently.

[Applause.]

DR. CAROLE WARSHAW: Thanks, June. That was really very thoughtful and helpful.

And do people have specific questions for June? Yes?

MS. ROSALIND WISEMAN: I think it was your third slide. Hi. I'm Rosalind.

MS. JUNE CRENSHAW: Hello.

MS. ROSALIND WISEMAN: So I think it was in your third slide where you said that trans people were more -- the assumption was that they were perpetrators. Can you speak a little bit about where that information is coming from, the perception? Who are you speaking about when you were talking about that the assumption was that most trans were perpetrators?

MS. JUNE CRENSHAW: So one of the things that Rainbow Response and other local LGBT organizations do quite regularly is interact with the community. So we have conversations with trans folks. We have conversation with the community. We talk about how the trans community is affected when they interact with police officers.

The assumption that if two or three of them are gathered out publicly that the assumption is that they're doing sex work. The assumption that oftentimes if there is some crime that's occurred and they are involved, that they are the ones that are arrested or harassed.

So it's -- it happens pretty regularly. We have town hall meetings. We have, you know, again, conversations with trans folks that are saying this is what my experience is when I interact in the community, when I interact with police officers.

MS. ROSALIND WISEMAN: Okay. Thank you.

DR. CAROLE WARSHAW: Other questions?

MS. KANA ENOMOTO: June, do you have any experience of how the mental health and the substance abuse provider community has responded? I'd like to think that given our field, we tend to have sort of a heightened level of awareness, but I could also be wrong.

I know that we've had to do a lot of work on both sides, both getting people to be aware of LGBTQ issues, as well as getting people to be aware of IPV issues and sort of the marriage of that. And then, behavioral health issues on top of it, I can imagine might be a challenge.

So I don't know if you've had experience or talked with people who've experienced the mental health or substance abuse systems as being responsive or not responsive?

MS. JUNE CRENSHAW: So one of the things that is most concerning with individuals that I interact with is the lack of trust for systems, the lack of having

culturally competent therapists, culturally competent service providers to understand our relationships and the unique aspect of those relationships.

Whitman-Walker Health, which is an organization in D.C. that provides HIV/AIDS care to the community, also is a very large provider of LGBT medical and mental health, has been around for nearly 40 years supporting the community in some capacity. I think one of their strengths is the mental health services that they provide and the referral process with culturally competent therapists that support the community.

Just 2 years ago, conversion therapy was outlawed in D.C. So that meant that oftentimes LGBT individuals would go to therapists and have to be exposed to particular practices that further harmed their mental health and their mental well-being. And so, I think that -- so to answer your question, I think that there is a long way to go toward making sure that there is the safety net that really is a safety net, that can be trusted by the community.

And getting to the community, getting to those underserved pockets of the community and building trust with them is a long, long process.

DR. CAROLE WARSHAW: A couple other things I was thinking about while you were talking. One is the history of traumatic experiences that many people who are lesbian, gay, trans, bi experience growing up as kids. Because of their sexual identity and sexual orientation, that becomes cumulative and so that the layers of trauma that people experience that may be added to other kinds of -- forms of discrimination and then stigma around mental health and substance use conditions that are layered on top of that.

So that's one of the things that -- one of the things that's come up in sort of our -- as a TA provider is that people working in LGBTQ DV programs, there's another layer of kind of key crime where people call pretending they need services and really then launch into whole public diatribes or call-in diatribes against the workers. So we're trying to get people into services where people say there is no shelter bed available, and they know there is.

So there's been a lot of work in the DV community around making sure that services are inclusive and welcoming and places that people may want to go. And one of the issues that's come up is around privacy and having private rooms and not communal spaces so that when even if the staff are trained, if other people who are in the shelter are trans or homophobic, how that comes up.

So there's lots of layers of things that need to be in place and around, you know, thinking about the mental health and substance abuse treatment systems or we talked about being served in mixed settings and when you're dealing with response of some other people in group kinds of settings and how to address all of that. So there's lots of layers of work and understanding to make places feel

safe for people to access their treatment.

And there was one other thing -- there are two other things I wanted you to comment on. One was maybe talking to them a little bit about identification of primary aggressor. Just the thinking about that, so that people working in a range of settings, not just the police, have some understanding of the dynamics in the world of coercion and control, not just the more obvious signs of abuse.

And the other thing, I was just thinking -- I just looked at the CDC NSDUH study, and the -- for bisexual women, primary aggressors were primarily men. And in lesbian relationships for two-thirds of the women who had experienced IPV, it was a female partner. So I was curious about that when you were talking. Interesting.

MS. JUNE CRENSHAW: Yes. So one of the things that you pointed on or you referenced is substance abuse in our community, right? So we know that it's very hard to find community and connections with other LGBT folks except for in bars, right? So that is -- that is one of the safest places that we can go to make our connections and to meet other folks and build connections. And so, it's always around alcohol or those types of ways in which to connect with the community.

And so, substance abuse in our community is extremely high, particularly for lesbians and for trans folks. And the conversation around, like you mentioned, all the years and years and years of trauma and the isolation and the need to self-medicate around just existing and surviving in the day is, you know, more trauma than most folks can deal with.

And so, there is a big problem in the community that's not talked about. There's a problem in the community that certainly we don't have enough service providers, therapists, and first responders to address and to start healing around the problems that are occurring. And it's just, again, starting dialogue around it, having conversation around it is the first -- the first step. But you know, just our community is not in a place to yet recognize that the need is so great.

DR. CAROLE WARSHAW: But it's interesting, I'm thinking about what you're saying about how much it's community outreach and organizing, which isn't true in the same way in lots of other places where DV is seen more as an isolated thing in a family.

MS. JUNE CRENSHAW: Right.

DR. CAROLE WARSHAW: But that's actually a community where people relate to each other as a community. So there are opportunities for organizing as well as outreach that exists --

MS. JUNE CRENSHAW: And our families are typically families of choice, right? So when we come out, we sometimes lose the infrastructure of our church and our parents and the friends that we've, you know, been raised with, et cetera, just because we're LGBT.

And so, when we lose that piece of it, right, so we're then building this new community and this new foundation, and if there is, you know, problematic issues of abuse or substance abuse or, you know, whatever that's occurring in that, it's a very fragile situation that's occurring that can have a domino effect of problems.

DR. DAN LUSTIG: June, I want to thank you very much for your presentation because I think not enough conversation is had on this. I've had the ability to supervise a lot of new therapists who've come into the field working with trans and LGBT individuals. One of the take-aways, if I were to add to what you are presenting on, is you know the cultural competency I think is spoken in many different ways, and I don't think that there is clear kind of discussion points about what we should be educating the field on.

Specifically, the wording that the systems use can be retraumatizing oftentimes. And so, you can have a lot of professionals come into the field feeling that they've had the background and the training to work, and if they're not from the community, the wording, the heterosexism wording that they use tends to be retraumatizing to that person. And so, I think the TA needs to focus in not just on the cultural aspects of LGBT, but the wording that's used. It's very, very prevalent.

MS. JUNE CRENSHAW: I would agree with you. I think that if we talk about "queer," for example, it's a very generational word that for folks that are in their fifties, like myself, when I hear it, I'm like that feels uncomfortable and unsafe to be referred to as queer. However, the younger generation is very comfortable with using that word, and it is a word that describes both for them their sexual orientation or their gender identity as being nonconformist.

And so, it is not, you know, a word that they're going to challenge with using, but you know, again, you're right. I think that each provider has to come into a -- has to build a relationship with the individual seeking care and develop a relationship around what is safe, what are safe words to use. You know, how do you refer to me? How do I want to be referred to? And how do I want my relationships to be respected in these settings?

And that is really ongoing dialogue. Because I will tell you that some days I am very, very comfortable with being called "dyke," and then the other days I'm like that is really, really nerve-wracking, and I'd really like the person not to do that. And it is dependent upon who is saying the word to me and the circumstances under which it's being said, and you know, so much of that retraumatize individuals. And it's a very, you know, personal experience that has to be worked

through.

DR. DAN LUSTIG: The last point I just wanted to make also is in response to your question around mental health and the addiction field. I would love to see program -- I think the addiction field has a lot of work to do in providing safe atmospheres. I've traveled many places in this country, and I rarely can find residential programs that are truly safe to a population at risk like this.

MS. KANA ENOMOTO: What are some things that -- oh. Can you speak to what some things are that might be done to make settings safer?

DR. DAN LUSTIG: Part of what we run into, I think, in the settings are some laws. So like many people are feeling comfortable to be in what is the sex of choice, so to speak. And so, in residential programs, women and men are not going to intermingle, and so that's -- a woman has the right, a legal right, not to be in a program with a man.

And so, when a person is in variety of psychological stages of their -- it's unhealthy for them to be in a program with a man, and so the laws need to be taken a look at as creating safer environments. We've got to make sure that there is environment that bathrooms are friendly to individuals if you can't make system-wide changes.

And really, I've seen the big thing in agencies is really underscoring to me the language. This week, I probably sat in two supervision sessions where the language of heterosexual staff is traumatizing to the client, and they are -- it was not done intentionally. It's not done in an aggressive format. But you know, I can see the biological reaction in the individual.

So we do a lot of training. We just don't do a lot of in-depth training, and that's -- I don't know if I answered your question.

FEMALE SPEAKER: I'm just wondering if you could -- are other people around the country in the local communities doing what you're doing here, and then also so who's at the national level having these conversations or leading them or raising the issues?

MS. JUNE CRENSHAW: So yes to both of those questions. There is a number of different organizations on a grassroots level and local level that's doing outreach, doing a lot of work in the community around a whole list of different things -- mental health, substance abuse, encouraging culturally competent training in the community, and also intimate partner violence.

On a national level, most of these organizations belong to NCAVP, which is the National Coalition Against Violence, and it's out of New York. And so, that's an umbrella organization that Rainbow Response is a member organization to, and

it gives us access to data and technical training around doing outreach and doing workshops and improving the conversations around domestic violence.

DR. CAROLE WARSHAW: There is also -- FVPSA also has recently funded in the last round the national technical assistance providers network in conjunction with a project in New York to begin to build a base of, you know, to develop guidelines for responding to intimate partner violence in the LGBTQ community. There is work at the Federal level as well.

MS. JUNE CRENSHAW: Yeah, the funding is still spotty.

DR. CAROLE WARSHAW: Yes --

MS. JUNE CRENSHAW: And it's really patchwork, right? And so, you know, one of the comments that Dan made around safe restrooms and gender-neutral restrooms and things of that nature, I mean, there is a big campaign in the D.C. area to make sure that the companies are -- that the laws are in place and that the laws are being enforced, and there is some type of penalty component to it, which currently there isn't one, right?

And so, it's just getting all of the systems in place that really supports the lived -- the improved lived experience of LGBT folks. And it is a -- it's a daily struggle to make sure that -- that those things occur.

DR. CAROLE WARSHAW: Also, I don't know how true this is around the country. I'm thinking of Chicago where there's a lot of services that were developed in response to the AIDS epidemic that were more geared towards gay men around healthcare and mental health services that women have worked over the years to make sure that they're gender responsive to women as well. So, and that they're also doing in the violence work.

MS. JUNE CRENSHAW: And you know, that was the start of Whitman-Walker, as gay men's health and the STD clinic, et cetera. And the lesbians were involved in, you know, making sure that we were a part of that and very involved in getting services as well, but also keeping our brothers alive during the height of the AIDS and HIV epidemic.

And so, the work is being done. You know, again, there is -- it's being done on a grassroots level, and it really needs the support of the local and Federal Government to really make the most impact in the community and effect change.

DR. CAROLE WARSHAW: One last thing, I don't know how much this has come up in your work around -- there are people I know from my work in the APA who have written -- done a lot of work on therapy with people who are LGBTQ and how to do that in ways that are really sensitive to the range of issues that people experience. And I don't know that that's very widespread or available. You

know, it's like if you find -- if you're looking for it --

MS. JUNE CRENSHAW: Exactly.

DR. CAROLE WARSHAW: -- you could find it, but it's not -- most people don't know about that, and we're looking for ways to make that more available to people so that's part of basic training and understanding and standards of care for people.

MS. JUNE CRENSHAW: I think that would be amazing if, obviously, the network grew and that there was the cultural-competent training and that individuals had access to it. And you know, there are some amazing programs that are in place, but if 60 percent of the population is not aware that they exist and are not tapping into them or aware of the fact that they're available to them, then we still failed to some degree.

MS. KANA ENOMOTO: So other questions? Is Elliott on the line?

Yeah. So I just wanted to -- Elliott Kennedy is our staff lead on our Sexual and Gender Minority Working Group at SAMHSA, and I just wanted to see if he had a comment or could speak to us a little bit. One of the points that you raised was about data and ensuring that the Federal Government is collecting data on LGBT populations. And we are making great progress. I think we have our LGB measures down, and we're working on the T measures to make sure we have some consistency across the systems.

But I wonder if Elliott is available to speak to where we are and some of the things that we're doing?

MR. ELLIOTT KENNEDY: [on telephone] Yeah, I definitely am. And thank you so much [inaudible].

In terms of data collection and certainly in HHS department wide, that's been a priority, we are moving forward with sexual orientation and are actively working to incorporate [inaudible], specifically in our NSDUH, National Survey on Drug Use and Health, which gives the most robust behavioral health-related data that we could get on LGBTQ folks.

With that said, I think more of the status in the field that is sort of an outstanding question is it's just like we've thought, particularly in the trans community knowing that substance abuse is a problem, but we don't really have good research on how you like identify [inaudible] a pressing concern.

If you have time, there are just a few things I want to comment on or questions [inaudible], and if you don't have, I totally understand. But one of them is SAMHSA is really interested in looking at trauma-informed care.

[Inaudible.]

MS. KANA ENOMOTO: Elliott, I'm sorry. But you're fading in and out. So the last point that you were raising, if you could repeat that?

MR. ELLIOTT KENNEDY: Oh, okay. I was just talking about community-level trauma and the perception that people perpetrating that's a lifetime experience, including [inaudible] in schools. So we're thinking about trauma-informed approaches to help people with projects starting at a community level [inaudible].

MS. KANA ENOMOTO: I should mention we stole Elliott from Trevor Project. So he has a great background in suicide and things about young people.

MS. JUNE CRENSHAW: So I didn't understand anything he said.

[Laughter.]

MS. JUNE CRENSHAW: I think he was asking whether there is work that's being done?

MS. KANA ENOMOTO: I think the way I heard the question was if you're aware of work that's being done looking at trauma at the community level and trauma-informed approaches at the community level, as well as looking at these issues on younger kids. So middle school and high school age young people, which is also a question I had as to what we're doing around prevention and education for --

MS. JUNE CRENSHAW: So I'm aware of two things that's occurring that is around data collection. The Mayor's Office of the LGBT Affairs is required on every 2 years to collect medical data or health data on LGBT folks. This year -- well, in prior years, they've collected it on GLB folks and not the T.

So this year, they are being very inclusive of the trans community and collecting that data, and they are doing it in this amazing random approach of identifying all the LGBT organizations in the D.C. area, asking them to provide their list of clients or customers and randomly selecting a number of individuals to participate with the survey and then having those participants identify other individuals that's not associated with the organization. And their attempt to do this is to do a deep dive into the community, getting to that -- those underserved individuals that would typically not have access to a survey or organization or that are living in a more private way.

So we're hoping to have the results of this health survey, which will collect the, you know, questions about a person's medical health and medical care, questions around their mental health and the mental health support, and just

questions about how they interact in the community as a whole. So we're excited about that, and it should be a preliminary report toward October of this year.

The other thing is I had mentioned SMYAL, which is an organization that deals specifically with LGBT youth, and they are doing a lot of work in the community around -- and HRC Foundation, by the way, is really heavy in work around youth, access to youth as they are in school and in other ways to do more outreach and prevention and connection with the community at a younger age. We know now that folks are coming out as early as 11 years old, and so to get to that community and to interact with them is really imperative.

DR. CAROLE WARSHAW: So it's time. So thank you so much. That was so helpful and thought-provoking, and I hope will actually help all of us to think differently about our work and SAMHSA at the Federal level to make a difference.

MS. JUNE CRENSHAW: Yes, absolutely. Thank you for inviting me. Thank you for your willingness to have the conversation, and I look forward to further conversations.

[Applause.]

Agenda Item: ACWS Future Priorities – A Conversation with the Administrator

MS. KANA ENOMOTO: So now it is my honor to introduce our next session, which is with my boss, Administrator Pam Hyde, who is here to, I think, more listen probably than talk. As I've already explained to the committee that you see advice as a product and are very open to what our advisers have come to share with us, but also you're welcome to share anything that you see as coming along the horizon and where we would be particularly -- where it would be of particular benefit for us to hear from, for these folks around women and girls.

So thanks.

MS. JUDY GRILL: Could I just change the battery? It'll take me 10 seconds. Thank you.

MS. KANA ENOMOTO: Sure. And with that, maybe I'll have people just go around and introduce themselves so Pam knows who's oriented to time and place and people.

So do you want to start, Karen?

MS. KAREN MOONEY: Yeah, hi. I'm Karen Mooney.

MS. KANA ENOMOTO: Just say who you are, where you're from so she --

MS. KAREN MOONEY: Hi, I'm Karen Mooney with the Women's Services Network.

MS. ANITA FINEDAY: Hi, I'm Anita Fineday. I'm with Casey Family Programs. I work with tribes.

DR. DAN LUSTIG: I'm Dan Lustig. I'm vice president of the Haymarket Center.

MS. PAMELA S. HYDE: I'm sorry. I didn't hear that.

DR. DAN LUSTIG: Sorry. I'm Dan Lustig, vice president of clinical services at Haymarket Center in Chicago.

DR. SHELLY F. GREENFIELD: Hi, I'm Shelly Greenfield. I'm at Harvard Medical School and McLean Hospital.

MS. JEANNETTE PAI-ESPINOSA: I'm Jeannette Pai-Espinosa. I'm at the National Crittenton Foundation and also with OJJDP's National Girls Initiative.

DR. CAROLE WARSHAW: Carole Warshaw, National Center on Domestic Violence, Trauma, and Mental Health in Chicago.

MS. PAMELA S. HYDE: Are there people on the phone?

MS. KANA ENOMOTO: We have no members on the phone.

MR. JOSH SHAPIRO: Sarah is on the phone.

MS. KANA ENOMOTO: Sarah is back on the phone. Sarah, do you want to introduce yourself?

[No response.]

MS. KANA ENOMOTO: Is Sarah's line not open?

MR. JOSH SHAPIRO: She's there. I see her on the line.

MS. KANA ENOMOTO: Maybe she's muted, yeah.

MS. PAMELA S. HYDE: So the battery is changed. The meeting is done.

[Laughter.]

MS. PAMELA S. HYDE: She's what?

MR. JOSH SHAPIRO: She's there.

MS. PAMELA S. HYDE: Okay. Sarah, are you going to introduce yourself?

[No response.]

MS. KANA ENOMOTO: In the meantime, we have Rosalind back. We're just letting folks reintroduce themselves to Pam.

MS. ROSALIND WISEMAN: Hi. Nice to see you. Rosalind Wiseman, educator, works with bullying all the time, homophobia, racism, all different kinds of messy stuff that happens in schools. That's what I do.

MS. PAMELA S. HYDE: Great. Thank you.

And thanks, Kana. I think at this point I prefer to think of Kana and I as running the place together, and I don't like to think of myself as the boss. So I obviously look to Kana for a lot of advice and help and direction myself. So you are lucky to get to have her as the person who helps you with your committee.

And I appreciate your willingness to spend your time advising us. Kana is right. I always -- people, sometimes the staff, they think I'm a little funny about this, but I actually just really look forward to these 2 days and enjoy them. And they're intense to get ready for and they're intense to follow up from, but they are an opportunity for us to step back and just talk to really smart people and listen to really smart people tell us about how you perceive the world that we are trying to work in and trying to influence.

So thank you for doing that, and thanks to all the staff for all it takes to do all this. I appreciate all of them.

I don't have a lot of prepared remarks here. I don't have any prepared remarks. I just wanted to see where your heads are thinking these days about our focus this time is really around the issue of treatment. We spend an awful lot of time talking about prevention and talking about recovery, and I just came from CMHS. I'm advisory committee hopping today. And the question was raised about our language around recovery doesn't sort of translate well sometimes for people. So they don't quite get it in the healthcare world.

But we're trying to think about prevention and community health and wellness and individual health and family wellness and that sort of construct all the way up through healthcare delivery systems. And then into the issue of having a life while having a condition, whatever that condition might be.

And I think we're at the point where almost 100 percent of us have something we're living with, whether it's diabetes, whether it's cardiology issues or asthma or you name it. Some of us, we're all living with something. And some of us happen to be living with mental health issues or substance abuse addiction issues.

So we are more and more trying to think about how does it -- how should it be that behavioral health should be thought of as just any other condition, and yet it has some really unique pathways and some really unique implications for community living, community wellness, as well as for healthcare delivery. So we're trying to think about all of that, and sometimes it can bounce us. Also that's why having a couple of days to step back and hear your best thoughts about this is really helpful to us.

The other thing that somebody just asked me this morning and I'll do 2 seconds on -- we'll do more about it tomorrow -- is sort of the context. Why did we choose to talk so much about treatment this time? Why is that the focus? And obviously, we've gotten some criticism for not talking about it as much as perhaps people think we should, and yet I think what we have come to understand is that our role in funding treatment is so small that really what we do is influence treatment more than fund it.

And as a consequence, a lot of that is less public. It's less obvious because we're back here talking to CMS about how their reg ought to look, or we're over here trying to figure out with HRSA how to develop data for workforce or -- for treatment workforce, or we're over here trying to work with ASPE on how to do prescription drug opioid prevention. We're, you know, doing something, but it's not necessarily quite so public always.

So I think criticism is part of the context in which we're doing this, but also just because we spent so much time looking at prevention and recovery, we thought it was time that we stepped back and looked a little bit at the treatment aspect of this circle that we're in.

So, with that, let me stop, and you guys jump in and either talk to me or ask me questions or whatever you'd like to do.

DR. CAROLE WARSHAW: So I'm thinking about -- I mean, I'm thinking about the context and the critique. And so, one is like SAMHSA doesn't fund treatment by step. So it's not like by choice. It's that's just how SAMHSA is set up, right? I mean, is there more of an option to fund treatment? I mean, the block grants are a very tiny piece of mental health spending funding. So that's one question.

The other is what actually influences clinical practice? And it's mainly research and best practices and sometimes academic medical centers. And so, it's like what's the role of the Federal Government in what kinds of treatment standards

there are? So it's a much bigger question than just SAMHSA.

And the third piece of my thing is that the reframing. The talking about recovery that's within a small world. And you're right. People don't understand what that means, and the treatment language is often very kind of pathologizing, focusing on what's wrong and how to fix it and not how to center on people and living their lives in a way that treatment is part of that. But the center is the person, and I think that people who are providing the critique are not coming from that place.

So I think being able to articulate what that means and that's part of what we think about what trauma-informed care means. There is lots of other places where there is discourse of patient-centered care or families, you know, that if the person is at the center, what are they doing? How do they want to live their lives, and how is this part of that? It can broaden out in a way that changes the center of gravity, which doesn't lose treatment but puts it in a different kind of framework.

MS. PAMELA S. HYDE: Yeah, those are great thoughts and comments because the critics see things like trauma-informed care as phooey. I mean, seriously. They see it as dealing with the worried well. That's not really the issue. So to the extent that we have embraced the concept of trauma and what it does to people and how it affects their health and well-being and their behavioral health, and we have really embraced that over years, they really dismiss it.

DR. CAROLE WARSHAW: I mean, even the stuff about epigenetics is a great way to link the science and experience and why they're both so important. And doing one without the other is really problematic. So it's just like thinking about where the place is where --

MS. PAMELA S. HYDE: Yeah, no, this would be very helpful. This kind of input would be very helpful because I think that the health world, I think, is getting more and more into learning that all the impacts and all the experiences that people bring to the care of diabetes or bring to the care of cardiology or bring to the care of oncology, I think they are learning that, in fact, all those other things do make a difference. So it's like the medical world is actually shifting to that, I think, a little bit more.

So I think we have -- to the extent that these worlds are separate, we have a lot to learn from each other.

DR. CAROLE WARSHAW: Maybe we ought to talk about that because I think about the how to frame things --

MS. PAMELA S. HYDE: Yeah, that would be great. That would be really helpful.

DR. CAROLE WARSHAW: -- and having the science around that.

MS. PAMELA S. HYDE: Yeah, because we aren't very scientific in the way we talk here. Part of the thing I think just in SAMHSA, we're only, what, 23 years old. If you think about how old you were or what you were like when you were 23 or what your kids were like when you were 23, you know that we're still growing up somewhat. I mean, we're sort of just at the beginning of our career if you think of us in that way.

And I think we haven't thought so much about sort of what's our place in the world of health and behavioral health and healthcare and public health. And that's part of what we've been struggling with over the last few years. So language would be helpful, how to frame our role there would be helpful, how to talk about it would be helpful.

DR. CAROLE WARSHAW: Because the thing with NIMH and other funding is you have to have a biological component to any research, and so it's like it's people doing more work that doesn't involve that. You know, there's disconnect. How do you create an umbrella that holds the best of all of that?

MS. KAREN MOONEY: One of the things that I've been concerned about in terms of trying to bring the substance use disorder treatment along and make it a little bit more current is that at least in our State, we use an admit/discharge model counting how many people. And really an appropriate, a more up-to-date and appropriate model would be to look at episodes of care that don't necessarily involve a beginning and end as program defined.

And so, I'm wondering if there's some work being done or some dialogue being had about how do you look at treatment that doesn't have an end, where we say, okay, well, I'm done. But does aim sort of like a hyperbola, closer and closer and closer to the ideal of a self-managed recovery as being the thing that we're really shooting for and what your thoughts might be about that?

MS. PAMELA S. HYDE: Well, it's interesting. I lived in a couple of different worlds in my career. One of the worlds I lived in for a long time was financing, and the financing world does make distinctions between sort of an entrance and an ending sort of like fee-for-service, I guess, if you will. And then they make a distinction between an episode of care. It's a type of financing.

And then they make this other kind of construct of managed care. Well, I'm going to essentially pay you to take care of this person's life. That's why we call it healthy lives. So we've talked more about episodes of care here, but we haven't really done what I think you're suggesting, which is to rethink how we do things like capture data and capture outcomes and stuff like that. I don't think we've had a serious conversation about shifting that. It's a good point that we need to think about as well.

MS. JEANNETTE PAI-ESPINOSA: I just wanted to tag onto what Carole was saying. We found that -- I mean, we work specifically with young women. So adolescent to, what, 20 -- 20 -- I don't know when you go from being a young woman to a woman, but in that early to mid -- that's part of the problem is twenties range. And what we've found and what I've seen over the last couple of years in our advocacy work and in the communication work we do is the minute that we stop talking about what triggered the trauma, we lose people.

So trauma, trauma, trauma. The result we get then is, oh, another version of the bootstrap mentality. "Well, they just need to get over it." But as long as we hold on to kind of what, you know, what was the person thinking or people tend to see the trauma in a different context and understand how it can be complex and over a lifetime and not even PTSD, where they think, well, still, after a while you need to get over that, too. So from we have really gone back to really focusing on not just talking about general health, but moving back upstream so that people understand the context.

Because they connect it to trauma in their lives, which may be, as you said earlier, Kana, very, very different and maybe not certainly wouldn't clinically qualify. So I think the more all of us that work in the trauma field are only talking about the trauma, I think it's going to -- I think it's created problems for us. So we've really gone back and had to relook at how we talked about it.

MS. KANA ENOMOTO: So do you mean, for example, child abuse or --

MS. JEANNETTE PAI-ESPINOSA: Yes, I do.

MS. KANA ENOMOTO: -- domestic violence or experiencing sexual assault, that kind of thing?

MS. JEANNETTE PAI-ESPINOSA: Yes, yes. So I think we see it a lot because - - because, you know, there is this good girl/bad girl thing in our society. So the girls we work with are automatically seen as bad girls. So, you know, we have to -- what are the tools we can use to counter that? Well, they just should have not had sex or should have just whatever it is. And so, we thought more of a move to brain development and trauma would help that.

But we started to see that people -- you know, they really, okay, but where did the trauma come from because I've experienced trauma, and look at me. I have three law degrees and all these other things, and I had trauma when I was a kid.

So we had to really go back and paint the context. And that's why ACE has been so helpful to us as a starting point for that.

So it's an interesting thing. I've really only started to see in the last couple of years when everyone started talking about trauma, it became again "eh, trauma."

MS. PAMELA S. HYDE: So what do you suggest in terms of -- so how have you changed the way you talk about it?

MS. JEANNETTE PAI-ESPINOSA: We don't talk about trauma without talking about the cause, the root cause. So --

MS. PAMELA S. HYDE: So the specific kind of --

MS. JEANNETTE PAI-ESPINOSA: Exactly, yeah.

DR. CAROLE WARSHAW: And I'm also thinking, you know, with the NCTSN that's done so much work on child development. So it's not just the trauma. It's in the context of what supports are there and what --

MS. JEANNETTE PAI-ESPINOSA: Exactly.

DR. CAROLE WARSHAW: So it gives it much more of a context. There are lots of things that are protective and lots of things that have the opposite effect, and it's that what context you live in and what kind of supports there are. So it gives people more contextual understanding. So you might have genetic loading and a lot of support. That's different than if you don't.

You know, it's like all those factors. So it's where we want and, you know, gives people more places to connect to it. So a range of ways people can be connected. So --

MS. JEANNETTE PAI-ESPINOSA: I think trafficking is a good example. So the only thing that moved in the last Congress and in this one maybe is trafficking. And I think the reason it moved the way it did is because there is an assumption of the intense trauma and the root cause of it. Not even looking at actually the trafficking isn't the beginning of, you know, what triggered their trauma. It's even before that.

But I think that, that was the power of really connecting something that people really can personally disassociate from and, therefore, feel like we really need to help these people, these young women. And we don't see that in child abuse, neglect, even domestic violence more so than before, but that same level of kind of really, I think, visceral reaction to it is not the same.

So we don't have the context -- the conversation that Carole is talking about is these things may have happened to you, but what did you have as a resource to buffer it? We never get there because there is just an assumption of everybody has what I found. So --

MS. PAMELA S. HYDE: That's interesting. I'm trying to relate to the issue of everybody does have some sort of trauma in their history. The issue is, in fact,

what did they have to deal with and how bad was it? I mean, there's a whole bunch of things to think about.

But I don't mean to wax so philosophical here, but I think there is a sense, the bootstrap thing, I guess. That's easy to say if you've never experienced what other folks have experienced and if you've had a strong family structure and enough money and good place to live.

And I think some of our veterans and people coming back, for example, are struggling with the issue of, well, I do have a place to live. I do have a family, and I do have this, that, or the other, and I'm still struggling. So what does that say about me? And I'm supposed to be the tough warrior.

And I think there is a lot of folks who are struggling with that issue as well, and so I think more conversation with how SAMHSA can frame this because we -- I mean, I've learned a lot. I was not a person who spent a lot of time working in the area of trauma when I came here. So I learned a lot from Kana and from some of the other staff here who have done a lot more with that, and I understand it a lot better than I used to.

I think there's a lot of -- and I was pretty open and sensitive to it, but I still didn't -- I didn't have that background. I didn't know how to think about it. I didn't know how to talk about it.

And I also come from a personal background of a lot of helping and caregiving, just the part of the country and a cultural background, for lack of a better term, that was very helping and loving and stuff. And it was still, you know, you've got to get yourself right with God kind of thing. You just got to do it. You got to be different.

So it's hard to know how to frame it in ways that people can hear it in different walks of life. But I am very struck by the critics right now who just really blow it off, and yet I would say these are some of the most traumatized people I have ever seen. That's why they're being so critical and the way they are. I don't know what their personal backgrounds are exactly, but you can see it come through.

DR. CAROLE WARSHAW: So that distancing and making it other -- those people who have a mental illness, who are dangerous to us, who need protection, and families need to -- I mean, all this stuff about the outpatient. I mean, it's all you would say what's your stance about people need to be controlled and managed versus people need to be supported and have, you know, a voice, you know, to be able to determine what their lives are like. And there's that gap there that there needs to be a lot more work around understanding.

You know, we have this litmus test that we use in our writing, which evolved over time is that if you are the person being talking about, would it make you cringe? You know, would you feel objectified? And so, as a standard and to have people think about what that means. And so, that was it.

There is another interesting thing about -- that's completely separate is around Medicare and substance abuse treatment for people who are older and there not being a lot of support for any inpatient treatment facilities for people who are on Medicare and how -- the kind of programs for people and how to support that.

MS. PAMELA S. HYDE: Actually, thank you for asking that because we are -- in the world of parity, we have been looking at the parity law that passed that really took on commercial insurance. And then last week, Medicaid put out the regulation for public comment about Medicaid parity. In between those two things, the President directed and there have, in fact, been some changes in TRICARE, the DoD folks, and in the VA to get rid of some of the issues that were getting in the way of parity for behavioral health benefits.

The one thing hanging out is Medicare, and they are both congressionally authorized. So law, limitations on inpatient care. A lifetime limitation on inpatient care for psychiatric care that the President proposed to eliminate in the 2016 budget. Whether or not Congress buys that or not is the question.

But we're also doing some work on analyzing Medicare for parity reasons, and obviously, lack of coverage of the medication-assisted treatment, lack of coverage of counseling for behavioral health. They do provide inpatient care, but only a lifetime limit. So that is an area that we're sort of -- the last bastion of parity that we're taking on.

And we're just doing the analysis right now. So, eventually, we'll see where that goes. But that's one of the leadership roles that I think that SAMHSA plays that you all see -- or I shouldn't say you all. You probably see it more than others, but the public doesn't see us taking those things on very much because we have to work that with our colleagues over at Medicare, and we have to work that with Congress or the White House and everything else. And it takes several years for us to work through that.

But we've identified that as a future thing that we have to get on. So we're on it.

DR. SHELLY F. GREENFIELD: Can I just? So I just want to echo the comments that Carole made and just in thinking about the bigger picture that you seem to be talking about. But this may be too simplistic, and I usually am pretty visual, and I would draw little boxes for you about how I would think about how it would go.

But just, you know, I guess in a way, the way I always think about making the

case is that you start with the public health impact, and I think there is lots of evidence about the rates of trauma through the population, the rates of substance use disorders and also the rising use of alcohol, for example, in society and other drugs, opioids and others. So if you just start with the prevalence rates, I think you almost don't really have to go any -- I mean, that's sort of your basic factual data. That's the public health impact of these things.

And then you go to the next box, which is a little bit what Carole was referring to, which is that we know that people come with risks and vulnerabilities, and we know that there is a very complex interaction between the risks and vulnerabilities, and it includes genetics and it includes the environment in very complicated ways. It's not -- nothing is unitary.

And that that then produces for people relative health and wellness and illness, and then at that level, you're looking at the individual and how they get treated, and then you're looking at the services system. And you know, I think many of the comments you've made sort of affect or come from each of those, you know, what are one, two, three, four boxes. And you, you all I think at SAMHSA kind of can draw lines as to where you actually have your biggest impacts.

You've been talking a lot about the services system in terms of Medicare and parity, in terms of right before you came in, we were talking a lot about service system delivery and its lack of responsivity to specific vulnerable populations, including LGBTQ or IPV. That's a specific population where in the services system itself has lack of responsivity, but then also the providers within that also don't have responsivity often due to training. And you all also impact that area.

So, I mean, in a way I would say that speaking the language of each of those boxes, so to speak, is really important. I think the public health language, which is you guys are great in terms of the epidemiology and the data. But the box that's around the science is an important one because there's credibility there as well, and there's lots of data coming out about, you know, as Carole said, the impact biologically early of trauma on the developing brain, which develops through the age of 25 at least.

And also on the genetic impact and the way in which that actually has, you know, long-term, long, long-term health impacts. So, I mean, I would echo what Carole said. I think there's lots of ways to, you know, put the language together, but also sort of put bigger picture around the places where I think you can easily draw arrows as to where you actually have a role and play a role.

MS. PAMELA S. HYDE: Actually, what you just said raises for me a dilemma and you can tell us again, this is why I love these meetings so much, just because it gives us a chance to step back. But you know, I do a lot of exactly what you just said in my speeches. The data is there. I use a lot of data in my speeches. I try to make the case and my point. I do a lot of talking about public

health and how behavioral health is a part of that and what behavioral health role is in that.

But it's one thing to be able to do that when I am the person who the audience is listening to, and I have 30 minutes to make my case. It's another thing when we're responding to -- I will use it in this context -- literally lies because -- and I say "lies." I use that strong word because it's been repeated and repeated and repeated in the face of evidence that it's not true. That's when it becomes a lie.

So we get that now constantly coming from our critics, and we have literally blog, which is usually 300 words or less, opportunities to respond probably 5 to 7 days later because that's quick in the Federal Government to get clearance. We have situations where we're in front of Congress, and we've got 5 minutes to do a presentation, and we often get cut off even at that.

So part of what I think we struggle with is how do we do -- how we send this message quickly in the contexts we are being asked to respond? And I don't think we're great at it yet. I think we're struggling to do that because SAMHSA, frankly, has not been under this kind of criticism recently.

That's not to say that it hasn't been at some point in its history, but this has been sort of the last year or two that we've been sort of beaten up on so regularly in ways that are unfair and inaccurate. But it's hard to figure out how to respond in some ways that doesn't have to do with me.

It's hard to hear it. It's hard for -- you know, to keep taking the crap, but that's not even the issue. The issue is what does that do to the field and the language in the field and the information that's getting out there about SAMHSA and about behavioral health, which I don't think is helping in the long run? So regardless of who's a believer here.

So your thoughts about how to do this quickly, fast, in a different context. Or who should do that for us? Because it may not always be us.

DR. CAROLE WARSHAW: That's what I'm thinking. Maybe someone could write an article in the Wall Street Journal, like E. Fuller Torrey, that talks about things in a different way. The New York Times or some of the digests that go out from the APA or AMA and they talk about things, having people who are outside who could write things that counteract.

MS. PAMELA S. HYDE: Yeah. We've got one or two people who have been very active in responding from a scientific point of view, sort of defending us, if you will. They're defending the issues. But it's only one or two. I mean, we haven't had a lot of other people jump in to do that, and I think there is a way in which I think I need to just go create a SAMHSA fan club or something.

[Laughter.]

MS. PAMELA S. HYDE: Have some people who are ready to respond. So your thoughts about that or how we would engage other people to think it's worth doing that kind of thing?

DR. SHELLY F. GREENFIELD: I'm not sure you can speak to the specific sources of the criticism and where they're actually coming from. Maybe I should already know that, but I'm not sure I completely know sort of where these are coming from, and you may not be able to speak to that. But I suppose that that would help me be able to better inform you about how I think what kinds of approaches I think would be useful.

MS. PAMELA S. HYDE: Sure. I mean, it's public. So it's not -- it's not like it's anything secret. But E. Fuller Torrey is one of them who constantly writes op-eds and other things. If you notice, they get -- they get their audiences from really fairly conservative or limited -- which are not the same thing because the Wall Street Journal is not limited, but it is a more conservative publication. And they get often op-eds in the Wall Street Journal.

They frequently will find other smaller places that they will -- he will take us on. He's with the Treatment Advocacy Center. But it usually is him. The larger Treatment Advocacy Center is not -- doesn't so much take us on as an organization. It's usually him as a person.

Another person is D.J. Jaffe, who consistently takes us on, and he has another organization that is similar to the Treatment Advocacy Center in the sense that they -- he's out of New York. So he argues consistently for more assisted outpatient treatment, more mandated community treatment for people with serious mental illness. That's their focus.

A third person, sometimes -- not always, but sometimes is Sally Satel, who takes us on sometimes in various and sundry ways.

And then in Congress, it's Congressman Murphy and some of his, frankly, Republican colleagues who are -- sometimes I think that their interest is more in attacking the Obama administration than it is in the context. But nevertheless, it doesn't -- regardless of why they're doing it, it doesn't help our field. It doesn't help behavioral health. It doesn't help SAMHSA. It doesn't help the messages that we're trying to give.

And I think SAMHSA has been characterized in that context in a very narrow way without seeing the breadth of what we do and without being really given the opportunity to talk about the breadth of what we do. So we've been struggling with how do we get that message out? How do we talk about it now more? Or when we do put out things that we do, like trauma work or whatever, it's just

completely written off as, you know, "worried well" kind of stuff that people should get over.

And literally they say that. D.J. Jaffe especially says that kind of stuff. So --

DR. CAROLE WARSHAW: But I've also read he's proposed legislation, mental health legislation.

MS. PAMELA S. HYDE: Yes, Congressman Murphy has, yes.

DR. CAROLE WARSHAW: So he has interest.

MS. PAMELA S. HYDE: He has, yeah. Well, we're struggling and working on that.

MS. ROSALIND WISEMAN: Thanks, Kana.

So the trauma-informed care information first came to me not very long ago, a couple of years ago. And I was sitting in a conference with mostly educators, and it made so much sense to everybody who was an educator that I was, everybody around me was just blown away. And it started with a pediatrician, the first presenter was a pediatrician talking about a program that she was doing in northern California. No, excuse me, southern California.

I've often wondered how to -- since that day, I've often wondered about how to share that information with just regular core curricula teachers. Because in my experience working with kids who have a connection of learning disabilities and social skills deficits that when you talk to a teacher who has -- because they've never, for the most part -- there's a link there. I'll get to it.

That most regular, sort of common core, every day, go to school teachers have only been trained -- with kids who have learning differences or are acting out aggressively, they've only been trained in restraining holds. That's what they get as far as their PD. And no one, very rarely are they talked about that some kids have oversensory issues, and that's going to make the situation worse.

So in the limited time that I talk to people about how to recognize a kid who has social skills deficits, you get these really pretty sometimes burned-out teachers who come up to you afterwards and say if I had just known this, I've got every kid -- I have kids in my head who I can just, right?

And I just think that the trauma-informed care, that they are such a willing group of recipients who actually look pretty burned out right now, who would not necessarily be your supporters or advocates. The people, just those, I think that people who are on the ground teaching kids, who are really burned out, would really respond to this strongly.

And I did -- I've watched other people do it, and I just think there's a link that needs to be made there that we're missing. So if I can help facilitate that. I've literally not known how to do it. But I don't think the people that you're talking about, nobody who actually works with young people on a day-to-day basis would ever have -- I can't even imagine the reaction. I can literally not imagine why somebody would say, "Oh, that doesn't make sense."

So I can't imagine it. So what's the connection? There are people, down on the ground people who would quickly become huge advocates who also really look burned out, by the way, right? Who really -- you know, who are going from being very burned out to "How can I help?" That I think is important. Not just like nice people who want to do business, but like people who are like pretty begrudging about like professional development, and they think its voice time and stuff like that.

MS. PAMELA S. HYDE: Yeah, and actually, those are great comments. I have a son who's an educator, and I have a partner who has a master's in special ed and taught special ed for a while.

She often says, and I don't think she would mind me saying this, that she thinks her call to do -- to get a master's degree in special ed and teach for a while was really more about her learning about her own trauma and figuring out how to deal with it and why she had such trouble in school and why she was labeled in the way that she was. So she learned a lot about herself in that process and was actually a great special ed teacher, but couldn't tolerate the organizational structures around it. So didn't do it for very long.

But nevertheless, I don't know exactly how to engage other folks. So I think that where SAMHSA is in its process -- and again, this is why I love these meetings that lets us step back and think about this -- is when you start getting criticism, you have to tendency to focus on nothing but the response to that criticism.

So I think we are at risk of finding ourselves focusing solely on serious mental illness or solely on people who do have to have mandated treatment because there are a few. I think there's a lot less than our critics think there are, but there are a few. So we have a tendency to kind of focus on where the criticism is instead of focusing on what we have to offer, what we have -- what we are out there able to do. So I appreciate your comments because --

MS. ROSALIND WISEMAN: Could I just maybe offer a suggestion?

MS. PAMELA S. HYDE: Yeah, sure. Absolutely.

MS. ROSALIND WISEMAN: School boards, obviously, around the country are as politicized as anything. And, but I think trauma-informed -- these are people in

their communities, and I would love it if like you were talking, like Carole was talking about it, like that tip sheet of what this is for school board people. Because they are appointed, many of them have no educational experience, and you know?

I mean, it's really an extraordinary thing to be a part of and to do professional development with them. And I hadn't thought about it until right now, but they're - usually these school boards are totally polarized between extreme conservative and extreme liberal. And God forbid, they have like a young teenager on the board because they're usually the peace maker as like the most mature people on the board.

But them getting information about this and the connection to different issues so that they could -- and then they'll feel good about like "I'm getting informed about these things," might on a grassroots level really make a difference, and it also might -- now this might be crazy. But it might actually maybe make things a little more civil on those boards anyway.

But I just thought maybe that might -- just if you could reach out. If that's one place to target, that might be an interesting thing to do.

DR. CAROLE WARSHAW: Well, with NCTSN, you have such a large network of people who are working probably with schools. I'm not sure, you know, who have those broad connections and can mobilize support, as you know, on a large scale. So that's another potential resource that you have now.

MS. PAMELA S. HYDE: Great. Thank you. Yeah?

MS. ANITA FINEDAY: So this is my first meeting. So I am --

MS. PAMELA S. HYDE: Welcome. Yeah, there is a few new faces around. At least you're new to me. So it's good to see you all.

MS. ANITA FINEDAY: So I work for a national foundation, for Casey Family Programs, and we at Casey talk a lot about our influence beyond what we actually fund. So very similar kind of thinking. And we work with a lot of other foundations who think similarly, and we all talk about our relative influence.

And I just wondered if there's an effort to develop more of a public-private partnership with foundations. A lot of foundations could do some of the things that you were talking about. They could respond to some of your critics so you didn't have to respond. You could have allies in foundations through this work who could respond with the research and the communications people. You know, the communications people are key, who can be at the ready and have responses to various critics.

And we also work with trauma-informed care, and I think we have those -- we have those sheets prepared that you're talking about, and we disseminate them. So just wondering about that private, public-private partnership and that that's something I think that could be a lot of assistance.

MS. PAMELA S. HYDE: Great thoughts. I think the answer is we do a lot of it in some areas and not as much as we should in others. Again, after the Newtown event in December of 2012, we spent a lot of the first 6 months of 2013 interacting with lots of foundations and lots of organizations that were trying to look at what had been raised to the fore, which is these sort of mass violence incidents. So we had a lot of interaction with them.

We did conversations with individual foundations, and we did -- who wanted to do something. They just wanted our thoughts. And we were doing a lot of connecting of people who wanted to do things, and we did some presentations to grant makers in health and to others. We haven't done that for a while, at least not at my level. Maybe we have some staff who have done that.

But, so that's something we probably could go back and sort of generate a little bit more. We had also done quite a bit of that work back when the Affordable Care Act was just starting to move, as they also wanted help about that.

We have lots of individual programmatic interaction. So our juvenile justice work with MacArthur Foundation, and there's a group that we don't actually fund directly, but we have been supportive of Creating Community Solutions group that's been doing work with cities and foundations around talking about mental health and youth and stuff.

But your point is well taken. I don't think we actively go out and seek foundations all the time. They come and seek us, I think. And again, there may be individual staff who are doing a lot of work with foundations, but not so much as a whole, I don't think. Is that right? So good point. Good point. We could reach out.

Well, there's Robert Wood Johnson, the Casey Foundation, the Kellogg Foundation. I mean, there's a lot of them that are -- MacArthur -- that have over the years reached out, tell us about stuff. So, great.

Any other thoughts or comments or --

DR. SHELLY F. GREENFIELD: I guess my one other thought, just in listening to what you're saying, it's just that I would kind of agree with you, though, that the approach of responding, you know, to single critiques probably is not your best strategy in the sense that, you know, I think there are people who are kind of stuck very much in having a one issue situation that they're -- you know, that they've been pretty passionate about for a long time. And some people listen to them, and some people, frankly, just don't.

So I guess what I would say is that you have a much broader purview and much broader charge, and you cover many different aspects of mental health and substance abuse -- care, treatment, education. And I think in continuing to I like the idea of partnering with different coalitions of different people, whether it's foundations or schools boards. But in trying to accurately represent yourselves as an agency is really representing all of this very large, you know, purview of mental health and substance abuse care, which includes the seriously mentally ill, people with serious and persistent mental illness. It includes people with trauma.

These aren't necessarily separate categories, but sometimes they are separate categories in terms of individuals. Includes people with substance use who may or may not have had trauma. I mean, the complexity of this is that, you know, it's very heterogeneous, and you all are trying to encompass all of it.

And you are going to get critiques from people where there's just a single focus and they just want a single focus, and that's how they see the world. But that's, frankly, you know, that's the elephant story of, you know, they just see the trunk, or whatever it is.

So that would be just one -- you know, one thought in addition to, you know, put little boxes that I was talking about earlier.

MS. PAMELA S. HYDE: Yeah. I'd love to see the picture of your little boxes to see if they, you know, line up -- and it sounds like they do line up a lot with how I talk about this when I do a speech or something. But I did hear a point about not responding to them is it's like a catch-22. And I personally go back and forth.

I think there's a way in which they have taken the stage and the public -- behavioral health conversation to the public, not so much to our field because I think our field kind of writes them off a little bit. But the public is hearing them. And they -- I give them credit in being very excellent communicators, and one of the ways they are excellent communicators is they stick to the message even if it's a lie.

You say it over and over again, and you know, you've heard the rubric if you say a lie often enough, it becomes believed. And I think there is some way in which SAMHSA is becoming understood to be an ineffective Federal agency because of their messages. And that's what I worry about because we have so much to do, and we have such an important role is to the extent that the public is not willing to support that or hear something different, it's hard.

So it's hard to know how much to go back at them and say you are not correct, and you know you're not correct. You know better. The latest one, which just came up this morning, was we have no physicians on our staff. It's just flat not

true, and they know it's not true. But they say it over and over and over again. So now the belief is that we have no medical leadership. And that's particularly difficult because I'm not a clinician. I'm a lawyer. I've been in this field forever, but I'm not a clinically trained person.

So, anyway, it's hard to know how much to go back at that and how much to just say, you know, that's not it. And I think, in all fairness, our department is struggling with that, too. They're struggling with trying to help us respond to those guys and at the same time not wanting to give them too much credit. So it's a back and forth we struggle with that.

DR. CAROLE WARSHAW: It sounds like the whole thing on --

MS. PAMELA S. HYDE: Again --

DR. CAROLE WARSHAW: You need the damage control based branch and this is the vision because I'm thinking -- I was thinking when you were saying that it's like who's the public? And who cares about a Federal agency who's not in the field, that if you're in the field, you actually have a better idea of what's going on? So I'm wondering what their reach -- I mean, I only know about it because I happen to be in this part of the world.

And the other thing I was thinking about is building on what you were saying, Shelly, it's like what's public mental health? You know, it's not -- I mean, it has been a safety net for people who have a serious mental illness and not like what's the public's mental health? How does mental health affect people's health and well-being and all kinds of things that everyone cares about, and how do we define what that means?

And these are all the pieces of it, and you're addressing all of them, and that's what you're -- it's like a public health -- you know, it's thinking about that in a way that defines it. So it's not like it's one piece of public mental health. Especially now with the ACA and, you know, that whole changing configuration of where mental health services are delivered, how do you define that and what's your role in it?

MS. PAMELA S. HYDE: Yeah. Your point is actually well taken because we are now at the point where we watch the metrics. And when you see one of these people write something, we can -- we can't see how many people read it because I don't know how many people read the Wall Street Journal. I don't know how many people read that exact op-ed. But when we have things on accounts that we can follow that how many people respond, they're getting fairly small responses.

It's sometimes in the 68, as opposed to 68 million. Or 527, as opposed 10,000 responses to the comment. So we're sort of watching those metrics a little bit.

And you're right. There's not a lot of response to it. So, again, we're trying to -- still trying to figure out how much is it important to -- I think Congressman Murphy is getting more attention publicly than these two or three naysayers. But they are feeding him, and he's an excellent communicator.

DR. CAROLE WARSHAW: Is there anyone else in Congress and the Senate who can do the opposite --

MS. PAMELA S. HYDE: Oh, yeah. Sure. We have people who are trying to help us. But obviously, they're in the minority at the moment. So they don't always get as much attention.

Yeah, so I appreciate kind of going down into this. It's different people are asking -- as I'm moving around the councils, different people are asking different questions about sort of how we're managing this context or the context in which we brought up this treatment question to the fore. So this is -- this is helpful. I appreciate the opportunity to chat about it.

So I know we're getting close. We got maybe 4 or 5 minutes left?

MS. KANA ENOMOTO: Yeah.

MS. PAMELA S. HYDE: So anything more on that or anything different than that that you would like to raise?

MS. KANA ENOMOTO: I'm just going to respond about Carole's question of who is the public.

MS. PAMELA S. HYDE: Ah, thanks.

MS. KANA ENOMOTO: For some of these, the public is those who might be concerned about acts of mass violence that have been committed by individuals. And so, the appeal is if only SAMHSA were effective, right, if only there were more AOT programs, which, you know, if you look at the Newtown Commission, what they recommended is to look at a continuum of care and more on prevention and promotion and coordination of care at the earlier levels, not more AOT.

However, that's -- right, so that's a public -- that is a ready public for some of these messages, as well as those people who are interested in or who believe that big Government or this administration isn't effective. So this sort of fits into that belief system. That here's another agency that is instead of focusing on this very important and real, and I don't deny it, issue of violence or, you know, people who are under treated or actually who go on to commit acts of violence, that's an issue. It's not the only issue, but it's an important one.

And they'll say, well, instead of focusing only on that, they are worrying about people who have been abused as children and now are struggling as adults.

DR. CAROLE WARSHAW: So is the gun lobby involved in the shifting that discourse towards --

MS. PAMELA S. HYDE: I don't think the gun lobby, per se, is involved in it, but the people who are in agreement with the gun lobby are the people who -- yeah.

DR. CAROLE WARSHAW: Are shifting. So there's that whole --

MS. PAMELA S. HYDE: And I personally have watched over the last couple years the conversation shift. I have heard the term "the mentally ill" more often in the last 2 years than I probably have in 20 years. So we're dehumanizing "those people" again. We're saying they're the people who commit the violent acts.

The other thing, the other statement of inaccuracy that one of these naysayers frequently says over and over and over again is that 50 percent of the violent acts in America are created by people with mental illness. In fact, he doesn't even say people with mental illness. He says "the mentally ill," which is not true either. I mean, it's the way he puts his data together, as you might imagine. Those of you who do data know that you can make any case.

But to the extent that you have people who are concerned about violence in the schools or you're concerned about -- they're concerned about all the stuff they're hearing. And the other thing I am convinced of -- I don't actually have facts about this, but I am convinced that some of these events were happening in lots of places, but they were local media events. And now every one of them is a national media event.

But frankly, the domestic violence situation, where the guy goes in and kills exactly the same number of his ex-wife, his ex-wife's parents, his kids, whatever, that's still a local media event. It doesn't become a national media --

DR. CAROLE WARSHAW: Unless it's a football player.

MS. PAMELA S. HYDE: Yeah, unless it's a football player or unless they used a gun or, you know, unless they had a mental health problem or something. Yeah, exactly. So I think there is something about the way the media is covering it, too, that it's both a pro and a con.

I mean, more people are talking about mental health, but they're more talking about it in negative ways. And I'm -- I just have to remain hopeful that the ultimate outcome of that will be more community conversations, and there are tons of underlying community conversations going on about the mental health of our children, about supporting young people in schools, about supporting families

who need help, et cetera.

So that's all positive. We have to keep our heads wrapped around that. I don't know if I cut you off in trying to just talk about who the public was.

DR. CAROLE WARSHAW: I have one other question unrelated. Although a lot of professional organizations have a much more -- like APA, much more nuanced views, lots of people hear that. They probably know that already. I also wanted to ask about the new initiative of community behavioral health centers with the pilot studies. Is that part of this focus on treatment as well of what -- can you say something quick about it?

MS. PAMELA S. HYDE: Absolutely. I've spent -- in fact, I gave all my feedback on the RFA to Dave this morning. But yeah, this is really exciting. It is something that came out of Congress when Senator Stabenow put together a both bicameral and bipartisan sort of coalition to get this through.

And we are just about to release the RFA sometime in the next, hopefully, month or 6 weeks. We've been working with CMS on the sort of payment methodology, and we've been developing a criteria, which we've had a couple of public comment sessions about. And then ASPE is -- Assistant Secretary for Planning and Evaluation is going to do the evaluation for us.

So it's a really collaborative effort within HHS. It's going to offer eight States the opportunity to be part of this demonstration, and the goal is -- now it's a long-term thing. So it's going to go well beyond this administration. So it's something that those of you who follow SAMHSA over time will definitely want to watch because it starts this year.

The demonstration States will actually get selected in the summer of '16 or January of '17 right before this administration leaves. But then the demonstration itself is over the next 5 years, next 4 to 5 years. So it's 2021 that CMS will recommend to Congress whether to expand the process or not.

And it really offers a way for community behavioral health clinics to get funded in a more fair and equal and cost-based and quality, value-based way. So it should provide more sort of some oversight on what kind of services and how they ought to look and how they ought to be put together, the comprehensiveness of them, but also how they ought to get paid.

So to the extent that we have had over time a real inequity in the way that community behavioral health clinics are paid, and that, the theory is, has some implication for quality is a real opportunity to do something different. And I think we have -- another question I got asked in one of the other committees was about workforce, and we were talking about just some of the stuff we're doing about workforce. But I am convinced, and Kana knows. She hears me say this

frequently.

I'm not necessarily a big capitalism person. But the fact is demand does drive behavior. And to the extent that the behavioral health needs of our country are being talked about and there's more opportunities and it's going to be in more places, I think the demand will drive young people looking at their opportunities in healthcare, because that is one of the growing fields in our country, but then behavioral health as well as the specialties inside healthcare. I think we'll see some more workforce development.

I'm old enough to remember when we didn't have enough teachers. We didn't have enough nurses. And you can see the raise in pay, the raise in prestige, and the raise in just how people looked at those workforces because the demand was there. So I think over time I do have to hold out hope that over the next decade that that will really change in behavioral health.

DR. CAROLE WARSHAW: Do you have any sense of where -- I mean, the community behavioral health centers shows integrated care -- where mental health services are going to be delivered? How that landscape is changing with all of the --

MS. PAMELA S. HYDE: Well, that's a great question, too. We sent you all out some data. I hope you got it. But it was kind of point in time data. It would have really overwhelmed if we tried to do over time data. But there's no question that certain kinds of care are more and more happening in primary care settings.

So when we talk about development of workforce, we're not just talking about behavioral health specialties. We're talking about also primary care specialty, and we're talking about specialties in other things. The example we often use is if you have a specialist dealing with somebody with complex diabetes, you want that person to know something about alcoholism and something about depression and how that affects diabetes care or cardiology care or oncology or any of those other specialties.

So we're sort of trying to think about do we help those other specialties know what they need to now, and then obviously, for some people, like people experiencing depression, they're much more likely to get their care or primary care practitioner, either nurse practitioner or a physician, than they are from a specialty care, unless it's really so severe that it becomes in need of specialty.

And Ellie McCance-Katz, our CMO, is really very articulate about saying that the future should be that these are conditions that should be dealt with in primary care, just like any other condition, until there needs to be a referral for a more intensive specialty care. And we're not quite there yet, except for perhaps for depression. Maybe that's one. But not all primary care physicians are well trained in how to deal with that.

DR. CAROLE WARSHAW: Or have time.

MS. PAMELA S. HYDE: Or have time to do it. So we've been thinking about that, too. How do we support primary care practitioners, and how do we support that sort of infrastructure and understanding the needs of people who present with those issues? Because a lot of times they don't want to ask because they don't know what to do about it.

DR. CAROLE WARSHAW: Right. But then there's the issue of actually what to do if there's complex trauma. So it's like there's this in between where --

MS. PAMELA S. HYDE: Yeah. Well, we should wrap up. If they don't know, maybe they do already, about the work that Larke and you and others have been doing about the --

DR. CAROLE WARSHAW: No, I know. But maybe that's another conversation.

MS. PAMELA S. HYDE: Okay. All right. Okay. Well, thank you. Sorry we don't have more time. It's fun to have the conversation, and it really does help us think about ways that we might address either the criticism or, more importantly, address the treatment needs and the integration needs and just the educational needs, the needs of educators and others. So I appreciate all of your comments and, obviously, appreciate the staff's work in supporting you so you can support us.

Thanks a lot.

MS. KANA ENOMOTO: Thank you, Thanks, Pam, for joining us.

And thanks to the members for a very stimulating discussion. I think there are some good opportunities for follow-up for us. So thank you.

All right. And with that, I'm going to move over to Nadine, who will tell us about our luncheon logistics.

MS. NADINE BENTON: Okay. So your lunches are here. And if you would see me over by the door, I'll make sure that you get that, and we will reconvene at 1:00 p.m.

[Off the record at 12:35 p.m.]

[On the record at 1:03 p.m.]

Agenda Item: Supporting Women in Co-Ed Settings – Core Competencies, Practices, and Strategies

MS. KAREN MOONEY: Welcome back to after lunch. Over the past year, SAMHSA CSAT has been working on the development of guidance for providing gender-specific services to women served in co-ed programs. We're interested in this because the vast majority of women receiving addiction treatment and mental health services receive these services in co-ed settings.

While we have written and published a fair amount of information about working with women in women-only programs, we wanted to make sure that the principles and lessons learned from this work could benefit providers of co-ed services.

I'd like to introduce Sharon Amatetti and Sherry Greenfield, who will discuss -- Shelly. I'm so sorry. Shelly Greenfield, who will discuss this work.

Thank you.

MS. SHARON AMATETTI: Thank you very much, Karen.

So as was mentioned earlier by Pam and Kana, the focus of the meetings this time is to put a little bit more focus on addiction treatment and treatment in general, and this session and the one immediately following it are about treatment. And I wanted to let you know that after we have this session, at 2:00 p.m., we are going to combine with the CSAT Advisory Council to have a joint session on the Pregnant and Postpartum Women's grant program. So we will probably wrap up just a little bit early for this session so that we can invite our colleagues on that committee in.

So to get started, we have been working on this issue, looking at the needs of women in co-ed addiction treatment settings. We have been working on the development of a guidance document over the past about 18 months now, and I just want to say that we've gotten a lot of support from our contractor, the Advocates for Human Potential and the project manager there, Deb Warner. So thank you to her.

We worked with a really wonderful expert group, who included both Dr. Shelly Greenfield and Karen Mooney, our two advisory committee members, and others who have helped us frame our thinking about this. So we're happy that they are actually here, two of them are here today to help the discussion. And I'm going to be tag-teaming with Dr. Greenfield during the presentation, and then Karen Mooney is going to help us with the discussion. So I hope we have a good, robust session now.

So just to create the context for why we were thinking that this was the important work that needs to take place. If you think about it, some of you are familiar with this data, some of you maybe not so much. But generally, about one-third of

treatment admissions are for women, and another two-thirds are for men. So men are the majority of people entering treatment.

In terms of programming, about one-third of programs say that they have some kind of women's programming. That doesn't mean that they necessarily are a women-only program. It means that they might have a women's group, or they might have a program for children of parents. In some capacity, they describe themselves as having some women programming. So, again, really the majority of services aren't geared around the needs of women, but more co-ed or for male sort of orientation.

And then the other important point is that the majority of women receiving treatment services receive them in co-ed programs. We have spent a lot of thought and time really perfecting what we think a women's program would look like, a gender-specific program. But it often speaks to programs that are only serving women. Whereas, the majority of women are receiving services elsewhere, not in those programs.

So we felt that it behooved us to give some time and attention to what are ways that we can enhance the experience of women participating in a co-ed program so that we can translate some of what we learned and worked on over time in women's-only programs to co-ed programs and also understanding what the differences are between those types of programs. So that was the genesis for this work.

So the sample question was given what we know about high-quality women's programs, what guidance can we provide for serving women in co-ed settings? And we undertook this project with a couple of strategies. We did a literature review and can tell you that there really wasn't a lot out there about serving women in co-ed programs. So there wasn't a lot that we could draw from, but we have extensive literature on serving women in women-only programs. Some of that work is published by SAMHSA over the years. And so, that was some of the basis of the literature.

We have our expert panel, which included a dozen mostly providers, but also other people who have done research and also worked in administration of women's programs. And then we have what we described as stakeholder review, which was principally the State women's treatment coordinators reviewed our work, as well as alumni of our Women's Addiction Services Leadership Institute. So they had early drafts of the document that we developed, and they were able to improve it significantly by providing feedback to the document.

So the way that the information was organized, we struggled with how to present our thinking and the salient points. So what we ended up doing was providing a combination of guidance statements which are really sort of principles about what we know about sex and gender differences between men and women, although

recognizing that women are not a heterogeneous group.

And then the other part was really providing about practices. So some overarching principles and guidance statements, and others are very specific about what do you do. The topics of the guidance statements were about addressing women's unique needs and experiences, about gender dynamics, trauma, health needs of women, mental health concerns of women, and then the issue of relationships.

So I just wanted to go through those guidance statements first and just give you a little bit of a flavor. And I'm going to ask Shelly to chime in as I go through this as well.

So the first was about addressing women's unique needs and experiences. And you know, I think this is information that is probably familiar to all the people in this room, but we spent a fair amount of time laying out in the document why there are some differences between men and women typically. Not always, but typically.

And that women's pathways to substance use, abuse, and dependence, can be different than men. Their motivation for treatment can be different, and recovery supports need to be different. And how should programming think about those gender differences in approaching the work that they do?

So this section, we really relied upon the literature review, as well as the experience of the expert panel and the people that we consulted with to review our material. In terms of gender dynamics, there was a lot of discussion about this and the gender dynamics between men and women and what colors and impacts treatment in terms of those gender dynamics.

The gender dynamics influence the content of what's discussed, as well as group dynamics. So it's sort of, you know, what are you going to present or what are you going to work on, as well as how does that work take place in the context of a co-ed program?

And Shelly, do you want to comment some more on that?

DR. SHELLY F. GREENFIELD: Sure. First, I just wanted to say that I'm just very happy to have the opportunity to be part of the expert panel and to contribute to the -- this -- the development of this document. And I was just saying to Sharon a little bit earlier today that I think it has the potential to be an important document for treatment programs just because of the nature that Sharon commented on, which is that most women are actually getting their treatment in co-ed programs, and most co-ed programs, I think, would like to be able to be responsive in some way, but there hasn't been guidance in that direction.

So I was very appreciative of being able to participate in the discussions and in talking to the document, and there were many, many, many excellent discussions. And Karen, I think, can attest to that as well.

So with regard to the gender dynamics issues, I just wanted to comment that in my -- in my program and in my research studies and research group, we've done qualitative research comparing women's experiences in an all-women's recovery group, which is the evidence-based treatment that we've developed, comparing it to a mixed-gender control condition, and which we have qualitative data analyses, where we found that the participants who were in the all-women's group therapy endorsed the perspective that they were able to actually feel themselves to be safe and comfortable in an all-women setting.

And that's, again, an outpatient group with all women in it, that they could be all aspects of themselves compared with the women who talked about their own experience in the mixed-gender controlled condition. And I would just say that what's interesting about that is that both groups of women were satisfied with their treatment, and yet there was this very qualitative difference in experience at feeling they could bring everything about themselves to bear within the -- within the all-women's condition.

And what we've found was consistent with literature that had existed previous to the studies that we had done, reporting that women often say they have a preference for single-gender treatment because they feel uncomfortable otherwise disclosing important issues that are relevant to addiction and recovery for them. And that includes things like histories of trauma, concerns about parenting and partners, concerns about sexual intimacy, and a whole host of other issues.

And many of the women who went through the single-gender group therapy in our study said that the things that they had actually discussed there were critical to their recovery, and they would never have discussed them in a mixed-gender setting. We also looked at affiliations amongst members within groups, and we found that within the group, women were most often likely to give a verbal empathic statement. And they would do this women-to-women in an all women's group, but in a mixed-gender group that the directionality of those statements were usually women-to-male, as opposed to in any other direction.

And so, we thought that the attention to the fact that the content of the discussion can be very women specific, the comfort and support of an all-women's group can actually provide an opportunity for women to express some of the things that are very critical in their recovery. And that in addition, the last bullet you'll see there is the staff training and clinical supervision.

And I would just make the point that both -- in studies, the groups are delivered in

a very specific way because the individuals deliver and the groups are getting weekly supervision. And one of the things that was discussed in the -- in the -- amongst the panel members was just that in helping programs that are co-ed to become gender responsive, the staff training and clinical supervision would be a very critical component to addressing some of these things.

MS. SHARON AMATETTI: Right. Yeah, and especially some of the other ways for which the staff can be helpful is really helping with the dynamics in the group, like about speaking up or deferring to men, and what folks will feel that they can safely disclose and that sort of thing, and that's very important there.

Another one of the principles was around trauma. Physical and psychological safety, of course, is of paramount importance. And you know, trauma, very prevalent, both women and men, might express itself a little bit differently. The type of traumas might be different in terms of the experience.

And I think, Jeannette, you were talking about the importance of really talking about the vent and the source, and that could be very different amongst men and women. So did you want to --

MS. JEANNETTE PAI-ESPINOSA: Yeah, I was just going to comment that, I mean, this group knows well that a large proportion of women with substance use disorders have had past histories of sexual trauma, either as children or adults or both, and that using trauma-informed approaches are critical to their recovery.

But I think also, just to build on what Sharon just said a moment ago, communicating the program priorities directly to staff for physical and psychological safety for both women and men would be a very high priority for co-ed programs. And in the end, that will benefit both women and men, as does the final -- as does some of the points around emphasizing strength-based approaches.

So these are, I think, principles that co-ed programs can adopt and use, and they will be of benefit to both women and men within the program.

DR. DAN LUSTIG: Do they -- sorry. Do they give a definition of what psychological safety net to them is?

DR. SHELLY F. GREENFIELD: You're talking about in studies that we've done?

DR. DAN LUSTIG: Yeah.

DR. SHELLY F. GREENFIELD: So our co-ed -- the document doesn't necessarily -- it references studies, but it doesn't necessarily -- it didn't do -- this document didn't do studies. In ours, I think psychological safety, to some degree,

meant that women felt they could bring, comfortably bring all aspects of themselves safely into the discussion.

MS. SHARON AMATETTI: On the topic of health, just recognizing that women have some healthcare needs that are different from those of men, and certainly during the reproductive years, OB and GYN issues are very central to most women. To incorporate that into the treatment milieu in outpatient co-ed settings or inpatient co-ed settings, actually.

DR. SHELLY F. GREENFIELD: So, again, I think it's important this group knows, I think, that evidence actually shows that substance use disorders often have a more rapid accelerating course to serious medical and physical consequences of addiction for women compared with men, with shorter time frames until you have serious medical consequences. And often women are even less likely than are men to access medical services if they have addiction. So they get sicker faster but are less likely to actually receive medical attention.

So addressing women's health is very important, and a number of approaches could be taken for co-ed programs, and they can include things, everything from screening for pregnancy, having -- having referrals for prenatal care and other reproductive healthcare, even if those are not provided onsite. Assisting women and encouraging women to have a comprehensive physical exam or having appropriate collaborations and referral pathways. Even if you get it, those are not onsite.

I think for both women and men, but I'll say for women, providing safer sex education and strategies to reduce sexual risk behaviors, which often, again, is neglected. And educating women, again, about the health consequences of their addiction and how to engage in health-promoting strategies, including things like smoking cessation, but also the provision of, as you can see just listed -- these are just some points -- you know, medication-assisted treatment, FASD education. We know that we haven't made as much inroad in that arena as we would like.

And smoking cessation, obviously, for both women and for men. And as most of you know, women and men sometimes do report different kinds of triggers for smoking and also different obstacles to ceasing smoking, and attention to those things is often useful.

But I think just even giving women the message in co-ed programs that they need to get medical care, and here's how to do it and here are referrals, that would be big because I don't believe that routinely actually happens.

MS. SHARON AMATETTI: In terms of mental health, we know that women have more co-occurring mental health issues. Twenty-two percent of all women have mental health disorders and 15 percent of men. And so, the risk for mental

illness we know is also elevated among those with substance use disorders.

The types of mental health disorders differ for women and men. More women have depression and anxiety and eating disorders. Men would more typically have attention deficit disorder and be on the autism spectrum. So different treatment needs based on the mental health needs of clients.

DR. SHELLY F. GREENFIELD: And I think, in addition, women with co-occurring psychiatric disorders and substance use disorders often -- often find that the other mental health disorder becomes a barrier to their accessing substance use disorder treatment often because they have defined their own problem as depression, anxiety, or another psychiatric disorder or family problems. And in the past, they've sought care for those disorders. The clinicians treating those disorders are often not trained to treat the substance use disorder, and therefore, this substance use disorder often goes undetected, under detected, or untreated.

And if they're in a substance use disorder program, often there is lack of attention to their co-occurring anxiety, depression, or eating disorder, or PTSD, for that matter. And there's generally been a lack of integrated treatment. So women often struggle more, much more, going back and forth between mental health care and substance use disorder care. It's often an obstacle to their getting well.

It can be a daily struggle for women and their clinicians in substance use disorder programs, and I think in being gender responsive, developing either some onsite ability to co-treat and integrate the treatments or, again, close associations and collaborations and to informing women that actually having integrated treatment for these disorders is very important for their treatment outcomes, both for the other mental health conditions as well as for the substance use disorder.

And it's just quite important for co-ed programs to understand that the burden of these illnesses disproportionately affects women because of the increased prevalence and because of the way in which that affects treatment outcomes for women.

MS. SHARON AMATETTI: So the final guidance statement was relationships. So we often talk about women being relational, and of course, men are relational as well. But the roles and the types of relationships can tend to differ, both in therapeutic and nontherapeutic types of relationships.

Shelly?

DR. SHELLY F. GREENFIELD: Yeah. So there's a lot of data that shows that family, partner, parenting relationships are very central to both women's pathways to addiction and also to recovery and that these things can be both positive and negative and aren't all in one direction. Women are in general more likely to have been introduced to substance use by a male partner than are men

from a woman partner.

Once addicted, intimate partner's relationships with children and other family can provide the support and motivation for treatment or can be triggering for relapse, depending on the context. But generally, it's not a neutral topic, and it's usually advantageous, disadvantageous, or a mix of both. And helping women consider their network of close others, looking for both positive supports versus negative attachments, it's quite important in the recovery process for women in addiction and for their treatment.

Having components of care such as an all-women's group, women's self-help, a single individual woman counselor can actually provide some of the support to help consider those relationships and their roles in addiction and recovery.

MS. SHARON AMATETTI: So Shelly was speaking about some of the practices and strategies that the expert panel organized for us. So this is really so now that we know all this, so what do we do with it, right? What do we do? What should co-ed programs do? How do they operationalize some of the guiding principles in the work that you're educating?

So the practices and strategies were organized along these five areas, around staffing issues; environment or facilities; having to do with assessment, treatment, and recovery planning; intervention and groups; and then recovery support services.

So around staffing issues. I wanted to mention that SAMHSA has done some work around the issue of working on the gender-specific issues of women and girls, and we talked previously about how this work has been incorporated into our women's programming. But we have a document, Developing Core Competencies for Mental Health and Substance Use Service Professionals, on addressing needs of women and girls, and it really is an effective tool that staff in both inpatient and outpatient residential programs could use to help train their workforce on understanding the needs of working with women and girls.

We also have an online curriculum that does a lot of the same type -- covers a lot of the same type of ground. So it would be very helpful. So there are tools that we've been working on to help support staff around these issues. But they also -- the committee also talked about matching women with primary women counselors, when possible, and also the importance again of clinical supervision for working with women and girls around the core competencies.

DR. SHELLY F. GREENFIELD: Yeah, I made reference I think just a little bit to some of these things. But I think different co-ed programs will need to use different kinds of strategies to implement some of these recommendations and that the -- all of the discussion in the committee, the expert group was very sensitive to this and wanted to provide sort of the broadest sense of

recommendation so that it could be anything from if you have enough of a cohort of women, you might consider having an all-women's group in a co-ed program and staffing it, if you could, with a woman counselor.

If not, you might consider at least trying to run groups with the highest proportion of women so that women don't feel as isolated and alone. If none of that works, having a woman staff person be a counselor, other clinician be able to meet specifically one-on-one with a woman patient who's within a co-ed group, to give that person -- to give her some additional time to address some of these issues.

And then also just partnering again with community resources, such as access to women's AA or other all-women self-help groups. All of these things could provide a gender-sensitive component of care within the context of, you know, a co-ed program. The other thing, again, we alluded to was this clinical supervision of all staff on issues relating to gender responsiveness for women, as well as in delivering evidence-based care that would improve overall the quality of care of both women and men.

And I think in terms of trying to understand gender responsiveness, I think even explaining that concept to staff, what does it actually mean, you know, taking into account the things that we actually know in terms of the factors that are most salient for women's addiction, most critical for women's recovery, is actually another important component of staffing and training.

MS. SHARON AMATETTI: Just one other point that was brought out was that some programs are so small that they'll say, well, that's the next concept, but we really can't do that because we aren't staffed that way. So another recommended strategy was to use gender-matched peer mentors, recovery coaches, people who are part of the program in other ways to help provide that sort of support.

MS. ROSALIND WISEMAN: Are we allowed to -- or do we do separate Q&A, or can we do Q&A while we go?

MS. SHARON AMATETTI: Why don't we just finish up a few things -- I'd like to touch on things -- and we then can have time for discussion. Karen is going to help us through.

MS. ROSALIND WISEMAN: Okay.

MS. SHARON AMATETTI: In terms of the environment and facility, I don't think it would be surprising to people to think that women more often than men would be influenced by the feeling of safety of a facility, the way it appears, how it -- whether feels like a place of sanctuary or continuing stress, you know, because of the way that it's put together. So those things were brought out. Having an area where even if it's co-ed program, but there might be space where women

can just gather either informally or a place where there is also a place for their children, if they're bringing children, and just making it a more comfortable sort of physical environment.

And then, of course, being a place that feels welcoming and warm and nonthreatening. And our NIATx program, which did the rapid change cycle study of programs, really helped a lot of programs with this piece of making a facility feel welcoming when you come in. It's an easy, low-hanging fruit for a lot of places to make those types of changes.

So this we thought to be important, and I'll let, Shelly, if you want to add anything about that?

DR. SHELLY F. GREENFIELD: No.

MS. SHARON AMATETTI: Okay. So then about assessment and treatment planning. This is, you know, the large part of the work, right? And so, really to address anyone who's experiencing -- women's experiences, knowing that there is a lot of shame and grief that women experience, and the assessment process really needs to be attuned to that and can be gender specific for a woman whether she's in a co-ed program or not.

Using trauma-informed and sensitive approaches. Recognizing and prioritizing women's family responsibilities and relationships. And the reason that people might not get to program all the time is not just that they're not compliant, but they have a lot of roles and a lot of things that they're juggling, and really understanding that and sort of building around it in the program to meet her where she is.

And then so look at the mental health assessments very carefully and identify a woman's strengths for her treatment planning. What are things that she brings to the program that she can go build upon? And I want to get Shelly to comment on that.

DR. SHELLY F. GREENFIELD: Yeah. I mean, I think all of these factors are important in women's addiction treatment. Shame is endorsed, I think, by people in general about substance use disorders in seeking treatment. But for women, it carries an even often larger burden of stigma, and shame is very frequently endorsed as a reason that people don't get care or an obstacle to getting care.

And as Sharon said, you know, women are often caretakers in their lives in numerous ways. Sometimes that involves children. Sometimes it's not children. It's other family members. It's parents. But that is a major role in not playing in their communities.

And family members can, as we know, be supportive or not be supportive. They

can be an obstacle, or they can be a help. And not making assumptions around what all those relationships mean is a critical component of care for women, and women actually endorse the relationships with significant others in their lives as critical in terms of their recovery pathway.

I would also say that there is some data that shows that women who have addiction problems are often endorsed -- they're much more socially isolated on a whole bunch of different scales than men with addiction. They often are more likely not to have significant others and people supporting them in terms of their recovery. So looking at this is really an important -- an important part of treatment.

And we already covered, I think, the need to assess the physical and mental health problems that are co-occurring with addiction. That's very critical for women. They often -- this often does not happen for them in traditional addiction programs, and again, often a program won't be able to provide it onsite. Just having the developed referral pathways and emphasizing and educating women that this is critical to their recovery is important.

MS. SHARON AMATETTI: And intervention and groups, Shelly did cover a little bit of this already in her comments. But really again considering -- consider gender in array of services offered.

Also if you have a minority number of your clients are women, but you could still possibly group them together so that they make up half of a group and not just do it sort of wherever it's convenient for people to attend, but really try and influence that. Those groups should be very helpful so that women are not dominated by men, but it's more evenly split in the groups that they're meeting in.

There are a lot of interventions and programs that are women-specific, evidence-based practices. We also have worked with developers of the Matrix program to do a women-specific Matrix intervention. If you look at a lot of those topics in there, men would not resonate with those topics, but they would be very central to the lives of women.

So if there's a way to deliver some of that information either in some separate individual sessions just for women. And if not, if it's really not possible, again the type of thing where our program just is too small to be able to handle that, they use some of the one-on-one time with the counselor to go over some of those issues so that a woman has the chance to explore that in a safe environment with her counselor.

Shelly, did you have anything else you wanted to add to that?

DR. SHELLY F. GREENFIELD: I would just again emphasize that we talked a little bit about this earlier about staff training, but that therapists can be trained to

encourage and to facilitate participation from all members of the group, men and women, but also to empower people to decline to participate or to elect to participate and not to force them to participate. And you can also ask them to participate through reflective listening that can be emphasized, in addition to active verbal participation, but for the group leaders to be sensitized to the potential gender dynamics within it.

And again, for programs to be encouraged to adopt the most appropriate evidence-based, women-specific treatment, whether it's the Matrix or a particular Seeking Safety, the Women's Recovery Group. There are a number of different ones that are there. And again, as Sharon said, in the situation where that's not possible to do, making sure that there is some one-to-one time with a woman staff person for that individual person would be very important.

MS. SHARON AMATETTI: Then the final practice was around support for recovery services and having programs that were reflected to see if the recovery support types of services that they typically help people to get connected with really are comprehensive for women. So housing, financial supports, working with child welfare, services for her children, food programs. Also the types of things that a man typically might not need as much support with that the woman might need, to really look more robustly at what types of services we present people with.

Flexibility of scheduling, understanding the very complex demands on women who are the prime caretakers for children in particular. And looking for some women-only self-help and mutual support groups would be important.

Shelly, do you want to add anything?

DR. SHELLY F. GREENFIELD: I don't think so. I think you've summarized really well.

MS. SHARON AMATETTI: Okay. So just I'll sum up this slide. One of the pieces of this new document, soon to be published, is that as an appendix, we have a self-assessment tool for programs, and it lists out all the different types of things that a program might want to consider to include to be more gender responsive to the needs of women.

And the way that it's used is that a program would say whether they are unable to do the practice, they don't do this, or they do it very rarely, or they do some of it. They're aware of the need and they'll do it sometimes, or they're committed to do this so most of the time they do this.

And after they go through all of these areas, they can get a picture about the ways in which they could strengthen their program. It has them do a little analysis of what their strengths and opportunities and their weaknesses are so

that it helps them develop a work plan for how to be more gender responsive to the needs of women in co-ed programs.

So I think we field tested it with some programs. So we're pretty excited about -- about how that worked for them. They thought it was easy to use and that it gave us some really good feedback. So I think that that's, you know, a nice addition that you can digest the information in the product by going through this checklist and how it plays out here on the program.

So, with that, I want to ask Karen if you would -- you might want to make some opening comments, having had the experience of being on the expert panel or add to the discussion.

MS. ROSALIND WISEMAN: Wait. Hold on. I have a question from what you all just did.

MS. SHARON AMATETTI: She's going to lead the discussion.

MS. ROSALIND WISEMAN: Oh, I'm sorry. I thought you were --

MS. SHARON AMATETTI: We're not ending.

MS. ROSALIND WISEMAN: Oh, that confused me. Okay. Sorry.

MS. SHARON AMATETTI: I think you missed the very beginning, Rosalind. You came in. Yeah, Karen was part of the expert panel.

MS. ROSALIND WISEMAN: Yes, I did. Yes.

MS. KAREN MOONEY: And I actually just handed Rosalind a copy of the checklist so I think that's what perhaps what made things a little bit confusing.

I think having worked on this, I really, really enjoyed the discussions, and such a wonderful sort of high point of all of the different things that we've learned about women's treatment in the last 20, 30 years, it kind of got consolidated in the process of developing this document.

And I recently had an experience in my State where we had a pretty big, scary issue with one of our women's treatment programs, and I was called upon to do a little bit of research about practice in the field as it's actually happening, rather than I'm writing it into contracts that it's supposed to happen. And ran across an old article by Beth Glover Reed from 1987 called something like "Why is it so hard to implement women's services?" Or you know, something like that.

And there was a little line in there that really resonated for me with respect to this work, this particular project, and it was that by developing specialty women's

programs that meet the needs of women so carefully and meticulously, we let the rest of the programs out there off the hook for having to address women's needs at all. Because we say, well, we have these fancy services, and so treatment providers who encounter women in their practice will try to refer women to the specialty programs, but the women who have to stay, there really aren't tools available to help work with them.

So this, I think, fills this gap just perfectly. So I guess that was my comment that I wanted to make before we -- before I open this up to discussion. That being said, what comments and questions and feedback do you all have?

MS. ROSALIND WISEMAN: Well, I had one for Shelly especially in honor of your honor recently, today -- this morning, right?

DR. SHELLY F. GREENFIELD: Last night.

MS. ROSALIND WISEMAN: Last night. So core competencies for working with women, can you give us your insights into like top three to five of what those would be? Or what are the challenges to achieve those core competencies?

DR. SHELLY F. GREENFIELD: Well, I could give you some of mine. I'm not sure if they'll be completely -- I do not think they're going to be consistent with the core competency curriculum at SAMHSA.

But you know, I think that the first thing is really to understand that women have basically, although they are -- although proportionately in the population more men than women have addiction problems, there's a lot of data that shows that once a woman has -- begins down the path, that pathway accelerates rapidly and more rapidly than that of men and that the rapid acceleration is within the physical health consequences and mental health and other social consequences.

So that's the first thing. It's sometimes called the telescoping course of addiction. It's kind of a core principle, and still not everybody --

MS. ROSALIND WISEMAN: Oh, I'm sorry, just to -- I was -- I'm sorry.

DR. SHELLY F. GREENFIELD: You mean competency of how to work?

MS. ROSALIND WISEMAN: Exactly. That's what I was thinking. That's what I would like your insights into of like what do you think?

If we are going to look for more women to work with women, those women who work with women, whether or not whatever -- you know, having a degree doesn't necessarily stop the issues, right, that might make it hard for a woman to treat a woman. And I just wanted to know -- I was really curious about what the report and what you all thought about, about what were the most important things that

the women who would be working with these women, what were their core competencies?

MS. SHARON AMATETTI: Can I just jump in and then go back to you, Shelly?

DR. SHELLY F. GREENFIELD: Yeah, yeah. You go ahead.

MS. SHARON AMATETTI: So the way we developed the core competencies guidance that we assembled a couple of years ago, we really looked at sort of the knowledge, the skills, and then the attitudes or attributes that staff would ideally have if they were working with female clients. And a lot of the issues resemble the topics that we talked about just now.

So issues about sex and gender differences, issues about family relationships and other relationships, understanding trauma issues for women, looking at considerations during pregnancy and postpartum issues, women's health and healthcare needs. And these are the types of knowledge and skills that we would hope that staff would bring to the work.

And then in terms of attitudes and attributes, do they have some shared experience with the people that they're working with, either because of their gender or their ethnicity or their perhaps age. Just things that they would bring that would make them empathetic.

Would they have respect for the clients that they work with and appreciation for their histories? Just having some experience with the service systems that women typically get connected to either voluntarily or involuntarily, but from a justice or child welfare or helping services that are in place, social supports.

So just appreciation for types of experiences women bring to their substance use disorder, how they got there, why they're in this problem, how to help them out. So appreciation for the whole recovery process is really what we were talking about in terms of core competencies for working with women.

DR. SHELLY F. GREENFIELD: And I would just say I was leaping to the knowledge, the knowledge part of it just because even though you would assume that many of those points of knowledge are known to many, they're not. And so, I was leaping to the first part because there is, just as Sharon just listed them, all of those areas that people need to really understand about gender differences and the burden, just the differences in terms of the burden that women have, all of those things are not generally appreciated by clinicians overall in the field.

So that's where I started from. But, yes, I think, you know, exactly the outline of knowledge skills and attitudes. And of course, you know, I think for men or for women, you know, respect and what we sometimes call natural curiosity in terms of what a person has experienced in the world and how it feels and seems to

them is the key starting place for most patients developing an alliance with a caring practitioner. So --

MS. KAREN MOONEY: I guess I would add to that as well. I do a fair amount of file review through the course of my work in both the mental health and substance use disorder systems and recently ran across a file that was the client was female. She came from rural Colorado, moved to the Denver metro area to get away from a man who was stalking her, who had delivered her washing machine. And it turned out that she reported this to police, and there were a number of other victims. In the file, this was referred to as "her legal issue."

So not every clinician, no matter how they are trained, necessarily carries an awareness of the complexities of some of these dynamics.

MS. SHARON AMATETTI: Other comments or questions?

MS. ANITA FINEDAY: Just a comment from working on an Indian reservation in a very rural area and being the judge who had to make a lot of decisions about where people were going, that we didn't have any kind of integrated treatment in mental health facilities, and so we always had to choose.

And sometimes it depended on the waiting list and who had an opening first, but the -- and I don't know if this is women or not, but this is where the workers always came down was if you had a choice, you should send -- well, almost always a woman, these were child protection cases, send her first for mental health -- to have mental health issues addressed because you had to treat those issues first before you can treat any kind of substance abuse issues.

And so, that is -- I have no idea if that's founded in any kind of research, but that's what the workers always pointed to.

DR. SHELLY F. GREENFIELD: So you are pointing out two things. One is that, unfortunately, the services systems have arisen in such a way that they are not integrated, and they are separate. So that, unfortunately, no matter what the data will show, is an administrative and organizational obstacle to delivering the care that we actually now have lots of data to show works best, and the care that works best is integrated treatment for mental health and substance use disorders in terms of both diagnosing and assessing what the various problems are and then co-treating.

And there's lots and lots of data now, 30 years' worth, that really show if you can integrate a treatment for depression and substance use, people stay. In substance use, eating disorders and substance use, anxiety and substance use, people get better. They get better, and they have fewer obstacles to their recovery.

Unfortunately, the services systems, the organizational structures, don't always allow us to do that in the way that we would most wish to. Say, you know, you were going to be forced to choose no matter what, which way you went, but the evidence would really show that integrating the treatments.

And therefore, that's why I think when we're talking about gender-responsive treatment and substance use disorder programs and a co-ed program helping women within the context of those programs know that the other co-occurring disorders are very important and that she will do better if all of them are treated together. Maybe not right this minute in this treatment program, but as soon as, as quickly as we can possible make it happen for you context.

Does that make sense?

MS. ANITA FINEDAY: Mm-hmm, yes.

MS. KAREN MOONEY: Okay. Well, if there are no other comments and questions, I think we'll go ahead and wrap up this discussion. Thank you very much, Sharon and Shelly. Appreciate it. And I guess that's it.

[Applause.]

DR. CAROLE WARSHAW: I think it's great that you did this, that you really, really --

MS. SHARON AMATETTI: Well, I thought that Beth Glover Reed's comment was so poignant from 1987 because we know that most people receive -- most women receive treatment in co-ed programs [inaudible] and hope you'll be more aware.

[Crosstalk.]

DR. SHELLY F. GREENFIELD: I was actually thinking in our earlier discussion about the LGBTQ communities also. I was thinking about my own Boston-based environment, and we have some programs that are very well known to be -- deliver mental health and physical healthcare to the LGBTQ community. And I think sometimes, just like you said with women, that sometimes let the general programs off the hook to really understanding and knowing and embracing that patient population.

And I think it's also true sometimes with IPV and other kinds of things that we talk about, that if there were -- it's wonderful to have a specialty program because you need them, but then if the general community thinks, well, that's what you do, then it does just like she said, lets everybody else off the hook to actually developing their skills and their ability to do the right kind, the best kind of treatment for the population.

So I was having the same set of thoughts.

MS. SHARON AMATETTI: I believe that they are done. I believe they're going to join us now. So we could take a little break and go off the record.

[Off the record at 1:51 p.m.]

[On the record at 2:05 p.m.]

Agenda Item: Pregnant and Postpartum Women (PPW) Grant Program – Future Direction

MS. SHARON AMATETTI: Hi, everybody. We're going to go ahead and get started now. I want to welcome the CSAT NAC to the Advisory Committee on Women's Services NAC, and it's nice to do this together.

I'm Sharon Amatetti from CSAT, and I wanted to introduce Andrea Kopstein, who is the Director of the Division of Systems Improvement in CSAT, who is going to be walking us through our program on pregnant and postpartum women, our grant program. The Women's Advisory Committee got some background material about this presentation in advance. What we really want to do is to tell you about the program, but also tell you about some of our ideas for moving forward and, more importantly, get your ideas for moving forward.

So, with that, Andrea, I'll turn it over to you.

DR. ANDREA KOPSTEIN: Okay. Good afternoon. And hopefully, I did make a lot of copies of this presentation. So, hopefully, if you wanted it, you got a copy of it.

Will be a brief overview of the PPW program, which is basically the PPW program is authorized under Section 508 of the Public Health Service Act, and that is one of the things that I think the women's council did get in advance is it basically states what the requirements are. And absolutely, you know that it's always been providing residential treatment care for these women and ensuring that their minor children, those 17 and under, can be with them in these facilities if they want them.

Also to provide services for those extended family members who are not in residential care with them. And a lot of other requirements. Since 2014, with ACA and everything, it also -- some of the requirements for this initiative also includes screening for things like depression.

The RFA was also included for the women's council in your package when you got it, and basically, it has a lot of requirements, this initiative. First of all, you're

offering comprehensive, coordinated, integrated, gender-specific, trauma-informed services. Individual and family service plans. Screening and assessments.

Recently, we've also added SBIRT practices, Screening, Brief Intervention, and Referral to Treatment, SBIRT for alcohol use disorders, screening for fetal alcohol spectrum disorder, and use of -- we're also interested in allowing the use of medication-assisted treatment for women in this being treated.

I'm trying -- let me talk about this. So, basically, a lot of what we want for these women and their children are pretty basic things. We want to improve their physical and mental health. We want them to have healthy pregnancies and have good birth outcomes. We also want improvement in the mental and physical health of their minor children.

The PPW program also wants to improve their parenting skills, family functioning. Basically, PPW wants reunification of families and to maintain those families that are still united.

And of course, so many of the outcomes that we want in this initiative are the same ones we want in many of our grant initiatives, which is decreased involvement in crime and violence and neglect.

PPW has been in existence since 1993, and I just want to introduce over here Linda White-Young, who works -- she has worked with PPW since its inception in 1993, and she has been the lead on this initiative through all these years and seeing it evolve and, basically, has done a lot.

So that, basically, from 2003 to 2014, we've founded 101 3-year PPW grants. These grants are generally about \$500,000 a year, depending on what they requested in their budgets. And in 2015, we'll be funding six new PPW programs.

And you can see from the map, basically, the States where these PPW grants have been have sort of clustered. There are quite a few in California, quite a few in Florida, a lot of them up in the northeast. But in the center of the country, there isn't much. And that's one of the things we're thinking about, and that's why this is called "future directions."

We basically -- this has been an initiative that doesn't fund a lot of grants every year. We generally fund somewhere between like 6 grants and maybe up to 16 or 19 in the bigger years when we've got more funding. But that's a very small amount that we are funding. We want a greater uptake at like a State level or a territory level because this is a very successful initiative.

Although it's evolved over time, it has terrific outcomes always. What we're doing

in this program has helped many, many women over these years.

Although we are doing more now to look at more recent cohorts, I have information that we had done for a previous presentation that actually Dr. Clark had done where they actually looked at some of the previous cohorts to see who is still providing some of these women's residential services. And basically, so our 2003 cohort had six programs, and five of those six are still providing many of the services that were funded by PPW, subsequent to having that grant. For the 2006 cohort, where we had eight PPW grants, all eight are doing that.

We will be reviewing more recent cohorts. We actually have a new contract this year, an analysis contract, which will allow us to look into what these grants are doing, these previous PPW grantees, and seeing what they're doing and how they -- we're very interested in how they're financing what they're doing.

Residential care, which PPW has required, is a very expensive treatment. But also we know that many of the things that are important in PPW programs can also be provided through outpatient and other recovery support services.

So here is just some statistics on the PPW women that were served. So we served 7,500 women since 1993. Over 40 percent were pregnant, but actually almost 60 percent postpartum. The biggest age group of these women is obviously the child-bearing years, 26 to 44, very few older than 45. Basically, half are white, but there are very large proportions that are -- 20 percent were African American, and 10 percent American Indian/Alaska Native, and about 3 percent other.

The most frequently used substances were alcohol, marijuana, cocaine, methamphetamine, and heroin, which I think is increasing everywhere at this point in time. Treatment duration, the interesting thing about this is PPW has had tremendous success with this. About half of these women were in treatment 121 days or longer, which can only be a better thing for them.

The next few slides are going to be talking about some of our ideas for future directions, but as Sharon said, we also want to hear from you about what we're talking about in terms of expanding this program. It's a family -- what we call a family-centered model that we use in PPW. And basically, we want to expand it to States, and we want to expand it using evidence-based practices and also finding out how can -- how can we leverage the financing that's out there to provide the services that make a difference for this group?

So these are some of our questions. So, basically, we're going to use this analysis contract I mentioned previously to do a State-by-State environmental scan in terms of trying to figure out what kind of family-centered programs are out there already? How are they being financed? What sources of funds are being used by States, territories, and tribes? How do they use the block grant? What

other funds do they leverage for this?

Basically, we also want to know what are some of the needs that these States and territories would say are needed by this population? What kind of disparities are out there that should be addressed? We also want to look at the current costs in the various locations.

Here in SAMHSA, we've developed for PPW in particular a 2-year work plan heading towards 2017. And basically, that work plan has three phases. But so it basically has a lot of steps that we're trying to take between now and then that will help guide and develop that new RFA that we've put out for the 2017 cohort.

So, so Phase 1 of the work plan, that's where we're looking at the existing PPW grant programs we use in the analysis contract, looking back to see what is out there? How is it being funded? How is it working? What are the varieties of family-centered models that are out there?

We will also be doing a financial analysis on a sample of States. Clearly, we're not going to do every State, and States are different. But we're going to try to come up with some kind of scientifically meaningful way of sampling these States and looking and seeing what they're doing, and we're also going to try to get input from those States we contact to find out what they think a family-centered approach should be.

Phase 2, one of the things we're doing, you know, also in the Division of Services Improvement, we have an initiative that many of you probably are familiar with, the Addiction Technology and Transfer Centers. And what we've done, there's an RFA right now out there to establish a Center of Excellence for pregnant and postpartum women. And the responses to that are due I think it was May 11th.

But basically, only the ATTCs are eligible applicants for this, and what they'll be doing is one of the things for sure they'll be doing in the first year, they're going to look and see what's out there already. What are the evidence-based practices? What is available?

And they are going to actually create a clearinghouse for these PPW-related materials that, hopefully, will be able to be -- you know, it's going to be available online, and hopefully, they're going to also do some training face-to-face, like they always do. They do a lot online, but not everything is online.

They will also be creating toolkits for these evidence-based practices that can be disseminated so that this can be spread to a larger, much larger, you know, part of the U.S. population.

Phase 2 also includes convening of a policy academy, which will develop a blueprint for adopting a PPW family-centered approach at the State, territory, or

tribal level.

Activities in Phase 3 of the work plan is to develop new or strengthen existing collaborative partnerships with Federal agencies to assist in the implementation of family-centered approaches at the macro level.

But basically, that's where we're heading, and hopefully, when we get finished with this, I know Kana will be coming in momentarily, very soon. But we definitely want some input on what we're thinking about this and how we might best go about it, and have we not included something that we should be including?

So, please, you know, listen to the questions and help us with this because, like I said, this is a terrific program, and we want to share it with more women and their families.

Thank you. And --

[Applause.]

MS. SHARON AMATETTI: Well, thanks very much, Andrea. Until Kana gets back, I'll help with the discussion. So if you could put the first text slide up?

But first, I wanted to ask this audience, how many of you are familiar with the PPW program?

[Show of hands.]

MS. SHARON AMATETTI: Okay. So a few of you, essentially. And how many people have had a PPW grant program that they've been connected with in some way?

[Show of hands.]

MS. SHARON AMATETTI: So two. Okay. So maybe you can also help us with this discussion somewhat more robustly as well.

So Andrea gave you a quick run-through for those of you who aren't so familiar with the program about what the expectations are, and I'm not sure that we actually said, but it's a residential treatment program. It's a comprehensive, residential, long-term treatment program for women and their children, where children can come into residence with the women. And I'm not sure if she actually included that in the slides. So that just got left out.

So it's a very intensive and expensive, expensive program, and it serves the women that are participating in it very well, we think. We've had very, very good

outcomes from most of the programs in it. But, so for the Advisory Committee on Women's Services, we've been talking about how do you reach more people with what you -- how do you spread what you're trying to do so that more people can benefit from it, from what we've learned?

And now here we are, 22 years into this, and we're asking, you know, are there things that we could change that would enable us to really transfer this knowledge more broadly? Are there things that we could change so that States would be in a better position to pick up the programs after they've been supported by us so that they have a longer reach?

What are the things that we need to learn from the States about their needs? Financing is changing. Do we need to change this program to respond to financing changes? These are the types of questions that we are really struggling with, and we want to use our dollars most wisely.

Andrea talked about that our dollars really are just a drop in the bucket, but we have other goals in terms of transferring knowledge. Andrea talked about the Center for Excellence, how can we use that to transfer knowledge so that more States, communities, programs can benefit, and ultimately, women and families can benefit?

So that's really where we are in our center. We're trying to get our head around that. And because you all have roles different than ours, here we are in a Federal agency, we want to hear from you about what your experiences are, if there are things that you can recommend to us to look at. We're going to be talking to other audiences as well, the same, similar types of questions. Help us. Help us figure this out so that the next iteration of this program is where it should be going, the direction we should be going.

The Advisory Committee on Women's Services got these questions in advance, and I hope that you've had a chance to look at the RFA, to look at the authorizing legislation because there are some -- there is very clear things that we need to do. This is not just what we want to do only, but there are things that we need to do, and that relates to what's in our -- what's authorized. And then what can we do, and how can we build on it?

So I'm going to open it up. I don't know if maybe any of the two of you who have had PPW programs want to just start by saying something about your experience with the program? Reflections, what would have made it easier, better? Keep it just exactly the way it is. Anything to that effect, I'd invite those of you perhaps to start.

FEMALE SPEAKER: Could everyone say their name, please, so I can get it for the record?

MS. SHARON AMATETTI: Could everyone say your name before you speak? And do we need them to go up to the microphone for people on the phone?

[Crosstalk.]

MS. SHARON AMATETTI: And do we have any -- Josh, do we have any portable mikes at all in this room? No, we don't. So I'm sorry, but if you could go up to a --

FEMALE SPEAKER: There's an empty seat next to a microphone. Yeah.

MR. ARTHUR SCHUT: Hi. I'm Arthur Schut from Denver. And really, Karen Mooney can tell you everything about what we did. So --

[Laughter.]

MS. SHARON AMATETTI: Just please speak a little loudly.

MR. ARTHUR SCHUT: Yeah, I think since 1996?

MS. KAREN MOONEY: '93.

MR. ARTHUR SCHUT: '93 -- it predates me -- we've had a PPW grant. We had an additional one that ended, I believe, in 2014, and we currently have another one right now. And I think that it has sustained itself, that we've sustained it as an organization. We have space for 16 families, 16 women and their children.

We have a [inaudible] childcare center in our facility that we operate. So we operate a school for the kids. And I think my current concern is what happens to our ability to sustain it as more and more payments are perceived to be provided by Medicaid? Because it's a residential treatment program, it's beyond the exclusion, and so therefore, Medicaid cannot pay for it.

And currently, we receive funding from TANF and county funds and, in some instances, actually commercial payment, although that's somewhat limited. So that's length of stay. And we have lots of private donations. We actually have an organization that has a foundation as well as a service delivery portion, and the foundation raises money. And it's a lot easier to raise money for women and children than it is for men, frankly. And really children.

So that's helpful, but my long-term sustainability issue is that the county is currently paying for it out of the county dollars because Medicaid was not paying for that kind of thing. As the perception is that Medicaid pays for more and more, our concern is that we will lose the county general fund support because they're anxious to offload their obligation into that.

I'd be glad to answer questions if anybody has, and Karen can add to my comments.

DR. CAROLE WARSHAW: What would it take to change the Medicaid's ability to fund those kind of programs?

MR. ARTHUR SCHUT: Pardon me?

DR. CAROLE WARSHAW: What would it take to change the Medicaid's ability to fund those kind of programs?

MR. ARTHUR SCHUT: Changing the Medicaid actually takes an act of God. I would say it requires a Congress united in their focus and function and --

DR. CAROLE WARSHAW: It's not any rule, though?

MR. ARTHUR SCHUT: It's in the rule that when Medicaid was passed, there was a concern that States would need Medicaid dollars to fund their State hospitals, and so they stuck this provision in the law itself. And changing it actually involves opening the law and redoing it, and no one has the will or stomach for doing that. And as concerns develop, what happens there?

And for decades, we have tried to find multiple ways to get around this, and that effort is not ending. And maybe someday we'll have a way to get around it, but right now it doesn't exist.

MS. SHARON AMATETTI: So I have a follow-up question for you then. So in light of this question, do outcomes matter? Does it matter if you're able to demonstrate that you have certain types of outcomes, or is that really a moot point because Medicaid is not going to pay for it?

MR. ARTHUR SCHUT: I think outcomes matter in general, and in particular in the context of the ACA, you know, you have health outcomes are tied to a variety of pieces of the healthcare system. So the fact that we enhance health outcomes, I think, is to our advantage, and we're clearly doing that not only for the moms, but also for the children. So there's a huge difference, and we connect folks to primary care that didn't have primary care connections before. We're doing a variety of things like that.

So the outcomes, I think, matter. Clearly, the people who receive the services think it matter. And there are a variety of other entities that think it matters. It probably matters to Medicaid, but Medicaid is in the spot where they really can't - can't change it.

MS. KAREN MOONEY: It's almost as if they -- this is Karen Mooney. It's almost as if the PPW program serves up the ball in a game of tennis. It serves it across

the net, and if the State is going to smack it and hit it back, we have to figure out how we're going to get funding from the State general fund, other funding sources to maintain and continue the game of tennis.

Unfortunately, it's been kind of an ace a lot of times, and we haven't been able to hit it back because either we haven't had the political will to sustain a program like that. It's not glamorous and sexy in the eyes of the public. It's much more fun to focus on scary things like the methamphetamine epidemic and that kind of stuff. We've got a good, solid program that has 16 beds. It doesn't benefit a huge number of people that, you know, just in terms of numbers.

So it's been very difficult to get the backing from the legislature. Actually, we're writing a decision item to request the kind of funding that it takes to sustain a program that's not cheap over time. So I think we will eventually be in the position of being able to hit the ball back because we're getting enough data over time from this program, but it really takes a lot longer than the term of a politician to see the kinds of outcomes that we get to make this actually work.

DR. CAROLE WARSHAW: Are you getting long-term outcome data for kids that could, over time, make a difference in terms of trajectories?

MS. KAREN MOONEY: The problem --

DR. CAROLE WARSHAW: Yeah, and the other question is will the ACA start to pay for some of these programs?

MS. KAREN MOONEY: Perhaps. Perhaps not. It all depends on individual -- like if we were talking about private insurance, then it depends on whether private insurance will pay for them, which, as Art has said, you know, is typically not the life of the program for somebody or an entire episode of care. We also then don't have enough children that are served to be able to look like a robust children's program, although now since 1993 a number of kids have gone through that program.

Our State data system is also not such that information on families is collected. So we have admission and discharge data on individual people who receive treatment as the identified patients, but there is no electronic record that goes along with the services that are delivered to the children. So they're essentially invisible to us at the State trying to make a case for the funding for this program.

So that's part of the reason that I get all excited about data and finance stuff is you can have the most glamorous program in the world and the coolest programming, but if it's not captured in the data and you don't have a way to bill for it and track the services that way, then you're stuck. And I think we're getting there, but we're not there yet.

DR. DAN LUSTIG: Yeah, thank you.

I'm an old PPW grantee, and I just want to briefly mention that as a program, it is truly the most comprehensive approach to addictions and mental health treatment for women. I think outcomes is really, really critical because that's what's going to help shape the argument on policy.

I do think, though, when reviewing the outcomes, it's not just taking a look at family-based outcomes, but also tying it to children. How the recovery of women has improved the lives of children. And I think that's a huge argument to make and an important argument to make.

I think the cost of the program is something that has to be looked at over time with the data by quantifying what parts and pieces of this program is the cost behind it. Because that appears to be the number-one question that funders have, politicians have is cost. I took all these notes, I'm sorry.

I think it's also trying to ask the question about why is it that residential treatment is so important for not just women, but women and children? And it's hard to get your arms around that because a lot of the data in the PPW program is geared toward the women and women's outcomes, and it's linked to the children. And I think it's important to look at that.

I think another discussion around the PPW model is that this ACE model would go a long way. I think right now, it is not in NREPP, but there are miscommunications around other family-based models. Like if you look on NREPP, HRSA has a model for family-based treatment, and I think it's going to be important to be able to package this. Over the last 22 years or 20 years, there has been lessons learned, and there is a real core group of principles that make up the PPW program. And I think that really needs to be packaged and educated around.

DR. ANDREA KOPSTEIN: Well, hopefully, the Center of Excellence is going to do some of that, you know, to help head in that direction because NREPP also includes promising -- you know, not everything is EBP. Some of the things that are in NREPP are promising practices, and those might be important.

But I think one of the things, you know, I'm looking at this Question 1, thinking -- and you've started to address it, but I think one of the things that would be interesting for us is we are going to look back and say, you know, the ones that have sustained it that don't have existing PPW grants, what have they sustained and why? What have they kept? What have they valued enough to keep it going?

And basically, I think we're thinking we also need to identify what are some of the critical components? If you can't have the Cadillac, what can you have that

would make a difference?

DR. DAN LUSTIG: Exactly. And my last comment is, honestly, I have never in my 25 years of working in this field have ever worked with someone who is more passionate around this than Linda White-Young.

DR. ANDREA KOPSTEIN: Yes.

[Applause.]

DR. DAN LUSTIG: I just had to say that. So --

DR. ANDREA KOPSTEIN: Absolutely. That is -- that's -- that actually made a huge difference for SAMHSA and for this initiative.

MS. SHARON AMATETTI: Could you just state your name for us, please?

DR. INDIRA PAHARIA: Sure. Indira Paharia, with CSAT.

I just wanted to make a comment about an outcome you could measure that would have also a financial justification. And that's you'd have to do it at a population level, but it would really be the avoidance of NICU cost, NICU costs. And those are the huge dollar costs for babies who are born to mothers who are addicted. Those babies go right into the NICU.

And this is a huge medical cost, and oftentimes, it's \$1 million per child. So, but you would have to look at it as a population, pre, post, and forward. You know, it's a little complicated because I know you're talking about a small sample size here, but I think what you're doing, this program has amazing potential, but just to look at the medical side where you could really have huge dollar savings.

DR. ANDREA KOPSTEIN: That makes sense. I know sometimes we've -- you know, we work sometimes in conjunction with NIDA or other NIH institutes, and sometimes, you know, they will also work on things. It's not a quick answer. But you're right. I mean, there could be, like you say, also the negative side, like you're avoiding -- like not just the positive things, but what are you trying to avoid?

DR. CAROLE WARSHAW: The costs of child welfare, incarceration, you know, people being in the system. If you had an economist that could do that kind of analysis, then you might be able to show the potential impact in many ways.

MS. JEANNETTE PAI-ESPINOSA: The other data point, and I work -- my agencies work primarily with girls in the child welfare system, juvenile justice around substance use disorders, who are young moms. Many who aren't, but many who are. And one of the things -- and we provide residential programs,

and I would love to have this kind of -- we don't have anything like this in terms of guidance or legislation.

One of my thoughts is I don't know if you are already or if you can collect data on sort of generational, you know, are you breaking generational cycles for families? So was the two generations before same situation as the mom that's in the PPW program, and you know, where are her kids going to be?

Since the program is so old, I'd imagine you might be able to, I don't know, collect some of that. But that's something that we've been asked, where it shows the money, right? Not really show us the money, but show us what's the measurable impact, and it's really difficult, especially with this small amount. But I think that's one place where if you have any level of data about how these are breaking generational cycles, I think that would be pretty significant.

The other thing that strikes me is same conversation is going on in child welfare and juvenile justice about residential placements and residential treatment. And so, in our -- I don't know if it's possible. I don't know what the barriers are in terms of rules and legislation, but it would be interesting to see whether there's a way to do a pilot or something where your PPW has a site that's working in cooperation with child welfare on a State level so that you have blended funding to support young moms and their kids who are in care.

Right now, you know, young moms and their children staying together is obviously preferred but doesn't always happen. So that's a possibility. And juvenile justice, too, in terms of young moms in both those systems are really invisible and don't have any support. Or if there's a way that you could get them as they're older. So maybe they're 17, and then they come out when they're 18, and they can move into a longer-term program.

So, I mean, that's really where we see the highest instances of their kids ending up in the system and addiction and poverty and the whole thing. So that, for what it's worth.

And then, lastly, there is a whole -- there are a lot of philanthropists. I know the Federal Government is getting involved in this conversation around two-generation approaches to ending poverty. But it also includes health, also includes all the things that are in PPW. It's a two generation. You could say it's a whole family. But they might even be interested in supporting filling the data gaps, particularly, you know, whatever you find after this teen comes in to do the things that you said onsite. I can't remember.

Specifically, there's just a lot of momentum around it, and it really is how do you - - how do you equally support two or more generations to end these ongoing cycles of poor health, poverty, the violence?

MS. SHARON AMATETTI: Andrea, could you put the next slide up? Thank you.

DR. ANDREA KOPSTEIN: Sure.

MS. SHARON AMATETTI: Those were really good insights. So one of the questions that we're asking ourselves is how the PPW grants, how are States, communities providing the services, or what could they do to implement them? Your thoughts there?

So over 23 years, not 23 years, but we didn't go back quite that far, but since 2003, we've had 101 grant programs. And if you remember that slide, a third of them are in California and Florida and maybe a New England State. So all of the rest of the communities and States, what can they do? What have they done? We know there is residential care for women and children without our funds, but we don't know that much about them.

MS. KAREN MOONEY: Well, for us, there really just isn't. The funds that we have available through the block grant, the women's set-aside has funded -- have funded two of our residential programs for women and children. And then there's one that's funded primarily with a county contract and another one that's funded primarily with the criminal justice contract, and that's it. So we have a total of five.

MS. SHARON AMATETTI: And if you could state your name again?

MR. ANDRE JOHNSON: Sure. My name is Andre Johnson. I can speak from the provider's perspective in Detroit. We really don't have an intuitive program in that community. I know there was once funding through CSAT. One agency was funded many years ago, and currently, what happens in our area is a State has a pot of money for women specifically, and those dollars are tied to women who do not have health insurance. So in most cases, the women are insured through Affordable Care Act.

And so, when I talk to my colleagues, a lot of them want to stay away from women and children programs because of the liability costs that are associated, and it's just a huge cost to really provide a strong program. That's one variable told to me. So I think there certainly is a gap in those services that needs to be strongly considered, and historically, the funding stream just hasn't been able to really sustain the services.

MR. ARTHUR SCHUT: There are a couple things that I think are -- so if I think about our organization opening another one, we have sustainable -- at this point, sustainable funding for service delivery and continuing it. I think one of the biggest issues is financial challenges, is actually capital. I mean, the capital to create the beginning, the space and all those kinds of things.

And frankly, what Medicaid provides, if Medicaid would ever fund it, what they provide in reimbursement is not enough to create the capital to set the space and hire people to begin to let them do those kinds of things.

Venture capital now has entered into substance use disorder treatment services, but clearly venture capital is in there because they believe that they're going to make a lot of money on a certain population that has to do with reducing general hospital costs and those kinds of things. And I'm not aware of anything that's capitalized in terms of this kind of program with venture capital.

And then workforce is a huge issue. There's just not qualified workforce, and specifically where you are right now, there was a recent funding of mental health crisis centers, behavioral health crisis centers, and they hired 800 new clinicians -- well, they're trying to, this one year alone. And if you look at that and you look in the marketplace, it's very difficult to hire qualified people who are dually credentialed in both substance use disorder and mental health services.

DR. ANDREA KOPSTEIN: Does anyone know? I can say that this Center of Excellence, that is workforce training. But also I know we have another initiative in my division that is new this year. It's called a Minority Fellowship Program, which is providing stipends. But you know what the issue was, is how many universities actually have advanced training in this field? It was kind of not exactly good news to find out about. It's not really as available as you'd like to think it is. So that's part of it.

Do you want to go to the next question, or do you want to stay on this one?

MS. SHARON AMATETTI: We'll just -- one more comment. Anita?

MS. ANITA FINEDAY: Just one comment. This is Anita Fineday. So everybody knows that Section IV-B of the Social Security Act is what funds welfare in the country, and what you may not know is that more than 30 States have waivers, IV-E, and that there is a move afoot to have permanent Federal finance reform of IV-E.

And a lot of people that I know, they believe it can really happen in this current legislative climate that we have. They do think that permanent Federal finance reform is going to happen, and the big push is for IV-E to fund prevention. And so, it seems like this would really fall in the prevention of placing children in foster care. So it could conceivably, if the numbers stay the same, you know, qualify for 50 percent funding under IV-E.

Don't know what that permanent Federal finance reform is going to look like, but the waivers are mainly laboratories for showing the kinds of things that are successful. So that should be on your radar.

MS. SHARON AMATETTI: And a couple of people have mentioned important collaborators and opportunities for financing that's helpful to us, and we need to think about that probably. We haven't really spoken about whether there is -- whether it makes sense for us to look at a mixed model of residential and then outpatient programming, somehow connected. Did you want to speak to that?

MR. ARTHUR SCHUT: I did mention that we track people to outpatient and provide outpatient services subsequent to the residential portion.

MS. SHARON AMATETTI: Has it impacted the length of stay, the stay for residential care in any way?

MR. ARTHUR SCHUT: Well, our length of stay shortened a little bit. I mean, one of the realities, which I'm sure you all know, is we all ration care because there's just more people than there is -- there are resources. So one of the ways you ration care is you shorten length of stay, and then you can serve more people because you shorten the length of stay.

If you do everything ideally, there are just huge numbers of people who could get no services at all. Is that the way I'd like to do business? No, but I've done this for decades, and it's pretty much the same now that it has been. So the rationing is part of our normal existence, and it's what we do. And there's no public policy about rationing. It's clearly pushed down to the level of providers.

But we do outpatient. We continue to do outpatient. We've done a number of things around connection to primary care using navigators. We actually had some assistance in that in our last PPW grant.

MS. SHARON AMATETTI: And have you looked at any differences in outcomes as a result?

MR. ARTHUR SCHUT: Not that I'm aware of. We have a -- we did when we had the grant piece that paid for a research piece, and we have a research department in our organization that does evaluations of SAMHSA grants as part of the Clinical Trials Network for NIDA, those kinds of things. But good research is expensive to get right.

MS. SHARON AMATETTI: Did anyone else want to comment before we go to the third question?

[No response.]

MS. SHARON AMATETTI: So this question basically says understand that we have legislative requirements. If there were no requirements, would you recommend any changes or alternatives to the model as it presently is outlined?

MS. KAREN MOONEY: I think I would look at a more robust connection with primary health as having it being a requirement of the program so that women are really set up to be able to care for their own health and for the health of their children, and they are fluent with being consumers of healthcare services.

MS. SHARON AMATETTI: Linda, I know that's been a passion of yours. Do you want to comment on that at all?

MS. LINDA WHITE-YOUNG: I think she said it beautifully.

MS. SHARON AMATETTI: Okay.

[Laughter.]

DR. DAN LUSTIG: Well, one thing I want to kind of piggyback on what Karen was saying is that I don't think the model does a good job at understanding addiction as a chronic relapsing condition because once a client moves from this into the community, as the gentleman over there said, you know, having treatment extenders, recovery coaches, those people working in the community is something that would be really, really an important piece to add to the model.

Just, and you can look at it, because I always like to -- you can look at this as recovery checkups. So just like people are required -- or not required, but should have a physical done once a year, it's constant kind of recovery checkup once they're in the community that really prolongs recovery. And we have strong evidence to show that. We have outcome data for that. We have 17 years of outcome data on that topic.

MR. ARTHUR SCHUT: If I might comment just about that model? And I don't know if this is true in every State, but most States have a system that's actually somewhat related to the data that you all collect. That when people aren't in for a certain period of time, they get discharged and then get readmitted and then get discharged. And so, having a primary care kind of model where we check in with people is really onerous in terms of the data collection and all the kinds of things that you have to do with people that makes it very difficult, frankly, to operate like the rest of the health system.

And as does some of the prescriptive pieces of State licensure in most States for the amount of information, psychosocial history information and all sorts of things you gather, for which there, frankly, is not that I'm aware little evidence that it is useful or helpful. And one of the challenges is being efficient in a system where everybody else has their own problems in terms of the rest of the healthcare system, but frankly, they don't have the kind of problems that we do in terms of how much our professional activity is prescribed externally.

And I think it largely dates to when most of the workforce was para-professional,

but we had generated enough information that it could be reviewed by a professional and we could become much more professionalized. And the challenges were saddled with a very huge amount of bureaucracy and administrative tasks that make it very difficult to do this kind of a check-in that you wouldn't do your primary care practice because you would have to reinstitute admission if it's been a certain number of days, et cetera.

I know it sounds odd for me to ask for regulation relief, but regulation relief and data relief. I mean, there are a lot of things that would be nice to know. It would be nice to have a conversation about what the essential database should be and then how we get high-quality data that have fidelity to run a few measures as opposed to I believe NIDA has 90 questions, depending on which tree you go down in terms of collecting information. So --

DR. DAN LUSTIG: There -- I agree that there is a lot of mechanics in doing recovery checkups, but NIDA has done a really good, rich project, these recovery management checkups, and has a model that's already been built, and that comes out of Chestnut Health Systems. But it will take a different look at how to do systems. It's not -- I mean, I think this is what is critical right now is that we are in a time of change, and I think this model certainly does not have to be reinvented since it's already done.

But I do think it can be tweaked, and NIDA has done a lot of publishing on recovery management checkups. So there is a clear model to use with that, and we've used that model in my agency for a little over 13 years. So it takes a different kind of approach to it.

MS. SHARON AMATETTI: Kana joined us. Happy to have you here. So I'll give you an opportunity to comment.

MS. KANA ENOMOTO: Yes, I apologize for being late. I had gone over to meet with our SAMHSA Tribal Advisory Committee, and so as one does with tribal leaders, you stay until the session is over. And so, that was a very robust and interesting conversation about historical trauma and what SAMHSA could be doing better to address the needs of tribes, and it went a little bit over time. So I apologize.

This was a topic that I wanted on the -- on the agenda. So it's a little bit of unfortunate pairing of agenda items because this is an important issue for SAMHSA. It is a big program, both the PPW program is a storied and important part of our portfolio, but as we were talking with the ACWS earlier today, the opportunity to influence what is funded out of the women's set-aside I think is an important one with the block grant.

And understand what pieces of PPW can or should be transported elsewhere and where are there opportunities for more of a multiplier effect so that we can

ensure that every woman who is struggling with substance use disorder can have a safe and healthy pregnancy and have a healthy baby, healthy birth outcomes. That is our goal to save lives across the country, not just for the people who are in the PPW program.

Obviously, we want that, but we also want to -- we want -- SAMHSA has an obligation and a role to improve birth outcomes for all women who are struggling with substance use disorder and are pregnant, and that's where the genesis for this conversation came from and some work in the substance use treatment to do sort of a 2-year look forward in terms of what are the pieces that we need to do?

Dan raised earlier and PPW is not on NREPP. So what's the -- what are the steps that need to happen? Should it be on NREPP, and how you do that, and what are the steps to go through? And that's really in our -- that ball is in our court. And so on.

And you know, I think there's a lot that can be done and that we're going to do as we have support of this really great model for so many years. So I will definitely catch up with Sharon and with the rest of the members and the leaders that are here to catch -- to get the nuggets of wisdom that you guys have provided to us. I'm sorry.

Thank you.

MS. SHARON AMATETTI: Thank you. Thank you.

DR. ANDREA KOPSTEIN: All right.

MS. SHARON AMATETTI: Thank you, everybody, for your good, thoughtful comments. Appreciate it.

[Applause.]

[Off the record at 2:59 p.m.]

[On the record at 3:14 p.m.]

MS. KANA ENOMOTO: Okay. So I think we're ready to get back. We have all our members here. Thank you very much. And I got my group update from Nadine. She says you guys contributed greatly to the conversation. So I'll look forward to reading the minutes and see what you all had to say.

So we have right now we're going to talk about high-risk/high-need girls and young women, which this is an important issue to me and I know many of you, and that's why we have -- I don't know if some of you have been tracking the ACWS over time, but we had an almost entirely adult-oriented panel of members

a couple of years ago. So there's been a concerted effort to bring on more people who understood adolescent girls and women and their issues.

So I think it's really been a challenge for us, particularly on the prevention side. I think we've done a better job with services, both adolescent treatment and kids with SED. We've done a better job of looking girls and young women. But, and but on prevention, I know we really, really fall short.

But I'm excited to hear what Jeannette has to say and what Rosalind can help us think about today.

Agenda Item: High-Risk/High Need girls and Young Women

MS. JEANNETTE PAI-ESPINOSA: It's late in the day. My friend Carole just gave me a chocolate-covered almond. So I'm ready to go.

[Laughter.]

DR. CAROLE WARSHAW: Would anyone else want a chocolate-covered almond?

MS. KANA ENOMOTO: Carole left some blueberries over there, too.

MS. JEANNETTE PAI-ESPINOSA: Sweet and savory. So thanks for this opportunity. I was supposed to do this in August, and I was stuck in a plane coming back from Mexico. So I kind of wish I was there now.

So I'm just going to -- what I'm going to share with you is really information on the use of the Adverse Childhood Experiences survey on our agencies that was done a couple years ago. And so, really we're interested in administration. I'll talk about that at the end. We did some things differently for the first time, and I could share some of that and some really preliminary results from that.

So this is our mission. Advancing the self-empowerment, health, economic security, and civic engagement of girls and young women impacted by violence and trauma. So we're 132 years old, as the national umbrella, and our agencies' average age is 118 years old, always serving women.

Now most of our agencies serve boys and young men, too. But what kind of binds us as part of -- what binds them to us as this family of agencies really is the support services to girls, young women, and women. We serve girls primarily who are impacted by the child welfare system, the juvenile justice system, homeless and runaway youth, [inaudible] and survivors of trafficking, girls in the intensive mental health support, substance use disorder. You name it.

The average number of placements they've experienced before they come to a Crittenton agency is 7 to 15. That could be in the child welfare and the juvenile justice side. So all just to paint a picture that, you know, we're talking about young women who have faced a lot of challenges in their life, primarily really through no fault of their own, but rather more as a result of the families and communities into which they were born.

So the pilot use of the ACE, and I just realized as I was sitting here today that we actually learned about the ACE and that Dr. Felitti at the Federal Roundtable on Women and Trauma. And so, we had -- I brought with me another staff person from the national and four or five executive directors. And one of the things that we've struggled with over the years is so there are 26 agencies, and the smallest annual budget is \$900,000 and the largest is \$121 million. So there is this huge diversity of settings, service array.

About 60 percent provide some level of residential, residential treatment. Some, in addition to that, do transitional housing, and some do some emergency shelter work. And so we struggle to figure out so given that diversity [inaudible] and that was one of the reasons when we looked again at the ACE, it really seemed to be something that would help us to define the population of the young women with which we work.

So this is just some background on the first -- the first two. We found out about the ACE, and right away, that group of agency directors wanted to take it right to the full board -- full group of agencies. Soon as the full group heard, we brought Dr. Felitti, and he came and shared more about it.

And they said, well, let's do it. And we said, well, when, and they said in 2 weeks. So we said, well, not 2 weeks, but maybe 6 weeks or maybe 2 months. So their choice really was to not focus a lot on protocol and perfection, just to do it. Figure out what we learned from it. And then do it again with, you know, implementing the lessons learned.

So it was about 6 weeks from the time we met with Dr. Felitti to when we closed the survey. We received about 1,477 questionnaires from 20 agencies in 20 States. So we did do it with males and females, but obviously, the larger share, 67 percent, of the respondents were female. The lion's share, almost 60 percent, were 13 to 18 years old. But really, the bulk of the girls that we serve are 15 to 17, but both it can be as young as 10, and that's not as -- 10 as clients coming in individually. So not children of consumers.

Forty-eight percent were youth of color; 43 percent were white. The largest group were African American at 24 percent. About a third were pregnant or parenting. Our pregnant/parenting programs are smaller. So the numbers tend to be -- tend to be a little bit smaller. Forty-three percent received residential

services or received services in the residential programs or treatment.

Our agencies, we have PRTF. So psychiatric residential treatment facilities, but we also have residential programs where they provide mental health services, but they don't require a diagnosis for admission. And that's a lot of our mother/baby programs. They may leave with one, but they don't come in with one.

Forty-eight percent receive services in school, in community-based settings. A lot of that was in school and after school. And 36 percent were not referred by the juvenile justice system, but actually 36 percent were in the care or custody of the juvenile justice system or the child welfare system, which is then delegated to our agencies.

So a general overall, we know generally we did a lot of comparing girls to boys, but this is just a quick snapshot of where the girls compare to the boys in terms of these would be their ACE scores. And I'm assuming everybody is familiar with the ACE, the 10 items? So 1 on the left and 10 being on the right.

So this was -- these are our results. So we compared the results to the national CDC study that was done in the 1990s. Fifteen percent of women having a score of 4 or higher. If you look at all, all the girls that were surveyed through our agencies, that was about 916, 53 percent had a score of 4 or more, 5-plus at 42 or more, and 3 percent had a score of 10.

So you can see the progression up, right? Girls referred by the juvenile justice system, 62 percent with a score of 4 or higher, 4 percent with a score of 10. Girls in foster care, 50 percent.

Now one of the caveats is that there is a significant degree of underreporting. So in doing the administration the first time, the agency said it'll look at a lot of girls are reporting a zero or a 1 or a 2, when even to get here they'd have to be a 3 or a 4.

So that led to some analysis of that in terms of so if you do -- if you administer it at intake and then you do it 6 months later or 3 months later, you're going to show a higher score because there's more safety and comfort in people. Young women are going to be more willing to share their score. So some of the agencies now have implemented, along with their other battery of clinical assessments and tools, this along with it.

Young mothers, particularly a large in the numbers for young moms. You see all young mothers, about 250, 61 percent with a score of 4 or more, 48 percent 5 or more, 4 percent 10 or more. And then juvenile justice highest, 74 percent score 4 or more, 69 percent 5 or more, and 7 percent 10.

And then young mothers in the child welfare system. And these may be girls who are in foster care or who are getting family support through the system. So 63 percent, 48, and 8 percent. So, clearly, compared to the national study and to some of the other community-based studies that have been done, you know the numbers are really off the chart.

So this is a group of women that are working with us on, I had mentioned it earlier, the app. It's part of the BOLD program. So we work with this group of women whose average score is an 8 and asked them the simple question. So what would you build? So you leave an agency. Let's say you leave a residential program. So highest level of care you receive, a residential program.

You may be 17. You may be 18. You may have one child. You may have two children. And then what happens? They feel like they've stepped off the edge of a cliff. So what I'll talk about later is what they'd actually build.

So we asked them, you know, what did they feel like they needed to heal and thrive, and we looked at two -- two women with very different trajectories. Tanya is on the left. She's 35. And Ashley on the right, who's 20. Tanya has -- had her first child when she was 13. She has four children now. And Ashley does not have any children.

And we just asked all the women in that group and then some additional women. So from your perspective, now that you're out, you have a little bit of distance, you know, what worked for you in the environment? We didn't say it wasn't the treatment, just that what worked for you? What do you remember? What do you retain? What do you use? And in the cases where we have moms, you know, and so what did you learn in that environment that helped you be a better parent, above and beyond the parenting skills?

So Tanya's response was it was a homelike environment. It was residential, but it was a homelike environment. There was -- we talked about relentlessly high expectations. She talks a lot about learning to dream and to have a vision of her life that's different. These are now things that you all well know. But a positive environment, calm, warm, welcoming, acceptance, compassion. People who really care, nonjudgmental.

Just the simple idea of being valued and having value. "My life has meaning," which then means "I can think about the future and that relationships are the most important to me." And she said, "You know, I thought relationships were the most harmful thing to me. And actually, I realized when I was there that they were the opposite."

So Ashley, 15 years later, very, very similar. You know, one of the constant themes is trusting the staff to walk the talk, and a really interesting articulation on their part of the -- they don't call it this, but the vicarious trauma that they saw

coming out in the staff, and that they were in settings where that was addressed and they were in settings where that was not addressed. And that they didn't imagine they could heal in an environment where there was all this trauma flying around between staff and not, you know, pick that up.

So, I mean, I think it just underscores, as you all know, the importance of, you know, emphasizing a set of core values that dominate the organizational culture. We can call that trauma-informed, but in the end, it's the consistency that they lacked for so long.

All staff being trained in how to maintain a caring and compassionate trauma-informed environment. Supporting staff in dealing with vicarious trauma and helping staff to address their own biases about girls.

A lot of conversation about, you know, staff that don't like girls. You definitely hear this a lot at juvenile justice, but you don't like girls. They're dramatic. You know, on and on and on. They're moody. And then they pick that up, and are really clear. Their first qualification to work with girls is that you should like them.

[Laughter.]

MS. JEANNETTE PAI-ESPINOSA: They're very -- you know, very true. They are hypersensitive, I think, to nonverbal cues in their environment, given their -- the skills that they developed to survive, right, and adapt. And I think that many folks don't really think about that. There are just some facilities that have great programs, and I'm sure you have all seen it, too, but they are the most depressing places to walk in the door. And I think that they're really, really clear about what they need in that aspect.

These are the core values that they named with number one as important. They're not in any kind of numerical order. But humor is really important to them. Obviously, patience both with them and -- how do they say it? "They need to be patient with us, and they need to be patient with themselves. We're not easy. They're not easy." And if we don't understand that, we're all going to lose out.

Again, the relationship focus, walking the talk, transparency, a real desire for justice and equity, to be part of creating a change in any environment, a real desire to give back, and to feel compassion. And again, the relentlessly high expectations.

So just in doing the training and technical assistance that we've been doing through OJJDP, as well as some other, is it's interesting that programs that are transitioning to trauma-informed, gender-responsive approach really want to focus first on safety, risk reduction, managing girls' behavior, rules and procedures, which from a liability standpoint make a lot of sense. But it's not what the girls remember at all.

And it's certainly not -- it's obviously safety is important, but if you look at gender and trauma-informed assessments and treatment, you would expect that those would be automatic, particularly if you're in the child welfare system, and it is not -- and the juvenile justice system.

So in the absence of the last bullet, focusing on the top four is pretty much a recipe for disaster.

So, again, just the -- just the emphasis from the girls about looking at the cues in the physical environment, shifting the culture from control to collaboration, the importance of clear core operating values and clear expectations for staff. So while all of this exists in numerous research studies, it was interesting for us to see that if you just sat down with a group of girls, they would just tell you the same thing.

And so, really looking at them as partners and leaders for change and giving them opportunities to self-empower themselves to be part of that change I think has been really important. And in our agencies extending what are the kinds of supports you can provide or they can provide for each other once they leave. So over the course of a lifetime.

And again, this just kind of reiterates their core points about relationship with staff that are genuine, caring, respectful, and honest, which does not mean they're going to be my mom or my best friend. It means exactly that. They realize that they can easily manipulate people because, again, that's how they've survived, and they want people that will call them on that, as well as be there to support them.

Also, I think they really are frustrated by the fact that there are many people that don't understand that they really -- they really don't have anyone they can trust. So they may come and see you as a therapist or they may go into a residential program, and that may be the first time they've felt safe to talk or to be who they really are, which we talked about earlier.

Acceptance. In the same way that they really -- up until they get some support, they really don't believe they have value or their lives have any meaning. So talk to congressional representatives, they say, well, what really -- what do they need? And you kind of -- you say, well, they need to believe in themselves, and they need to believe they have value. And they look at you as though, well, doesn't everyone have that?

So that's where the whole, you know, what works and building evidence like we talked about in the PPW discussion is difficult because those forces that are going to be most powerful to change are really very difficult to quantify. So I think that's where we ask them why they don't have hopes and goals. They don't

believe they can have hopes and goals. So they first have to believe that.

And a recognition that their anger and distrust is a natural outcome of their lives, not necessarily is a mental illness. So they talk a lot about "I have anger issues, but you'd have anger issues if you had my life." I'd say, "Yes, I would."

But I think the interesting part about involving them in the ACE is that it has really been very empowering for them. So they look at that data, and generally when I use it in working with the women who either testify for us in D.C. or who have worked with us on program development, it's provided as an educational piece of information that invariably they'd ask if they could take it.

That they, you know, they feel like it's a validation of the fact that they're pretty amazing because they have the score and they're still standing and they're good parents. And they do have hopes and dreams. So it's less triggering and more reassuring, I think, in those instances.

So, but they do get trapped, even absent all that, and I apologize this is really small to read. But I'm going to kind of walk you through it a little.

So we call this the vicious cycle. And this is just something we use because we were realizing that, you know, we kind of have to span the systems of care, as well as poverty alleviation and mental health. And we kept getting trapped in, well, they just need to do this, and you just need to do that, or [inaudible].

So a way to visually say, yes, many of us have adverse experiences as children. If we have buffers, if we have resources, we get what we need. We don't end up here in trauma, where we have toxic stress; you know, that the genetics kicks in; you know, a negative impact on our brain development, which then pushes us into poor outcomes, which all our systems are based around the poor outcomes, right? They're not upstream. They're there.

And then, again, if we don't get support in poor outcomes, we end up in poverty. And this is a cycle that continues for an individual and a family generation after generation.

So if you read research on any one of these quadrants, it becomes clear you actually could escape the vicious cycle based on your own resilience if you have enough support. But not one of these quadrants provides enough support to get you out. So we either have to focus holistically on one or work on all four at the same time. So it's just a model we created to help visualize it.

So, obviously, we have ACE as part of the adverse childhood experiences, but we also look at things like bullying, stalking, cultural trauma, exposure to war, community violence, and then, of course, all of that being compounded by oppression and the intersection of numerous oppressions.

So I think that's it. Yeah, short and sweet. So one of the things we've done with the ACE this time around is we had a committee of the agencies' development protocol. So now there's a standard protocol. We provided training for anyone that was administering the ACE. They are now administering it one-on-one or two-on-one, but not in large groups.

And in addition to that, we've added 7 of -- there are 22 agencies participating this time. Eight of those agencies are piloting well-being domains in the areas of coping -- coping, stress, I can't remember what -- coping, stress -- shoot. I'll think of it. So coping, stress, and -- oh, connectedness. Coping, stress, and connectedness.

So now we're going to be able to look, really look at, you know, the ACE up against the well-being domains, and our goal all along has not been that the ACE is the end. It's the beginning, right? So how do we really focus on the resilience, and you know, over time, over a different array of service settings and for other opportunities to improve their well-being domain.

So we added this time around some of the other factors you see you up there in terms of bullying, exposure to war. We have far more -- I think in this study, right, in this administration we're at about 950 girls. And almost 33 percent of them are immigrant girls, which shocked me. About 10 percent that are trafficking survivors.

And in looking at the well-being indicators, it's interesting because if you look just -- if you look at each indicator in and of itself, so you look at the stress level on the girls, it's actually not very high. They don't report it being very high. Well, again, adaptation, right? But then when you look at it up against the connectedness and the coping, you see obviously stress goes up as connections go down and coping goes down.

So it'll be interesting what happens there. We're working this time around with Dr. Roy Wade, who is a Stoneleigh fellow, but he's also at CHOP, Children's Hospital of Philadelphia.

And in looking at the adverse experiences that are not -- don't happen in the family environment, like bullying, stalking, and I don't remember the other things that he's looking at right now, it doesn't seem to track to the same -- there's a clear differentiation in terms of the impact of those external experiences and the internal childhood experiences. So we'll see what that nets out in the end.

But the BOLD program is three components. Again, this is the brainchild of these women that have come out of the agencies, and so I talked about the app earlier. It really is a caring health community where they come together to provide advice and support.

We're going to link the SAMHSA treatment locator into crisis text line. They'll be able to geomap. They'll be able to see who lives close to them. So if they want to share an apartment with somebody, they could actually geomap who's in their area, send them a message, and then -- and then they'll also have access to women, people like all of us sitting around the table, for resources, advice, and connection.

Then the other -- the second piece is called Quest, and it's really self-advocacy, leadership, and civic engagement. And then a third piece is Circles. It's a poverty alleviation program. So those are all the three pieces they felt like were needed for -- to build a movement to change -- to change the reality of young women and women among themselves.

Yeah, they're pretty amazing. I should have added more slides.

[Laughter.]

MS. JEANNETTE PAI-ESPINOSA: I must have had less time in August. I do talk fast.

MS. ROSALIND WISEMAN: All right. Thank you very much.

I have a question just to start off, but also -- but before I do that, anybody have any burning questions they would like to ask? Or insights, thoughts?

[No response.]

MS. ROSALIND WISEMAN: The one question that came up to me was when we empower these young women to -- at the ideal, you know, the self-advocacy, being able to speak for themselves, be able to speak to people who or be able to navigate around when people are powering over them, is there a thought about these girls in terms of managing themselves when they are interacting with authority figures that are controlling?

One of their values was controlling or -- well, it's right in front of -- controlling over what was it -- to collaboration. So what happens when they're in the residential -- you know, how do we walk or help them through? That could be difficult when they receive something that they think or perceive to be controlling and not collaborative, right, from staff?

So you talked a little bit about staff having maybe a hard time with this, and that we're giving the girls, the women a new framework, you know, based on what they want, and then the day-to-day of they're in a facility, the fine line between this collaboration and control or what they would perceive to be control. And how do we give the women skills to be able to manage themselves in ways that they

are handling themselves well with an authority figure who might think they're talking back to them. Just having an opinion or a disagreement is talking back and is a disrespect of authority.

MS. JEANNETTE PAI-ESPINOSA: Well, I think -- and I think for the most part when they talk about controlling environments, they're talking about prior to coming to our agencies. So I think that everything from communication skills to obviously self-regulation techniques. So a lot of the agencies doing DBT, from anger management and from the sort of very transparent communication core value system, I think.

I've gone into almost all the agencies and even in the pretty restrictive environments, if you look across our agencies, they're still pretty open and flat. So, I mean, there is still a lot of encouragement for if you're feeling -- "I see you're feeling uncomfortable. Can you tell me what that's about?" Versus just ignoring that.

And staff really having, you know, in their own supervision being constantly trained and, you know, brought back to what are the expectations both for the girls, but also for the staff and how they play off each other.

MS. ROSALIND WISEMAN: Questions or connections that people made from the rest of the day to this, to this session?

MS. JEANNETTE PAI-ESPINOSA: I had one thought, and I was having it during the PPW discussion and kind of alluded to it. It's all -- it's interesting to me that I think just a lot of the similar discussion going on here is going on in other systems. But because the girls are younger in some cases and may be in the custody of the State, I don't know how to -- maybe the question is bringing everyone together. Is there a way to bring everyone together so, you know, that kind of the -- it's as though good child welfare and good juvenile justice would help divert them from being in PPW or being in some other program.

But that doesn't happen all the time because most systems have their own issues. So how do you -- how do you come together to reduce the instances of young women ending up as women in deep-end programs for women? And I don't have an answer to that. It's just kind of a constant frustration that we wait until some magic age, and then they can enter this set of programs. Then they leave this set of programs.

So 21 to 24 is a huge black hole, and that's plenty of time for them to get lost again. And I don't know how we can do that, but just want some genius mind here like Carole --

[Laughter.]

DR. CAROLE WARSHAW: You know, I'm just thinking about something that Stephanie Covington wrote about women in close incarceration and what women said would have the wrap-around services they needed to not go back were the same things they would have needed to not go in in the first place. So it's just thinking from the beginning what -- at least to do all the prevention and the services and have things be more coordinated.

And I don't know. I don't have any -- I'm just thinking with the changing landscape of the ACA and medical homes, and are there ways for people to get together and think about what could it look like? Because there are so many pieces and moving, you know, everything is changing, to come up with what would it take at each stage to kind of help change the trajectory of things.

Like one of the things that I know, when Bryan Samuels was at ACYF and talking about this, those who were doing work on those kind of protective factors, and the way that they were looking at it is like how would this affect the programs that they funded, and not how do you look at economic priorities and where resources go in the first place, you know, where there is still some opportunity for crosstalk among agencies, at least in this administration and hopefully again.

But to think of do the economic analysis as well as the what works and where you invest money and how that can make a difference and also what that would look like and where there's evidence. And put that together for girls and women because I don't think that exists.

MS. JEANNETTE PAI-ESPINOSA: And it's interesting because as some of the young -- as the women get older, so some of them I met when they were 15, 16, 17, and I see them headed toward 25, and I'm thinking your brain's almost there. Just keep going. It's such a clear trajectory, and you know when they leave. It's like I was just trying to call one of them who says, "When I'm in trouble, I push everybody away. So don't let me."

Well, you can only call somebody so many times. But you know, that way to kind of just be a life raft. And I think that's why they built BOLD, and the app is actually called The Society, why they built that. So they very intentionally named it The Society. Because they always feel outside of the society. So they wanted to create something for themselves.

And they struggled for a long time about what would they call themselves or what would they call. So we ended up with "sisters" and "friends" after about 6 months. They just started calling each other sisters and called us friends, that I think that is that kind of -- they can take it wherever they go, but still be everywhere because it's a national thing. So --

DR. CAROLE WARSHAW: And it's so inspiring. I mean, just --

MS. JEANNETTE PAI-ESPINOSA: It is inspiring. It just -- they started out --

[Laughter.]

MS. KANA ENOMOTO: Well, I think for SAMHSA, we do have a Healthy Transitions program that we started in 2014 with a dual purpose. One is to engage -- it came as part of Now is the Time. And so that is -- obviously, there is strong emphasis on engaging folks for the first time.

It's just, as we know, half of all mental illnesses show up age 14 and three-quarters by age 24. So we're trying to get that group of folks that might be having a first episode of whatever, and 18- to 25-year-olds are also the least likely to engage with care. So it was trying to get that sweet spot.

Another purpose was to get those young people who had already been engaged in systems and help them to make a positive transition to adulthood because so many of the systems, you know, if you're aging out at 18, and you don't have a support base in the community, how do you make sure you can navigate all the different supports and services that you might need, that you might benefit from that can keep you from falling into the adult systems, that 21 to 24.

And so, you sort of graduate at 18, and you know, it's basically "see you in a few years," right? But not in a good way. And so, Healthy Transitions was developed also with the intention of doing, I think, weaving together the different systems, and they're talking to one another and they're engaging folks, that they can provide to young women and young men who are outside of the services the supports and the connections that they need so that they don't fall back in, in ways that they don't want to.

For those programs, the Healthy Transitions does place a really heavy emphasis on the peers. That's both for having family peers, especially for that initial engagement for people that might be having a first episode to make sure that there are supports and connections with other parents who might have navigated these challenges before. But then for those kids that might not have a rich family support kind of connections, but they're the young people who are going through the same things. And I think some of it is that credibility stuff that you've talked about, Rosalind, for young people, that the system doesn't have quite the credibility --

MS. ROSALIND WISEMAN: Right.

MS. KANA ENOMOTO: -- that we want it to, and so the other people who had those same experiences are better spokespeople and are better, you know, navigators in some ways of where to go and who can you trust and when is a good time to ask for help?

[Pause.]

MS. KANA ENOMOTO: But I do think it's grants to States that are working with communities because especially with these issues, moving across systems, so we need that State policy, you know, connection to understand how we're going to get a little assistance to be able to navigate State requirements when we're having our kids crossing over in and out of assistance.

So some of an interesting piece of feedback that I just got from the other -- that's why the other conversation was a little bit longer was because in my presentation on historical trauma, I did include a reference to the ACE study and showed some of the data about relationship between higher levels of ACE and different outcomes. And I got quite a bit of feedback about how the A in the ACE, the ACE scale is being used in ways that are different from I think what was originally intended.

So it's like being brought into classrooms where middle school students are being, you know, administered the ACE scale and taking their scores and comparing them, talking about them, and then comparing their community with other communities in the State.

MS. ROSALIND WISEMAN: Kana, can we have -- when people say things like that, I get -- you know, that it's so difficult to get one survey or one piece of information into a school, and I'm not -- I am actually challenging that as like a truism or truth in a school. Because it's so difficult to get any kind of any testing, that doesn't really happen a lot in schools. So not that it's like not true, but I'd like to know where that really is coming from.

Like is there -- is that just -- is that one anomaly that happened in one crazy place, or is there really a movement here of this being irresponsibly applied? I think that's a really important -- that causes great anxiety for me because then we -- if that's what happens, like it's being used badly, then it'll shut the whole thing down.

And it's -- it's so difficult to get information into schools that that's really like when I talk about school boards, I talked about that earlier. They would be bananas on this stuff. They wouldn't let it happen. You'd have to go through -- the amount of things you'd have to do to get that in just doesn't seem -- that there is something off to me about that.

MS. JEANNETTE PAI-ESPINOSA: Well, I don't know about -- I don't know about middle school, but there are some States that are doing sort of community-level assessment. I hadn't heard that they were in the schools like that, but they are --

MS. ROSALIND WISEMAN: You can't ask middle school students about anything to do with their sexual experience or else the whole place is going to

like explode. Really, like that would be --

FEMALE SPEAKER: It could be charter schools. It could be charter schools or outside of public, and that's where they're using it.

MS. ROSALIND WISEMAN: Yeah, I just want us to be -- so like I'd really like to know where that's happening. Because if that becomes like the belief amongst the system, then that's a really big problem.

MS. KANA ENOMOTO: I think this is with particularly vulnerable populations, and so I don't doubt the veracity of what our council member just told us. I think they are observing it. I think we did ask -- I did ask if there was -- she thought there was an opportunity for us to talk with the State because I don't think that's how the ACE scale was, you know, developed or intended to be used. And that is the concern.

That's why we did put GATSBI or now GATSBIR on the table because there was a concern about how people might charge forward and start asking people questions about trauma in ways that they weren't prepared to get the answer or they weren't prepared to deal with the results in an informed way. And so, this sort of also gives me anxiety because it is bad. It's like, ah, that's not what we wanted people to do.

I'm only happy that -- I think the State is actually thinking it's doing the right thing. She said they're just -- they're all about being trauma informed, and they're charging forward with the ACE.

MS. JEANNETTE PAI-ESPINOSA: Is it Washington?

MS. KANA ENOMOTO: No. But they're a State which shall not be named. But they're -- you know, again, I think it's with very good intentions that people are doing this. Because they say, wow, our State is really having a problem with X, Y, and Z. So here is the answer. And in fact, it's not an answer. Right? It gives us a little bit of information about perhaps the root causes, but it's not actually a tool to getting to an answer. The tools for healing and for recovering and for developing resilience are elsewhere.

And so, if we're only putting out the data about what's wrong with you or what's wrong with your community, it sends a very negative message, and that's what the concern from this member was, was, you know, there is this focus on the ACEs. And they're telling us what's wrong with us, and they're showing us how much healthier we are than other communities. And you know, what are they going to do about it?

And so, that was the challenge. I'm sort of curious, and Anita, you may -- I don't know if you know about the State or if you may have some experience with some

of this because it is a larger tribal community, communities that are affected or Native communities are affected. They're also interested in how you guys dealt with it.

Now those are girls that are in a care setting. So it's a lot different than in a school.

MS. JEANNETTE PAI-ESPINOSA: Right. Right. Yeah, I mean -- I mean, obviously, you're right. And first of all, it was adult -- it wasn't designed for an adolescent population, first of all. So, I mean, that's one caveat. I do know that there are a lot of people that have just gone crazy with it, and there are States, as I said before, that are just doing it everywhere. And I'm not really sure -- I mean, obviously, the goal is to have a healthier community, but I don't know that they have -- they're not, by and large, mental health professionals that are doing it.

And I know that there is some concern from Dr. Felitti and Dr. Anda about that. But I also know that some places are also using a 10-item resiliency scale questionnaire -- not scale, it's a questionnaire to kind of, I don't know, connect that to the ACE. The problem when we looked at that, is that total is more -- well, that did actually trigger some of the girls.

They asked questions such as "I know that my mother loved me. Yes or no." Well, if you have to say no, that's not really such a good thing. So there are basically 10 questions like this, and we are like, "No, we are not using that."

So I think it does have its limitations, most definitely. And it really -- in our case, you know, it is not really clear. First of all, it's not a clinical assessment tool. It's used just as much to inform policy as it is to inform practice, and that we are -- at the same time that we're doing this second administration, we're also working with Dr. Wade to create a youth-informed version of a tool that would look at childhood adversity.

So it's based on qualitative focus groups with young people, and it will also connect to well-being. So that, again, it's not -- the message is never, you know, your ACE score is not your destiny. It's where you began, right? But without that information, yikes.

DR. CAROLE WARSHAW: You should have a saying. "The ACE score isn't your destiny."

MS. KANA ENOMOTO: Right. Right.

MS. JEANNETTE PAI-ESPINOSA: Yeah, the middle schools are way too young for --

MS. KANA ENOMOTO: Well, and I had a lot of questions about if you're in middle school, and you say, "I've been sexually abused." So what's the responsibility to follow-up on that? And you know, a nonresponse or a nonfollow-up is also -- right.

DR. CAROLE WARSHAW: And there's a questionnaire?

MS. KANA ENOMOTO: Yeah, giving it to an IRB, or I don't know what they were doing with it, or going through a school board. We couldn't even get a SAMHSA person to go talk to a Montgomery County local school like PTA. It took a year to get permission to send a speaker to talk about substance use prevention for middle schoolers. I can't imagine how they got --

MS. ROSALIND WISEMAN: But that speaks to your point, your earlier point. Montgomery County is a county that protects its students vigilantly. Right?

MS. KANA ENOMOTO: Right.

MS. ROSALIND WISEMAN: I would just really -- I just -- I just think it's incumbent upon finding out the answer to this to be -- to ask the in the weeds questions, like was there an opt-out clause? When you go and ask the States that they should ask the in the weeds questions if this is -- to ask the specific questions that would get to an understanding of how -- well-intentioned as it probably was, of how it occurred, how it was given to the students.

Because I think my experience, once this stuff starts to get out at some -- this is another part of not doing this well, that there will be a group of parents that flip. And then you've got another hurdle. So just I think it's an -- it's incumbent upon like to actually know the specific questions to ask the school about, well, whatever it was this person was reporting, about how it, in fact, actually was approved to be administered and how it was actually administered.

MS. JEANNETTE PAI-ESPINOSA: Could we have an almond --

[Laughter.]

DR. SHELLY F. GREENFIELD: I just also think the conversation is just a reminder. You can't just randomly ask people questions, right? I mean, I'm sorry. You ask questions that are sensitive in settings where you have a goal and an objective about helping an individual in that direction. And you can do endless harm by asking questions where you're not prepared for the answers, and you don't have a plan for what you're going to do about that.

And it's that comes up in a lot of different services for specifically where vulnerable people, you know, young girls or whomever, you ask questions, and the institutional response is not helpful. That person may never answer a

question again truthfully because what they've learned from the experience is that it's a bad thing to have told somebody "in an organization" or in authority or something else anything because then all that's going to really happen to you is something that's worse.

So, I mean, you know, there is just within the healthcare setting, it's even an issue because, you know, as we try to integrate mental health and substance use services into primary care medicine and primary specialties, often the training in those specialties doesn't actually provide, you know, the kind of training that people need to be able to procure the answers to certain kinds of questions. And we can't really do those things separately, you know, because it's not helpful.

So the schools are just kids -- also a lot of things are meant to be done directly with a provider. It's not meant to be like a self -- you know, a self-assessment, you know, even at older ages than middle school.

So, anyway, that's just -- I mean, there is one thing about there are differences between being sensitive to people who may have experienced trauma versus, you know, thinking that the best approach is to start asking every question under the sun without any preparation as to what you should do. But hopefully, that distinction is not -- is more obvious than it would seem, you know, from some of this conversation.

The only other thing I wanted to say that I think is really great about the information that you provided is, you know, I think that it does not surprise me and it didn't surprise you that when you asked the girls the questions about what they needed, they could tell you what they needed or what they would like and that -- that it was nicely presented, but that's so commensurate with what the data would tell you they need. And I just think, you know, including that perspective, you know, from like a qualitative standpoint into all the rest of the things that we do is a really pretty key thing to do.

So that was just great to see.

MS. ROSALIND WISEMAN: Do I need to officially close this session? Is that like part of the thing you've got to do? Am I officially closing our session? Okay. Because -- well, you did. You did a very nice job closing the session. So I want to --

Okay. So I'm officially closing this session. Thank you very much.

[Applause.]

Agenda Item: Review and Discussion of Joint NAC Questions

MS. KANA ENOMOTO: Okay. Well, good. That gives us a little bit of extra time, and again, I apologize for not being here. But we can perhaps, as we move to this next section, which is our consideration of the questions for the National Advisory Council that are about treatment. And you should have it behind your agenda. I have --

We're looking at three questions that we're asking all of the committees to look at. One, what should SAMHSA's role be in influencing the provision of behavioral health treatment? Aside from grant funds, what types of investments can best leverage SAMHSA's limited resources? And how can SAMHSA best influence the cultural, gender-specific provision of behavioral health treatment in healthcare?

So, sorry I'm pausing because we usually don't use the term "behavioral health treatment." But we don't treat health. We treat disorder. But in any case.

So, I mean, you've heard a little bit of me alluding to and others talking about the ways in which SAMHSA can influence the delivery of services, and I'm interested to hear more about, you know, when Pam was here, you were talking about what are we doing around Medicare, and how are we talking with schools and other places where care might be delivered?

Are there thoughts that you have about what more we could be doing to influence how services are delivered on the ground?

DR. CAROLE WARSHAW: Can I ask a quick question to start? Where do you feel like you actually have leverage now, and is it mainly over public sector funding or over mental health and substance abuse treatment in general? Like what -- where are you starting from, and what is within your purview, and then what do we want to think about outside of that?

MS. KANA ENOMOTO: Sure, sure. Okay, great. I believe you did get some data sent out to you, but you probably saw that we paid for about 5 percent of all services. So 1 out of every 20 treatment dollars is coming from us, or less. So on the mental health side, I think it's actually less than 5 percent.

So Medicaid and Medicare are the largest payers, and followed probably by State funds and private pay and private insurance. And we're way down there in terms of the folks who are actually paying for dollars. We are a larger part, proportion of the funding under the control of the single State authorities for substance abuse. So that's one place where we have been historically more influential because a big part of the State treatment dollar does come from SAMHSA, although we're a pretty tiny proportion of the State mental health dollar.

But even, even there, Medicaid is increasingly a player with the State substance abuse treatment world. And so, we've been -- we've focused almost exclusively on the public sector for mental health, for treatment of mental illness and addiction. But increasingly, I think we're looking, you know, MHPAEA has an impact on everyone. The ACA has an impact on lots of folks, so public and private pay.

So we are trying to expand our role, our connections, our conversations in the third-party payer world across, you know, public and private, as well as what should we be doing? I don't think we're strong influencers over what purchasers are doing. So what are the Fortune 500 and other companies doing with respect to behavioral health? But I think we understand that that's a place we need to expand.

DR. CAROLE WARSHAW: And is there anything in the legislation of SAMHSA that gives you a mandate to influence treatment? Do you have a clear role, or do you have to figure out your role?

MS. KANA ENOMOTO: We -- I would say we don't have a mandate to influence the provision of care for all populations. I think we have permission, right? We have -- it's different. And what we have to do and what we may do are two different things.

So I think we have -- we are within our authorities to advance behavioral health for the Nation. We have certain mandates to pay particular attention to in the public sector. People with addictions, primary prevention for substance abuse, and people with serious mental illness and children with serious emotional disturbances are our mandates.

DR. CAROLE WARSHAW: Okay.

MS. KANA ENOMOTO: And then -- and then not necessarily by mandate, but by funding we have some authorities. We do have our grant programs, which focus on specific targeted issues. So, again, kids with SED, people who experience chronic homelessness and serious mental illness, people who are in the criminal justice system. We have lots of programs that Congress funds and has offered us and that we conduct, but they're not quite the same as a mandate.

There's nothing that prohibits us. You were asking Pam earlier, too, was there something that prohibits us from funding treatment? And it's not that we don't fund treatment.

With the block grant, much of the substance abuse dollar is used for direct services. On the mental health side, it's a little bit more mixed because it's such a tiny proportion that often States, because they have had more experience with third-party payers and billing insurance, States have, I think, more frequently use

their mental health dollars to fill in in those places where they are not able to bill.

So maybe the direct clinical care is more billable to Medicare or other sources, but they're not able to pay for staff training or new infrastructure development, things like that. You know, the introduction of new evidence-based practice, that kind of thing is hard to pay for. And so, those block grant dollars, I think, are very helpful to States to cover those things.

DR. CAROLE WARSHAW: I think a lot of times, since we were talking to people about mental health in America is that with these moving over to private pay with the ACA that some of the background services where there is evidence that support people living in the community might go by the wayside when it's a more medical model, medical home approach. And whether there's concerns about that, and I'm wondering what role SAMHSA might play in elevating the importance of all of those services?

MS. KANA ENOMOTO: Right. Well, that's, you know, with the introduction of parity and the ACA and Medicaid expansion, some people might say, well, now you don't need the block grants because, you know, it's just a very simple math, right? Like if you were paying for services before, now the services are covered by insurance, now you don't need that money. You can put it into -- move that money to CMS, for example, to pay the Medicaid bill.

Well, what we have had to explain to people is that, first of all, there is enormous treatment gap. So half of all people with mental illness, 80 percent of people with substance use disorder don't get treatment. So it's not like if we don't have this \$3 billion, it frees it up. People need -- more people who end up in getting treatment need treatment, and so there is need for far more than \$3 billion.

And what we've done with the block grants is we've prioritized paying for services for people who remain uninsured because there will be people who remain uninsured. Paying for services that are not covered by insurance. You have IMD and other things that keep insurance from paying for direct services, and those services that are not the types of clinical services that get covered by insurance that we know, the wrap-arounds, the supports, the recovery supports that -- the family service, the family-based treatment. Things like that that don't -- that aren't billable, but that do foster recovery and are evidence based.

So, and then grant funding those things that are not -- that are infrastructure and workforce development, things like that, and data. So we've already sort of -- and I think Administrator Hyde was already very visionary when she came. I mean, she sort of saw 10 plays down the chess board. Okay, well, if this passes, then this passes, and this means people will want this money, and so we need to make sure that our money is focused on paying for those things as aren't already covered.

And so, we'd already been moving in that direction when the ACA even passed because other people were paying, were already using. So those people who already had Medicaid, people were using third-party payers, and we needed to make sure every one of our dollars was going to a cost that wasn't able to be covered elsewhere. So, so that's -- you know, so we are about trying to keep the whole system, that whole treatment package available to people irrespective of what's covered by insurance and not covered by insurance.

DR. CAROLE WARSHAW: So I guess one last question about the landscape. With behavioral health integration and healthcare homes and those people I know who are [inaudible] that's where services are delivered, and that's what is paid for, that within a medical hierarchy, mental health services won't be paid, reimbursed as well as, you know, the physician head of the team or whatever, other services.

And then people won't get the kind of more like trauma, trauma treatment, the kind of treatment. So it'll end up being self-pay outside or, you know? I'm just trying to figure out what kinds of mental health services might be delivered where kind of have a sense of the array of what is happening where to fill in other kinds of gaps and to play a role in influencing that everyone gets what they need. That it's not just all based on who is able to garner the dollars. We're going to need structure in these systems that there is real not just parity, but the right distribution of resources.

MS. KANA ENOMOTO: I think -- in SAMHSA, I think the ACA does require CMS to consult with SAMHSA on the health homes that are related to behavioral health. So we are playing an active role with them in reviewing the applications or the proposals. But I think you are also raising a good point that could be -- that could point to something that SAMHSA could continue to do. You know, how are we using our influence to ensure that those -- that people are able to get the services they need, that providers are reimbursed adequately for those?

DR. CAROLE WARSHAW: So it's not just case management, medication, and supporting taking your meds, as opposed to, you know, services provided.

MS. KANA ENOMOTO: Right. So, actually, maybe we could -- someone -- are we -- Nevine, how are we recording our recommendations? Because I do think that tomorrow there is going to be sort of a time to go around from committee to committee. Is there not?

MS. NEVINE GAHED: No, there's a particular --

MS. KANA ENOMOTO: A session?

MS. NEVINE GAHED: -- session in there.

MR. JOSH SHAPIRO: I think it's the session right after lunch.

MS. KANA ENOMOTO: Right. So, right. So we'll report and discussions for our breakout. No, that's not it.

No, it's the 9:30 a.m. A selected NAC member will report findings from NAC meetings. So it's tomorrow at 9:30 a.m.

That's okay. So the point is that we are going to have to tell everyone else what we have as recommendations for what SAMHSA can do. So I think that just I want to start recording some of the recommendations, and I think that's if you want to maybe help us articulate that, Carole? You don't have to say it for the group, but if you would, how would you phrase this?

FEMALE SPEAKER: She does.

MS. KANA ENOMOTO: No, she does not have to do it. How would you articulate that recommendation?

DR. CAROLE WARSHAW: There's no one who's going to play a role in overseeing the breadth of the delivery of mental health services and what kinds of services are delivered in what environments as things are changing to make sure that there aren't huge gaps and that people -- the kinds of services that people need are actually happening. And then [inaudible] that allow them to continue that people actually provide that and that there's quality in how they -- you know, kind of overseeing the landscape as the public agency and trying to influence that as you see what the needs are and where -- how things are shaping up.

I don't know if that's right?

MS. KANA ENOMOTO: We can't necessarily appoint ourselves oversight responsibility.

DR. CAROLE WARSHAW: No, I know.

MS. KANA ENOMOTO: But we could sort of -- SAMHSA could serve as sort of a watchdog or a --

DR. CAROLE WARSHAW: Yeah. I mean, who else is going to do that? Everything is so fragmented, particularly in mental health. And maybe less so for substance abuse pertaining to treatment, and so I think some sense of as things restructure, that their needs are being met and --

MS. KANA ENOMOTO: I think mental health is fragmented, and substance use is probably absent.

MS. KAREN MOONEY: I think so, too.

MS. KANA ENOMOTO: Yeah. So there are sort of different players feel like they have a role with mental health, and I think substance abuse is because it hasn't been part of the system, is sort of hiding on people's radar. So there does need to be -- SAMHSA can play a spokesperson role or a leadership role in monitoring the quality of --

DR. DAN LUSTIG: That's actually what I wanted to mention was, you know, I know this is happening in some States. I don't know in all States. But the whole concept about educating the MC, the managed care providers, on addictions and the right way or just looking at the outcomes of addictions and the right approach. It is so horribly being missed by MCOs that they are taking the lens of primary care and applying it to addictions. And it's causing a poor approval of a good system of care.

And I think SAMHSA could play a very critical role of, you know, there's volumes of education that SAMHSA has of beginning to do some type of education with MCOs. Because even though I believe that the parity rules in its mission was the best thing, MCOs have really discovered very creative ways in getting around parity when it comes to addictions treatment. And the example --

MS. JUDY GRILL: Could you speak into the --

DR. DAN LUSTIG: Oh, I'm sorry. An example of that would be opiate addiction. To get them into medical detox is an act of God. At least in the community-based setting. So let me emphasize that.

Because their withdrawal history has got to be problematic enough that warrants that, and so they're saying they don't need this. So I think SAMHSA could play a key role in that educational piece.

The other thing that I think is critical, and I heard through the rumor mill about rules, some rules being changed, like 42 CFR. That is a huge barrier for addiction providers to participate in any of the Affordable Care Act. It is -- it's a challenge for continuity of care, and if that doesn't change, I think the addictions field will literally die on the vine.

And then I think, you know, the issue about really taking a close examination of the language we use, and I want to give this as an example. The behavioral health integration across the United States has always assumed that it's mental health and addictions, okay? It is always when you walk into a room, whenever there's a discussion, behavioral health appears to do this.

But how it's developed, how it's kind of laid out, I can tell you in Illinois, in Cook

County, its systems of care were built around -- reimbursement rates were built around the mental health rules and regulations. So when the 1115 waiver got approved, residential addictions treatment was out.

So I think it's important that if we are going to use encompassing language, that it really is encompassing language. And if it isn't, that we make concerted efforts to talk about two different areas. And I think now more than ever, the educational piece. I feel like I'm repeating myself, but it's played a strong role because so much policy is being developed right now because of the lack of education.

DR. SHELLY F. GREENFIELD: So I completely agree with what you're saying, and I think SAMHSA could position itself, given that you've already identified the treatment need gap in the United States, the enormous treatment need gap, both in mental health and in addiction.

And so, given that gap, SAMHSA, the role for SAMHSA, you could say, is to continue to provide, you know, education for all stakeholders regarding effective means of -- both organizationally and individually through evidence-based treatments, effective means of providing care. And that includes many of the products that SAMHSA has already developed and many of the programs you're already historically administering.

And probably now more than ever there is roles for all of those things, as, Kana, you just articulated. And I also agree with the idea that, I mean, we've been hearing over and over again. People are not very well trained at all in this, and you know, even some of the most sophisticated providers, if you go talk to them, I mean, I always go and talk about women and addiction to all these places. And all these people are so well trained, and like their eyes pop out when I present the data, and I think -- I keep thinking this is going to be boring for everybody because everybody already knows these things. And they just don't, frankly.

So you keep thinking, gosh, it's like 20 years later, and you guys don't know this still. But really and truly, that's really the case. They really don't. We were just having a sidebar conversation about this in the addiction realm, and you know, the whole issue on medication-assisted treatment.

I mean, really and truly, like I mean, you've got like 1 percent of providers out there who really get it about MAT. People are not following the data. They don't know about all the studies. They actually don't know what that means. They don't know how to provide it.

So we can think it's all clear, but it's out in the services provision world, none of that is clear, and there's a lot to be done. So I think all of those roles, which you have traditionally played, now more than ever, I don't see those disappearing. In fact, may be even more critically than ever before.

And then the only thing I would say is I think we were talking when Administrator Hyde was here about partnerships. And I do think there are a lot of strategic partnerships for SAMHSA to have, and we talked a little bit in the meeting and outside of the meeting. You know, partnerships with a lot of the professional organizations, some of which you already have strong partnerships with, but others of which you could really foster, I think, are really important, including, I would say, the physician groups.

Really important to be also partnering with physician groups, who will be -- you know, throughout systems will be in positions where they will be helping set tone, policy, distribution of services and care. And a lot of physicians are very poorly educated about mental health and substance use disorders.

I mean, for addiction treatment still, the average medical student gets 2 hours a year of lecture, and for behavioral health or psychiatric care, it's about 4 weeks. So I mean, still it's really -- if you haven't gone into that as a specialty area, you really don't necessarily know that much about it.

So anyway, I would just -- that was some of the things I would add.

DR. CAROLE WARSHAW: I was just thinking about even like online certification courses around like medication-assisted treatment or, you know, let people get out of the -- do we accept that that's doable by online?

MS. KANA ENOMOTO: Well, we do have a pretty -- well, actually --

DR. SHELLY F. GREENFIELD: It's not that it's not necessarily -- I mean, I just talked about a lot of different kinds of things. But some of it is providing physicians education on how to do medication-assisted treatment. Some of it is actually providing education to other clinicians in other specialty areas about the fact that medication-assisted treatment is a strongly evidence-based component of care in what has traditionally been only about behavioral interventions.

And so, the idea is, just like many other areas of psychiatric care, behavioral healthcare, or whatever terms you want to use, we have behavioral treatments, and we have pharmacotherapeutic treatments, and we have other psychosocial treatments. And what we try to do is use all those treatments because the more we have, the better for people who are in need. And not everything is going to work for everybody.

So the more tools you have in your toolbox, the more likely you are to be able to serve patients. But there's a lot of resistance toward that in the addiction world, you know, because there in the past were not that many, you know, effective medications. And we don't ever think about those in isolation. We think about them provided with other behavioral treatments.

But they are effective in women, and certain disorders, especially opioid dependence, they could be the difference between people being alive and being dead, actually. So that's a pretty critical thing, and would you ever deny somebody medication for, you know, their MI or their diabetes? I think not. You know, you might tell them to use diet and exercise, but you're not going to not give them medication that they need.

So this is a very not up to date view, and there's a lot of education that really is needed throughout the entire behavioral health, mental health, and substance abuse/addiction, or whatever words we want to use, treatment services. And it's we would wish it were not as massive as it is, but the need is really gigantic, actually. So --

MS. KANA ENOMOTO: So I heard you say, Shelly, one was the need for partnerships with outside groups, including physician groups, in terms of galvanizing support, increasing awareness for these issues writ large. And then I think in a more tailored fashion really focusing on either medical education or other -- how to help professional education about these issues because there's a lack of awareness.

We have lots of tools, Carole, in terms of physician training for buprenorphine, for naltrexone for first-responders, and naloxone. And we have lots of tools out there, particularly actually in pharmacologic therapies for addiction treatment. We have fewer tools for psychotropic medications for mental illnesses because it's largely been developed outside of Government and are available in lots of other places. But that's not a place where we've done as much work as we have in our Division of Pharmacologic Therapies in CSAT.

But so those are -- do I hear you correctly?

DR. SHELLY F. GREENFIELD: Yes.

MS. KANA ENOMOTO: So there's the specialty training on naltrexone and buprenorphine. But before then, there is the, you know, primary medical education of what are we teaching our young med students or our residents about substance use and --

DR. SHELLY F. GREENFIELD: But it's not just the primary medical education. It's really physicians who are already out --

MS. KANA ENOMOTO: And in practice, right.

DR. SHELLY F. GREENFIELD: -- and in practice, in service, and it's in all of the allied health professions. And I just also think that for SAMHSA to continue to do its mission, you also can gain support through partnerships with all of these allied professional organizations that -- who can partner with you.

MS. KANA ENOMOTO: Right. We talked about what could we do with OB/GYNs about substance use disorder, that kind of thing.

DR. SHELLY F. GREENFIELD: Yes, exactly.

MS. KANA ENOMOTO: Okay. So are there other things that folks are seeing as opportunities? Anita?

MS. ANITA FINEDAY: The other profession that I would add to that, and I agree with you about physicians, but the other group of professionals that you need to add to that list I think are judges. Judges are locking up kids for things that they need treatment for. They need mental health services, and they're ending up in jails.

And we know that a lot of kids cross over from foster care to the juvenile justice system, and judges are also just completely ignorant about the majority of this research and what really these youth need.

MS. KANA ENOMOTO: I think is there a judges college?

MS. ANITA FINEDAY: Well, there's an organization that comes to mind. It's the National Judicial -- no, wait. NCJFCJ, the National Council of Juvenile and Family Court Judges.

MS. KANA ENOMOTO: Yes. We had talked about that. We have a GAINS Center, which does a lot of work on criminal, juvenile justice largely on the mental health side, and they have brought in I don't know which association of judges, but associations of judges and tried to do some trainings at judges colleges about -- about mental health and substance abuse issues. But certainly I think given the rate of kids with our issues being involved in the system in family courts, it would be more outreach there.

MS. SHARON AMATETTI: Yeah, we also have our National Center on Substance Abuse and Child Welfare, and we've had an online tutorial for judges and lawyers about substance abuse and mental health co-occurring issues in these families. And the National Association of Drug Court Professionals have really stepped up in doing more work around family drug court education as well, and we support family drug courts and trying to do more work training professionals.

But again, it's a big audience out there.

MS. KANA ENOMOTO: So just we talked a lot about roles, things we could do. I suppose Question Number 2, which is aside from grant funds, what types of investments can best leverage SAMHSA's limited resources, i.e., staff time,

technical assistance, policy, et cetera? I think some of what you said feeds into that in terms of outreach here or TA there, partnerships.

But how can we best influence the cultural/gender-specific provision of behavioral health treatment in healthcare? So this gets a little bit more into what the focus of this committee is in general. How can we do more to advance treatment, the best treatment possible for women and girls?

MS. KAREN MOONEY: I think maybe a little bit more use of cooperative agreements. So not necessarily grants specifically, but using cooperative agreements to require communities to leverage their resources, with then some technical assistance from SAMHSA around doing that.

I think that would get people into the application mode and then think about what they want mode without having funding be the basis for what it is that they're trying to do. So it's set up to be sustainable from the beginning rather than something they have to build in over time.

MS. KANA ENOMOTO: I don't -- so it would be helpful for me to get a little bit more if you have an example that you're thinking of that you see be successful. Because for us, cooperative agreements and grants are not so substantially different.

MS. KAREN MOONEY: Okay. Well, Colorado is participating in one already right now through JJDP for the family drug treatment courts, where we're -- the purpose of the project essentially is to fuse the principles of family drug treatment courts into all dependency and neglect cases State wide. And we're in the middle of it so I can't tell you how well it's working, but it's certainly being approached from the perspective of everybody bringing their own resources to the table to make it work.

MS. KANA ENOMOTO: I think we can do some grants like that already as cooperative agreements that may not be a grant and -- a cooperative agreement is actually a type of grant. So it's not sort of cooperative agreement instead of grants.

MS. SHARON AMATETTI: I know a little bit about that grant program. I think it was more -- it's more of an experiment so they're really testing some hypotheses about how to infuse principles than having a definitive "you should do it this way." So they're using a cooperative agreement mechanism so that they have more of a collegial, I guess, interaction.

But we could. We don't really, but that -- that's a way --

MS. KANA ENOMOTO: Right, right. We do different -- some of our grants are cooperative agreements. Some of them are not, and it's they're -- I don't think

any of them are -- would necessarily be described as it's not about getting the funding. It's still pretty much about getting the funding, but we do attach more requirements.

I mean, the definition of cooperative agreement is substantive Government involvement, Federal Government involvement. It's really not -- the difference isn't is there money involved, or is there not money involved? And so, you know, it's whether the Government, Federal Government is seen as a partner versus as basically a donor. So, but --

MS. KAREN MOONEY: Yeah. I guess my comment is sort of based on the perception of when you look at a funding announcement and you look down the column that says how much, it is along the side if you're thinking about where you're going to invest your energy to apply for something. And those cooperative agreements end up being a relatively small amount of money. So they're not quite as enticing as, okay, let's look at something that's maybe going to provide a portion of our operating expense for a period of time that it's there.

So I guess, and I don't know, I maybe misunderstand a piece of that technical bit, but --

MS. KANA ENOMOTO: Yeah, so our cooperative agreements, some of our cooperative agreements are quite large, and so that's not it. We don't make that distinction that way.

MS. SHARON AMATETTI: It's more about a planning grant, cooperative agreement versus direct services funding right away and, Karen, the planning stages in the program.

MS. KANA ENOMOTO: Right.

DR. CAROLE WARSHAW: So I'm wondering about you have the GATSBI project, which is about trauma-informed, and part of doing trauma-informed is gender responsive and culturally attuned-in, relevant. So it's like is this what you should do?

So it seems that what does it mean to provide the behavioral health services in primary care in light of all the things that need to be part of it as a way of being there for people who are receiving services and what needs to be in place? So I don't know whether it needs to be a separate thing, or it's a kind of overall what are key elements that need to be in place regardless of what actual treatment you provide.

And it might mean that there's specific kinds of treatment that are going to be more gender inclusive or gender responsive or trauma specific, but it's the overall approach, and then there may be specific things that would be different. I don't

know.

Because I'm thinking about that if you had an extra panel on gender-responsive, you know, substance abuse treatment, right? So that you could do something like that for primary care, for behavioral health so that for people who want to do it, they'll be -- they'll know what the best thinking is, what that means and how to do it. What it means in primary care is more complicated because there's going to be such a range of what's available there.

So, again, like with the panel that you just did, it's like what are options depending on what resources you have. But you wouldn't want -- gender responsive has to be trauma informed and culturally relevant and gender inclusive. And so, anyway.

MS. KANA ENOMOTO: So I'll just recap these two things that I heard. So I think, Karen, aside from the technicalities of what type of grant mechanisms, I'm getting caught up in like mechanisms because that's part of my job, too. But I think what you're saying is do more where there is an upfront expectation of a joint contribution, that the grantee, at whatever level, whether it's a State, a community, or a provider organization, is being required or asked to upfront bring more of their own resources to the table to do a joint partnership, to advance a particular practice or issue or something like that.

So whether we do it as a grant or cooperative agreement, that the intention is not just here's \$500,000. Go do some services. And then in 3 years, that money is going to go away. It's going to be more what are you going to do with it with your own resources to keep this thing going? So that's what I'm hearing from you.

And then I think what you're saying, Carole, is I think we've done some good work kind of in our own wheelhouse about what's gender responsive, what's gender specific, what's trauma informed, what's trauma-specific services for kind of the choir. So, within our systems, we know what those things are now, and we've got tools for that.

But how do we translate those tools or adapt those tools for use by a more general audience who is increasingly getting into our business? So for those primary care providers who are now going to be seeing and managing more mental illness and addiction, how could they also be gender responsive? What do they need to know about gender-specific services? What do they need to know about trauma and addressing trauma in their settings?

Is that --

DR. CAROLE WARSHAW: Well, yeah. But I'm also thinking it's not so much primary care providers who are going to provide behavioral health services. I think the idea is that they'll be sensitive enough to find out their needs and then

make referrals to people who will be in primary care settings.

FEMALE SPEAKER: Maybe.

DR. CAROLE WARSHAW: So I don't think it's realistic that behavioral health -- that primary care providers are going to actually provide the services so much.

MS. KANA ENOMOTO: I think they're going to provide. They're already providing a lot. We know that.

DR. CAROLE WARSHAW: I mean, it's medication mainly.

MS. KANA ENOMOTO: Mmm, no.

DR. CAROLE WARSHAW: No?

DR. SHELLY F. GREENFIELD: Well, I mean, just that's such a complicated issue. I mean, I think, you know, again, if you go back to addiction treatment, 90 percent of everybody has never had any, and the definition of any means ever having once talked to a clinician in your entire lifetime about your substance use problem. Only 10 percent of people can endorse that, and after that.

So 90 percent of everybody has never had anything. So I don't know. I think the issue around what will happen is just unclear, and a follow-on to what you were just saying I was thinking about is, you know, I think the idea of providing -- you know, I think you were maybe starting to work toward like some kind of a tip or multiple kinds of tips that basically take some of the information that's already been done but helps a whole host of individuals who are not necessarily in this business begin to adapt it.

Within that, I would say that there are now a lot of models out there. They've been written about by lots of different people about how you best do some best practices around integrating behavioral health and addiction care into primary care, including how do you -- which things can you put into primary care? Which things are you still going to have to refer out to specialty care? How are you going to know the difference?

So for those of us in the business, some of these things seem so obvious. But for most people who are about to get into the business, none of it's obvious in the least, and so I would imagine that there's a large role for SAMHSA. And you know, as Carole is saying, like providing that type of education.

I would say around the gender specific, I think all the more. Like these types of educational programs, tips, tools, making them available in the best possible way. But also I would say trying to also assist with in whatever the ways are removing obstacles to providing gender-responsive care to the populations.

I think you heard even in the last one, when we were talking about the PPW, you were asking about obstacles to providing those services if you don't have that grant program. And you were starting to hear a lot of obstacles. I think there were so many obstacles.

So I guess, I don't know what your sense would be that obstacles clearinghouse or something, you know? I mean, or something. But you know, identification of obstacles across States, sharing best solutions to removing the obstacles. I don't know that I can use the word "advocating," but maybe, you know, within other Federal Government agencies about what are the ways that they could assist in removing some of those obstacles so that gender-responsive care for girls and women could be provided?

Some of those things seem to me to be pretty big, actually, in terms of provision of treatment for girls and women with addiction and mental health problems.

MS. JEANNETTE PAI-ESPINOSA: I think in my mind just I think about I don't know whether you think that or whether the agency thinks of itself as a thought leader. And I think in this area, you certainly are. But --

MS. KANA ENOMOTO: I think we like to think of ourselves as thought leaders.

[Laughter.]

MS. JEANNETTE PAI-ESPINOSA: I think you're far ahead of a lot of people and agencies, and I think you probably don't give yourself enough credit for that, particularly when you're kind of plowing through the weeds every day of this article or that article. But I think -- I do think that you are, and I do think that you're -- at least the Federal agencies that I work with, you're far ahead of them and also I think huge segments of the field.

So part of it may just be a shift in mindset that you really -- you have a lot of things going on. You know a lot. You have a lot of data to mine. I mean, I think that there's a gold mine there that, I mean, I think I learned three new things at this meeting I didn't know, which I should know, but I didn't know. If I don't know them, there are probably a lot of other people out there who should know them.

So a little bit of, you know, being a thought leader. I think you do a great job of being a convener, but I think being a thought leader is still yet a little bit different.

MS. SHARON AMATETTI: Can I ask one clarifying comment about comment that was what Dan said about 42 CFR being a big obstacle for our ACA funding. Can you just go a little deeper describing that?

DR. DAN LUSTIG: Sure. So under Rule 42 CFR, you cannot redisclose

information from an addiction provider. So with all these States that set up all these insurance exchanges, you can't participate -- as an addiction provider, you can't participate with the insurance exchanges knowing that they're going to redisclose that information to anybody else that's in the exchange that's with -- that is privacy in the client's care.

So if you can't participate, how do you work with coordinated care, which is a really important piece to a person's medical treatment?

MS. KANA ENOMOTO: So I did let that pass because we are in a rulemaking process right now. So I don't want to dive into it. But I think we can bring it up tomorrow, and I'll let the Administrator respond. I think there's also some education that we at SAMHSA do and that there are States that are successfully -- and providers and HIEs that have successfully managed to navigate with technology solutions.

DR. DAN LUSTIG: And that was actually on the bottom of my list. But with that being the case, then I think it would be critical for all -- how do we get that information then to all the other States?

MS. KANA ENOMOTO: Yes. Right, right.

DR. DAN LUSTIG: Where, and it's been 2 years.

MS. KANA ENOMOTO: Right, right. So we're doing -- we're doing some of the leading work with the Office of the National Coordinator for HIT on the ACA education. We're piloting stuff in I think two counties now on people being able to select "I want to share this data," "I don't want to share that data," and "I want to share it with these people and not with these people."

So it's complicated from the technology point of view, and it will take some investment by the field. And it takes some political will to want to make that investment in order to include substance abuse treatment data -- or substance abuse data, frankly, because it's even whether or not you have --

And it's an issue, and I think we need to educate where there are perceptions that it's not possible to share and talk about how it is possible to share, and then we are also in a rulemaking process to sort of adapt a 20-year-old or a 15-year, 18-year-old statute and rule to we're not doing paper and pencil, you know, charts anymore. So it's not like -- it's not the simple thing of you can actually Xerox copy and mail my chart to these people. We're not there anymore.

We're like it's going off into the cloud, and who's going to have access to it, and how do you create the computer system so that some people can pull it down and other people can't pull it down. Or some people can pull parts of your chart down and not other parts of your chart down.

And it is. It's complicated, and it requires technology, and it requires probably some new rulemaking, which we're trying to navigate. And then we need to educate systems and educate consumers on what that means. And you know, it's hard to educate consumers, but there's lots of -- even just with HIPAA, it's not as complicated -- well, it's complicated. It's complicated for 42 CFR because a lot of providers are hiding behind HIPAA, right?

You can't talk to us about your son or daughter because of HIPAA. Well, in fact, I'm a provider. I can listen to you, what you'd like to say. I can't necessarily disclose things because of HIPAA, but I can listen. HIPAA doesn't prohibit listening.

And you know, there's other things. I mean, lots of -- I've been to doctors' offices, like well, we can't do that. I was like, um, no. Actually, let's look that up. That's not true. But they feel like it is true. And so, there's -- and we've -- you know, HHS has tried to post some clarifications about HIPAA on its Web site, but that's still, you know, you have to go seek and find that clarification on the Web site, and if you're not so inclined, why would you do that?

So there's a lot that has to be done about privacy education for healthcare providers in general around HIPAA, and the 42 CFR follows closely behind that.

DR. CAROLE WARSHAW: And there are other groups advocating for that kind of data segmentation around other sensitive issues. People like Planned Parenthood, and you get an adolescent, you know, coming in for treatment, and parents having access or who is the primary insurance, who carries the insurance. So there's people working on that

MS. KANA ENOMOTO: Yes, right. Yeah. But we are very proud of our team that came under the great leadership of Dr. Clark and his being way out there in terms of the importance of EHRs and the issues of 42 CFR Part 2 that we had the technology. The coding was already being developed when other people realized that they need it. So ONC said, okay, SAMHSA you keep going with it. You do it for all of us.

DR. SHELLY F. GREENFIELD: So we are thought leaders.

MS. KANA ENOMOTO: We are thought leaders. Any other?

DR. CAROLE WARSHAW: Really great.

MS. SHARON AMATETTI: So do you want to get a volunteer for tomorrow?

MS. KANA ENOMOTO: Yes. I would like to get a volunteer for tomorrow. A volunteer or a nomination.

[Laughter.]

FEMALE SPEAKER: I nominate Shelly.

DR. SHELLY F. GREENFIELD: Ooh, it can't be me. I'm going to be at NIDA tomorrow. Sorry.

FEMALE SPEAKER: You could do it.

MS. ROSALIND WISEMAN: I'm out. Dan is new.

DR. DAN LUSTIG: I'm new.

MS. ROSALIND WISEMAN: I think it's really good to invite someone new.

DR. DAN LUSTIG: No, no, no, no.

[Laughter.]

MS. ROSALIND WISEMAN: Because you'll make us look good. He's new and he does -- right? Don't you think so?

DR. DAN LUSTIG: You can't do this to the new kid on the block.

MS. ROSALIND WISEMAN: I know. Anita is new, too. You could do it to her, too.

DR. DAN LUSTIG: And I'm a man, thank you.

[Laughter.]

DR. DAN LUSTIG: And I'm the only man on the committee.

MS. ROSALIND WISEMAN: Which means we're being --

DR. DAN LUSTIG: I could break at a moment's notice.

MS. ROSALIND WISEMAN: I think that means we're being awesome. I'm not going to be here tomorrow.

MS. SHARON AMATETTI: I nominate Jeannette.

MS. JEANNETTE PAI-ESPINOSA: No, no.

MS. SHARON AMATETTI: You could do it.

DR. DAN LUSTIG: Look at you -- yes.

MS. ROSALIND WISEMAN: What is so scary about this? This is not that scary. This is not that scary. Is it that scary?

MS. JEANNETTE PAI-ESPINOSA: I really think you should. You're going to provide the written talking points that you just wrote down or no?

Carole said we'll do it together.

MS. KANA ENOMOTO: Okay. Carole and Jeannette will be our spokespeople.

FEMALE SPEAKER: Next time, the new kids will --

MS. KANA ENOMOTO: You guys, I will make a Xerox of what I just wrote down. You can interpret as you will and ad lib if you want, however you want. That's fine. And Dan, you're on deck. Dan is on deck.

You know, I've got full, but not maybe that much --

[Crosstalk.]

MS. ROSALIND WISEMAN: The seating chart.

MS. KANA ENOMOTO: The seating chart.

MS. ROSALIND WISEMAN: Oh, I have it right here. I'm not next to him.

MS. KANA ENOMOTO: I think they try to mix.

MS. ROSALIND WISEMAN: Carole, I'm sort of next to Jeannette. I'm right -- do you see that? I'm at a neighboring table. So you could take my seat.

MR. JOSH SHAPIRO: You can blame me for the seating chart. I made it.

[Laughter.]

DR. CAROLE WARSHAW: We want to rearrange now, huh?

MR. JOSH SHAPIRO: It's really not a big deal. If you want to switch seats, it's truly not. You can do whatever you want.

MS. ROSALIND WISEMAN: I have one last question.

MS. KANA ENOMOTO: Yes?

MS. ROSALIND WISEMAN: Which I've been meaning to ask about all day and almost forgot. I'm not going to be here tomorrow because I'm doing a keynote for the American Association of Occupational Therapists, and the reason I'm bringing that up is because when I was doing the preconference call with them, they talked very enthusiastically about a partnership that they're doing with you all, with SAMHSA.

Does anybody have any -- I'm getting blank stares.

MS. ANITA FINEDAY: The American Association of --

MS. ROSALIND WISEMAN: Occupational Therapists. Any -- does it ring a bell or is there any insight I could get for my speech tomorrow or any thoughts or any things you want me to, you know?

MS. SHARON AMATETTI: You could have emailed us in advance.

MS. ROSALIND WISEMAN: I know. You know what, Sharon. You're right. I apologize. You're right. I totally forgot about it.

MS. KANA ENOMOTO: -- track down the particulars for us of that partnership. I don't know if they're involved in our recovery to practice piece. I have talked to the occupational therapy folks just in casual ways about their strong interest in behavioral health, but they're not the group that comes to the --

MS. ROSALIND WISEMAN: Right. Yeah, I just -- I was going over -- like I was looking through something, and then that popped up. And I had totally forgotten. So I just -- but I'll figure it out. I just thought maybe you'd -- okay. Thanks.

MS. KANA ENOMOTO: I would say one point that we would say to any allied health professional group is that we recognize the value and the need for all of our, again, allied health professionals to understand mental health and substance abuse issues because they affect, you know, all aspects of our lives. And SAMHSA does stand ready to be a resource to them, and also if they have thoughts about how we could do better by like the population that they normally serve, I think we'd be a little bit to that.

I think there's probably two ways. There's people with mental illnesses and substance use disorders who, by virtue of whatever -- they have issues they have experienced -- need occupational therapy. But then also people who for different reasons need occupational therapy also run into mental health and substance abuse issues over the course of their -- over the course of their recovery.

MS. ROSALIND WISEMAN: Okay.

MS. KANA ENOMOTO: So, you know, that intersection we'd be happy to talk more about it, about what we could do.

Agenda Item: Public Comment

MS. KANA ENOMOTO: So, okay. Now would be the time for public comment.

MR. JOSH SHAPIRO: Should we just ask?

OPERATOR: Thank you. At this time, if you have a public comment, please press *1 on your touchtone phone and record your name. Just a moment for the first comment.

[Pause.]

MS. KANA ENOMOTO: No comment? Okay. And I won't take that personally because we do have -- today have several councils going on in competition with us. So we don't have as many audio followers as we sometimes do.

So, Operator, are there any public comments?

OPERATOR: Not at this time.

Agenda Item: Closing Remarks/Adjourn

MS. SHARON AMATETTI: I do want to let people know that John Campbell came back with detailed tables.

FEMALE SPEAKER: Oh, wow.

MS. SHARON AMATETTI: He was very enthusiastic. He made copies of everything. So please feel free to take a copy.

[Laughter.]

FEMALE SPEAKER: He does a great job.

MS. KANA ENOMOTO: John is one of those people where you think while you're so grateful that someone is passionate about what they do, which is -- and John, as you heard, is very passionate about the block grant.

MS. SHARON AMATETTI: And knowledgeable.

MS. KANA ENOMOTO: And knowledgeable. Passionate and knowledgeable

and the author of most of the regulation. So we're grateful for him thinking about the women's set-aside in that way.

It was a very good meeting today. I'm sorry to, again, have missed part of it. For that part that I have participated in, I think we have a wonderful assemblage of folks who give us great insight. I'm looking forward to following up with some of you for some of the concrete suggestions that you gave while the Administrator was here.

And other comments, you know, I hear you. We are going to partner more, I think, and I want to have a concerted effort to engage particularly our medical colleagues, but our other professional colleagues. I think the idea of doing something around school boards.

And I mean, and I think trauma is one issue. But seriously, like I had a colleague who was like tennis team friend who said, "Oh, wouldn't it be great if you could come talk to my school board?" And like literally a year later of meetings and sending documents, like to talk to a middle school board. To get someone from SAMHSA to go talk to the school board. About substance abuse prevention, which I thought was shocking that why wouldn't you want to talk about substance abuse prevention in Montgomery County?

But, so I think some of that work would be great. I think thinking more assertively about what we can do to educate providers, both our own providers, as well as non- sort of independent providers about our issues about being gender specific and trauma informed specifically because, obviously, it's the rest of the committees' job to worry about the other stuff. But I think it's our committee's job to worry about being gender responsive, I think.

You know, I loved the conversation about girls, and I was glad we had it today. How our Children's Mental Health Initiative is -- it is strengths based, family centered, and youth driven, and that's the emphasis for a lot of our programs that involve youth. But I don't know if we do enough of it at our level. You know, how are youth really informing what we're doing and that we really need to think about how to have that authentic voice and the credibility to young people.

Because it's so easy to dream up stuff in D.C. and you think it's going to fly, and then it may or may not when it sort of hits the ground. And how do we prevent those kinds of flops from happening by keeping those chains of communication open. And I'm sorry that Sarah was not able to join us in person today, but we'll be able to --

FEMALE SPEAKER: She was on the phone for much of the day.

MS. KANA ENOMOTO: Yes, I know. I know. But I think it was hard with the hearing and the noise and us being able to hear on the phone as well. So I think

just, but in an ongoing way, there are those of you who listen to girls a lot and can bring that voice. And then Sarah herself, as a young person, can bring that voice.

So I think that will be helpful because if we have invested, we need to invest more on women. But I think that listening to girls will help us so perhaps in the future we won't have as many women that we will have to be treating.

So thanks very much, and I look forward to tomorrow, and we'll have more great information about what we're doing and of our fearless leaders over here sharing our contributions in the general session.

So thank you, guys, and with that, our meeting is adjourned. Thank you.

[Whereupon, at 4:58 p.m., the meeting was adjourned.]