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Substance Abuse and Mental Health Services Administration

Advisory Committee for Women's Services (ACWS)

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Conference Room 8-1070
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Transcribed by:
Alderson Court Reporting
Washington, D.C. 20036
(202) 289-2260

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PROCEEDINGS

Agenda Item: Call to Order

MS. GERETTA WOOD: Good morning, and welcome to SAMHSA. I'm Geretta Wood, SAMHSA's Committee Management Officer. And as the DFO of the Advisory Committee for Women's Services, I officially call this meeting to order.

Before we begin, I have just a few announcements. Please silence your electronic devices, and also please remember to speak into the microphones so that those listening can hear clearly and so that the transcriber can know who you are.

Council members Velma Murry and Starleen Scott Robbins are joining by phone. And for our ACWS members participating in the meeting by teleconference, please identify yourself before speaking and please mute your computer speakers to eliminate feedback over the phone.

If you have any technical difficulties, please contact Josh Shapiro at jshapiro@capconcorp.com.

I note for the record that the voting members present constitute a quorum, and I now turn the meeting over to Kana Enomoto, Chair.

Agenda Item: Welcome Members and Roll Call

MS. KANA ENOMOTO: Thank you, Geretta.

And good morning to everybody. I understand we've experienced a few miracles in order to get us all here.

[Laughter.]

MS. KANA ENOMOTO: So that's a good sign. I think we're going to start with a roll call for our recordkeeping, and we'll just go around.

I'm Kana Enomoto, SAMHSA.

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

DR. SHELLY F. GREENFIELD: Shelly Greenfield, Harvard Medical School,

McLean Hospital.

DR. JEAN CAMPBELL: Jean Campbell. I'm the Director of the Program in Consumer Studies and Training at the Missouri Institute of Mental Health, which is part of the University of Missouri-St. Louis.

MS. ROSALIND WISEMAN: Rosalind Wiseman, author and educator.

MS. SHARON AMATETTI: Sharon Amatetti, SAMHSA's Center for Substance Abuse Treatment.

MS. CLAUDIA RICHARDS: Claudia Richards, Center for Substance Abuse Prevention.

DR. MARGARET E. MATTSON: Margaret Mattson, SAMHSA.

MS. HARRIET C. FORMAN: Harriet Forman, retired special -- preschool special education consultant.

DR. YOLANDA B. BRISCOE: Yolanda Briscoe, Director of Santa Fe Recovery Center and the Pregnancy and Postpostum Women's Grant in New Mexico.

Thank you.

MS. JOHANNA BERGAN: Johanna Bergan, Director of Member Services of Youth MOVE National.

MS. GERETTA WOOD: Geretta Wood, SAMHSA.

MS. KANA ENOMOTO: And if we could go around the room and just introduce the folks who are joining us today? Our favorite Irene Goldstein has the fastest hands in the west, best writer ever.

[Laughter.]

MS. IRENE GOLDSTEIN: Thank you.

MS. NEVINE GAHED: Nevine Gahed.

MS. MICHELLE HAYES: Michelle Hayes, Office of the Administrator.

MS. KELLY ZENTGRAF: Kelly Zentgraf, National Association of State Alcohol/Drug Abuse Directors.

MS. SARAH WURZBURG: Sarah Wurzburg, also NASADAD.

MS. SARA AFAYEE: Sara Afayee, SAMHSA.

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

MS. KANA ENOMOTO: And the famous Josh from Capcon Corp.

[Laughter.]

MR. JOSH SHAPIRO: Oh, I'm sorry. Josh Shapiro, consulting contractor.

MS. KANA ENOMOTO: And I believe we have Mr. Heer, who can't speak because he's listening. Thank you.

Harriet?

MS. HARRIET C. FORMAN: And the people who are --

MS. KANA ENOMOTO: Yes, and the folks on the phone, please?

DR. VELMA MCBRIDE MURRY: [on telephone] Hi, I'm Velma McBride Murry at Vanderbilt University and a committee member.

MS. STARLEEN SCOTT ROBBINS: [on telephone] Hi. I'm Starleen Scott Robbins with the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services, and I'm the designated women's services coordinator and also the president of the NASADAD Women's Services Network.

Good morning.

MS. KANA ENOMOTO: Great. Good morning. So thank you both for joining us on the phone.

And I would ask you to feel free to tell us when you can't hear us and for -- we are not in the usual rooms downstairs where you all have been with us before, where we have the mikes where we press the buttons and you can actually hear quite well. We are in 8-1070, which is the Administrator's conference room upstairs because we have a number of meetings going on today. It's quite a buzz in the building.

And so, for committee members, if you would remember to speak into your microphones, and you'll have to speak pretty loudly. So the relaxed pose that Carole has right now, that's how I usually sit, and people can't hear me on the phone when they're on. So we just have to lean forward a little and speak up because our members are kindly joining us for the full day. We want to make sure that they can be engaged by hearing every valuable word that we say.

Due to other commitments, Dr. Vince Felitti is not able to join us today, but we do have our newest member, Rosalind Wiseman, and I'd like to just do a brief intro of you and then let you speak to our members and introduce yourself.

But as she mentioned, she's an author and educator in children, teens, parenting, education, bullying, and social justice. She wrote Queen Bees and Wannabes: Helping Your Daughter Survive Cliques, Gossip, Boyfriends and the New Realities of Girl World, which was the basis for the movie Mean Girls. I didn't know that. But I do have my copy of the book at home. I can bring it tomorrow.

[Laughter.]

MS. KANA ENOMOTO: And she followed up with Queen Bee Moms and Kingpin Dads, showing that parents experience peer pressure and conflicts that their children go through.

Thank you, Rosalind, for joining us. And would you like to just say a few words to the committee?

MS. ROSALIND WISEMAN: Sure. Thank you so much for having me.

And I've met some of you last summer. Was that last summer?

MS. KANA ENOMOTO: Yes.

MS. ROSALIND WISEMAN: Last summer. I actually grew up in D.C. and -- is this good? I grew up in D.C. and just moved to Boulder, Colorado. I'm a native Washingtonian, and after 20 years after college, and I just moved to Colorado. And so, I'm back here. So thanks for giving me the opportunity to come home.

What I'm working on, which I hope would be a contribution to this effort is I work very hard to figure out what is really on the ground about what is facing girls in this country and also how it, of course, intersects with boys. I'm doing a lot of work on not just on Instagram and Snapshot and all of the things to do with technology, but I've gotten very interested in gaming, for better and for worse, about social norming and how girls are interacting in that space and how meaningful it is, meaning it means something to girls about how they -- how boys are interacting with them, how they're trying to participate in that space and in some ways are getting really abused in that space.

So I do a lot of work on how to make things relatable to young people and then transfer that to parents and teachers and educators. I do a tremendous amount of work on professional development in schools around the country.

And in the fall, I have two books on boys and social dynamics of boys coming out. One is called Masterminds and Wingmen, and it's very similar to Queen Bees for parents, and it very much integrates boys and girls together. And then I have another book called The Guide, and then there's a sort of inappropriate word in the subtitle. So I don't feel comfortable saying it right now.

[Laughter.]

MS. ROSALIND WISEMAN: But it's for high school boys. It's not derogatory towards women. But in all seriousness, it's a high school manual for boys. And the thing that has been so extraordinary for me is that 200 boys and girls helped me write these books. For 16 months, they helped day in and day out for no other reason, reward, but maybe if they -- if I write them a recommendation for work or for college. And those will be coming out in the fall.

MS. KANA ENOMOTO: Great. Thank you.

So just to get folks familiar with the agenda today, I'm going to make a few comments about what SAMHSA has been up to since we last met in August. Then we'll have updates from each of our members, and then we have our members of the SAMHSA Women's Coordinating Committee, who have also been very busy, and they'll give their update.

We have a break. We'll be having a great session on transition age girls and young women. I think "emerging adults" is the new term. And Johanna has agreed to be our discussant for that.

We were going to have a luncheon speaker, Juana Majel Dixon from the -- actually, our SAMHSA Tribal Technical Advisory Committee, who's been active on the VAWA work. But she's unable to join us. She's not able to come to the staff meeting. So we will be on our own for lunch, but folks can still -- I think we're going to go downstairs to buy our lunches and then come back here or take a walk or whatever --

MS. GERETTA WOOD: No, actually, they'll be brought up here.

MS. KANA ENOMOTO: Oh, they're being brought up here. Okay, thank you.

Then, at 1:30 p.m., we'll have a conversation about SAMHSA's public health approach to trauma. We've been doing some work, trying to get public comment and come up with a common definition. That will be followed by a discussion. Carole has agreed to be our discussant for that session.

Then we have at 3:00 p.m., disparities for women in the criminal justice system. Sharon really put a lot of effort into thinking through this session. We're very excited to have -- that will be a session where we have outside speakers coming

in. And Yolanda has agreed to be our discussant for that session.

And then public comment and adjourning at 5:00 p.m. Do we have anyone signed up for public comment as of now? No. So we may be adjourning a little bit early. We shall see.

Agenda Item: Remarks by the Associate Administrator for Women's Services and Adoption of Minutes for the August 8, 2012 Meeting

MS. KANA ENOMOTO: So I will try to keep us on time and be brief with my remarks. It has been a whirlwind since last August with some really tragic events happening. Both between Hurricane Sandy and then Sandy Hook, SAMHSA has been through a lot. So have the people of this country.

And we have, as an organization, been very involved in responses to both Sandy and Sandy Hook. Sandy Hook, as you know, the events in Newtown, have led to a presidential initiative where the President announced in January his plans to reduce gun violence, increase safety in schools, and improve access to mental health services. And SAMHSA, along with our partners in HHS and across the Government have been working very closely with the White House since that time.

And today, the President's budget will drop, is dropping, being released, right? Someone said, "Is the budget going down?" I said, "Well, yes." But no, that's not what that means. It's a term of art, I guess. But at 10:00 a.m., they will be announcing the President's budget proposals for FY '14, and that will include a significant package to address mental health services for -- particularly for transition age youth. So we're focusing on youth 16 to 25 years old and their families, and we're very excited about that.

You will hear more about the President's budget tomorrow both at the joint NAC meeting, and you're all invited to participate in an after-hours stakeholder meeting at 5:30 p.m., which we'll be doing nationally, which we'll go over in detail all the parts of the President's budget. But what I can tell you now is that we have never seen such significant and sustained interest in these issues and just an increasing awareness and desire to change social norms around mental health, mental illness, negative attitudes, and to the degree we can bring it in, substance abuse.

At SAMHSA, we see these two things as quite interrelated, as you know, and we're trying to bring that awareness more broadly. But the efforts, you'll note -- Jean, I don't know where you are on this camp, but we've gotten quite a bit of feedback from a certain segment of stakeholders that we shouldn't use the word

"stigma" because the word "stigma" itself sort of reifies that mental illnesses themselves are bad, and therefore, there is a legitimate stigma attached to them. That's how stigma technically, the semantics of it.

And so, if you happen to believe that there's nothing inherently wrong with mental illnesses, but there are negative attitudes, prejudices, and discrimination that come along with them, then you don't -- you wouldn't use the word "stigma." So we don't use the word "stigma" in our public documents, and we are very proud that the White House did not use the word "stigma" in their public documents. And that we are focusing on reducing negative attitudes and discriminatory behaviors in order to help people be accepting and supportive of people with mental illnesses, to be aware of the signs and symptoms of mental health problems in young people, and be willing to facilitate referrals to supports, whether that is peer, professional services, or supports.

So that's been a very exciting effort that has consumed much of our time. And on other fronts, we did in October celebrate SAMHSA's 20th anniversary. We were established in 1992, I guess. And that -- we had a great event. We actually -- we did it, and this was in a context of constrained finances and a lot of attention to how people do events and meetings and conferences. If any of you ask any SAMHSA staff person, they will tell you that our conference and meeting process has become very even more bureaucratic than before.

But in that context, we managed to have a really lovely 20th anniversary celebration. We had our previous Administrators come. So Elaine McDowell, Joe Autry, Charlie Curie, Terry Cline, and Ric Broderick all joined us, and we had engaging panel discussions about how we think the field of behavioral health has evolved in the last 20 years, as well as the role of SAMHSA. And you really saw, you know, the coming -- where before, things were very, very siloed, and we were just struggling to have an identity as mental health and substance abuse separately and independently, and the split of research and services that occurred. And that was really what was kind of at the forefront when SAMHSA was first created.

And now where we've evolved, where we're kind of going back to how do we integrate with healthcare? How do we be part of the Affordable Care Act and the changing healthcare system and yet maintain our integrity and our identity and the clarity that substance use disorders and mental illnesses are different things that substance use prevention and mental health promotion are important things to pursue.

We're just in an intellectually and, actually, I think system-wide different place, a very, very different place in the last 20 years, and it's good to see that evolution. I think we have had the right leaders at the right time over the course of our history, and so that's very gratifying to see.

DR. JEAN CAMPBELL: And also recovery.

MS. KANA ENOMOTO: Absolutely. I'm sorry, yes. Recovery. Absolutely. Recovery and resilience I think were two thing that have definitely come to fore in the evolution of SAMHSA. And the consumer movement, the movement of people in recovery from addictions, that has also transformed. And youth I think is the most cutting-edge part of that.

On March 23rd, 2013, we celebrated the third anniversary, if you can believe it, of the Affordable Care Act. Feels like just yesterday. And yes, January 2014 is around the corner, where we're going to see 62 million people have increased access to mental health and substance abuse services, both through Medicaid expansion exchanges and parity.

So we couldn't be more thrilled about that. The Secretary launched a week-long celebration around the Affordable Care Act anniversary. We've noted that tens of millions of Americans are already benefitting from stronger coverage like the preexisting conditions. For children, it's important that children can no longer be discriminated against based on those preexisting conditions. The access to preventive services, clinical preventive services with no cost is important.

And 6.1 million Medicare beneficiaries with the highest prescription drug cost have saved an average of $700 a person on their prescription drugs. So that's already been in the last 3 years.

I guess the one that I hear the most, and it probably reflects the age of the people with whom I work, is that the law has already helped 3.1 million young people gain coverage under their parents' plan. And I think that's a very exciting thing for parents to know that their child, once they graduate from school, will still have access to health insurance up until they're in, hopefully, a job that will provide them coverage of their own.

So over the next year, millions more Americans will benefit as the law expands and we have more affordable insurance products available. Now beginning in January, insurance companies cannot turn down people with preexisting health conditions. And here it says "such as being a woman."

[Laughter.]

MS. KANA ENOMOTO: Such as being a woman. I don't know if that is, in itself, a condition. But -- yes, but we do know that women are charged -- I think we've talked about it before that women -- the average premium for a woman has been much higher, and that's going to get changed. The rationale being that, I guess, women have higher healthcare costs, women of childbearing age have higher healthcare -- potential healthcare costs and live longer. There you go.

And then on October 1st of 2014, when the health insurance marketplace is open for enrollment in every State, giving individuals, families, and small business owners a simple, convenient way to find coverage that fits their budget. So the department, as you might imagine, has been very busy on all of this, and we're quite thrilled. We expect to release a final rule on parity, the Mental Health Parity and Addictions Equity Act, in the fall of this year.

So there's been quite a press on us, on the department to move on this, and we're happy to say that the ball is moving, and we are looking towards later 2013 to get that out. And that will be important because what it is, is we've clarified earlier in January how Medicaid should include parity in its benefits. And this rule will get a little bit more specific about nonquantitative treatment limitations and exactly how that parity implementation should look. So very, very positive.

And as I mentioned, Juana Majel Dixon isn't joining us today, but I just wanted to note that the Violence Against Women Act was reauthorized in 2013. There may be some of you who know more about that than I do. It was originally passed in 1994, reauthorized in 2000 and 2005, and has really changed the landscape for victims who once suffered in silence.

This reauthorization is exciting because it does include expanded protections for Native Americans, and we do have -- in anticipation of Juana being here, I think we have under Tab 5 a one-pager about what the implications are because -- and I've been able to participate in some of these discussions. It really has been quite distressing about tribal jurisdiction over non-Indian perpetrators of domestic violence. And so, this hopefully strengthens the position of tribal women everywhere.

So tribes will now have the optional authority to investigate, prosecute, convict, and sentence Indians and non-Indians for a set of crimes including domestic violence and violations of protection orders. And in the fall, the new reauthorized VAWA clarifies tribes sovereign power to issue and enforce civil protection orders against Indians and non-Indians and has provisions for LGBT individuals who are victims of domestic violence.

So including a nondiscrimination clause that prohibits LGBT victims from being turned away from services like traditional shelters on the basis of sexual orientation or gender identity. And the act now explicitly names LGBT people as an underserved population, which allows organizations serving LGBT victims of domestic violence to receive funding from a grant program that focuses specifically on underserved populations. And it allows States at their discretion to use certain grant funds to improve responses to incidents of domestic violence among LGBT people, and this bolsters the law's enforcement, prosecution, and victims services efforts within States.

So, again, I think a lot of great progress has been made on that front. And so,

although we won't have a chance to discuss it, I hope you do take the opportunity to learn more about what that means for the communities that you serve or work with.

And budget, we can talk more about budget later. You're going to get a lot of doses of this budget at the joint NAC tomorrow and then if you choose to stay later in the day for the full briefing. I'm happy to also answer any questions.

One thing that I will point out to you that I probably won't get into later is that we continue, SAMHSA continues, the President continues to support a proposal for grants for adult trauma screening and brief intervention, which is focused on -- it's a services research project to develop and test screening and brief intervention for trauma on women and adolescent girls in primary care and other general medical settings.

So in the IOM report on clinical preventive services for women, it did identify domestic violence screening as a recommended clinical preventive service. The way that got written included screening for current domestic violence and past trauma.

While we know that there is fairly robust evidence base and as well as sort of clinical tools available around domestic violence screening in primary care, we do not have that same level of evidence around -- and tools around trauma screening, past trauma screening. And we've had folks like Dr. Felitti and others who've done wonderful work in this area, but it is not yet at the point of a very quick and easy clinical screen that could be administered by a nurse practitioner or a PA or a doc and that they have a brief intervention or a referral protocol that would go along with it.

And so, that's what we're trying to develop in our GATSBY program. It's a small program, $2.9 million. It was in the 2013 budget as well. Of course, we didn't get that appropriation. We have a continuing resolution for this year. So we're happy to see it again in the 2014 budget.

So that is it. So now we are going to adopt the minutes. Are we adopting the minutes?

Oh, I'm sorry. I do need to mention that we are having a SAMHSA all-hands budget briefing this afternoon at 4:00 p.m. So we're giving our staff a quick preview of that. Sharon won't be a part of that all-hands staff briefing because Sharon will be taking over chairing the meeting for me. I'll have to leave just before then to join the Administrator for the budget briefing. So thank you, Sharon, for that.

Okay. So adoption of the minutes. Does everyone -- everyone has the minutes in their binders? These minutes 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.

If you have any changes or additions, they will be incorporated in this meeting's minutes. If not, may I have a motion to approve the minutes?

DR. JEAN CAMPBELL: I move. Although I have to say I think they rephrased in some cases to make it sound better.

[Laughter.]

MS. KANA ENOMOTO: Irene can be thanked for that. She makes us all sound eloquent.

May I please have a second?

DR. SHELLY F. GREENFIELD: Second.

MS. KANA ENOMOTO: And we note that Shelly Greenfield seconds.

Thank you. The minutes are approved.

All right. Great. And now the moment that you've all been waiting for, the moment that I've been waiting for, which is updates from our great members. And I'd like -- it would be great if each of you would just take a few minutes to tell what you've been working on, what you've been thinking about, what worries you, what excites you, what advice you would like to offer us. And you'll have plenty of other opportunities to give us advice. So this is just a preview of the advice.

We can go, starting with Carole?

Agenda Item: Updates from ACWS Members

DR. CAROLE WARSHAW: Well, our center has been doing --

MS. KANA ENOMOTO: Maybe you want to give a quick view of what you do?

DR. CAROLE WARSHAW: Okay. Oh, the mike. Sorry.

So the National Center on Domestic Violence, Trauma, and Mental Health is funded by the Family Violence -- the Administration for Children, Youth, and Families, HHS Family Violence Prevention and Services Program, and we are

part of a national, small group of TA providers for people receiving funds, which are all the domestic violence programs in the country and the State coalitions.

And part of our mandate, we're one of four special issue resource centers, and one of the other ones is the health resource center that's part of Futures without Violence. And they've been very involved in the women's committee -- the new --

MS. KANA ENOMOTO: Right. HHS Women's Coordinating Committee.

DR. CAROLE WARSHAW: Women's Coordinating Committee around part of the new women's preventive health benefit packages around screening for domestic violence and other trauma. And there are two other centers in that group and along with the culturally specific resource centers and the National Indigenous Women's Resource Center.

So we do a lot of work together and try to think about policy as well as research. And part of our -- the other part of our mandate is to work with the mental health and substance abuse systems and to infuse a kind of DV, trauma -- culture, DV, and trauma lens into work that's done within those systems, and we'll talk about that more this afternoon.

And also as part of our new mandate in this round of funding is to help build an evidence base for trauma treatment in the context of domestic violence when women are still under siege, which raises a whole other set of concerns than when you're looking at trauma that just occurred in the past, and we'll talk about that more.

So one of the things we put out this year recently was a formal literature review around trauma treatment in the context of DV, whatever there is, which isn't that much. But at least it's a review and critical analysis of that. That's on our Web site. We had a quarterly newsletter where we did -- had had some commentary about mental health and gun violence and a small research report.

We are working on a study, which I'll also talk about this afternoon, that will hopefully come out in the next couple of months about mental health and substance abuse coercion in the context of domestic violence and how abusers use those issues as another way to control their partners, and what are the implications for that in terms of mental health and substance abuse treatment, but also in terms of advocacy and the legal system that we're very excited about.

So, and then we're developing tools and guidelines for mental health providers and, hopefully, for substance abuse providers on addressing these issues in those contexts. So --

MS. KANA ENOMOTO: Great. Exciting work.

We don't have to go around the room, but you are welcome to.

DR. SHELLY F. GREENFIELD: Sure. So this is Shelly Greenfield. Let's see, I am -- have multiple roles. I am a professor of psychiatry at Harvard Medical School. I spend my time at McLean Hospital, where I do a variety of things.

I am a researcher in alcohol and drug abuse treatment development and implementation and with a specific focus on women and on gender differences. And more recently, I've also been spearheading something that we call the Women's Mental Health Initiative at the hospital. And I participate as well in the National Institute on Drug Abuse's clinical trials network.

So we've had, since we met in August, a variety of activities in all of these areas, and I'll just mention them briefly. So the first is we have completed a randomized controlled clinical trial of a new treatment manual that manualized treatment for group therapy that the National Institute on Drug Abuse has funded. It's a two site clinical trial. Basically, it's a group therapy. It's a 12-session group therapy, and the purpose of it was really to enable treatment programs to have an evidence-based group treatment that would encompass women both other mental illnesses and variety of substance problems, as opposed to either no comorbidity or a specific comorbidity or only one type of substance.

And we've completed the trial and analyzed the results, and we've gotten really excellent results. And we're just finishing now to, we hope, submit a paper on that and more on that as we do that, I hope, in the next 3 months. But we did show that we were able to decrease substance use during the treatment, but the big news is really that people maintained their gains for 6 months post treatment.

So, and these are women who had alcohol, cocaine, I mean, just prescription drugs and a variety of other co-occurring disorders. So we're pretty excited about that, and we are working on the results paper from that.

So, in addition, I have chaired the Gender Special Interests Group for the Clinical Trials Network for the last 10 years, and we had an opportunity to present to the steering committee meeting a variety of work in the Clinical Trials Network that we've done on women, including HIV risk prevention and other things. And that was a great opportunity for many of us to come together and look at a collective body of work.

And finally, in the last couple of years, I've been spearheading something called the Women's Mental Health Initiative, which at our hospital we are -- we serve populations of girls, probably from the ages of 14 all the way up through women who are in older age. We have many programs that are actually focused on girls and women, and what we are doing is initiating what we hope will be a division of women's mental health, which will basically encompass all of these programs so

that we can increase our collaborative efforts across programs.

And we had a symposium that was in a science practice symposium and recently had an all-day visit from Dr. Donna Stewart, who is the outgoing chair of the Women's Health Department -- Women's Health Division in Toronto, and had an opportunity to learn a fair amount about integrating a whole host of services for women's health and mental health.

And so, those are some of the things that we're doing, and I hope that's helpful and what you were looking for.

MS. KANA ENOMOTO: Can you tell me what was the nature of the 12-week intervention? You said it was a group intervention. Is that peer led? Is that professional led?

DR. SHELLY F. GREENFIELD: So this is a professional led, manualized group therapy, and the idea behind it was that it would have both an all-women composition and that it would also have women-focused content for each session. It's a 90-minute relapse prevention weekly group that can be added to other kinds of treatment.

But the real innovation in this particular recent study was that we did this on a rolling group admission, which is more typical of what's done in community practice, so that we've demonstrated that you can start it and continue to add members. The members come in and out. And the members, the patients in the groups, actually, I think are fairly representative of the women who actually show up to treatment.

So often studies restrict, have many exclusion criteria. So both of those things, it was meant to be an off-the-shelf kind of manualized treatment. So we've done it in two sites and trained a number of therapists to do it. And as I said, we're just kind of finishing, and it's premature for me to say everything until it's gone out for peer review. But that's what we've been working on.

MS. KANA ENOMOTO: Was it for women coming out of a gender-specific treatment setting or from a coed treatment?

DR. SHELLY F. GREENFIELD: So it varied. It could be stepping down from coed treatment. It could be coming out of an all-women's treatment. It could be coming directly from the community. So we had folks coming in.

I will say we published results of a very small pilot trial several years ago that had good outcomes, but that was a very small trial, and this is a larger treatment trial.

MS. KANA ENOMOTO: Sharon had raised the issue the women's committee and Sharon have been doing some thinking about SAMHSA's sort of next steps.

And we've -- do you want to just say a few words, Sharon?

MS. SHARON AMATETTI: Yes, just briefly. And so far, this is a just a conversation, but really looking to see how we might provide more support, information, guidance, conversation around serving women in coed settings in a gendered way. We've had a lot of focus on women-only programs, but not so much on coed programs.

MS. KANA ENOMOTO: So that just --

DR. SHELLY F. GREENFIELD: Yes, so that's actually an area of interest. And as I said, you know, hopefully, we'll be presenting sort of these results at two national meetings a little bit later, and as I said, we'll be sending off the results. And hopefully, then we can have more discussion on the treatment itself. But the idea is it could be added to treatment programs.

MS. KANA ENOMOTO: Shelly, if we could just ask you to speak up a little bit?

DR. SHELLY F. GREENFIELD: Sorry. That could be added, I hope, to treatment as usual, either in a mixed gender or gender-specific setting. So, but as I say, we think we've had some good results, and we're about to, hopefully, submit and be published, I hope, in this coming year. So that's where we're at.

MS. KANA ENOMOTO: Thanks. Jean?

DR. JEAN CAMPBELL: Thanks. Hi. My name is Jean Campbell, and I'm a research professor in mental health and Director of the Program in Consumer Studies and Training. And I am both a researcher and a woman and a consumer of mental health services and have spent a large portion of my career focusing on involving people with psychiatric diagnoses in the process of producing new knowledge through research.

And over the last -- I think the most significant thing that's happened to me is I retired in the end of January, although I have to say one of the dangers of retiring is, is that you have just as much work to do, and you get a lot less money for it, which has happened to me. And my family keeps reminding me that I'm retired and I need to cut back and do the things that I had anticipated doing.

I had a near-death experience about a year ago, and which slowed me down a little, but also made me rethink about creating a new chapter in my life. But I don't want to let go of the work I've done over my career, and I think one of the things that it makes you reflect about just what your priorities are in life. And one thing that I've been really disappointed in myself and in the field is, is that although we've come a long way including the perspective of mental health consumers in our dialogue, and I think the evidence of the New Freedom Commission and the focus on recovery and the engagement of peers at all levels

of policy, treatment, service delivery.

In my own institute -- I wanted to hand these out -- we were undergoing a messaging and branding exercise for the Missouri Institute of Mental Health. And when I looked at these -- my card is in there -- I found there wasn't any mention which makes the Missouri Institute of Mental Health unique -- online programming, consumer studies, and training -- or mentioning them supporting it. We were the coordinating center for the largest study of peer services funded by SAMHSA that ended with the recognition of consumer-operated services as an evidence-based practice. No mention of that.

So sometimes I think about it. My goal had always been to create more people like myself that have the experience -- a person's experience being involved in research, and that hasn't been as successful as I would like. And then I see that the impact, even in my own institute, isn't as great, like there's no one to carry on that program or provide that voice.

So I've had to think about rededicating myself. The struggle continues, as they say, and that be reminded, although there are small changes, those are cumulative. And to celebrate those things that where we have made advances and just grid down to our core around those things. I think this issue on violence, gun violence. Every day I wake up to hearing somebody on the TV saying "dangerous mentally ill," and it's very disconcerting to just hear those words. But it has created a rededication.

And I think the major thing over the last year, one of the major, I was on an editorial board of two that ushered this paper on behavioral healthcare homes, which you may not know, but it's one of the efforts that SAMHSA is supporting. They're spreading throughout the States. Missouri is one of the first States that got that, and we created a paper on that.

It's an integration, bidirectional integration of health and mental health because of the issue of early mortality of persons with mental illness, which is 25 years. And that by bringing those services together, in this case in community mental health centers, it's one of the ways to address that. And we were able in this document, which I think is going through review -- in SAMHSA, it takes a while to get it out to the public. But they're moving from -- it's funded. These behavioral healthcare homes are funded under the ACA, and they originally adopted a chronic care model.

But we were able in this article to transform the chronic care model into a recovery-based model within that document. So I'm very excited about that because you'll probably hear me talk about promoting well-being here and wellness because I don't think we have enough emphasis on that. And to think not only in clinical terms, in terms of the treatment of illness, whether that be physical or mental, but also the promotion of wellness, which SAMHSA is also a

leading edge on doing that.

MS. KANA ENOMOTO: Thank you, Jean.

I can't speak for MIMH, but you have a great legacy here, and COSP has a great legacy here at SAMHSA. So thank you for that work.

MS. ROSALIND WISEMAN: So you asked what we were worried about. So I've focused on that since I already introduced myself.

I really work with schools. That's where I -- that's where I am day in and day out. So my worries, my concerns are based around that. And I'm going to learn a tremendous amount being a part of this organization, of this committee.

I do a lot of work with what is now sort of the "bullying movement," for better and for worse, really "and for worse" because teachers are very reactive about -- and rightfully so, about every conflict now being called bullying in the school, which does not allow for except for innately sort of common sense and intelligent administrators to understand the complex dynamics that are going on that lead to the conflicts among children.

So one of the things that I'm very worried about and did not realize until the last couple of years was that people -- vice principals in the schools are the people who do discipline in middle school and high school. They are not trained in any capacity. So they're doing the discipline, but they have no training for -- to recognize who it is and what they're dealing with.

So I'll just because I want to be mindful of time, that just be very specific about there are many children with social skills deficits and disabilities mainstreamed into school. And in a lot of ways for better, right? Of course.

But when you have a child, what I have seen and what I've really paid attention to and have been speaking to administrators about for the last 2 years is that we have children who are either more likely to be perpetrators, more likely to be manipulated into perpetration by children who are more socially savvy and more socially aggressive so they can get the kids who are on the autism spectrum disorder or are -- and have even like the combination of some kind of ADHD. That the socially intelligent children can push those children to perpetrate against other children.

And then, in teaching, you always see the second hit. You never see the first hit. You never see -- you rarely see the child who actually created the situation, that created the problem, right? So you get the kids who have the least social skills actually being identified as the problem, which, therefore, means that it looks to the kids, to the public, to the group of children all around, not just to the specific children involved, that the adults actually cannot -- are either incompetent or

unable to address the situation effectively.

On top of that, you have vice principals who, when you really press them on this, and I had to admit it myself, is that the only thing they've been trained on is restraining techniques.

FEMALE SPEAKER: If that.

MS. ROSALIND WISEMAN: If that. And so, then you have children who have high sensory challenges, and the only thing that the administrators know how to do are restraining techniques. So, of course, that contributes to children with these kinds of challenges having significant mental health challenges and also not wanting to go to school, very understandably, and being seen as being really aggressive and really hostile. So then they get these labels of being mentally ill in some way and all this stuff, right?

So, as I'm listening to you, I'm feeling like that is an issue that really that I would put out on the table that I know that administrators want help with and that certainly there are children in the country who are desperately trying to figure out how to handle this. So that's my first concern.

My second concern is about pornography and the ways in which we talk to young people about it. When we talk to young people about it's denigrating to women, they're not going to listen. I think that one of the things again I'd like to put on the table -- and I'm not sure, I'm obviously just learning my way here -- is that young women are also consuming pornography, and they are feeling like this is what is expected of them in their sexual behavior with young men.

They know that they might not want to do the things that they are seeing, but they feel that there is an expectation that that's what they should be doing. And if they can't advocate for themselves, it becomes so confusing to them about how to advocate for themselves.

And I've been working really hard to try and figure out a way to speak to young people in ways that they will connect with about this issue because, ironically, we talk to parents when they have children at 11 or 12, we think about having these sort of age-appropriate sex conversations, if we have them. And the initial onset of seeing pornography is 11. So adults are talking to kids as if they've not seen this, and the chances are that those kids have seen very intense pornography, right? So the parents are getting all nervous about talking to their children about their first birds and the bees conversation, and this kid's like "I saw it on my phone yesterday," right?

So it's a place where I think there's a lot of shame and a lot of not understanding how to have the conversation. And so, those are the two things that I'm worried about, and those are the two things that I think this group of people are uniquely

positioned to be able to think about.

MS. KANA ENOMOTO: Certainly on the bullying piece -- and those are very thoughtful comments. On the bullying piece, SAMHSA is one of the supporters of stopbullying.gov. We were part of the group that formed that. And so, happy to have more conversation about how we can make a connection or facilitate a conversation.

Harriet?

MS. HARRIET C. FORMAN: Well, I'm going to change the topic.

[Laughter.]

MS. KANA ENOMOTO: You do early childhood.

MS. HARRIET C. FORMAN: Well, actually, I've been retired for quite a number of years. So I just want to talk about --

MS. KANA ENOMOTO: And Harriet, if I could just ask you to speak into the mike? Thank you.

MS. HARRIET C. FORMAN: Okay. Harriet Forman. I've been retired for a number of years, and just to switch from Jean's, I've been retired and I love being retired.

I just want to mention something about as an outgrowth of the Affordable Care Act, I just want to tell you something you may not be aware of is that as an older person, my insurance now is focusing very much on wellness. And I've been delighted to find out that my insurance pays for my health club membership. And it pays for my massages, and it's just wonderful.

[Laughter.]

MS. HARRIET C. FORMAN: So it's my Medicare Advantage Plan, and it's affordable, and it's wonderful. And it's keeping me healthy, and I'm almost 70 years old. And this is what 70 years old looks like anymore. And it is helping because of the Affordable Care Act.

And so, the other thing I'm following these days is the work that's happening at the Supreme Court with DOMA. And I want you to know that the research coming out is that marriage equality is healthy. People who are in marriage who are gay and lesbian are healthier. And the research is showing that children growing up in homes with same gender parents are doing very well, thank you.

And so, it is healthy to be raised by gay and lesbian parents, and this is also

being documented by good research. And so, it's important that we counter the negative research with the good research that's going on. So I just think that's important that that research gets published and gets out there because there's a lot of bad research out there, and it's important that we get the word out that that research is not accurate.

So that's just things that I'm studying. We should get that out there, too. Thank you.

MS. KANA ENOMOTO: Thank you.

DR. YOLANDA B. BRISCOE: Hello. Yolanda Briscoe, and I had to write down all the different committees I'm on. Starting out with the Pregnancy and Postpartum Women Grant that was given to New Mexico, I have just been asked to consult on that grant. And we're looking at engaging, retaining, and also increasing capacity. For some reason, women are not seeking treatment when they are substance dependent or abusing and pregnant, and so that's what the grant is for.

I'm also teaming up with UNM, University of New Mexico, for a program called BFIT. We came up with BFIT. It's Brief Family Intervention Therapy for engaging families in treatment while there's a lot of intergenerational substance dependence in New Mexico. So we're trying to engage the family in treatment.

There is a matrix model that includes the family, but for some reason, they're just not showing up. So we're going to address that.

I'm also on the Recovery-Oriented Systems of Care Advisory Committee. We're trying to bring recovery-oriented systems of care into New Mexico. And also on the mayor's LEAD Task Force. LEAD stands for Law Enforcement Assisted Diversion, and that comes from Seattle. They already have a LEAD program. Where instead of taking people to jail for using drugs, we're working with the law enforcement to divert into treatment.

Thank you.

MS. JOHANNA BERGAN: Hello. I'm Johanna Bergan, and lots of things have happened since August.

I served on the board of directors for an organization called Youth MOVE National over the last 3 years and was happy in September/October to transition onto staff, to really dedicate the time that I wanted to be dedicating to this work. And with that change -- that change came about because Youth MOVE National was able to advance to our next stage in our growth.

So this organization formed originally from youth coordinators working in system

of care, federally funded sites. They formed an advisory council, had a conference, and started talking in the mid 2000s. And from that created a goal of having a national organization that was youth driven to exist. And as of October 1, 2012, we exist.

So we had a relationship with the Federation of Families for Children's Mental Health, and they served as our assistive area organization through our formative years. But we're really excited to be on our own. So that feels really good. Yes, it feels really good to have our nonprofit status approved, too, because that was a nightmare. But we're on the other side of it. So it's smooth sailing.

So I serve as the Director of Member Services. Our organization is built in a membership formation. So youth organizations across the country can become members of our organization. So we have 59 chapter organizations, and I am their contact/technical assistance person, and that has been a huge growth.

So my work has focused on helping our individual chapters identify their purpose and vision, and there are, it turns out, not surprisingly, lots of reasons for young people to want to have a place to go to talk about the social system experiences that they've have. So the majority of our young people have lived experience in mental health, juvenile justice, some sort of substance abuse treatment, and child welfare, and they come together.

We incorporate and embrace sibling experience and peer experience and the support that that brings. And so, my work has been to help individually the chapters find a focus. Do they provide social supports? Do they provide recovery treatment program supports? Are they activists? And if you're 16, you want to be everything. So --

[Laughter.]

MS. JOHANNA BERGAN: So we help prioritize. And so, what we found -- and my work over the last 6 months and moving forward this year is to help our organizations determine what their population of focus is, mostly geographically. So working on having a local model, serving a city, a small county area, and then also those who work on a statewide level. And there's been really exciting work in that idea of having a youth-driven organization within each State.

And so, I'm also really excited to say that we have our first chapter who is their own independent organization. So Youth MOVE National, as of January 1, is a model that we're working really closely with, so providing youth voice within the social systems across the State of Oregon.

So like day-to-day is helping individuals with things that come up -- how to have a conference, how to talk to their teachers, how to do whatever is happening. And we do a lot of things. But overall is to really provide a model for how to have

a youth movement everywhere in this country. And so, there's a lot of really great work happening there.

DR. JEAN CAMPBELL: Do you have a Web page or Twitter account?

MS. JOHANNA BERGAN: Yes. We do. You should find us. Social media is great right now. Because as I was traveling here yesterday, our Web site hit a hiccup, and I'm here. So I'm not fixing it.

But youthmovenational.org should be active by the end of the week. But Facebook, Twitter, Tumblr, you can find us and lots of our chapters. So most of my work is virtual with our chapters, and that's something I work on a daily, too, is how to safely share resources and communicate with young people. And they're really helping us pave the way there.

DR. CAROLE WARSHAW: Will we be finding out more about that or later, when you're discussing --

MS. JOHANNA BERGAN: Yes. Oh, sure. I mean, I'll keeping talking about things that I know and work with throughout the day. And I love to talk about it.

I think the other thing, Jean, you talked about lived experience, and I just think of the other thing that my peerage is working on is we were introduced to the idea of youth voice in its very infancy, and it was grasped on so many levels and started to be incorporated. And now we are aging out of whatever said youth definition exists. And this is a new area as well.

So our effort is to continue to look back and bring up the next level of youth leadership to make sure that it continues, but also determine what do we do? I mean, we are basically creating jobs for ourselves, or we don't have them. So when we were youth, we were an expert because we had experience. But now we're experienced and have so many other experiences. Where do we go with that? And that is a conversation that those just a few years older than me are actively engaged in, and I'm really glad of that.

MS. KANA ENOMOTO: And we do have a session on emerging adults, and I think that will be perfect for that.

DR. JEAN CAMPBELL: The Web site is youthmovenational.org? Do I hear you? Okay.

MS. JOHANNA BERGAN: Correct.

MS. KANA ENOMOTO: Try it on Monday.

MS. JOHANNA BERGAN: Monday.

DR. JEAN CAMPBELL: I'm going to get your Twitter feed, too.

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

And Starleen or Velma?

DR. VELMA MCBRIDE MURRY: Sure. I'm willing to jump in. This is Thelma McBride Murry. I'm a professor in community psychology at Vanderbilt University, and prior to that -- I moved to Vanderbilt in 2008.

And prior to that, I was at the University of Georgia for 16 years serving as a professor there and also co-director of a center that focused on family research, and we targeted primarily rural African-American families. Spent quite a bit of years examining through just basic empirical research, longitudinal work, identifying patterns that increase the protective nature of children raised in poverty-stricken rural communities and trying to understand how are they and their families able to navigate risk, navigate through those risk factors, and then enhance the well-being and development of their children. And when I say "children," they're from ages 7, and I studied them at that time, on through adolescence.

From those 10 years of longitudinal data on these families, we took those protective factors and turned them into preventive intervention programs. And the area that I'm specifically interested in are factors that delay the onset of sexual onset for African-American girls and boys. And then the subsequent behavior of these individuals once they become sexually active with the primary focus is time phased to reduce HIV/AIDS transmission among rural African-American youth.

And I focus on this population because many of you probably know, the rising rates of new cases of HIV/AIDS are more prominent among young people residing in southern regions of the United States. And so, Georgia was an opportune environment to find ways to prevent the behaviors that place these kids at risk.

So the first program that we developed and tested through a randomized controlled trial of 700 families was called the Strong -- or is called the Strong African-American Families, and it is a family-based, community-delivered preventive intervention that targets both family and youth, parents and youth in enhancing their skills in parenting, and for kids, youth, it's enhancing their what we call interpersonal protective processes, helping them feel really good about themselves with regard to self-esteem, racial identity, racial pride. And then equipping them with what we call resistance efficacy skills and knowledge of being able to make determinations about when risk opportunity situations are available to them and then how to navigate their way out of that.

So we now have 5 years post intervention exposure data on these individuals, and we're seeing that the program has sustainability over those 5 years and that we're seeing lower incidences of sexual risky practices including alcohol and substance use to a very lower -- we've been able to decrease the age of sexual onset among the young people with greater manifestation of protectiveness for the African-American girls in terms of no pregnancies among these girls upon graduating high school.

And so, with the program having such a positive not only efficacy data, but also with the sustainability, we can conclude that it's also effective, I wanted to find a way to develop a different delivery modality for this program because of the cumbersomeness that it causes families to have to come out to community centers during the course of 7 weeks to be exposed to this program 2 1/2 hours each night that they came out over the course of one time per week over 7 weeks. And so, I transported this program, the Strong African-American Families program into a technology-driven, interactive, computerized program so that all of the programmatic information, including the activities, are embedded in this virtual world.

So the question is do families, including parents and youth, internalize information about a program that's been shown to be effective in reducing risky behaviors? Can they -- do they internalize it just as well if the program is not delivered by humans? Can they receive it and internalize it just as well if it's delivered via these virtual characters on a DVD interactive format?

And so, we launched the project in Tennessee, rural Tennessee, which is what I'd moved my work into, into Vanderbilt, and that's what I'm currently doing. It's a three-arm randomized controlled trial where one group of families are randomly assigned to receive the program through the traditional in-person delivery modality. The other third receives the program totally through computer technology interactive format. And then a third, the other third receives mailouts on positive parenting, positive youth development, and knowledge about HIV/AIDS and alcohol use.

And so, we just finished the first preliminary data, which I've just been chomping at the bits to see what was going to happen to this project. And I'm happy to say that our preliminary data shows that families are internalizing the information with very similar kinds of patterns that we saw with the humans delivering the program. So technology appears to be working at present from pre-test to post test on these families.

But we're seeing a differential pattern in terms of how the program delivery modality is being received by parents versus kids. And so, the youth are responding much more positively toward the technology format than parents, and so what we're seeing -- what we're saying first is that rural African-American

families do receive information well via technology. However, for some topics, particularly around parenting, that's where we saw the greatest variability in parents' response to the program in person versus the technology is when we began to focus on those sessions that were particularly targeting changing those important parenting, protective parenting processes.

So that's what I've been doing in terms of my research. And as people were talking about what they've been doing with their time, I started thinking about how much I've become involved in other kinds of committee work beyond this wonderful SAMHSA committee work that I'm doing. And so, I am -- I've been -- I have been appointed to this committee that's being sponsored by UNICEF and USAID, and the sole purpose of this committee is to begin to understand what has been published in the literature on preventive interventions that will inform low and middle lower developmental countries' knowledge about what they can implement at the country/national level in order to enhance the survival rate of children and women and, well, mothers.

And so, I have been -- so I am on the committee that focuses on maternal child health, and so we're looking at the literature on both preventive interventions that have been done in the U.S. and across the world that have targeted -- that have been developed specifically to reduce the multiple births among young women. We're also trying to determine how might we -- what programs have been developed and shown to have effectiveness with regard to increasing the well-being of girls in these countries, and we're looking at what can be done to increase or lower the mortality rate among young children.

And so, it's been a really wonderful opportunity to, first, read a lot of the literature, and some of it is not as scientifically based when you look at what has been done in other developing countries in tests and their preventive interventions. But it shows what has emerged from this is how important it is for researchers in the U.S. to really begin to look at how work is being done in developing countries that can also inform the work that we do, rather than our thinking about how our scholarly work should be informing the work in developing countries. So it's been just an incredible opportunity to work with scholars from around the world as part of this committee.

The other project that I've been working on is I'm on the Institute of Medicine's Board of Children, Youth, and Families, and we focus a lot on a lot of the issues that the SAMHSA, this SAMHSA committee on, including looking at issues of trauma and as it relates to both males and females, but more importantly, this notion of sex trafficking of U.S. or domestic girls, which we oft times refer to that as an international phenomena, but we're seeing that occurring very prevalently in the U.S.

And then the last committee work that I've been involved in, the Institute of Medicine recently developed a workgroup whose charge is to look at the

scientific and policy work that could inform us about what can be done to improve the health, safety, and well-being of young adults. So if you look at the research literature, we know a lot about children's development. We know a lot about adolescent development, and we know a lot about the elderly development. But the two populations that are almost invisible are studies of young adults, young people ages 18 to 28 or 30, and then the middle adults.

And so, this group has been charged with bringing together experts in the field that will then develop a report, and this report then will lead to hopefully some supported empirical studies to begin to examine some of the issues that emerge from this committee work.

And so, other than that, I've just been hanging out.

MS. KANA ENOMOTO: All right. Thank you very much, Velma. It sounds like you're extremely busy.

DR. VELMA MCBRIDE MURRY: I am very busy.

MS. KANA ENOMOTO: Great. Okay. Starleen?

MS. STARLEEN SCOTT ROBBINS: Yes.

MS. KANA ENOMOTO: I'm going to ask you to keep it fairly brief. I apologize for that. But we also have our SWCC members that we want to give a chance to speak.

MS. STARLEEN SCOTT ROBBINS: Okay.

MS. KANA ENOMOTO: Thank you.

MS. STARLEEN SCOTT ROBBINS: Starleen Scott Robbins, and I am the women's services coordinator for the State of North Carolina, and I'm also the president of the Women's Services Network under the auspices of the National Association of State Alcohol and Drug Abuse Directors.

And I just wanted to give you an update on what the Women's Services Network has been working on. We are preparing for our annual meeting in June, and the four subcommittees have been working to complete their goals for the year.

The Criminal Justice Committee has been working on how the Women's Services Network can collaborate with the drug court to ensure that women are provided appropriate substance abuse treatment services, and also women who are reentering from the criminal justice system and ensuring that they have access to gender-responsive services.

Our Outcomes Data Committee has been working on looking at how States are providing therapeutic services to children of women who enter into treatment and how they're tracking outcomes and how the network can help support that.

The Pregnant and Parenting Women Committee has been focusing on medication-assisted therapy and pregnancy and FASD, and our ROSC for Women has been looking at different approaches for recovery-oriented services specifically related to women.

And just one other thing. We just started, after a strategic planning process, the development of a workgroup to develop a guidance document for States to identify resources for assessing trauma-informed organizations and compiling the continuum of trauma-informed approaches that are available for women currently.

And that's it. I tried to be brief.

MS. KANA ENOMOTO: Oh, you were brief. Thank you very much, Starleen, appreciate all the work that you and the WSN are doing. So, great.

MS. STARLEEN SCOTT ROBBINS: Thank you.

MS. KANA ENOMOTO: With that, Sharon?

Agenda Item: Updates from SAMHSA's Women's Coordinating Committee

MS. SHARON AMATETTI: Okay. Thank you very much.

We have a SAMHSA Women's Coordinating Committee here, and I've spoken about it before. And --

MS. KANA ENOMOTO: Sharon, if we could ask you to speak up? Sorry.

MS. SHARON AMATETTI: Speak up? Okay.

The SAMHSA Women's Coordinating Committee is a group of internal staff who meet regularly to discuss women's issues and work that we're engaged in at the agency. And we have a lot of different things going on and a lot of different activities, and some of the staff that staff that committee are here today -- Linda White-Young, Margaret Mattson, Claudia Richards, Jon Dunbar, Sara Afayee, Jeff Oppenheim, and I think that's it in the room. And Nevine.

But a few of us wanted to just get some reports out on work that we're involved

in. And we know that we're very tight for time so these are just brief presentations to give you a sense of some of the things that are going on. And after the presentations, I just want to add a few additional words.

But first, Margaret Mattson, Dr. Margaret Mattson, who's a research scientist in the Analytical Services Research Branch in the Division of Evaluation, Analysis, and Quality, in the Center for Behavioral Health Statistics and Quality here at SAMHSA, is going to tell us a little bit about the work of her center and how we're also doing -- they're doing some work around women's issues. And Margaret comes from NIAAA, actually. So we're really happy to have her, and Margaret, you're up.

DR. MARGARET E. MATTSON: Okay. Thank you.

Just so that you have a more workable abbreviation for the name of our center, it's called CBHSQ for short. And some of you may remember when our center was the Office of Applied Statistics. But in the last few years, we have expanded our scope, reorganized. So we are now a center, and our Director is Admiral Peter Delaney.

Our job is to -- we are a statistical unit, and our job is to collect data and analyze it and disseminate reports on behavioral health topics that support the mission of SAMHSA. We have three major databases, which many of you may be familiar with.

DAWN, which is a national sample of emergency room visits. We have NSDUH, which I'll be talking about later on today, which is interview-based of the population 12 and over. And we have TEDS, which is treatment admissions for substance abuse and mental health.

We try to reach a wide audience from the media to laypersons to researchers. Our major products are Short Reports and Spotlights on a wide range of topics. Of interest to this group is we have produced about 60 female-specific reports that are entirely focused on issues relating to women and girls.

And in addition, most of our other reports present the data in a gender-specific breakdown. So I would say about 75 percent of our reports have gender-relevant data. And we also publish special data reports and journal articles.

We've been fortunate enough to be able to work with our Office of Communications, and our reports have recently been attracting even more media coverage. You may have read about energy drinks. Our report really initiated a lot of media coverage on that topic. Of course, everything is available on the Web page.

A couple of new things that we're doing to try to reach out to a larger audience is

we're going to be converting our one-page Spotlights to written in a lower reading level, a less than high school reading level so that, hopefully, we can reach out to other parts of the community as well. We're also trying to kind of get modern and use social media as a means of disseminating our work. We use Twitter and Facebook and a number of other social media, which are so far to in people in my age group, I had to go to a lecture to hear about them. But they are effective at reaching young people, and we're seeing a lot of passing on of the messages and those things called "likes." So it's helpful.

[Laughter.]

DR. MARGARET E. MATTSON: You're laughing, too, because we're --

A couple other new things I wanted to tell you about is we're attempting to make our reports more comprehensive and integrated by putting data together from some of our -- from more than just one survey in a report. We used to just talk about emergency visits or interviews, and now we're looking at where the cross-cutting issues would allow us to work in more than one database in a report.

And the final overall new thing is if you haven't seen any of our reports lately, we have -- we do have a spiffy new format. It's very colorful, very nice. So we hope that will be a more attractive format.

So this is just some examples of the wide range of topics that we cover. Some of them specifically on women and girls. Others just including a breakdown of gender within a larger report. We address licit and illicit drug use, mental health problems, and so forth in many population groups -- pregnant, elderly, justice system, racial groups, and so forth.

I think the easiest way to inform you of what you're most interested in, which is the gender-specific reports, we have a bibliography which lists the 60 or so of these gender-specific reports. We're in the process of updating it. The last version was last year. I have a few of those older ones with me, but we will be updating it at the end of the month to be totally current, and we'll be happy to send those out.

DR. JEAN CAMPBELL: They're not in our binder right now?

DR. MARGARET E. MATTSON: They are not, no. And lastly -- well, okay. Okay. And lastly, this has how to get more information on our publications. On the SAMHSA Web site, you go to data outcomes and quality, and you could see all of the reports. There are links to PDFs of all the reports. You could inspect detailed data tables, and there's also an online analytic tool that you can use to create your own customized tables.

MS. KANA ENOMOTO: Thank you, Margaret. We absolutely appreciate you

being in CBHSQ and dedicating some time and energy to do some women and girls specific things that's really been needed, and it's great for us.

I just want to let the members on the phone know that Geretta is going to email you the presentations. We're sorry you don't have them, but check your emails, and they should be arriving soon.

MS. SHARON AMATETTI: And for the members in the room, the presentations are in your binder.

Thank you, Margaret. Margaret also told me that there's going to be a new SAMHSA publication on women and girls on the characteristics of pregnant teen substance abuse treatment admissions coming out on April 25th, and as soon as it's released, I will send everybody an announcement of that new product.

Great. Now I'd like to have Claudia Richards, who is a senior adviser to the Director of CSAP. Claudia wanted to share some information about National Prevention Week.

MS. CLAUDIA RICHARDS: Thank you, Sharon.

Yes, I'd like to give you a brief overview of the exciting activity that we're launching this year called the National Prevention Week. Basically, give you a little bit of background information. What is the National Prevention Week?

Well, the National Prevention Week is a SAMHSA supported annual health observance dedicated to increasing public awareness, action around substance abuse and mental health issues. The observance will bring individuals and organizations, coalitions, States, and communities together through local events and promote prevention of substance abuse and mental illness and mental, emotional, and behavioral well-being.

This slide pretty much describes in terms of background information. Again, we're launching this as the second year. We started in 2012. In terms of the dates of the observance is May 12th through the 18th of 2013.

We have identified three specific goals for this observance -- to provide opportunity for community members to learn about behavioral health issues and to get involved in our prevention efforts. Secondly is to raise awareness about prevention resources supported by SAMHSA and other entities. And thirdly to celebrate the work that communities and individuals do to prevent substance abuse and promote mental, emotional, and behavioral health well-being.

In terms of the alignment with the other Federal initiatives, the first is aligned with the National Prevention Strategy, and this is aligned with regards to the strategic directions as well as the priorities of this initiative. With regards to the strategic

directions, it focuses attention on healthy and safe community environments, clinical and community prevention services. In the area of priorities, it addresses preventing drug abuse and excessive alcohol use, mental and emotional well-being.

Next, it also aligns itself with the priorities aligned by SAMHSA's strategic initiatives, and that involved two initiatives of SAMHSA. The first one is the prevention of substance abuse and mental illness and, two, the public awareness and support. Again, all of the SAMHSA centers support this observance within their respective agency programs and other initiatives.

With regards to the target audiences, it's kind of threefold. We have our primary audiences involving CBO prevention organizations and other coalitions, other audiences that include individuals involved in prevention efforts, and also our general population.

With regards to the theme for this year, it's titled "Your voice. Your choice. Make a difference." In terms of the way we have operationalized this campaign, it involves a segment of days, which specifically focus on daily themes. I'm not going to address each theme, but you can describe it in your notebook in terms of specific activities that we're encouraging the general public and also coalitions and other CBOs to take part of.

Also I wanted to bring to your attention we have a participant toolkit that you may be interested in, which provides ideas for celebrating National Prevention Week. It contains the tools and materials promoting National Prevention Week through our social media and other channels. Also it includes fact sheets and other important issues on behavioral health that corresponds with each daily theme.

We also provide other links that would be of interest to you relative to resources regarding behavioral health services. In terms of one of the outcomes of the 2012, the toolkit was downloaded 2,112 times from the SAMHSA store during the month leading up to the National Prevention Week.

Next I'd like to talk a little bit about the prevention pledge. This particular pledge offers 12 actions that people can pledge to take to lead a healthy lifestyle and support prevention efforts in their communities. In terms of some of the major highlights, it involves SAMHSA's Facebook page, and it's also available in printable documents in English and Spanish through our National Prevention Week Web site.

In terms of some of the major outcomes, more than 1,300 pledges were taken in 2012, and pledges was viewed 2,300 times or more on SAMHSA's Facebook page. Nine hundred pledges were taken through the Facebook application, and 500 people signed prevention pledges at their community events. Eight hundred pledges were downloaded from the National Prevention Web site.

Next I'd like to discuss a little bit about our promotion and outreach efforts. This Web site provides you with information on updates about the National Prevention Week, as well as easy access to the observance of our toolkit. Again, it's downloadable, the prevention pledge and other event-related materials and available resources.

I'd like to draw your attention to the Web site, which is a cross-promotion that would help other Federal agencies and national organizations. In terms of some of the multiple Federal agencies and national organizations we're involved in, it's with the Drug Enforcement Administration, the Office of National Drug Control Policy, the National Institute of Drug Abuse, the Centers for Disease Control and Prevention, Department of Justice, and Department of Education, and other national organizations.

Again, some of the specific purpose of the Google ad campaign involved us to raise the general awareness of the National Prevention Week. Also we want to increase the public engagement with the prevention pledge. And thirdly, we want to promote the toolkit to the National Prevention Week target audiences.

In terms of the outreach to bloggers, I'd like to indicate that in 2012 it was targeted outreach to 26 English language bloggers and 20 bloggers who write for Hispanic audiences. In terms of some of the major highlights of the outcomes in 2012, 27,000 total pages were viewed between February through June of 2012 on this Web site. Also, bloggers wrote 33 posts about the National Prevention Week and reaching a combined audience of over 60,000 people.

Also I'd like to bring to your attention the Twitter promotion that reached more than 750,000 users. The Facebook posts about the National Prevention Week generated more than 1,200 likes.

In terms of the media coverage, it has involved more than 100 different media, including our traditional and online news outlets, also English and Spanish speaking bloggers. This is an example of one of the -- I don't know for sure if it's going to play.

MS. SHARON AMATETTI: I don't think we have time, Claudia, to show it. Thank you.

MS. CLAUDIA RICHARDS: Okay. But for more information, we have a National Prevention Week coordinator, David Wilson. And before you leave, I'll make sure you get a one-pager handout that will be a little fact sheet that you can take back and disseminate and share with your colleagues.

Thank you.

MS. SHARON AMATETTI: Thank you, Claudia.

I'd now like to turn over to Jon Dunbar-Cooper, who's a public health analyst in our Division of Systems Development in CSAP. And he's also the project officer for the Fetal Alcohol Spectrum Disorder Center for Excellence. And he wanted to share some information about the center's Screening and Brief Intervention and the Parent-Child Assistance Program initiatives.

Jon?

MR. JON DUNBAR-COOPER: Yes. I just want to mention that the program is mandated by Congress to improve the health and well-being of individuals with an FASD in their families. So, to that end there, we have actually been doing a lot around evidence-based approaches for women.

In 2008, we awarded nine contracts, subcontracts to look at interventions for women in clinical settings. And the two I'm going to talk about today are the Screening and Brief Intervention and Parent-Child Assistance Program.

The SBI includes 10 to 15 minutes of intervention at the initial intake and reassessment and also consists of education and goal setting to help women achieve or maintain abstinence. And the PCAP uses an intensive model in home with women and children over a 3-year period. It complements traditional substance abuse treatment.

At the end of the third trimester, we have very good outcomes, as you can see. For the women that had a past history of drinking, at the end of the third trimester, the number was 1,362 women, 99.19 percent of them had stopped drinking. And for the group that had a past 30-day use, more heavy drinkers, 98.55 percent had stopped at the third trimester.

The data reflects outcomes based on the initial screening and at risk, I already mentioned the 30-day past use. At risk was defined by the reports of high tolerance the T-ACE and TWEAK. TWEAK is usually a better tool that's used for pregnant women than the T-ACE, but we used both in this instance here.

And as you can see, 99 percent of women reported abstinence by the third trimester, regardless of eligibility status. That is regardless of whether they were just casual drinkers or 30-day drinkers, in the past 30 days.

And in the last biannual report, 24 percent said that they had used contraception effectively, and 28 percent had no alcohol use, and the combined of the two groups, 34 percent stated that they had also practiced contraception and abstained from alcohol. Eighty-six percent not at risk for alcohol exposed pregnancy compared to 100 percent at risk at the beginning of the program.

We have been having some internal discussion with CSAT and with ACF this year not too long ago around the approaches that we have that have shown evidence for effectiveness for women addicted to alcohol in clinical settings. And we do know that they're most often not recognized or diagnosed, and there can also be impaired information processing from prenatal alcohol exposure and brain damage and have a higher risk of substance abuse, difficulty negotiating safe sex problems, recognizing danger.

So the importance of this is that there could be women in clinical settings out there that the clinician or the treatment modality is not appropriate because they may have an FASD, and you don't know that if you can't screen and actually identify it. So this complements traditional clinical settings for women with an FASD that go unobserved.

As I've just discussed, modifying the treatment to address FASD can reduce the incidence of alcohol-exposed pregnancies. Also we have a fact sheet that just came out on strategies for improving care for women, and more information and resources can be found at the FASD center Web site. We also just did an e-blast. If you go on this site, here it will give you information on how you can access that information.

Thank you.

MS. SHARON AMATETTI: Yes, a quick question. Just because of time. We're behind.

MS. ROSALIND WISEMAN: Okay. My one question is can you explain to me what -- this was all self-reporting, right? This was all self-reporting? So can you just explain to me how that was verified or confirmed by its -- or was it confirmed by any other measure that they were actually doing the things they were saying they were doing?

MR. JON DUNBAR-COOPER: I would have to get back to you with the people who actually did the program. Unless, Jill, are you on the line?

MS. SHARON AMATETTI: They're muted.

MR. JON DUNBAR-COOPER: They're muted, okay. So I could get back to you.

MS. ROSALIND WISEMAN: I would be really grateful. Thank you.

MR. JON DUNBAR-COOPER: You have my contact information.

MS. ROSALIND WISEMAN: I do. Thank you. Thank you so much.

MR. JON DUNBAR-COOPER: Certainly.

DR. JEAN CAMPBELL: Could you send out to us the electronic versions of these slides?

MS. GERETTA WOOD: The electronic versions of the slides?

DR. JEAN CAMPBELL: Yes. Because I can't share these with my -- they're too small, a lot of them, to read, and I'd like to go back and do a presentation at my institute on what occurs here.

MS. SHARON AMATETTI: Great. Well, I'm glad there's interest. Thank you, and I hope that every time we meet different members of the Coordinating Committee can do reports out.

So I just wanted to add a few things, and I'll make it really brief in the interest of time. Our committee also staffs a Coordinating Committee on Women's Health. So we have our internal SAMHSA committee, and then HHS has a Coordinating Committee on Women's Health. And they have been working -- it's a large number of different subagencies in HHS participate, but the Office of Women's Health is the lead.

And they have been charged with looking at the preventive services that are part of the Affordable Care Act, and we've been talking some about that this morning. One of the areas that they're particularly working in is around the interpersonal violence screening. One of the recommendations from IOM was that screening for interpersonal violence become part of the preventive packages of services that are included.

And right now, a cross-agency group is planning a research symposium that's going to take place in October at the Natcher Center at NIH to really sort of look at what some of the research gaps are around this issue. So they're working very hard. Mary Blake and Sara Afayee are staffing that planning committee for the symposium.

So that's going on. I also wanted to mention that not only is it National Prevention Week that mid week of May, but it's also National Women's Health Week. That's a week that's coordinated, again, by the Office on Women's Health, and it's always around Mother's Day. It kicks off on Mother's Day. And SAMHSA has been working with Rosalind Wiseman to do a program that day.

MS. ROSALIND WISEMAN: Right.

[Laughter.]

MS. SHARON AMATETTI: An in-service program that we're really excited about. And again --

MS. ROSALIND WISEMAN: You sort of gave me a little bit of a --

MS. SHARON AMATETTI: We're getting all the things signed and taken care of so that we can make that happen. And so, we try and do something special for the agency that week. Last week, we had a tea. This week, we're having Rosalind -- last year, we had a tea for that week. Exactly.

And then I just also wanted to let you know the fallout of all the problems we've been having with our conference approvals and the pressure on Government to be more conservative and careful about conferences. That we've decided to not hold a women's conference next summer. We have a long tradition of having a conference every other summer, a big national conference. But we won't be having one in 2014, and we hope that we can still have one in 2016.

So that seems like a ways off, and we'll see how things fall out by 2016 with the budget. And just we recognize that these are not normal times, and we have to respond appropriately. So I did want to let you all know that that decision has been made.

With that, we actually are a little bit over time. So let me turn it back to you, Kana.

MS. KANA ENOMOTO: Well, I appreciate you guys actually keeping it brief, and so we'll take just a little stretch break. I think you can call it a one thing break. So you have time to go do one thing, and we'll be back here at 11:00 a.m.

[Break.]

MS. KANA ENOMOTO: Okay. So we are calling back to order for our session on emerging adults. So as we've talked a little bit, we've touched on a little bit transitioning from adolescence to adulthood is always a challenge and even more so when we look at substance abuse and mental health issues.

So today our presentations from our great center folks will focus on support programs for girls and young women, statistics on binge drinking among transition age women, prevention services on campuses, and recovery strategies. So we are going to start off with -- Rich, are you starting? We are starting with Margaret Mattson.

Agenda Item: Transition Age Girls and Young Women

DR. MARGARET E. MATTSON: So I'm going to be talking about a particularly harmful form of drinking, which is binge drinking among transition age women

and girls. The emphasis is on women and girls, but we'll see that this is a public health problem for males as well.

So I'll start with a little terminology. Am I doing this right?

[Pause.]

MS. KANA ENOMOTO: And for members, although they're small, you do have these slides in your binders. So, Margaret, do you want to go ahead, and we can just look at our slides in our binders while you're --

DR. MARGARET E. MATTSON: Yes. I'll continue.

All right. The first -- or the second slide was going to be an outline of the talk. The first topic is going to be some terminology and definitions. The second is going to be some descriptive and prevalence data.

FEMALE SPEAKER: Excuse me. Could you tell me where we can find this in the notebook again?

DR. MARGARET E. MATTSON: Do you know what tab that is?

FEMALE SPEAKER: Tab 4. Thank you so much.

DR. MARGARET E. MATTSON: Tab 4, okay. And the second topic is going to be borrowing or using NSDUH data to talk about prevalence, and the third major part is going to be looking at consequences of binge drinking for both males and females.

Okay. Terminology. What is transition age? And I'm sure most, if not all, of you are familiar with that. It's a period between 18 and 25 years of age. Now in analytic work, the statisticians call this age group the "young adults." But in recent years, developmental psychologists have gotten even more descriptive, and they now refer to this as the age of transition and even more colorful is a period of extended adolescence.

And that means that in contrast to previous generations where by the age of 18 to 20, they were taking on adult roles. They were more launched in their lives. And today, there seems to be a subset of people within this age group who are not yet launched. They're financially dependent on their parents, still not on their own. They're kind of in a holding pattern.

So, as you can imagine, there's a lot of interesting sociological literature on this group, but the aspect that I'm going to concentrate on today is their markedly high prevalence of alcohol use.

Okay. Has anyone seen this slide like 100 times? No? Oh, okay. So I can talk about it. I know Dr. Greenfield has. Anyway, the key idea here is that all of this data is based on personal surveys where the respondent is asked, "How many drinks did you have in the last 30 days?" And as we all know, people define "drink" differently. Some people think a drink is a sip of wine. Other people think a drink is a water glass full of vodka.

So there needs to be a standardized explanation of what a drink is, which is used across all surveys and allows comparability of data across surveys. So the universally used term is called the standard drink is shown here. It's varying amounts of the different alcoholic beverages, and the bottom line is that these specified amounts represent the same amount of ethanol, the same amount of alcohol. So the value of this is it gives a metric or a measure that's independent of the type of beverage and the volume of beverage. It's a standard drink.

And so, it contains the same amount of alcohol regardless of the beverage type, and this is explained in various ways to respondents in surveys, including the one that I'm going to be talking about.

A couple of definitions from NSDUH, which are -- everybody knows what NSDUH is, the National Survey on Drug Use and Health, which is SAMHSA's biggest survey, a population-based survey of a very large nationally representative sample of individuals over the age of 12. So it's really a benchmark survey that is used extensively. So this particular survey defines binge drinking, which is our topic, as five or more drinks on the same occasion, at the same time or within a couple of hours.

And it's five or more drinks for men, and for women, some agencies do it a little differently. They use four drinks for women, and actually, NSDUH is going to be changing to that definition. But for the current data, it's defined as you're a binge drinker if you had five or more drinks on one occasion within the last 30 days. That's how the timeframe is set for all of the questions, within the last 30 days.

Heavy drinking consists of five or more drinks on the same occasion for each -- for 5 or more days in the past 30 days. So you have to have binged 5 times during the past month to be considered a heavy drinker. And again, other agencies define that differently.

All right. I'm going to -- we're going to look at some NSDUH data now, and just so you know the approach that I'm taking, I'm going to start with sort of the broad national picture just to give you context and then start narrowing it down by gender, by age, and then by age and gender so you can see how the prevalence data changes as you look at more and more specific subgroups.

So the national picture is about half of the population are considered current drinkers, which is just it's defined as 1 drink in the last 30 days. If they report 5

drinks in the last 30 days, they get thrown into the binge category. So any use is a pretty mild and not an excessive drinking group. So about half of the population self-report at that level. About 22 or 23 report having a binge day in the last 30 days, and around 6 percent report heavy use.

So that's the big picture. When we start looking at -- when we start looking at age differences is where patterns start to emerge. This is anyone who's a current user, this part of the curve represents binge use, and this is heavy drinking. So these are inclusive categories. In other words, if you're up here, you're here and here.

I'm sorry. The other way around. If you're here, you're also here and you're also there. Here, you're also anyway --

MS. KANA ENOMOTO: Margaret, you have about 5 more minutes left.

DR. MARGARET E. MATTSON: Oh, 5 more minutes. Okay. All right. Then let's get onto an even better -- I thought I had 20 minutes. I'm sorry.

Okay. This is the really telling slide. This shows the age progression for men and women for binge drinking. And over the peak level of binge drinking, the peak prevalence is about 35 percent, and that occurs in the early 20s for women and similar for men. You can see that males reach a higher peak, but it follows a similar kind of progression and similar kind of dropoff with age.

And this is just a more compact version of what I already showed. And it just highlights the fact that for any form of drinking, the 18- to 25-year-old group is alarmingly high and with males a little bit more in magnitude, but we see that females are not very far behind.

So what's the public health burden in terms of numbers of people affected by this? We see that there is over 5 million, almost 5.5 million females who fall into the binge drinking category and about 8 million men. So this is about 13.5 million people who are at risk for serious consequences of binge drinking.

So how often do binge drinkers binge? And the unpleasant reality is that in females, it's about 3 to 4 days per month that they report binge drinking and a little bit more for males, 4 to 5. So this sounds like a lot of heavy partying on weekends.

Not only are there a disturbing number of binge drinking days, but 45 percent of the population reports a total of 16 to 19 days of any drinking within the month. So not only are they engaging in binge drinking 3 to 5 times a month, but also other drinking that does not reach the binge level.

One of the groups that stand out as the most represented, there's actually three.

I should not have put this in bold, but if you look at all females 18 to 25, 38 percent of them are white, 41 percent are college graduate, and 35 percent are essentially single. So these three groups seem to be the highest in terms of engaging in risky behavior. Employment really isn't that much of a difference between employed and unemployed. So we're looking at those three characteristics of a high risk group.

Has the picture changed over time? Disappointingly, no. The dotted lines are binge drinking. The blue is males. The red is females. We see that in females, it is practically flat. There have been no statistically significant differences since 2002 in the rate of binge drinking.

Males, there's a little bit of a hint that it might be dropping down. But we don't know if that will be sustained. So the point is we're not making any progress in this area, especially with women.

And the real key idea here is binge drinking is harmful because essentially what's happening is a very high dose of alcohol is being delivered in a short amount of time so that there's a big toxic hit to all of the organs of the body. So having five drinks at one time is much worse than having five drinks in the course of several days.

Youth may be especially sensitive, since we know that neurological changes are still occurring up to the age of at least 25. Women have special vulnerabilities. They reach -- for various physiological reasons, they reach a higher blood concentration for a given amount of alcohol than do men. They develop drinking-related problems at lower drinking levels and after fewer years than men. And of course, there is the great vulnerability that women have that's not shared by men due to reproductive issues and issues involving sexual assault.

So this is a very nice slide from CDC where at the top they summarize the risks of excessive drinking for everyone, which is in the white, and highlight in particular the problems for women -- miscarriage, stillbirth, premature birth, low birth weight, fetal alcohol syndrome, SIDS. So many vulnerabilities for women and for their offspring from excessive drinking.

So, to wrap up, I think this data shows us a couple things. Binge drinking has serious consequences, and it's a public health concern for all young adults 18 to 25. There's a large number of people in this country at risk from the consequences of binge drinking, and women and girls are at special risk. Their body handles alcohol differently, and they are vulnerable to certain alcohol-related consequences that men are not -- rape, assault, unintended pregnancy, and harm to their fetus if they are pregnant.

The data, as I mentioned, from this is from the National Survey on Drug Use and Health, NSDUH. You can find more information on our Web site, and other

sources of current information on binge drinking is a recent CDC report and also NIAAA's longitudinal study called NLAES.

So that's it.

MS. SHARON AMATETTI: Kana kind of disappeared. Okay, thank you very much, Margaret.

We're going to hold all the questions until the end when we have a discussion that Johanna is going to help us with.

Next, I'd like to have Richard Lucey, who is a special assistant to our Director in CSAP, talk to us about college age students. And Rich, you also work with the Department of Education, and you have a background from years of work in this area.

MR. RICHARD LUCEY: I do. Thanks, Sharon.

I do want to thank Claudia, Sharon, and ultimately Kana for inviting me to present for a little bit for you here today.

As Sharon mentioned, I'm the special assistant to the Director of SAMHSA's Center for Substance Abuse Prevention. Prior to coming here, which was about 4 1/2 years ago, I worked for 9 years in the Office of Safe and Drug-Free Schools at the Department of Education. And prior to that, I worked in the Prevention Bureau for New York State.

I've been in the substance abuse prevention field for just about 22 years, and my primary focus over that entire time has been specifically looking at substance abuse issues among college students. So that's a little bit of a background as to what qualifies me, if you will, to talk about this particular issue.

On a personal note, I'm the oldest of six, and I have five younger sisters. So I've always had a keen interest in women's issues and women's services. But I'm going to take a little bit of a broader context that's just not focused solely on women's issues and take a look at some more data points and issues around specifically college drinking and some mental health issues among college students and what the research is showing us as to what's effective, what's not in working with this population across several different agencies across the Federal Government, including SAMHSA. And then I have some core resources for you to avail yourselves of.

So taking off of what Margaret had talked about, here are some stats that simply look at the differences between full-time college students and part-time college students or those not in college. This has not changed much over the last 20 years. Typically, full-time college students will always be in this age range the

higher use group. More so than part-time college students or those in the same age range that are not enrolled in college.

And as Margaret talked about, the classifications of current drinkers, typically past 30-day use. Binge drinking, I am very happy to hear NSDUH is going to move to the gender differentiation in terms of binge drinking because that will at least be then in line with two of the other major surveys or I should say three major surveys that colleges and universities either administer themselves or are part of. That being the Monitoring the Future Study has that gender differentiation. The American College Health Association has its National College Health Assessment, as well as the Core survey, which is administered out of the Core Institute at Southern Illinois University at Carbondale.

So current, binge, and then petty is typically the number of binge drinking episodes in a given period of time. And this just simply shows you that full-time students in all three categories will typically outpace those who are part-time or not enrolled at all.

These are the consequences on an annual basis, and we get this information from our partners at the National Institute on Alcohol Abuse and Alcoholism. The Web site is down there at the bottom for you. Of course, if you're looking at the spectrum of consequences, the most extreme ultimately would be death. And each year we see more than 1,800 college students die as a result of alcohol-related unintentional injuries. Primarily, a lot of those do come from motor vehicle crashes, but certainly we fit into that category alcohol poisonings, which often -- sometimes in a high-profile case you will hear about alcohol poisonings happening on a campus or not.

There's no real good database to capture that information as to how many alcohol poisonings a year. I know that NIAAA often uses the FARS data and other things out of the Department of Transportation, as well as the CDC, to capture this. But if you take a look at some of these other consequences, almost 100,000 incidents each year that are related to alcohol, related sexual assault or date rape, and then we move up into the hundreds of thousands of negative consequences related to unprotected sex, unintentional injury under the influence, or being assaulted by another student, either the victim or the perpetrator, if you will, having been drinking at the time.

I want to take a quick look at some mental health statistics because we do know that the mental health of college students is a contributor, if you will, to high-risk alcohol use. And we get this information from our friends at the American College Health Association from that survey I mentioned, the NCHA, which is the National College Health Assessment. These are numbers, the most recent numbers from last spring, and this looks at the past 12 months.

And I'm going to break some of this down into gender for you in just a moment,

but take a look at the last year, 46 plus percent of college students felt things were hopeless. And that's an awfully harsh word, isn't it? That they feel things are hopeless.

Thirty-one percent feeling so depressed that it was difficult to function. Anxiety comes into play. Loneliness comes into play, as does anger, and then, ultimately, suicide ideation, either an attempt and then, unfortunately, sometimes a completion.

There is some information that we get from ACHA that takes a look at the mental health of college students, and you'll see across these four areas, females outpaced men, if you will. So you're looking at here in terms of feeling things were hopeless, again from last year's survey, 48.8 percent of females as opposed to 38.8 percent of men. Same is true for depressed, around unable to function, overwhelming anxiety, and they're just about neck and neck when it comes to considering suicide.

Now interesting, if you look at diagnosis or actually getting treatment for this type of a mental disorder on the college campuses, again women are being diagnosed more and/or seeking treatment more than the males are across these issues of depression, anxiety, and panic attacks. So the women are at least -- college age women and college women, students I should just say, are actually seeking out help in the help centers and counseling in the counseling centers. So that's actually good news.

So what are we doing across the Government? Here in SAMHSA, we have our strategic prevention framework, and this is the core planning process that we promote to all of our grantees or to anyone who is looking to develop and implement a prevention program. This is not much different than what we used to use when I was at the Department of Education, which were the principles of effectiveness. That phrase may be familiar to you.

In fact, the only difference between those two planning models is the building capacity piece. That we didn't have specifically in the principles of effectiveness. But it typically comes down to these things -- doing these assessments, figure out where your issues are, identify the appropriate program to implement, implement it with fidelity, and evaluate it.

So we have learned over the last year because we've been specifically doing some outreach to some of our grantees, we have grantees who are funded under our strategic prevention framework State incentive grants as well as our Partnerships for Success grantees that are actively collaborating with colleges and universities in their surrounding area. So we're very happy about that.

And our drug-free community grantees are doing the same thing. We're helping to make that connection with the local universities and colleges in their area. So

this strategic approach to prevention is one that we continue to promote and that many people, especially our grantees, are using.

We look to our colleagues at the NIAAA for the research, as I mentioned. I showed you some of those negative consequences. In 2002, they came out with a seminal report that is still active and being used and referenced on college campuses and in their communities across the country. They ranked, according to four different tiers, the strategies that are most effective in preventing alcohol abuse among college students from Tier 1, which is absolute evidence of effectiveness, all the way down to Tier 4, which is the evidence of ineffectiveness.

In that category, you typically will find education when used alone. We know that education alone is not effective. Many campuses go the BAC route. If I simply educate students on what their BACs are, or if they handed out the BAC wheels or the calculators, if you remember those. That just simply informing students about their BAC levels is also not effective.

The largest group in there is Tier 3. Those are what some would call the promising approaches, those where there's not yet enough empirical evidence to show that they're absolutely effective with college students. And one of the resources I'll show you in a moment has a great little chart in it that breaks down all these different strategies.

In Tier 3, a couple of the things I wanted to note for you. Regulation of happy hours and sales. And this specifically is a women's services issue. When you look at ladies night. It is something that many colleges grapple with, with the local bar owners who are having ladies nights.

I can give you a story of when I was working in New York, and I was actually going to a campus coalition conference and got in the State car, was driving across State, and got into the Syracuse area. Had the radio on. You know, when you're on the throughway, you're kind of paralyzed. You know, you're not really paying attention. You're just doing it by rote.

But something snapped me out of that, and it was a local ad, radio station, college radio station. They were having a specific promotion for ladies night, shorter the skirt, the cheaper your drink. And I nearly almost went off the road when I heard that. I couldn't believe that a bar could be that bold. I mean, that's like almost the extreme of ladies night.

But this is something that colleges have been grappling with for quite a long time of ladies nights. They get in for free or a lot of cheap drinks over a period of time, say, from 8:00 to 10:00 p.m., and then the males come in at 10:00 p.m. I mean, it's almost like you don't need to wonder why the sexual assault numbers are as high as they are from the NIAAA study.

So we're looking, and I should say the NIAAA is looking specifically at these promising approaches. I will tell you in Tier 1, one of the most effective approaches to prevent alcohol abuse among college students is brief motivational interviewing. The program you often hear about is SBIRT, which is Screening and Brief Intervention and Referral to Treatment.

We talk about language. We try to get people to realize that SBIRT is not a strategy. That's a program. But brief motivational interviewing. Sit on one-on-one with a counselor, a trained counselor, talking to students about their drinking behavior and how that compares to their peers is one of the most effective ways to prevent alcohol abuse on the college campuses.

Quickly moving along, from my past life at Education, and these are the two books that I brought along, which we have copies of this that we can actually send to you. You'll get my email address, and I can send them to you. When I was there, we had a grant program that was specifically looking at what campuses have what we considered model programs that have evidence of effectiveness. They're doing great work. They would be considered either exemplary, effective, or promising.

And for our first 22 campuses, regardless of whether they were public/private, rural/urban, large school of 50,000 students/small school of 600 students, they had these 7 elements that were in common across the board in terms of what their effectiveness was -- leadership among the president, senior administrators, faculty, students; coalition building; all the way on down to sustainability and taking a long-term approach to prevention.

We had a second cohort of 12, and that's the blue book you're seeing. These are some field experiences of these, and we wanted to take a look and see if things changed over the period of time in funding these campuses. And it just takes a few of them a little bit further. Communication skills became that much more important. Talking about what it is that you do, why you're trying to do it with the media or with senior administrators or business owners or community officials. Strategic planning, it's ongoing. Just like prevention is not a finite process, it's an ongoing and ever-evolving process.

So I'm going to close with some core resources here. Whenever I talk to folks that are looking to either get into this work of collaborating with colleges and universities about what the issues are, I point them to these particular Web sites. First of all, the Federal portal that gives all of the information about all of the Federal agencies' efforts around underage drinking prevention is at stopalcoholabuse.gov. The NIAAA site, collegedrinkingprevention.gov, which is where you can download a copy of the 2002 call to action, as well as the 2007 update to that book.

And then the Network. The Network is a volunteer organization, a national volunteer organization of 1,600 plus colleges and universities that are -- actually we brought them in last April here at SAMHSA. They specifically wanted to take a look at our strategic initiative number one, which as you, I'm sure, have read about or heard focuses on emotional health, underage drinking, suicide prevention, and prescription drugs. All four of those things cut across college campuses.

And so, we brought them in for a couple of days, and they have now aligned their national and regional efforts to our work. And so, we're very proud of that as well.

Last piece here is what are we doing currently, or what are some future opportunities for us in this realm? We're very happy about the Partnerships for Success grants. They've recently posted at the end of March. The application is currently out for this grant program. Specifically looks at this age group or includes this age group of traditional college age students. So we're looking at underage drinking and prescription drug misuse.

National Prevention Week is May 12th through the 18th of this year. Each day of that week has a specific theme to it, like underage drinking prevention, suicide prevention, building emotional health. And we're encouraging colleges to tie into that. Even though it's a traditional time for colleges to have graduated, more and more colleges are going year-round, especially with summer courses or J-terms that necessarily start right after graduation.

And then, lastly, we're collaborating with the Department of Education, and this is where I want to end. We're at a very difficult time in the landscape of prevention when it comes to substance abuse, preventing substance abuse among college students. Typically, the two primary agencies that have the largest portfolios working with this population were NIAAA for the research and the Department of Ed with its grants and its national higher ed center.

They ceased operation of the higher ed center at the end of October of last year. They no longer have grants specifically to colleges around the prevention of high-risk drinking. As Margaret mentioned, the prevalence of high-risk drinking among college students over the last 20 years or so has hovered between 39 and 44 percent. Has not changed no matter what survey you look at.

And with that significant resource going away and nobody else -- understanding there are budget constraints and such, no one else stepping in, if you will, to fill that gap, I'm more fearful that that number is going to go even higher. Because, as we know, as resources go away and focus goes away, prevalence will go up. So that's just something I wanted to bring to this committee as something to be aware of.

And there is my contact information as well as the SAMHSA store. Certainly, if you wanted copies of either of the two books that are in circulation, when we learned that the higher ed center was closing, we scarfed up as many copies of those two books as we could because those are two seminal books to read in this particular topic. So feel free to send me an email, and I'd be happy to send those to you.

Thank you.

MS. SHARON AMATETTI: Next we're going to ask Eric Lulow and Kaitlyn Harrington for a presentation. They're from the Center for Mental Health Services in the Child and Families Branch. Is that correct?

MR. ERIC LULOW: Child and Adolescent and Family.

MS. SHARON AMATETTI: Adolescent and Family. Thank you.

Both of these staff people are relatively new to the agency, less than a year each, right? Yes. So they're going to be talking a little bit about ongoing grant program on emerging adults and some of their topics related to that.

So, Eric, go ahead.

MS. KAITLYN HARRINGTON: All right. So this is an outline of the presentation. We're now focused on certainly an overview touching on the sort of issues that impact youth as they're transitioning into adulthood. And then we'll also discuss an initiative here called the Emerging Adult Initiative, and then also some resources that we have that are available.

So as has been talked about already, our transition age youth have a lot of issues and opportunities and challenges that they come to face with. And for youth who have been involved in the system, these challenges can be even greater.

So, for example, youth that have been involved in systems have a higher risk of being involved in the criminal justice system. For example, in 2007, 17 percent of all serious violent crime involved a youth offender.

They also have a higher risk of teen pregnancy. There was a study conducted by the University of Chicago that showed that women were more likely to become mothers by the age of 21 than young men were to become fathers by the age of 26, which indicates multiple childbirths by individual women. The women in this study were also far more likely to be living with a child they had given birth to in comparison to the fathers.

So these youth are also more likely to become homeless at some point in their

life. A large proportion of the homeless population on any single day are between the ages of 18 and 24. Teen mothers have a higher risk of becoming homeless than their peers. In fact, currently homeless teen mothers are often served by interventions that are created for adult families, if you will. So we don't address the unique needs of teen mothers.

Also homeless pregnant teens lack the financial resources and access to adequate healthcare that will lead to increased risk for low birth weight babies and high infant mortality rates as well.

So other issues that these youth come to face with are education achievement and attainment. Unemployment among youth between the ages of 16 to 19 was 26.7 percent in November of 2009, according to the U.S. Department of Labor. It's also important to note that youth in transition after system involvement find it difficult to find employment that offers healthcare benefits, and access to services or rareness of services that are available to them is also a challenge.

For youth leaving foster care or juvenile justice facilities, youth who have run away or who have dropped out of school, or youth with disabilities also increases the risk of these challenges.

So now my colleague Eric is going to discuss the initiative that I mentioned previously, which touches on these issues.

MR. ERIC LULOW: And first, I just want to say thank you to Kaitlyn for helping me present this because when my supervisor asked me to do this, I had to admit that I knew very little about women. So --

[Laughter.]

MR. ERIC LULOW: That many of my exes will tell you.

All right. So one thing I do know a lot about, though, is about the issues that young people face when they are in transition. I am a young adult with lived experience. I actually grew up in the foster care system, and I was homeless at 18. So I went through a lot of these issues that these young people are going through and stuff.

So I'm really happy to see that we are working towards addressing these issues, and so one of the ways we are doing it is through the Emerging Adult Initiative. It's currently in its fourth year. And what they're working on is providing supports and services for young adults ages 16 to 25, and they have a kind of twofold system for how they're doing that.

One is by providing direct services for young people so they can navigate through that transitional period, as well as working with State leaders, local

leaders, and such to create policy changes within the States to provide long-term sustainable attainment and cooperation, to provide integrated services for young people.

And so, through this initiative, we actually have seven States that are currently funded. That's Georgia, Maine, Maryland, Missouri, Oklahoma, Utah, and Wisconsin. And every year, these organizations get together to have a statewide meeting time. So they bring their statewide team so they can work around adjusting these issues in a collaborative effort.

And so, some of our objectives. Let's go quickly through these. To create a very youth-guided system of care approach. And so, this is really about empowering the young people to take control of their own case management and as well as take control and to have a part in organizational restructuring and systems improvement. So it's really that ability to control their own lives and to help improve the system for the next generation of young people coming up behind them.

We also look at the four main areas that young people struggle with, and that's going to be through the education, employment, housing, and mental health and co-occurring disorders. So helping to address those particular components the initiative has a huge focus on.

Also looking at decreasing contacts with the juvenile justice and criminal justice system. There is a very large component around DMC issues, around that as well, too, to focus on that. And then, like I said before, linking and integrating local systems with the State, tribal, and territorial levels to create a statewide systemic change in how we provide the services in these populations.

One of the really strong key components as well is family and peer support, and I know that a lot of times for young people who are transitioning, family support and supporting the family members of these young people often takes a back seat to supporting the young people. What we've found, as I'll mention here in a minute, that it's not necessarily the best practice. So we want to make sure that we serve the families and the young people as well, too. And I'll explain that in a minute. And then just services coordination around what their needs are, the needs to be met.

And so, some data here on that, how we're doing with this. I think one of the biggest things to point out is that the housing is actually we've seen improvement by about 52 percent of the young people who have come into this program have had more sustainable long-term housing, which really can help, from our experience, can really help ease a lot of anxiety, a lot of tension, a lot of those kind of things, and they can focus more on like educational needs and other stuff as well, too.

Some of the things that we have seen that are actually negative, with the binge drinking, we actually saw a decrease, a negative change, if you will, of about 1.2 percent -- so not significant -- but that follows with the trends that Margaret was mentioning earlier. As young people progress from 16 to 25, that increases generally. We also know that a lot of young people are turning 21 in this timeframe and are starting to drink or at least drinking more regularly.

And also one of the things we hope is happening is we'll see this is largely self-disclosure. So young people are becoming more trusting of the supports that they are having and are disclosing these issues more readily.

So some of the lessons that we've learned from this initiative is that having involved adult allies equals better outcomes. So that if we can connect young people to mentors, to positive supportive adults, to employment opportunities or various things like that, young people will often succeed better.

One of the other real big initiatives is around youth peer-to-peer supports, and this is something that we're really excited about. These often will have a better buy-in with the service that's being provided if there's another young people who's experienced that that's guiding them through that process.

And so, one of the things that happened out of our last annual meeting is young people really kind of rallied around together about providing these peer-to-peer, youth peer-to-peer services, and a lot of our States are now actually doing Medicaid reimbursable youth peer-to-peer services. And so, it's really encouraging to see that.

And as I mentioned before, support to all family members is a best practice, and the reason why I say that is a lot of times when young people are in that transitional time period, they have often had conflicts with their caregivers and things like that. And so, now they're kind of on their own, and they don't want any kind of collaboration to be happening with their caregivers. So a lot of times, the case workers will just stop working with the family members, and they stop receiving support.

But anything can happen with a young person's progression, and they might want to come back in contact with those family members. They might want to reestablish those relationships. So it's important to keep providing those supports and services to the family structure while maintaining the autonomy for the young people in the process.

And one of the main challenges that we've found is the opportunities for consumer organizations to collaborate and work with these youth and young adult groups. One of the challenges we think with that is that a lot of times young people who are in transition view going into the adult consumer system as being a failure. They didn't get their stuff together before making a transition,

and so it's something that we're focused on helping to normalize because a lot of times young people will need to make that transition.

And so, we're looking at integrating opportunities for consumer organizations to be a part of these efforts, and so a lot of when we have our annual meetings and such, we will ask that a representative from the adult consumer movement be at the table and be a part of that process as well, too.

So some of the strategies once again for supporting emerging young adults, and this comes from a variety of different partners. It's really how us and adult allies support young people, and that's through various different resources that are here. We have these links where you can obtain these things, and if you do want any of these resources, our contact information is going to be at the end of the slide. You can just feel free to reach out to us, and we'll get it to you.

But some of these things come from Child Welfare. I'll point out the Getting Solid one there is actually one of the ways that it's like a guide created by Foster Club to help young people develop permanency pacts with adult allies. So it's a process for how young people can actually form relationship with adult allies around what is this particular adult ally going to be able to help me do, whether it can be like transitioning into school or getting stable housing. So it's about those individual components.

And then one of my favorite ones is "T time," and this is the 21 things that you're going to need before you turn 21. So it's a guideline for all the things that you need to kind of get together before you -- as you're making that transition. So, but these are some of the things that you can do on an individual case management sort of level.

And then some of the things you can do, because like we said, one of the important components of this is involving young people in the system and organizational change components. And so, we have some resources around that as well, too. The first one we actually created for this particular program, and it is different categories of where youth groups and youth organizations on a local level should be functioning and the different kind of activities that they should be doing to engage their community and to help improve their leadership skills and such. And the others are about doing advocacy work, about sharing your story, what is both safe and effective, all those components there.

And then, lastly, working on a national level, we have some really great youth empowerment organizations, such as Youth MOVE National, which is actually supported through your SAMHSA, as well as other groups, such as Foster Club, which is for foster care alumni and people who have experienced the child welfare system. They have a great internship program there every summer that educates and trains young people in how to be advocates and how to do system reform efforts.

And also the Congressional Coalition Adoption Institute, which is for all of the young people with child welfare and adoption backgrounds, and they actually work on a national level by interning for congressional members. So these are great opportunities for young people to really be a part of this growing dynamic and youth movement.

And one of the practices we know for engagement is we really want to interpret for young adults this idea of having adult allies. I know from my own personal experience I thought I could do everything on my own. So one of the things that I've learned over the years is I would not have succeeded if it wasn't for my adult allies, and that's one of the things we're trying to teach the young people is to develop those relationships, that trust and that rapport with adult support.

Continue to provide services to the family because one of the things that we've seen and general trends that when young people get older, they want to reconnect with family members. So we want to make sure that we keep those avenues as open and as healthy as possible.

And then we keep working with our consumer and adult ally volunteers. One of the best examples we've seen from this initiative is actually in Maryland where they have from their adult consumer movement a young person who is a youth outreach coordinator, and they actually work with our local Emerging Adult Initiative sites to help them with like their youth stuff. And so, youth see this first off in the adult consumer world as a peer mentor in a lot of ways, which is really I think the most promising result in that collaboration between youth organizations and adult consumer organizations. So we're really excited about that.

And so, we're going to -- I know we're going to hold for questions, I think. But we have our contact information here if you want to get any of these resources or ask us any additional questions about these things.

And thank you for having us.

MS. SHARON AMATETTI: Thank you very much.

Thank you to all of the presenters We have opportunity now to talk about what they said and your experience with these issues and how they relate. So I'm going to turn it over to Johanna to conduct this portion of the meeting.

Agenda Item: ACWS Discussion

MS. JOHANNA BERGAN: Well, thank you, Sharon, for asking me to kind of direct this conversation. I feel like our three presenters have shared my life

experience for me. Thank you.

[Laughter.]

MS. JOHANNA BERGAN: And I'm not one to overly share, but I think that you -- this grouping of presentations hit a lot of the important nails that I've identified from personal experience.

And also maybe I'm directing the conversation so I don't just talk at you for the next 30 minutes because I have a lot of thoughts. So I have a few questions proposed. I think we could maybe take a few minutes to ask direct questions, if you have clarifying questions for the presenters. But if you could think about as we go through these, through our discussion, helping to identify ways that SAMHSA's current initiatives, programming, and research could be slightly modified to focus more directly on women and girls instead of maybe creating a brand-new program that in this budget world may not happen. I like to be realistic.

And then also to think about sharing specific things that are happening in your work to bring to the table that haven't been highlighted. So those are my goals in terms of discussion leading.

But does anyone have specific questions or clarity needs from the presenters?

MS. ROSALIND WISEMAN: Can you clarify for me, you said education alone is not effective when you were talking about the four different. Could you clarify that for me, please?

MR. RICHARD LUCEY: There are some schools who will simply put out brochures, if you will, during a health fair, and that's their prevention program. Simply giving students fact sheets for educational material like that without any other wraparounds, part of a comprehensive program is ineffective, in and of itself.

MS. ROSALIND WISEMAN: So a university perceives that they've done the education if they -- we'll throw them a bone and say if they do it at the health fair, they put it up in the bathroom stalls, maybe they put them in the dorms like just somewhere, you know, right? And so, that would be like we've done that. That's what you mean by an education?

MR. RICHARD LUCEY: Right. Right.

MS. ROSALIND WISEMAN: Okay.

MS. SHARON AMATETTI: As the parent of two college age students, both of the schools that my children attend do effort around their orientation week,

where they make them all go. They sign in online. They have to take a course online, and the parents actually are encouraged to take the course as well, and I would say that's probably educational, but not -- doesn't shape behavior.

MR. RICHARD LUCEY: And orientation is usually the first point where students are getting their real introduction to college culture. And like Sharon said, I mean, it doesn't stop at orientation. I mean, and so, obviously, throughout the year, because there are many other points in time, whether it's homecoming, big football games, I mean there's plenty of other educational moments or situational times during the year which education has a role. The whole issue is just education by itself is not effective.

DR. JEAN CAMPBELL: I had a couple of observations that were related more to modification or suggestions. To you, Richard, when I looked at the two books you passed around in your presentation, I saw some use of the data and feedback, but not very aggressive. And I was thinking that a focus on an aggressive CQI, continuous quality improvement process would be really important for these programs in terms of having quality team and more than just having it inform the strategic planning and also how the data is then disseminated.

And the second thing would be to involve peers in that continuous quality improvement process, maybe in refining the types of questions that are asked and also informing the goals. We focus a lot on peers now providing the services. But it's really important, the type of questions you ask leads to type of answers that you get.

So those two things I thought seemed to be somewhat absent. It isn't like you were opposing them, but I thought that that could really improve the issue of effectiveness in your peers. Because a lot of programs are really promising programs, and to get from promising to effective, a CQI process would be really good. And particularly because you emphasize fidelity tools, and that would be the means for doing that.

And for you, Eric, in your -- when you were describing your program and you were looking at outcomes, you were using the knowns. And what I noticed was is that you didn't have any well-being indicators. You have an absence of illness. You called it psychological distress, but there were no measurements of anything related to well-being like self-efficacy and hope and empowerment, meaning in life, goal attainment, those types of issues.

Which it would now that we're looking at a more holistic concept of recovery, it's both treatment of illness or the absence of illness, but also we don't want to fall into enemy -- that we want to look at the level of well-being because that lead to resilience so that -- and that would be important to look at in those programs. So that would be a recommended change. I don't know, you'd have to maybe talk to

Margaret since you're in the division that --

DR. MARGARET E. MATTSON: We'd love to have that conversation.

DR. JEAN CAMPBELL: So those were my two comments. Thank you.

MS. JOHANNA BERGAN: Are there -- specifically, are there areas that you are identifying where there could be a shift in additional focus specifically to girls in transition or this age in the presentations?

MS. ROSALIND WISEMAN: I have another question. I'm sorry. Do the girls believe in the evaluations, and I think this would include yours as well, that drinking five drinks a day is a bad thing? Like do they even --

DR. MARGARET E. MATTSON: I don't think they -- I don't think they fully grasp that. I think their level of -- their perception of risk is not what it should be. Do you agree with that?

MR. RICHARD LUCEY: Yes, over time. I mean, the five or more and then the gender differentiation of four or more over time. We know that's the point at which problems then can begin to occur, impairment and things like that.

Anecdotally, though, among college students, five drinks is a drop in the bucket.

MS. ROSALIND WISEMAN: Right. So they don't even --

MR. RICHARD LUCEY: So coming to the whole idea of don't believing in, yes, and it also does speak to Margaret's piece about a drink is a drink is a drink. I mean, most people on college campuses think of the red Solo cup.

MS. ROSALIND WISEMAN: Right.

MR. RICHARD LUCEY: But that certainly is more than your typical beer or your wine, 5 ounces, and things like that. But somebody says, "Yeah, I only had three drinks." But they're looking at a 24-ounce Blue Moon or something, that's then into 8.2 drinks. So that's part of the issue there is a definition or a perception issue.

DR. MARGARET E. MATTSON: And it's disturbing, I mean really disturbing to me that not only is it the culture to go out and drink, but you pre-drink, you know? Are you familiar with that term, pre-drinking? To me, that's appalling. You know, you're going out for an evening of drinking, but you get drunk ahead of time so that you can really be in the swing of things.

I think by the time -- I think they're even just losing track of how much they've consumed, in addition to being unaware of what's safe.

MS. ROSALIND WISEMAN: Well, it's confusing because -- I'm guessing. Because in some ways they don't guess about this that adult women, I mean the joke amongst my peers is your doctor asks how many drinks you've had, you always cut it in half, right?

You're sitting with your doctor and she says or he says to you, "How many drinks?" or you fill it out on these evaluations, and you go, "Well, I have two glasses of wine a night," right? Because you're sort of fooling yourself. You don't want to tell your doctor how much you're drinking a night.

I mean, I think women my age are drinking a lot, a lot a lot. But we know better to be honest, right? Or to even hide it from ourselves, more to the point.

MS. JOHANNA BERGAN: The flip side of that is I was wondering in these questions, when these questions are asked to young people, are they asked in a different way, or is this asked in the same way as I'm asked at my doctor now that I'm an adult? And I'm wondering that because my intervention my freshman year, when there were overage of write-ups for drinking under age of 21 was for our resident assistants to have us pour into glasses what we thought a drink was. We were trying to make that page.

And we did it wrong, right? We filled our red Solo cup, and we laughed. And I would be like -- that was the whole hall we went down high fives because we thought we were only drinking 3 drinks, and it turned out we were drinking like 12 drinks. And we were so proud of ourselves.

So instead of halving it. It's like, "Oh, no, these are my servings. I'm drinking more." Like it's a stature. And I'm just interested in the reporting differences and how those questions are asked. Or even being able to define a sexual assault incident.

MR. RICHARD LUCEY: So on the issue of how the questions are asked, obviously, you're looking at different surveys, whether it's the NSDUH Monitoring the Future, the Core, or the NCHA. Interestingly enough, when I did my master's thesis, I took a look at the last 50 years of one of the areas I looked at was 50-year history of drinking on college campuses. And one of the things that we found, I found with other help was didn't matter the survey with all these different methodologies and different questions, the numbers were fairly consistent in terms of the prevalence of drinking among college students.

That's why I said that 39 to 44 percent didn't matter which survey, and so that's one thing. The other issue is people often are skeptical of the numbers because it's all self-report, but there is also plenty of research out there that show that self-report surveys are valid and reliable.

So it's typically the students who want to be the skeptical ones, especially if a school is going to implement what we would call a "norms misperception" campaign. Because what the research also shows, if you reduce the misperception, you'll also reduce the actual use. We've had campuses who have actually then implemented a "how we did our survey" campaign. So that students did understand this is all numbers that came from you. Here's how we did the survey.

Once they understand the mechanics of it, then they're pretty much onboard. But I think you're right, Rosalind, in terms of some of the underreporting. There is that. But overall, the numbers are pretty valid.

DR. CAROLE WARSHAW: Is there any information about context? And there are social norms about drinking, but there are other context like some of our data around coercion and IPV into using or preventing, which I'll talk about later. Or about clubs or what kinds of things support more drinking versus --

DR. MARGARET E. MATTSON: Fraternities.

DR. CAROLE WARSHAW: -- where do people go to drink and --

DR. MARGARET E. MATTSON: I mean, fraternities are a huge culprit, right?

MR. RICHARD LUCEY: Yes, I mean, your top three high-risk groups on campus are your first-year students, student athletes, and members of Greek letter organizations. Mostly the frats, but often the sororities as well.

You bring a -- Carole, is it?

DR. CAROLE WARSHAW: Yes.

MR. RICHARD LUCEY: A good point. Because the field somewhat struggles with that particular issue when they're looking at the definitions of binge drinking. I mean, we can say it's five or more drinks at a setting. But then the question is, well, what do you mean by "a setting" and in what context? I mean, that doesn't necessarily get that clearly defined in many of these definitions.

So that certainly plays into it. Some schools actually individually will define that, but I think you're looking at like homecoming, some of the big athletic events. That's contextual. Rush for Greek letter organizations and when they're actually recruiting, which many schools now delay until spring and no longer do fall recruitment and rushing. As we know, that first 3 months on campus is a high-risk time so they've actually deferred it.

DR. CAROLE WARSHAW: I was also thinking about predatory behavior and when that's likely to happen and when people are drinking in their peer groups

versus with mixed groups and how that plays out.

MR. RICHARD LUCEY: Well, unsupervised house parties is certainly a concern in the communities. I mean, many detractors will say when you're looking at the 18 to 21 debate, which is amazing that debate is still around even after almost 30 years, right? That you're pushing --

MS. HARRIET C. FORMAN: Legal drinking, is that what you mean?

MR. RICHARD LUCEY: Yes. The legal drinking age. That you're pushing, if you don't control it on campus, you're just pushing it into the community. I mean, that's often what we hear. But unsupervised house parties happen regardless.

And that is often a time not only in actual establishments where you do have to deal with date rape drugs, like Rohypnol was always a big issue, as well as some others. But certainly in the unsupervised house parties, whether it's connected to a fraternity or not, and it's usually the frats that are involved, but not always. But that's certainly another contextual.

MS. SHARON AMATETTI: Also the housing set-up makes a difference, too. Where my daughter goes to school, they're building a big new dorm. It's a freshman dorm. It has suite-style living, which seems really appealing. But the problem with that is that a girl or guy could stay inside their suite and never be seen during the evening.

If you have bathrooms that you have to go to down the hall to throw up in, someone will know that you're throwing up in the bathrooms down the hall. And so, the observance of students coming and going is influenced by even the way the housing is set up.

Rosalind mentioned the vice principal's critical role in behavior issues at schools, and I think the resident assistants perhaps are somewhat overlooked in terms of how strong their influence is in freshman dorm living. And Johanna, you mentioned that yours tried to an educational event, and you all interpreted that another way.

But there is such a wide range of responsibilities and roles that the RAs are given and training and expectations, it really depends what floor you're on in terms of enforcement of different behaviors. And I'm not sure the extent to which that role has really been looked at closely by universities.

MS. JOHANNA BERGAN: Have you also thought about what training is available and if a university had done more training in this area if they had better outcomes?

DR. JEAN CAMPBELL: I was curious if you have any data on readiness for

change? Have you utilized that metric at all?

DR. MARGARET E. MATTSON: No, not that I'm aware of.

DR. JEAN CAMPBELL: That might be very helpful. Because I was sitting here, and I was -- and I may be wrong on this. But I couldn't get it straight in my head if the motivation of these college age and I would say high school age young people, is their motivation to control drinking? I think not. Or is their motivation getting drunk?

And I think that the interventions and the approaches would be different whether you're addressing an audience that is trying to control drinking versus one that their goal is to get drunk. And that's when I was thinking of the are they ready to change, or are they in a mindset where you may have to rethink how the questions you ask or the educational approaches and the programmatic approaches and maybe like in the readiness to change assessment there's different stages from being ready to sustaining that readiness to the remission in that cycle.

So there is still a part for controlling drinking, but when you're addressing an undifferentiated audience I think like these freshmen, for example, that they may not even be ready to change. They're out there -- the pre-drinking is so they can get drunker.

DR. MARGARET E. MATTSON: Their goal is to get drunk.

DR. JEAN CAMPBELL: They can achieve --

DR. MARGARET E. MATTSON: Not to have a few drinks, but to get as drunk as they possibly can.

DR. JEAN CAMPBELL: And not -- without detection, too.

DR. MARGARET E. MATTSON: Without detection. Yes, you know, on the opposite end of this spectrum, and Rich would probably know more about this, I've heard that there are some schools that have actually special sobriety programs for recovering drinkers. I'm sure it's in the minority, but --

FEMALE SPEAKER: Local high schools?

DR. MARGARET E. MATTSON: Yes, but there are some of them that are -- I mean, they're really oriented. There's a special dorm. There are programs. There are mentors. And that really sounds like something if we could have more of that for those who are ready to change.

DR. JEAN CAMPBELL: That would be if they wanted to control drinking, right.

DR. MARGARET E. MATTSON: And to be in an environment that reduces -- you know, reduces the availability and also the perceived value of being drunk. So that's, I mean, that's one thing would be nice to see that increased.

DR. YOLANDA B. BRISCOE: What you're talking about is a culture, a total different culture of not drinking. I moved to a State 8 years ago that 50 percent of the high school students don't even graduate. So this notion of college is it's a different culture. It's a culture of families all drinking together, and funerals, weddings. When you go to a restaurant, what's the first thing they ask you? "What are you going to drink?" They don't ask you, would you like some heroin, or would you like a little crack with your meal?

So it's pervasive. One of the questions that I had was 8 years ago at a residential treatment and in outpatient, we were seeing strictly heroin, strictly alcohol. We don't call them "dirty" or "clean" UAs. We call them positive or negative. But we are seeing it is the rare individual who comes into treatment that does not have a benzodiazepine in their system, and I'm thinking that that might be a large cause of the deaths because if you mix two downers, you're going to die

DR. MARGARET E. MATTSON: A very bad combination. Yes.

DR. YOLANDA B. BRISCOE: A very bad combination. We have seen a real huge upsurge of benzodiazepine with alcohol. It's no longer just alcohol.

MS. ROSALIND WISEMAN: Do you see that? Are you guys seeing that in both of your -- what you were reporting out to us?

DR. YOLANDA B. BRISCOE: Or is it measured or taken into account?

MR. ERIC LULOW: That I'm not aware of. What we've looked at is drug use. We haven't looked at like any different issues around what it is, so we can look into that further into how --

MS. KANA ENOMOTO: Eric, if you would speak into the microphone?

MR. ERIC LULOW: Oh, I'm sorry. Yes. No, we haven't. But we can look and see like what particular illegal drugs are being used, rather.

DR. MARGARET E. MATTSON: Yes, and actually, that's a great idea for a report that our center could look into because we have emergency room data. We could look at combinations of benzo and alcohol for emergency room visits, and we can also look at the self-reports in NSDUH.

So, I mean, we've looked at that in older people, adults. But in this younger age

group, I'm not sure, I think that's a really great idea.

MS. SHARON AMATETTI: The second most prevalent used substance is marijuana in the 18- to 25-year-old range. And of course, it's complicated now with all of the State laws that are changing around nonfelony convictions and acceptable use.

DR. YOLANDA B. BRISCOE: With the benzodiazepine, your heart will stop.

MS. SHARON AMATETTI: Right. Oh, yes.

DR. YOLANDA B. BRISCOE: Versus with marijuana. So --

MR. RICHARD LUCEY: To Yolanda's point, one of the slides I didn't bring but presented a couple of weeks ago at a different meeting, this wasn't college student specific, but it was the 18- to 24-year-old age group. And this was out of the NIAAA looking at hospitalizations. And over the last 10 years, I think it was between 2002 and 2010, that over that 10-year span, hospitalizations that related to only alcohol use increased by about 25 percent. Alcohol with another drug went up about 76 percent.

So that co-occurring issue of alcohol in combination with is a huge spike over the last 10 years of hospitalization issues. So that certainly is something that others are looking at.

DR. YOLANDA B. BRISCOE: And the ignorance around it is astonishing. Our registered nurse sits everybody down, and, "You are going to die, even -- if you leave here, do not mix the two because it's not the alcohol that's killing you. It's the combination."

MS. SHARON AMATETTI: And benzodiazepines alone is the second-highest cause of unintentional death from that.

DR. SHELLY F. GREENFIELD: And I am -- I'm glad that we're having this focus and presentation on transitional age use and that Margaret, also Richard, you were presenting the issues around drinking because it's been a perfect storm over the last 15 years of multiple things in this age group, and we really haven't been able to make that much headway, as Margaret's data would show.

In other words, there's been a narrowing of the gender gap for all the substances, including alcohol, over the last 30 years and especially pre- and post birth cohorts before and after World War II. There's actually a narrowing of the gender gap that's actually closed now for prescription drug abuse in teens and transitional age youth. And there's a decreased perception of risk amongst both girls and boys.

Girls, as Margaret points out, have what we call telescoping course of drinking problems because of their physiologic vulnerability, but they don't really know about that. Many young women actually don't perceive that actually drinking if they're pregnant is necessarily an adverse problem, which is really kind of hard to believe 25 years later. And what Richard just presented about the fact that if you just inform people, it doesn't seem to do much good, when that converges with a time in people's lives where they consider themselves invulnerable and immortal, which is in mid to late adolescence from a developmental stage, that's a very -- also a big, perfect set-up.

So this has really been happening over the last 15 years, and I would just add when you think about the culture on college campuses, one part of that culture really is, you know, you said it's been 30 years since the change from 21 to 18. But for kids, what that means is it's illegal for them to drink until they're 21. They get all their other citizen's rights at age 18, including serving in the Army and all sorts of other things, serving in our armed forces. And for them, they consider this their -- something they wish to do and want to do, but it's an illegal thing. So, in fact, it becomes more attractive, and it goes underground, and they're going to do it anyway.

And now the pre-drinking that you're talking about is extremely dangerous. And when you talk about combining it with pills, which all these kids have access to all these pills anytime they want them. So it's really been a perfect storm, and I think if we're talking -- I think it's for both boys and girls, but if we're talking about young women where the physical vulnerability is very rapid. They get addicted quicker and have more consequences.

It's really a serious problem that I think we really haven't made a lot of headway on. I mean, we've tried, and there are a number of different approaches that have been tried. But as you point out, it's not like we've really come up with several best ways to do this. I mean, there are ideas, but we are -- I feel like we're very behind the curve on this, and so I'm glad it's being highlighted here. I think it's a big issue for women's health.

It's not just women's mental health. It's women's mental health and their health because this has many, many really adverse consequences for women's mental and physical health. So, anyway, it's a great session. I think it's really an important focus.

I would be interested to know other opportunities to collaborate on programs that would be really evidence-based that we could utilize in different settings.

MS. JOHANNA BERGAN: I'm interested in if there's been some overlaps -- I think I'm looking at Richard's slides -- between the alcohol use of college students, so really the percentage of binge drinking and heavy drinking, with those students reporting feelings of depression and anxiety. I'm wondering, I'm

suspecting there's a strong correlation, but has that been done?

MR. RICHARD LUCEY: Yes. Actually, the American College Health Association is a good group to look at --

MS. JOHANNA BERGAN: Okay.

MR. RICHARD LUCEY: -- in terms of that National College Health Assessment. It's one of the more comprehensive tools out there in terms of looking at the substance abuse issues along with the mental health issues. It provides individual campuses with a much clearer snapshot of what's happening.

I don't have it directly in front of me, but I do know they had come up with top 10 factors or things that were having an impact on students. And interestingly enough, you would see many of the mental health issues like depression, sleep disorders, and such, and alcohol didn't pop out as a singular issue in the top 10. However, we all know that --

DR. CAROLE WARSHAW: Is this defined by the kids?

MR. RICHARD LUCEY: This was I think it's through the compilation and the analysis of all the surveys that they've done and taking a look at these top 10 issues, and alcohol doesn't pop out as a top 10 issue. But its connection to the top -- exactly right.

MS. JOHANNA BERGAN: So, because I'm intrigued by the higher percentage of girls in seeking treatment for receiving a diagnosis of mental health and if we talk about even if it's a brief one-on-one intervention, be it with a peer or an adult, about drinking at a time that they're reaching out for help about anxiety or sleeplessness, if there's an ability to hit the most vulnerable population when those overlap?

And also we haven't talked about eating disorders, but I think it's very prevalent in managing that change for girls in college and what happens to your body when you turn 18 and when you go to college and when you eat that food and when you drink a whole lot of alcohol and how you, in turn, manage that change on your body.

DR. CAROLE WARSHAW: And I think a related issue is if for kids who are taking medication either for medical problems or for mental health problems, and those interactions with alcohol. I just heard a number of people I know whose kids died who had epilepsy and were probably drinking and not -- just didn't know about the combination. Or kids who've had to lead more restricted lives when they were at home because everyone's very vigilant, and then they get to college and then --

MS. JOHANNA BERGAN: Is there a naiveness to our doctors who don't --

DR. CAROLE WARSHAW: Yes.

MS. JOHANNA BERGAN: -- inform young people who aren't of legal age of the consequences?

DR. MARGARET E. MATTSON: Kids who are on ADD medications, antidepressants.

DR. CAROLE WARSHAW: Yes, all of that.

FEMALE SPEAKER: And diabetics.

DR. CAROLE WARSHAW: Yes, kids with diabetes, kids with epilepsy, any kind of medication.

DR. MARGARET E. MATTSON: What you mentioned earlier about is there a correlation or an overlap between substance abuse and mental health is one of the next things that we were going to look at with the NSDUH data, actually see what that cross-tab looks like.

MS. JOHANNA BERGAN: Yes?

MS. ROSALIND WISEMAN: I have another question about one of the challenges I have with the kids I work with is friend groups tend to drink around the same amount. And so, they know the most about each other, about who's drinking and what drugs, what prescription drugs they're on or you just know that about your closest friends often.

But it also means that you feel like you don't have the credibility to talk to your friend who you think is running off the rails because she's going to look at you and say, "You're drinking just as much as I am. So why are you even talking to me?" And alcoholics are amazingly good at being really manipulative in their conversations. So you end thinking, "You're right, let's go party." Right? Like "I'm crazy for even bringing this up."

So I'm interested about in both of the reports about sort of the peer -- the mechanisms of peers because, obviously, they know this. They know the most information. They care the most. They're the most invested, basically, in the relationship. They're going to be there at the moment of crisis, for the most part. They are going to be the ones that will keep that kid safe or not, be able to intervene effectively or not.

But they are those people in those really important moments that I have found consistently that they won't talk to the person because they feel like it's going to

come right back on them, that you're drinking just as much as I am. So you don't have any credibility to talk to me.

So I don't know. I just thought about that. Like as you guys were talking, I kept thinking about these kids trying and wanting to reach out to their friend, regardless if they went to college or not or where they were socioeconomically. There's this great, great feeling, deep feelings of "I need to reach out to this person. I have no idea how to do it."

MR. ERIC LULOW: One of the things that we look at when we're training our young people to be peer advocates is to be able to establish appropriate boundaries with young people that they're working with. And so, even though like they have similar life experiences and come from the same backgrounds and such, like when our conferences, like our peer and youth advocates won't drink. They won't participate in those kind of activities to set a positive example to the other young people that they're going to be there in case someone is in recovery, those kind of things, and really set a foundation around the safety measures that there are in place for that.

And what we try and do is develop plans with all the young people that are in the program so like if there is an issue of relapse or there is an issue of concern, that gets addressed, that there is a process to follow that the young people have helped develop ahead of time. So that like when someone comes to them and says, "Hey, I think that you are drinking too much. You're mixing things that you shouldn't be mixing. We need to have a conversation about this." They've already worked on like how that conversation is going to go before they're in that moment, which makes them more likely to follow through with that.

MS. ROSALIND WISEMAN: What about if the kid says to his abstinence friend some version of "You are way too extreme. You are like you are over there, right? Like I've got it." What's the content of that conversation?

MR. ERIC LULOW: I'm not sure. I'm sorry?

MS. ROSALIND WISEMAN: If you have a kid who's a peer leader, right? And peer leaders are usually seen as being like the good kids, right, or they might have cleaned themselves up and now they're the good kids. And so, they lose credibility sometimes because they're the good kids. Right? They get to go to conferences where they get to talk about these kinds of things.

How do you -- what's the most effective response, in your opinion, about how a kid who's got the rep for being the good kid, the abstinence kid, the one who takes you home. So the kid will be used to get you home, but what's the strategy that you give these kids to be able to be credible to the kid who's drinking?

MR. ERIC LULOW: I think that the "I've been there, done that" component of

that peer-to-peer relationship really sets a good foundation for that rapport and respect. So we've never really -- personally, I've never seen like an issue with that where a person disrespected. I think that it normalizes that negative behavior and that there is the possibility to recover from that.

So I think it really kind of sets that like we've gone through the same issues. This is how I overcame those issues, and I was there where you're at now. So this is like kind of how that dialogue and conversation happens. But --

MS. SHARON AMATETTI: One of the things they do on college campuses sometimes is they have a no consequence reporting. So you're told that nothing's going to happen. But what would be great is later, 2 days later, the peer shows up. There was no consequence, but can I be helpful to you? Or even if that would be actually ideal.

MS. JOHANNA BERGAN: I'm wondering if there's a step between when Eric is talking about peers and when you're talking about peers.

MS. ROSALIND WISEMAN: I'm talking about friends.

MS. JOHANNA BERGAN: Yes. So what I've seen, and this is kind of spurring ideas in my head, is I'm trying to help my friends, like we're just in high school. We don't know anything about this conversation happening. And I probably can't tell my friend because they're going to point the finger back at me and go into this ridiculous conversation.

But I can tell Eric's peer, who is not the "best peer." Now they're a peer by a once-removed relationship, and that person who has the training is, we're hoping to find and show in an evidence-based way, more able to help that peer than even you could. So, and you are more apt to go to this trained peer leader who's within 4 years the same age as you than you would to your vice president of your school, who is not going to handle the situation.

MS. ROSALIND WISEMAN: Or the vice president of the SADD chapter or something like that.

MS. JOHANNA BERGAN: Yes. Yes, and I think maybe that's the language difference I was hearing?

MS. ROSALIND WISEMAN: I think you're right. I think you're right.

MR. ERIC LULOW: Okay. Yes, that makes sense.

MS. ROSALIND WISEMAN: Thank you. Thank you.

MS. JOHANNA BERGAN: Oh, we have 1 minute. My stomach is growling.

[Laughter.]

MS. SHARON AMATETTI: Do you want to wrap it up?

DR. YOLANDA B. BRISCOE: Can I ask one more question?

MS. JOHANNA BERGAN: Oh, yes.

DR. YOLANDA B. BRISCOE: Our registered nurse, I told you what she tells the clients. Don't mix them. You're going to die.

The counselors, on the other hand, use the motivational interviewing. Have you done any research on that? Because you're telling me that you're drinking six drinks, and that seems to be okay, and what's that like for you? It's a very different event -- effort.

MR. RICHARD LUCEY: Yes, actually, the NIAAA is squarely in Tier 1. Of those four tiers of effectiveness, brief motivational interviewing shows up squarely in Tier 1 as being one of the most effective approaches to address this issue. And to Jean's point, this is exactly where mainly Prochaska's stages of change theory comes into play, where the trained counselors are finding out from the person they're talking to about their behaviors are they are at a precontemplation stage? Are they at a contemplation stage? Are they at -- so I don't even dig my heels in. It's all about readiness, that whole point, and that's why you need trained people that are doing this one-on-one.

DR. MARGARET E. MATTSON: And you really need them in emergency rooms, too.

MR. RICHARD LUCEY: Oh, yes.

DR. MARGARET E. MATTSON: They're so pinched. They're so strapped that not many of them have the luxury of having a trained person on the staff. So somebody is brought in with alcohol toxicity, talk about a teachable moment.

DR. CAROLE WARSHAW: That makes me think about the rape victim advocates, where there are trained volunteers who go in when someone needs to have a rape exam. So maybe there's some kind of peer work that we could pursue when people are in a crisis and maybe more open to listening or when they're coming out of it before they reconsolidate.

MS. JOHANNA BERGAN: My sister is a resident assistant, and she -- the calls that she handles and the things she does are not for her residents because her residents are too scared to go to her because she's mandated to report. She deals and helps the peers the next building's residents.

And that's one step removed, but feeling like, oh, she has a little bit of training. Maybe she knows what to do, but she's not going to report on me. That's -- they want that advocate.

Well, it's a very broad ability to summarize everything that we talked about. I think that what I'm hearing is there is -- there are -- there's overlaps. And if we can look at where substance abuse and mental health overlaps at college age with women and girls with just looking at that area and kind of targeting our work there, it seems like everyone has a correlation to add, and there's not one population.

I mean, even if it's not just girls, we could focus specifically on those in greatest need.

Thank you. Thanks, everybody.

MS. SHARON AMATETTI: I'll turn it back to Geretta.

MS. GERETTA WOOD: If we could break now and reconvene at 1:30 p.m. So we will reconnect with the folks on the phone at that time.

Thank you very much.

Your lunches in through this door. They're labeled, and the drinks are there as well.

[Break.]

MS. KANA ENOMOTO: Welcome back. We have our members here, returned from lunch. And do we have Velma and Starleen on the phone?

MS. GERETTA WOOD: Starleen is on the phone.

MS. KANA ENOMOTO: Okay. Thank you, Starleen. I think we may not be getting Dr. Murry back.

MS. STARLEEN SCOTT ROBBINS: Kana, I'll be on until 4:00 p.m.

MS. KANA ENOMOTO: Fabulous. Thank you, Starleen. We appreciate it.

So while we're bringing up Mary's presentation, let me say a little bit about Mary. Many of you already know her. They saw the waves as she came in the room. Mary is a legend in her own right.

She's done fabulous work for SAMHSA in our area of trauma, trauma-informed

care. She's the project officer for our National Center for Trauma-Informed Care, as well as our National Center for Promoting Alternatives to Seclusion and Restraint for Trauma-Informed Practice, which is a bringing together or our S&R work with our trauma work, which I think recognizes that you really can't have meaningful elimination of -- or we really can't achieve the goal of eliminating seclusion and restraint if we don't promote trauma-informed context for treatment.

She's also a project officer on mental health transformation grants that are focused on implementing trauma-informed frameworks. And she works strategically within SAMHSA to increase capacity for delivering trauma-informed services, supports, and technical assistance in grant programs across the agency.

It doesn't say it here, but Mary is also just a really fantastic consumer leader and I think came to us with a background in doing like economic development work and fostering empowerment through I think self-sustaining and meaningful employment and self-employment. So I have lauded Mary and her efforts for many years. She's a great asset to SAMHSA.

With that, I will let -- Mary is going to present to us, and then we'll have a 45-minute facilitated conversation by Carole.

Agenda Item: SAMHSA's Public Health Approach to Trauma

MS. MARY BLAKE: Great. Thank you, Kana. Thank you.

And hi, everybody. I know some of you, not all of you. It's great to be here. And I'm happy to talk a little bit about what SAMHSA has been doing. We've actually been very, very busy over the last year in terms of our work around trauma and trauma-informed care.

I'm going to talk a little bit about what we've been doing at the bigger picture level. I'm not going to go in depth on all of the slides. You've got the presentation in your binders, and so on some of the data slides, I'm not going to go into details. But we can certainly get you more information about some of the data that is there in the slides.

And then I'm going to talk about some specific activities that we've been doing looking at gender and stuff like that. Okay? Great.

So I have to figure out how this thing works.

I'm left-handed. So left, right. You know what I mean, right? The brilliant people can't do something as simple as left and right.

So I'm not going to go through the strategic initiative on trauma and justice. I know that we've been talking to you about this for a couple of years. But just as a reminder that trauma is a major initiative for SAMHSA. It's one of our top priorities to frame the work that we do, and I just wanted to just highlight the purpose is to create trauma-informed systems that allow us and others to implement prevention and treatment interventions and to reduce the incidence of trauma, as well as to mitigate the impact of trauma in the lives of people. And also let me just say communities, and we'll talk about that in just a minute.

And then, you know, the other side of it is given the prevalence rates of trauma in the population of people with behavioral health issues, it's also to help us really more specifically in a targeted way address the needs of people with mental health and substance use issues. And especially those who are involved in the criminal justice system, the prevalence rates are practically 100 percent for people who go into criminal justice system.

And as you know, that's becoming kind of a primary place of let's say point of services, let's put it that way. So we saw that it would be a very good fit to put the trauma and the justice piece together.

So I want to talk about some things, some developments that have occurred over the last year, maybe a little bit over a year. One is that we've started collecting GPRA data on the experience of trauma, and I think that's a really significant and important step that we've taken. So does everybody know what GPRA data is?

MS. ROSALIND WISEMAN: I do not, no.

MS. MARY BLAKE: So GPRA data is data that we collect as part of the Government Performance Reporting Act. And it's basically data that's collected across a number of different areas. For the services side of things, we collect this data when people present to our grant programs for services, and it collects a whole variety of data, including housing status, employment status, and a whole range of things.

And now we've started asking, starting off with a key question, and that question is, "Have you ever experienced violence or trauma in any setting?" So we've just started kind of looking at what the data is beginning to tell us across many of our grant programs.

And as you can see, the prevalence data of people who give a positive response to the question kind of mirrors what we've kind of talked about, known anecdotally, what's been suggested through other evidence. So, for men, a positive response of slightly over 60 percent, and for women, almost 75 percent.

Once a positive response is given to that initial question, then there are I think four follow-up questions that are asked. So we know that there was this bad experience that the person identified has having something bad or something traumatic happen to them. And now these four questions are really looking at what impact does that have?

And so, we've asked questions in terms of have you had nightmares or thought about it when you didn't want to? Have you tried hard not to think about it, went out of your way to avoid situations that remind you of it? Were you constantly on guard, watchful, or easily startled? And have you felt numb, detached from others, activities, or your surroundings?

As you know, these are kind of some of the elements of a PTS screening, PTSD screening. So this is SAMHSA's first effort at collecting data across our grant programs that are specifically related to traumatic experience as well as impact of those experiences. This is a first cut. I think that we're continuing to look at how we can best ask questions that will help us get to understanding the problems and kind of guide our thinking in terms of how do we respond and how do we know that the response is effective?

Would that be fair to say, Kana?

MS. KANA ENOMOTO: Yes. And I think we recognize that people who have experienced traumatic events don't always manifest their emotional distress through PTSD or PTSD-like symptoms.

MS. MARY BLAKE: Yes.

MS. KANA ENOMOTO: But again, as Mary said, this is our first effort going into this domain. Now, Mary, are these just -- these are tracks. So these are CMHS. Are these also being collected by CSAT?

MS. MARY BLAKE: I understood that they were being collected by CSAT. Do you know, Linda?

MS. KANA ENOMOTO: Linda, do you know?

MS. MARY BLAKE: My understanding is that they were being collected across both centers. But I can certainly have an answer to you before the end of the day today, a definitive answer, okay?

So, so I think this is really important. I think the other thing to remember is that -- is that how people understand or think about or talk about their experiences and the impact of those experience, we all know can be quite variable. And so, we should still probably think that the response rate to that first question is probably

an underreport, especially when you think about what does "traumatic" mean. You know, if this is something that as a woman, having been abused beginning preverbal all the way through my childhood and then through domestic violence or whatever, I may not know anything else. So I may not think of the word "traumatic" and respond that way.

But I may have all of these impacts and sustained over time, but I just haven't put it together to give the response that the asker is looking for in the screening. Does that make sense? Yes.

All right. So this is a big -- this is a big step, I think, for SAMHSA, and we can cull this data by gender. And so, I'm hopeful that perhaps we can ask for a report on the data. Maybe you all will have some thoughts about what you think might be useful in terms of how to report on this data for your own interests. So think about that. And this is our first step, and we're looking forward to kind of refining and moving forward with the data collection piece.

Now I'm actually, speaking of data, I'm going to skip by a bunch of slides. And now it's stuck. I'm doing the left one, too.

MS. KANA ENOMOTO: Josh, could you help us?

MS. MARY BLAKE: It's stuck. Oh, now it's not.

[Laughter.]

MS. KANA ENOMOTO: We have a little bit of a delay.

MS. MARY BLAKE: Okay. It's a bit of a delay.

MS. KANA ENOMOTO: Are you skipping by those?

MS. MARY BLAKE: There we go. I'm skipping by them. Those are the treatments. Those are the treatment ones. Again, you've got the presentation, but if you want to get your questions to me, I can get some responses to you specifically about the treatment ones, okay?

I wanted to talk about another major development here at SAMHSA, which is really looking at how SAMHSA articulates its concept of trauma and trauma-informed care. So there are certain diagnostic criteria or diagnostic definitions, if you will, of what trauma is or post traumatic stress disorder. There are also different ways of articulating what trauma-informed care is.

And we felt, for our purposes, that it would be useful for us to have kind of a common platform from which we're operating and articulating. How are we approaching the issue of trauma, and what does it mean for the services we

deliver, for the technical assistance we provide? And then also what are the core ingredients or principles and framework of trauma-informed care?

As you know, trauma-informed care has taken the world by storm, across multiple different sectors, and it doesn't always look the same. It's an emerging field. And so, SAMHSA really wanted to kind of land on some place solid for our purposes when we talk about trauma-informed care. When we talk about trauma and why it matters to the population we serve, what is the common -- what is the core of what we mean by that?

And so, SAMHSA developed a concept paper, and the development process for the concept paper on trauma and trauma-informed care, it was about a yearlong process. We actually did kind of an analysis of all of the major thought leaders and models around trauma-informed care. We looked at trauma interventions developed over the last 10, 15 years. Then did kind of an analysis of where are the -- what's common across all of these models?

Then we started to frame out kind of an approach to trauma-informed care that was what are the common elements in terms of principles, in terms of implementation? What are we talking about? And so, we've brought together an experts group, included people across multiple disciplines, included folks from the research side, included folks from intervention and practice side, noted long-term thought leaders in the area of trauma, trauma intervention, and as well as survivors.

So we brought together people who have been doing this work for a long time, and we had I think it was a day-long, might have been a day and a half long meeting where we kind of presented kind of the framework from which we had pulled common elements and engaged in basically a very, very productive facilitated dialogue with these folks to help us think about what are we missing, where do we need to refine our thinking, and stuff like that.

After we had the experts meeting, we went back and we drafted a concept paper. We had an internal working group that kind of reviewed the concept paper, provided comments, and then that was revised and then sent back out to the expert group that we had pulled together. And then we had a draft that we felt sufficiently comfortable with to put out for public comment.

That concept paper on trauma and trauma-informed care was also sent out to Federal partners. I believe we got over 20,000 comments. So it was a very healthy, healthy dialogue. Hmm?

MS. ROSALIND WISEMAN: Are we allowed to ask questions now or --

MS. MARY BLAKE: Yes. Feel free to jump in. I don't want to just talk at you. Uh-huh?

MS. ROSALIND WISEMAN: Were these comments constructive, or were they -- like what was the nature of the comments?

MS. MARY BLAKE: So, I mean, I would say that the bulk of the comments really focused on what we had termed in the initial draft our definition of trauma. That was the area that generated I think the most comment and the most concern. And I think that in that area, where we really saw people were struggling with what's the difference between SAMHSA coming up with a definition and a diagnosis?

And so, that's where we really came back to the table internally and said we're not really articulating a diagnostic or a cluster of symptoms. What we're talking about, what we're really trying to do is understand or develop a concept of trauma that will be meaningful to people in the field.

So really when we were in -- let me go over that definition for you. This was -- I'm sorry. I'm talking to you, and it's just so foreign to put slides on. I'm engaged with you, not with the slides. So I always forget about the slides.

But anyhow, this is what I just said, okay?

[Laughter.]

MS. MARY BLAKE: So the concept of trauma, and now we're calling it a concept -- you see we revised our slides already -- was really looking at what happens when somebody -- what are the things that have happened that cause somebody to be traumatized?

Well, something bad or multiple bad things happen. And they are experienced or interpreted or understood by the individual in a certain way, and they have a lasting effect or impact. So when I say "understood," I don't mean that the person says that bad thing happened to me, and that's what this means.

But if you think about it, a woman or a child has been sexually abused. A little girl has been sexually abused, and because of kind of that feeling of shame and all of that, she starts to feel like "I'm no good. I'm a bad person in this world." Okay? That's the understood we're talking about, okay? And that can shape some of the behaviors and some of the longer-term consequences for that girl in her life, okay?

So when we say "understood," I think some of the comments we got from the field were, well, the person may not know that what happened to them was traumatic, and that's not really what we were trying to get at. So there was an event, a series of events or circumstances. So we also wanted to account for neglect, extreme neglect and other types of things -- so it could be a cluster of

circumstances -- experienced by a person as physically and/or emotionally harmful or threatening.

So experience doesn't mean, again, cognitively understood as such. But there's something either in the body or in the way what happened is put together for that person in their understanding of themselves or themselves and the world that over time has a lasting adverse effect on the person's ability to function.

Comments? Thoughts?

DR. CAROLE WARSHAW: I'm wondering --

MS. MARY BLAKE: And I'm sorry. I don't hear very well. So if I look cross-eyed, it's just I can't hear you.

DR. CAROLE WARSHAW: I'm just trying to think about the post traumatic growth or the positive effect, if there's any? I mean, it's not in the concept of trauma, per se, but where that gets folded in so people don't feel like they're just damaged.

I mean, I think you worded it really nicely, but I'm just trying to think about --

MS. MARY BLAKE: So the concept paper actually then quickly moves to healing. So I think that we just pulled this out, but the truth is, is that we recognized that to put out the message that this is something that people can grow from and that this is not in the sense of serious persistent mental illness. This is your death now, or this is -- you know, this is what you're subjugated to for life in the very clinical understanding of things.

And I think, to be perfectly honest, the healing, the recovery, the resilience part of it is so important for the field that's focused on serious to persistent mental illness. In other words, there's a true alignment between recovery and healing from trauma in the sense that it's possible, okay? Does that get to your concern?

DR. CAROLE WARSHAW: Yes, yes.

MS. MARY BLAKE: So, yes, it is actually articulated very nicely, I think, in the concept paper. So let me ask you, did any of you know that this was put out for public comment, and did any of you respond?

DR. CAROLE WARSHAW: It did go out.

MS. MARY BLAKE: I know you did, Carole.

[Laughter.]

MS. MARY BLAKE: Yes, perfect. So I think you were reached out to specifically for response, which I may not have seen. But I did see your --

DR. CAROLE WARSHAW: Our. Our team response.

MS. MARY BLAKE: Yes. So, anyhow. So did you have a question, Johanna?

MS. JOHANNA BERGAN: No.

MS. MARY BLAKE: No. Okay.

So we came up, and so we're actually really now looking at this more in the context of a concept rather than a definition because definitions seem to be a really big buzzword, and not in a positive way.

MS. ROSALIND WISEMAN: That's why I asked you about the comments.

MS. MARY BLAKE: Yes. No, no. Very, very much on point. And it's also interesting because I think the biggest concern was really -- I mean, there was concern from the general public. But a lot of our Federal partners had particular questions about the definitional aspects of trauma.

DR. YOLANDA B. BRISCOE: And probably the American Psychiatric Association group making the DSM-V, and they are definition driven.

MS. MARY BLAKE: Yes, very much definition driven. I mean, the whole trauma arena with the DSM-V has kind of taken its own kind of road, eh? So I won't comment any further on that.

So then we also wanted -- so the idea is that this is how we understand and how we'd like to present our understanding, our concept of trauma to this field because we think, well, it would be a very powerful way to inform practice and service delivery design. It will also be thought of as a way to inform how we provide technical assistance and even over time how we might measure effectiveness of services and programs, okay?

Trauma-informed approaches. So one of the things that we were looking at, historically, the language has been trauma-informed care. But we recognized that trauma-informed is really the way services are organized and delivered and the manner in which they're delivered. And so, trauma-informed approaches can be implemented in care environments or non-care environments, right?

So they could be delivered in a criminal justice environment. They could be delivered in a school environment. So the word "care" seemed to be quite limiting in terms of people understanding the relevance of understanding trauma

and its impact and rethinking how they engage with people. So we started to look at rethinking things and really now talking more about a trauma-informed approach.

And so, this was the draft that we came up with. A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands -- there you go, Carole.

DR. CAROLE WARSHAW: Yes.

MS. MARY BLAKE: Understands potential paths for recovery. Recognizes the signs and symptoms of trauma in clients, family, staff, and others involved with the system. Resists retraumatizing by the way they do business, and responds by fully integrating knowledge about trauma into their policies, procedures, practices, and settings. Any questions there?

[No response.]

MS. MARY BLAKE: All right. And so, this is kind of the approach that we're seeking to articulate and we decided to frame what were -- oops, what were key principles. And just so you know, these are still in work. We're just finalizing the concept paper. I think we had 10 or 11 or 12 in our initial draft, in our initial draft and that one problem we got is that's too many. We started to kind of look at can we bring some together?

But some of the principles were safety was pretty universal in the field that's an important principle. Trustworthiness, transparency, empowerment, voice and choice, collaboration and mutuality. So these were some of the core principles that we're looking at. And then we wanted to put out a guidance for a trauma-informed approach.

And so, basically, what we're doing there is we're saying looking at how this concept of trauma has been articulated, looking at what a trauma-informed approach does, and looking at some of the guiding principles, how do your governance and leadership kind of align with the concept of trauma-informed approach and understanding of trauma? How do your policies support an organization that resists retraumatization, that allows for recovery or a strength-based approach to occur?

So we're looking at all of these different domains in which the key principles may have impact or may need to be looked at. Okay? And I'm sorry. I'm running out of time.

Did you want me to go any further? This is still a work in progress, and I know that we will get the final draft to you -- yes. Yes. All right? So that's what we've been doing, and we've kind of looked at even developing a rubric for assessing

how are our policies doing? How is our governance doing?

I just want to say that SAMHSA is taking a comprehensive public health approach to our work on trauma, and this is way too much to take in. But this is basically we're doing an analysis of all of our programs and activities to see kind of what's the fullness and the depth of what we're doing around the area of trauma and justice and how can we align all of that work under our strategic initiative.

Yes?

DR. JEAN CAMPBELL: I was just thinking that your previous slides really fall into what would be a fidelity tool.

MS. MARY BLAKE: Exactly.

DR. JEAN CAMPBELL: That it's like you're one step to creating that protocol with what you have developed.

MS. MARY BLAKE: And that's one of the things that we were really hoping to do when we started looking at developing the concept, the key principles, and the kind of guidance is to develop the strategy for being able to do exactly that and measure how we're doing in terms of being trauma-informed.

Carole, you had a question?

DR. CAROLE WARSHAW: No, I just know that Chris Sullivan and Lisa Goodman are working on a trauma-informed measure that we're going to be partnering with them on piloting.

MS. MARY BLAKE: That's great, and that's a great --

DR. CAROLE WARSHAW: I think they're thinking about it for Mr. Brown's organization, but we're going to meet --

MS. MARY BLAKE: It is for outcomes or for --

DR. CAROLE WARSHAW: We're developing a trauma-informed outcome measure for -- again in the context of domestic violence, we're about to start doing focus groups, which --

MS. MARY BLAKE: Wonderful. And it's a great segue, Carole, actually to what I wanted to talk about, which is our cross-agency collaboration and now bringing it over to the women's issues in particular.

I think that I've spoken to you before about SAMHSA's work with the Federal

Partners Committee on Women and Trauma. We have our Federal partner representatives who keep reminding us add the word "girls" to that. So it's women and girls in trauma.

It's a very, very active Federal partners committee. SAMHSA is the co-chair. The Department of Labor is the chair. When the committee started out, SAMHSA chaired it under the great guidance of Susan Salasin, and Susan Salasin retired, and we asked the co-chair from Department of Labor, Carol Boyer, to step into the chair position, and I was asked to take the co-chair.

We have over 34 agencies and operating divisions involved, and from very diverse sectors. So I just actually came from an event at the DoD. We have four different operating divisions within DoD involved. We have many different agencies within HHS, including NIH, ACF, AHRQ, HRSA. So a whole number of agencies from HHS as well as Labor, OSHA, OPM. I mean, just very broad.

And we've done two Federal roundtables. The first one was really to kind of create a common understanding of trauma across the Federal partners and the work we were doing around women and girls. The second one was held in 2011, and that was focused on really looking at what's happening across all of these Federal sectors in terms of responding to issues related to trauma. And this year, we're now working to develop instead of an in-person meeting -- as you know, that's become really, really hard to do, especially when you're putting multiple agencies together to do that. So we're doing -- for this one, we're doing a series of webinars.

The first one should be happening in June, and we'll make sure that we get a push on the announcement of the webinar series to you all directly. Okay? And we're very excited. We're just narrowing down the topics. We know that one of the topics will definitely focus on the behavioral health, the intersect of interpersonal violence, domestic violence and behavioral health, and we're very excited about that.

The other thing that we're currently working in our Federal partners workgroup is we're updating our monograph. So how many of you saw the Women and Trauma Committee monograph that was published in 2010? Yes. So we can definitely send you the link to where that's posted actually on one of our partner agency Web sites.

We're doing an update. But we're not doing the whole monograph update. We're updating by agency and then articulating kind of where our committee is going, just to keep everybody out there up to date on what we're doing, what we're learning, and what progress has been made. So we're very excited about that.

One of the really exciting things for the Federal partners committee is the degree

of collaboration across agencies that has occurred as a result of this Federal partners committee. I'm not going to go there. One of them is our collaboration with the HHS Office of Women's Health. At the national level, they've been developing a trauma training initiative focused on helping community-based organizations, CBOs, understand trauma and its relevance to what they do and think about becoming more trauma informed.

So SAMHSA has been an active partner with them in terms of we've done a review of the curriculum, and we're in ongoing dialogue and consultation with them in that work, and that's been very exciting. And I can certainly get more information to you about that initiative. I don't know if you ever do webinars, but we could certainly invite our Office of Women's Health colleagues to come and talk to you, if that would ever be appropriate or something you'd be interested in.

Another thing that we are doing is we're doing more collaboration around the issue of interpersonal violence. So we're currently working with an HHS working group, really developing a symposium on interpersonal violence and brief counseling. And SAMHSA, of course, is very much looking at how does trauma fit into the paradigm of thinking about interpersonal violence and screening and counseling, as well as the behavioral health impacts of interpersonal violence. And actually, we have a very good collaboration, and that includes a number of operating divisions within HHS.

We're also working with a White House working group that's looking at the intersection of HIV/AIDS, violence against women, HIV/AIDS, and gender-based or gender-related health disparities for women. And so, that is a committee that's kind of developing an initial report, and we're looking again at how we can work across Federal Government to kind of more specifically address these issues.

One of the things that we'll be doing at SAMHSA is that we're going to be doing more cross-training around trauma-informed care with some of our portfolios related to HIV/AIDS and have already been doing a lot of cross-training with the substance abuse treatment end of things.

The last thing that I just wanted to mention, because I think I've gone over the major points, is what was it? SAMHSA is also very interested in looking at really trauma in the context of community. So community violence, community prevention, and community responsiveness. And this is something that we'll be working on over the next year, year and a half, to kind of start to articulate kind of our understanding of that.

So in a similar way that we've worked on the individual trauma, the words "individual trauma" raised also concern when we talked about that because, as we know, trauma is never an individual problem. But we were trying to make the distinction between community-based violence, historical or historical trauma,

some of those things that can impact the individual that have a different nature to them as well. And so, that's some work that we will be moving forward on. So --

Agenda Item: ACWS Discussion

MS. KANA ENOMOTO: Okay. Carole?

DR. CAROLE WARSHAW: So I thought we could start with people who have questions for you to clarify or to take things further, and then we could talk about some of the specific issues you asked, you wanted to add into the conversation. What do you think?

MS. MARY BLAKE: Sure. I mean, I have --

MS. STARLEEN SCOTT ROBBINS: This is Starleen. I have a question.

MS. KANA ENOMOTO: Hi, Starleen.

MS. STARLEEN SCOTT ROBBINS: Hi. So do you have any idea of when the paper is going to be available? And also, for the Federal partners group, have all of those Federal partners agreed to use this platform in their policies and when they're putting out funding requests, et cetera, so that we're hearing the same language when we hear from them as well?

MS. MARY BLAKE: So I can't speak for all of the Federal partners, per se, but let me just say that a number of our Federal partners are embarking on their own journeys for articulating what is trauma-informed care and all of that. So I think that SAMHSA's goal with creating the concept paper on trauma and trauma-informed care is to provide leadership, but not to mandate across Government that everybody has to use the exact same framework.

I think that from some of the work that we've been doing, we're seeing some synergies, albeit it not the exact same definitions or language. But I think it's a good question that you ask. In terms of the concept paper, I don't know. Kana, do you have any -- I mean, I think I could be safe saying this fiscal year.

MS. KANA ENOMOTO: I hope so. I haven't seen it yet. It hasn't come up to us.

MS. MARY BLAKE: Yes. I mean, I think that it's on a fast track. And actually, my colleague Sara Afayee is here, and she's been working very closely with Larke on the development of the concept paper. Do you know if we have a timeline?

MS. SARA AFAYEE: The only thing I can say with that is along with the Federal

partners, they're planning to have meetings with some of them and to bridge some of the gaps before I think the concept paper actually comes out. And like you said, it has to go up to the Administrator and to Kana first.

So, like you said, we're not really sure when it will --

MS. MARY BLAKE: I mean, I can say that at this stage of development we're basically incorporating final changes into the concept paper. We will be having some individual conversations with some of our Federal partners to kind of clarify some of our thinking around what we're doing and to hear from them in terms of what their strategy is, what they're doing.

So it has to go through the clearance process. So it's hard to give you an exact timeframe. I would like to say this fiscal year and hope that that's a safe way to put it.

Starleen, did that answer your questions?

MS. STARLEEN SCOTT ROBBINS: Yes, thank you. I appreciate it.

DR. JEAN CAMPBELL: Yes, I would love to see a table of contents for the concept paper because --

MS. STARLEEN SCOTT ROBBINS: It's difficult to hear whomever is speaking.

DR. JEAN CAMPBELL: Oh, I'm sorry. I was in the lean-back position. I said I would like to see a table of contents for the concept paper because I know that you just gave a broad overview here. So I just wanted to know if these topics are in the paper.

Trauma prevention. Did you look at trauma prevention? Or is that a new or ancillary area?

MS. MARY BLAKE: Well, let me -- okay, so let me reframe your question. That's a great way to dodge a question, isn't it? No. We actually --

[Laughter.]

MS. MARY BLAKE: I'm not trying to dodge the question. I don't think that we go into great detail around trauma prevention, but let me just say, Jean, actually we are starting to do very active work with our Center for Substance Abuse Prevention and really starting to kind of do more work in the area. And I think that's where the community piece really comes in as well.

DR. JEAN CAMPBELL: Well, that's what I was thinking.

MS. MARY BLAKE: So that is where we're starting to really build our work. So stay tuned.

MS. KANA ENOMOTO: I would say that, Jean, if you think about the kinds of events that we consider trauma. So domestic violence prevention, child abuse prevention, and community violence prevention, they do have other Federal homes.

MS. MARY BLAKE: Yes.

MS. KANA ENOMOTO: So in terms of what's within SAMHSA's bailiwick, I think to the degree that we can be trauma-informed in the work that we do around substance abuse prevention, mental illness prevention, that is certainly our domain. But these other kinds of things are less sort of what we have under our authority.

DR. JEAN CAMPBELL: But it is an opportunity to think outside the box. And you were putting it in the SAMHSA box, and I was -- I thought I was hearing that this was a collaboration of the different agencies --

MS. KANA ENOMOTO: Well, it is.

MS. MARY BLAKE: This is SAMHSA's concept on trauma and trauma-informed care. But that said, we are doing a lot of collaboration. So we may not go directly into domestic violence prevention, but we may leverage our expertise to work with our colleagues at ACF around that.

So, again, you know, just piggybacking on what Kana is saying is that we'll look at prevention in a certain way and really lend our expertise around behavioral health to the activities of our Federal partners in fully implementing that.

DR. CAROLE WARSHAW: I think that articulating what -- with some clarity what we mean by trauma-informed is really helpful to people doing all kinds of initiatives, including prevention, because people want to understand what it means, and then to think about how that might apply in the different areas that they're working, which is almost everything that people are working with, particularly for women, trauma-informed has become what everyone is thinking about. But they're not sure what it means conceptually and then what it means to implement it.

And so, this is really helpful. So I was going to make a few comments and then open it up to discussion. Is that what you were thinking?

DR. JEAN CAMPBELL: I had -- I wanted to finish just a couple of other -- just curious, how about trauma and the promotion of wellness?

MS. MARY BLAKE: That's very good. Again, I think we're looking at -- we're looking at our Center for Integrated Health Solutions, which is a collaboration between SAMHSA and HRSA. It's starting to explore the role of trauma and trauma-informed practice in terms of wellness, in terms of recognizing the comorbid conditions. So definitely it's something we're looking at within the Center for Mental Health Services.

DR. JEAN CAMPBELL: And then the last one I just was curious. Do you identify promising practices or EBPs in terms of trauma-informed care? Trauma-informed approach, excuse me.

MS. MARY BLAKE: Sara, do we look at specific trauma interventions in the paper? I can't remember. No?

MS. SARA AFAYEE: It was a part of the concept behind -- of course, we did a whole bibliography of the various ones, but it's not actually in it.

MS. KANA ENOMOTO: And I think the national center has already done a whole monograph that this is a pretty exhaustive review of different trauma-informed approaches. So --

DR. JEAN CAMPBELL: I was just -- I don't get a sense from what is said here, because it's at this level of generality, what exactly it looks like when you see it.

MS. MARY BLAKE: I think if you -- actually, you could even go onto our Web site and see the draft that was put out for public comment. If you look, I think you'll find that I just can't go to that degree of detail in a limited amount of time. But I encourage you to go take a look at that because I think it articulates very much what is a trauma-informed approach, how is it different than a trauma-specific intervention. I mean, it goes through actually in what I believe is good detail, but you can certainly let me know if you think that it's not because -- or Kana or whomever.

So thanks, Jean. I always like your comments.

DR. JEAN CAMPBELL: And I would contact you? If I go look at it, I would give you feedback?

MS. MARY BLAKE: Well, you can certainly contact me. I mean, I don't know that we're incorporating the feedback anymore. We had the public feedback part. But I'd love to get your thoughts and --

MS. KANA ENOMOTO: Is it possible for people to see the public comments? Did we use UserVoice?

MS. MARY BLAKE: Did we use UserVoice?

MS. SARA AFAYEE: We used with a blog. You can view the comments on there. So --

MS. MARY BLAKE: Yes. That might be interesting for folks, actually.

MS. KANA ENOMOTO: You could also scroll through what people already have said about it in the comment period.

MS. MARY BLAKE: Yes.

DR. JEAN CAMPBELL: I didn't mean to cut you off.

DR. CAROLE WARSHAW: No, no. It's fine. I was happy to hear it.

So there are a couple of things that Mary and Sharon asked me --

MS. KANA ENOMOTO: Lean in.

DR. CAROLE WARSHAW: Oh, lean in.

MS. KANA ENOMOTO: When you touch the mike, it actually makes a big sound for the listeners.

DR. CAROLE WARSHAW: Oh, okay. Asked me to talk about, which were really about thinking about trauma and trauma-informed approaches in the context of interpersonal violence or domestic violence. And so, a couple things, and then to get your input and feedback in thinking about the integration of all of these ways of thinking and how it's experienced by women.

So the first thing is that in our thinking, we think about this in terms of an integrated, accessible, welcoming culture, DV and trauma-informed approach. So how do you -- and I think that's inherent in a lot of the elements that are in the concept paper and definition. So that by thinking about for survivors of domestic violence, most of the trauma definitions have looked at trauma that occurred in the past, and that is healing and recovery from trauma that occurred in the past.

And for many survivors of domestic violence, the trauma is ongoing, and their responses may be, in fact, a response to ongoing danger and isolation and coercive control. And how do we factor that in and think about that in our approaches?

And in fact, maybe next time we'll have the data ready in our report about the study we did with the National DV Hotline on mental health and substance abuse coercion, but we know that abusers use those issues to control their partners and will call their partners crazy, will deliberately do things to drive them crazy

and make them feel like they're "losing their minds." They'll prevent them from accessing services and getting custody of their kids and seeking treatment and controlling meds.

And same thing with substance abuse, coercing people into using and then undermining their attempts at sobriety. And so, how do we factor that in so there's the traumatic effects of the abuse and the effects of the ongoing coercion and control and thinking of that as part of the abuse? It comes up a lot of times in custody battles and people's credibility in court.

So having that more integrated approach is important, and that's part of why those responses have been siloed. And the other thing around culture is that it not only affects the kinds of violence that women experience, but also people's responses and what -- not only what may be oppressive, but also what's healing and what strengths and resources they can draw upon. And it also comes up in terms of services and whether services are attuned or not.

And the other way we've been thinking about this -- and this is a lot in our partnership, you may know Gwen Packard, who is in Albuquerque, and she's with the National Indigenous Women's Resource Center, which is part of our Domestic Violence Resource Network -- about individual and collective trauma, maybe not seen as much as community trauma. So like she -- I remember her telling me about a workshop that was at one of the conferences she did, a regional conference where everyone in the room, all the leaders had A scores of between 8 and 10.

And so, what does it mean when individual trauma is a collective experience, and how do you think about that differently? And yet there are people who were leaders in their community around transforming all of this. And what does that mean, and what does that take?

So we've shifted our thinking about how do you think about those both together. So those are just some other dimensions.

One of the other things that came up, and I recently finished a draft of a report from the DV Trauma Knowledge Exchange meeting we had almost a year and a half ago, and I was pulling things out of what people said and recommendations. And one of the things, and I think Norma Finkelstein raised this as well, is that doing screening and assessment or even trauma-specific treatment isn't always trauma informed. So the way it's done isn't necessarily actually sensitive.

And so, we separate those, but how do we think about those together, and how do we add in the other layer of an abuser trying to actually control the treatment? So it's having a more complex matrix that may be applied to different people that we have that in mind.

And the same thing with trauma-specific treatment, there's a big push to have evidence-based treatments, and yet what do you do -- what kinds of healings or approaches to healing are appropriate when someone is still under siege? And there's just very little research.

Our review looked at a few more cognitive behavioral therapy kinds of interventions that were adapted for survivors of domestic violence, and a couple of the people were out of the relationship on average for 5 years. So it doesn't apply to people who were still under siege, although there were specific elements that were addressing ongoing contact with the perpetrator around custody and visitation that leaves you still having to deal with those fears and fears around custody.

So we've been thinking about what's the applicability of more complex trauma treatment models that there isn't as much of an evidence base for because they're not manualized. It's like an array of possible ways to -- kind of tools for supporting healing and recovery and resilience and kind of restoring a developmental path that's been maybe disrupted by trauma and a relational matrix where the healing is part of the harm that occurs in a relationship. This is in yours, too, that the healing is part of the relationship.

So how do you have that and then be able to tailor that to people's individual circumstances and cultural context, particularly when there are circumstances that people can't control like what's happening with the abuser, what's happening economically that's changing? And how do we start to bring in other kinds of research methodologies that allow you to measure that when things are more complex and changing when you don't have an N of -- a large enough N over a really long period of time because we can't afford that? And what kinds of modeling and other techniques that are coming from other areas that would allow us to tailor interventions to people's real lives and complex situations?

So those are some of the things we've been thinking about. One of the issues for us is when you take on screening and assessment and brief intervention is the huge training need for how do you help people do it well, to ask in ways that aren't judgmental, impunitive, and blaming. There's the safety and privacy and confidentiality issues are addressed. That how you document in a medical record that may be used against a woman in court, so that people are trained to do that.

That there is access to advocacy resources, that people understand how do you then address immediate safety issues when you're thinking about your treatment plan, and how do you have the access to resources in the community? And one of the ways that we've found in our work to do that is really through collaboration, both at the local level with domestic violence programs and mental health providers and substance abuse providers and also at the State level.

And so, part of what we're hoping that SAMHSA will be able to do is help facilitate some of that process. We're going to be doing a study with Joan Gillece, NCTIC, and NASMHPD of State mental health directors around how are they addressing these issues, and what kind of help and technical assistance they could use, and what kind of recommendations. We're going to have a small virtual meeting, I think -- because a real meeting won't be able to be supported -- to bring together States, domestic violence coalitions, and State mental health directors to think about how can we support collaboration around trauma initiatives that are already happening in the States with DV programs?

And I was going to -- yes?

MS. MARY BLAKE: I mean, the only thing I would suggest, Carole, is that you also bring together survivors from both of those systems as a way to kind of move the work forward. I think that you can do it at the State level, but you also need that ground level support, right?

DR. CAROLE WARSHAW: Absolutely. And I was just going to segue into talking about that. But in the DV movement, many, many people are survivors and self-identify. So it's part of our -- how we all talk about things. And so, yes, we were planning to do that as well.

But the other pieces, you were definitely talking a little about some of the peer work, and one of the projects we were doing in Illinois, it was with an OVW ending violence against women with disabilities grant was two pilots sites. It was a partnership between a large DV program, a community mental health center, and a State psychiatric hospital. And the ideal is to really build that collaboration with people who really understood the experience of people, using those systems and working in those systems to reduce the kind of polarization and lack of understanding.

But at the center, what we were hoping to do is really -- on the peer recovery support specialists who were working both in State hospitals and in community mental health centers. And in our TA group was Lucy Sajak, who runs the Growing Place empowerment organization, which a peer-run community-based organization, to do that cross-training and to think -- because Illinois changed from a grant program to a fee-for-service Medicaid program that was potentially to provide community support and services that were Medicaid billable. And one of our thoughts was that peer support organizations could provide supports to women who were in a domestic violence shelter who wanted more support and that our DV advocates didn't have the resources to provide it and that people working in recovery centers would also have -- learn about domestic violence, but also have resources and supports for women who then identified a need for more resources around domestic violence because people weren't asking.

And when we started the project, we did focus groups that I had talked about at

this meeting I think it was a year or two ago, that women said that nobody talked to them about any of these issues, that there was no gender-specific or gender-responsive programming in mental health settings, although there is in substance abuse. And that no one talked about trauma and that they really wanted that. And that they also wanted access to DV programs.

So a lot of our work on the other side has been to really provide kind of the collaborative relationships to reduce the kind of negative attitudes and discrimination that many DV advocates had just from their own ignorance or lack of experience and out of fear to build those partnerships so they could better support women in their programs. Same thing with Patti Bland, who works with us around women and substance abuse and how to help programs be welcoming, inclusive, and accessible to women with a whole range of needs often related to trauma, but with the collaborations in the community to support that work.

And so that women are better served in DV programs, but when women are referred to other systems, that they're referred to people who understand trauma and domestic violence in culture because that's often the other side of what doesn't happen and that everyone understands the legal ramifications of those issues. So those are things that we're all kind of thinking about.

We're also doing some work around trauma-informed approaches to the courts and how to help support people in the legal process. We have a handbook for attorneys that just begins to do some of that work. Olga Trujillo has been working with us on that.

And one of the things I've been thinking about -- Olga Trujillo, Mary Malefyt Seighman, yes -- is around Jack Shonkoff's concept of optimal trauma, tolerable stress, and toxic stress, and how do you help move from the toxic stress, so the overwhelming trauma kind of stress to something that's more tolerable? That if you have the right supports in place when you're experiencing something that's traumatic, that it helps you actually build your capacity to manage that for people who are negotiating adverse systems.

So I'm thinking with some of the youth work, if you're in child welfare, you're in the criminal justice system, you're in a psych hospital that isn't trauma informed yet, how do you help people through those allies, which is a lot of what peer support does, to manage their experiences in ways that doesn't take the same toll. So it's just another way we've been thinking about that.

So we have a trauma-informed special collection that's going to come out any day on VAWnet, which is the Violence against Women Online Network that's with the National Resource Center on Domestic Violence and the CDC that Andi Blanch also worked with on. That's a lot of resources about trauma and trauma-informed services for domestic violence advocates, but obviously for everyone

else.

So it just raises a lot of issues that I'm hoping we can talk about, ones that kind of touch on your work and ways that both trauma and domestic violence come up for you and ways that you've found to integrate your responses to that or questions you have about being able to do either some of the things that Mary talked about or adding the DV end.

DR. YOLANDA B. BRISCOE: Well, I appreciate that there's an emphasis on making safe environments for people who are -- individuals who are seeking supports and how we can retraumatize, simple things of just environment and making sure that there's policies that support the safe environments for anybody in any situation such as, well, for us in substance abuse how you talk to somebody, what the environment looks like, the ratio of men to women and that everybody be trained. It's just vital.

MS. MARY BLAKE: That was part of the thinking when we brought the seclusion and restraint elimination work together with the trauma work was that while intended to keep everybody safe, often the practice replicates the experience of previous abuse. And so, really looking at safety and reframing it a little so that understanding trauma and its impact is a big part of understanding what safety can really be.

And some of our work around seclusion and restraint reduction, what we're seeing is that if you can help bring down the level of stress and triggering and retraumatization within the organization or institution, that also creates a greater sense of safety or feeling of safety from staff because they themselves are not always in a state of hyper alert. And so, even if something starts to happen, they're not in that kind of fight/flight automatic mode because life in general is less stressed.

So it's been really interesting, and so, yes, the safety piece is really important in helping really understand safety through the lens of understanding trauma and its impact and recognizing that people served are not the only ones who've had these experiences. Whether or not you take it on directly or not, having the staff just even understand trauma and its impact can be helpful to them in their own lives and understanding how they are, the way they are, and can be conducive to better relational work with the people they serve.

So one of the things that we've learned through some of the work we're doing with our TA centers, building that understanding and awareness about trauma and its impact is, in and of itself, helpful to almost everybody.

DR. CAROLE WARSHAW: And I think, just to build on what you're saying, that part of why this is so important and growth promoting, why people get excited about it, because you do understand your own responses and your own

reactions to other people. And unless you are able to do that, then it's really hard to be trauma informed because if the relational piece is so central.

And that's why some of the infrastructure support is having the kind of reflective supervision which is often dropped out when there are funding cuts for people to be able to understand their own responses and an environment that's not judgmental so they have that experience themselves and then can respond in ways that aren't just at the expense of other people or at the expense of themselves and people in their own lives.

You think about what's potentially transformative about trauma informed. It's to create a world where people actually treat each other with dignity and respect and transparency. It's like human-informed with an understanding of trauma. It has a lot of potential for prevention if people actually embrace that.

And you think about the policies that there's a lot of emphasis on being trauma informed at the Federal level, but there are a lot of policies in other arenas that are antithetical to that, that create conditions that are really harmful to people, not from this administration, of course, but just to start to articulate.

There's a panel from ACYF on protective factors for youth, and a lot of it has to do with having a caring adult relationship or a supportive environment, but what about economic conditions and other political considerations that we could use that research to say and it makes a difference what we do in these other arenas. So we're not just sticking to the -- our service arena, but also the implications for other kinds of policy. If we don't have a voice in that, who's going to say that?

So I think the social justice piece is really central, and I know you had that in your definition. Thinking about it on an advocacy level, but also at a policy level, I think it has a lot of potential.

MS. ROSALIND WISEMAN: Can you talk to me about -- I'm thinking about the girls and emerging adults. Is that the correct -- is that what 18 to 25s are called? I mean, okay.

DR. CAROLE WARSHAW: That's what they told me.

MS. ROSALIND WISEMAN: Can you talk to me about some of the girls being -- who have experienced on both sides abusive relationships and their -- who have been in abusive relationships as the victim of that and also has -- can you talk about the messiness of that a little bit and how that informs what we're talking about here?

DR. CAROLE WARSHAW: I'm not the best person to talk about that because I haven't actually focused on work in that area, but there are a lot of people who have that I could get you references for. But I think because there's been such a

backlash about women's issues that people have been almost afraid or reluctant to go there.

There was a double issue of violence against women a number of years ago that myself and others did about women's use of violence and I think people think about the context of it and whether it's really coercive control or if it's fighting back or mutual, that the concerns of defining domestic violence in terms of the physical violence and not in the ongoing context of course of control makes a difference.

MS. ROSALIND WISEMAN: No, I very much -- I know. I mean, I remember -- I remember that when it really was very -- we want to talk about the full experience of girls' lives, and we do. But it was in the political context of being able to recognize or acknowledge sometimes girls' experiences of perpetrating violence and abuse.

I would like to see us be able to walk that fine line, to be able to acknowledge it without taking away from the very real experiences of girls as victims.

MS. MARY BLAKE: And I think one of the things we know about trauma is that if you've experienced trauma or violence, then you develop adaptive behaviors, coping mechanisms. Sometimes those can manifest as abusive or traumatic to somebody else or behaviors that I think that really understanding trauma's impact and really looking even at the fact of helping a young woman or emerging adult or whatever we want to call them, we could even go down to transition issues if you'd like. But helping them understand how the impact of trauma on the body and on the -- kind of on the psyche and on the spirituality, the relational aspects really shapes the way a young girl is with others, and not just how she sees herself, but also how she interacts with others.

And I think that's one of the real defining things about trauma against women and girls is that we're so -- and forgive me for generalizing, but we tend toward the relational, and the impact of trauma is so very relational for us. And so, when you can start to work with people to really understand the dynamics of trauma and its impact, then you really kind of have to step away from the blaming side of it, and you're really moving into kind of what's happened and what can be done. You know what I'm saying?

MS. ROSALIND WISEMAN: Yes, the thing that I'm thinking about is that when we're working with girls who have these experiences, they often are also the first people who are getting into fights at school.

MS. MARY BLAKE: Yes.

MS. ROSALIND WISEMAN: And so, it's a huge -- like we talked about in the morning that we really oftentimes are disciplining in incredibly counterproductive

ways for girls. And so, one of the things that I've consistently seen is that those girls are very, very quick to fight other girls and at the same time are -- and are labeled as being violent, abusive, aggressive, whatever. Although they're calling it drama, they're violent, aggressive, those kinds of things. Yet they are also in abusive relationships with their partners.

And so, you have these two things going on at the same time, and they also can very easily -- they don't look like anybody's definition of a victim because most of the kids are scared of them at school. But they are also, and when you were talking, it just brought back I was teaching recently, and a group of girls -- it was a coed group, coed. And a group of girls were talking about fighting and recording the fight, right, and betting on who was going to throw the first punch and who would hit the most or whatever.

And the boys -- and I was really struck by this. The boys were much more, as a group, were much more cognizant of the manipulation that was occurring to get them to fight. They might have to fight anyway. But if they were put together, they were much more understanding of the dynamics of that, whereas the girls I was working with, who very much reflect what you're talking about here, literally could not get there. They were immediately into "I have to like absolutely" and "Let's fight right now," and I'm not aware of the ingredients that are making me do this.

MS. MARY BLAKE: It's that amygdala --

MS. ROSALIND WISEMAN: Now the boys would fight anyway, but they at least knew it. Does that make sense?

MS. MARY BLAKE: Yes.

DR. CAROLE WARSHAW: I was just thinking about Stephanie Covington has a new manual coming out on Beyond Violence for women who were -- incarcerated women who used violence or were convicted of violence. And she did focus groups with women for a long time to develop it, to kind of understand what their experience was and what would be helpful to them. And so, I think that would be fascinating, I mean really helpful to learn more from girls' experience about what this is for them and what makes a difference and what helps and what the context is, what function it serves for them.

MS. ROSALIND WISEMAN: Do you know when that will be out?

DR. CAROLE WARSHAW: Soon, because she's getting endorsements. I'm supposed to review it.

[Laughter.]

MS. ROSALIND WISEMAN: So, 6 weeks to a couple of months?

DR. CAROLE WARSHAW: Yes.

MS. ROSALIND WISEMAN: Okay.

MS. MARY BLAKE: People who hurt hurt.

MS. ROSALIND WISEMAN: But I think the thing that I worry about here --

DR. CAROLE WARSHAW: What's really important is --

MS. ROSALIND WISEMAN: -- is we still have this vision of girls who are abused as these very passive sort of stereotype, and one of the things I think that's really important is to reflect the complexity sometimes of these girls. Not to take away from their experiences, but to acknowledge the complexity of who they are as people because they can be really -- they can just look real tough --

DR. CAROLE WARSHAW: Women fight back, too.

MS. ROSALIND WISEMAN: Absolutely, sure. But it also doesn't stop. Right. All of those things are true.

DR. CAROLE WARSHAW: Yes, it's all much more complex.

MS. MARY BLAKE: That's something certainly to be addressed in the broader work around bullying. I mean, really recognizing kind of the factors that are in place in that whole context.

MS. KANA ENOMOTO: I think our NSDUH data has some startling statistics that I think 1 out of 4 girls between the age of 12 and 17 actually perpetrates an act of violence, and this is hitting, kicking, or punching.

DR. CAROLE WARSHAW: And that's, again, where it's tricky. It's like the act of violence and then the context of how in control and whether it's -- what does that mean? And I think to learn more about that is really important to --

MS. KANA ENOMOTO: If you think about if you've experienced trauma and you are in a fight or flight mode --

DR. CAROLE WARSHAW: Then you're going to --

MS. KANA ENOMOTO: -- then half of the responses will be flight, and half of the responses will be fight. And that's why you see this level of aggression elevated among girls that have had some difficult experiences.

DR. CAROLE WARSHAW: And as girls feel more empowered, that that becomes a way that it can manifest, as opposed to not, that you can't go there.

MS. KANA ENOMOTO: So I think we're about at our time. So I thank you for the conversation. And I do hope, well, we can recirculate the link to the --

MS. MARY BLAKE: To the monograph. Sure.

MS. KANA ENOMOTO: To the monograph for folks to look at, and if you do have comments, please send them to Geretta or to Mary directly. But --

DR. CAROLE WARSHAW: I have one more comment.

MS. KANA ENOMOTO: Go ahead.

DR. CAROLE WARSHAW: I just want to say that the work that you're doing, Mary, with the committee and the Federal roundtable on trauma that really was initiated by SAMHSA has been so important and had such tremendous ripple effects. And it's been many, many, many years of work building to this critical mass. And I just feel -- I just want to acknowledge that.

MS. MARY BLAKE: Thank you. I think that we find it very powerful. And quite frankly, we're shaped by what we're hearing from our constituents, the thought leaders in the field. So it's really it's back on all of you.

MS. KANA ENOMOTO: And I do think it is a testament to Susan Salasin.

MS. MARY BLAKE: Their division.

MS. KANA ENOMOTO: Their division and just dogged diligence in keeping the issue of trauma for women on the table. Against whatever odds, she managed to keep it going for the past 25 years, and so we are standing on her shoulders as we do our work.

So we now have time for a 15-minute break. So if we could come back at 3:00 p.m. Jean seems greatly relieved. So we'll see you back in about 15 minutes.

Thank you.

[Break.]

MS. SHARON AMATETTI: Are we about ready to get started again, everybody? Yes, no?

[Pause.]

MS. SHARON AMATETTI: We're going to go ahead and get started now. If everybody would join with us in welcoming our next presenters? This afternoon, we wanted to spend some time focusing on the issues of women -- incarcerated women, women in the criminal justice system. And we're very fortunate to have some local folks who have done a lot of work in this area. They're nice enough to join us this afternoon.

Both Brenda Smith and Maureen Buell were at our National Women's Conference this summer and really gave wonderful presentations there on this topic, and both of them are, as I said, Washingtonians. And so, we're very fortunate to have them here.

Dr. Smith is a professor of law at American University in the Washington College of Law, and she also teaches in the Community Economic Development Law Clinic. She's the project director for the project on addressing prison rape. And so, today she's going to speak to us about disparities for women, especially women of color in the criminal justice system.

And afterwards, we're going to hear comments from Maureen Buell. Maureen Buell is a correctional program specialist with the National Institute of Corrections here in D.C., and she leads NIC's Justice Involved Women Initiative with a focus on assisting jails, prisons, and community corrections in the creation of evidence-based, gender-informed policy, procedures, and practices. So Maureen is going to share some thoughts on Brenda's comments as well as have some information about her own work for us as well.

And we have an hour to have Brenda and Maureen speak with us, and then we have asked Yolanda to help us lead a discussion afterwards about what we've heard and what we're thinking. Okay? I'm going to turn this over to Brenda. I want to let you know Brenda actually broke her toe this morning, and so she hobbled here to be with us and didn't let that get in her way, and we really appreciate it very much.

So thank you.

Agenda Item: Disparities for Women in the Criminal Justice System

DR. BRENDA V. SMITH: Oh, you're welcome. And I want to introduce my student, Morgan Girard. And Morgan is chauffeuring me because I think everybody agreed that I shouldn't be driving a six-speed and shifting with a broken foot. So right after we finished class and we did her supervision, I importuned her to drive me here, and she said okay. That's fine.

MS. SHARON AMATETTI: Thank you. Thank you, Morgan.

[Laughter.]

DR. BRENDA V. SMITH: So I know that you guys have the slides already. And what you should know is there's no way that we'll probably get through, that we're going to spend a lot of time on each of them. But what we wanted to do is we mailed it, my presentation and Maureen's together, and so you have that information to go back to, especially just in terms of statistics.

I also think it bears mentioning for a little bit is sort of why I lead a little bit of this double life. You know, I do the project on addressing prison rape, but I co-direct the Community and Economic Development Law Clinic at American. And actually, Morgan asked me. She said, "I was actually going to ask you how did you start doing all of this criminal justice stuff?" And I said, actually, the better question is how did I start doing all of this community and economic development stuff?

And the fact is, is I started out doing criminal justice work, and in fact, Maureen and I met each other in that way when I was doing some work with NIC. But I did a Kellogg fellowship in '93, and one of the things that you had to do was you had to do something totally different from what you were doing. And so, I decided that it was very important to get some understanding of money and finance because I think that oftentimes people who are interested in doing progressive work are great rhetorically, but they don't know what anything costs, right? And sometimes they don't know how to deal with things, right?

And so, that's sort of the reason that I continue to do work in these two areas, and I think that as we start talking about all of the reentry stuff we're really seeing how sort of development and economic development plays a real part in sort of crime reduction, prevention, and things like that. And so, I really wanted to kind of make the case about why it's important to focus on the punitive state and also about women's role in that.

Okay. So these are my objectives. We're going to talk a little bit about the punitive state, talk about what it is. You're going to see a lot of criminal justice statistics for individuals and the population in general, and we're going to look at criminal justice issues for women in particular.

We're also -- can everybody hear me? Yes?

MS. SHARON AMATETTI: Yes, and you're also on the mike here.

DR. BRENDA V. SMITH: You can't hear?

MS. IRENE GOLDSTEIN: Almost.

DR. BRENDA V. SMITH: Okay. So I'll see -- is that better? Okay. Perfect.

And so, then we're also going to talk some about collateral consequences of criminal justice system involvement. We're going to look at those consequences for the health, for women's health, for families, and also for communities. We're going to talk about two intervention models, and one is work that Maureen has done. There are going to be lots of slides on that. I'm just going to introduce it, but she's going to talk about that in her comments. And she's also free to pop in as well.

And then I'm going to talk about some work that we do in our legal clinic, and it's a piece of scholarship that I'm working on and I'd also like your feedback on it. And then we're going to talk some about opportunities for work and collaboration in this area.

Okay. So when I talk about the punitive state, that seems like a very academic term. And so I want to talk some about that, but I also want to talk about the relationship of minority overrepresentation to the punitive state.

So when I'm talking about punitive state, what do you think I'm talking about? Don't cheat and look ahead, okay? All right. Yes, I saw you. I saw you. So what am I talking about?

[Laughter.]

FEMALE SPEAKER: You're punished for any kind of mistake that one makes.

DR. BRENDA V. SMITH: Right. But you're also talking about the involvement of the state in doing that and having sort of very specific consequences for that that have an impact, right? So we're talking about laws, right? Most of us are familiar with those. Traffic laws, laws against drug use, all of those things. Not so much drug use, but drug possession, distribution, things like that. Then there are also the sanctions that go with that.

But then there are also all kinds of other benefits that have also become a feature of the punitive state. So, for example, even though we know that education has sort of the biggest impact in terms of reducing recidivism, Pell grants are no longer available for people who have certain kinds of convictions, right? And so, for example, if any of you have kids who are applying for school or whenever they're in school, there's a specific question that says, "Have you ever been convicted of?" And so, again, those are also sort of the involvement of the punitive state.

And then there's also the stigma that's attached to that, which I think is very difficult to address. Now, of course, that stigma may be very different depending

on what community you're in. And so, what happens is sometimes when there's so much overrepresentation or so much involvement of particular communities in the criminal justice system, the stigma actually declines. And then given that, it's very hard to talk about prevention when there isn't stigma, right? Okay.

So when we look at the punitive state, it's important because punishment has a place. You know, I've got four kids, and you do different things with each of them. You do bribery. You barter. And sometimes there's punishment involved.

And so, there is a strategy, and as a strategy, it does have sometimes an impact on improving behavior. And there's always this tension between sort of the punishment, but also giving a benefit so that people improve their behavior. And so, given my background, which was first as a public defender, then running a program for women who were in custody, I've spent lots of time trying to mitigate punishment and trying to figure out what kinds of incentives can get people to turn their lives around.

So I'm not going to spend a lot of time going through this because I think that you all know this. Seven million people under custodial supervision -- prison, parole, probation. One in 33 adults under correctional supervision, and that's for all people. And obviously, those numbers are different depending on your race, and that's where disproportionate minority confinement comes in.

We know that it's highly racialized. Black men are six times more likely than white men to be under supervision, and it's three times more likely for African-American women. And then, of course, you see the numbers for Latinos as well. Okay.

What we do know right now about imprisonment is State prison admissions are declining, and I don't think they're declining because people are not committing crimes. I think that they're declining because we can't afford to imprison people for committing crimes.

And so, this is a really good thing because people are looking for other options and opportunities. Federal prison admissions are increasing, and I guess this isn't on the slide. So why do you think they're increasing? Huh?

MS. LINDA WHITE-YOUNG: Because they're privatized.

DR. BRENDA V. SMITH: Okay. Linda says privatized. Good try. No.

[Laughter.]

DR. BRENDA V. SMITH: So what else? What do you think?

MS. ROSALIND WISEMAN: They're building more prisons.

DR. BRENDA V. SMITH: No. Not more prisons. Immigration. Right. Immigration. Sort of the biggest rise in Federal prison populations are related to people who are in prison for immigration matters, okay?

So this is what we know in terms of the kinds of offenses that people are serving time for. About half of Federal inmates are in for drug offenses, and we know about that and sort of the mandatory minimums, or at least what used to be the mandatory minimums for drug offenses. The reality is, is Federal judges are still using those as guides. Nobody is going to kind of go outside of those guidelines very much.

Then, again, the 35 percent public order offenses and, again, largely weapons and immigration. Less than 10 percent of Federal prisoners are in for violent or property offenses. Now those numbers are very different in State institutions, and so we're just talking about Federal institutions right now.

MS. ROSALIND WISEMAN: I have a question.

DR. BRENDA V. SMITH: Yes?

MS. ROSALIND WISEMAN: Why is weapons separate from violence? Why is it like that? Why is it largely weapons and immigration? Why are weapons and immigration placed together and not weapons and violence placed together?

DR. BRENDA V. SMITH: Because the fact is, is that weapons can be just possession of weapons or moving weapons that are not connected to actually having used the weapon to commit the offense.

MS. ROSALIND WISEMAN: So like assault and battery, we're making the distinction between those?

DR. BRENDA V. SMITH: Yes, we're making the distinction between you're using the gun to do something with as opposed to owning the gun when you're not supposed to own it or trading the guns or selling the guns, right?

MS. ROSALIND WISEMAN: Okay. Got it. Thank you.

DR. BRENDA V. SMITH: Okay. You're welcome. Good question, though.

All right. And you see that the numbers are down from 2009 in terms of the noncitizens who were being held, but the fact is, is that it's still quite high, okay? So we're talking about like a 2000.

So, again, here are sort of the numbers about folks who are under correctional supervision, and you can see that the largest number of people are on probation,

right? On probation and parole. But you still have about 1.5 million people who are in prisons. And when we talk about prisons, we're talking about facilities that are longer than a year, right, typically.

Now let's talk about imprisonment and sort of the gender piece of this. One of the things that we know is that men are more likely to be in prison. Men are more likely to commit crime. That's one of the things that we know in terms of the differences between men and women, or maybe we are much more -- or maybe we're much more attuned to sort of going after men for particular offenses.

I'm doing some work on looking at female staff who abuse men and boys in custody, which has some very interesting -- there's some very interesting data there, both in terms of sort of interdiction, apprehension, and also prosecution. But let's just focus on this for a while.

What you see is that in terms of the total number of people who are incarcerated per 100,000 is 732.

FEMALE SPEAKER: Per thousand?

DR. BRENDA V. SMITH: Yes, per 1,000. Sorry. But then, when you look at men, it's 1,352. It should be per 100,000. Sorry. Okay. And then you can just see the difference between white, black, and Latino, right? And I'm going to look at my slide because that kind of cuts that off a little bit.

But you can see that the numbers for African-American men are 4,749 per 100,000 as compared to 678 for white men and 1,775. So, clearly, there are some disparities there. And then this is what we have for women, right? And so, again, 732 per 100,000, right? But again, those big disparities by race continue even when you control for gender.

This is a really nice slide that Maureen put together, and it does a really good job in terms of talking about the differences between men and women in custody. We see much more significant past histories of abuse, both physical and sexual. I actually think that those numbers are low, and those numbers have been -- those are very, very modest numbers and very conservative numbers. I know that there are people who I've talked to who would say that those numbers are more like 80 or 90 percent of women who are in custody have histories of physical abuse and probably around 70 percent for sexual abuse.

High rates for mental illness, substance abuse histories. We know that there are a large number of women who are parents and primary caretakers and much higher numbers of unemployment. Same thing, and again, you can see these numbers.

One of the interesting features, one of the interesting sort of statistics that we know and information that we know is that in terms of caretaking of children, prior -- like when men are imprisoned, I'd say it's around 80 percent, a little bit more than that, maybe 85 percent of their kids are taken care of by the mothers of those children. And for women, that number is almost inverse. It's about 20 percent are taken care of by the fathers of those children. Again, so we're talking about secondary impacts of imprisonment.

Okay. So in terms of focusing on women, I think that one of the things I remember attending this meeting, the International Conference on Population and Development in '93, and one of the big aha's that they got at that conference was that there's a multiplier effect when you devote services to women, right? That those services go out to their children. They go out to the community. They go out to others because, more often than not, women are performing a caretaking role.

And so, that's one of the reasons. One is the caretaker role, but one is that you have the potential to multiply the impacts of your work by focusing on women. That's not to suggest that you don't focus on men either, but that's also one of the reasons. Okay?

Again, these are just some of the statistics, and I'm not going to talk about this. Do you want to go back?

MS. SHARON AMATETTI: The increase versus decline --

DR. BRENDA V. SMITH: You mean increase versus decline as opposed? Well, you know, you also have to think about the end, right? In terms of 93 percent of the folks who are incarcerated are men. And so, you can have I don't want to say a relatively modest, but you're going to see more of a jump. If there's a jump in women, it's going to be a higher increase because you're dealing with a lower, a smaller end to begin with.

Okay. And we know a lot about the increase. And I'd say that a lot of these, we've talked about mandatory minimums. Parole revocation, again let's go back and start thinking about the punitive state. So much of what happens to people is that the punishment is not just while they're in custody. It's also after they leave as well.

And so, many, many often multiple requirements that they have to meet not only to their probation officer, but there may be other systems that they're involved with. So, for example, if they've got to maintain employment. Well, if you can't get a job. If you've got to go to drug treatment, which means you're going to have to attend a certain amount of meetings. If you've also got obligations in terms of being able to have visitation or custody of your kids. You can imagine sort of the multiple systems that people are involved in.

Okay. So let's talk a little bit about what the consequences are for individuals, families, communities, and the economy. And again, I'm moving very quickly through these because I want to make sure that we have an opportunity to talk.

So these are some of the punitive consequences. We know about loss of liberty. Increasingly, loss of child custody. Under the Adoption and Safe Families Act, you have a very limited period of time to make permanent plans for your kids. If you don't make plans for them, then you're going to lose custody of them, and your rights are going to be terminated.

There's a great article by a woman called -- I'm going to kill myself. I'm happy to send it to you, but it's an article about legal orphans. And it talks about kids whose rights have been terminated to their parents, but they have not been adopted. And so, they're adrift in the system. And there's a move about in many States, right, to give those children back the opportunity to get back with their parents. And so, loss of child custody.

Exclusion from employment. In many places, there's a question that says, "Have you ever been convicted of an offense?" Right? And for many people, I mean, in an already tight market, that takes you out, okay.

Exclusion from public housing. Doing some work with some students who are doing some work in New Orleans, and they have to do a big report talking about impediments to fair housing. And a big one is large imprisonment population.

The loss of geographical mobility. If you're under supervision, you can't move for a job because you can't often be supervised in other jurisdictions. No educational loans, and again, a huge one, disenfranchisement, the loss of the vote. And the limitations on military and Federal employment.

The ABA has a really cool resource out there where you can actually click by State and see what the collateral consequences are by State. And it's one that it's certainly worth taking a look at.

Oh, again, another -- disclosure in legal and social records. Access to school, higher education, sex offender registration, adult sentencing for youth. These are all some of the consequences for youth. And again, these are again -- and I didn't talk about occupational and business licenses.

One that I want to talk about as well is a big one. The absence of men of color in communities. There is some work out there by a really great scholar, Dorothy Roberts, and another guy, Donald Braman, who talk about the fact that the absence of men of color in communities makes it much more difficult for women to negotiate for safer sex practices. Right?

And so, it creates a community -- it creates a climate where, for example, what you have to do is you can't negotiate for things. And so, it creates a situation where women often put up with a lot of things that they shouldn't put up in order to maintain a relationship.

Okay. We've talked about legal orphans, the instability of care arrangements for kids and for elderly people. All right. And one that I know you've already talked about, trauma.

Other impacts on the community. A lot of fragility, and then also the lack of representation which goes directly to the lack of a vote.

The impact on the economy. Imprisonment as a business where you have many low-income workers who are actually working in correctional environments. And again, because time is not going to permit us to talk about all of that, that's its own separate issue where you have people who are working who are members of these communities, but who are also participating in the business of imprisonment, right, and what that creates.

MS. MAUREEN BUELL: Do you want to go right through?

DR. BRENDA V. SMITH: You know what? I could, but if you want to, because we have an hour, it might be good to talk about this, and then I'll go to my part.

MS. MAUREEN BUELL: Okay. So I'm jotting down notes. It's so hard to not talk when Brenda was talking, but I was jotting down some notes that at the very end of this we'll talk a little bit about.

So what I wanted to do is just spend a few minutes talking about some of the things that we've done at NIC to really begin to look at the differences between male and female offenders. And really what we've done since the '70s, but I want to say in a big way since probably mid '90s is really have been looking at research not only internal to criminal justice, but also looking at external research that impacts women. So looking at information around behavioral health, around education, around physical health, all of those issues that impact women in the world certainly impact the women that we have within our incarcerative setting.

And so, really some of the things that we've learned over the years is that a criminal justice policy is usually developed on the largest cadre of people, and within criminal justice that happens to be men. So what we've done is we've taken these policies and procedures, and we have applied them to women. It happens in education. It happens in behavioral health. It happens in physical health as well.

And one of the things -- and I'm going to skip around a little bit here. But one of the things that's been interesting is that in the '70s, there was this whole

movement against rehabilitation. Nothing works. There's a fellow, a researcher named Robert Martinson who said we've looked at all these studies. Really nothing works with incarcerated populations.

And gratefully, there's been a shift since then based on some of the work of some of the Canadian researchers, but also some folks who are in the U.S. that really began to look at some of the factors that really seem to be impacting how people get involved in the criminal justice system, what happens to them when they get in the system, and then what happens to them when they transition out. So those tools have been really helpful because I think what it's done is further professionalized the correction field, but the problem has been that it's good enough, is that there's a lot of researchers who will say because there aren't these huge empirical studies with women offenders that what we have, even though it mostly represents male offenders, it's really good enough, and so we've been sort of going with that.

And in some ways, it really does have a positive impact upon our work with women, but it's missing the boat in a lot of ways. What they call criminogenic needs within criminal justice, there's something they call the "Big 4." And the Big 4, we're really looking at criminal history, criminal thinking, criminal peers, and some personality attributes. And so, all this stuff is supposed to be what really contributes to offenders getting involved in criminal justice, and it all works the same for men as it does for women.

And then some more researchers kind of expanded upon that, and they added a couple other categories. They looked at family marital status. They looked at education and employment, substance abuse, and how folks use their leisure and recreational activities.

What they didn't look at are those things that with women really seem to be -- they would refer to them as "needs" with women, but the research that's been done that's been emerging the last 10, 15 years on women is really saying those needs actually contribute to women's risk. And so, those needs are things around trauma, women's experiences with trauma, with issues around child care, transportation, low self-efficacy -- a woman's belief that she can actually be capable of doing something, that she can achieve something -- issues around parenting, healthy relationships, and realistic employment, given the kinds of skills and such that women bring into the criminal justice system.

So a lot would be what we call -- the researchers, we call it sort of the gender neutral research, the stuff that's supposed to be as applicable for men as for women. But we're saying, yes, it has impact, but you're missing the boat on some things. And part of the problem is a lot of the researchers will say, well, you can deal with that through responsivity. You can deal with that by, for example, the issue around parenting. Responsivity would be, well, if we make -- if we create the ability for a woman to get to treatment with child care, we've

dealt with that parenting issue.

What the feminist researchers are saying or the folks who are more involved with looking at issues with women is that that's not the only issue. The issue is that if women are out there. They have their children. Say, if they're in the institution, they can't see their children. They are perhaps in the process of TPR because systems external to criminal justice and the criminal justice system will not create the ability for caregivers to bring children in. TPR can be started.

That has impact on women's behavior. So it's more than responsivity.

DR. JEAN CAMPBELL: What is TPR?

MS. MAUREEN BUELL: I'm sorry. Termination of parental rights.

DR. JEAN CAMPBELL: Thank you.

MS. MAUREEN BUELL: Brenda had mentioned the Adoption and Safe Family Act, which was enacted during the Clinton administration. And there was an unintended consequence with that, and what that was, was that ASFA was meant to free up more children for adoption because there were kids that were kind of lingering in the foster care system.

What ended up happening is for both men and women, but more with women is they -- a larger percentage of them actually have custody of their children, a lot of those women who are going into the correctional system, as Brenda was saying, still have custody of their children. And they have that child with a caretaker, but that if the caretaker and the systems that are managing the child in the community and the correctional system does not make it easy for that child to come into the system, then States can actually begin termination of parental rights if the woman has lost contact with her child for 15 out of 22 consecutive months.

So that has a huge impact. That's pretty significant.

DR. BRENDA V. SMITH: And Maureen, what's the average sentence for women? Is it like 3 years?

MS. MAUREEN BUELL: It's about -- it's about 3 years. Still shorter for men, but when you look at this 15 out of 22 months, and you look at the percentage of the women that have children, this is a big deal.

You folks are familiar with the work of Dr. Stephanie Covington. This is a definition of "gender responsive" that she has coined. There's been some variations on it over the years.

So what we're really trying to do is we then absorb this not battle, but it's been a challenge with a lot of the criminal researchers who are saying they will go out and do training across criminal justice and say what works well for the men works just as well for the women, and then we'll come in afterwards and say but there has been emerging research about the impact of trauma.

We know that men experience trauma. We know that men are sexually abused. We know that they're probably at higher rates than we're hearing about. What we also know is that that abuse and that trauma, the abuse tends to drop off for males as they hit adolescence. It increases for women and for girls as they move through adolescence and into adulthood because of rape, domestic violence.

We also know that folks handle trauma differently. Women tend to internalize it. Men more externalize it. So I know within our institutions, we see a lot of cutting, a lot of self-abuse with the women. And there's, again, you can spend days talking about the ramifications and the theory and the information about that with women offenders.

So what NIC did over a number of years, really starting in the late '90s, is that we developed what we called assessment classification tools that are actually validated norms and validated on women. So these are actually tools that were built with solely, entirely a cadre of women as the end, as opposed to mostly men with some women in there.

And what we discovered is that there were these different areas, as I mentioned before, trauma, parenting issues, relationships, that really played out differently for women than it did for men, and it was contributing to the women's pathways into criminal justice. So I think one of the things that we struggle with is that there aren't those big gold standard empirical studies on issues around women's entry into the criminal justice system and women offenders.

But the smaller studies, and there's tons of them, smaller, qualitative studies are all pretty consistent in identifying that these are issues that are really behind women coming into the criminal justice system. So if you look at the percentage of women that come in with trauma and sexual abuse as children, and then you think about what we know about substance abuse, about why women use substances. They often use substances to mask trauma.

And women get introduced to substances oftentimes differently than men. They use it differently than men. They often use it to maintain relationships. So what we're not saying is that we shouldn't hold this population accountable for the behavior that brings them into the system. But it really means that as we develop these tools and validate them on women that what they're allowing us to do is really begin to sharpen our practice with this population. It lets us think about what the resources are that we should be developing if we want to improve

outcomes with women.

So instead of taking programs and such that are developed and used primarily for male offenders, and the only difference is that maybe it's being delivered by a female to a group of females, we're finding that that really is not very helpful. That programs that really focused on issues that are more prominent or unique to women are critical.

Carole?

DR. CAROLE WARSHAW: I was wondering, do the tools include the context of when coerced -- women are coerced into using or when they are the ones who end up being caught literally holding the bag by an abusive partner? What's the context of --

MS. MAUREEN BUELL: There is an element of that in the women's risk need tools. One of the things that the Big 4 and the Big 8, the criminogenic needs for males is they talk about both men and women use drugs. And both men and women may have criminal associates.

What they're not talking about is oftentimes a criminal associate for a man may be his buddy, as opposed to it might be the partner or the father or the husband, the boyfriend of the woman. So that's a difference. Oftentimes, women will use substances to keep a relationship together. So there are some differences.

When we look at women's violence, we find that everybody is talking about how women are becoming so much more violent. What we're finding is that we're seeing more violence, but that violence has a different quality to it oftentimes. A lot of them are simple assaults. A lot of them are defensive violence. A lot of them are -- women's violence tends to be somebody who they know. Oftentimes it's a child. With men, it's oftentimes more of a stranger.

I think about, and I've seen this in my own experience as a practitioner when I was a parole officer, you would see two criminal records. You would see robbery for a man and robbery for a woman. And what you would see with the man oftentimes is that he went in. He forcibly broke into the house, pistol whipped the woman, and took the jewelry right off her hands. With the woman, she may have gone in with the man, or she may have been waiting out in the car.

Not that there aren't that percentage of women that are dangerous because there definitely are. But there's oftentimes a qualitative difference that we're not paying a lot of attention to.

DR. BRENDA V. SMITH: And Maureen, I was going to also add one other thing, which I think is really interesting, particularly when we look at lethal violence often with women. Just the way -- this is the law teacher talking. Just because

of the way that women commit lethal violence, particularly if it's an intimate partner. They plan. And that brings them into more serious offenses, right?

DR. CAROLE WARSHAW: Because spontaneously, they're not going to be strong enough.

DR. BRENDA V. SMITH: Right. Right. Because men have a wider array of tools that they're able to use in order to control. And women, because oftentimes we plan, we fail to -- we've got one shot, and --

DR. CAROLE WARSHAW: So it was premeditated because it was the only way you could possibly be safe.

DR. BRENDA V. SMITH: Exactly, which brings you into murder one.

DR. CAROLE WARSHAW: Well, women are not only coerced into using, but also into criminal activity, and then they are the ones -- you know, it's just how that gets parsed out and then those questions would be great to have some of that. Or afraid to call the police because then that factors into it.

MS. ROSALIND WISEMAN: I'm sorry. I know these are all like -- I can tell every single one of these is so deep, right? I just want to make sure I'm understanding this correctly. You're saying that women more often, because they feel that they have a narrower margin of error, say it that way, that they have to plan more to commit whatever act it is to achieve whatever goal.

But in contrast, men, who are more impulsively violent, they are not planning in the way that women are planning?

DR. BRENDA V. SMITH: Oftentimes they're not, and I was only talking about lethal violence here.

MS. ROSALIND WISEMAN: No, I understand. And so, therefore, the consequence would be in a system that the woman's behavior was seen as in some ways more lethal or obviously more premeditated, more aggressive.

DR. BRENDA V. SMITH: It meets the elements of the offense for premeditation, which will get you murder one. More serious offense.

MS. ROSALIND WISEMAN: Right. Gotcha. All right.

MS. MAUREEN BUELL: Just for the last couple of minutes here. I particularly like this slide. On the left-hand side, I want to talk about the Big 4, the Big 8, these are all the things on the left hand that are supposed to work just as well for men as they do for women-- criminal history, anti-social attitude, challenges with employment, finances, family conflict, history of mental illness. And they are

applicable to women, but what we've been finding where we've actually been able to validate these tools is that you get much sharper information if you include these issues here in terms of not only custody, at what level of custody in an institution that you hold a woman, but also in terms of your program planning.

One of the things that we've been finding is that a high-risk woman in a prison looks more like a medium-risk man, and so that has implications for the number of women that are going to prison. It has implications for that they're oftentimes held at higher level so they can't access programming. They don't have access to building reentry plans like a man might.

So what we're really trying to do is get this information out because it really has cost implications. But it also has implications, as Brenda was saying, in terms of family systems and just in terms of creating programming.

As you look at housing safety, you know that housing is a challenge for men as well. But for women, not only trying to find a house for herself that's safe, that is affordable, that will take her and her children. But you also have to think about is she safe in that house? Is she with a partner that will be abusive?

Women are also held accountable for being in living situations where they're not safe and the children aren't safe. So even though that's the best that they could do, they're often held accountable for that level. And when Brenda was talking about parole revocation, again, as a former parole officer, one of the things that we never asked about was why can't you get to treatment? Why can't you get to this appointment?

So when we think about they have to pay restitutions and fines, which they should. They have to go to drug treatment. They need to find employment. Those things are important. We have to do that as citizens. But then when you factor on top of that they have the children. They have to be sure that they can feed and clothe the children, get the children out to school, be sure the children come home, and then there's somebody that will be at the house.

If they have children of different ages, they've got to get a child to school. They have to dress that child and get that child along with them. So there's all of these complications that we've never asked about. And the one thing I'll just leave you with is I can remember having brought a woman back to prison, giving her so many chances to do treatment. Some years down the road, when I got smart about often it's the system that's the impediment, is the woman told me that the reason why she didn't go to treatment.

This is back, and we still do it some, but when we were doing mixed treatment groups. So this woman actually stopped going to treatment not because of child care or transportation, but because there was a man in that treatment group whose father had molested her as a child. Nobody is going to talk about those

issues that bring them to the attention of the criminal justice system.

So I'll just end with we don't have the giant empirical study. We've got lots of information that is consistent about what these issues are that seem to be bringing women into the criminal justice system and not assisting them in being successful once they're back in the community.

Carole?

DR. CAROLE WARSHAW: I'm thinking about something that Stephanie, it was in one of her articles, which we had also talked about this, was when she was talking to women about what they need around reentry. All those kind of wraparound services to support them. It's the same things they would have needed before that would have helped them never end up in the system in the first place.

And it's like when you think about that, I mean, there was a webinar, a webcast that ACYF did with the FYSB office like, I don't know, a couple of months ago. It was around the child welfare system and DV, and there was a video that they showed -- and it may be still on their link -- where it had this one screen with all the things the woman had to do to maintain her custody of her children once she entered the system. And the screen was just filled with -- I mean, when you looked at it, it was overwhelming, and you think about someone who's trying to kind of deal with those systems.

The other thing is about being able to hide from an abuser when you're wearing -- I think that Richie had talked about this at one point, about if you were wearing an ankle bracelet or you can't really move around. So that when you think about mobility for a job, but also even to be safe, sometimes that's another factor. So --

DR. BRENDA V. SMITH: And this is actually really -- and we also have to think about the impact that trauma has on people's sense of efficacy and what they can do and whether they think that they can be successful.

So, you know, one of the things, and this is sort of putting on my project on addressing prison rape hat, is that when women are victimized or abused as children, then they become much more susceptible to abuse in other institutional settings. And so, often that abuse continues in treatment, right?

I'm actually talking to someone in D.C. who is looking for an expert because the woman was sexually abused in a treatment program right here locally. They are also victimized when they are in custody as well, and also if any of you work with juveniles, you know they're victimized also in residential treatment, right? So that untreated trauma creates all kinds of other risk, and it becomes reinforcing.

I'm not going to go to the PowerPoints, but I'm going to talk through them. Maureen, if you would just --

MS. MAUREEN BUELL: I'll move you in the right direction.

DR. BRENDA V. SMITH: -- move me to the first part that talks about legal clinics. Keep going. Okay.

So one of the things that I think that you talked about is the wraparound services and sort of the connection to reentry. And because I sort of have my feet firmly planted in both of these worlds, one of the things that I have been doing or I've been seeing come up and that I've asked my colleagues is what is the impact of the punitive state on what we do?

I'm at American. We have 11 clinical programs. Those are just the formal clinical programs. And what we do is we take a certain number of students. We have about 250 a year, and those students represent clients.

We've got 23 faculty and 6 staff people. And so, I asked my colleagues, well, how does imprisonment come up or punishment come up in your clinics? And I was astonished. You've got these little stories. A family member who files a tax return in the imprisoned person's name while they are incarcerated. And so, when you come out, you have penalties for failure to file taxes for someone who worked under your name and your Social Security number, okay?

Facts of the woman's past imprisonment is a factor in assessing whether she's able to obtain a civil protection order or, when we go into the women in the law clinic, being able to get her kids back.

Credit card debt accrued in an imprisoned person's name. People who want to have copyrights on their music and art that they've created while they are in custody. Criminal record a factor in gaining asylum. Imprisonment, again, is a factor in an asylum claim.

Challenges to getting services for youth or other individuals who are in the justice system who have disabilities. The loss of SSI benefits because of your past history, and also public housing and not being able to go into public housing.

So one of the things that I've actually been thinking about a lot in our work with the Community and Economic Development Clinic is that one of the things about community and economic development is it really doesn't see people who have criminal justice backgrounds as a real asset because, you know, CED is about assets. And these folks are really not seen as assets.

And so, really what we're trying to do, at least what I'm thinking about, is how do we create a situation where these folks are viewed as assets and where we can

take part in sort of that whole project of getting them back into the community? So one of the things -- and of course, Morgan doesn't know this, right, because this is rarely what we talk about in class -- is I'm on sabbatical next year for an entire year.

And so, one of the things that I'm really looking at is I'm looking at sort of the thing that I sort of did my Kellogg on, which is how to build enterprises that increase people's capacity, right, and sort of linking community and economic development work with reentry work and sort of dealing with many of those issues that keep -- that sort of create barriers for people to be able to participate in treatment, get their kids back.

So I'm going to stop here so that Maureen can talk, but if you have anybody -- if you know any programs that are interested in mobile pet grooming salons, food trucks, right, or urban farming or landscaping, those are some of the initial ideas that I'm thinking about and, obviously, of connecting these to communities where these women are embedded.

I already have conversations going on with the U.S. probation officer for the Federal -- for D.C., but I'm also looking for some other opportunities to work with people around the country if they're interested in doing something.

DR. CAROLE WARSHAW: I was just going to mention Vermont Works for Women. Do you know that program?

DR. BRENDA V. SMITH: I do.

MS. MAUREEN BUELL: I'm from Vermont.

DR. CAROLE WARSHAW: Oh, yes. So, right.

MS. MAUREEN BUELL: I know them well.

DR. CAROLE WARSHAW: Yes, okay. Great.

DR. BRENDA V. SMITH: Right. Right. And wider opportunities for women here and stuff like that. So who've done some really -- but it's very important that we all be talking together.

DR. CAROLE WARSHAW: And if we develop these to help support women, that is a part of reentry to the workplace.

DR. BRENDA V. SMITH: Right. Right. Because we're talking we're working with the same women at different places.

MS. MAUREEN BUELL: I think I actually covered most of the comments. What

I think I'd like to do is I see we've got 5 more minutes. So if we have some questions, we'd love to answer them. And if we don't, I have a question I'd like to ask Brenda.

[Laughter.]

MS. MAUREEN BUELL: But if anybody has anything that they wanted to ask?

MS. SHARON AMATETTI: Yolanda was going to help us with the discussion. Maybe you want to do the question to Brenda first, and then --

MS. MAUREEN BUELL: Oh, okay. Okay.

DR. BRENDA V. SMITH: This is hard. You ask hard questions, Maureen.

MS. MAUREEN BUELL: No, I want to get your opinion about something.

DR. BRENDA V. SMITH: Okay. All right.

MS. MAUREEN BUELL: Because one of the things you were talking about is the racial disparity, and that certainly is an issue. And I know that when we -- even with the women offender work, we are not actually -- we're looking broadly. We're not looking at Latina, African-American women, and so we're guilty of that as well.

But a sentencing project just came out with a report about that there has been a reduction in the rates of African-American women in the system, that there has continued to be an increase of Latina women and an increase of white women.

DR. BRENDA V. SMITH: And white men.

MS. MAUREEN BUELL: And white men as well. And I just wonder if you had any comments or any thoughts about that?

DR. BRENDA V. SMITH: Well, do you want me to like -- do you want my conspiracy theory?

MS. MAUREEN BUELL: I do.

[Laughter.]

DR. BRENDA V. SMITH: Okay. So one of the things that I -- one of the things that I think, and I've known this, I mean, it's been around for a long time. Sort of the numbers of white men who are coming in the system have increased. And I think that it's all a feature of sort of the punitive state, right?

The thing is, is you have to be able to feed that beast, right? And the Latino men, the African-American men, they're there. And so, I think a lot of white men are coming into the system for the same reason that African Americans came into the system, because of the lack of job opportunities, the lack of employment that's hit everybody.

And I also think that one of the other phenomena that are bringing those guys into the system is meth. Okay? And so, that's a big issue that's bringing whites into the system. Okay, sort of meth is sort of the new thing that we are concerned about, and so I think that that's sort of what's going on.

In terms of what's happening with African-American women, I don't know. I don't know. One of the comments that I wanted to make just about sort of -- you know, sort of another gender thing is there was actually just an article in the newspaper. It was really talking about death cases, though, but about how often people who have lower culpability will end up with higher sentences than the people who had greater culpability, and that -- right.

Right. And that happens very often for women in drug offenses, right? Plea bargaining and also in terms of cooperation and because of what we know about women and trauma and fear. I remember having a client who was involved in a series of robberies, and she was a co-defendant with this guy. This guy got less time than she did because she would not talk.

She would not say anything about him because he told her if she talked that he would kill her kids. And she said, "I'm just going to do my 6 to 10, and my kids are going to be fine." And she did not talk. He walked, and she went to prison.

And that's another -- again, that's that whole efficacy piece. Do you have the ability -- I mean, he had threats. And she had a sense that he could actually complete those threats, where she didn't have that kind of power.

DR. CAROLE WARSHAW: Yes, so it's not just self-efficacy, it's real genuine threats. I mean, that's a piece of that --

DR. BRENDA V. SMITH: Right. And another interesting thing, too, just in terms of going to Maureen's question about, what do I want to say, race and ethnicity of the sentencing, the U.S. Sentencing Commission, and Mona has done some work here, where there are more likely to be departures for white women and Latinas than there are for African-American women who are perceived as being more powerful and much more running things, right?

And so, you don't get that departure because you were coerced because there's a sense that you were an equal partner. And that's one of the reasons. That's one of the ways that race and ethnicity kind of go in together.

So we're going to shut up and then let Yolanda talk.

Agenda Item: ACWS Discussion

DR. YOLANDA B. BRISCOE: Well, I moved about 6 months ago, and I threw away a bunch of magazines, but I kept this one 6 months ago -- it's Beyond Prisons -- because it was just so powerful.

And what it talked about -- because I wondered why the disparity, why the overrepresentation of people of color in prison? So it talked about that even though whites, 70 percent drug users, who was in the State prisons? Black and Hispanics. Why?

So I read through all this. SAMHSA helped with this. Behind bars in America's prison population. About 15 years ago, Ani DiFranco in one of her songs and one of her concerts, she talked about modern-day flavor.

DR. BRENDA V. SMITH: Exactly.

DR. YOLANDA B. BRISCOE: And still wondering why, why? How did it happen? Well, reportedly, it came about because of the war on drugs and building of prisons. In Grants, New Mexico, if there was no prison, there would be no economy.

DR. BRENDA V. SMITH: Exactly.

DR. YOLANDA B. BRISCOE: They've got to fill those beds because we've got to have jobs. So why are blacks harsher sentences for possession or crack cocaine happens to be more of a black in general drug? Now meth for whites. Outdoor drug sales, where are they? They're in communities where poor and marginalized people hang out in corners. The concentration of cops in those areas and race-specific sentencing for judges.

So what we're looking at is clear discrimination, and all the civil rights movements and all the strides that were made during the civil rights, we're going back to that same kind of discrimination because it affects jobs and employment, education. It used to be that Pell grants in prisons, they would offer education to prisoners so that when they left, what a novel idea, when they left the prison, they would be employable.

Well, we're in a society where you did something bad, and so we're not going to -- we're going to punish you. We're not going to offer any incentives. And so, it's a cycle of this poverty that one of the obstacles for getting treatment in my facility is if you're a State looking for State funding -- so we don't collaborate. We don't

work together.

If you've been in prison and you've had 3 months, a month of sobriety, you no longer qualify for State funding. So you must go to outpatient. Well, for outpatient, a lot of the individuals that we see have no transportation, have child care issues. So they would have been in treatment before going to prison or jail, had they been able to go to treatment before having to end up in.

And so, it's we don't collaborate. We don't work together. Insurances will not pay for somebody who's been in prison or jail if you've had a month of sobriety. So although there are drugs and alcohol in prisons, it's a little easier to stay clean when you're in a controlled environment than when you get out. So it's a revolving door where we don't talk to each other. We don't collaborate.

The education system, I mean, it's thousands. I can't remember because I'm really bad at math. But the thousands of dollars in savings if you educated somebody versus you put them in prison. So the education system doesn't talk to the correctional, and correctional doesn't talk to treatment.

And so, we all, I'm included, try to do what we can given what we have, but if we talked to each other and collaborated, I think we'd -- we would be better off working together. So like in As Good As It Gets, we're drowning here, and I just described the water. So what are some of the things that can be done?

I think one of the things is collaboration, working together to try to -- we're doing that on a city level with the LEAD program. Law enforcement diversion practices. We've also got a group that's restorative justice to minimize the trauma and actually helpful to the community and to the offender.

And in this Yes! magazine, which you've nodded, you've seen it, there are some programs that are happening around the country that are -- the people are just saying, you know what, we're just going to have to do it ourselves.

DR. BRENDA V. SMITH: Exactly.

DR. YOLANDA B. BRISCOE: What you were talking about, some of the programs where getting people employed who otherwise wouldn't be employable because on the bottom, it says have you ever been in jail? Do you have a felony? And if you have a felony, well, who's going to hire you?

DR. BRENDA V. SMITH: It's interesting, one of our clients, a woman, learned data cabling in the Federal Bureau of Prisons. Data cabling is huge. You know, putting that stuff -- can't get a job because she had a prior record, right?

DR. YOLANDA B. BRISCOE: It's criminalizing drug addiction because that's what got them in there. So now they've become criminals.

MS. ROSALIND WISEMAN: One of the things I talk about with private school kids, because I work with -- we've got these very wealthy private school kids who have great privilege in all different kinds of ways. One of the things I think we need to do a better job of, and I've been doing -- I've been doing it in the last year. Because of the boys book I was writing, I had to try and figure this out. A kid who had gotten into a fight at school made me think about this.

So lots of private school kids don't think there is racism and certainly don't think there's classism. They don't think -- they really don't. For the most part, they really don't. And they have all different kinds of arguments about why that's the case.

But the place where I get them to stop arguing with me about that, which I would love them to understand, and like this helps me put more depth to it, is I say to them, okay, I'm not going to ask you people who's doing drugs. I'm not going to ask you who's drinking. I'm not going to do that. But let's say it's a fair assessment that many of you are.

Well, when you get in trouble for doing those kinds of things, you don't have a school resource officer at your school. Who takes care of it? When you get caught, what's the worst thing that's going to happen to you? The worst thing that's going to happen to you, I know this is a big deal, but the worst thing that's going to happen to you is you'll be suspended or expelled from school. And the thing you are the most stressed about is it getting into your college transcript.

At public school, not even bad scary public schools, but like normal public schools -- I used to say it like even schools in northern Virginia, they have school resource officers. And if you get caught, you have entered the system. So don't talk to me about how that this is the same because it's not the same. And they stop arguing at that point.

So I would love for -- I think that even you cited a slide with like all of the different things. I think that would be -- these children, this is such a have and have not society. The children in private schools are really many of them will become in positions of leadership, and they need to really understand what that privilege looks like.

And so, those kinds of slides you were talking about or listening to this to even more inform it, to me, is not just giving them the like "you need to understand your privilege," but for them, as they become -- for awareness that they can then incorporate now and then as they grow older. That to me would be really imperative.

DR. BRENDA V. SMITH: I sit on the board of one of these tony private schools that my daughter attends, and every year, there is some alcohol, drug, sex

mishap. It's a mishap.

MS. ROSALIND WISEMAN: Always.

DR. BRENDA V. SMITH: But it's not a criminal offense.

MS. ROSALIND WISEMAN: Ever.

DR. BRENDA V. SMITH: And exactly as you've described it, it is --

MS. ROSALIND WISEMAN: Always gets taken care of in-house, always.

DR. BRENDA V. SMITH: Always. Always.

MS. ROSALIND WISEMAN: The same problem, completely different reactions.

DR. BRENDA V. SMITH: Yep.

MS. ROSALIND WISEMAN: But I think that if the kids got -- I think that they get it. If you explain it to them, literally that the thing that I know is when they stop arguing. That's when you know you've sort have gotten them to a place of, "Okay, I get it."

DR. BRENDA V. SMITH: I guess I'd be interested in like you've heard like all of this information. What are the things that kind of make you scratch your head and go "hmm," you know?

DR. YOLANDA B. BRISCOE: Where do we start?

DR. BRENDA V. SMITH: Where do you start? Right.

DR. YOLANDA B. BRISCOE: But having that understanding when we have a clinical staff meeting and we're asking somebody that was caught with contraband in the facility, we have to look at it from the implications and what got them there versus you were smoking marijuana in the bathroom, and now we've got to kick you out.

Knowing those implications and how somebody got to our place and what they're going to gives us pause to be a little bit more compassionate and understanding. With understanding comes compassion. That's the whole thing.

DR. BRENDA V. SMITH: And I guess also I would just make a pitch just because I would say in the last couple of weeks, I've been hearing a lot about medical and treatment providers and sexual abuse of people who they are supposed to be caring for. So I would also make a pitch to have that conversation with staff members because it's retraumatizing.

And I actually think that there may be a little bit more going on than I guess I had assumed. And maybe it's just the weather's getting warm. I don't know.

DR. YOLANDA B. BRISCOE: That's part of it. Spring fever. But we have to have twice a year talks on boundaries and --

DR. BRENDA V. SMITH: Yes.

DR. YOLANDA B. BRISCOE: -- just vulnerability of individuals coming into treatment. And still we'll have a med tech who's found his or her soul mate.

DR. BRENDA V. SMITH: Yes. Yes.

DR. YOLANDA B. BRISCOE: Because you're substituting one addiction for another and not wanting to deal with your addiction, go outside of it, and start a romance. And that can happen in treatment.

DR. BRENDA V. SMITH: And the only thing that I would inform you of is that there is some effort to have some legal liability for treatment providers, particularly State-funded ones, for that behavior.

MS. ROSALIND WISEMAN: There's not legal liability at this point?

DR. CAROLE WARSHAW: There should be, and certainly medical board liability, where people lose their licenses.

DR. BRENDA V. SMITH: Right. Individually. But I'm talking about for the program and -- for the program and also for like the addiction and what is it in D.C.? What's the name of it? Addiction Prevention Resources Administration, something, for APRA or whoever But sort of both State and also for the institution.

DR. SHELLY F. GREENFIELD: I guess one of the things that I hover over is for women in particular the issues around the fact that pregnancy and childbearing and having children can be so incentivizing toward treatment and getting clean. And that the system we've set up in general makes it harder to get treatment if you're pregnant or have children and punishes and disincentivizes. You know, it does the opposite.

So we have people who don't really want to come forward if they're pregnant or they have small kids because they're afraid of losing their kids, and they don't get treated. We have people who get incarcerated and are kind of on the pathway to their worst fears. We have people who could come into treatment sooner in a pregnancy that are worried somebody is going to report them.

And it's just I feel like it's so -- what's the word -- just so does not take advantage of the things that we know that actually really work for people. And the punitive side of it has actually been more intense in the last 10 years, I think, just even by State laws. A lot of these things come past my desk in terms of amici briefs and things like that across various States. But anyway, this is one thing just to focus on the women that I find very disheartening at this point.

And then also just the issues around the drug courts, which we also know. I mean, I just feel like we have a lot of body -- it sometimes feels like if we just would put into practice the body of evidence that already exists we would be doing a lot better than we have -- than we are at the moment. I mean, there's a lot of data that show that drug courts do incredibly well if they're hooked up with good treatment programs and people are incentivized to do treatment.

So hearing the presentation and some of the data, it's not -- some of the statistics are new to me just in terms of their recency. But feels very -- it's very disheartening.

MS. MAUREEN BUELL: If I can just take a moment? I mean, you bring up some opportunities because we do have some information. And one of the sea changes I think within criminal justice has been the evidence-based practices, even though it doesn't quite apply to women. I think another huge piece, and SAMHSA is really a part of this, is around trauma and trauma-informed practices.

I think one of the huge things that's just beginning to find a foothold within criminal justice is that these folks have come in with criminal convictions, but that a good percentage of them are just coming from some pretty dysfunctional background. If you look at the ACE study, the adverse childhood experiences, and then you apply that to criminal justice population, I mean, man. It just says it right there.

So I think that -- I think that trauma and trauma-informed practices is beginning to kind of seep in a little bit. One of the issues we have is that around training staff, that you don't have to be a clinician to do some of those things. A lot of it is just speaking with respect and dignity to somebody.

Boundaries is an issue, and certainly as we talk about training staff to become more trauma informed, you also have to be sure that you meet those boundaries. But I think another opportunity is around this move to reentry. And frankly, it's not because -- or I don't think it's because people finally want to do the right thing. It's because there's no more place to put people.

But within that, criminal justice is focused on the individual. It's never been focused on systems. I think one of the things reentry is doing is it's forcing us to look at the fact that human capital, social capital, communities of practice, that these things are all really critical and that there's some research behind it that

shows that this has impact.

So I think there's some opportunities here that we can capitalize on, and the last thing is I just thought about when you said you did some work with grants. I mean, one of the grants is a privatized facility in New Mexico for women offenders.

And one of the things with the privates is that, I mean, they have to make a profit. And if you have beds that go unfilled, you've got to fill those beds. You've got to find a body. Now if you've pulled somebody from a lower level treatment facility into -- this is big business. They have lobbyists on the Hill.

DR. BRENDA V. SMITH: So, Maureen, I wasn't going to go all conspiracy.

[Laughter.]

MS. MAUREEN BUELL: I'm just speaking from the prison industrial complex, it might actually better. But if it's --

MS. JOHANNA BERGAN: In response to your previous concern today, which isn't all that conspiracy, I think, but talking about the increase in white males because --

DR. BRENDA V. SMITH: That was a theory maybe?

MS. JOHANNA BERGAN: Right, yes. Right, because of unemployment, I'm just wondering with the 26.7 percent unemployment of 16- to 25-year-olds, if we can know what's happening in our next 2 or 3 years of data that will come back?

DR. BRENDA V. SMITH: You know, you have this whole thing right now where I think, okay, there are a bunch of different shifts that are going on. One is because people that we care about are going to prison, I think that there has been more space created to do more progressive things, right? Because I think that the fact is, is the fact that there are more white people going to prison that we got to do something about it, right?

MS. JOHANNA BERGAN: No, I don't really want to go there because --

DR. BRENDA V. SMITH: Yes, but it's the truth. I mean, it's the truth, and so I think that there are some huge opportunities. I also think because we're in a recession there are huge opportunities. California is -- anybody here from California?

FEMALE SPEAKER: Lived there for 10 years.

DR. BRENDA V. SMITH: Okay. I mean, they were having people dying every

day, and they were paying a lot of money to the courts because of not being able to provide the care that they needed to provide constitutionally. And surprise, surprise, they were like, oh, okay. Well, we're going to release a whole bunch of people.

And 4 years ago, those people were not releasable, but when you don't have money, you can release them, right? And then people have to get really creative about what they're going to do about them.

Linda, I saw your hand. One of the things that I think -- and I say this about funding, right? There are funding opportunities out there, but I think sometimes the people who really are doing the work, the way that you have to, all of the I's that you have to dot, T's you have to cross in order to get the funding, they never get there. The people who are doing sort of that work at the ground level, they never, ever get there.

And so, what I heard you say, and I think it's Shelly, right? Is that what would be really -- what I took from what you had to say is it would be really cool if in a community people who were really doing the work could get together, sit down at the table, talk and say, okay, I do this. I do that. This person involved in the drug court system, and they're also involved here, multiply involved here, had a set of principles that didn't involve increasing, sort of amping up the level of punishment and sort of really figuring out where they could go to sort of resolve this, right?

And I know that that's what these grants are supposed to do, but they actually don't really do that. You know, powerful people or powerful institutions are the ones that end up with them, and sometimes that sort of micro-level contact that you need to have, you know? And that's one of the things that's been great about being able to be in an institution where, to some degree, you get subsidized to do your work. And so, you can just say, "I'm going to do this." And then you can try it out, and you can get a chance to work with some of the people you work with.

I think that that's one of the things that would be very -- ways to kind of make these interventions smaller and more intimate. Does that make sense, or is that heresy?

[Laughter.]

DR. YOLANDA B. BRISCOE: It could be both. I wanted to bring up another point as well. And you touched on it about the community impact and society, the impact on society.

DR. BRENDA V. SMITH: Right.

DR. YOLANDA B. BRISCOE: We see so many grandmothers bringing their children to visit their parents in treatment. And I think the grandmothers get forgotten, the grandmothers who are raising children.

Six months ago, my daughter went through a divorce. So her and her 6-year-old are living at home with me. Oh, it takes a lot of energy. When I was in my 20s I don't remember feeling tired. I just did it. Now, oh, my gosh, they're a lot of work. And so, I wonder about women who are now raising their grandchildren more and more, and I know that there's some work being done in Africa because of HIV and AIDS and grandmothers raising children.

So I just want to remind us all to not forget about the grandmothers.

DR. BRENDA V. SMITH: The intergenerational impacts of this, yes.

And then I saw a hand back, all the way in the back?

FEMALE SPEAKER: She's recording us. She needs to be able to hear.

DR. BRENDA V. SMITH: Okay. Okay, sorry.

MS. SHARON AMATETTI: I wonder if the people on the phone, either Thelma or Starleen have anything they want to --

FEMALE SPEAKER: Thelma is not on the phone.

DR. YOLANDA B. BRISCOE: Starleen, do you have any questions?

[No response.]

DR. SHELLY F. GREENFIELD: I guess I was thinking not just only in the levels of the communities, which is very important, but also thinking about State-level priorities around legislation that would actually move people in a mandatory way toward drug court systems for certain sorts of offenses and provide the treatment opportunities to start directing the money in that direction, which is a larger system kind of initiative or way of moving things forward.

Because right now, it does seem like many of the incentives are what I would call perverse in terms of what we know would work and also to your multiplier effect.

DR. BRENDA V. SMITH: Right.

DR. SHELLY F. GREENFIELD: I don't think we can ignore the fact that kids who are growing up unable to see, let's say, their mothers in situations where perhaps somebody has been incarcerated, where they have not been violent or dangerous toward their children, but have a drug problem that could be treated,

and then there would be better maternal and child outcomes is actually really antithetical to what we know from a neurodevelopmental model actually works over the life span. It's the opposite.

So it's just -- and then the other thing is, of course, from a fiscal standpoint, other services sectors start holding that bag later. So you're going to pay now, pay later. Just where do you want to pay, you know? You're going to pay in kids who have come out of this who are going to need more assistance in various ways because they weren't provided for, or you're going to pay up front now for lower cost treatment that we know actually works for people who are addicted and have now been incarcerated because of whatever the circumstance was but really didn't have access to treatment to begin with.

DR. BRENDA V. SMITH: I was actually recently at a Kellogg event, I guess a couple of months ago, and one of the things that's very interesting is that a number of foundations are saying you know what? We were thinking about 4, but really what we're going to start is we're going to start with pregnancy. And so, we are going to target pregnant women, and we're going to work with them, and we're going to incentivize them with prenatal care, services for housing.

There's all of the studies about sort of the most important indicator of literacy is whether your mom can read and write. And so, that's where they are going, sort of starting there. And I guess the only thing that I would say is that we have to be so careful about sort of anything that you make mandatory ends up becoming, as you say, perverse or perverted in some way. So --

DR. YOLANDA B. BRISCOE: Linda, were you going to say something?

MS. LINDA WHITE-YOUNG: I just wanted to make a note about SAMHSA's large emphasis on creative employment for women who are actually coming into treatment. So when you said that, I thought about that, and I still manage the pregnant and post partum program here, and we are really having very good outcomes. In part, our employment rates are very high at discharge. So we seem to have really good retention rates, and I think it has a lot to do with the fact that there's still a large emphasis on employment. Because remember, even before we got into our current economic situation, women were always having a problem getting jobs, to stay employed to take care of their families.

And so, poverty has been an issue for women for a very long time in this country. And so, programs that I remember people like East Bay and all of those people had some kind of bakery and some kind of process where they could get these women employment skills and get them employed. So a big shout-out to your gardening, but I think poverty has a lot to do --

DR. BRENDA V. WHITE: Huge.

MS. LINDA WHITE-YOUNG: -- with it because most of these women are coming into treatment have about 2.7 children. And those are the ones that are victims, and that's the ones they're trying to gain custody of. So we really have to try to figure that out. So I think we have to -- I think the poverty issue in this country has a lot to do with going and getting into the incarceration system.

And I remember the homeless program in D.C. asked that question why was that the man that she was living with was selling drugs and he went to jail? And so she was selling drugs. And things happen. So I just wanted to note that. That for women, poverty really hasn't changed a lot in this country.

DR. YOLANDA B. BRISCOE: Anybody else?

FEMALE SPEAKER: I appreciate you all allowing me to come here today. I didn't know, I'm taking more of a geopolitical approach toward basically the different socioeconomic classes going along with pure poverty. As women in society today, we have to understand that old-fashioned values and old-fashioned, you know, culture, culturistic traits are different from what women nowadays are experiencing, which might be another indication of why more women are becoming -- entering the system.

Basically, because they're brought up in different ways as compared to you go back several years ago, it was completely acceptable for women to raise a family and raise children. But nowadays, more and more women are gaining access into the workforce. As far as like the same jobs that men have, women have. So they're living that kind of same lifestyle. So they have the same type of mindset. So, therefore, they may enter the system at increased incidence rates and that could be kind of looked at it as kind of a more geopolitical approach with the different socioeconomic classes, and maybe we could reduce the incidence rates in the future.

MS. SHARON AMATETTI: Okay. Thank you.

And thank you so much. Can we give a round of applause to our presenters?

[Applause.]

MS. SHARON AMATETTI: A very stimulating food for thought conversation. Thanks, everybody, for pitching in and despite the heat.

I think we want to just make sure now a little time for some public comments.

I don't know if our public visitors have anything that they want to say? They've been with us. No? Josh, is there anyone on the telephone who wants to -- no?

Okay.

Agenda Item: Closing Remarks/Adjourn

MS. SHARON AMATETTI: So we're coming to the close of a really interesting day. Thank you so much, ladies. Bye.

Geretta?

MS. GERETTA WOOD: We do have a couple of announcements before we adjourn.

In the back of your notebook, you'll find your honorarium forms. We need to collect those from you before you leave. So if you want to give me those today or tomorrow, that would be great.

MS. SHARON AMATETTI: I wasn't quite ready to adjourn. Sorry. I know it's really hot in here. So one thing that we didn't talk about is if you have any suggested topics for our next meeting, which will be in August because we would very much like to tailor these meetings towards areas that you'd like to share with us. If either you'd like us to pursue something that you'd like a presentation on, if you would like to make a presentation on some area.

MS. ROSALIND WISEMAN: You're talking to us?

MS. SHARON AMATETTI: Yes, talking to you.

MS. ROSALIND WISEMAN: I would like to think about that.

DR. JEAN CAMPBELL: And I already put in my request.

MS. SHARON AMATETTI: What was it?

DR. JEAN CAMPBELL: We had a couple of suggestions at the last meeting that we need to --

MS. SHARON AMATETTI: Could we bring those up again? Jean, did you want to share with everybody what it was, or maybe you already did?

DR. JEAN CAMPBELL: Oh, I recommended in August that to put on the agenda, it was stated so well in the minutes, but --

MS. SHARON AMATETTI: Okay. Something that we didn't get to this time?

DR. JEAN CAMPBELL: Yes.

MS. SHARON AMATETTI: Okay. So we'll revisit --

DR. JEAN CAMPBELL: And there was actually two things. One, I didn't bring -- I mean I didn't bring up and I found in the minutes when I was reviewing it as well. I don't now remember what it was, but --

MS. JOHANNA BERGAN: I think, Jean, originally you were talking about a focus on wellness.

DR. JEAN CAMPBELL: That one.

MS. JOHANNA BERGAN: And I would like to second that. Again very elegantly stated.

MS. SHARON AMATETTI: We'll check the minutes, okay? All right.

DR. SHELLY F. GREENFIELD: This is related, but in discussions earlier with Kana and just I think we were also trying to figure out a way that if SAMHSA would also like to use expertise around this table in ways that we could provide even if it were offline by some of us doing something that would be useful to you all, that I think many in this group would feel like we would be happy to do that.

So I know that there are things around -- rules around if there were a meeting, but on the other hand, if there was an idea that a subgroup of us could provide something to all of you.

MS. GERETTA WOOD: A subcommittee would need to receive a charter, and that could take for up to a year. But there is another way to get interaction, and that is to do what we could call homework assignments where --

DR. SHELLY F. GREENFIELD: That's what I mean --

MS. GERETTA WOOD: -- you give your individual --

DR. SHELLY F. GREENFIELD: That's what I'm talking about. And if we had homework assignments, we, as individuals, could talk to each other if we wished to. Like I'm not allowed to call, I can call --

MS. GERETTA WOOD: It needs to be individual. According to the Federal Advisory Committee Act. It would need to be individual comments. But that's a very good way to get feedback on certain things.

DR. CAROLE WARSHAW: We could work together as a group in anyway?

DR. SHELLY F. GREENFIELD: No, no. She's saying no.

DR. CAROLE WARSHAW: So we can't.

DR. SHELLY F. GREENFIELD: But so -- I mean, I guess what I would say, I'll just speak for myself. I would be willing to receive a homework assignment.

[Laughter.]

FEMALE SPEAKER: That would be useful.

MS. GERETTA WOOD: That's the easiest way to do it.

DR. SHELLY F. GREENFIELD: Because I would be very willing to receive a homework assignment, if that would be useful --

MS. GERETTA WOOD: Thank you.

DR. SHELLY F. GREENFIELD: -- for you all. So, and just I guess I'm thinking that there are a lot of things that we have come up both on the phone call in August and today, there are many very important issues that are being addressed and discussed. And I think in different ways, they touch on different people's areas of expertise, and I would be very happy to provide something if it should be helpful to you so that you could also maximize the use of my being on this committee.

So I'll speak for myself.

MS. SHARON AMATETTI: Thank you. That's a generous offering. It's noted and appreciated.

Yes, Yolanda?

DR. YOLANDA B. BRISCOE: My experience in doing something that's not typically what I do on a day-to-day basis pushed me to learn even more. So maybe shaking it up with something that you're not used to doing, being a moderator for that might be helpful versus "oh, my gosh." But I think it was helpful because I really learned even more. So --

MS. SHARON AMATETTI: Well, that's what we did this afternoon. Okay. I got you.

DR. YOLANDA B. BRISCOE: By moderating something that I'm not doing on a day-to-day basis. I'd also like to remind again maybe something about the aging population and if you're going to target a group?

MS. SHARON AMATETTI: That reminds me, on the Coordinating Committee for

Women's Health, there's very active interest in aging women's issues, and I could ask my colleague down at the Office on Women's Health to come up and speak about that, get a conversation going next time if that's an issue that resonates with you all.

Okay.

MS. JOHANNA BERGAN: I'd also be interested in we've discussed prenatal and post natal care frequently throughout the day. So maybe more specificity there. And if we were to have that as a topic, I'd be interested in teenage parents.

MS. SHARON AMATETTI: Okay. Very good.

And look for that new advisory that's coming out April 25th from us on that as well.

MS. JOHANNA BERGAN: I've got some notes that they would --

MS. SHARON AMATETTI: Yes, thank you.

All right. Well, of course, you're encouraged to continue to suggest ideas after this meeting today, but I do want you to think about that because we want to make good use of this time, and to keep you interested also is very important.

So I know you have the joint meeting tomorrow, another busy day. And that's going to be downstairs. And I will turn it now back over to Geretta to close us out.

MS. GERETTA WOOD: The only thing that's left is Sharon alluded to the August meeting. The tentative dates would be the 14th for the ACWS and the 15th for the joint meeting.

FEMALE SPEAKER: Of when?

MS. GERETTA WOOD: August 14th and 15th. I know August is a tough month. Appreciate all of you participating. It's great to have names to put with faces and look forward to the meeting tomorrow. It should be very interesting. So if no one has anything else, I guess we're adjourned.

FEMALE SPEAKER: I have a question. Is that going to be a virtual meeting?

MS. GERETTA WOOD: It will be videocast as well, but it is an in-person meeting. Oh, you mean in August?

FEMALE SPEAKER: Yes.

MS. GERETTA WOOD: Right now, it's tentatively an in-person meeting unless something changes.

FEMALE SPEAKER: Okay. Thanks.

MS. ROSALIND WISEMAN: So we'll just call in if we can't make the -- like these people did today?

MS. SHARON AMATETTI: But we really do encourage you to come in person if you can. You can see what a difference it makes. It's very hard to hear. I mean, we did do an all-day meeting, when was it, by phone. Was it August? And --

MS. ROSALIND WISEMAN: I know, but like lots of people aren't here in August, right? Like anywhere, right? They take family vacations.

MS. GERETTA WOOD: I have brought that up.

MS. SHARON AMATETTI: Like a million times.

MS. JOHANNA BERGAN: I feel like there have been dates offered September, October --

MS. SHARON AMATETTI: When we collocated with other meetings in some place other than D.C.

MS. GERETTA WOOD: I think September is, excuse me, a PACT month.

MS. SHARON AMATETTI: Thank you, everybody.

[Whereupon, at 4:40 p.m., the meeting was adjourned.]