

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

Advisory Committee for Women's Services (ACWS)

**April 2, 2014
Hilton Garden Inn
14975 Shady Grove Road
Rockville, MD**

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Committee Members Present

Pamela S. Hyde, SAMHSA Administrator
Kana Enomoto, Chair
Nadine Benton, DFO
Sharon Amatetti
Deborah Baldwin
Johanna Bergan
Mary Blake
Yolanda B. Briscoe
Jean Campbell
H. Westley Clark
Nevine Gahed
Irene Saunders Goldstein
Shelly F. Greenfield
Elinore McCance-Katz
Karen Mooney
Samia Noursi
Jeannette Pai-Espinosa
Josh Shapiro
Brenda V. Smith
Wilma Townsend
Carole Warshaw
Rosalind Wiseman [on telephone]
Geretta Wood

PROCEEDINGS

Agenda Item: Call to Order

MS. KANA ENOMOTO: Good morning. Good morning. This meeting is now called to order.

[Pause.]

MS. KANA ENOMOTO: All right. Good morning. Thank you, everyone, for joining us today.

We appreciate your flexibility and adaptability as we've had these changing circumstances, and I really want to thank Josh and Cabezon for doing a lot of work, and Geretta and Nadine and others for really doing hero's work in moving us in one day -- in one day.

I mean, we had two changes of venue yesterday. We're trying to find hotels. We said here it's going to be this place, and here it's going to be that place, and I know you guys are coming in into an uncertain situation. But we appreciate it.

And SAMHSA's building is closed again today. The fire was contained yesterday, but they are still checking, doing air quality checks and running through things. They're letting folks into the building just to get their laptops and go back home. So it is a challenging situation, but luckily, nobody was hurt. And the fire was contained, and there wasn't any damage to our building.

So, and since they were going to occupy in several weeks, it's much better that they had the fire now than in 3 weeks.

So let's recognize that we -- Rosalind will be joining us for some part of the meeting by phone and also possibly Vince. So Rosalind Wiseman may be joining by phone as well as Vince Felitti. They're not able to be here in person.

Agenda Item: Welcome Members and Roll Call

MS. KANA ENOMOTO: And then we'll go around the room now and do a roll call of who is here. We're really fortunate to have some new members, and we're excited about that. And I think we'll have a great conversation today and over the next couple of days, which will engage people's hearts and minds in a great way.

So, Jean, would you like to start?

DR. JEAN CAMPBELL: Jean Campbell. I'm from Missouri, from the Missouri Institute of Mental Health, which is part of the University of Missouri-St. Louis, where I just retired, had my retirement party on Friday.

MS. KANA ENOMOTO: Oh, congratulations.

DR. JEAN CAMPBELL: And they did a little roast of me.

[Laughter.]

DR. JEAN CAMPBELL: I actually asked for it. But once you're being roasted, you wonder if that was the best choice. And I have an open house on Sunday for my house. So I'm looking forward to moving to California.

MS. KANA ENOMOTO: Oh, wise choice.

DR. JEAN CAMPBELL: Yes. So email will change, phone will change. But hopefully, SAMHSA will be able to keep track of me.

MS. KANA ENOMOTO: We can only hope. Jean, thank you.

DR. JEAN CAMPBELL: Oh, thank you.

DR. YOLANDA B. BRISCOE: My name is Yolanda Briscoe, and I do several things. I [inaudible]. I also do consultations among women [inaudible] addictions. I also have contracts with Native American Pueblos in Santa Fe. I live in Santa Fe, New Mexico, but I travel throughout the State. I do consultation, and I'm very excited to be here and meet all the new members.

DR. CAROLE WARSHAW: My name is Carole Warshaw, and I'm at the National Center on Domestic Violence, Trauma, and Mental Health. Substance abuse is part of our work, but the title was getting too long. [Inaudible.] We work with all of the service providers in the country, the specific resource centers in the country, and also with the regional mental health and crisis management. We work on child trauma [inaudible].

MS. BRENDA V. SMITH: Hi. My name is --

OPERATOR: Hello, this is the operator. Kana, are we ready to begin?

[Laughter.]

MS. KANA ENOMOTO: The horse is out of the barn. We are beginning. Are you able to hear us?

OPERATOR: I am. I actually have Rosalind with us. She has joined us inside of pre-conference. She is on a separate line. Whenever you are ready, I am going to move you over to the main conference.

MS. KANA ENOMOTO: Okay. Do we have to start over? Well, we're not starting over. You can go ahead and move us over to the main line. We've already started on our introductions, and we'll just continue with that.

OPERATOR: Okay. Not a problem. One moment, please. Please be advised, when I move you, there will be music. Once I stop the playing of the recording, I will then turn it over to you, Kana.

[Laughter.]

[Pause.]

OPERATOR: Welcome, and thank you for standing by. At this time, all participants are in a listen-only mode until the question and answer session of today's call. At that time, if you would like to ask a question, you may do so by pressing *1.

Today's conference is being recorded. If you have any objection, please disconnect at this time. I would now like to turn the meeting over to Kana. You may begin.

MS. KANA ENOMOTO: Great. Thank you.

Do we know how many callers we have? Operator?

OPERATOR: At this time, I'm showing that there are five participants.

MS. KANA ENOMOTO: Okay. Great. Thank you.

All right. We are -- we are continuing with our introductions.

MS. BRENDA V. SMITH: Hello. My name is Brenda Smith, and I'm a new member. I teach at American University in the Law School. I co-direct a community and economic development clinic, but I've spent a long time doing work with women in custody. I used to run a program -- I guess I ran a program for about 10 years at the Lorton Minimum Security Annex here, and a lot of my scholarship is on sexual violence in custody. I recently finished a stint on the Prison Rape Elimination Act Commission, and I've been doing a lot of work in that area and a lot of work on sexual violence and trauma in custodial settings.

MS. KANA ENOMOTO: Thank you.

DR. SHELLY F. GREENFIELD: Hi. I'm Shelly Greenfield. I'm an addiction psychiatrist by training. I am professor of psychiatry at Harvard Medical School, and I work at McLean Hospital, which is a large psychiatry affiliate of Harvard Medical School. And there I have several roles. I'm the chief academic officer. I'm also the new -- newly named chief of a new Division of Women's Mental Health, where we're integrating substance use and psychiatric care for women across the age spectrum with multiple different types of psychiatric disorders.

And I have spent the last 10 or 12 or 13 years doing funded research through the National Institute on Drug Abuse and also NIAAA that's focused on treatment development for women with substance use disorders and also co-occurring other psychiatric disorders.

DR. ELINORE MCCANCE-KATZ: Hello. I'm Ellie McCance-Katz. I'm the chief medical officer of SAMHSA.

MS. KANA ENOMOTO: Okay. Thank you.

Kana Enomoto, Principal Deputy and Chair of the Advisory Committee for Women's Services.

MS. NADINE BENTON: Nadine Benton, the acting Designated Federal Officer for the Advisory Committee for Women's Services at SAMHSA.

MS. SHARON AMATETTI: Sharon Amatetti, the SAMHSA women's issues coordinator and also collaborating on the child welfare issues.

MS. JOHANNA BERGAN: Hello. I'm Johanna Bergan, and I serve as the Director of Member Services with Youth MOVE National, supporting our chapter memberships. Currently 70 chapters of young adults across the country working on the local and State levels to infuse youth voice into the social serving systems and improve them by doing so.

MS. JEANNETTE PAI-ESPINOSA: Hi. I'm Jeannette Pai-Espinosa. I'm a new member, and I lead the National Crittenton Foundation. We're 130 years old, and we're the national umbrella for 27 agencies that provide direct services in 32 States and the District of Columbia, serving girls and young women, primarily those that are in the child welfare or juvenile justice system, high mental health needs, addiction, very high scores.

I'm also Co-Director of the National Girls Institute, which is part of the Office of Juvenile Justice and Delinquency Prevention, and I chair the National Foster Parent Coalition. I'm very excited to be here.

MS. KAREN MOONEY: I'm Karen Mooney. I'm also a new member. I am here

in my capacity as the president of the Women's Services Network through NASADAD. The Women's Services Network is an organization that's made up of all the women's treatment coordinators from all of the 50 States or those States that have designated a women's treatment coordinator.

I am the women's treatment coordinator in Colorado, and as such, I oversee all the expenditures for the women's set-aside, as well as the Medicaid-funded program for pregnant women.

MS. IRENE SAUNDERS GOLDSTEIN: I'm Irene Saunders Goldstein, and I write the minutes for this meeting.

MR. GREGORY ALTHAM: I'm Greg Altham, Alderson Court Reporting.

MS. KANA ENOMOTO: Great. Thank you.

MS. GERETTA WOOD: I'm Geretta Wood. I'm the committee management officer for SAMHSA.

MR. JOSH SHAPIRO: And I'm Josh Shapiro, and I'm the one who sends all the emails.

[Laughter.]

MS. KANA ENOMOTO: Thank you, Josh.

MS. NEVINE GAHED: Nevine Gahed, Special Assistant to the Principal Deputy Administrator.

MS. KANA ENOMOTO: So, Operator, how are we doing? Oh, and on the phone? We have Rosalind?

OPERATOR: Currently, at this time -- I'm sorry. Are you able to hear me, Kana?

MS. KANA ENOMOTO: Yes.

OPERATOR: Okay. Let's see. We're still at -- we're still at five.

MS. KANA ENOMOTO: And are you able to hear us?

OPERATOR: Yes, I can hear you very clearly.

MS. KANA ENOMOTO: Oh, great. And Rosalind, and she's on the line. Would she like to introduce herself?

MS. ROSALIND WISEMAN: [on telephone] Sure, if people can hear me?

MS. KANA ENOMOTO: Yep.

MS. ROSALIND WISEMAN: Okay. Okay, good morning, everybody. I really wish I could be there in person, and really wish I could see everybody. I wish I could be at two places at one time. But I'm working in Omaha, Nebraska, today with a community -- with an organization called -- oh, gosh. I've got too many things on my mind. I'm working with a group for safe communities -- golly, excuse me -- Community First.

And then we're working with a group of boys later this afternoon. I work with them in social justice and shifting the culture, trying to shift the culture in schools to be able to teach social confidence, academic engagement, and bullying prevention together in a way that makes sense in a holistic way.

And I just -- I wish I could be there in person and be in two places at one time, but I'm really looking forward to [inaudible].

MS. KANA ENOMOTO: Okay, great. Thank you.

Okay. So I, again, just want to acknowledge that we are in a different location today. So for those people who are on the phone, please bear with us if there are any technical glitches. And for our members, there was a fire yesterday at dawn in the building next to SAMHSA, and so it took most of the day to contain the fire. There is some smoke damage in SAMHSA. So we are -- we've decided to relocate the meetings for today and tomorrow.

We have five different meetings happening today in three different locations. Geretta Wood, our SAMHSA committee management officer, Cabezon, and our contracting officers on the different contracts -- there is three different contracts related to the five different meetings. So people did quite a bit of work yesterday to find alternate sites, which is amazing that it has come together this well. But again, if there are any glitches, we hope people will understand that, and we will work around them.

The CSAP National Advisory Committee is over at the Washingtonian Hotel, and the three other meetings happening today are over at the National Cancer Institute. Tomorrow, we will be at the Agency for Healthcare Research and Quality near the SAMHSA building.

FEMALE SPEAKER: And Kana, we just found out that parking is \$4 a day at AHRQ. So we might want to let people know.

MS. KANA ENOMOTO: Okay. So if people didn't hear, parking will be \$4 a day for those who are planning to come visit us in person. But I think for the committee members, they're going to have a shuttle. Is that correct?

MR. JOSH SHAPIRO: Yes.

MS. KANA ENOMOTO: Okay. Great. So we have acknowledged our three new members. That's wonderful. We have Brenda, Karen, and Jeannette, and they're each bringing specialized expertise, which is wonderful.

And yes, Jean?

DR. JEAN CAMPBELL: Do you know when the shuttle would be leaving from here tomorrow?

MR. JOSH SHAPIRO: Yes. 7:30 a.m.

DR. JEAN CAMPBELL: The shuttle will be leaving from here?

MR. JOSH SHAPIRO: From here at 7:30 a.m., yes.

DR. JEAN CAMPBELL: Tomorrow?

MR. JOSH SHAPIRO: Yes.

DR. JEAN CAMPBELL: Thanks.

MR. JOSH SHAPIRO: And it's a quick ride. It's probably no more than 5 minutes.

MS. KANA ENOMOTO: And then, well, so I'd like to acknowledge four members who will be leaving us at the end of the year. They will be with us through the next meeting, but our next meeting will be a virtual one. So we won't be face-to-face again before we have Johanna, Yolanda, Vince, and Jean cycling off.

So we wanted to thank you each for your participation in the committee so far. Again, each of you has brought your perspectives. You've been very helpful in our thinking. And we'll still have you, I think, in our summer meeting, correct? But we won't see you after that in our next spring meeting. So thank you very much.

DR. JEAN CAMPBELL: I thought it was really sad. I was thinking this morning about leaving here, and just when you get the hang of things, so to speak, what's your role in the committee, you know, what you have to contribute, getting to know people and become friends is exactly the time when you're leaving. And it brings a lot of sadness for me to say good-bye to people in person here.

And also I hope in the future that we will be able to recruit someone that can speak for the consumer -- consumer voice here because that perspective is

unique, and I thought that's probably something that I've contributed in a way that people may not think about policy to programs from that perspective.

I mean, I'm also a professional. So I walk both sides of the highway, so to speak. But I think that that's important to keep that perspective in the dialogue.

MS. KANA ENOMOTO: Right. Absolutely. Absolutely. I think SAMHSA is committed to having a recovery perspective in most of its work, as well as the perspectives of the treatment professionals, the prevention specialists, the community folks, and folks who are our allies and not necessarily in the direct behavioral health field but who touch our populations of concern. So --

DR. JEAN CAMPBELL: There may be a time when there won't be as many perspectives. We'll have a more collaborative vision to move forward. And at this time, I think we're like the blindfolded gentleman feeling the elephant, that we all have some partial truth, and it needs all of us to really arrive at some of the best solutions for going forward.

MS. KANA ENOMOTO: Well, we certainly appreciate you, Jean. I know I remember -- Jean may not remember me, but I was part of the Division of Knowledge Development and Systems change back in the day when Mike English was there, and Jean was the Director of our coordinating center of our Consumer-Operated Services Program, which was a multimillion dollar, multiyear, multisite study to really -- this was one of the first efforts to really test the efficacy of consumer-operated services versus treatment as usual.

So you've been a great leader for the field and for folks with lived experience. So thank you, Jean.

DR. JEAN CAMPBELL: Well, thank you for that homage to my past.

[Laughter.]

FEMALE SPEAKER: It's better than a roast.

MS. KANA ENOMOTO: It wasn't a roast.

DR. JEAN CAMPBELL: That was a little different.

MS. KANA ENOMOTO: Yeah, I'm not funny enough to roast people.

[Laughter.]

MS. KANA ENOMOTO: Yolanda, did you want to speak to your experiences, and Johanna, you're on deck then. If you would just --

DR. YOLANDA B. BRISCOE: Sure. There were times every now and then when I could add something, compared to this amazing group, share experiences and also not only just add [inaudible] and offer another voice, another culture to this group. And all the different perspectives that then I take away with me and that I continue to remember and use in my work.

And also State level -- not yet on a national level, but on a State level, part of those [inaudible] systems of care advisory, currently all of this helps to go back and present to our State, which really struggles, like a lot of States do. But I think in the areas that I work. You're right. I mean, what Shelly usually says, "Okay, I got this." [Inaudible.] It's been a wonderful, enriching experience [inaudible] to see how SAMHSA works and how [inaudible].

MS. KANA ENOMOTO: I think your input has been invaluable, and again, as we've noted, there are different perspectives here. And I think, Yolanda, you've been able to keep us sort of grounded and real about, you know, this is many folks here are working at a national level and not necessarily seeing people day-to-day or having people come in. And you're going like, "These are the women who are coming in, and this is what they're experiencing, and these are the challenges that as running a provider organization we are grappling with on a day-to-day basis."

And so, I think that's really helpful for us to keep things real and be informed by that frontline perspective. So thank you for that.

DR. YOLANDA B. BRISCOE: Thank you.

MS. KANA ENOMOTO: You've been brave enough to charge into the fray when needed. So that's commendable. Thank you.

Johanna?

MS. JOHANNA BERGAN: Yes, I wanted to just say thank you for this opportunity. I also felt a little in the unknown beginning my service here, but I have felt very listened to and acknowledged as I became more willing to share a young adult perspective, and I'm thankful for the opportunities to lead our discussions around young adults. And specifically, the lens of girls in their teenage and college years, that discussion has been helpful for me, and I've been grateful to see and watch and feel that SAMHSA staff have listened and come back to clarify and continue to engage not only my perspective, but also that of other young adults.

And I'm just thankful for this experience and know that moving forward, I have a much firmer grasp of all that SAMHSA has to offer and do in the field.

So thank you.

MS. KANA ENOMOTO: Thank you.

And for as early as Johanna may appear to be in her career, she's actually had a very formative role in creating Youth MOVE, which is our national youth in recovery on the mental health side movement, and that's really a growing presence and force to be reckoned with in the behavioral health field. So I think that's wonderful.

And as you see, we've branched out, bringing the adolescent girls. We've continued to bring that adolescent girls perspective with Jeannette and then with Sharon, and she'll talk about it later, but with her webinar series that has been really fantastically successful.

So, you know, I think you can feel proud that you were our first sort of youth member here. Not our first, but a leading youth member here and helping SAMHSA to kind of get its head wrapped around that perspective and that lens. So that's great. Thank you.

And is Vince on the line? No. Well, I mean Dr. Felitti.

FEMALE SPEAKER: It's 6:30 a.m. in California.

MS. KANA ENOMOTO: Right. Yes, yes, yes. It's early. As Dr. Felitti doesn't need much introduction, he has been a wonderful presence on the committee, and you know, he brings the trauma lens. But he has really been a strong proponent around integration and talking about how do you bring that trauma perspective as well as the behavioral health perspective into that primary care setting and help people understand their behavioral health as it is a part of their overall health and help docs help systems, help settings understand that as well.

So his strong voice on that has been really valuable, and we look forward to all of you continuing to be with us in the fall or the summer meeting as well. So this isn't yet good-bye, but I did want to let you share in person. And I think it also serves as somewhat of an introduction to our new members to see and hear how other people have felt the experience. So I guess you can expect that there will be some fuzzy navigation for a little -- couple of meetings --

[Laughter.]

MS. KANA ENOMOTO: -- as we cast about and figure out what it is that we are here for. But it does come together, and every perspective as it is shared is valuable. I don't get out much. Some of us at SAMHSA do get out more and really have our ears to the ground.

Some of us get caught up with things like buildings on fire and making the

payroll. So we don't get to hear as much about the issues that you are leaders around, and so it is wonderful perspective. And again, I think keeping the voice around women and girls really loud and present is helpful because it is one that is easy to get lost.

And that is why we have this committee so that it keeps SAMHSA in touch with what the issues are around these particular populations and for us to know what's kind of the latest and the greatest and the most pressing needs here. So it's helpful, and everyone's perspective continues to be very useful.

Our first order of business today is to adopt the minutes of the August 14, 2013, meeting. I believe all of you received the minutes in advance of this meeting, right? Are they -- no? Don't we usually send them out in advance?

[Background conversation.]

MS. KANA ENOMOTO: Okay. Well, then. All right. So where are the meeting minutes?

MR. JOSH SHAPIRO: They're at Tab 2. Oh, I'm sorry. So ACWS is after joint council, the second main tab in the back of the book.

MS. KANA ENOMOTO: The second main tab in the back of the book. Okay. I see. Tab 2 under the ACWS tabs.

All right. So these minutes were certified in accordance with the Federal Advisory Committees Act, FACA, regulations. Members are now being given the opportunity to review and comment on the draft minutes.

They haven't been provided a copy with the certified minutes?

MS. NADINE BENTON: No, I was told that they didn't have to get a copy. So I did not send them a copy.

MS. KANA ENOMOTO: Okay. Well, you now have a copy of the certified minutes.

FEMALE SPEAKER: They look good to me.

MS. KANA ENOMOTO: Okay, and if you have any changes or additions, they will be incorporated in this meeting's minutes. May I have a motion to approve the minutes?

[Motion.]

MS. KANA ENOMOTO: A second?

[Second.]

MS. KANA ENOMOTO: Second. Minutes are approved. All right. Thank you very much.

Next time, we'll get them out to you in advance.

MS. NADINE BENTON: Yes.

MS. KANA ENOMOTO: Thank you.

All right. So now is the chance for me to share with you about what we have been doing since August. We have had some interesting obstacles as well as some really great successes. When Nevine was talking to me about March, she's like, "Well, and then you can talk about the shutdown." I was like, oh, my God. I blanked it from my mind.

But we did have a 3-week shutdown in October, which had an impact not only on SAMHSA, but on the field and our grantees. We, unfortunately, had to delay some grant announcements and awards of funds to States and communities because during that time, we could not do our official business, only if it was lifesaving.

We did have some Commissioned Corps and political, Pam -- Administrator Hyde was able to work because their salaries are not tied to the appropriations. But -- in the same way. But we did -- we did discontinue our regular operations.

So we delayed data gathering for the National Survey on Drug Use and Health that would have impacted the provision of drug prevention, treatment, and research data, and SAMHSA staff has had to -- SAMHSA staff and the contractor staff have really had to scramble to make up for 3 weeks of lost time in a massive survey, surveillance effort. And we did stop all of our grant monitoring to States, tribes, and territories, delaying the provision of technical assistance and support to our grants by our Federal staff.

Most of our grants did continue to operate, and contracts funded on past year funds were able to continue to operate. But there were certainly a number of difficulties, which really hampered our progress.

And it's one of those sneaky things that 3 weeks of not working on grant announcements and contract statements of work for the current fiscal year, I mean, losing 3 weeks of time in development is really very difficult for us. So we have been scrambling all year to try to catch up for that time to still make timely announcements and awards in FY '14.

So we did finally get a Consolidated Appropriations Act in January after operating on a CR for the first quarter of FY '14, and actually, that was really great news for SAMHSA. We did receive the President's Now is the Time -- funding for most of the President's Now is the Time initiative. We had \$115 million in support for most of the programs that were listed in the FY '14 President's budget. And this was increasing access to mental health services in response to the tragedy that occurred at Sandy Hook.

We were appropriated \$55 million for Project AWARE to improve access to mental health services or to improve screening and identification of issues in schools, as well as to improve school safety, reduce bullying, prevent violence in school settings, and foster school-family-community partnerships around the behavioral health of children. So those, it's based on our Safe Schools/Healthy Students model, which we've been doing for a dozen years, spent \$2 billion.

We still don't have any States doing Safe Schools/Healthy Students statewide, and so Project AWARE is seen as a next step for that, where we're asking the States to apply. The SEAs are going to be the applicants for that, and then they will work with communities to implement Safe Schools/Healthy Students around the State.

In partnering with that, there's \$40 million for the State grants and \$15 million, which will go to mental health first aid. So we're both promoting this improved school climate, violence prevention, and substance abuse prevention, mental health promotion with the Safe Schools model, and then adding to that a mental health literacy and awareness component with the mental health first aid. And that will be at the State and the local levels. So we're very excited about that.

We also received \$20 million for Healthy Transitions. Johanna smiles. It is -- it's a very exciting program to support youth ages 16 to 25 with mental health and substance abuse problems. This is for youth, both youth who are already in the child-serving system and helping them transition to an adult-serving system. It's also to identify those youth that are at high risk or have emerging problems.

So that -- so programs to reduce the duration of untreated psychosis, for example, would be included in this program, as well as some efforts to educate communities about what serious mental health problems look like in young people so that they would be able to be partners with schools, with treatment providers, with juvenile justice to identify those kids that are most at risk and would most benefit from connecting with the system, really as well as getting parents and young people to create networks because I think that's often the best way for people to get engaged, feel engaged, and develop a sense of trust with a system that can provide services and supports to help them change the trajectory for long-term health.

So we're excited. Those will also be State grants, where the States build some

infrastructure for that and partner with communities to provide enhanced services and supports.

We also received \$40 million for behavioral health workforce activities, which is very exciting because it's the biggest infusion that we have seen in a long time around workforce development efforts. Thirty-five million dollars will be for a jointly administered activity with HRSA to develop a behavioral health workforce education and training grant program, which will focus on training master's level professionals, mental health professionals, as well as paraprofessionals, which will include peers, but not be limited to peers. It can include promotores, community health workers, and others.

But the professionals will be -- I think five different professional groups will be highlighted, including social workers, Ph.D. psychology interns, and nurses and counselors, probably a couple of others or another that I'm -- MFTs, I think. So that is -- that will be a HRSA announcement that's coming out shortly, and we are partnering with them on that.

And in addition, there was a doubling of our Minority Fellowship Program. So an additional \$5 million added to SAMHSA's MFP program, which focuses on training doctoral level -- the original program focused on training doctoral level providers to work with -- and who are knowledgeable about communities of color.

In the \$5 million expansion, it will be to train master's level professionals who are committed to working with transition age youth. That includes \$2 million for addiction counselors, master's level addiction counselors. So we're thrilled to have that growth with a focus on providers who can address disparities issues as well as the youth in transition age group.

There are some other highlights about the budget in 2015. We'll go into more depth tomorrow, but in broad strokes -- I'm sorry. In 2014, another piece that's relevant to this group is that we did eliminate -- we did have a reduction in our Access to Recovery program. So that is in half, \$50 million, and there is an addition of a new set-aside in the mental health block grant. And that is 5 percent set aside for the dedicated to the -- to the treatment of early serious mental illness, including psychosis.

DR. JEAN CAMPBELL: Including what?

MS. KANA ENOMOTO: Including psychosis. So it can -- so we're working closely with NIMH on developing guidance for the States on how to implement that. So that is already happening. The States already have or are receiving these funds. And both block grants received some increases. So the mental health block grant received an increase that would accommodate the 5 percent set-aside.

So they are new funds dedicated to the treatment of early serious mental illness, which would include the efforts like RAISE-type work and efforts to reduce the duration of untreated psychosis and that first episode work. But it's not limited to that. It is for the spectrum of serious mental illness.

DR. CAROLE WARSHAW: The Wall Street Journal is wrong.

MS. KANA ENOMOTO: The Wall Street Journal is wrong, yes.

[Laughter.]

MS. KANA ENOMOTO: Not all of the Wall Street Journal is wrong, but their opinions of SAMHSA seem to be misguided and ill-informed.

DR. CAROLE WARSHAW: I just wanted that on the record.

DR. JEAN CAMPBELL: Well, the people they publish, their attitudes are misguided.

MS. KANA ENOMOTO: Well, you know, I think there is -- there is validity to -- in pieces of different people's perspectives, but I think it would be great to have a more open dialogue to really get certain facts out into the open, that the vast majority of our budget on the mental health side is dedicated to the services and supports for people with serious mental illness and not -- we don't necessarily like the term of the "worried well," but that is not what we see as the recovery model benefiting is really --

DR. JEAN CAMPBELL: Well, it is really opposition to the recovery model. So, in a sense, the critique has an element of truth in that it is naming us for heralding recovery and wellness, which we believe is the path toward the future, as opposed to just relying on biomedical interventions and coercion.

MS. KANA ENOMOTO: Right, right. Yes, I think the recovery model does emphasize sort of an element of self-direction, but that doesn't mean that it's to the exclusion of medications and medical treatment and psychiatric services, et cetera. So I think we perhaps have not -- I think Ellie can be more eloquent about it, but we have not been as articulate about our emphasis on, in fact, improving treatment in the traditional sense, as well as the range of supports that people need to achieve their full potential, which -- so I think we have a way to go in helping people understand what it is -- what SAMHSA means by its recovery approach.

You know, we do support people making choices in their lives and self-direction, and many and most people do choose a route of medication and psychiatric treatment in conjunction with other services and supports.

DR. JEAN CAMPBELL: Well, early on when I did a presentation on recovery here for this committee, and one of the points that I made that isn't understood as well in the field -- there needs to be more research on this -- is that it's both the treatment of illness plus the promotion of wellness that leads us to recovery.

DR. ELINORE MCCANCE-KATZ: Well, I'll just say that, of course, I agree with what Kana is saying and what you just said. I think that it's -- I think that there's a lack of understanding of what the term "recovery" means, what it encompasses, and I think we have to do a better job of making the public aware of that.

I also think that at least in that particular op-ed piece, they make claims that simply -- that simply don't make any sense. They don't seem to recognize that some of the tragedies that have occurred were people who were not known in the system. And so, some of -- a lot of the programs, some that Kana has just described, are programs that would help us to recognize earlier people who are having difficulties in the system before they get to the point of being a risk to themselves or to others.

I think that's really worth talking about, and I know that we're going to be doing that at SAMHSA.

DR. JEAN CAMPBELL: Well, also they attacked the consumer movement and SAMHSA's long support over the last 20 years of the consumer movement, and they attacked the support of Alternatives, which is the national consumer conference, by incorrect -- incorrectly looking at it as how to play with your dog or fingerpainting. So they really trivialized what we talk about, and maybe we can continue that conversation this afternoon when we talk about wellness.

Because the promotion of wellness, again, is an important part of SAMHSA's agenda, in addition to the treatment of illness. And of course, Wall Street Journal and its supporters, like TAC and the people that write for them, don't really appreciate that approach at all. They think that we're misguided in that approach, and the consumer movement is misguided. We're part of the problem, not the solution.

MS. KANA ENOMOTO: Right. Yeah, there certainly are -- we have challenges in terms of balancing the different perspectives.

DR. JEAN CAMPBELL: But I think we should be proud and stand up because I think that we're on the right track.

MS. KANA ENOMOTO: Yes. I think -- I think what I see really is a big part of the what I would say misunderstanding is that we have led very clearly in the recovery movement, and that is work that people know about, and it's very visible. And I think what they're not seeing is all the work that does go on in the

block grants around supporting people with serious mental illness, all the work that we're doing to prevent chronic homelessness for people with very serious conditions, as well as addressing criminal justice issues and trying to divert people with mental health problems away from criminal justice, to prevent their involvement, to divert them into services.

I think, you know, the work that we're doing around children with serious emotional disturbances. I mean, I think we have done a lot to foster evidence-based treatment services and supports to the folks who are most vulnerable, and that's just not what -- that's not, I think, what our critics are seeing. It's not as visible to them that the vast majority of our funding does go to those types of programs, which are absolutely grounded in the research and in the evidence base.

But we do have a very visible piece of our portfolio that they feel is softer and that they don't really have the perspective on, on its value. So I think it's an ongoing -- it's an ongoing conversation, but it's not one that we're shying away from. I think we're very happy to engage about the role of science, the role of treatment, the role of the evidence base in what we do. Because I think we have a lot to be proud of, as well as the role of recovery, of the consumer movement, about self-directed care, et cetera.

I think it's all a piece of what people need to be -- to be better in their lives, and that's what we're trying to do. And I think you have to look at the whole person and, you know, on both sides only looking at part of the person, I think you're guilty either way you slice that, right? So you can't -- you can't eschew one or the other. You know, we have the great honor of walking the tightrope in between.

DR. ELINORE MCCANCE-KATZ: I also found it troubling that they seemed to take the perspective that individuals that are living with mental disorders somehow shouldn't have choices about their treatment, that others should make those choices. And in all other aspects of medicine, now healthcare reform is about personal involvement. People are encouraged with every other kind of condition to take control of their lives and their treatment.

I don't think that people with mental or substance use disorders should be excluded from that.

MS. KANA ENOMOTO: Agreed, agreed. And I think it's what I also feel in some of the critiques is that they see people with serious mental illness as a monolith, you know? And people are not all the same. And I think in all of healthcare, it's the same. I mean, you recognize that not everyone with diabetes is the same. Not everyone with breast cancer is the same. And so, you have to address their various needs, their various perspectives, where they're coming from, and that would be the same in behavioral health. And that's a challenge.

DR. SHELLY F. GREENFIELD: I would just add that along the same lines as what you're discussing is that as with almost every other type of illness, we've discovered that the earlier you can intervene, the better off people are. And the brain, as we know, is continuing to develop all the way into the 20s and probably into the late 20s. And therefore, the earlier and earlier that you can identify early symptoms of any abuse disorder -- substance use, mental illness, and others -- and intervene appropriately, you are likely to actually make a large impact on the health of the population, as well as the individual -- you know, individual involved.

So all of the efforts to bring the evidence base around early prevention and then early intervention and pathways to treatment that's effective are very important for individuals, but also really for the full health of the population. And that's one of the things, obviously, under healthcare reform we're interested in keeping the population healthy, and these are ways to go about doing that, too.

So just like every other -- every other almost, cancer, everything else that we discuss.

MS. KANA ENOMOTO: Right. Right, right, right. You know, I think I like to point out that you don't address the diabetes issue by focusing only on end-stage renal disease.

DR. SHELLY F. GREENFIELD: Exactly.

MS. KANA ENOMOTO: You know? I mean, certainly it's an important component. You absolutely need to do it, but that's not -- that's not the whole of the picture. And so, that's why we're so really pleased about, and I don't mean to beat a dead horse, but we really are pleased about the Project AWARE work and the 5 percent set-aside, which give us an opportunity to do -- build awareness, to do prevention, early -- you know, engagement, early intervention, bring families and communities together, as well as foster good treatment systems for that early intervention population.

So --

DR. JEAN CAMPBELL: Well, the ACA also really -- besides shifting the cost in terms of our rising costs in medical care, it really is emphasizing whether you follow the chronic condition model or looked at the recovery model. That is part of self-management. But that's true for all conditions. It's not only prevention, which is important, but also self-management, which is part of self-direction as well. And I think that that point is missing.

So it isn't like the recovery model is out there. It really, when you look at the models of the chronic care condition, the -- you know, you have your team arrayed around the individual, and the individual is responsible for making -- for

managing their condition to a large extent.

MS. KANA ENOMOTO: Well, I think -- yes. I think we have shared goals. The goal is to help people overcome or manage their condition in whatever your perspective is. And so, I think starting from that place of a shared value is important, and we'll continue to go forward with that.

I'm sure people are apoplectic because I've gone way off the agenda.

[Laughter.]

MS. KANA ENOMOTO: Shelly?

DR. SHELLY F. GREENFIELD: I just have one other thing I wanted to mention. When you talked about the behavioral health workforce development and \$40 million, with the \$35 million that's dedicated to joint effort with HRSA. And I'm not 100 percent sure of this, but it's my understanding that in terms of workforce development, this doesn't include physician workforce development.

And I did just want to mention that because I think just with the movement toward integrating care models, I think it's worth stating that workforce development in the physician community across multiple disciplines is incredibly important. And it's both important in terms of our primary care clinicians that they have a greater awareness of how to effectively work with patients who have behavioral health needs, and also within my own field, within psychiatry, we are always concerned about workforce development to integrate addiction treatment and early intervention.

So I have had other meetings at other times in the last 5 years around this topic, but I wanted to raise it here, just for SAMHSA to be aware that I think as you advocate for a variety of areas of workforce development, the physician workforce development should not be neglected. And I think it's something incredibly important as we move forward with new care models.

MS. KANA ENOMOTO: Well, that's a great perspective. And although physicians aren't necessarily part of the Project AWARE or the NITT funding, HRSA continues to have rapid growth, I think, in the number of behavioral health professionals in the National Health Service Corps, and we partner with them in a number of ways with both BPHC and the BHP, Bureau of Health Professions and Bureau of Primary Healthcare.

And you'll hear more about it, I think, in the NAC or Joint NAC meeting, but we are adding a strategic initiative at SAMHSA on workforce, which will be led by Anne Herron. So I think your perspectives on that will be really helpful to help us.

DR. SHELLY F. GREENFIELD: I would be happy to contribute to that discussion.

MS. KANA ENOMOTO: Yeah. That would be great.

We're a little bit behind. So I'm going to just select some highlights of what I need to share with you all. One, so budget 2015. It is fascinating. It is exciting for us, and you will hear more about that at the Joint NAC meeting because I think I'm doing that, too.

And I wanted to mention particularly in this meeting, thank Jeannette for inviting me out to a meeting called Fostering Girls' Strengths, which was a partnership with Crittenton and RWJ, and they had a really stellar group of folks there to talk about issues of vulnerable girls and young women. And it was fascinating to me, you know, that's not necessarily the space that I usually work in. And so, it was very -- very helpful for me to get more concentrated time with folks who are working with girls and young women, not just the behavioral health piece, but more the population.

And so, to see the advancements as well as the really challenging issues of they're sort of -- they're not children, and they're not boys. So it's that the young adolescent women or young girls get sort of left in this nether place of if you go to a meeting and you talk about girls, then people say, "What about the boys?" If you go to a meeting about women, people forget to talk about the girls and the young women because they think the children's people are talking about the girls, and the children's people want to talk about the boys and the girls or the boys.

And then you have issues about -- and certainly absolutely valid issues about looking at young men of color. What about the young women of color? You know, that kind of thing.

So it was really a very good meeting, Jeannette. I don't know if you wanted to share some of what you will have as next steps on that.

MS. JEANNETTE PAI-ESPINOSA: I think we're still working with RWJ to figure out what the next steps are. I think it really kind of grew out of our frustration, which you very aptly talked about, which is, you know, we have girls who are young moms and they're still considered girls, even though the issues they're dealing with went beyond that. And our agencies really work with young women who are deep in, multisystem, multigenerational.

So it's a long road to go for them, but we've just had a lot of success, and we have -- I was telling Johanna, we have a youth advocacy, the consumer advocacy program where we've been matching up young women who are under 25 with former consumers that are over 25 to do some peer-to-peer support and

mentoring and advocacy. And I think we just have a huge concern about how long do you wait? Do we wait until they're women when, obviously, as you've said, intervention as early as possible is the best way to go.

And most of them are -- they needed it 10 years before we get to them. So I think it's a frustration. You know, there's a lot of interest in talking about girls and violence, abuse and neglect overseas, but not here. We continue to hit brick walls with really the -- I think it's the point at which girls become perceived more as potentially sexual objects or sexually active that they shift sort of from girls who are cute and are somewhat helpless to bad girls. And you know, once you're a bad girl, you're always a bad girl.

So I think it's how do we pull people together? Even those people who work with that population don't see it similarly, and we need to just get over that and get on with it. So we're kind of struggling with what the next steps are. It didn't kind of go as we had hoped it would. It was well worth it, but still there are a lot more internal barriers even within the community, people that focus on it, as you all know. So we'll figure it out.

MS. BRENDA V. SMITH: I think the developmental issues are really hard. I just testified at a hearing. I was asked to come in and talk about some really disturbing stats about the involvement of female staff in victimization of men and boys in custody. And so, I was talking about the sort of female staff/boy piece of it.

And one of the things that was really interesting that sort of resonates, I think, a little bit with what Jeannette said was that people felt very comfortable -- they were talking about boys here. But felt very comfortable talking about, you know, well, they're 16, but they really look like they're 24 or 25. And so, people can be excused for this victimization against them. Okay? And this was in a meeting on the record by people who were supposedly leading the efforts to protect them.

And I think that a lot of times that people with young people who have been engaged in risky behavior or who have addictions problems or who are sexually active early sort of begin to think that that actually means that they're adults, when developmentally they really aren't, right? And they're really not thinking about sort of the issues of trauma, and certainly we see that a lot in all kinds of systems.

And it seems to me that a lot of the research that's come up about development, which we addressed initially, kind of has to be folded into this. Well, no matter what they look like, you know, "body by Fisher, mind by Mattel."

[Laughter.]

MS. BRENDA V. SMITH: I mean, they're still in development, right? Right. So -

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MS. JEANNETTE PAI-ESPINOSA: And we see a lot of traction on the issue of trafficking, which is, you know, we're involved with that, and our agencies work with that population. Yet we're concerned about the lack of -- these are the same girls that are self-harming at 10 and 11, right? So, again, we're waiting, we're waiting, we're waiting. And we don't need to wait. So --

DR. CAROLE WARSHAW: Yes. I was thinking about all the focus on domestic minors as far as sex trafficking and not seeing young people who were engaged in sexual activity being perpetrated as victims. But at least there's some beginning --

MS. JEANNETTE PAI-ESPINOSA: Oh, yeah. Yeah. There is some.

MS. KANA ENOMOTO: It sounds like to me that there is some work to be done on that intersection of a developmental approach and a gender-specific approach that we've been really good, I think, in the past few years of looking at gender-specific, trauma-informed, and then how do you add that developmental layer to that?

MS. JEANNETTE PAI-ESPINOSA: I think the impact of the multigenerational, there is some expectation that one knows what it is to be healthy or to be healed. And most of the young women we work with, maybe 10 generations back, they have no idea. There is no -- they see that in each other, which is why the matching them with older folks seems to be really helpful.

MS. KANA ENOMOTO: Well, thank you. Thank you for that perspective, and that's a fascinating issue that you guys are grappling with. So thanks.

I want to -- I'm going to skip the TEDS piece. We will get that out to you guys. There is -- I want to let you know about some personnel changes that we have happening at SAMHSA.

We have had a new Director of the Office of Policy, Planning, and Innovation, Mary Fleming. That's the office in which, actually, our committee management sits. So Mary is wonderful. She's just come to SAMHSA fairly recently. She has a rich history of managing, developing, and overseeing behavioral health services in a number of States and communities.

So prior to joining SAMHSA, she was the chief executive officer of Allegheny Health Choices. She was responsible for fiscal, clinical, and quality oversight and reporting for the Medicaid-managed behavioral healthcare of the county. She's brought a great financing lens. She's not a -- I don't think she's a clinician by training, but she's brought a great perspective on how services are organized and financed at the local level, which really informs the work that we're doing.

And she's also a wonderful manager and a salt of the earth human being and wonderful to work with. So we're really happy to have Mary as part of the team, and Ellie also sits with Mary frequently.

DR. ELINORE MCCANCE-KATZ: She's great.

MS. KANA ENOMOTO: She is. She is great. She has a calming presence. You guys will meet Mary, and she's a calming presence, which is greatly needed.

Miriam Delphin-Rittmon, whom some of you have met, has left SAMHSA. She was a political appointee working with us for 2 years. She's gone back to Yale University, where she is a professor. She was a major leader for us on our workforce efforts, and she also took a very strong interest in our PPW program and helped look at some of the data there, which you'll hear more about when Dr. Clark comes.

Is Miriam going to be on the phone for that? No? No. So Dr. Clark will be coming to talk to us or phoning to talk to us about that a little bit later.

And I wanted to acknowledge that Shelly Greenfield will be honored on April 11th at the ASAM Conference as the recipient of the R. Brinkley Smithers Distinguished Scientist Award.

[Applause.]

MS. KANA ENOMOTO: This award recognizes and honors an individual who has made highly, not just meritorious, but highly meritorious contributions in advancing the scientific understanding of alcoholism, its prevention, and treatment. So Dr. Greenfield will be delivering a lecture. Gender Differences -- yay -- in Addiction: Implications for Women's Addiction Treatment.

So thank you. Congratulations.

And as others of you have honors and awards, let us know, or if you hear about your colleagues that have them so we can make those announcements and share them.

Some of you -- how many of you were able to join the prebriefing on March 13th, where we talked about the new SI document, strategic initiatives? A number of you were -- many of you were not on it.

DR. JEAN CAMPBELL: I was on it. I can't recount anything about it.

[Laughter.]

DR. JEAN CAMPBELL: It went on for a long time.

MS. KANA ENOMOTO: There's no test. Well, that's good feedback. Thank you.

[Laughter.]

MS. KANA ENOMOTO: My riveting presentation didn't burn a place in your mind? That's okay.

Luckily, you'll have a chance to revisit some of those issues tomorrow. So, but we are looking forward to a conversation tomorrow about our future strategic initiatives. So workforce is one of them, and the idea of that -- I hope that you all did receive the draft paper, and it was mostly the prebrief was really to get those who wanted just a glimpse of what it was that we're doing and some explanation of it before we engage, try to have a substantive conversation tomorrow.

I think what we didn't want to do was tomorrow just run you through the document, but actually sort of start off. So for those of you who've had the document or you probably have it in your binders, if you would please look at it because we do want to have a conversation about whether -- what you think about the directions we've outlined.

So, you know, some of the points like that you've made, Shelly, we can -- we have an opportunity. We plan to edit the document or incorporate the comments of the councils into the document before it goes for public comment. So this is the opportunity for you to advise us. So this is -- it would be helpful for you to have at least a glancing familiarity with it if it's in the document because we aren't just going to be walking you through point by point what it is. It is meant to be a feedback conversation tomorrow.

And so, with that, let's see. And then we're going to review the joint councils agenda. So tomorrow, we have budget, FY '15 budget, and we will be talking about the impact of behavioral health and healthcare integration on SAMHSA. For those of you who did look at the document, we have changed our strategic initiative, which used to be called health reform, and we are calling it healthcare/health systems integration. Because as we're looking forward and we hit that wonderful \$7 million goal for enrollment, you know, the ACA is here. It's happening. It's -- you know, it's here to stay. We are enrolling people in insurance, and there will be a new way of looking at healthcare and, thus, at behavioral health.

And so, we are not calling the initiative health reform, but it's healthcare/health systems integration. And that's really a lot of where, I think, it's a new -- not a new lens. It's been a lens, but I think it's really a growing lens on everything that we're doing is how it relates to the overall system, whether it's financing or the actual clinical practice or the systems that oversee all of them.

We will have a report-out about the SAMHSA Youth and Young Adult National Advisory Council. So we're -- or committees. So we're excited about that.

We're talking about the strategic initiatives, and then we're going to do breakouts for that. So you'll have the opportunity to sort of talk -- we're rotating the SI leads, is that right?

MS. NADINE BENTON: I think so.

MS. KANA ENOMOTO: So we'll go into small groups, and then the leads will come around. So you'll get to talk about and provide input to each of the leads in a smaller group setting. I think that might be more helpful than going sequentially through all of them in the large group.

MS. JOHANNA BERGAN: Is there an easy place to see who the leads are for each of the initiatives?

MS. KANA ENOMOTO: Ah, well, I can tell you. I don't know if there's an easy place to see it, other than --

MS. JOHANNA BERGAN: I didn't know if it was in this --

MS. KANA ENOMOTO: -- in the document. So prevention will continue to be Fran Harding. Trauma is still Larke Huang. Healthcare/health systems integration is Suzanne Fields. HIT will continue to be Dr. Clark. Recovery support is still Paolo del Vecchio, and workforce is Anne Herron.

MS. JOHANNA BERGAN: Perfect. Thank you.

MS. KANA ENOMOTO: And so, the other thing to note is that data outcomes and quality have moved into a SAMHSA internal operating strategy, where we've done -- we've really accomplished almost all the things that we set out to do in the original strategic initiative, and now we're really focusing internally about how we are using data, how we are producing data, how we're sharing data and promoting quality.

There is still a quality piece, I think, in the healthcare/health systems integration one. But, so that is no longer -- data is no longer a strategic initiative, and communications is no longer its own strategic initiative. Not that we're not doing communications. We are doing communications. We are doing military families. Both of those are just getting more embedded into the warp and woof of what we do on a daily basis and require less of a dedicated, concentrated policy focus for the Administrator.

Yes?

DR. JEAN CAMPBELL: I would like to see, though, that data is responsible to the councils as it makes these internal decisions. Maybe some sort of reporting out because there are still a lot of issues around what will be the indicators for the different -- it wasn't finalized the last time we really saw it. There's still a lot of issues around how we're collecting well-being or what populations we're assessing.

MS. KANA ENOMOTO: Right.

DR. JEAN CAMPBELL: So I would like to see some sort of reporting out or some inclusion of people from the councils in that dialogue, not to just have it -- have them go their own way in the woodwork.

MS. KANA ENOMOTO: Right, right. You know, again, data, we still -- we have a Center for Behavioral Health Statistics and Quality. We continue to have a fairly robust data portfolio, and so that it's not an SI doesn't mean you won't hear about it at council any longer. It just means that we -- you know, we have these weekly strategic initiative meetings where we get sort of a convening of all the chiefs, and we talk about what the next steps are for each thing, and we labor over it pretty considerably. So --

DR. JEAN CAMPBELL: I'm just concerned about the national framework --

MS. KANA ENOMOTO: Yeah.

DR. JEAN CAMPBELL: -- and I think it needs work, and it needs some accountability, and it needs to be able to change.

I was on a research and evaluation subcommittee, led by Ron Manderscheid, where we're looking at datasets that would collect more recovery-oriented data. And there were recommendations made to SAMHSA based on it was like a year and a half, just concluded like 6 months ago, and to see what happens with those recommendations, how they're integrated within the data collection portfolio.

MS. KANA ENOMOTO: Right. Right. So, again, I think there will be a seventh group. So we'll have six, seven sessions. One for each SI, and one will be a general kind of bucket one where you can bring up the other issues that you have that related to either the old SIs or other issues as you see them, or more general, overarching issues. So I think that's -- there will be that opportunity as well.

Okay. With that, any questions, other comments? Any questions about tomorrow's agenda?

[No response.]

MS. KANA ENOMOTO: So please hold your calendar. We do have the date for the next ACWS meeting. It will be virtual, and it will be on August 26th. We'll be sending out a reminder "save the date" email after this week's meeting. But I'm just going to get that out there right now.

We realize that August is a tricky time for many people, but in general, they're all tricky times. So you just have to find the time. And we also have to balance this with our grant reviews. So we do it at the same time as the center NACs and the centers have to review grants, RFA reviews and to certify them. And so, we need to do it closer to when we're making those awards.

Okay. Well, that is -- I think that is our remarks, and I will go ahead and turn it over to Sharon who will update us on what the SWCC has been doing.

MS. NADINE BENTON: Do you want to do the committee?

MS. KANA ENOMOTO: You know what? I'm going to ask each of you to throw in, to pipe up and share whatever other pieces that you like as we go along today. I think most of you have done that and can continue to do that in a more organic way, if you would?

Agenda Item: Updates from SAMHSA Women's Coordinating Committee

MS. SHARON AMATETTI: Okay. Well, thank you.

So, SAMHSA, just for those of you who are new, has a Women's Coordinating Committee, which is a group of staff from throughout the agency who come together to talk about issues that are relevant for women and their ongoing work and also to brainstorm ideas for the agency about areas that we want to look at. It's a great group of staff. We have about 12 members from throughout all of the different centers who come together every month and talk and plan things.

This most recently, we've been working together to develop a webinar series on girls, and as the conversation has reflected this morning, that sometimes girls get overlooked in our work or we're focused on women and not girls. We do have activities around adolescents at the agency. Some of them, we have actually CSAT has a large adolescent treatment portfolio. Prevention does a lot around adolescence, of course.

And there are some new initiatives that Kana just mentioned that are going to have focus on transition age youth. But the committee really wanted to talk

about girls and, you know, gender issues in adolescence. So we had an opportunity, partly because we weren't going to be doing a big national women's conference this coming year, to repurpose some of our resources to put together an initiative that was reflective of girls' needs.

So we came together as a committee. We also reached out to a lot of partners in the field and also colleagues at other agencies to ask them, you know, what do you think we should talk about in this webinar series? It's SAMHSA's opportunity to provide some information around girls, and where do we start? And it was pretty hard, actually, to decide and prioritize what issues we were going to focus on.

I don't know who's controlling the slides. Is that you, Josh?

MR. JOSH SHAPIRO: Yes.

MS. SHARON AMATETTI: Could you just advance it?

MR. JOSH SHAPIRO: Sure.

MS. SHARON AMATETTI: So, you know, we debated and talked and thought about it, and we knew that we wanted to provide research on best practices and critical thinking on the topic that professionals working with girls and young women would want to know. We had six that we were going to roll out, and each session was really to address a key area of what is important to adolescent girls, their challenges, opportunities, strategies for supporting girls.

We created the webinar series to increase the behavioral health workforce understanding of needs and concerns of girls and then just bring more visibility and attention to these concerns. So that was, you know, what we set out to do. I don't want to leave you with the impression that we covered everything that needed to be included.

We're excited about having an opportunity to launch this. We wanted to also really create a community conversation around the webinars to just get some increased visibility to the issue, and so that is what we're doing. In your binder, there's more information about each of the individual webinars. There is a page for each of them. I just don't -- they're actually not in the order that the webinars are rolling out, but all the information is there.

So we've completed two of the six. The first we called Growing Up Girl: Adolescent Development and the Unique Issues Facing Girls. And that was an introductory sort of setting of the stage webinar. We had Trina England from HRSA, who is the head of their Adolescent Health Branch, kind of as a guest moderator for us. Elizabeth Miller, who's the chief of adolescent medicine at University of Pittsburgh Medical Center, participated, as did Scyatta Wallace,

and really were helping us frame girls from the development issues as well as some of the psychosocial issues that girls go through.

The next webinar we had in March, *The Girl in the Mirror: Behavioral Health in Adolescent Girls*. We invited Steve Hinshaw from Berkeley to talk about his concept of the triple bind for girls. We also had Wendy Lader talking about girls and self-harm.

The next one coming up this month, later this month is about *Girls and Substance Use*. I'm going to be talking a little bit about some of the data that our Center for Behavioral Health Statistics helped me pull together about girls versus women or versus boys, and then we're going to highlight the NIDA's principles of adolescent treatment, as well as talk about three different models of evidence-based practices for working with girls.

Following that, we'll do *Digital Girls*. We all know how important social media is in the lives of young people. We have Rachel Simmons, who is a very well-known author and speaker, talking about her perspective and what she knows about how social media can both support and actually is troublesome for girls. And then we have our own staff person, Danielle Tarino, who is a younger SAMHSA staff person who going to really talk about social media and recovery.

In June, we have one we're calling *Sanctuary and Supports for Girls in Crisis*. Our new advisory committee member Jeannette Pai-Espinosa is one of our speakers, as well as Stephanie Covington, and they're going to be here talking about girls with very high need, high risk.

And then our final webinar in July is *The Power of Youth Development and Recovery Supports*, really to talk -- it's for youth development and what girls say they need for ongoing recovery supports. And actually, Youth MOVE has been supporting that webinar as well.

That slide is just on the Web site that's the graphic you'll see, and there is the Web site if you want to get more information. But for the members here, they are in the binder.

DR. JEAN CAMPBELL: How many people attended the first two?

MS. SHARON AMATETTI: I'm just so happy that you asked that. So we had planned for up to 1,000 telephone lines. We did a modest promotion of the event, and almost immediately, we had 3,000 people registered for the first two. Which usually you get about half of your people who actually register will actually come and attend.

But when we tallied what we had, we had 1,700 people who attended either on that first one. That meant that all 1,000 lines were used, and I can watch the

information about who's on there. They were on the whole time. And some people met in groups, you know? They shared a telephone line, and then some people would just call in if they can't actually access the Web site because it's full.

So we had great participation for that one. The next one, over 3,000 people again registered, and 1,500 attended. So there is clearly interest in the series.

We're also working with the National ATTC to help with CEUs for participating, free CEUs. So, of course, that makes it very attractive, and they are going to house the webinars on their Web site so that as soon as we can get them all cleaned up and captioned, they're going up on the Web site, and people can continue to access them and to get CEUs.

DR. JEAN CAMPBELL: So they're archived?

MS. SHARON AMATETTI: They will be all archived, right.

DR. JEAN CAMPBELL: And were you able to collect demographics?

MS. SHARON AMATETTI: Yeah, so. I'm so glad you asked that.

[Laughter.]

MS. SHARON AMATETTI: And this is pretty much for the first two, very similar. So we asked them when they first came on, we gave them, you know, one of those polling things that you can do to see who was on the phone. So about a third were mental health counseling type folks, 21 percent education/youth development/peer support. Substance use prevention/treatment, 19 percent. Government research policy, 7 percent, and then there was a category of "other" for 20 percent.

And it was very similar for both the first and the second webinar. Now do you want to ask me how they were evaluated?

[Laughter.]

MS. SHARON AMATETTI: Let me tell you a little bit about that information and feedback that we got. And again, you know, just very similar across the two. So for the first one that was Growing Up Girl, so we asked about level of presenter knowledge on a scale of 1 to 5. The average ended up 4.72, and for Girl in the Mirror, presenter knowledge 4.77 out of a scale of 5.

The level of usefulness of the information for Growing Up Girl, it was 4.32. For Girl in the Mirror, 4.5.

Rate the overall webinar, 4.29 for the first one and 4.45 for the second one.

So really nice comments. I just wanted to give you a sample of what they said. For Growing Up Girl, the question was, "What did you like best about the webinar?" And they said, "combining medical with the psychological perspective of adolescent girls." "Each of the speakers was knowledgeable and vibrant." "I appreciate that I have several new resources I can immediately utilize within my practice." "It was helpful with my work and my own daughter." "Wonderful information to keep me motivated in working with girls." "I like the suggestions given for programs working with girls." "Looking forward to upcoming webinars."

For Girl in the Mirror, "What did you like best?" "There was actual information provided on how to deal with this population. Other webinars I participated in were self-promoting and not a how-to." "I loved hearing about mental illness not as a bad thing, but instead as a reality." "Current research is always something that can be difficult to stay up on. It was wonderful to have a succinct and relevant discussion of some of the current studies done." "The differences in perspectives given a researcher, therapist, young person in recovery." "I really appreciate this topic and the series being offered through SAMHSA."

So I feel very positive, obviously, about our results so far, and I think the rest are going to go very well. Also we have Kait Abell in our Office of Communications is helping us with some social media work on this.

Now we didn't have to promote the first two very actively. So it's not so much about promotion for the remainder. What we really want to concentrate on is conversation, have girls tell us what have been helpful to them. So we're going to be setting up -- I don't know the term for it. Sorry. It's something like a blog, but it's not a blog --

[Laughter.]

MS. SHARON AMATETTI: -- on the SAMHSA social media page, where we can stimulate conversation. There will be some tweeting going on. There is actually tweet traffic that we didn't necessarily stimulate, but some of our partners have stimulated. Youth MOVE has been tweeting about them, which is great.

So this is something that I'm learning about, so it's not so much the social media presence to advertise them but to really just keep -- make it a deeper, richer conversation is what the purpose of that will be.

Just, and the next webinar series, again, is going to be about substance abuse and girls, and I'm going to be doing a little piece in there. And I just wanted to give you a few highlights from my presentation that Margaret Mattson and Rachel Lipari from our Center for Behavior Health Quality Statistics have pulled together for me.

This group already knows this, but I'm going to explain that unlike in adulthood, that girls use most substances at equal or higher rates than boys. I don't think a lot of people know that outside of the field. Girls have almost a 3-to-1 experience of major depressive disorder when compared to boys.

And interestingly, in 2012, for the last year that we have data, we found that for the first time, more young people 12 to 17 report smoking marijuana than cigarettes. So it's crossing over now. You know, I think we can expect that trend to continue as the perceived risk of marijuana use goes down.

So that's a little bit about the webinar series. Like I said, it's not everything. It's just an opportunity for to have more conversation, build a community around the issues, and hopefully, infuse some of the other work and opportunities that we're being presented with to infuse girls' issues and gender issues into that work.

So thank you.

MS. JOHANNA BERGAN: Just -- thank you, Sharon -- an anecdote about evaluation. I send out lots of resources to our chapter contacts, and I have gotten more emails about how to get on the Girls Matter! Web site, how to find the recordings, how to follow that than anything I've done yet this year.

So, you know, young women who are leaders in chapters 18 to 25, lots doing peer support, were very excited about this, and I was appreciative because they are individuals who would not ever be able to attend a conference or a training, and this was very accessible to them. So thank you.

MS. SHARON AMATETTI: Thank you. Carole?

DR. CAROLE WARSHAW: I mean, that sounds really exciting. So would you be willing to share what you come up with around the social media and how to create that community? Because one of the issues that come up for us is around how do you monitor it and people posting -- you know, other people posting that you need to -- that aren't so great. So when you figure that out, would you share that perhaps at the next meeting --

MS. SHARON AMATETTI: Yeah, I mean, they have kind of figured it out. It doesn't mean I've figure it out. But you know, Kait Abell and also my contractor, Advocates for Human Potential, have wonderful staff who I also should give credit to, have really worked hard to pull together this wonderful webinar series. Deb Warner and Kristen King from there is their social media person, and I'm sure they'd be happy to advise you or anyone else here.

MS. JOHANNA BERGAN: And the Twitter handle is #girlsmatter2014. So you can see what happens --

[Crosstalk.]

DR. CAROLE WARSHAW: -- just any of that stuff that actually helps enrich what we all put out would be great.

MS. KANA ENOMOTO: Great. Thank you.

Yolanda and then Jean?

DR. YOLANDA B. BRISCOE: I think this is fabulous what you're doing. It's so timely. I'm obviously biased, and I think it's founded in reality that fewer and fewer people are reading. And so, the TIPs, which I always found so helpful, to be at the cutting edge of what was happening and to be able to read about what I needed in regards to recovery, but fewer and fewer people are reading. I go in people's offices, and they're nicely tucked, the TIPs.

And the information, just recently what you sent out about chronic pain, and that's wonderful information, but a lot of people look at it and tuck it away. So this, I think, addresses how people are -- more and more people are able to at least look at a webinar for a couple of hours versus a whole day and the expense of going to the workshop. I commend you on that. I think it's wonderful.

I would like to know how you are going into places where maybe they don't have -- there are places, no cell phones, no laptops. And maybe individuals who are incarcerated or in treatment to get some of the viewpoints of the young women and also young lesbians, get all their input who don't have that accessibility.

MS. BRENDA V. SMITH: Sharon, one of the things that when you said that there was a resource that SAMHSA just released that came through the National Juvenile Defender Center, which is the guide for helping families support their LGBT children, and so I think that, you know, as Yolanda said, it's so important. I mean, so there's this group, but also there are so many other places, particularly in the juvenile justice system, for example, because I mean just the work on how to really work with girls and certainly in a lot of the work that I'm doing, like a big piece that I'm working on now is the youthful inmate standard part of the Prison Rape Elimination Act, which has a specific standard that says that you have to have sight and sound separation, you know, sort of like under the Juvenile Justice and Delinquency Prevention Act.

And so, States are really scrambling to figure out not only how do you do sight and sound separation, but also how you provide sort of treatment and also appropriate activities. And so, as you're talking, I'm writing this down, and I'm definitely going to send it out to my networks, right?

Because there are -- there are places where there is a huge incentive to use this

material, and what you're going to find is you're going to find that people who are not necessarily your usual suspects are going to be using your information for different purposes. Because I've already seen something that you sent out that's on the whole juvenile justice listserv.

DR. JEAN CAMPBELL: I just had a general comment. You know, over the last couple of years, the first webinars were real exciting, and everybody was interested. And then there was this deluge of webinars, and it got to be old hat. And I was actually disparaging doing webinars and trying to think outside of the box for other ways to make contact.

But I think this is a really good example of the importance of identifying need, great need and interest, those two things coming together because this, obviously, is more successful than almost any series that I've heard. And you're not only in bringing people to the table, but also in your evaluations as well, that I mean, people's interest, they were satisfied with what they got there. And I feel like they're going to be coming back for the whole series, and you might even have an increase in demand.

So it would be good to also promote this series and look at it in terms of what really worked as instruction for people who want to do webinars in the future, picking topics or people or what the best practices are, because I think this is a good lesson for that. I would guess that you didn't have people just reading off of the slide that was on the screen.

MS. KANA ENOMOTO: Well, as with everything that Sharon does, the product is always of the highest quality. For those of you who've ever worked with her, she --

DR. JEAN CAMPBELL: But I think it could be helpful for those of us --

MS. KANA ENOMOTO: Sure.

DR. JEAN CAMPBELL: -- that are in doing health communication and sharing our results or interested in training. I mean, I would love in my webinar series that I've done to really be able to market, identify, and have the type of success that you were able to achieve. And I'm sure I could learn a lot from looking at your program and the series.

MS. SHARON AMATETTI: Yes. I mean, we debated that when we talked about just kind of do we want to do another webinar series because of the fatigue about webinar series.

DR. JEAN CAMPBELL: Exactly.

MS. SHARON AMATETTI: So it was important to try to keep it as interactive as

possible. I would have liked to have made it even more dynamic, you know, with video clips and all that, but with 1,000 phone lines and the amount of time we had and the resources, we ended up making it a little simpler. But that is, you know, appealing.

MS. KANA ENOMOTO: Thank you. I'm going to let Shelly and then Karen and then Yolanda.

DR. SHELLY F. GREENFIELD: Just two quick comments, which is it will be really important that you get it up on a server that's really easy to access because a lot of people will want to make use of that, and we've already got the resource. So, and then to be able to advertise to people that that -- basically that there have been good feedback and that that resource is available because you'll see that continuing to pay dividends.

And then the second is that people have already identified additional topics, and you might consider, you know, even if it's a smaller series, like a two or three of these in the year to come, building off of this. Because I think you're learning that there's a huge information gap in this area. So --

MS. KANA ENOMOTO: Thank you. Karen?

MS. KAREN MOONEY: And I just want you to know that in Colorado, working with adolescents has always meant working with adolescent boys until about 6 months ago.

MS. SHARON AMATETTI: And 6 months ago, what happened?

MS. KAREN MOONEY: Well, people started asking about what you sent out in the emails, saying that the webinars were coming, and sent out the links to the webinars and said register. And it's made a difference.

MS. KANA ENOMOTO: Cool. That's good to hear.

Yolanda and then Carole, and then we are going to break.

DR. YOLANDA B. BRISCOE: The fact that it's only an hour, an hour and a half is helpful. And I am one of those -- webinars, if you look at webinars, you start to do your email. And you start to talk, and people come in the office and interrupt you. But for an hour, an hour and a half, you can have it part of your staff meeting and everybody together, and so then it can open up that dialogue versus one single person sitting in their office, watching a webinar. So I think it's a wonderful idea.

Thank you.

MS. KANA ENOMOTO: Are you saying our 2-hour stimulating conversation on the strategic initiatives was not bite-sized enough?

[Laughter.]

MS. KANA ENOMOTO: Carole?

DR. CAROLE WARSHAW: One of the things we're thinking about doing for our upcoming webinar series is including some conversation guide. So that when people see them as a group, they can have a discussion with materials to go with it. Because it's hard to think about how you really engage people at a distance.

MS. BRENDA V. SMITH: Just one last comment. I was thinking about something that you said, Yolanda, that we didn't really kind of address, which was like how do you get it to communities that don't have access to these kinds of resources? And one of the things that we did that actually has been quite useful for like localities is that -- and specifically for kids, it's we were doing some work trying to get materials into kids, and States were just kind of aren't really trying to let you have that kind of contact.

And so, we actually did a series of graphic novels, which are online that actually the jurisdictions can come and print out, which actually has some screens at the back where kids can finish the story and also a series of questions that they can ask the kids. You could also use them as a peer education model, kind of get the kids to do it.

But one of the other things that we found is that the literacy level for the kids -- no, the literacy level for the staff was about the same as the literacy level for the kids. And so, the staff were actually using the materials that we had produced for the kids.

And they were a series of just very simple graphic novels dealing specifically with a particular kind of trauma, which is sexual victimization in custody, and sort of talking about different kinds of scenarios and how you report and what do you do? And also leaving space for the agencies to put in like their hotline numbers or to talk about their policy or whatever. And I'm happy to share those with the people because -- right.

FEMALE SPEAKER: Yes, please.

MS. BRENDA V. SMITH: But going back to your point, one of the critiques was that they were not in Spanish or in other languages. And you know, we didn't have the resources to do that, but it's certainly something to think about. And it goes to your question, your point about sort of having a little bit of a guide. But it's kind of a sneaky way to get material in and to get kids to look at things.

MS. KANA ENOMOTO: Are those available online?

MS. BRENDA V. SMITH: Yeah. And they're free.

MS. KANA ENOMOTO: Where? Just for people on the phone who won't be able to get an email.

MS. BRENDA V. SMITH: Yeah. They are on our Web site. It's www -- no, it's wcl.american.edu/endsilence. And I will also have my staff person just kind of send them around. And the great thing was that kids thought that they were corny and because then that meant that they had something to say. "Well, you didn't say this," or "You didn't say that," or "That's not really how it happens." Because really what you're trying to do is to get them to talk about it, right?

So, anyway.

MS. KANA ENOMOTO: All right. Well, thank you.

DR. JEAN CAMPBELL: They were corny on purpose?

MS. BRENDA V. SMITH: Yes. No, it was actually really an intended concept.

MS. KANA ENOMOTO: All right. Well, thank you.

We're going to take our break now, and we are going to come back at 10:45 a.m. because we have Ellie here, Dr. McCance-Katz, who's going to talk to us about behavioral health primary care integration as well as get some -- share with you what she's been doing, the role of the CMO, and other aspects of advice we can provide.

Thank you.

[Break.]

Agenda Item: Conversation with SAMHSA's Chief Medical Officer

MS. KANA ENOMOTO: Okay. So if I could get folks back to the table, we have Dr. McCance-Katz here.

I think we appreciate that -- I appreciate Ellie coming here from the beginning of the meeting and just getting a sense of the group and being able to participate already. But Ellie, Elinore McCance-Katz is our chief medical officer, a new

position for SAMHSA. She is really a wonderful addition to our leadership team.

She's board certified in general psychiatry and in addiction psychiatry and is a distinguished fellow of the American Academy of Addiction Psychiatry. She's been working in the field of addiction medicine for 23 years as a clinician, teacher, and clinical researcher. Her specialty areas are pharmacotherapy for substance use disorders; clinical pharmacology of drugs of abuse; drug interactions; cocaine, alcohol, opioid medications development; and co-occurring HIV disease, hepatitis C, and addiction.

She's been leading for us on our HIV portfolio and is a wonderful advocate and speaks very eloquently about the need to bring the HIV and hepatitis services and awareness into the behavioral health setting because we have populations that are at such high risk and that it's good practice to ensure that people get all the services that they need in one place.

So I'm happy to have Ellie here. She's billing it as a conversation. She may have some things to share about what she's doing, how she is helping us to define the role of CMO at SAMHSA, and then some of the work that she's doing that you might have some suggestions for her.

Ellie?

DR. ELINORE MCCANCE-KATZ: Thank you.

Yes, so I was just going to talk about a few things and, hopefully, get some feedback from all of you. It's already been so impressive to me. I wanted to be here at the beginning so I could hear about all of you and what you're doing, and I know this is going to be great to help inform some of the projects that I'll talk about in just a couple minutes.

So the two projects that I was hoping to get some feedback from you about are issues related to opioids and prescription drug abuse and also an area that I'm working on in our HIV program, which is bringing HIV care into behavioral health settings, both substance abuse treatment programs and community mental health centers. And I'm very interested in getting your feedback about how we can better engage and retain in treatment women and girls.

But I'll tell you about what I do, some of the things that I do, if I could see the next slide?

So Kana had asked me to just mention some of the -- some of the things that I work on at SAMHSA, and happy to answer any questions you have about those things. But mainly, I think being the first person to hold this position at SAMHSA, one of the things that Pam and Kana and I have talked about at some length is what should the role of a chief medical officer be? And I think that in some ways,

it's a trial where we are kind of figuring out those things, but some of the things that I work on are just to provide some clinical insights, advice, both in prevention and substance abuse treatments or to centers, CSAP and CSAT.

In particular, I work with them quite a bit on the issue of prescription drug abuse, which is such a huge issue for our country right now, as well as medication-assisted treatment for opioid use disorders. That's an area that I've spent a lot of my career working in. So I'm happy to do that. And I've also been working on the overdose prevention programs at SAMHSA, including the overdose prevention toolkit, which we released last summer.

I also work with the Center for Mental Health Services, and some of the things I work on with them have been -- so I'm working on the 5 percent set-aside to the States, working with NIMH to develop some guidances to the State about how to work in the area of early intervention, particularly first episode psychosis, but also other approaches to serious mental illness in the early stages.

I'm working on guidelines for bipolar disorder. I also work on dementia and specifically have been working with Paolo del Vecchio on issues related to inappropriate use of antipsychotics in elderly with dementia who are mainly living in nursing home settings. We have a workgroup on looking at the current definition of serious mental illness, and I don't know if any of you participated, but we had a call just a couple of days ago to start to get feedback from stakeholders on this issue.

I've done some of the work with other colleagues at SAMHSA on Medicare Part D, which was the plan by CMS to remove protected status from antidepressants and antipsychotics, which is not going to go forward at this point. And we think that's a good thing at SAMHSA. And have done some work on suicide prevention and workplace.

So one of the new programs that I've been working with CMHS, that's the Center for Mental Health Services, on is a clinical support system for serious mental illness. So this comes from a model that I actually worked on before I came to SAMHSA through work with the Provider Clinical Support Systems for buprenorphine and opioid therapies, and I thought that was a pretty good model and one that we could use for approaches to training on serious mental illness.

So we will be launching that over the next year. And this is a 2-year program right now. We're going to see how it goes. But we'll have stakeholders in the field that will be presenting trainings on specific disorders, such as schizophrenia, bipolar disorders, schizoaffective disorder, major depression, anxiety disorders. And we'll be talking -- they'll be providing training materials on everything from epidemiology to how to treat to long-term outcome. So I think this will be -- I think this will be very helpful to the field.

I am SAMHSA's lead person now for HIV and the viral hepatitis programs, which means that I just kind of oversee the work of a lot of people. There's a lot of people that do really good work on these issues within SAMHSA. They've been doing it for a lot longer than I've been at SAMHSA. So they're very helpful in that regard.

We are going to be taking some new directions with HIV and viral hepatitis. I'll talk about that in just a couple of minutes. But I also work with some of our other operating divisions within HHS on this issue, as well as other departments within the Government, like the Department of Labor, Civil Rights. ONDCP has an interest in HIV. So I do some liaison with them as well.

I work with HRSA on their HIV and viral hepatitis programs, and I actually sit on an advisory committee to them for these particular topics. And then I do a fair amount of work with liaison with other departments. I've listed them there.

Another thing that I've had the opportunity to do, one of the reasons I came to SAMHSA was I was very interested in healthcare reform and new ways of providing treatment and improving treatment to people that have behavioral health disorders. So you may know that the Affordable Care Act provides for the development by States of health homes that will provide wraparound services for people with serious illnesses, and mental illness and substance use disorders have been specifically mentioned as target areas for health homes.

So the way the law is written, SAMHSA has to review all of the State plan amendments in this area. So I get a chance to see what all the States are planning, and as part of a workgroup, we provide input to the States about how they can improve and incorporate behavioral healthcare into their State plan amendments for health homes.

I'm also working on the workforce issues. Before I came to SAMHSA, I was involved with the President's Emergency Program for AIDS Relief. It's also called PEPFAR. And I continue that work at SAMHSA. I think that's very important work. It takes programs that we know work here at home and introduces them to other countries and cultures where they can incorporate them in their own way into their --

DR. JEAN CAMPBELL: Could you speak up?

DR. ELINORE MCCANCE-KATZ: Yes, I'll speak up. We also at SAMHSA have a role in the U.S. Preventive Services Task Force, and I lead a workgroup where we are able to comment on the issues that the U.S. Preventive Services Task Force takes up and how they undertake their research, as well as reviewing their documents prior to public release. So we think that's important work. It's aimed toward prevention mainly but covers a wide range of issues that behavioral health impacts.

I've been involved with work for the ICD-10. I think this is probably going to be delayed for a year. I'll just tell you my own personal view of that is hallelujah because we aren't ready, and we hope that with an extra year, behavioral health providers particularly will be better equipped and ready for the changeover.

We have some webinars that have been developed that are available for people to get some training on issues related to ICD-10. The relationship between DSM-V and ICD-10 is a webinar that will be given by APA I believe later this month. And we also have FAQs on our Web site if anyone is interested in that.

Yes?

DR. JEAN CAMPBELL: Is this further development of the ICIDH? Is that the international classification?

DR. ELINORE MCCANCE-KATZ: The ICD-10 is the international classification.

DR. JEAN CAMPBELL: Right. It used to be the ICIDH?

DR. ELINORE MCCANCE-KATZ: Yes. So it is what's being used internationally. The United States is still using ICD-9. We are quite -- it's been quite a long time since ICD-10 has been in use by the rest of the world, and there is some real interest in going to ICD-10 because it better describes conditions, much more detailed descriptions, and that, I think, will lead to the ability to better treat and to be compensated for the treatments we provide and complexity of treatments that we're providing to people.

I have some special projects that I work on. Marijuana is a big issue. Right now we have a special workgroup that's actually led by Dr. Clark, who will be here later to speak to you, but I have a couple of initiatives within that. And then I do other things -- traveling, talking, you know, do stuff like that.

So that's what -- that's what -- that's sort of what I do in a nutshell, and if you have any questions, I'd be happy to answer those. But if you don't, we could talk about gender differences in opioid and prescription drug abuse.

So last summer, maybe all of you saw this, CDC came out with some information that really I thought really gave me pause in that women tend to be more likely to be treated for chronic pain. They are given opioids more readily than men at higher doses. They use them for longer periods of time, and opioid analgesic overdoses are a growing problem. This is really quite a large issue.

And for women, more than five times as many women died of prescription pain medication overdoses in 2010 as they did in 1999. So this is a big problem for women. Particularly for non-Hispanic white and American Indian or Alaska

Native women, they have the highest risk of death from prescription opioid overdose.

Can I have the next slide?

And women 45 to 54, most affected. You probably have read some of the lay press coverage of the rather large increases in neonatal abstinence syndrome that result from a pregnant woman's chronic use of opioids, could be misuse, also happens in women that are treated for opioid dependence. But this has gotten a lot of attention in the lay press, for better or for worse. And then, again, prescription pain medications are involved in 10 percent of suicides in women.

So these are very serious issues that I think are important for us at SAMHSA to be aware of and to start to think about in terms of our specific programs.

Can I have the next slide?

So some of my questions to you had to do about whether you might be able to make recommendations to us about how to best engage and retain women in treatment programs for substance use disorders and whether you have specific recommendations for how SAMHSA could help to strengthen prevention and treatment interventions for women and girls in this area.

It's been the case for many years that men far outnumber women in treatment. In my own clinical experience, a lot of women have trouble coming to treatment because they tend to have the childcare responsibilities. But I suspect that there are other reasons as well. So I was wondering what your thoughts are about these kinds of issues and what we might be able to do?

Yes?

MS. KAREN MOONEY: I think one of the real biggies for me is that the requirements of the women's set-aside are no longer required to be reported back to CSAT when the block grant reporting happens. And if States aren't required to report on it, they're much less likely to do it. So even though it's still a requirement of the women's set-aside that transportation and childcare be provided, when there's no mechanism to report it, the powers that be who shift with the political winds say, oh, we don't have to do that because we don't have to say that we are.

So I think building that accountability back into the block grant reporting requirements would be huge.

DR. ELINORE MCCANCE-KATZ: Okay. That's great. Thank you.

Yes?

DR. CAROLE WARSHAW: Related to domestic violence, one is that women are often prescribed more pain medication when there is undetected domestic violence or other kinds of abuse or trauma as well without recognizing what that's for and the pain from actually experienced physical injury. And then, on the other hand, there's forced use by abusive partners and they're sabotaging recovery and not allowing women to engage in treatment.

So we're doing a lot of work around those issues and have some data on that that we could share with you.

DR. ELINORE MCCANCE-KATZ: Oh, that would be great. Thank you. That would be really good.

DR. JEAN CAMPBELL: I think there needs to be more of a focus on looking at particularly opiate addictions upstream as opposed to downstream once a person is addicted. I have a personal interest in this because when I was really ill a couple of years ago, I became addicted to Dilaudid, and I began -- even before I was addicted and people kept assuring me -- oh, it's very painful, what I had, pancreatitis -- assured me when you read the hospital brochures, the handouts, they said cessation of pain is our number-one priority. They constantly were coming in and telling you to rate your level of pain.

There is -- and paying much less attention to addiction issues. And oftentimes, you find you're addicted when your last prescription runs out, and then you're faced with detoxing, titrating down. There's no information given to you about that. I wouldn't have thought to go seek substance abuse services at that point.

And then when I had surgery just recently for a minor condition, they automatically gave me Percocet, just gave it to me, didn't ask me if I had problems with addiction. All of these tend to be upstream problems because it's very easy to become addicted. It's very hard to detox from that addiction.

And not only at SAMHSA, but it just seems like the focus in all of our services is downstream after it becomes a chronic problem, as opposed to really thinking about how we can prevent this from happening and how to give supports early on and train the doctors so that, you know, just assuring you, "Oh, you're not going to become addicted. Just don't sell these pills out on the street." Joke, hahaha.

MS. JEANNETTE PAI-ESPINOSA: There's a lot of conversation in child welfare and juvenile justice about the medications used, and we see a lot of young women who, like you said, they don't realize they're addicted because they're not smoking pot anymore or they're not drinking or they're not -- they're very healthy. They get out of care, and all of a sudden, they realize that they were addicted to prescription medication.

So, you know, dealing with that and then finding nonnarcotic methods to manage their pain, their anxiety, is -- there's going to be some legislation, but I think definitely to get to them before they're out of the system, which is some of what we're having the older women do with the younger women and ask them questions about, "Do you know why you're taking that? What is it?"

DR. ELINORE MCCANCE-KATZ: Yeah, yeah. Do you see that as a problem with the prescribers?

MS. JEANNETTE PAI-ESPINOSA: Oh, yes. Yes. But that's what the legislation is about. We have some young women that are coming out at 18, and they're on 5 or 7 medications. They have no idea what they are. They don't know what they're for. They know what their general diagnosis is --

DR. ELINORE MCCANCE-KATZ: So are these from pediatricians? I'm just kind of interested who's doing this.

MS. JEANNETTE PAI-ESPINOSA: They may be from pediatricians. They may be from psychiatrists. It depends on their -- what system of care they're in and who their caregivers really are.

MS. KANA ENOMOTO: Carole?

DR. CAROLE WARSHAW: So this leads to the question of like from a medical perspective of people undermedicating pain because they're afraid of addiction and then overmedicating without attending to the pain. So it has to have a more complex set of guidelines of how to adequately treat pain, how to help people negotiate if you do become addicted, how to help people through that process, or how to do something else with pain management so that it doesn't get pulled to one side or the other. But it's more complicated.

MS. JEANNETTE PAI-ESPINOSA: Yeah. I mean, the focus really is controlling behavior. It's not -- I mean, because you see the African-American girls, the Latino girls on higher levels of medication to control behavior, which may be only expressing their anger, which if I had their lives, I'd be pretty angry, too. So I mean, yeah, it is much more complicated than that. But --

MS. KANA ENOMOTO: Shelly?

DR. SHELLY F. GREENFIELD: I return back to my earlier point about training the physician workforce because there's been -- for adult women and young adult women, there's been a fair amount of evidence that shows that people, women, because of a higher level of stigma attached to addiction in women, especially pregnant and parenting women, often are not defining their problem as being addiction. Because it's so highly stigmatized, they define their problem

as "else," like family related, depression, anxiety, and other kinds of issues, seek care often from non-mental health and behavioral health clinicians. That's where they go, and there, it is underrecognized or underidentified and undertreated and then often stigmatized because we've done not a very good job in actually educating the physician workforce.

And we still haven't done it in spite of initiatives for the past 25 years. It's still the same as it was 25 years ago in terms of physician education. And so, if you think about women appearing in OB/GYN offices, pediatric offices, adolescent medicine clinics, primary care clinics, and you haven't trained that workforce to identify care for women in a helpful and collegial, collaborative way, you will continue to miss these issues.

And because women are just not generally going to come forward and say, "I'm pregnant and I have a toddler, and I'm having trouble with prescription meds or alcohol" because they fear they'll be stigmatized and penalized for that, as opposed to telling somebody that they're having a collaborative patient-physician or patient-clinician relationship with about a healthcare need that they have and then feeling, you know, that they will be heard and then referred.

And I think that this becomes an ongoing cycle. This is why I was saying earlier that training of the workforce, the current and the coming up workforce is really quite key because I think you'll continue to see this. And these are healthcare issues that are nonidentified because people do not have the education and training. We wish they would, but they don't.

And unless you provide it, and you know, physicians can learn. They can learn, but they need to be trained, and they're not trained, frankly. They're not. So --

MS. JEANNETTE PAI-ESPINOSA: One of the things that we've done, as a follow-on to that, that's really simple is we've educated them about the ACE. We did the ACE in our agencies working with Dr. Felitti, and many of them, they see that, and all the pieces of their lives fall together. And they are just like, "No wonder I'm like this. I've done a great job. I'm still alive."

And a lot of that falls away, and their ability then to self-heal and be introspective and understand where their anger and their anxiety is coming from, it's just like that. I mean, it comes back. They get triggered. But it is significant in their healing process, and it's just a simple piece of information.

DR. CAROLE WARSHAW: So that's in the program. Not for the physicians?

MS. JEANNETTE PAI-ESPINOSA: Yes. Yes.

MS. KANA ENOMOTO: I want to let Yolanda jump in.

DR. YOLANDA B. BRISCOE: In following up with the workforce and training, geriatrics as well. We're seeing a real shift in older women becoming addicted to opioids because their doctors didn't -- couldn't imagine that this person would become addicted. And then the challenge for us is, is treating a group of women when "I have nothing in common with these -- those kids who, those addicts or long history of addictions." There is a lot of shame around, "But I'm a grandma. How could this have happened?" But there's very little education of the individuals that we have met, and even on a personal level, family, friends, and relatives who were told during cancer treatment to "take this Ativan. It will help you with the nausea."

No, that is a highly addictive medication that if you stop it all of a sudden, you may get a seizure. And it's happened a few times. One actually passed away because of you're an older woman, and so you ought to know better and you're not an addict. And not even one question about do you have any young kids staying at your house? Do you have any children or -- children because it starts young or teenagers in your home, make sure you hide these or put them in a safe place.

So I think a refocusing on older women is -- I think is really important.

MS. KANA ENOMOTO: And we do have an upcoming TEDS report that says that of the female admissions, those reporting primary abuse of prescription pain relievers was three times -- for 65 and older, three times more women than men. So 7.2 percent of women 65 years and older were prescription pain reliever admissions versus men.

DR. YOLANDA B. BRISCOE: But the treatment, how do you work with a group of women who have such vast differences in backgrounds?

MS. KANA ENOMOTO: So Brenda, then Johanna, then Jean.

MS. BRENDA V. SMITH: There was actually a really great -- I don't know if anybody saw the article in the New York Times magazine about the drug problem in Vermont? You know, and actually, the main protagonist was a young woman.

And so, I mean, I think a lot of prescription -- and again, my experience has been institutional settings, a lot of institutional settings. And it's really about behavior management, and a major way of managing behavior is sort of masking, deadening people's behavior. You're really trying to keep them from acting out. And so, there's not a -- so the training piece is really key.

But then also, as you said, sort of the downstream just -- I mean, it just seems to me, and we're starting to do it, that there's a lot more education about what you do with prescriptions. Because the fact is, is that we all get prescribed more

medicine than we need -- for everybody, for us, for the dog, you know, everybody.

[Laughter.]

MS. BRENDA V. SMITH: And you know, everybody I would imagine, if you think about it, has a little cabinet with prescriptions that maybe they're not even expired, but you actually didn't need all of the ones that you had, which you paid so much money for them, you're like "I'm not going to throw that away. I might need it later on," you know?

[Laughter.]

MS. BRENDA V. SMITH: And then, you know? But then it's very easy, and you're not hiding it. And then it's very -- I mean, those are controlled substances. And it even seems to me like an education campaign about throw your prescriptions out, right, or either lock them up or lock them down would be really, really useful. Because the fact is, is people continue to take medicines even after they don't need them because they're around and they're available and because if the physician prescribed them, then maybe they do something. And then, you know?

So I mean -- so there's the big solution, and then there's the really little one, which is, you know, throw the stuff out. Or either tell physicians not to prescribe so much of it, physicians.

DR. ELINORE MCCANCE-KATZ: So I have to say we have programs at SAMHSA --

MS. BRENDA V. SMITH: Right.

DR. ELINORE MCCANCE-KATZ: -- that work on training physicians.

MS. BRENDA V. SMITH: Right.

DR. ELINORE MCCANCE-KATZ: And I'm interested in what other kinds of educational initiatives you think we need because the uptake on the physician is it's not terrible, but given the number of physicians in this country, it's not big. It's not huge. So what would you -- what else could we do to reach more of them?

MS. JOHANNA BERGAN: So I live in a very small town in Iowa. So sometimes the roles our physicians play are many faceted, and I have a skewed perception of community leaders. But where I'm from pharmacists are key because we have no idea what the doctor prescribes us, and we have -- I know the five pharmacists in my town. I can name them all. I know their personal choice.

And they are the ones that tell me why this was prescribed, why this is prescribed. They ask me -- they ask me first, you know, "Oh, why are taking this?" And are this key line of defense and have helped me make decisions to take or not to take. And have also called my doctor and advocated for me when they think that it's not the correct solution. And from something as small as switching a birth control, antibiotics for my children, to anxiety medications.

And if we can help them feel more able to do that, to ask the questions, and then also identify them as key people able to spot potential addiction, and we have had excellent -- every time we do them, twice a year, the free drug back days. So the police officers are there, but nobody checks the label. So it doesn't matter what you bring back. Every time they have exceeded their expectations for the medications brought back. They have been very effective.

MS. KANA ENOMOTO: Jean, then Carole.

DR. JEAN CAMPBELL: I'm not sure if I'm psychologically predisposed to addiction, you know? I don't think there necessarily has to be that mental health component to becoming addicted, and I think it's a very complex. But whether there is or not, I mean, I could be. I have other predispositions as well.

But what I think is the problem is, is that oftentimes, like you were saying the grandmothers, and I'm a grandmother, you walk out of a health issue, health crisis being addicted. And you have these conspirators which are your physicians, I would say also the cash nexus people, you know, the hospital and the doctors wanting you to be a happy health consumer as well. I think there's that component.

But I'm thinking back to the '60s where women began to assert their self-determination through the work of Our Bodies, Ourselves, and it would have been really helpful to have had like a pamphlet even sitting around that had how to avoid opiate addiction, you know, for the person receiving help and maybe getting maybe a consumer guide to detoxing after you've left -- after you've left the hospital.

I mean, sometimes you can do it just by cutting your pills, taking Jacuzzi baths, you know, you can get over that. You don't need -- the solution isn't to go out on the street and start buying opiates, most people. But it can be hard. But there are initial steps you can take. So, you know, a guide to detoxing.

And then I think there needs to be greater training for alternatives to opiates. I mean, we take a pill for everything, and I think that pain self-management, yoga breaths, or those things need to be integrated into care. I mean, we're going to talk about wellness, but some of the practices of wellness could be extended to pain self-management by the practitioners and training those skills so that for the person who doesn't want to become addicted or who has become accidentally

addicted, that they're able to take some control over that situation.

MS. KANA ENOMOTO: Carole?

DR. CAROLE WARSHAW: It occurred to me that maybe there's a place for pop-ups in electronic health records around if you're prescribing opioids or other things that might be potentially addicting, and what kind of questions you'd ask, what kind of information that gets printed out to hand out, what kind of when do you check back in and make sure that you check on the next visit around addiction issues. So that might be a way to remind -- we found with VD that if it's right there, then people will think about it, and they won't -- they might not otherwise when they're really busy.

Another thing to think about, methadone treatment and what happens in that whole industry and how hard it is to maintain that. I don't know a lot about it, but I just know from people who are tied to that how challenging that is and how expensive. So there may be alternatives.

MS. KANA ENOMOTO: Jeannette, then Johanna.

MS. JEANNETTE PAI-ESPINOSA: Just a specific thing. A graphic novel, but that really focuses on like our young women, they know they have addiction issues, which is the irony. So something that really focuses on that population and that you know you have an addiction issue. You're clean from X, Y, and Z, but what's the connection to prescription medication, I think would be readily consumed by young women.

And I'm talking about young women, girls a little bit older, so around 17, 18, 19. But are about to transition out of some system and be on their own and will be expected to make more of their own choices. I think that would be something they would really pay attention to.

MS. KANA ENOMOTO: Johanna?

MS. JOHANNA BERGAN: I recently read an article in the Atlantic that sounded sort of like an advertisement to switch from opioids to heroin because it was so much cheaper. And I wondered if there's any -- if there's been thought about that?

DR. ELINORE MCCANCE-KATZ: So, I'm sorry, say that again.

MS. JOHANNA BERGAN: So it was specifically about women and that the reason I read it is because whenever soccer mom terminology comes up, I am reminded that I live an hour north of what was the meth capital of the world, where they were selling to moms as their primary audience. So they were -- yeah, it was great.

They were identifying that opioids were the drug of choice for moms who, you know, were coming into addiction. And that they did them out by how expensive they were, and because of the crackdown, it was harder to get prescriptions, et cetera, et cetera. And the deep drop in the street heroin prices, and that the transfer for financial reasons was to heroin.

And then, at the very end, indicated the concern for, well, when you buy heroin, you never know the quality or what it might be laced with. And so, they go from a known -- "I know exactly the quantity of what I'm taking. I understand how I will feel because I just did it." -- to this unknown of heroin. And that this population just doesn't understand, it can't fathom what happens when it's laced with something. And just we can be a step above the game as they crack down and make something harder to access, where will they go next?

FEMALE SPEAKER: Let me just add, I know you know this, and many in SAMHSA knows, but just because you asked the question about how best to engage and retain women in treatment programs that there is a considerable convergence of all the literature around using gender-responsive approaches for women, and SAMHSA has an initiative that Sharon is leading around how you do gender-responsive, single gender, women-focused treatment in coed settings.

And that the issues around gender-responsive treatment acknowledging potential trauma, co-occurring and other psychiatric disorders, allowing focus on interpersonal relationships, which are very key to both addiction and also recovery in women, that those things -- and some of women's special needs around related to transportation and childcare-related issues, that these are all things that have been demonstrated over and over, and over and over, and over and over again as being necessary for engagement.

And also, retention, when you provide them, actually women are retained. Once women enter and are retained, their outcomes are at least as equivalent if not better over time than are those of men.

So that, that just because you asked the question, I just think worth kind of discussing and just mentioning and making sure it's part of the record in terms of the response.

[Pause.]

DR. ELINORE MCCANCE-KATZ: So can I have the next slide?

So the other thing that I wanted to hear from you about was relationship between women's behavioral health issues and HIV. Of course, for women, the primary mode of transition is heterosexual sex, often associated with intimate partner violence, unfortunately. And this very much disproportionately affects African-

American women, and I've just given you a couple of statistics.

I can't imagine that anyone would not find it stunning that African Americans are only 14 percent of our population, but they account for 44 percent of all new HIV infections, and that African-American women represent 64 percent of new HIV infections in women.

So -- can I get the next slide?

So one of the things that we're doing, and I'm very, very happy to have this opportunity -- so I've spent a lot of my career working in kind of the cusp of HIV and viral hepatitis substance abuse issues and mental health issues, and that means that I've spent time working in HIV programs as their consulting psychiatrist. And it's very hard to get attention paid to behavioral health issues in these programs still and in programs that are some of the best in the country.

Not a lot of attention has been paid to the relationship between behavioral health and HIV outcomes. I have been saying for many years that you don't -- you're not going to get a good HIV outcome if you don't take care of the mental illness, if you don't take care of the injection drug use, if you don't take care of these issues with HIV. No big surprise that people are not adherent, that they're not coming to appointments. They're not having the best outcomes.

And we know this because this has been published on many, many times, most recently being the so-called cascade where we see that we have over a million people with HIV in this country and roughly 25 percent of them getting antiretroviral treatment. In the United States, I just think that's -- it shouldn't be that way.

But I think one of the reasons for that is that we have not paid attention to all of the needs of people who are infected with HIV. They are not just an HIV infection. And so, we have the opportunity at SAMHSA to make some changes in some of the thrust of some of our programs, and one of them has to do with a new RFA that will come out soon that will seek to collocate and integrate care for HIV into behavioral health settings.

So for people who have HIV infection and who are connected with their behavioral health providers -- be it community mental health centers, be it their substance abuse treatment program -- they would be able to get HIV care in that setting. Some folks don't want to schlep out to the HIV program or to the primary care doc for their HIV treatment. They'd rather get all their care in one program that they're connected with, and that's what this RFA seeks to do.

But given the really disproportionate impact of HIV in women, and particularly women of color, I was hoping to get some input from all of you about how we can best serve women in our HIV programs in general and specifically this program.

DR. JEAN CAMPBELL: SAMHSA doesn't generally answer the "why" question. It's more we focus on the services and how people should access those services once they have the condition. But I was -- our colleagues at NIMH, for example, are supposed to be answering the "why" question.

So my "why" question is why do African-American women have such a high percentage of the incidence of AIDS? What is the science telling us that can inform -- can inform our services? I mean, I immediately thought, well, why is that?

DR. ELINORE MCCANCE-KATZ: Well, I think that there is -- there is some information available on that. I think there are also studies that are currently ongoing. But some of it does have to do with issues around feeling confident to negotiate safe sex and issues of relationships that are difficult for a woman to be able to maintain her own safety.

Those are things that have been published very recently, and in fact, those reports are mainly from CDC, but it looks to be that those are issues that are quite common and something that probably our programs should be looking to address.

MS. KANA ENOMOTO: Carole?

DR. JEAN CAMPBELL: Well, I think we also need to bring the "why" questions and like the research studies into our conversations in terms of our presentations and our references because just what you shared there is important for the RFA, for example, that that knowledge -- you really need to know the "why," even if it's coming from the CDC or NIMH or NIH, in order to provide the most effective services.

And I could see that could relate to the opiate addiction as well. Why -- you know, why that those occur, what does the science tell us, and make that available so people can become informed as we're developing our public policies and our programs.

MS. KANA ENOMOTO: And I do think that we do that when we generate our announcements, and we do have that sort of background in the RFAs. In fact, last year, we did focus on our -- the CSAT HIV portfolio focused on HIV in women of color and with substance use disorders, and the request -- I mean, they were -- CSAT was given the charge of if you want to focus on a population, please look at tell us why from a data perspective we need to look at a particular population and get at the science of that, the epidemiology as well as the services and the population's risk profile.

So I think we are doing that pretty consistently. Let me let Carole and then

Brenda and then Shelly.

DR. CAROLE WARSHAW: I was just going to mention the White House --

DR. ELINORE MCCANCE-KATZ: Well, and SAMHSA plays a role in that. So we have part of our HIV team is working on that.

MS. KANA ENOMOTO: Do you want to say what the document is?

DR. ELINORE MCCANCE-KATZ: Yes, can you show the title again?

DR. CAROLE WARSHAW: It's the intersection of HIV/AIDS violence against women and girls and gender-related health disparities interagency --

DR. ELINORE MCCANCE-KATZ: Exactly.

DR. CAROLE WARSHAW: So there's a lot about some of the --

MS. KANA ENOMOTO: The "why" factors.

DR. ELINORE MCCANCE-KATZ: Yes.

DR. CAROLE WARSHAW: Lifetime trauma, ongoing domestic violence, all those kinds of things are in there, and a lot of agencies involved in working on that.

So one of the things I was wondering about was the WIHS study. We have a whole bunch of these sites. There's like 20-something sites. And there's a lot of work around mental health diagnoses and substance abuse related to in populations with women who either have HIV/AIDS or who are at risk and trying to look at the intersections.

There's a lot going on. And so, I assume you're kind of connected with those folks who are doing that work and some of the HIV programs who I know from early on, they were addressing trauma and maybe not the mental health/substance abuse so well, but thinking about it. So I think there's a lot of openness to that and people doing that work.

MS. KANA ENOMOTO: And Ellie, I think, has been a really wonderful addition to our team because she has so much credibility in the field and in this area that, you know, I think that's been helpful to bring -- raise the profile of behavioral health issues in the HIV world because she does have those connections. It's been great.

So Brenda and then Shelly.

MS. BRENDA V. SMITH: One of the things that I feel like is unexplored, and Jeannette and I kind of look at it -- I don't know if we were looking at each other the same. I need to put on my glasses so I could actually see. But you know, one of the sort of interesting statistics, and again, this is coming out of my work on the prison rape commission and sort of the recent data that came from BJS, is that I think 1 in 12 kids -- no, let's say 12.5 percent one year and I think about 10 percent of kids who were in custody indicated that they had experienced sexual victimization in custody.

Okay. Very high rates of sexual activity going on in custodial settings. Unfortunately, disproportionate impact on men and women of color. One of the tasks for the commission was to look at the public health consequences of sexual victimization in custody, and we never did. We didn't. There was only one CDC study that was done in a prison in Georgia where they looked at a bunch of men who came in who were negative, and then a large number of them were positive after they left.

And I just think, you know, when you're talking about sort of what are the reasons. I'm not suggesting that that is, but it seems to me that that would be a really fertile area for exploration, particularly since so many low-income men and men of color have contact with the criminal justice system, and it is very clear that there is a lot of unprotected sex going on in these institutions.

MS. KANA ENOMOTO: So thank you, Brenda. I don't mean to cut you off, but we have 4 minutes. We have to keep on a tight schedule because we have to go offsite for lunch. So I want Shelly and Jeannette, and then we'll let Ellie have a few words.

DR. SHELLY F. GREENFIELD: So this is just a quick one, which is just that the NIDA Clinical Trials Network developed and pilot tested gender specific for women and for men safer sex building skills that have been documented now, and the papers are out, I mean the outcome paper.

So just in terms of taking research practice, there are now a series of studies and secondary studies that have looked at gender differences in sexual practices and also in the main outcomes of demonstrating efficacy and effectiveness of those gender-specific safer sex building skills, so for men, for women. And they were done in substance abuse treatment programs, but they could actually find homes in other types of healthcare settings.

And one of my concerns is often that as we do this research, that it's harder to get the transition to practice, as all of us know. So just to capitalize on something that's been developed and tested now by our partner, you know, National Center on Drug Abuse.

And then the final other thing I just wanted add in is that we find that alcohol use

and binge drinking is actually a tremendous additional problem in all of the populations, including those that are opiate dependent, seeking other services in terms of transmission of HIV, and that that actually plays a large role for women.

So, you know, drunkenness, unwanted sexual contact, and interpersonal violence are often fueled by drinking. And we've seen a rise in drinking levels in women. So that's just another area of potential intervention.

MS. KANA ENOMOTO: And just to note that the program that Ellie is talking about, which will come out soon, has a substance abuse prevention component to it. CSAP is a great collaborator on this, and so the service provider organizations will be collaborating with community preventionists to do. So that's actually a really great perspective that you described. We could make sure we get that NIDA, those resources connected with this program.

Jeannette?

MS. JEANNETTE PAI-ESPINOSA: And I'll make it really quick. My comment was that I think the data is great, but I think it only defines, identifies, and measures the symptoms. And I think to really address your second bullet, we have to look at the race and gender construct of our society. I know we can't do that here.

But I think it's really -- when I talk to the young women that we work with, they know how to have safe sex, and they know how to not get pregnant. That's not why they're coming up positive or they're getting pregnant. It is a level of invisibility, marginalization, lack of self-worth, lack of self-esteem, and the lack of love, frankly, that they will do what they need to do to get what they think is approval and love.

They'll have children. They'll have unprotected sex. And it's really, it's so deeply embedded not just in themselves, but in our social construct. I think it has to -- for the women that we work with, and we go up to 35, we really have to focus you are worth it. You are valuable. You need to protect yourself, protect your children. It's not about -- it's not about access to birth control. I mean, it is in some instances. But by and large, that's really not why they're getting pregnant. They know contraceptives, will stop, in order to get pregnant.

So it's more complicated, and I think we tend to focus on the symptoms and not their really, really deeply embedded root causes, and that's not even talking about how poverty affects all of that, too. So I think a really different tact for your second bullet would be more effective than sort of a more traditional approach around behaviors and skill building.

MS. KANA ENOMOTO: Ellie, do you want to say a few words to close out?

DR. ELINORE MCCANCE-KATZ: Just thank you for your comments. It's very helpful and will, I think, inform some of what we talk about with our grantees. I can see some of this being woven into technical assistance to our grantees. So thank you.

MS. KANA ENOMOTO: And thank you, Ellie, for coming. In a very short time, she's become a D.C. powerhouse, much in demand and well respected and really influencing SAMHSA and its policies and its programs. So thank you for coming, joining the committee, and thank you all for your robust comments.

And now I will let Nadine talk to us a little bit about logistics.

MS. NADINE BENTON: Okay. We have 1 hour for lunch today, and we will be going to Café Tokyo. A room is already available for us there, and a shuttle will be out front to take you there. The shuttle holds 10 to 12 people, I believe. But in addition that, Sharon Amatetti will be driving and has offered to take four or five people as well. And we will meet back here at 12:45 p.m.

MS. KANA ENOMOTO: And we'll have Dr. Clark talking about PPW. So we'll want to be on time. Thank you.

[Break.]

Agenda Item: SAMHSA's Pregnant and Postpartum Women (PPW) Program

MS. KANA ENOMOTO: So let's go ahead and get started. We are fortunate to have both Dr. Clark and Administrator Hyde here.

Operator, are we back on the line?

OPERATOR: Are we ready to begin now, Kana?

MS. KANA ENOMOTO: We are ready to begin.

OPERATOR: Okay. Stand by. Let's put you back in that main conference. Right now, I have you outside the conference system so that the chatter would not be heard. So one moment, please, and I'll move you back over.

MS. KANA ENOMOTO: Thanks. Okay. And while he's doing that, just if members could keep their cell phones maybe off the table and limit use if possible just because we're getting a lot of feedback on the sound system and the recording that we're trying to do.

[Pause.]

OPERATOR: You may begin.

MS. KANA ENOMOTO: Well, welcome back to SAMHSA's Advisory Committee for Women's Services. We are very fortunate in this session to be joined by Dr. Westley Clark, Director of the Center for Substance Abuse Treatment, who's going to talk to us about recent findings from the Pregnant and Postpartum Women Program.

In addition that, we have Administrator Hyde here, who is also joining the committee and listening to the presentation and for some of the discussion about this important program and where we might take it in the future. So, with that, I will let Dr. Clark, who will need to leave as soon as he's done because he's actually chairing the CSAT NAC at the same time as he's here today.

DR. H. WESTLEY CLARK: Yes, but this is an important component of SAMHSA agenda. So I was really pleased to be invited to present a discussion of our Pregnant and Postpartum Women Program.

I always like to start my discussions by pointing out that the President points out that we need to address the needs of dependent pregnant women and provide for the health of their babies. The administration's National Drug Control Strategy calls for increased family-based treatments to ensure that families suffering from substance abuse are not further torn apart.

Next slide, please.

The Office of the National Drug Control Policy points out that as many traditional treatment programs do not allow for the inclusion of children, a woman may be torn between the need to care for her dependent children and the need for treatment. So they point out that this has to change. Women should not feel torn between seeking treatment and caring for their families, and there are many model family-based treatment programs around the country that prove families do not need to be separated in order for them to achieve success in treatment and recovery, and this whole family-oriented approach is part of the warp and woof of many of our programs.

Next slide, please.

SAMHSA's program for pregnant and postpartum women is family centered. The PPW program looks at services from a family-centered perspective and building on the strengths and resources of the entire family, that we attempt to expand our projects beyond their capacity to engage and love and support the fathers of children to improve outcomes for their children. So it's not just the mom and, where it's appropriate, we try to preserve the whole family dynamic.

Projects are building capacity to provide integrated care for minor children, those less than 17 years of age, of mothers in treatment. There is special attention being placed on designing well-coordinated and integrated care for minor children who cannot reside in the facility, as well as older children.

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When we look at our data, among pregnant women age 15 to 44, 5.9 percent -- and these are NSDUH data -- were current illicit drug users based on the data averaged between 2011 and 2012. Among pregnant women 15 to 44 in the 2011-2012, an annual average of 8.5 percent reported current alcohol use, with 2.7 percent reporting binge drinking and 0.3 percent reporting heavy drinking.

And 15.9 percent of pregnant women between the age of 15 and 44 had smoked cigarettes in the past month. We always like to keep people -- remind people that nicotine and tobacco are issues.

Next slide.

The combined data for 2011-'12 indicate that most alcohol use by pregnant women occurred in the first trimester. That's another issue. And this is also true for drug use. The behavior during the first trimester and our assumptions that people haven't discovered that they're pregnant, 17.9 percent first trimester, 4.2 percent in the second trimester, and dropped to 3.7 percent in the third trimester.

6.6 percent of women reported binge alcohol use in the first trimester, 1.1 percent in the second trimester, and 0.4 percent in the third trimester. So the binge drinking, which is often associated with many problems, drops fairly substantially, but it doesn't go to zero, which is another thing that I like to remind people. When the numbers don't go to zero, there are still issues in terms of screening.

When we look at treatment -- next slide, please -- the portion of female pregnant treatment admissions remained relatively stable between 2000 and 2010 at 4.4 to 4.8 percent, but there were some shifts in the substances of abuse. An increase in percentage reporting drug abuse from 51.1 percent to 63.8 percent, and a decrease in the percentage reporting alcohol abuse from 46.6 percent to 34.8 percent.

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Poverty and limited access to healthcare contributed to the pervasiveness of substance abuse among pregnant women of low socioeconomic status. Pregnant women with substance abuse problems may not seek prenatal care for fear of being reported to law enforcement or social services agencies, and there

are jurisdictions that have fairly robust rules and impose that on the prenatal clinics to not only test for it, but report people who test positive for drugs.

Next slide.

So let me give a brief overview of our PPW program.

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Statutory authority states that residential treatment grants for pregnant and postpartum women are authorized under Section 508 of the Public Health Service Act, as amended. The program's purpose is to expand the availability of comprehensive, residential, substance abuse treatment, prevention, recovery services for pregnant and postpartum women and their minor children, those less than the age of 17, equal to or less than, including services for nonresidential family members of the women and the women's children, which we read as including fathers of the children and/or partners of the women.

Next slide.

Part of SAMHSA's strategic initiative includes trauma and justice, and you've all probably gone over that. And in accordance with the strategic initiative on trauma and justice, the PPW program aims to reduce the pervasive harmful costly health impacts of violence and trauma by integrating trauma-informed care throughout the program to help the behavioral health and related symptoms.

Next slide.

SAMHSA launched two -- the PPW program's history involved the launching of two 5-year nationwide programs in 1993, which focused on women and their children. There were 29 grants under the demonstration grant for residential treatment for women and their children, and there were 25 grants, the Services Grant Program for Residential Treatment for Pregnant and Postpartum Women.

And the focus was on expansion of services, including detox for pregnant women, counseling and referral, HIV education, confidential HIV testing, and therapeutic and developmentally appropriate interventions for infants and children exposed in utero or affected environmentally and emotionally by parental drug use.

Phase I, our lessons learned were that comprehensive services are essential, that pretreatment and children's services must be included in the treatment model, that outcomes improve with the integration of substance use and mental health services, that services should be culturally sensitive, and that collaborative arrangements with partners help to foster family stability and reunification where appropriate.

We also learned that ongoing staff training is critical. Evaluations provide critical information for the improvement of treatment and efficacy and effectiveness, and that family needs should be incorporated into best practices and that the projects must plan early to ensure sustainability. I'm fond of saying that you get the grant on Monday and you're planning on sustainability on Tuesday, you've got one night to celebrate.

Our PPW program Phase II from 2003 to 2012, we had 83 3-year grants were funded. In 2014, the PPW application closed Monday, and we anticipate funding up to 16 new 3-year grants.

Here is a chart which shows our Phase II PPW grants. And as you can see, they're distributed across the country, but mostly east coast/west coast. Some States like Florida, Texas have got grants. 2011-2012 -- next slide, please -- as you can see that, again, this is mostly east coast/west coast, and that is part of the problem with a small grant program.

Next slide.

Program goals. Decrease the use and abuse of alcohol, tobacco, illicit and other harmful drugs, including inhalants, among pregnant and postpartum women. Increase safe and healthy pregnancies. Improve birth outcomes because that appears to be from the congressional point of view one of the things that justifies the residential approach. They're really interested in making sure that both the mom and the child are safe.

Reduce perinatal and environmentally related effects of maternal and paternal drug abuse on infants and children, and improve mental and physical health of the women and children.

The other goals. To prevent mental, emotional, and behavioral disorders among the children, to improve parenting skills, family functioning, economic stability, and quality of life. To decrease involvement in and exposure to crime, violence, and neglect, and to decrease physical, emotional, and sexual abuse for all family members.

So as the PPW program has progressed, the projects are now required to screen, provide interventions for the presence of co-occurring substance use disorders, depression, anxiety, and trauma. For example, projects are now required to screen and provide interventions for alcohol misuse, fetal alcohol spectrum disorders, and tobacco use.

Now while FASD is a low-frequency phenomenon, our target population is a population that uses substances. Therefore, the screening is applicable and appropriate because it is among this population where FASD might be found more frequently because it is a target population. Projects must incorporate

trauma-informed approaches, and projects have identified a need to expand capacity to address postpartum issues.

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Projects are now required to maintain MOUs or MOAs with agencies and organizations to ensure the populations of focus have access to required services, maintaining in some cases up to 80 partners in their networks. We find in this population, as many populations in the vulnerable population spectrum, a wide range of services need to be addressed. Increasing the access to maintenance therapy for pregnant and postpartum women who are dependent on opioids, medication-assisted treatment. Ten of our 27 active projects are certified and/or affiliated with opioid treatment programs to administer methadone.

PPW programs are being evaluated to identify best practices to capture lessons learned.

Next slide.

Eighty-three percent of our 2003 projects have sustained their residential treatment programs, and 100 percent of our 2006 projects have sustained their residential treatment programs. And we're continuing to evaluate outcomes for the PPW program to assess sustainability and essentially our return on investment.

When people are seen by the PPW program, a discretionary grant -- our discretionary grants have served over 500,000 women. Almost 16,000 were pregnant women. Since 2003, the PPW program itself has served 7,500 women, and approximately 43 percent were pregnant, and approximately 57 percent were postpartum. Our active grants are currently serving approximately 1,900 women, with 48 percent pregnant and 51.6 percent postpartum.

Next slide.

When we look at the age demographics from our active 2011-2012 grants and our grant portfolio since 2003, we note that the 60 percent of the women in the 2011-2012 portfolio between the ages of 26 and 44, 39 percent are between the ages of 18 and 25. When we look at our PPW grants since 2003, that ratio didn't change much.

But when we look at pregnant women in our CSAT discretionary grant portfolio since 1999, we see there's fewer women in the 26 to 44, more women in the 18 to 25 years of age. But again, and then we have 5.1 percent between the ages of 45 and older in our general portfolio at CSAT. So it raises the issue of how the portfolio in general deals with the needs of women. Since the targeted

programs are focusing on women in the PPW range, it's not clear what our other discretionary grants are doing.

Next slide.

When we look at race and ethnicity, this slide demonstrates that across the board in the active PPW grant from 2011-2012, 49 percent are white in the PPW grant since 2003. That's 52.5 percent. So roughly 50 percent of the women in the PPW program are white.

In the 2011-2012, 14.4 percent were black or African American, but in the PPW grants in general since 2003, that's 21 percent. So between 14 and 21 percent.

When we look at pregnant women in discretionary grants, there are fewer white women, 44.9 percent. More African-American women at 26.4 percent. So that raised the issue of making sure that we have culturally appropriate, culturally sensitive strategies.

When we look at Hispanics, 25.8 percent of the active PPW grants have women identified as Hispanic and Latina. In the portfolio since 2003, that's 26 percent. So that's remained fairly constant. When we look at the general discretionary grant portfolio, it drops down to 19.2 percent. So there are fewer Hispanic women in the general portfolio.

The multiracial groups remains the same across the platform. We have a large number of women who identify themselves as "other," at 17.9 percent of the active grants in 2011 and 2012, 13.7 percent of the PPW grants since 2003, and 13.4 percent of the general portfolio.

Next slide.

Five most commonly used substances by women in the PPW program. Looking at the 2011-2012 cohort and the portfolio since 2003, we see alcohol, marijuana, methamphetamine, cocaine, and heroin are the major substances of misuse, with alcohol and marijuana and methamphetamine being the dominant ones, all above 25 percent, with cocaine and heroin at 17.1 percent and 14.3, respectively.

When you look at the PPW grants since 2003, again it's alcohol and marijuana. Methamphetamine drops down to 15.2 percent. So in the grants overall since 2003, methamphetamine wasn't as prevalent, but it's still 15.2 percent. And cocaine is much higher at 26.2 percent. So I think these capture the variations on the theme that drug cycles are not stable. They vary. They fluctuate.

Next slide.

When we look at treatment duration for women in the PPW program by length of stay, it is distributed across timeframes. We look at 0 to 30 days, 31 to 90 days, 91 to 120 days, and 121-plus days. What is revealing is that in the active grants from 2011-2012, a third remained longer than 121 days, and when we look at PPW grants since 2003, it rises to almost half. The smallest number is actually the 91 to 121 days at 11.5 percent in the active grants, and 8.5 percent in the aggregate grants since 2003.

When we look at where care is provided in the next slide, the organizations providing PPW services, I like to note that six of the active grant programs are Federally Qualified Health Centers. When we talk about integrated care, it is important for us to realize that the PPW program is actually pulled into community health centers as a part of the portfolio. Forty-three of the grants are nonprofit private, 21 are nonprofit public, 6 State government, 4 are towns and villages or tribes, and 2 county government.

So the providers are diverse, with nonprofits being the dominant delivery system and a smattering of others. But again, noted that six of our grant programs are Federally Qualified Health Centers. So they, too, are concerned about the welfare of pregnant women and postpartum women and their children.

Next slide. Well -- next slide.

Okay. At intake, 33.8 percent report no substance use in the past 30 days. That increases to 83.7 percent in 6 months, and that's true for both the active grants and the grants of 2003.

Next slide.

When we look at the specific substances alcohol and marijuana, you find reductions in substance use in terms of alcohol and marijuana.

Next slide.

When we look at the other range of substances for which inquiries are made, we find there's heroin, morphine, all our prescription drugs are on the portfolio, and we find those reductions are consistent. But the key issue is that women acknowledge using a wide range of substances, and we should be dealing with those, and we're attempting to deal with those in the PPW program.

Next slide.

And back to the substances, as an afterthought, again, jurisdictions are screening for this among the women in the perinatal period, and so this becomes important for us to identify in a wide range of substances. But when we look at -- we also look at mental health because we think that's an important part. So we

find a reduction in depression symptomatology, a reduction in anxiety symptomatology, and a reduction in hallucinations. Now we only have a small percent of women, at 5.3 at intake, that admit to hallucination, but it drops to 2.7 percent.

Trouble understanding or concentrating or remembering, sort of cognitive distortion secondary to substance use, drops from 42.5 percent to 28.2 percent, or a 33.8 percent reduction.

Trouble controlling violent behavior, that is at 44.6 percent. Not a large number on admission at 12.7 percent, but it does drop from 12.7 to 7 percent.

Attempted suicide is at 1.9 percent. It's a small number. It drops down to 0.6 percent. So even though it's a 68.8 percent reduction, the fact is it's not a prevalent issue, but it should be screened for because, indeed, there are a lot of stresses in the lives of the women when they present for treatment.

Next slide.

There is a reduction in risk factors. The arrests, employment, social connectedness, being housed. Now housing is not much of -- there's not much of a change because this is a residential program and the focus is on substance use. Reduction in injection drug use, and a reduction in unprotected sexual contact. It drops from 90.8 percent on intake to 79.5 percent 6 months later, but it's not zero.

So from an HIV and an infectious disease point of view, it is a concern. We don't want the Government to be in the position of telling people not to have sex. The question is how to tell people to have appropriate sexual -- protected sex, if you will, during the recovery period where they are vulnerable and their decision-making may be still influenced by the substances they were using.

Next slide.

We have a lower percentage of newborns testing positive for drug screens. If you look at this slide, newborns, they didn't test positive -- are testing negative at 56 percent, but newborns at intake tested positive at 44 percent, and then when you go to newborns delivered during treatment, 91 percent test negative. So the deliveries that occurred during treatment of the newborns are clearly in a much less vulnerable situation from the substance abuse perspective because only 9 percent test positive. And that, I think, is a tremendous commentary for the program.

Next slide.

When we look at clients and their children, living arrangements and parental

rights, at intake, a significant number of women retain their parental rights, although their children may not reside with them. And one aim of a family-centered service is to reunite families when this is in the children's best interest.

So if you look at the numbers here, we tracked -- we've been able to track 4,703 children for the active PPW portfolio. The estimated number of children for whom clients have retained legal rights, 3,890, almost 3,900. And the estimated children for whom clients have lost parental rights was only 813. And the estimated number of children living someplace else due to a court order is 2,061.

But the key issue with the last number in the active portfolio is the women still retain the legal rights to their children, and at the end of the program, only 813 of those children are children whose parents have lost parental rights. And so, then when you look at the whole PPW program, you see that almost 20,000 children were involved, and the 16,000 of those 20,000, or 19,508, the parents retained their legal rights and only 3,082 are the children for whom the parents lost their legal rights.

So, ideally, keeping families together should be a public policy goal, and the PPW program seems to be achieving that. Ideally, it should be one where the child is in the best situation.

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PPW services focus on engaging the entire family. We find that 58.5 percent of the pregnant women receive -- in our active grants receive family services, and then 60.2 percent of postpartum women receive -- our active grants receive family services.

So that raises the next question of future direction, and the question should be do we expand and deepen the analysis of the client-level qualitative and quantitative data generated by the program to further evaluate the effectiveness of the models of care being implemented, because we've got different models being used by different programs; identify the constellation of services that positively impact treatment completion and mental health outcomes, and examine the service utilization and fidelity to evidence-based practice.

We need to be able to apply these programs to these findings to guide program policy and funding decisions at national, State, and local and provider levels, particularly with the fact that we've got health reform in place in many jurisdictions for women that once you're postpartum, you often lose your public support. So in the Medicaid expansion States, if we can benefit from the lessons that we've learned, we can continue to help both the moms and in many cases the fathers, but also the children.

Next slide.

Healthcare reform should increase access to treatment, increase access to integrated and coordinated care and recovery support services. We believe that there should be an increasing engagement of fathers and other family members where appropriate in the treatment and recovery process. And I always throw in the phrase "where appropriate" because, again, if it's not safe, we don't want that to occur.

But the problem with policy reinforcing psychoactive substances is that the drugs and the alcohol can drive a lot of the decision-making on the part of the affected person. So safety may not be an issue in the same situation when it comes to the family dynamic.

And we need to implement systems of care for children with a focus on birth, development, and mental health outcomes and establishing systems of care for transition age youth, working with the full spectrum of services available both through health and like the CHIP program and other social services that are promoted by agencies like the Administration for Children and Families, Department of Justice, et cetera.

And then establishing systems of care for transition age youth, 18 to 25, some of whom are pregnant and needing assistance and learning how to be parents. So these are things that we're learning from the PPW program.

MS. KANA ENOMOTO: Thank you. Thanks, Dr. Clark.

And I think Shelly has agreed to facilitate our discussion?

Agenda Item: ACWS Discussion

DR. SHELLY F. GREENFIELD: Sure. So I'm just seeing a lot of this data for the first time, and I just want to commend you on the program because I think the data that you presented both highlights the great need in terms of the rise of use of alcohol and drugs in the population and including also tobacco in that group. And the tremendous risk to maternal health, but also to neonatal health and outcomes.

So that's a great need, and these are very important programs. I think some of the data -- you presented a lot of data, but some of the data that struck me that really seemed very compelling are some of the substance abuse and the mental health treatment outcomes, which are, I think, pretty robust and significant in terms of the decrease that you see in a wide range of substance use, along with decreases in depression and anxiety.

Also, some of the major risk factors that you outlined that you saw at baseline, there's also significant decreases. And then, finally, I think the other issue when you're looking at pregnant and postpartum women is that the newborns, the proportion of newborns that have tested positive at baseline versus during treatment is significantly lowered.

So these are major outcomes that you've assessed that are actually quite significant, I think, clinically both for the moms and the babies, but also overarchingly lead, I think, to improvement in public health outcomes as well. So I think the programs seem to be showing that they have -- you know, are producing outcomes that you would hope for in initiating these.

I think I would underscore just a couple of other things that you said, which are just that in this area in the last decade, we're also seeing tremendous rise in the use of alcohol and drugs amongst women now initiating use in exactly the same proportions in the earliest age ranges. We actually are seeing greater and greater numbers of women in childbearing years and reproductive years who are using alcohol and drugs and, therefore, even pre-, pre-, pre-partum, the need to address that use.

Because as you point out, a lot of the use amongst pregnant women is in the first trimester, and as you said, you'd like to see it all go to zero, and it doesn't. But on the other hand, it appears that once women are aware that they're pregnant, that most will actually stop using. But that leaves you with that vulnerable time when people are not aware that they're pregnant. And so, I don't think this problem is going away in terms of the rise of use.

And so, the idea of having a tiered approach to trying to have as much screening -- education for women, then screening in all healthcare settings for use of all substances -- tobacco, alcohol, and illicit drugs -- because as you point out, it's across the board, and being able to intervene as quickly as possible, followed by targeted programs for women at all stages of pregnancy and postpartum seem to be a critical and key area.

So, with that, I would just -- those are my opening comments, and I think there's a lot of material here for people around the table to engage in.

DR. CAROLE WARSHAW: I just had a quick question. Did you look at the outcomes based on length, duration of treatment?

DR. H. WESTLEY CLARK: Not yet. We're --

DR. CAROLE WARSHAW: I just wondered if the length of treatment really made a difference in the outcomes or --

DR. H. WESTLEY CLARK: We think so, but again, we're mining the data. So --

DR. CAROLE WARSHAW: Important for funding --

DR. H. WESTLEY CLARK: Yes.

DR. CAROLE WARSHAW: -- what people actually need and what makes a difference in someone staying that long versus being --

DR. H. WESTLEY CLARK: We're looking at length of treatment. That is one of the concerns that we have because the question is how long do you need to be involved in the treatment process? We do know that the children, the babies are actually healthier in the -- when they deliver. So they're normalized, if you will, which is in terms of birth weight and Apgar scores.

DR. CAROLE WARSHAW: And is there like treatment continues after the residential phase?

DR. H. WESTLEY CLARK: That's the next question. What happens --

DR. CAROLE WARSHAW: With supported wraparound services?

DR. H. WESTLEY CLARK: As we're fond of saying is what happens after the release?

MS. KANA ENOMOTO: So we can keep discussing, but if people have a specific question for Dr. Clark, he needs to go back to his council meeting in the next couple of minutes, and Pam has a question. Do you guys have questions for Dr. Clark?

MS. JOHANNA BERGAN: Do you know, are there specific treatments and practices that focus on the transition age youth, the 18 to 25, that are -- that is different than what they use for the older women?

DR. H. WESTLEY CLARK: We think that the data suggest that there's a need for such a thing and part of the objective needs to be -- because we find there's a difference in the behavior of those two cohorts. So as we mine the data and you look at the programs, you have to say, okay, how do we deal with the 16- to 18-year-old women or young women who are pregnant, and they have different psychological dynamics that need to be addressed? As well as slightly older women also. But these things all have to be characterized.

MS. KANA ENOMOTO: Jeannette, and then Pam has a question.

MS. JEANNETTE PAI-ESPINOSA: Just to add on quickly to what Johanna said, and that is I hope that you share this data with your colleagues at ACYF because as they try to reduce an emphasis on residential placements and residential

treatment and shrink the amount of time, when we see young moms that are coming in as young as 11 and 12 that have multiple acute co-occurring disorders, that if they can see your data -- and the timelines you put on your data are great, and they're less than the timelines they're talking about.

So some kind of collaborative conversation or project would really be -- because otherwise they're feeding into your -- they get to 18, and then you get them.

MS. KANA ENOMOTO: Pam, your question?

MS. PAMELA S. HYDE: I don't know if this is a question for Wes or for the rest of you. Is there any studies out there about -- or data about the impact on newborns of marijuana use by itself, just marijuana? Do we know anything about that?

DR. SHELLY F. GREENFIELD: There's some data -- I think it may be more based in animal models -- that show some harm. But I would get back to you, actually, more specifically on neonatal outcomes and marijuana

MS. PAMELA S. HYDE: I think --

FEMALE SPEAKER: The literature certainly didn't. They didn't see any in human infants --

DR. SHELLY F. GREENFIELD: I remember it as being more marijuana, more animal-based data. But I will get back to you.

MS. PAMELA S. HYDE: Yeah, because that obviously is a burgeoning issue for us. So to see whether or not there are any physical impacts on youth if you could.

DR. H. WESTLEY CLARK: Okay. Well, thank you.

DR. JEAN CAMPBELL: You mean from secondhand smoke or --

MS. PAMELA S. HYDE: No, I mean for use. Primary use.

DR. JEAN CAMPBELL: Oh.

MS. PAMELA S. HYDE: So we know if a pregnant woman is using illicit drugs, there could be or is a physical impact on the newborn. So what's --

[Crosstalk.]

MS. KANA ENOMOTO: I'm sorry. This session isn't over. We're going to continue our conversation. Thank you.

MS. BRENDA V. SMITH: Kana, one thing that -- I mean, this was really amazing information, and just on the sort of notion of integration, the thing that I really thought about is that, you know, a moment -- you know, we all know that in terms of the studies that sort of motherhood and pregnancy and parenting is a really opportune moment to get women to change behavior, right?

But there's also all of that data out there as well about sort of the need to sort of work with families, you know, in terms of language enrichment and things like that. And it just seems to me like -- and I'm wondering because you don't want people to stop drug use pregnancy and postpartum. You want it to be an ongoing effort.

And I wonder if sort of -- and I know that there are issues with this -- whether there are ways to sort of connect some of this with other programs that have had some really good success, like Head Start and things like that. And wonder whether that's going on as well, whether there are linkages that you're already making with those kinds of programs as well, where a lot of these kids may get services.

Do you understand what I'm saying?

DR. SHELLY F. GREENFIELD: Absolutely.

MS. BRENDA V. SMITH: Not wanting to sort of widen the net and kind of keep people in it, but it seems like those, again, in terms of talking about integration, and you talked about ACY -- you know, it just seems like that might be a really good partner.

DR. SHELLY F. GREENFIELD: I would just -- I think those are really excellent points. I have two things to say. I mean, we know that part of the rise in marijuana use among youth have to do with a decrease in their perception of risk. We also know that women who become pregnant, one of the potent predictors of ongoing use is their perception of risk.

In other words, those who perceive it as lower risk will continue to use. It's very common sensical, but it's also being borne out in data. And so, you could envision if that's where you start from, unless you have treatment to help you understand risk, that that may continue postpartum into the next phase of the person, the woman's life, but also the child's life.

And then the other thing that is ongoing, and just these are all overlapping but related spheres, is that, you know, it's become fairly acceptable for mothers of young children to drink alcohol as part of a common cultural dynamic in our society. That that's not -- that those two things are not considered to be antithetical to one another.

That requires, I think, another round of public education along with education in a whole host of other ways. That seems to actually have been at a very sharp increase in this last 10 years and I think leads to some of the CDC and NSDUH evidence that shows the rates of binge drinking among women in that age group, including women with children and young children who are dependent on them.

So I would just -- those are some of the things that are -- you know, if you can catch people early and continue, it's not just during this pregnancy period, but it's really, you know, now you have a chance to be healthy. You be healthy, your children will be healthy, and that includes taking care of yourself and not using substances for yourself, for how you want your children to model their behavior over time on you. Those are all places that there could be a lot of partnering around different kinds of educational efforts or treatment efforts.

MS. KANA ENOMOTO: Did you have a comment?

MS. PAMELA S. HYDE: Yeah, I was going to react to that, the issue of perception of risk, because, as you well know, there is increasing conversation and statements by people from the highest levels about that marijuana is no riskier than alcohol. That's the language that's being used now all over the place. Marijuana is no riskier than alcohol.

So the assumption is that alcohol is not risky. So that -- I mean, that's implied in that statement. So I was kind of going where you were is how do we start thinking about defining the risk in ways because we know that the abstinence message by itself is not -- I mean, we tried that historically. That didn't work.

But there is also evidence in SBIRT and other things that if you actually tell people what is a risky use of alcohol, for example. So it's part of the reason why, I mean, my head has recently been quite a bit around this issue of what do we need to be doing about marijuana, getting ahead of the issue, rather than waiting until we've gotten the problem that we had with alcohol before we started looking at prevention of upstream issues.

DR. SHELLY F. GREENFIELD: Well, I think -- if I could just respond? I think that's so important what you're saying because to model marijuana policy on our policies around alcohol and tobacco, where those have become such giant health problems, and to say that, well, because those are licit substances and this is illicit, somehow following that model.

I mean, when we know that huge proportion of health risks are attributable to alcohol and tobacco and ongoing, even now in 2014, now to add and make a troika of three doesn't necessarily seem to be in the best interests of the health of the public. And it's, I would agree, from a public health and clinical standpoint, it's very worrisome. And it's worrisome for adults, kids, et cetera.

And as you know, the rise in the use of marijuana and marijuana that's more potent than ever before is actually quite startling in and amongst young people.

MS. KANA ENOMOTO: Carole?

DR. CAROLE WARSHAW: I was going to come back to what you were saying. I was thinking that I may be wrong. What you're saying is it's not just about ongoing work around substance abuse prevention, but overall enrichment and well-being. And to have that be once there's an opportunity because people are engaged in a program, to then kind of connect to all the other things in a positive way on top of that.

DR. SHELLY F. GREENFIELD: Right. And also --

DR. CAROLE WARSHAW: Beyond the treatment and --

MS. BRENDA V. SMITH: Exactly, into these other spaces because one of the things that Dr. Clark, I think, talked about were these 80 partners, right, and all of these partners that have been engaged. And it seems to me that they've probably become educated, you know, sort of educated and invested in the project. And so, they may be also another important space to be looking.

DR. CAROLE WARSHAW: Right. I think because there's so much siloed work, and this is a place where people are coming together. There's a lot of opportunity for community-based work. Not just treatment center, of course.

MS. PAMELA S. HYDE: Just a quick answer to your question, and I am not the expert on this. Kana may know more about it than I do, but we do have Project LAUNCH, of course, and there's other conversations going on about early childhood as a major priority for the Secretary and for the President, frankly.

So there's a lot of connections, everything from the connection of trauma and young kids, but also -- or psychotropic meds in young kids, but also ACF and Head Start marrying up with behavioral health programs. And Project Launch does a lot of that kind of partnering at the grantee level.

I think the issue for us, and it's about our whole theory of change, is how do we take that concept and not just say, good, you grantees do the right thing in your community. But rather, how do we take whatever we're learning about those kind of connections and make them more broad?

DR. YOLANDA B. BRISCOE: I wanted to bring up in our State, we have a PPW grant that's out in the middle of nowhere. Driving there, it's mind boggling how there could just be nothing for hundreds of miles, and here is this program that's doing a wonderful program.

No, it's in Carlsbad. And this program has been through three different agency administrations in the past years that they've been a PPW grantee. So I went to provider training not about just trauma-informed services -- because they've all learned, and they go to webinars and they go to trainings -- but I didn't hear much about what kind of supports for the staff who come in to do this work and are themselves traumatized?

And there is so much trauma with the staff that it's all they can do to get up in the morning to go to work when their work environment is pretty atrocious and have been completely continuously traumatized.

The second question that I had is Medicaid doesn't pay for residential treatment. So that's not helping us. What is -- how is this information then being transferred to other levels, higher levels because residential -- and I have a residential program, and I don't think it's the cure-all, end-all. I don't think it's for everybody. It's one level of care.

But when you come and you send somebody way over here, and their family is way over here, teleconferencing just doesn't get it. And when way over here, there aren't the supports, those 80 different supports, we have maybe 3 or 4 in a State like ours. So how does that information get passed along of this is what we're doing and is working for us. Have you tried this? And what about working on -- how does that information get spread for the people who are being successful at these grants?

Because the statistics are all what anecdotally anybody who works with women and children would have told you that, yeah, the babies are going to come out healthy. And the babies are going to be healthier and the moms are going to do great, but they're going back home to generations of this.

MS. KANA ENOMOTO: I think within the PPW network, they've done a really nice job of building sort of communication mechanisms and supports across the grantee community. But part of the conversation we're having now is the foundation for, as we look ahead, and I'm wondering, gee, how are we taking pieces of this and making it transportable to other places?

And I mean, Shelly is seeing this data for the first time. This is important data. It hasn't really gotten out there yet.

DR. YOLANDA B. BRISCOE: It's significant.

MS. KANA ENOMOTO: So, I mean, that's a first step is to share this information, that this is the effectiveness that we're seeing of the program and piquing interest in greater investments and greater adoption even without having the grant. But then breaking down some of the pieces or studying them further

so that we can take pieces from it and go to new -- new programs. But then within the program network, also how do you improve practice? How do you help people share information and best practices?

DR. SHELLY F. GREENFIELD: I just wanted to pick up on a couple of things you said that are -- and also something Carole said earlier that I think are important. We were talking about future data analysis. It would be helpful to characterize the population that benefited from the longer-term residential treatment programs so that you can also begin to define the populations that really benefit from those services.

Because I agree with the two main points you made, which are that residential -- these data actually will support that for targeted populations, residential treatment is actually incredibly important and effective. And as you say, it's not always paid for by insurance and, therefore, is not always available to people who need it. And I think it's important to underscore when you have outcomes that, in fact, this population benefits and actually requires it. So that's one part of it.

And then the second thing that you said is really also incredibly important is what do you do where that's not available for people? Or when they are being returned to their communities, what are best practices around helping people sustain their gains and continue to be healthy, in spite of the fact that they may return to social networks that are actually not as supportive or can actually be the opposite, you know, counterproductive.

What are the best practices at helping people sustain on those kinds of gains? And also what's the what we sometimes refer to in treatment research as the "effective dose" of the treatment that they need when they get back into their communities to sustain their gains? Because there may be a correlation also if you could do slightly longer-term follow-up between effective dose of an intensive treatment and how much it takes in order to go back to the community where you don't have those supports, but you yourself could be able to sustain those gains and know where to reach for help, even if it's not as robust in terms of what's there.

So, I mean, the two points that you made are really, I think, very critical in terms of for the data analysis, that could be used to support, help -- help that. I think those are good things.

MS. KANA ENOMOTO: Those are great, great suggestions. Thank you.

I'm sorry, Carole. But part of the perks of being the Administrator, you get to have the last word. So we are running --

MS. PAMELA S. HYDE: Well, I don't know if this is the last word, but it's my

word.

MS. KANA ENOMOTO: Well, I think we're running into the next time, and you need to go. So --

MS. PAMELA S. HYDE: Okay. I just wanted to say one more comment about that, which is, again, I'm not the expert in this area at all. But certainly, many of the programs that I've visited over the years and one of the best pregnant and postpartum women programs, one of the early ones that I saw that actually brought kids into the program actually created the environment so that women could come back, just like you'd come home for Christmas or you'd come home for Hanukkah or you come home for whatever your holiday is.

And or not even from a holiday point of view, but just when you come over for dinner, or whatever. And those are really the things that insurance doesn't pay for. I mean, it's hard enough to get them to pay for this program.

But the other thing about the dose, about that, so the point -- the question was sort of do we have research that says something about that particular piece of the model? Because I think one of the things we're going to have to do as we become more and more insurance based is show insurance companies why that's -- which pieces of the model or which pieces that they don't like to pay for actually would help them.

And they're very attuned to money. So you show them how that has an impact on their readmissions or their next set of issues, it will make a big difference. And there's another piece about that I was going to ask about, if you knew. Shoot. It's in the residential program. Oh, the dose.

Sometimes about dosage, we also think it's all or nothing. So the dose may be people like to say, and I can't tell you how many times over the years I've been told, they need to stay longer. They need to stay like 2 years instead of 6 months, or instead of 28 days, they need to stay 6 months, or whatever it is.

And it is, I suspect -- and I wonder if there's research, if you guys have that -- that it's not so much exactly how many days you spend there, although I'm sure there is some data about that, but it's more about keeping the connection that you guys were talking about, creating a connection either to the program or to somewhere else that you can stay connected.

And that's the dose issue. It's not sort of an all-or-nothing kind of a dose issue.

DR. SHELLY F. GREENFIELD: Well, I would say you kind of hit on all the complexity of doing this type of research.

MS. PAMELA S. HYDE: Yes, yes.

DR. SHELLY F. GREENFIELD: But what I would say is you have -- it looks like you have some robust data where you could actually, that's what I was saying, begin to characterize your population. Who is that population that stayed 121 days? How did they differ from those who stayed the shorter periods of time? And then what are their outcomes? And you may be able to then characterize a certain at-risk population that will benefit from the longer lengths of stay, another group that actually will do well with a shorter amount.

And then the other thing I would just add, Wes mentioned quantitative and qualitative data. Insofar as you're able to do qualitative data analysis where you actually speak with both the staff that's delivering the care, but also the patients themselves, and actually begin to ask them what they found to be key, helpful parts of their care, I think you often can actually get another level of appreciation for what the care is.

So this is the complexity of doing this kind of research, but I think you have a lot of information where you could probably start to parse some of it, and it would be a contribution to the field also.

MS. PAMELA S. HYDE: Or if that longer group actually doesn't have anyplace else to connect and they're staying because of the connection, then can you create the connection somewhere else or create it in the model of the program in some fashion?

DR. SHELLY F. GREENFIELD: Yes, yes.

MS. PAMELA S. HYDE: That's great. Thanks.

MS. KANA ENOMOTO: All right. Thank you.

MS. PAMELA S. HYDE: Yes, thanks for letting me play in your world for just a few minutes.

[Laughter.]

MS. KANA ENOMOTO: And thank you, Shelly, for your facilitating. Appreciate that, for leading our discussion.

So we are transitioning to our next session, which is on wellness and behavioral health. So we have Deborah Baldwin and Wilma Townsend coming to share with us. Where is Wilma?

MS. WILMA TOWNSEND: Right here.

MS. KANA ENOMOTO: There she is. Wilma is hiding out.

[Pause.]

MS. KANA ENOMOTO: So I don't know if our agenda says this, but Wilma's activities at SAMHSA, not just at CMHS, correct?

MS. WILMA TOWNSEND: Right.

MS. KANA ENOMOTO: Because we have one of you is from CSAT and one of you is from CMHS, but today we have Deborah Baldwin, who is our Acting Director of the Office of Consumer Affairs in CMHS, and Wilma Townsend, who is our team leader in the Division of Pharmacologic Therapies, but she's also been part of the Office of Consumer Affairs in CMHS and has been very active in our -- SAMHSA's participation in the Million Hearts campaign.

Wilma was also in Consumer Affairs in CSAT, working on Recovery Month and other activities. So, and Deborah is joining us from block grants. So we have a multi-talented team here who will talk to you about what we're doing around a Million Hearts and other things at SAMHSA.

Agenda Item: Wellness and Behavioral Health

MS. DEBORAH BALDWIN: Thank you, Kana.

Actually, we've been -- Wilma and I have been sharing the job for quite some time around wellness and the Office of Consumer Affairs. So I'm actually going to yield to Wilma today because Wilma has been serving somewhat as our in-house expert on wellness, and she certainly has developed the program that I'm now overseeing and managing in the Office of Consumer Affairs at CMHS. So I'm actually going to let Wilma talk about wellness today.

One of the things, though, that I wanted to follow up with you all on, the last time that you met, we shared some data on block grant, women's utilization of mental health block grant services. And so, I actually brought a presentation for you. I'm not going to go over it. But I put it on the table. I'd like for you all to take a look at it because it does follow up from the data for -- I think you all looked at 2010 data. This is 2011 data that we collected in 2012.

But it provides you a very good pictures on the numbers of women that's been served in the public mental health system, as well as the types of utilization measures that we collect under the URS system. And so, I'm not going to go over that today because I wasn't asked to do that, but I did want to follow up and share the data with you.

And so, Wilma is going to talk about wellness with you now.

MS. WILMA TOWNSEND: Okay. Good afternoon.

[Laughter.]

MS. WILMA TOWNSEND: I feel like I'm running from here to there. I've been going to the different buildings where we are today. So, but this right here is my love. So you'll get to hear the passion in my voice about this as well, too.

Before I get started, this issue, as I go through it, around wellness, I don't in some cases delve it out in terms of the data for women. But this is a major, major women's issue because over 51, 52 percent of the persons that we service are females and that we know that the females -- in many cases, we partner with FDA because we know that the females are the ones who really set the tone about the food we eat, okay? And so, how do we get to them is a major issue, even within the substance abuse and mental health world. Okay?

So with that as an intro, I'm going to go through just some of the data and stuff that tell you some of the positive things that we're doing, and hopefully by the end of this, you'll be able to go back and think about what you can do and what you can generate within your communities.

Cardiovascular disease is the leading cause of death in the United States. And more than a quarter of Americans age 18 years or older have a diagnosable mental health or substance use disorder. So when we did some rough calculations around that, what it really comes out to is about a third of those individuals who are dying from cardiovascular disease are individuals with substance abuse and mental health problems.

Nearly half of the U.S. adult population will experience some mental disorder within their lifetime. So if that's the case, then how is that equating into this whole problem around people dying earlier?

Next slide. I cannot advance it from here? You have to do it?

MR. JOSH SHAPIRO: No. Yeah, I'm sorry.

MS. WILMA TOWNSEND: Okay. That's okay. People with behavioral health disorder die earlier than the general population, with cardiovascular disease being the main culprit. You know, most people don't realize that. They think about people with mental health and substance abuse disorder dying from overdose, dying from suicide. But our main way in which we die is from cardiovascular disease.

What we find is that as we go into recovery, whether that recovery is from

substance abuse or whether it's from mental illness, that there are things that have happened to our body, some because of a little bit of age, some because of what our body has gone through because of our illnesses. Okay? And that but we have a tendency in our society if someone showed up at an emergency room and said they had a mental health problem and a mental illness, and they were showing some signs of primary care, then they would send them up to the psychiatric ward and would not deal with the issue of the physical illness.

Now that's something we're trying to change, as you all know, you know, where we're having the integration of primary care and behavioral healthcare. But it's a major culprit. So what we're saying is by pursuing wellness, we can reduce the disparity in the mortality.

When we first started -- next slide. When we first started this program, we had a steering committee that we worked with from all across the -- people from all across the country. And one of the things that made for this initiative to be effective is our wording. And by us using the word "wellness," I was really surprised at the number of individuals, especially with mental health problems, who jumped onboard with this because they felt like it was about them and talking about them in a positive way versus talking about them and their illness.

So that's a biggie for us that we tackled this talking about your wellness and what you need to do towards your wellness, not about how your illness can kill you, okay?

Behavioral health problems and cardiovascular disease are highly intercorrelated. Individuals with severe mental illness experience diabetes, hypertension, obesity at a rate of 1.5 to 2 percent times greater than the general population.

Now depression has been shown to be an increased risk of stroke in women. We know that many, many, many women who have mental health problems and substance abuse problems also have depression, which then leads to cardiovascular problems. Individually, behavioral health problems represent a large proportion, up to a third, as I told you, of all Americans who die from cardiovascular disease and strokes.

The economic cost of comorbidity behavioral health problems are significant. What we -- the University of Maryland did this report back in 2011. And if you look, it's cardiovascular heart disease and congestive heart failure. And 69 percent of individuals with behavioral health problems have congestive heart failure. Don't know anything until something happened where they end up in the hospital. Same thing with cardio heart disease, 73 percent don't know anything.

So if we know this, how do we help -- how do we help people to understand and become aware and get screenings and get assessments and get help, you know,

and to live a different type of lifestyle so that they won't have this?

Next slide.

This is the cost factor. This is the one that really got me. Individuals who have behavioral health problems, if you look at the one for cardio heart disease, for an individual who is just a general public who have it, it costs the system \$8,000. The cost for somebody who have a behavioral health problem, \$24,000.

Look at diabetes. We know -- we know that a number of -- some of the medications that we take makes for gaining of weight, which results in diabetes. Look at the cost, \$9,000 for a general person while for a person with behavioral health problems, who have mental health and substance abuse problems, cost the system \$36,000.

So we need to invest ourselves in a different way. Now we need to figure out how do we get the message out and how do we work with people so that they don't have to go through this?

Next slide.

So some of the early mortality risk that we know -- tobacco. Folks, our number-one concern and number-one reason that we need to think about, 75 percent of individuals with behavioral health problems use tobacco products. Seventy-five percent, while the general public is 23 percent. And what's not up there is that the average person who has a mental illness smokes three packs of cigarettes a day. For persons with substance abuse, they usually smoke about two packs of cigarettes a day. It's killing us. It's absolutely killing us.

Obesity, you know, a study on obesity. People who binge eat, found 51 percent of them have more history of depression. Medication side effects I've already talked to some about that. And just substance abuse disorder, use of alcohol and drugs, it lends itself that HIV, damage to the liver cells, pancreatitis. You know, it goes on and on. So how do we get people to be able to see the risk factors and be able to do something about it?

Next slide.

Poverty, social isolation, and trauma, you all was talking about trauma earlier. It has a major impact for us. And then the lack of access to quality healthcare. It is critical, absolutely critical that we have a healthcare system that will look at people's healthcare who have substance abuse and mental health problems and not see it as, oh, it's just one of those symptoms because of their illness and not deal with the symptoms of the healthcare itself.

Next.

So what is wellness? What are we talking about when we talk about wellness? Wellness is not the absence of the disease, the illness, and stresses, but the presence is on the person having a purpose of life, active involvement, and satisfying and social in work and play, joyful relationships, a healthy body and living environment, and overall happiness. Just what everybody else wants.

Next.

Now I'll be the first one to tell you when I do this presentation with consumers, I say to them easily we all want it, but we all got to work towards it. It doesn't come for any of us, whether we have an illness or not.

So what we put together, in fact, the individual in recovery, mental health recovery from New Jersey, Peggy Swarbrick, put together for us these eight dimensions of wellness. And there's nothing new about it -- you know, emotional, financial, social, spiritual, occupational, physical, intellectual, and environmental. All of those things have an impact on your wellness.

I don't know whether you all saw last week there was a study that came out, I forgot the group who does it, but they do it every 3 years or so where they rate the States on their wellness, and then they do certain cities. And it came out last week, and they use most of these things right here to be able to determine that. The place that we all should be living where we'd be the happiest is Provo, Utah.

[Laughter.]

MS. WILMA TOWNSEND: So what we do with these eight dimensions, though, is that each year, each year we focus in on one of those dimensions and try to get people to decide on what are the things that would help them in their wellness in that particular area. You know, like one year, the first year we started, we did social.

And we wanted to start it where it would be something we could do social that would not make people feel as if they had to be -- have a partner or have to -- so we decided we would do line dance across America. And people did line dances and showed us, because you don't have to have a partner. You just get out there with a bunch of people, and you have fun, laugh.

We did financial the next year, and we did a whole thing around how do you budget on low income? So we attempt to each year focus in on one dimension, and then we get people all across the country to do something within that dimension.

Next slide.

So our wellness initiative is about promoting to improve wellness of people with behavioral health problems by engaging, educating, training providers, consumers, and policymakers so that everybody can understand how do you do this? What do you do? What are some of the options you could have? Promote ways to improve behavioral health and incorporate the eight dimensions of wellness into recovery.

Motivate actions to incorporate wellness as a means to enhance the quality of life while increasing years of life. We want to see that on average, persons with substance abuse and mental health die around 52 years old. That is horrible, absolutely horrible.

You know, so our thing, if we can get us to live until we're 62. Now we won't be able to retire. But if we can get us to live until we're 62 over these next few years, we would have made great strides, great strides.

Next slide.

SAMHSA has promoted this agenda through developing the National Steering Committee, like I told you. We have more than 46,000 organizations serving over 31 million Americans who signed up to take the pledge and be a part of our wellness initiative. So if you have not done that, I'm going to show you in the end how you do that, okay, because you've got to sign up and you've got to do some things. I don't want you to just come here and hear me.

Partner with FDA to educate consumers, providers, and policymakers on how to improve wellness. You know, FDA really has been a strong partner with us in getting the message out.

Developed and disseminated some wellness materials that I'll show you in a minute that have gone out all over the place. We also convene a National Wellness Week. That Wellness Week is the third week of September of every year. And that week usually get people all motivated, and they get involved and they do things, and then we attempt to get them to continue doing things throughout the year.

So our National Wellness Week this past year, we had over 300 community events that people, they send us either -- see, I'm not technically savvy, but they send us pictures. They send us Instagrams. They send us a whole bunch of stuff to show us what they're doing. There were over 700 wellness events and activities across the country. And 46 States, including Puerto Rico and Guam also participated.

We also support and make sure that we have information at the Children's Mental Health Day. Recovery Month, we have partnered with the Recovery Month folks, and we try to get -- most of the events that people do for Recovery

Month, we try to get information out to all of them on wellness and have people there to do some things around wellness as well.

As well as the Community Anti-Drug Coalition of America, who have over 5,000 community coalitions. So we try to also delve into there, with them as well. And then our last big partner is the Million Hearts, and I'll talk some more about that later.

These are some of the -- go back.

MR. JOSH SHAPIRO: Oh, I'm sorry.

MS. WILMA TOWNSEND: Go back. These are some of the events that people have put all across the country, and this is one where they had a community wellness fair.

Okay, the next one. This one, the group decided -- it was Peer Link, and the national, the technical assistance center and the national empowerment center got together and put together this. They called it "Wellness is mind, body, faith, and soul."

And so, they put up on their Web site this little thing, and whatever you do, you could send in something to them. And a lot of it is artistic. So they have consumers who send them their interpretation of wellness through an artistic means. So if you ever go on -- you can go on their Web site now and see some of those things.

Next one.

This right here is the one at Rutgers University, the young lady that I told you who put together our eight dimensions of wellness, she's gotten Rutgers University to really jump onboard with wellness. And so, they do a whole thing around behavioral health and teaches heart healthy wellness to children, which is really, really good, you know? And so, the school had changed their lunch program as a result of it, and the PTA has set up some things around wellness so that it gets to the parents as well, too.

This one I love because this is me. This is where a number, a number of mental health and substance abuse agencies, as well as consumer organizations, have started doing community gardens so that they can learn how to grow food, especially in places where there are what they call the "food deserts." And that when they go and start, they will start these gardens and things, and the consumers get into it. Most of them are also putting a piece to it where they're teaching them how to cook the food as well.

The side effect of this, though, is not just the losing of the weight and all of that.

But most of these community gardens are right there in the community, and so they're building relationships and friendships with people that they would never have thought of before.

Another one that a number of them are beginning to do is these runs and walks, and I am amazed at people who does the running and walking as an advocate thing, that if they see a little sign up, they come out. They don't care who you are. And so, it has turned into a real community event that is being directed by consumer organizations, you know, which has lent itself to something really, really good.

Next slide.

So if you go on this Web site for the wellness stuff, you'll see where we have a map across the country, and each event that if people tell us about their event, we put it on the map. So you could click on your State and see what's happening in your State around wellness. So I want to see all of you on the map next year.

Again, this aligns with the Million Hearts initiative. And again, the Million Hearts initiative is an HHS initiative where they're attempting to try to save a million lives by 2017. And if we think about that, that means that for persons who have substance abuse and mental health disorder, we need to try to save 300,000 lives by 2017, okay?

Now how we do that, we don't have a way of being able to measure that as well as they do. They just came out last -- 2 weeks ago telling us how they're going to measure whether they've done it or not. They're going to look at the number of people who've died from cardiovascular disease, the number of people who went to the hospital, and emergency room visits, okay? That's hard for us to be able to do.

I'm in the process of working with them now to see whether there's any kind of way when they do their data, will they be able to ask the question whether a person had a behavioral health problem so that we can try to equate that. But for us to be able to meet that, if they do, it means all of us need to be out there talking it up. We need to be out there talking about wellness to our whole population, to everybody, okay?

So it is a major feat. The most at this point that we at SAMHSA can do is more of awareness, education. But at the same time, I think with doing things like the gardening and the walking and giving out a little bit of money that we will see some impact and that we can make some changes.

Next.

The Million Hearts has focused on four areas for them to try to get people to be able to save lives. A is for aspirin. They call them the "ABCs." A is for aspirin. B is for blood pressure, that they want to see some things around blood pressure going down. They want to see a decrease in cholesterol and a decrease in smoking.

We have focused our attention around blood pressure, cholesterol, and smoking because it's very hard to see and get people around the area of aspirin, okay? And to be quite honest with you, we don't want to turn people off within our population to tell them to take another pill. If their primary care physician tells them that, we want to encourage them. We want to help them, but we don't want to say we're pushing another pill.

Next.

This is the wellness store where you can go and get a lot of information. We have community activation kits of what you can do in your community. We have those posters are big posters that you can put on your wall. We have some brochures and the Web sites to all of the projects that I've talked about, not just us but the FDA and the Million Hearts and things.

Yes, Jean?

DR. JEAN CAMPBELL: You didn't mention the research and evaluation.

MS. WILMA TOWNSEND: I didn't. Because it was -- I had it as a footnoter, okay? The research and evaluation that has been done is, in fact, it's been done twice now by -- the first one was NASMHPD that showed that we died decades earlier and that showed what we were dying from and how it impacted us.

DR. JEAN CAMPBELL: I was thinking of our subcommittee that we did.

MS. WILMA TOWNSEND: Which one?

DR. JEAN CAMPBELL: The research and evaluation subcommittee on wellness that Ron Manderscheid chaired.

DR. JEAN CAMPBELL: Oh, I didn't. I'm sorry. I'm sorry. Yes. As part of the National Steering Committee, we -- within that committee, we set up a research and evaluation subcommittee. That subcommittee work was to look at what are some of the things that we could do from an evaluative point of view that would help us to be able to see whether we were measuring anything over these next few years.

A, they were the ones that helped us come found out that it's a third of the population. That's number one. Number two, they were able to give us some

outcomes pieces for us to be able to really look at, and that's what we are targeting most of our stuff around is their outcomes. C, because of what they did, it has made for us to be able to partner with CDC. I don't even know whether you all even know that or not, to partner with CDC because we, SAMHSA, decided that we would give out a little bit of money to fund some projects that would do some things around wellness towards the Million Hearts goal.

And the first year we did it, we had -- we funded 12 projects, and those 12 projects were the pictures of those different things that I showed you of what they did. This year, because of what that group did, we decided to have some conversation with CDC that could they tell us of people who had behavioral health problems and also had cardiovascular disease, where was the communities or the States where there was the highest rate? And they were able to do that for us. We were absolutely shocked.

And interestingly enough, it correlates with the Million Hearts. The Million Hearts have -- down South, many of the Southern States, they called the blood pressure, what do they call that, the blood pressure -- oh, I forgot the name of it. But it's where many people have major cardiovascular disease, and it comes from blood pressure and stuff. And it's because of the eating habits, okay?

When we did -- when CDC did that data for us, the exact same States. So this year, we are able to fund only four, and Texas, Alabama -- no, Louisiana didn't apply. They didn't apply. Texas, Alabama, Washington State. That's what else was -- Washington State and Oregon State are also very high. I would never have thought that, ever. But they're also very high.

DR. JEAN CAMPBELL: We also made recommendations for data collection going into the future because there's very little that collects data on wellness and recovery. It's more focused on cessation of illness.

MS. WILMA TOWNSEND: Right. And because of that, SAMHSA just -- they're putting together the common data plan, and so one of the things I was able to do was because of that recommendation was to put that in to that group to say, and this is why. Now I don't know whether it will get in, but we was able to put it in there that they collect that data.

So, with that, I think that's it. Oh, take the wellness and Million Hearts pledge. There are the Web sites for you to be able to go and take the pledge. Become a wellness and Million Hearts partner. We need you badly. And if nothing else, if you think of this. If you just get to a couple of people, who knows, you may be saving somebody's life.

And this isn't something where I'm asking you to give money. I'm not asking you to go and walk anywhere or anything. If you can do that, do it. But I'm asking

you to take the pledge and to let people know about this. And if you need anything from me, get a hold of me, I can send it to you. You know, if you want to do a presentation, I can give it to you. I can give you whatever you need because we've really got to get this word out there to people.

One of the things that we got last year from one of the 12 projects, I don't know whether you all -- do you all remember the guy who was found on the side of the road in Columbus who had substance abuse problems, and he had this beautiful boss. And the national press picked him up, and Dr. Phil picked him up, and da-da-da-da?

He ended up where one of the projects we funded in New York, he ended up doing a video for them. And the video is absolutely magnificent. So if any of you even want a copy of that video, I can send it to you so you can use.

Because he shows himself in this video the way he looked, he dressed. He didn't have no teeth in his mouth, the way he looked when he was picked up that day. And then he goes through his recovery process. And as he recovers, he talks about his recovery from his substance abuse, but he also shows you the recovery in his wellness. And all the way until you see him as this man that you would never know with a suit on that's a businessman. That's just -- it's a really good video that this consumer organization put together.

So, with that, I will stop and see if you have any comments or any questions.

Agenda Item: ACWS Discussion

MS. KANA ENOMOTO: Jean has agreed to be our discussant.

DR. JEAN CAMPBELL: I think I'm going to -- I have some comments and questions --

MS. WILMA TOWNSEND: Okay.

DR. JEAN CAMPBELL: -- to lead a short discussion here. I think, first of all, that both Wilma and I are sounding the clarion call to wellness for all of you, and I think that this is another way in which it really shows that, historically, SAMHSA really opens the door to new ways of looking at behavioral health. And this is another step in that direction.

And I think that SAMHSA is really an innovative enterprise. When I look at the banner we have here in front of us, the first thing is behavioral health is essential to health. And the way that SAMHSA has been emphasizing that, I would say the greater part of the emphasis has been on physical, physical health, and the

integration of physical health and behavioral health.

But also here, you have people recover, which is very innovative within our field, and that opens the door to thinking about positive psychology and how mental wellness and the promotion of mental wellness supports recovery. I was reading this innovation article in the airplane magazine. And it said for an innovative enterprise that you have to ask yourself three questions. First is why? Second is what if? And then third is how?

So I structured my comments basically to address those three. I thought I would take the "why" part and put on your shoulders the "what if," which can be the imagining, and then the "how," which is what our next steps can be.

So my question is why are women and girls important to the behavioral health recovery model and our understanding of the impact of physical and mental wellness on behavioral health? Because that was the hardest thing for me joining this group was thinking in terms of gender because, generally, I don't, except within my research, but not within my policy in how to speak as a woman.

So asking ourselves how an understanding of the impact of physical and mental wellness on behavioral health has an important gender connection, and I found that women are the major consumers of health services and health news. So, and you actually brought that point up, Wilma.

And they are also the primary caregivers of others. They make decisions about seeking or advocating services for their children, spouses, partners, and aging parents. So women really are the ones to carry this message of wellness or effective carrier for this message of wellness in our society.

And I don't know. When I was briefly looking at the minutes this morning, I noticed I made a recommendation that members of this group receive the wellness initiative emails that announce what events are going on, and I wondered if people were receiving those? Have you been getting those?

So this is -- well, see, this is a good place to start is for our committee to receive those announcements because it will let you know when the third week of September rolls around. And sometimes there are webinars that our wellness group holds, and sometimes statistics come out. I'm always finding interesting things and encouragements about physical health are in there. And I think that we have to make sure that people in this group receive the wellness initiative emails.

So the role of gender in the lives of girls and women as they develop mentally across significant phases of life, I think, underscores the importance of focusing on the promotion of wellness for behavioral health, particularly if you consider the cultural context and how gender socialization in female development and

behavior affects their well-being.

And we've talked -- I was struck by Jeannette, is that, how you were talking about not only looking at the clinical factors, but also the issues of love and self-efficacy. And I would add hope, goal attainment, empowerment. Those components of positive psychology or well-being are critical to recovery. That's the mental wellness part of the component along with the physical wellness.

So if we look at the cultural context and how socialization affects female development and behavior, you also see that it really has great impact on the social roles that girls and women adopt over time. And therefore, we need to include in our discussions how externally induced risks, such as -- and we have today talked about poverty, discrimination, violence, presents challenges to healthy mental and physical wellness of women and girls.

And I thought that's why your comment -- I was going to say, oh, that's exactly what -- one of the key points that I wanted to make. But we must also draw attention to I think the long overlooked and compelling strengths and capacities that provide a firm basis for psychological growth and health of women and girls. In other words, we need to change the conversation to at least have some equity between the promotion of wellness and looking at those factors that support wellness.

I know this is what happened in that research and evaluation committee. Every single time we would have a conference call, all these people would present all this data, but it was all about illness. And I kept saying, well, where are the factors on wellness? And then I'd give some examples. And I mean, that's why we came out with the recommendation that wellness wasn't being measured, just the cessation or treatment of illness.

So in addition to the treatment of illness, what if we comprehensively promote physical and mental wellness in the behavioral health recovery model? In other words, it would be in your slides. It would be something that would be brought up. It would be a point that would be considered. And how do we do this in our roles as women, professionals, and members of this committee?

And that's my question to you. What if we promote physical and mental wellness in our models of behavioral health recovery? What would that look like, and how would we do that?

MS. JOHANNA BERGAN: Thank you, Jean. I love the questions that you posed.

And thank you, Wilma, for an awesome presentation.

This is like naptime for everybody, right? And I'm on the edge of my seat going,

"We have to talk about this."

So thinking about our wellness in a whole or holistic way is so important for young people, and I have a conversation about it every single week, right? Because I think we are infinitely hopeful, and so it doesn't take very long for us to get to the "what if" question. And we probably won't ever get to the "how" question because we're in the "what if" world.

But I have a great example of what can happen. I had the honor to step in at the last minute and present on the SAMHSA Wellness Wheel at the Alternatives conference this past December, and it was an awesome opportunity. Unfortunate that I had to step in, but I so enjoyed presenting on one of SAMHSA's initiatives that I just had complete buy-in with and just wanted to share and spread the word.

And the day of that presentation was also the final deadline to present proposals to the Georgetown Training Institutes. So I wrote until the late hours of the night an entire wellness track proposal and submitted it in the small box, which was for one proposal. And both the youth leadership track and the general track councils or committees who chose the proposals reviewed that and accepted it, and we are now presenting based off of the SAMHSA Wellness Wheel, nutrition -- nutritional, financial, physical health sessions both in the youth leadership track, but also in an additional wellness track throughout.

And so, it can happen. People are very excited that sessions are being offered not once, but twice for most of them. And we're in the final stages of confirming with National Harbor the opportunity to have a 5K run with our mini-community that has sprung up after being in one hotel for 5 days.

And so, I think that this is just the beginning of what can happen, and my intention is to just continue to see that wherever I show up. What are we doing? Where is the wellness component along with this? And I just -- I think that, Wilma, you mentioned a couple of times there's a little bit of money behind that. I don't want us to underestimate the role that SAMHSA can provide simply by talking about wellness.

The Wellness Wheel that is offered and used fits very well with curriculums that are being implemented by schools across the country. My hometown school district is evaluating two or three different curriculums. What do we implement? They all fall within this circle.

I've been a holistic health counselor and a natural foods educator in my other life, and the models in the circles of life that we use are in line with the SAMHSA Wellness Wheel. And so, I'd rather talk about SAMHSA's Wellness Wheel than any of these other -- I mean, we should all be talking about the same thing.

So I think the "what if" can be now. And support with the Web site to map our events is awesome and continuing to talk about it on the national level is important, and young adults will connect and can connect with the message of wellness in a way that I briefly mentioned to Shelly we just can't connect with numbers on another PowerPoint screen.

MS. DEBORAH BALDWIN: Well, let me just say something, just to get back on what you're saying, that is just wonderful what you're doing. And just for sake of folks here that don't know as much about SAMHSA's wellness initiative, we have a Web site that we can add all of you to. So as Jean mentioned, so you can get and receive all the information that we're collecting and promoting around wellness.

And I have to tell you that there is not a week that goes by that we don't receive calls asking for this package so they can put together either a community organization or a stakeholder group to promote wellness. And so, I just want to let you know that there's lots of information out there, and we're going to make sure that your names will be part of the list of folks who will get the emails notifying you about any information that goes onto our Web site.

So I encourage you to look for SAMHSA's wellness Web site and see what's there.

MS. WILMA TOWNSEND: It's the number-one, at least when I was there, it's the number-one site where people go. It's the number-one thing that people go into our store and ask for.

MS. DEBORAH BALDWIN: And there are lots of materials in the store still.

MS. WILMA TOWNSEND: They run out. They run out every month. I'm going to tell they run out every month. So now people are having to download because we can't keep up with the pace in the number of people.

I wanted to say a comment to what you're saying, though. How would I see a system if it was more wellness oriented? There is a county in California, I can't remember the name, but it starts with an A. They have changed their whole system that it has to be wellness.

The contracts that they've set up, that they have to look at the eight dimensions of wellness of people. Their -- how they look at the outcomes is not just based off of symptom management, but based off of -- I'm amazed at what this county has done. They've done a lot based off of using the wellness concept.

DR. JEAN CAMPBELL: Well, I'm going to California. So I'd like to know --

[Laughter.]

MS. WILMA TOWNSEND: I'll give you the name of the people who are doing it because it's a partnership between the county system, the consumers of that system, and the providers. They've all gotten together and said this is the direction. And they've included primary care into it as well.

MS. JEANNETTE PAI-ESPINOSA: Is it Alameda County?

MS. WILMA TOWNSEND: That's it. That's it.

DR. JEAN CAMPBELL: I'd say the greatest promoters of positive psychology or mental wellness that we've found has been those people that provide services based on their lived experience. They're generally called peer-run programs or consumer-operated programs, used to be peer specialists. But there are many other roles that people with lived experience are now playing throughout the system.

And because their practice comes from a value based on positive psychological dynamics that it's been in terms of scientifically shown to promote positive psychology or well-being.

MS. WILMA TOWNSEND: And one of the things about Alameda County is that within their contracts with their providers is that they have to have a referral agreement set up between the peer-run organizations and the provider agency, as well as they are to have looked at whether or not they should hire peer specialists and peer recovery coaches right within their provider agencies as well.

So it's really -- it's a different -- how this system has gotten to where it has is just amazing to me.

DR. SHELLY F. GREENFIELD: Could I just mention one other thing? It's maybe just a little bit possibly tangential to this discussion, but around wellness. But I have often found both in terms of critical engagement in research with people who have substance problems who are very ambivalent about engaging in treatment, that one pathway to engaging is actually to discuss how to help yourself stack the odds in your favor to be well and healthy into your future. And that engagement with treatment that's often difficult for people, that's often a route in.

So I see these things as all of one piece. You know, it's a way to begin to engage with people, and people can often through all different age ranges, you know, older women -- we were talking about that population earlier -- young people can often engage with a set of activities that they're otherwise ambivalent about when they're working toward a pathway of wellness and health, and that this becomes an integrated piece of that.

So I sort of see it from all the way from the beginning in terms of engagement with folks, all the way through what we think of sometimes as the recovery process.

MS. WILMA TOWNSEND: Right. And that was my point when I said we had the steering committee that we found by even just using that language.

DR. SHELLY F. GREENFIELD: Absolutely.

MS. WILMA TOWNSEND: It's an engaging language, and it makes for people to have a sense of hope that they can.

DR. SHELLY F. GREENFIELD: Yes. And I'm affirming and confirming.

MS. WILMA TOWNSEND: So, and that whether they're substance abuse or mental health. Yes.

Yes?

DR. YOLANDA B. BRISCOE: At one of the pueblos that I contract with -- and out of respect, I won't tell you which one it is -- but a shift to calling the behavioral health to the wellness program was huge this past year. They had people starting to come in. And the folks who come in get this wheel, get this because it's part of who they have been, and that's been really helpful.

And also as part of recovery, there is a saying that it doesn't matter the years, it's the quality of years of recovery. Or 20 years ago, I asked my grandmother, "Wow, grandma, I'm so proud of you, 50 years of marriage." And she said, "Fifty years of misery."

[Laughter.]

DR. YOLANDA B. BRISCOE: So it's not the quantity. It's the quality. So if we get people to live to 62, it's going to be 10 good years.

MS. WILMA TOWNSEND: Another thing I would say is that for us, for me, for me, the wheel is very symbolic to me because culturally for me it makes for it's not a beginning and an end, okay? It's continuous. Life, until you die, it goes.

And that so, for me, it was a big thing having it as a wheel, culturally, versus having it as a beginning and an end. Because whenever I see something like this, that's the way I think of it.

DR. JEAN CAMPBELL: It needs to be twirling on your slide like --

[Laughter.]

MS. WILMA TOWNSEND: I wish. I don't know how. I told you I'm not technically --

MS. BRENDA V. SMITH: Wilma, this is so helpful. I think in a couple of weeks, I'm doing a plenary at a big legal conference for lawyers. It's our Association of - American Association of Law Schools, and this is for all of the clinicians.

MS. WILMA TOWNSEND: Well, you need to give it to them.

MS. BRENDA V. SMITH: Well, but here's the thing. The opening plenary is on the pursuit of happiness, and so I'm going to use the wheel because explicitly it's about dealing with issues --

MS. WILMA TOWNSEND: And if you need --

MS. BRENDA V. SMITH: -- of mental health and substance abuse for lawyers and law students because we're seeing a real increase in pretty serious mental health issues.

MS. WILMA TOWNSEND: And if you need help with putting some slides together for yourself, we have a contractor that can help with that.

[Laughter.]

MS. BRENDA V. SMITH: Okay. Okay. All right. Great.

We even have an exercise of a tree, and with leaves so people can really identify --

MS. WILMA TOWNSEND: I know. I developed -- I came to Louisiana and did that 15, 20 years ago for you all.

MS. BRENDA V. SMITH: Perfect.

MS. WILMA TOWNSEND: That's where they got it from.

MS. JOHANNA BERGAN: My colleague at Youth MOVE, Brianna, has developed a self-care training that she offers, piloted first in a corrections facility for the staff. How do you take care of yourself? A 6-week program identifying the key areas of wellness, which is very exciting.

MS. WILMA TOWNSEND: Yes, it is. Well, as you can see and as you've heard even from your colleagues here, there is many things that you can go back and do. And really, I love what you're doing, absolutely love it.

So if we can get all of you to get some of this out, it would be really, really good. And if -- I know Deborah is going to get you on the Web site and stuff, but on the -- you all got the handout and you see where the Web site is, you can go on at any time because they're always putting up new stuff, always. They put new stuff up weekly. Absolutely weekly. So go on there and do stuff.

DR. JEAN CAMPBELL: And you know, like the pledge, I was thinking another thing that we can all do is you can always in meetings or in conversations with people, you can always say, well, what about wellness? Don't we need to also include wellness in this discussion?

And then you can go back later and find out if they did it, like I did today, which gave me an opportunity to make that point. But following up to see if they did it. Because maybe one time doesn't work, but to keep the discussion alive.

MS. KANA ENOMOTO: So what I would like to do, just in terms of the email, just as a person who is everyday unsubscribing from unsolicited emails, I think we would send out -- I'm happy to send out a link to the members so that you guys can elect to subscribe.

And again, Jean, in response to your comments from last time, that's why we had this session today and we are giving everybody all of the resources so that if they want to choose to get the emails, they can.

MS. JEANNETTE PAI-ESPINOSA: Have you hit a million? How close to a million are you?

MS. WILMA TOWNSEND: You mean, for the Million Hearts? No, we're not close on it. No. In fact, I met with -- we all got together from all of HHS that's part of the Million Hearts, and they're just beginning to start being able to count because we had to come up with a mechanism to be able to do it.

So, no, we're not -- I mean, they're just beginning. So everything and anything that anybody could do right now would be extremely helpful. I mean, every consumer organization I go to, I talk it up, and you would be amazed at the number, we have running groups now or walking groups, and it's making a difference.

We have seen where another one that was really good, a number of the consumer organization have partnered with local nursing schools, and that the nursing schools are coming in, the student nurses, and taking people's blood pressure. Inevitably, at least once a week, they'll find somebody that they tell them you need to go to the doctor or to the emergency room right now. They're saving lives right then and there.

So, and even then at community mental health agencies and substance abuse agencies, we need to be doing that.

MS. KANA ENOMOTO: But I do want to congratulate Wilma and team because the CDC has been very vocal in their praise of SAMHSA as a partner on the Million Hearts campaign. It is a priority for the Secretary, for the department overall, and SAMHSA has been one of the most active partners and players in that and really recognizing and taking responsibility for our populations and our constituents.

I think we do have a row to hoe, however, in terms of it seems that for many of the people in this room, the link between wellness and helping people avoid really negative outcomes is very intuitive for the people in this room. Like you sort of get it that if we can do the wellness, we can get them into lifesaving treatment. We can keep them on a path of health and out of juvenile justice, criminal justice, homelessness, you know, risky behavior, et cetera.

I think that link is not obvious to everyone. And that is where we do run into some challenges in terms of, well, why are you doing a line dance for health? Why aren't you providing more intensive treatments for people with very severe disorders?

I think we have a responsibility to make those links clearer. You know, how does a focus on wellness avoid chronic homelessness? How does making sure that people have financial stability avoid homelessness, criminal justice involvement, suicide, et cetera?

And for those of us who have been in the field or have lived these things, we see it. It's like that's an obvious because people weren't paying attention to it before, and we saw the revolving door and the high-cost, high-need situations. And we see that when you really address the whole person, you can avoid that.

But that message isn't getting out there. So then I think that makes us very vulnerable in the wellness conversation about why are you doing a 5K run? Why are you doing morning meditation? Why do you have a quiet room at a conference? That's an additional cost. That's a waste of money. Why aren't you paying for more medication? Why aren't you getting more psych beds?

MS. WILMA TOWNSEND: And it's real important. Some of the ways in which you connect that dot may be that you have someone who have a behavioral health problem who can help make that dot. What I normally do in this presentation, to be quite honest with you, is I tell my own story as part of it to make the connection for people. But you're not -- I know you know that. Okay?

But if you're doing it before a group of lawyers, for example, they won't know that. They won't understand that. So that connection needs to be made, and so

there's another piece to this. So that's why if you want to talk to me about it, I can help you with that or whatever, but that connection is critical because people don't get it. They really don't.

DR. JEAN CAMPBELL: That's exactly what I was going to say, Wilma, was how we learned in the consumer movement the power of telling one's story and how that lived experience was the key to really understanding recovery.

And when you showed the picture of the community gardens, for example, a person's experience in a community garden, growing something, eating the food, I mean, their story alone, not even knowing the people that I know, that their story alone would be a story of recovery and empowerment. And that makes the connection. A person's lived experience makes that connection.

MS. WILMA TOWNSEND: But we have to be able to tell the story in a way of how it helped that life, but how it also goes back to the system and helped the overall system, too. We can't just tell our story about us. I try to make sure that I do show both. That's critical.

MS. KANA ENOMOTO: Right. Right. If you're here talking to the American Association of Law Schools, and you've got a bunch of public defenders or prosecutors saying, well, how does a community garden relate to the repeat offender that I have that's coming through and taking up my time and my docket and blah, blah, blah, right?

So they -- I think, Jean, you're seeing a community garden, and that tells a whole story to you. You can fill in a lot of those blanks.

MS. WILMA TOWNSEND: But they can't.

MS. KANA ENOMOTO: And other people don't have that.

DR. JEAN CAMPBELL: Well, it's a good public health model, the community garden is a good public health model to provide that example. And with the courts, and there is --

MS. KANA ENOMOTO: I think healthy foods and food deserts, I mean, that certainly it's an in general good public health activity. I think the question is why is that SAMHSA's space?

MS. BRENDA V. SMITH: But you know, Kana, it's really interesting because it's funny that you talk about sort of public defenders. So, for example, my husband actually works in a public defender organization. And about 3 months ago, one of the lawyers in the office committed suicide. Committed suicide because he felt like he was not successful, that he hadn't been able to do what he needed to do in order to sort of get a better result for the client.

And so, that whole organization has moved toward wellness and about -- and really about talking about -- getting people to talk about when they're not feeling well. Because I actually think -- and I think that you're right. It's very intuitive for us because I think most of us work in organizations that are very high stress, and so I totally get that connection. But I think that focusing on -- it's interesting.

What I see about the wellness language that's really appealing is that it's a more -- it focuses on resilience and building strength, which is much more hopeful. And the reality is when you're trying to do disease prevention, you want to give somebody something to focus on other than disease. You really want to give them something that's much more hopeful that they can look toward, and I think that that's --

MS. WILMA TOWNSEND: But I think that the issue that I think Kana is talking about is you're absolutely right. But when you're sitting at a Federal level, the question becomes is that the Federal job, or is that the job of the people that you leave it alone and let people in their communities come up with that? And we see it as part of the Federal job because it's a bigger picture.

MS. BRENDA V. SMITH: Absolutely.

MS. WILMA TOWNSEND: It's a much bigger picture, and people -- even when you talk to your lawyers, even if you talk to your husband's company, they're going to say we can handle this because we've set this up for wellness. We want people, da-da-da.

So what is it that SAMHSA then -- why are we in this business? And it's because it affects all of us, not just that person who was not, but even severely mentally disabled individuals.

MS. BRENDA V. SMITH: But I think it's SAMHSA's role to articulate that --

MS. WILMA TOWNSEND: It is.

MS. BRENDA V. SMITH: -- as a part of the services that you provide. It's just in the same way that drug treatment or pharmacological -- you know, better pharmacological tools. It's like strategies around wellness and what exercise does and what meditation does, what impact does that have on health, right? And so, and that's also an element of many treatment programs as well, right?

Exactly. Exactly. So --

DR. CAROLE WARSHAW: And I think, you know, one way to think about this is there's the whole public health focuses more on physical health, and there's no notion of public mental health except for treating people who have a serious

mental illness. And I think transforming, creating a notion of what public mental health and well-being is and how to promote that is -- and to build evidence around that, and what creates engagement?

Because part of what happens, you know, it's not just that someone has mental health symptoms. It's the social isolation and the lack of engagement in community and connection to other people, and to build social engagement and community. And so, there's other aspects, civic aspects of it as well as individual aspects that might be worth thinking about it and measuring.

MS. JOHANNA BERGAN: And telling a very specific story. So when we talk about young people who participate in a community garden, sure, we have a story. But the reason we share it is because they have created a mentorship relationship across generations, and we can draw specifically on the mentorship bodies of research that says it's okay, or we talk about the young people who are being trained in mindfulness. And there's a body of research that supports that's going to help the school environment with bully protection.

So we don't just talk about all the stories. You very strategically share which message that you kind of connect to a convincing argument. And we have been in communication -- my community is funded through W.K. Kellogg to do some food and fitness work, and we worked for a while with someone at the foundation of Wellmark Blue Cross and Blue Shield in North Carolina, and she specifically was helping us. We realized, hey, the insurance company should fund us because we're going to save them money because we're doing all these good things.

Nobody has connected those dots, rights? And we all believe them, but there is nothing on paper that shows that community gardens and more local food and removing the food desert actually saves you money in the doctor's office, even though we believe it. And so, she was really talking about this is what we need to see before this is going to happen, and here are the steps that you can participate in, in the community to get us to that argument where it will actually convince someone who doesn't have a lived experience.

MS. WILMA TOWNSEND: Thank you. I've got run back to the other place.

DR. JEAN CAMPBELL: I think we really moved the dialogue a step further with this conversation, and I think that that was really good.

MS. WILMA TOWNSEND: Thank you all.

MS. KANA ENOMOTO: Absolutely. Thank you. Thank you, everyone.

So we have a break, and we'll come back.

[Break.]

MS. KANA ENOMOTO: So, Operator, we are coming back online?

[Pause.]

MS. KANA ENOMOTO: All right. So I apologize. I've gotten a little bit off the agenda because I had some slight discrepancies between versions. So we are going to adapt.

And I'd like to ask Samia Noursi and Mary Blake to do their presentation on some of our intimate partner violence and trauma work that SAMHSA has been doing first, and then we'll go into an ACWS conversation. Carole will be our discussant on some of this trauma conversation, and then we'll let that evolve into an ACWS broader conversation around priorities.

I think that's probably a cleaner flow, and I don't want to cut you guys short on your presentation. So we will have about 45 minutes for this part of it, if that's okay? All right.

So thanks. Go ahead.

Agenda Item: Briefing on HHS Intimate Partner Violence (IPV) and Trauma Symposium and General Trauma Screening and Brief Intervention (GATSBI) Technical Experts Meeting

DR. SAMIA NOURSI: Can I start? Okay. So I'm Samia Noursi. I am with the National Institute on Drug Abuse. I will be giving you here a short summary of a symposium we held on December 9, 2013, at the NIH Neuroscience Building.

This symposium is focused on intimate partner violence screening and counseling. I'm one of the three chairs of the symposium and the whole initiative. I'm the third chair. Dr. Nancy Lee is the first chair as the Director of the Office on Women's Health, and the second chair is Dr. Marylouise Kelly from the Administration for Children and Families.

So some of you may know this information, but I'll just go briefly about why we actually held the symposium. As you all know that IPV is a big problem, and on average in the U.S. about 24 persons per minute are victims of rape, physical violence, or stalking by an intimate partner. So IPV affects more than 1 in 3 women in the United States each year, regardless of their age, economic status, race, ethnicity, or sexual orientation.

The research shows that victims of IPV often suffer from multiple lifelong health consequences, and they are -- can include emotional trauma, physical impairment, chronic health problems, and even death. IPV costs the U.S. approximately \$8.3 billion every year, and that's in combined medical, mental health, and lost productivity due to the injuries and illness.

A centerpiece of the Affordable Care Act of 2010, particularly Section 2713, articulate commitment to preventive services for women to screen and counsel for interpersonal and domestic violence. The IOM and the U.S. Preventive Services Task Force also recommended that IPV screening and counseling become a part of women's preventive health visits.

Dr. Koh, in early 2013, charged the Office on Women's Health with holding this symposium. At that time, I would say that was like in February of 2013, Dr. Nancy Lee from the Office on Women's Health and Dr. Mary Louise Kelly pulled various agencies to get together and plan for the symposium.

Next slide, please.

So the goals of this symposium, as we were asked to convene, is to review the body of evidence on screening and counseling for IPV in healthcare settings and the context of violence across the life span and also to encourage input from researchers, medical practitioners, Federal colleagues, and other stakeholders to provide insight on challenges and barriers to screening and intervention for IPV, with the ultimate goal of identifying gaps in research on IPV screening and counseling in primary healthcare setting and to develop ideas for new research to fill those gaps.

So the participating agencies were a large number of HHS agencies listed here in alphabetical order. Carole Warshaw was part of the meeting, obviously not as part of the Federal agency. But from the Federal agency, I have Sharon Amatetti and Mary Blake, who are part of SAMHSA.

Next slide, please.

So, as I mentioned before, about February 2013, we got together. We had one or two representatives from each one of the Federal agencies, and we discussed whether it's something that the agency can commit to basically in staff time. And we started meeting on a biweekly basis. This was a very time-consuming process, and we wanted to have the input of all the Federal agencies to ensure that their mission and goals are in the agenda of the meeting.

We also wanted to make sure that grantees and practitioners in the field who are working this area coming and presenting and listening to the presentations. The meeting was mainly supported by the Office on Women's Health at HHS, but all

the Federal agencies who participated in this effort provided some kind of support. Some traveled speakers, some helped with the graphics, with some of the printed materials.

But given that the budget was very low, we actually ended up doing most of the work ourselves, the staff, including registration of the participants the day of the meeting, et cetera. So, but it was a great -- I think it was a great collaboration effort across all the agencies involved.

DR. SHELLY F. GREENFIELD: And you had to cancel it once and redo that.

DR. SAMIA NOURSI: Yes, I forgot that. So the meeting originally was supposed to be held on October 4. And as you recall, the Government was shut down on October 1st. So thanks for reminding me.

[Laughter.]

DR. SAMIA NOURSI: I was trying to forget that.

DR. CAROLE WARSHAW: And didn't we have snow the day of the actual meeting?

DR. SAMIA NOURSI: Yes. So we were actually ready to have the meeting on Friday, October 4th, and then the Government was shut down. So we had to redo the whole thing again. Basically, contact all the speakers, contact all the participants, and you know, revisit the agenda because some of the -- we wanted to make sure some of the -- all the speakers can make it.

And it was a miracle. Everybody was able to make it because we jumped --

DR. CAROLE WARSHAW: Despite the horrible weather.

DR. SAMIA NOURSI: Oh, yeah. Right. And the day of the meeting was December 9, it was actually ice and sleet and snow, and the Government was delayed in opening. But we still held it. We said we have to do it.

So it was amazing. But honestly, I think that was really a testimony to the commitment of all the agencies involved. We actually came back on Thursday from the shutdown, which was October 9th, maybe? And then I get an email from Sharon, saying, hey, would you guys want to hold the meeting here at SAMHSA? And everybody went back, and we found a space, and you know, we met again. And within 2 months, we had the meeting again. So that was great.

So the agenda was a packed all-day meeting. We started at 8:30 in the morning, and we finished at 5:00 p.m. We had our keynote speaker was Dr. Jacquelyn Campbell. She basically wanted to discuss now that we know how to

screen, what does brief counseling look like? And that was her talk in the morning.

Then we had two panels throughout the day. The first panel was on identifying intimate partner violence in clinical settings, looking at client, provider, and system level considerations. We had three talks. That was an hour panel.

And next slide, please.

The second panel was in the afternoon, and then we looked at intervention in the clinical setting. We had five presentations, and we looked at some of the intervention programs that are out there and some of the intersection of IPV with other problems such as drug abuse and discussed some of the couple of base modalities that are out there. So that was the second panel in the afternoon.

Next slide.

We had a lunchtime discussion, and that was an important area that people felt that it needed to be discussed. And that is looking at survivors' perspective. We had Lisa James from Futures Without Violence and Amina White from NIH, and they brought up the perspective of the survivors and how they look at this problem. We also showed a video, I believe, a short video also on how to do counseling and screening.

When we were meeting from February until November, folks felt -- from the various Government agencies felt that there were many, many topics that they feel it's important to include during the day where people wanted to present or listen to. And due to the fact that it was only a day meeting, we decided to have breakout sessions where people can choose to either present at the breakout session or join the discussion.

So we had three -- four breakout sessions in the morning, one to four, and then we had five breakout sessions in the afternoon, total of nine breakout sessions. The logistics of coordinating it was challenging, and we had for each one of the breakout sessions three moderators. We had one Federal staff, and we had one researcher and one clinician.

And the sessions started with the moderator presenting 5 minutes each just to get the discussion going, and then opening it to discussion. They also had protocols to follow. Basically, we requested at the end of the session, they will present three or four gaps in this particular area that they feel the field has, what are the gaps that they identified? Because as you remember, that was one of our goals from the meeting is to identify gaps in the field. So we had nine breakout sessions.

Next slide, please.

I would like to just bring to you some of the highlighted discussion that we had. I have to start by saying I believe that we had very rich discussion throughout the day. It was a great meeting. Everybody, we had surveys, and people thought they got a lot out of it.

So I will not be able to share with you with all the information that we had from the meeting. I have a report that just finished, and it's 50 pages. So I sure cannot give you all the information, but it will be available very soon, and people can access all this information. So I'd like just to highlight some of the information that was discussed.

This slide are from the actually presentations from the panel, not the breakout sessions. So some of the information that I shared in the beginning was emphasized, how 35 percent of women report physical violence, rape, or stalking by an intimate partner at sometime in the past. That's a very large number of women, and we're talking about sometime in their life.

We did -- have made some advancement in protecting of our victims from IPV. As I mentioned, the U.S. Preventive Services Task Force and the ACA, they both include and encourage for screening for intimate partner violence.

So how do we define screening? There was some information about how do we define that? So it is a use of a test, examination, or other procedure that is rapidly applied to identify individuals with early disease, such as IPV-related health issues, to prevent morbidity and mortality.

So we did make some advances. We know what screening is. But there are some barriers that still exist that prevent effective implementation of IPV screening and counseling, and some of those are, for example, lack of sufficient evidence-based intervention and exclusion of the victims during their own screening and intervention. That was a big issue that really prevents from having effective implementation of IPV screening and counseling during these sessions.

Gaps in research about IPV identification that were presented during the meeting by the speakers on the panel include, for example, defining what are the best practices for identifying risk and diagnosing IPV, moving beyond the choices of best words to use and looking more at the clinical facilitation of spontaneous unprompted disclosure as one of the questions.

What is the best way to train professionals to provide appropriate and ethical care for an adult or child victims? Do screening approaches differ in different healthcare settings and for different populations? With regard to intervention, how can harm reduction counseling be improved? How can the connection between the clinical sites and community resources be improved?

As I mentioned, there were nine breakout sessions, and the morning breakout sessions were focused on screening and assessment of four topics, and the afternoon were on counseling and intervention. So some of the highlight discussion from those breakout sessions in the morning were, for example, what do we know about screening and assessment?

There was a consensus that we know, for example, that evidence supports routine screening. Multiple brief screening tools have been tested and validated. There are several.

IPV impacts multiple physiological, neurological, and behavioral systems and causes varying adverse health effects. I'm sure all of you would agree with that as well. Provider education is necessary. That is not sufficient.

What do we need to know about? We need to learn more about -- that's with regard to screening and assessment. We need to know more about disease pathways to better inform IPV intervention, diagnosis, treatment, and management. We need to know more about outcomes of patients.

We need to learn more about tools on processes, if there are harms that result from screening. Cultural factors, sexual minority populations, we don't have information about those very much, and survivors' perspectives.

In addition, how to normalize universal IPV screening and intervention. How to link electronic health records while maintaining the confidentiality of the patients. How to expand IPV screening to include lifetime exposure of violence. And finally, ways to include men to share in the burden of prevention of harm.

With regard to counseling and intervention, we know that interventions have been tested and proven efficacious. We know that IPV and history of trauma affect multiple health systems and should factor in diagnosis and treatment of chronic and acute conditions.

We know there are effective trauma intervention, and they are based -- most of the ones are based on -- I'm sorry. Let me just back up. What we don't know is we don't have information about participatory research. We are missing information about multidisciplinary intervention, about comorbidity, about health intersections. For example, how IPV intersects with drug abuse, substance abuse. We have some information, but it's not clear. And we need more research on use of technology to improve screening and intervention.

Participants during the breakout sessions noted that there should be given a special consideration and focus on protecting patient confidentiality and safety when balancing specificity and efficiency in a healthcare setting and need to build relationship between provider and patient to encourage disclosure and participation during screening and treatment.

I want to keep going. I know I have only 5 minutes. So let's -- okay.

So I went back and looked all the notes from the presenters during the panel as well as the breakout sessions, and given that I work for the National Institute on Drug Abuse, that doesn't mean that NIDA is going to support this. But as a researcher, there were four areas that are big areas, but those are the four areas of research that needs to be looked at.

Develop improved screening and tools and patient care practices. Tailor intervention and treatment to patient and delivery settings. Develop improved prevention for IPV, and we need to fill the knowledge gap in IPV surveillance data and clinical research. I have detailed information about that. If any of you would like that, I will be happy to share my notes.

So the recommendation of the day is to change the role of IPV screening and counseling in patient assessment by healthcare practitioners to determine how to train providers to diagnose and counsel. We need to improve or enhance ways for performing screening. Very important to include survivors' perspectives. And need to look at system-level interventions not only at the individual level.

I think the next slide, please. I'm sorry I have to rush a little bit.

Screening for IPV, this is not an extra job. Jackie Campbell mentioned in the beginning of her keynote, and I think that was something that resonated with a lot of people, it's not an extra job. This is the responsibility of the healthcare provider to screen for IPV.

It should be treated as a health problem. Sometimes when the IPV -- the person who has an IPV come to the doctors, the doctors forget that they may have other problems and not just IPV. So that's important to look at the holistic, the life of the person and not just as only this particular issue if they discuss it with them.

I did talk about the survivor and the system-wide change is essential. I think there's one more slide?

MR. JOSH SHAPIRO: Yes.

DR. SAMIA NOURSI: Okay. So before I wrap up, I just wanted to say that we have several resources that were developed and are actually being developed in the process right now. And they will be all posted on the second bullet. The first one we actually videocasted the meeting, and it's archived now at the NIH Web site. So you can listen to the entire meeting.

We have a Web portal that's sitting on the National Library of Medicine. We developed a Web portal, and it includes all the meeting material. And we are in

the process of obtaining or, what do you call it, going through the 508 compliance of all the slide presentations. Yes, 17 of them.

So, as soon as they're done, they will be posted on this Web portal, and we developed a fact sheet on violence against women. It's also posted there on the Web portal, and another two things that I forgot to mention here is we were asked -- we were invited by the Journal on Women's Health to host a special issue, get a special issue focused on this area. And this special issue is being developed, and it will be published in the fall of this year.

So look for that, and we will link to it, but I don't think we can put the whole thing because of copyright issues. But it actually highlights all the talks of the day, and we have a lot of -- everyone who is coauthoring an article there actually was at the meeting. So this is very exciting.

And Sharon and I, after the meeting, we realized that the area of interpersonal violence and drug abuse is not fully delved into. So we both are co-chairing a working group, an interest group that we meet every other month, and we have how many members? A lot of --

MS. SHARON AMATETTI: I think we have about 13 Federal partners.

DR. SAMIA NOURSI: Partners.

MS. SHARON AMATETTI: Federal partners.

DR. SAMIA NOURSI: Right. Federal partners that are meeting now and discussing about all the work we're doing and hoping that we can come up with some ideas for joint efforts, but also to be about to disseminate some of the information that we are learning.

But the main thing that I would like to say is that I know there is perception outside that the Federal agencies don't know how to work together, and I think that was a testimony to how we really work so well together. It was a great experience, and we are actually working on several activities right now among many of us. So that was a great thing to do.

So that's it. And again, I will be happy to share more of the details. I'm sorry I had to rush, but as I mentioned, there's a lot of information. But if you keep your eye on the portal, you will see, hopefully, the report published very soon.

DR. CAROLE WARSHAW: Right. I think the portal that had the information, prior to the meeting also had a lot of really useful information.

DR. SAMIA NOURSI: Yes. Definitely. Definitely. We developed an annotated bibliography about all the screening tools that are out there. It's posted there.

All the Federal agencies that participated, they have a link, and all the information about their agency with the work they're doing on IPV is posted there. So it's a great resource.

That's all.

MS. MARY BLAKE: That's all?

[Laughter.]

DR. SAMIA NOURSI: Thank you.

MS. MARY BLAKE: Great. Thank you, Samia. That really was actually a wonderful process to be involved in on the planning side, and it was really an amazing meeting. And so, kudos to the three co-chairs, and SAMHSA is really looking forward to our ongoing collaboration on the issues of IPV screening and counseling.

You're going to see that there are synergies in what Samia has just talked about and what I'm about to talk about. And just to provide a little bit of historical information, which you all know, I believe, because I think Kana discussed it last year?

MS. SHARON AMATETTI: Well, we do have some new members, Mary. So not everybody heard.

MS. MARY BLAKE: Okay. Great. Well, over the last few years, SAMHSA has included or the President's budget has included a grant project called Grants for Adult Trauma Screening and Brief Intervention. And to date, it has not been -- it has not been funded.

And so, this year, the Administrator tasked our trauma and justice strategic lead, Larke Huang, and Larke has asked me to work with her on this, is to do some groundwork around general adult trauma screening and brief intervention in the event that a program would be funded down the pike or just to kind of further develop recommendations for an approach to general adult trauma screening and brief intervention. And why there's so much synergy is because the IOM report that Samia was talking about, talked not only about the critical issues of screening for intimate partner violence but also addressed a need to really take a look at prior trauma.

SAMHSA's interest in this area is to really identify essential elements and approaches for screening adults. So it's not focused -- or at least our work this year is not focused on women, although women are a big part of the discussion. What are the essential elements, and what do we know and what do we need to develop around screening for trauma more broadly speaking in primary care

settings?

So when we were tasked by the Administrator to see what we could do to use -- to leverage existing resources, no new money for it, we determined that we were going to host an initial meeting of experts, a small meeting of experts, drawing upon some of the work that had been started with the IPV symposium, but also experts who were looking at other aspects of trauma across the life span. Start with a meeting to bring everybody together, and then follow up that meeting with between four and six virtual meetings with a purpose of developing some products or tools that can inform our work.

I am going to jump around on this slide, and I'll tell you the reason is that in your handouts, you've got the full 40 or more slides. What the presentation has is the kind of the outline of what our experts meeting was and what the charge was, but also includes all of the speed presentations delivered by our various experts that were asked to present on the topics.

So I'm going to -- thank you. I'm going to ask -- I'm sorry?

MR. JOSH SHAPIRO: Josh.

MS. MARY BLAKE: Josh, thank you, Josh. I'm going to ask Josh, I'm going to tell him what slide to move forward to. I'm not going to stop on every slide, but you have this rich material to see what some of the content that was discussed at the meeting is.

So, for right now, what I'd like to do is just walk you through the agenda. So we can go to the next slide. This was a day and a half meeting. The beginning of the meeting really started with a welcome and an overview of the goals of the meeting. I'm going to articulate the charge to the group, but it's on a later slide. Right now, I'm just going to review it.

The charge to the group was to identify best and promising practices for trauma screening and brief intervention in primary care and other health settings. So we brought in experts who were working in health settings beyond primary care, even though our interest is to really further knowledge in the field around screening and brief intervention in primary care.

Second charge to the group was that through this experts meeting, which was the launch of our GATSBI initiative, over the year was to integrate best practices in developing trauma-informed approaches. So trauma-informed approaches to screening and brief intervention. So we're looking at the interventions, but also in the way the interventions are done.

To identify gaps in areas for further research and inquiry related to screening for trauma. And screening for trauma is a very broad, a broad thing to tackle, and

we'll tell you how we outlined the agenda for the meeting to kind of get at that.

And then, the fourth charge was to provide a framework for developing a model or to move forward with essential elements around screening and brief intervention in primary care.

So that was the charge to the group. That's how we led off the meeting. And then we did a brief round robin where we allowed the experts, because we had about 25 experts there -- oh, and I did want to mention we invited key Federal partners from CDC, from NIDA, from Office of Women's Health, from HRSA. So a number of our key Federal partners who are looking at these issues also participated.

We asked our experts to go around and to describe -- to describe one essential element on the topic that they wanted to lead off the meeting with as part of their introduction. We then went to four broken-out sessions, speed presentations, followed by 45 minutes of discussion among all participants and then 15 minutes of discussion opened up to our Federal partners to join the discussion.

The first listening session was really looking from the experience of people who are trauma survivors. We asked them to talk about their experience around screening and brief interventions. And then we moved into looking at program models for screening and brief intervention, then we went to trauma informed. What are the environments? What do we know about establishing environments and practices or methods of engagement that are conducive?

So if we could go to -- if we could go to slide 6, please?

So when we asked our lived experience panel when they were setting up their speed presentations, and we worked with our panelists prior to the meeting, we asked them to lead off the meeting, to talk about from their experience what makes a healthcare setting safe or empowering? What factors might impact what you would want to share or not share about your experiences in your life, in particular your traumatic or adverse events? And in what ways is it helpful or not helpful to be asked about these experiences?

So that was the charge to the first group of speed presenters. We had very robust discussion that followed that. You can take a look when you get home at the slides that were put together by each of our speed presenters to get a sense of the direction that they were going in.

A lot of the issues that came up were on how their prior experiences in healthcare settings might impact whether they felt safe or not, and that needed to really be taken into account when we look at engaging in screening and brief intervention in primary care is that prior experiences with healthcare matter.

The other thing that came up is, you know, the need -- or the idea of how we use language and how we ask the questions. Why are you asking? Why do you want to know? And what are you going to do with the information? A lot of that also came out in the IPV symposium, really important issues to be looked at.

And really the importance of the engagement piece. Rather than just asking a question and staring at a computer screen or at the form you're filling out, what is the manner of the engagement is really helpful, especially when you're asking people about their life experiences.

So I'm going to ask Josh to forward us to slide 14 because now I'm going to -- sorry, 15. There we go. Keep going, 14, actually. But keep going. That's it. Oops, that's it.

All right. Our next two speed presentation sessions were focused on experiences of program models, different approaches that are being used around screening and brief intervention. We recognized that we had people from an array of settings. We had people from HIV treatment settings where health screenings and IPV screenings and other types of screenings were routine. We had a presenter from Kaiser Permanente, who's implemented a really interesting approach to screening for intimate partner violence in healthcare settings. Brigid McCaw was one of our speed presenters.

We asked people from primary care. We had some people from primary care settings and some people from family, like community-based family healthcare settings where they're looking not only at the adults, but the implications of what's going on with the adults on the kids.

So we wanted to get a sense of what is the setting you work in, who are you screening, and for what? Some people are screening for IPV. Some are screening for adverse childhood experiences. Some are screening for, you know, abuse in childhood. But different people were screening for different things.

We wanted to know what do you do with what -- why are you screening? We know that you're -- you know, what are you going to do with the information, and what do you hope to achieve once you get that information? So is safety the goal for your initial screening? Is that your first goal?

Is it you're really looking at identifying risk factors for future violence? Are you looking at health outcomes, and how are you determining what outcomes you're hoping to achieve by asking questions about a history of abuse in childhood? You know, what does that mean? How does that --

So our presenters had very diverse experiences in terms of what they were doing around screening. We were also asking them how do you use the information

you gather? And what's your decision-making process for what you do once you get certain types of information? How do you know to do a brief intervention or to refer? And where would you refer, and how would you know where to refer?

So these are all very complicated questions. So you can see our first series of speed presenters were Richard Mollica from the Harvard program on refugee trauma, and he was really talking about some tools that they've developed for diverse cultural -- cultural environments in healthcare settings. We had Dean Kilpatrick and we had Brigid McCaw, and you have their slides for their speed presentations.

Our next set of presenters for these -- for answering the same questions were -- we should have that. Were -- I don't see them listed here, hold on. Oh, yeah, on slide 23, Barbara Niles, Teresa Descilo, and Todd Rentschler, and you have their speed presentations.

Our final round of speed presentations took place later in the day. And if we go to slide -- sorry. Thank you. I'll let you know what were some of the questions that we were asking them to think about as they were developing their speed presentations. And those questions really were what kind of change process is necessary? So you can go to the next slide.

What kind of change process is necessary to create a trauma-informed -- uh-oh. We want to go back. I'm sorry. What kind of change process is necessary to create a trauma-informed medical setting? How do you assess organizational needs and strengths? How do you look at workforce development?

So these were some of the questions that we asked our presenters on trauma-informed environments to focus on. What are the workforce needs? One of the things that we learned from our presenters and we also know from the work that was done on the IPV symposium is that primary care physicians are not comfortable for many, many reasons asking questions about current or prior abuse or violence or adverse experiences.

One is that they feel it will take a lot of time, and they don't have that kind of time. Number two, they don't want to open a can of worms. Number three, they don't really know what to do should somebody say yes. These are just some of the issues that come up in the primary care settings, and they're important issues because they're all very real.

And so, our presenters around the trauma-informed care or trauma-informed environments really started to talk about the fact that workforce development is a major area that needs impetus, and it's also something that came out in the symposium on intimate partner violence. In some ways, it's even a larger lift to get doctors to understand the value of it when you're asking about abuse or trauma that happened many, many years ago because they don't quite make the

connection.

We ended the first day really looking at what were some of the core issues that came out of these three different sectors of speed presentation: survivor experience, practice models for screening and intervention, and environmental and engagement factors related. And then we asked them to dialogue a little bit about from their perspective where were there gaps and where were the areas for further discussion needed?

We then went into our second day of the agenda, and that is on slide 42.

And that day, we had opening reflections, and then we went into a round robin facilitated discussion, where do we go from here? What we wanted -- what we wanted our experts to do was to help us think about designing what the next steps would be for the GATSBI initiative. What are the topical areas for further discussion in our virtual meetings?

What are the products that might be most useful to the field to be generated in this fiscal year as a result of this engagement? Who are the people that we need to invite into the rest of our discussions over the course of this year as we think about identifying these critical essential elements for screening and brief intervention?

And so, where we are now is we are just working on our summary report of the experts meeting and laying out a strategic plan for the rest of the year. We're going to share that with the experts who participated with us, get their comments and feedback, and then align an agenda for the rest of the year, in particular identifying what are the product needs.

And then -- and then we will have a summary report of the actual meeting that launched the initiative, and then we will engage with our Federal partners as well to look at kind of the developments that are happening, for instance, in the area of looking specifically at IPV so we're not duplicating our efforts. And then we'll see what happens next year.

And I don't know, Kana, if there were anything that you wanted to jump in with at this point?

MS. KANA ENOMOTO: No.

MS. MARY BLAKE: Okay. So that's where we are with this. It's an ambitious agenda. We got really great feedback from our Federal partners, as well as from the experts who participated. Carole Warshaw from our advisory committee was part of the expert panel group.

So thanks very much for the opportunity to present.

Agenda Item: ACWS Discussion

DR. CAROLE WARSHAW: Okay. So a few comments. I wanted to say that the way that you structured that meeting with the speed presentations, which left a lot of time for discussion, was really great because it was a meeting of a group of experts. And it allowed a way to frame the discussion and also starting with people who had lived experience with trauma to start off really made a difference and draw out the issues in a very real way into the room and really reshaped the whole conversation.

And I think the questions that came up at both meetings about why are you asking, and what are you going to do with the information? How is that going to help me? And concerns about is this going to further stigmatize me? Is this going to generate a judgmental response? Is this going to force me into mental health treatment and medication? What do busy primary care providers do? They write prescriptions.

So there's a lot of thoughtfulness about what are we doing and why. And the same thing for IPV screening, there's been a lot of work done for the last -- since the early '80s on how to do it, what to do, and it's really educating the workforce around how to do it well, how to address issues of confidentiality. They're screening tools. And I think one of the mistakes we made early on in calling it screening to make it more palatable and medicalized was that screening is something you do to someone, and it's not how do you engage in a relationship that makes it safe enough for someone to want to tell you.

You know, in some of the work we did early on, people would come in. Maybe they'd be asked seven times before they disclosed when it was the right time for them, when they thought about it, and when it was the right person. Because people assume that when you ask, then you're supposed to do something about it to change their life. And if you don't, then there's a problem. You know, thinking about when someone asks you a question and when you feel like you're going to be perceived differently.

So there's lots and lots of issues. And I think so the issue around trauma-informed care is really critical. It's like how do you help people train the workforce and create environments that health providers ask in ways that they're not going to react, and they're going to manage their feelings not at the expense of the people they're talking to or at the expense of themselves and their lives. And that's -- that's very labor intensive. It's very relational, and it's very often antithetical to the culture of medicine.

And so, thinking about smaller programs where people like Eddie Machtinger,

who does a women in HIV program, or where there's a cohesive group of people who really are engaged together and can create a different environment, thinking about that in a whole system-wide approach is much more challenging and thinking about how to do that.

So it raises lots of questions. And you know, thinking about the intersecting issues and how do you move that forward and how people think about this. So there's the intellectual part that raises awareness, but how people operationalize it and how you have the ongoing supports in clinical settings.

You know, when I used to run the behavioral science treatment for primary care residency, it's like we were there with the residents. We had a support group for them. We had lots of opportunities, and we videotaped. We could come in the room while they were talking and help model how to do that differently.

And so, it's really thinking if we want to think over the long run about how to transform healthcare so it's more integrated, it's thinking about all of those levels and who provides those supports from the ground up. So, and the other issue is what kind of interventions do you have in place?

I think one of the things that Futures Without Violence, Lisa James' work is developing more tailored interventions that moving from more general interventions to someone is in a reproductive health setting, asking the questions about reproductive coercion, having some brief interventions related to that and warm referrals so there's someone that you can make the connection with. Working closely with domestic violence programs in the communities so that there are those resources often onsite in healthcare settings makes a difference when you think about general trauma screening.

What do you have in place there so it's not like then you have to go someplace else. So it's a lot of layers, but it's also, I think, really exciting times to be thinking about how to do that in a more holistic way rather than in a piecemeal way.

And I just want to say that your pulling together all of that information is amazing. You know, because people in the workshops, people -- it's like kind of random conversations of people with ideas all over the place that didn't get -- you know, got captured on butcher paper, and you turned it into a report.

DR. SAMIA NOURSI: We actually ended up sending the notes to all the speakers and all the breakout session moderators to take a look at the notes that we have and have them edit them, and then we took them back. So that's why it took us such a long time to get the report out. So it's there.

DR. CAROLE WARSHAW: Well, yes. But I just want to say that there's been a lot of work going on around what -- how to do screening and intervention. I think part of the motivation I know from the Family Violence Prevention and Services

Administration part of this was there's not a lot of research to support it, and research has not been funded. And part of why there hasn't been a lot of research is because it hasn't been supported to look at the impact of interventions.

And a while ago, the U.S. Preventive Services Task Force downgraded screening for domestic violence, for IPV to a C, there's not enough evidence, when it's like why wouldn't we ask people about what's happening in their life that's affecting their health, mental health, and well-being? You know, you don't have to have the evidence for asking about chest pain or headache.

So because we were talking about screening, it lost what it's really about. So it's, again, taking that step back about what people are going to think about.

DR. SAMIA NOURSI: So we are hoping with regard to our meeting that the various agencies, the Government agencies, nonprofit agencies, that they take a look at the gaps that were identified in the report and say, "Oh, we can do this." Obviously, the Office on Women's Health at HHS doesn't feel that this is their meeting. They came up with the gaps. Dr. Nancy Lee was very clear. I'm hoping that agencies will take a look at the report and say we can take that part. We can fund that part. So given the scarce resources. So --

DR. CAROLE WARSHAW: One of the things we'll be doing, I was mentioning to Samia, is developing a webinar series and modules on mental health and DV, mental health trauma in DV and substance abuse trauma in DV in the next year. So we'll have those, but also you'll have the Office of Women's Health developed with Futures, and we worked on the mental health one, a series of e-learning modules with videos that are being evaluated before they can put them out in the world. So they'll be -- I think they developed them for a lot of different settings so that people can actually see how you actually do the asking, inquiring, those kind of things.

DR. SAMIA NOURSI: Right. I think a lot of the healthcare professionals, you know, social workers, clinicians, always look for, you know, further education, if they want CMEs. So we're hoping some modules will be developed to take those and offer CMEs for some of the professionals based on that information.

DR. SHELLY F. GREENFIELD: I was just going to -- so I appreciated very much Carole's comments because I agree that how multilayered all of this is. But in trying to just think about what some of the goals are with regard to the healthcare system and what the group would like to accomplish over time, the issue around the U.S. Preventive Services Task Force on screening, I forget what the statistic is that the primary care physicians say, but if they did all the screening that was just recommended after A, they would spend about 2 1/2 hours to just do that, and they would never get to anything else.

And so, the burden on them, you know, is fairly significant. And lest people who are interested in IPV feel isolated, this is the exact same argument about screening and brief intervention for alcohol and substances, and it's been the argument made that, A, we don't know what to do; B, we don't have the time for the last 30 years. And it's in the literature, and you see it over and over again.

So one of the issues is systemically and systematically what can be done? And one of the things that Carole was just saying, which I thought was really important, is just this idea of how you build something that's very relational to allow people to know that there's a safe environment provided so that when they have -- when they get to the place where they feel like they wish to communicate, they know that there's a safe place for them to do it.

Because you cannot push people to -- it's actually fairly adverse often to push people to disclose things prior to -- there's two sides. One, you don't want people in unsafe environments, and you want to be able to help them bring forward an unsafe environment so you can intervene. But two, you also can't push people to disclose things that will actually make things worse for them. So how you within a very busy primary care arena begin to build a setting of safety so that people feel that they can do it.

Just one quick thought I had is just, and I'm sure this is already being done. So it's just the idea around whether you can administer within the healthcare setting or you pilot some very, very brief computer-based things for people to do that so they can -- and it doesn't have to be that they're disclosing anything. It would just more be an interactive, here is one of the things we think about. This is how it affects people's health, blah, blah. This is what your practice is interested in. If you should ever encounter these circumstances, blah, blah, these are the people you could talk to in the practice. We have people who are --

You know, that way, you're not asking people to disclose anything, but you're giving them permission and you're also giving them the signal that if they wish to, there's a safe place. And people -- and that often provides the safe setting for people to feel like they can relax.

MS. MARY BLAKE: You know, it's interesting that you bring that up because I think a major point of interest that came up in our GATSBI meeting was brought up by Brigid McCaw and Dean Kilpatrick, was exactly that kind of tool. And we actually think that we may focus one of our more intensive discussions right on that. And I think there was a lot of synergy in the room conceptually around that. There's already been some work that's already been started around that.

So that's a very interesting thing. And I think the other thing that came up is really looking at how, you know, looking at that relational model, but also how do you provide the education to the primary physicians and to the medical school training they receive that allows them to take a universal precautions approach?

DR. SHELLY F. GREENFIELD: Yes.

MS. MARY BLAKE: Which is really building in a deeper understanding on the prevalence and the impact of violence and abuse and trauma on patient health and well-being so that whether they ask or not, when they start to see certain things, they might be more aware and more sensitive.

DR. SHELLY F. GREENFIELD: So this would be my fourth episode of talking about workforce development and the investment that should also be made in physician and medical student education, which currently is not funded in these arenas for behavioral health and substance use disorders. And that in fact, given the role that physicians play in all these primary specialties, to continue to complain about their lack of education without investing in resources to actually provide it is not really fair, frankly. So I would just make that point.

MS. MARY BLAKE: Duly noted. Thank you.

DR. CAROLE WARSHAW: You know, I wanted to just build on what you both said because I think truth is there are some places where -- like Deb Houry's work at Emory, where there's a kiosk in the emergency room. So the idea to screen and identify is the idea to provide information that allows people to feel like -- to think about their choice about disclosing it.

One of the things that really struck me while I was doing some work for a talk at Brigham was an article around there is literature on working with survivors of childhood sexual abuse in primary care settings and OB/GYN settings. And one of them, someone was saying we want to be informed that we're going to be asked so we can determine the provider's readiness to hear.

Because we always think about the patient's readiness to change and to really -- you know, what makes it safe. So this really struck me. So the idea of universal precautions is when people understand the pervasiveness of trauma and its impact, it's not only when certain things come up, but how do you say, talk about are there things that have happened in your life that might affect how you experience this procedure?

So do it so people don't feel like they have to disclose, but that you assume that people may -- that any kind of medical procedure may be potentially retraumatizing or all the things about standing up and whether they're sitting down or they're undressed when you have your first conversation. It's like thinking through, going through all of those things that would change how you do clinical services. And so, that universal level is something that could be, you know?

Other thoughts?

DR. YOLANDA B. BRISCOE: Another example of SAMHSA modeling what they tell everybody else to do, collaborate, collaborate, collaborate. So I'm very pleased to hear that you continue to do that. It's not easy to get -- it's certainly not easy to get everybody together at the same time and for everybody to work together for a common cause. You do this, and you do that. You have money for this, and you have money for that, and let's see how we can do something about one out of three because that's significant.

DR. CAROLE WARSHAW: But I also think that some of the work on the IOM and the U.S. Preventive Task Force came from advocacy efforts to make that a priority issue and that that helped drive that. I think it was mostly women who are part of our interagency group who are committed to actually making a difference. And so, there's -- you know, I think the work that you've been doing around the women and trauma, the interagency group, for the last couple of years also built some of that collaborative structure that was already in place when these issues came up.

So I think --

DR. SAMIA NOURSI: And you do have a lot of representation from all of Government agencies, not just HHS and the women and trauma workgroup, right?

MS. MARY BLAKE: Yes, I've talked to this body about our Federal partners committee on women and trauma, which has been around for 4 years and has really done some awesome work. We have over 33 agencies represented on that, including Department of State, Department of Education, HUD, ACF, multiple bodies within NIH. I mean, it's --

DR. SAMIA NOURSI: And Labor, DoD.

MS. MARY BLAKE: -- really DOJ, DoD. And actually, Department of Labor assumed the chair of that committee when Susan Salasin retired, and I came in as the co-chair. So, I mean, it's really great. It's really owned by -- this committee and the work that it does is owned by so many of our Federal partners. So, yes.

DR. SAMIA NOURSI: I think when it comes to those, I mean, I've noticed that when it comes to issues that are woman specific, there's a lot more collaboration. Seriously.

[Laughter.]

MS. MARY BLAKE: And we also bring cookies and coffee and -- it's true, seriously.

[Crosstalk.]

MS. MARY BLAKE: We know about quality of life, quality of life at meetings.

DR. SAMIA NOURSI: Thank you.

MS. MARY BLAKE: Great. Thank you. Collaboration.

[Laughter.]

MS. KANA ENOMOTO: Thank you guys. Thank you.

[Pause.]

MS. KANA ENOMOTO: So I do appreciate this conversation as well. I think the trauma screening effort is less -- you know, I think what was the motivation for doing that? It was a theme that you guys have brought up many times is that catching things earlier is better and provides you a greater chance of helping a person avoid negative outcomes and achieving positive health.

So the idea behind GATSBI in the first place was we sort of wait until people show up with the heart attack before we ask about their blood pressure. Because we wait until they're in criminal justice, we wait until they're in child welfare, we wait until they're in residential treatment or in a psych hospitalization, then we ask them about trauma. So we know how to do trauma-informed specialty care. We're getting very good at that. But, gee, why did we have to wait until now?

So screening was the place where we went to because, gee, wouldn't it be great if we could catch it in pediatrics, in OB/GYN, in primary care, and other places? However, but there would be no loss if we found out some other way of creating safety so that the information could come out earlier for people before they get hospitalized, before they try to commit suicide, before they get arrested.

And so, if that's through patient education or public education and creating safe spaces for people to -- and providing tools and skills for people to hear the information in a positive and constructive way, that would also be a success in, I think, our minds. So it's not about creating the perfect screening tool and the perfect brief intervention, but it is about creating evidence-based ways of problem identification and risk identification that can lead to changing the trajectory for -- in GATSBI's case for women and young women.

MS. BRENDA V. SMITH: Just one question. Do we ask these same questions of men?

MS. KANA ENOMOTO: What, trauma questions or --

MS. BRENDA V. SMITH: Yes.

MS. KANA ENOMOTO: This meeting, the GATSBI meeting that they had was men and women. It wasn't limited to women. The GATSBI grant program request is based on the IOM recommendation. And since the IOM recommendation is for universal screening of women for IPV, including past histories of abuse, that is focused on women. But the work that we're doing before we get those grants or that funding for those grants is more broad.

MS. BRENDA V. SMITH: Yes, I ask, and obviously, a lot of my experience is with women and trauma, but certainly one of the things that's coming out of some of the data, specifically given the work that I'm doing with boys and sexual, it is that there is a lot of experience of trauma both for women and for men that they never talk about, and nobody ever asks them any questions. So --

MS. KANA ENOMOTO: Sharon, do you want to speak to this?

MS. SHARON AMATETTI: Just that, yes, that was coming out for us also in a lot of our initiatives and meetings and planning. We did hold a meeting that Mary Blake and I oversaw last summer on men and trauma and histories of trauma to try and understand that a little bit better. There are some proceedings from that meeting, and SAMHSA has actually formed a men's coordinating committee as a result of that meeting to help bring out those issues across SAMHSA programs. They're getting a little bit of a slow start, but we're trying to mentor them along.

MS. BRENDA V. SMITH: And it's hard because the fact is, is that violence against women gets so normalized in certain kinds of ways, and so I just you want to -- you know, it's important that this space where we're talking about sort of women's services that you're really talking about that. There are so many things that we're doing for women that really do have some particular applications for men who are also very much underserved in the trauma stuff.

So, for example, a lot of the work on sexual violence in custody has really been around trying to find trauma services for men who experience sexual victimization in custodial settings, and there's just not a lot out there in terms of men's services in trauma. So sort of think about that a bit.

DR. CAROLE WARSHAW: And one of the things people have been thinking about that there's been a lot of attention around, around for men who are perpetrators who are also victims of trauma.

MS. BRENDA V. SMITH: Right.

DR. CAROLE WARSHAW: How to factor that in in a way that doesn't feel like

it's excusing men for being perpetrators and holds them accountable, but also understands, helps them understand the root, particularly when there's racism and oppression that's layered into that experience. We need to look and kind of like think about that to help shift their perspective.

Well, when there's actually a community that's cohesive that people want to stay part of, there's leverage when there isn't in other places, and how do you help create that when it doesn't exist? You know, there's a lot of --

MS. BRENDA V. SMITH: I raised that because I'm thinking about that very hard. One of my sabbatical projects is trying to sort of parse out sort of female staff victimization of boys in custody. And so, I'll be in contact with you, Sharon, because maybe that would be helpful.

DR. SHELLY F. GREENFIELD: I also didn't want to leave the misimpression that I -- that using the tools where we usually call them screening tools, you know, are ineffective for people in healthcare settings regarding trauma experiences. But I thought that Carole's point that it needs to be sort of the context around which you are providing, asking those questions needs to be carefully attended to.

I think, actually, there's a fair amount of data that shows when you present a person and women in the particular with the questionnaire, often they're actually fairly self-revealing in a questionnaire about their experiences. I just think you want to make sure you're building around that appropriate context that's safe for them to say those things so that you've got both things going at the same time.

And sometimes screening and brief interventions, you know, there is just sort of an idea you do this one-time thing, you screen this thing, and then boom. That's not really exactly going to be the right approach for trauma, I think, of any type.

DR. CAROLE WARSHAW: Yes, I think it's like what you were talking about that provides information that then people can choose where to reveal because some of the people think, oh, you're screening at a kiosk. It's anonymous. People are more comfortable talking and turning to a computer. And then you hand it to -- it goes directly to a provider who you may not want to know, as opposed to you choose then whether.

It also raises the issue around electronic medical records that we're trying to do some work around and how to incorporate questions but also with pop-ups that provide responses and referrals and information, but also thinking about sequestration of sensitive information. Like one of the things for electronic health records with domestic violence, that even having an address might be a disclosure that's unsafe. You know, not just sequestering information that's sensitive and choosing which providers have access to that information.

I was talking with someone, Cindy Southworth, who's at the National Network to End Domestic Violence, who does their tech safety stuff, and she said that HHS hadn't -- had been reluctant to issue any guidelines around compartmentalizing any information that's sensitive at this point because there's controversy around physicians saying we need to have access to all information because, otherwise, people might not get treated well, and patient safety and privacy groups saying we want to have control over who sees what.

So I was wondering what the status of that was or what was coming up.

MS. KANA ENOMOTO: Well, tomorrow, you'll have the opportunity to stop by and talk to Dr. Clark about our HIT initiative. And you know, I think we've actually been leading some of the work around data segmentation from IIC.

DR. CAROLE WARSHAW: Segmentation, not sequestration, right?

MS. KANA ENOMOTO: And giving how do you -- what are the "break the glass" thresholds for person is unconscious, I need to know what I need to know before I administer medications versus how do people decide which information they'd like to share with whom.

And you know, a couple of years ago, it was a moot point because we didn't have the technology to do it, and I think some of the investment in technology development that SAMHSA has done along with the private sector vendors, we are getting closer to having those tools that people can use.

MS. JOHANNA BERGAN: At one point, there was a group in Maine -- don't ask me details -- that was developing something like the kiosk, except it would -- you could just do it at any computer, and it would print out a report for the individual. And it didn't go to anyone else. And then the individual, it was focused towards transition age youth. When they saw all their thoughts on paper in front of them, were better able to prioritize the visit to whatever doctor they were about to see.

And I don't know that it ever went as far as to anyone analyzing results from that, but just to give -- because sometimes checking the box is so impractical. So let them check the box for themselves, and it does that. Does that self-identification change what happens in the doctor's office, their name and address, entering that data?

MS. KANA ENOMOTO: It certainly is something that Vince, who's not here today, but has brought up many times, is that it's sort of a comprehensive health assessment that people can keep online and fill out for themselves and bring to their doctor if they so choose. It's something that he's advocated quite a bit around.

Agenda Item: ACWS Priorities for SAMHSA

I would, if you don't mind, like to switch gears a little bit. We can continue on the trauma identification piece, but also go to a broader thinking or perspective about what the ACWS priorities might be or where you all want to focus or how you could feel like you are being best used and most helpful to SAMHSA?

As Administrator Hyde has often said to the committees is that she does see advice as a product. She does see that as the service that you provide. Oftentimes, committees are very anxious to do projects and that we have engaged in at that level to greater and lesser success over the years. And that's not necessarily off the table, but I think, you know, she really values you as individuals and people who represent not just your own professional experiences, but stakeholder groups and broader sets of perspectives. That's why you're selected.

And so, that advice, both individually and collectively, is valuable to the organization, and so I don't want people to feel like you need to do something else in addition to come to these meetings and share your thoughts. But I want to also allow the esteemed membership of the group to kind of identify what you would like to do or how you could feel best utilized.

Or perhaps an easier one is to start with is areas that you'd like to think about talking about for our next meeting in August, any topics? Today was quite a good, deep, broad, ripe conversation around a lot of things.

DR. YOLANDA B. BRISCOE: Women and aging. I think 10,000 women turning 65 every day? That's a significant amount of women.

[Laughter.]

MS. KANA ENOMOTO: That's a lot of women.

MS. BRENDA V. SMITH: I guess, obviously, I'd like to talk about -- and I know a bunch of people here sort of have those connections as well, but I sort of feel like sort of my connection with the criminal justice system, both juvenile -- I mean, just sort of across the system and then also looking at some of the real changes that are happening in the criminal justice system specifically because our criminal justice population is really decreasing.

And so, those folks are really coming back out into the community, and so certainly around reentry. And so, some of the issues, some of the trauma, alcohol and drug addictions actually were sort of the gateway often for people to be in custody, but I think that you also can't assume that those issues have been dealt with in custody, right?

And that often there's a fair amount of trauma that occurs in custody that people come back out with. And so, I mean, I think that that's also something to sort of think about and something that I think it would be worth that I could certainly bring.

And then I guess the other piece is sitting in -- and I think for any of us who are working in universities, but I think specifically with lawyers. We increasingly have sort of the issue of substance abuse. It's a huge and mental health is a huge issue with lawyers.

MS. KANA ENOMOTO: For the profession?

DR. CAROLE WARSHAW: You mean with the people they're working with?

MS. BRENDA V. SMITH: No, with -- for the profession -- for lawyers, I mean. Yeah, well, and the thing is, is we actually -- I mean, in my own institution, we have a wellness initiative. The faculty actually has ongoing, just like in any educational setting, where your people present scholarly work, we actually several times talk about linkages to counseling and services for our students. During exams, we bring in animals, like puppies and things.

So it's a -- trauma is, yeah, I mean, it's a pretty serious issue in the profession and certainly something that we are thinking about very explicitly. And as I said, there's going to be a major presentation on it in this conference at the end of the month. So, I mean, that's also something that I'd be interested in, sort of talking about those connections to professional organizations, at least some big cohorts, and lawyers are a big cohort.

MS. KAREN MOONEY: I'd like to see us -- I'd like to see us talk about the ideas and the concepts that we talk about here, how do those get implemented, and then how are people held accountable for implementing those? It's kind of embroidery on my previous comment about block grant reporting, but I really see if there isn't a way to hold folks accountable, I see things getting kind of fragmented off into little bits and going well here and not going well here.

And I think women have a right to be able to expect a certain quality for treatment that is funded by the Government and that we have a responsibility to make sure that that happens.

MS. KANA ENOMOTO: So are you asking how is SAMHSA held accountable for doing the things that the advisory committee recommends or --

MS. KAREN MOONEY: No, how are people out there in the field, States and private practitioners and agencies, held accountable to do the things that SAMHSA has established are best practice or things that should be modeled.

Because I see SAMHSA really kind of jumping in there and doing a lot of implementing and putting out there a lot of good ideas, but I don't necessarily see them being implemented in the field in a way that's constructive or helpful.

MS. KANA ENOMOTO: Right. Yeah, I think it's also -- it is we find ourselves as an organization in the interesting position of kind of leading without a lot of sticks or carrots, really. We have a small budget, and we're not -- we regulate in a few discrete areas, but we're not a big regulatory body.

The block grants are what the block grants are, and so we do -- Pam calls it, was is it, leadership by -- leadership by annoyance or something.

[Laughter.]

MS. KANA ENOMOTO: I mean, we just persist. But it's a lot of leadership in voice versus kind of regulation and oversight. Even with our grants, the discretionary grants, people have to choose to apply for them. And we -- I mean, we monitor and we have oversight on our grants, I think, like very closely, and there is accountability within the discretionary portfolio, within the block grant portfolio. But we fund a tiny percentage of the overall treatment and prevention system.

And so, what -- our ability to force people or require people to do things is fairly limited. So there's a lot more cajoling, persuading, leading by example, providing the information, trying to make a case. But we can certainly have conversations about where we think, for example, the quality framework might go or what we do in our program integrity efforts and looking at the block grant monitoring, et cetera.

DR. JEAN CAMPBELL: I'm not sure if SAMHSA would or could take up this issue, but I thought I would at least share with you that a major concern within the mental health consumer movement right now is the implementation of involuntary outpatient commitment that I don't know if you're aware. There was a big push by the consumer movement over the last couple of weeks to get our State representatives not to approve the doc fix because they put that rider for the involuntary outpatient commitment pilot in there. And then there's the broader Murphy bill as well, which also takes SAMHSA to task.

But one of the biggest issues is around the utilization of coercion and force in service delivery, and I know it's in substance abuse, and there are these elements. And at least where there's an opportunity to look at the research, be aware that there are people advocating. I meant, in this case the doc fix, I went and looked. All of our liberal Democratic representatives voted for it for the reason of the reimbursement for the docs. But even -- even with our outreach and the opposition to it. So, I mean, it's a very difficult issue.

But it would really good if in some way that SAMHSA could look at the issue of coercion and force. I'm not saying as a priority for Vince, but it's still pretty endemic within the service delivery system, both I meant there's the coercion that people don't get their money because their payee is coercing them. There's coercion for sex around money.

I meant there's treatment coercion and provider coercion, and then there is this internalized coercion within. And I just think it's something -- since I won't be around anymore, I just think it's something for you to be aware of that the consumer movement is organized around this issue, and it's the most important thing. It's the touchstone of where their advocacy is right now.

MS. KANA ENOMOTO: Yes, we're pretty aware. We are aware.

DR. JEAN CAMPBELL: Well, I know SAMHSA is. But I meant if there's some way to deal with this issue in a reasoned or even in small ways.

MS. KANA ENOMOTO: You know, I think we did -- it was small, but important that we had a meeting on assisted outpatient treatment that Ellie and Paolo led on several months ago. And I think that was an important and productive conversation. I don't know if it's something that would -- that is -- I think it is relevant to women. I don't know if it's -- I mean, I think that sort of crosses over both genders on that one. So that may be something for the NAC and/or for the Joint NAC to also consider.

Because I also -- I think when you talk about -- I think there are some pretty big differences of opinion also between mental health and substance abuse, on the value, the role of coercion, if you take sort of a criminal justice, sentencing type, I think people see that, drug courts --

DR. JEAN CAMPBELL: Well, there was a time when SAMHSA was supporting meetings and discussion groups and stuff. I went to them. This was like 10, 15 years ago when I think the delivery of services was on a trend to liberalize itself and eliminate coercion, and I think it's now, particularly with Sandy Hook, and that it's turned a corner again.

MS. KANA ENOMOTO: Sure. Jeannette, and then I need to check, do we have public comment?

MR. JOSH SHAPIRO: No public comment.

MS. KANA ENOMOTO: Okay.

MS. JEANNETTE PAI-ESPINOSA: I think that when you asked that question I just blanked out because there's so much that what we've talked about with so

many. But in terms of building on what you're already doing, I think because we serve so many young moms, and that is just such huge gap, anything that can be learned or transferred or conversations begun from the PPW project I think would be invaluable.

I mean, child welfare and juvenile justice don't even require States to report the number of young moms or parents, young parents. So there's no data there. Well, we did our ACE study. So the N was about 1,300. About 900 of them were women, and about half were young moms. And their scores were off the charts, off the charts. Young moms in juvenile justice, not surprisingly, were the highest, and then child welfare and mom, young moms. And that there, I know there's a lot of conversation there about the reduction in teen pregnancies. That's not true in this population.

The Hilton Foundation, I don't know if you saw, they released a report on young parenthood in the California child welfare system. The first data I've actually seen that really compares the pregnancy rate in the system-involved groups versus not, and it's -- I think it was three times.

I mean, that's a place where addiction, mental health, it all comes together. I mean, we could wait until they're 18, but they're pretty malleable and pretty hungry to change at a younger age. They're young kids. So to the extent that even facilitating conversation on that with PPW data as background would be tremendous.

DR. SHELLY F. GREENFIELD: I was just going to say that I'm not sure I'll be able to join the August meeting. But I thought Yolanda's suggestion, I was just thinking about it more in terms of older age women with mental health and substance abuse disorders, that there tends to be a lot of focus on the rest of the age span as it's kind of often a very neglected area, even though when you think about it, the population demographic in terms of the numbers of women who, you know, will live into whatever, late life.

And then a lot of the issues actually are around mental health-related illnesses and how those -- what the services actually are and what kinds of comprehensive services there are, you know regarding loss, grieving, dementia, other brain diseases. And then now with Ellie's presentation, you know, the rise in prescription drug problems. It just does seem like if you're talking about services for women, the Advisory Committee on Services for Women, that's a pretty big, broad group. And I do feel like it gets kind of shunted off to the side, and it might be worth considering that demographic and the needs and what -- where we are with that.

So I may not be present for that discussion, but I just -- I would second that motion as something worth considering.

MS. KANA ENOMOTO: And I don't know if they got funded or they proposed that the Administration on Aging either got a proposal or got an appropriation to do research on elder abuse because that was discussed earlier when Medicare had its sort of comprehensive assessment or wellness assessment, and we couldn't get elder abuse in there because it didn't have sufficient evidence base.

And --

DR. JEAN CAMPBELL: Well, we had the multisite on seniors.

MS. KANA ENOMOTO: Right. So that was the integration of primary care, mental health, and substance abuse for older adults that we did back in the '90s. But this was -- what I'm talking about is specific to screening for elder abuse in a Medicare population, and the challenge of getting that into an annual screening regimen was that there wasn't enough evidence that you could screen and detect and improve outcomes from the screening. So --

So, Carole, you wanted?

DR. CAROLE WARSHAW: Well, there are a couple of things that I was thinking about. One was you mentioned the drug and mental health courts, and I don't know a lot about them. I know -- I just wonder about their impact on women and how that's all playing out. And I don't know from some people who report on those courts, they're not so aware of intimate partner violence. And I also know some other courts that have trauma initiatives and that that's been really important. So maybe just some information about that would be useful.

I'm also thinking about with the pregnant and parenting transition age youth and teens around -- we've done a lot of work around child trauma and parenting around, you know, in the context of domestic violence, but [inaudible] for child welfare, a lot of people. But often the parenting piece is part of what is healing for young women, and so that's another aspect that's not just a focus on kids and kind of learning about child development. Like Alicia Lieberman and Patricia Van Horn's work around child-parent psychotherapy, I think it's really a wonderful model of how to kind of do that dyadic work, as opposed to just focusing on symptom reduction.

And then the other piece I was thinking about was the women's services coordination that's on the -- we had talked about this in the past -- on the substance abuse side. There's nothing equivalent on the mental health side, and there's nothing about gender-responsive mental health treatment, although a lot of treatment services are for women.

So I was thinking about like if we looked at where could SAMHSA influence, you know, mental health and substance abuse outcomes for women over the next however long, and where could we be helpful in that? You know, and kind of

where are the places where things could move forward and both at the idea and, you know, kind of highlight the program, but also at the moving things forward around accountability, rather than it being all piecemeal.

What's the value of kind of a group of people that come from different places that could be more integrated thinking with that goal as to think about and see if there's some place that things could move. I don't know. That may be too broad. It's sort of been percolating. I mean, how can we make the most difference --

MS. KANA ENOMOTO: Right.

DR. CAROLE WARSHAW: -- by having this committee? I think that's what we all feel. It's not just having the ideas and having a great discussion, but how could our spending our time here make a difference not just in our own arenas, but in other arenas where we wouldn't normally have access because we're in a part of the world.

MS. KANA ENOMOTO: So if I may just react quickly to that?

DR. CAROLE WARSHAW: You may.

MS. KANA ENOMOTO: And this is really I have, I think, some choice points for the group, which is there are, just from what I've heard, data issues, aging, accountability, quality, PPW, coercion, criminal/juvenile justice, and mental health/substance abuse sort of along professionals who are in the workplace. And teens, I think, and pregnant and parenting girls. There are a lot of issues that we could do.

So, I mean, we could do sort of what we did today, which is take a pretty rich topic, get some staff or Federal partners in, talk about it, have the group discuss it, and then sort of sit there with I've gotten good input. I've gotten great ideas for how we could analyze what we need to ask for PPW, where we should go with that, and you all have made some comments. I've got to go check back with the 16 and 17 block grant applications, and we'll probably have good news for you.

But you know, there are -- so just in that -- in this experience today, even with this conversation today, you all have given me things and probably Ellie things and even the Administrator, I think we've all gotten things that we will then apply in our work and that we might not have gotten had we not had this focused conversation about women and girls. So that's by itself, as we are doing the committee, it is helpful. So I want you to feel that.

But if we take -- let's say we take a topic that we think is important, whether it is aging or whether it is let's -- we've done, I think -- I don't think we're done with it, but I think gender-specific treatments in substance abuse is really way pretty

advanced, and we've done less of that focused work on the mental health side. And when I asked prevention, we really struggle on the prevention arena about what are you doing for girls? What are your data for girls? What are your programs for girls? Even though they exist, I think how does prevention for girls differ from prevention for boys?

So let's say we wanted to take gender-specific approaches as a topic, we could bring in great outside experts and have another conversation like this one, and you guys would, by raising the issue, having us bring in experts, stimulate thinking and conversation for SAMHSA. Or you guys could have more dedicated time amongst yourselves to make a set of recommendations that here are eight things that we want SAMHSA to think about in its work for formulating gender-specific approaches.

All right? So those are two different things that we could do, or we could have, again, staff come in and talk about a program. This is more around I was thinking PPW. I'd love to have a continued conversation about bringing back the PPW data, and as you've said, what are the different -- what are the components of this program that worked, for whom, for how long? What are the differential outcomes that we're seeing? How could we export some of that? What other questions do we have to ask?

MS. SHARON AMATETTI: Kana, if I might add to that? Because you said that we have a pretty good idea what the model is. I think Shelly and Karen are working with us on this issue about in coed programs because more women are served in coed programs, and the specialty programs are really translating what we know about.

MS. KANA ENOMOTO: Right, right. So I mean we could do this gender-specificity conversation or adjusting gender in either single-sex programs, coed programs, like that can be a conversation that we have here. Jean had suggested should we -- should SAMHSA do a white paper?

There are different ways that we could do this work. So whatever the topic is, I guess I'm interested in finding out what would be most appealing to you. We could seriously kind of dive into PPW and do some -- ask for some data runs, ask for different pieces of information for you to come back and say, given that, here is some suggestions for where SAMHSA could go with this program.

Same with our behavioral health court collaboratives. They are in the -- have identified trauma as a central unifying theme for the courts and the provider systems that are working together, and that's mental health and substance abuse. And they've resonated around trauma, and they're going into a second round of grants that says the trauma training is essential. And so, that is a lens that they've taken.

But does this group have additional information? You know, you'd like to hear a presentation on what's going on with that group, provide feedback to SAMHSA on that particular program, the HIV program that Ellie was asked about. So that would be advising us on sort of specific programmatic focus and we have the staff here for leading it who shaped those programs, who would be able to benefit from your very targeted advice.

DR. SHELLY F. GREENFIELD: I mean, it just seems to me that it's really -- in some ways, it's a mix of the two in the sense that there are certain programs that you all have developed or are developing. And insofar as we hear where some of those programs are, we can then provide feedback as to where you are, like we did, for example, today with the PPW programs, and then there could be follow-on with that and maybe development.

So, but then there seem to be maybe other areas that may have been visited 15 or 16 years ago, but there have been other priorities. I mean, for example, we've mentioned -- this is just one of many -- but older age women. Perhaps there was an effort, and then maybe it's been in other places. So maybe that's a place where you invite experts in just to jump-start a conversation about kind of goals.

So it seems like it's, to me, anyway, it sounds like I would imagine a productive day or meeting would be a mix of those two things. Taking current programs that you're doing, hearing where you're at, having feedback from us. But areas where there may be newer initiatives or places to go, we might all benefit from having some experts in where that gets the conversation and maybe some discussion.

So that would just be one thought as you were rolling out all the possibilities of which there are dozens. So --

DR. CAROLE WARSHAW: I was thinking about beyond the next meeting because every meeting is filled up with interesting topics that seem like because they're happening or because someone is interested or someone is presenting, as opposed to having some sense of an agenda. You know, how we're moving things forward for transition age youth, for young women, for women dealing with mental health/substance abuse, for older women?

You know, just some sense of -- for criminal justice -- somewhere like where are things are moving forward in different dimensions that we have different interests over time. Or there's something in between or there's some -- you know, we talked about this last time. There is some movement, or you've incorporated something. We want to know about that, that something has changed or that we have new ideas about, or so there's some way that there is an ongoing kind of a conversation about the things that might make a difference.

I know it's hard to staff that, but this kind of thing.

DR. JEAN CAMPBELL: It's like coming up with an agenda for our crew?

MS. KANA ENOMOTO: Right, right. Yes, it is challenging because I've been chairing this committee for a while, and we have tried a number of different approaches. And one of the challenges is coming up with getting these 10 people this time to talk about what you'd like to do for the next year, and then the next meeting, 4 of you are gone. And I've got 4 new people, and you know, that kind of thing. Then they say, "But what about my issue, which wasn't represented the last time?"

So that has been one of the challenges. However, if you go with something a bit broader, like something like looking at gender specificity across kind of --

DR. JEAN CAMPBELL: As opposed to looking at gender within an integrated environment, gender specificity. A lot of things we can look at that affect women, but they're not necessarily at this point a women's issue or that hasn't been differentiated, as opposed to things that are clearly gender specific.

MS. KANA ENOMOTO: Yes. Or sort of I guess what I was thinking was that if we said how -- as a running theme, how is SAMHSA addressing gender, what are some principles in how we address gender in either coed settings or single-sex settings, and you could do that over the course of several meetings and build that, build a set of -- a common understanding for us. I guess it's not really a set of principles because I think those are out there in different places. So it's not really coming up with a separate work product, but as a theme going over something like that.

Or a theme around how are we addressing the needs of young women -- teens, girls, young women? Anything like that as a theme over time. We could do something like that if the group had a specific priorities or could choose, but that means that, you know, the 20 other topics that you all brought up today can't -- maybe you can have a rotating -- like if we had three sessions, I mean, if we came up with like a standard protocol, we have three sessions every meeting.

One session is sort of the topic du jour and sort of the thought-provoking -- right. But then the other two sessions are we're going to -- what's the topic that's moving the ball down the field for young women at this meeting? What's the topic? Are we going to focus on gender specific and how to address gender in coed programs or how to address the needs of women in coed programs?

How do we address the needs of women and girls in mental health settings? How do we address the needs of women and girls in prevention programming? Right. Like that could be a series of talks that we would do, one in the spring, one in the fall, one in the spring again.

MS. JEANNETTE PAI-ESPINOSA: Since I'm new, what is the most helpful to you and your staff?

MS. KANA ENOMOTO: Well, I know what tends not to be helpful, which is getting the group to try to do projects. That is not helpful, A, because it seems like a good idea when you're in the room, and then all of you go back to your lives, and you're very busy. And then our staff end up trying to, you know, extract comments and edits and things from people who have other things to do.

And then they do the work anyway, and we've got lots of projects already. So that's probably less helpful. As I said, even the way we did it today, which was relatively ad hoc, they were mostly topics that were requested from last time for this time. And then my request to talk about these meetings, these trauma screening meetings that had just happened.

So --

MS. SHARON AMATETTI: Yes, if I could also reflect over the time that I've been coming to meetings. There was a period of time where we were giving presentations from outsiders about work that we weren't involved in to this committee to make it interesting for you all, and then I think we realized, wait a minute, this isn't serving any of our purposes. So having staff talk about projects in-house that we're trying to develop or grow or change and getting your feedback about it has been very helpful, I think.

DR. JEAN CAMPBELL: I like this meeting as one of the better meetings over -- when I look back over the years. I think that members, and I appreciated the discussion around wellness, and I'd asked for that. And I was glad that one last chance and it got in. It was important to me, but also to have you discuss it.

But I enjoyed the other discussions, too, because there was interest and passion. If it wasn't something that I knew, it was something that I got interested in or got ideas about because we share -- you know, we may not know it, but we share a lot of common history and understanding. And I thought that having things that people requested was a good approach, although not as focused. You can't say, well, we just do what people request. But it has more thought that goes into it.

DR. SHELLY F. GREENFIELD: I liked your idea of the three sessions, two of which are things where you're moving the ball down the field continuously, and like a third session may be something that you all designate, like you did today on the screening, a program that you're developing you want input and feedback on. I mean, I like that approach because it's two things that are longitudinal and one that's kind of episodic like what's rising to your agenda that you want to bring here for feedback.

MS. BRENDA V. SMITH: Just one other thing that I would add is that one of the things that I thought was really great about the wellness discussion was that it was much more of -- it was much more of a concept. I mean, there were specific things, but it was sort of -- it was sort of in some ways more theoretical, right, and sort of like an overarching theme.

And I wonder if that's also something, maybe something to add to the agenda, which already have broader mobile conversations about something that sort of run -- is a thread that runs through many things. Wellness was a great one because it's like all sunshine and flowers, right? And that was a good one.

But one of the ones that I think Jean mentioned, which is sort of underlying some of this, is the issue around coercion. And coercion or inducements of some kind in order to get people to do things. And I don't know if there are other themes like that that are worth talking about, as well.

MS. KANA ENOMOTO: So what I propose is that we will go -- oh, I'm sorry. Johanna? No, go ahead.

MS. JOHANNA BERGAN: So one thing I thought about today -- on the ideas. One thing I thought we might have done today in the misreading of the agenda or the topic was to think about the strategic initiatives, which I am expecting that we'll talk about more tomorrow. The young adult panel that is presenting tomorrow, as we prepared for our panel, decided to look at those strategic initiatives and advise on where we thought youth voice needed to be infused.

And as I did that, I sort of thought about where women and girls' voices and issues needed to be infused more than other places as sort of prioritizing. But we didn't have that kind of broader SAMHSA strategic conversation today, which is one that we've touched on in the past. But I've appreciated this.

MS. KANA ENOMOTO: So why don't we -- the SAMHSA folks who are here will get back together after this conversation, sort of put back out to you some choices, based on what you've given us today as sort of what would be some -- and I think we need to focus and maybe we will just vote, but like what are some -- name a theme or two themes that you want sort of carried through, whether it's disparities or coercion or wellness or whatever else that we could do. What are two topics that we want to kind of stay focused on over the course of the next several meetings?

And then are there sort of ad hoc places where either we want to get your input or where you feel like we really want to hear about this next time? And then let's do that, and based on your feedback, we can set the next few agendas and get that back out to you for your thoughts.

MS. JEANNETTE PAI-ESPINOSA: Well, it almost does cut across the generations. I mean, it looks different when you're 65 than it does when you're 15.

MS. KANA ENOMOTO: All right. Well, thank you all very much. I appreciate the meeting.

Do I need to do -- Nadine, do I need to do anything else to close this out?

Agenda Item: Public Comment

MS. NADINE BENTON: There are no -- I did not get any public comments in the mail, but --

MS. KANA ENOMOTO: Right. Oh, we have to ask if there are any public comments?

MR. JOSH SHAPIRO: I asked on the -- I asked the operator to ask, and there were none.

MS. NADINE BENTON: There were none?

MR. JOSH SHAPIRO: None, yes.

MS. NADINE BENTON: Okay.

DR. JEAN CAMPBELL: We outwaited them?

Agenda Item: Closing Remarks/Adjourn

MS. KANA ENOMOTO: Yes. And so, we are -- what is the next date of the meeting, August 26th?

MS. NADINE BENTON: August 26th.

MS. KANA ENOMOTO: Okay. So we will see you or hear from you again on August 26th. Thank you all for your great participation today. I'll see you, most of you tomorrow, and we'll see you again, talk to you again on August 26th.

OPERATOR: That concludes today's conference. All lines may disconnect at this time.

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