

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

**Advisory Committee for Women's Services (ACWS)**

**August 26, 2014  
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Committee Members Present:

Nadine Benton, DFO  
Kana Enomoto, Chair  
Sharon Amatetti  
Johanna Bergan  
Yolanda B. Briscoe [on telephone]  
Karen Mooney [on telephone]  
Brenda V. Smith [on telephone]  
Carole Warshaw [on telephone]

Other Participants:

Sara Afayee [on telephone]  
Holly Berilla  
Rebecca Flatow [on telephone]  
Nevine Gahed  
Irene Goldstein  
Pamela S. Hyde, SAMHSA Administrator  
Curtis Oliver [on telephone]  
Josh Shapiro  
Danielle Tarino  
Geretta Wood

## **PROCEEDINGS**

### **Agenda Item: Call to Order**

MS. NADINE BENTON: This meeting is now called to order.

OPERATOR: Excuse me?

MR. JOSH SHAPIRO: We're going to start now, Kevin.

OPERATOR: Oh, okay. One moment. I'll transfer you over to the main conference, give the scripting and title to Ms. Nadine Benton.

MR. JOSH SHAPIRO: Thank you.

OPERATOR: One moment.

[Music playing in background.]

OPERATOR: Welcome, and thank you for standing by. At this time, all participants are on listen-only mode until the question and answer session of the conference. At that time, if you'd like to ask a question, you may press \*, then 1.

Today's conference is being recorded. If you have any objections, you may disconnect at this time.

I would now like to turn the call over to Ms. Nadine Benton. You may begin.

MS. NADINE BENTON: This meeting is now called to order.

### **Agenda Item: Welcome Members, Roll Call, Approval of Minutes, and Remarks**

MS. KANA ENOMOTO: Thanks, Nadine.

This is Kana. To the members and any audience who are with us today, we greatly apologize for the delay. We had, obviously, unexpected technical difficulties, and we really appreciate your perseverance in getting onto the line.

So we do not have everyone on the line yet. I believe -- could we just do a quick -- are they on listen-only? Can they speak?

MR. JOSH SHAPIRO: I think they can speak.

MS. KANA ENOMOTO: Okay. So for our members who are attending, if you would just go ahead and say who you are.

MS. BRENDA V. SMITH: [on telephone] Brenda Smith.

MS. KANA ENOMOTO: Great.

DR. CAROLE WARSHAW: [on telephone] Carole Warshaw.

MS. KAREN MOONEY: [on telephone] Karen Mooney.

MS. KANA ENOMOTO: And Yolanda, do we have you?

DR. YOLANDA B. BRISCOE: [on telephone] Yes, you do.

MS. KANA ENOMOTO: Great. Okay. So we have four of you. We hope that Johanna will be joining us. Unfortunately, Jeannette Pai-Espinosa thought she would be able to be with us today, but she is up in the air somewhere between Mexico and Portland due to some travel difficulties and weather delays that she's run into. So she sends her regrets.

Because we have only half of our -- less than half of our members present, we've received advice from our General Counsel that we can go forward with this meeting, but we cannot vote on our minutes from the past meeting today. So we are going to double up at our next in-person meeting in April. Yay, in person.

SAMHSA, as you can see, we continue to experiment with remote meetings. Knowing how long and tedious very long conference calls can be, we've pared this meeting down originally to 3 hours, now down to 2 1/2 hours. Only a half an hour of waiting. So we're going to -- we're just going to move quickly and get through the agenda and not keep anyone over time.

We thank you very much for setting aside the time to participate in the meeting today.

Next spring, we will be here together at SAMHSA. I believe it will be on April 8th. So for those of you members who are continuing on, we appreciate you and look forward to seeing you. Nadine will be sending out a "save the date" soon.

Today, folks we do not have with us, in addition to Jeannette and Johanna right now, Rosalind Wiseman, Vince Felitti, Jean Campbell, Shelly Greenfield, and I'm sorry, Jeannette and Johanna are not with us right now.

So now we can move on to our business. I will keep my remarks as brief as possible I just wanted to let some of you know, and I think you have received an email with the presentation. It's not my presentation, but a presentation that I had the good fortune to see and hear while I was participating in the Asian Pacific Economic Cooperative meeting last week in Beijing, China.

It was the first time for -- it is the first time for the APEC, which is a collection of the world leaders, both the economic leaders, the Secretaries of Commerce and Finance, as well as the Presidents and Prime Ministers of these countries and the Health Secretaries to gather and make sort of multilateral commitments to addressing various issues to foster the economic health of the region. For the first time, the APEC has focused on behavioral health as a major factor on the economic well-being of the Asian Pacific economies.

And so, I was invited to participate in a workshop on this topic, talking specifically about the economic impact of mental illness and substance abuse on the U.S. economy, as well as the global economy, with estimates from the World Economic Forum of \$6 trillion in direct and indirect costs of mental and substance use disorders by 2030, and 35 percent of all lost economic output due to illness. And that is greater than all cancers combined and significantly greater than the second leading cost driver, which is cardiovascular disease.

So mental illness and substance abuse is about \$6 trillion in direct and indirect costs. Cardiovascular disease is \$1 trillion in direct and indirect costs, and that's in second place. So our conditions collectively have a greater burden than diabetes and chronic respiratory diseases combined.

So those are -- those are economic estimates that most people don't know or appreciate about our conditions, but they are rising on the global stage of Finance Ministers and Secretaries of Commerce worldwide, just because they are seeing the importance on our fiscal viability.

At this meeting, one presentation was given by Jane Fisher, professor in the School of Public Health and Preventive Medicine at Monash University, also the Jean Hailes Professor of Women's Health. And she spoke specifically about gender differences and the burden of mental disorders that I think you'll find very interesting. So that's what I've sent out.

She shows -- now we know that depression and dysthymia, taken together, are the leading cause of disability burden among the mental and substance use disorders. Some estimates we received are that for the United States, they predict that dysthymia and depression together create about a 1.5 percent drag on the GDP, when you take together disability, loss of life, presenteeism, and absenteeism.

So these are very, very significant cost drivers for our society. And if you look at

the presentation by Dr. Fisher, you'll see that the disparity between women and men on -- on the burden of dysthymia and major depressive disorder is significant. So I think you'll see some really interesting data on years lost to disability, you know, adding up to the billions and as well as some disparities in the prevalence of common mental disorders, common perinatal mental disorders in high- and low-income economies, as well as low and lower-middle income economies.

So, you know, it is good to know the issues of relationships, family violence, reproductive health, discrimination and devaluation, socioeconomic disadvantage are identified globally as risk factors for perinatal common mental disorders, as well as that protective factors have been identified as education, employment, structured direct care by a trusted person, and strong relationships. So these are all things that we know and value, and I think Dr. Fisher's presentation does a nice job of outlining that.

And so, in the global sense, the call for gender-specific services and disaggregation by gender is also being made, especially when you look at the cost of depression worldwide. So it's important to know that for this committee.

Moving on to other things, in August, earlier this month, August 11th to the 13th, SAMHSA convened a prescription drug abuse policy academy in partnership with the Association of Territorial -- State and Territorial Health Officers. We had 10 States that sent teams to D.C. to work on their policy strategies to address the number of deaths and the number of emergency room adverse health effects of prescription drug and opioid use. And also looking at issues of like the use of opiates by pregnant women and neonatal abstinence syndrome as a priority.

So that was a very successful summit that we hosted in mid August, and at the end of July, we also participated in the Secretary's 50-State meeting, where we brought, I think, about 47 States, their State health officers or their secretaries or their cabinet members around health and substance abuse and public health together to talk about the prescription drug overdose issue in particular. So that has -- it's been a busy summer.

Sharon has additional information, if you would like, about the NAS I think it's a guideline or a toolkit?

MS. SHARON AMATETTI: There is a development of guidelines for working with opioid-dependent women being developed, and also technical assistance is being developed about that.

MS. KANA ENOMOTO: Yep. Yep. So there's -- there's more coming from SAMHSA on that in this very hot topic.

And very quickly, on budget, we -- the Senate Appropriations Committee did

release a report, a markup of our 2015 proposal for the budget. They did eliminate GATSBI. So our proposal for the Grants for Adult Trauma Screening and Brief Intervention, which we had had a lot of hope for. Now the fact that they took it out doesn't mean a whole lot because it's just -- it's their -- it's one side of the legislature putting forward a report. It's a nonbinding bill, and we do not believe that the House will move an FY '15 Labor-H bill this year.

So we are anticipating a full-year CR, at least a partial-year CR for sure, and we'll see after the election. But many -- many of our folks are predicting a full-year CR or something similar. So we're a little bit distressed about the show of a lack of support for GATSBI, but we're also hoping to talk to folks and see if we can understand where that came from.

They're keeping the block grants level, the main -- they are increasing work around prescription drugs and medication-assisted treatment, continuing support for Now is the Time and our workforce effort. So more to come on budget.

We -- our SAMHSA's -- our process is we are submitted or getting ready to submit our FY '16 proposal to OMB, and we anticipate, as usual, a President's budget for '16 coming out sometime in February. So by the next time we meet in April, we'll be able to talk to you more about what the administration has planned for SAMHSA in FY '16.

Now, finally, I'd like to acknowledge -- we acknowledged folks in person last time, but this would be the last meeting for Yolanda, who's with us. So thank you very much, Yolanda, for your service. And leaving ACWS with Yolanda are Vince, Jean, and Johanna. So we're sad to see the four of you leaving, and we are -- have appreciated all of your advice and your presence.

And we are looking forward to getting a new slate of members into the April meeting. So we'll be introducing them in the coming year.

DR. YOLANDA B. BRISCOE: Thank you.

MS. KANA ENOMOTO: Thank you, Yolanda. Yolanda, did you want to say anything?

DR. YOLANDA B. BRISCOE: Oh, just thank you, and don't forget all the humor that I brought as well.

[Laughter.]

MS. KANA ENOMOTO: That's right. Good times. Good times. Okay. So --

DR. YOLANDA B. BRISCOE: That's all.

MS. KANA ENOMOTO: -- thank you. So we are not doing great on making up time, but I will -- Sara has also been really patient and had signed on on time, together with Karen. And so, I'm going to hand the floor to them.

Sara Afayee, a public health adviser at Center for Mental Health Services here at SAMHSA, and who has been working with Larke Huang, who is our strategic initiative lead on trauma and justice, is going to present our SAMHSA working definition of trauma and principles and guidance for a trauma-informed approach.

And Karen Mooney, our ACWS member from Colorado, is going to be our discussant. Okay. Sara, are you on?

MS. SARA AFAYEE: [on telephone] I am. Can you hear me?

MS. KANA ENOMOTO: Yep.

## **Agenda Item: SAMHSA Working Definition of Trauma and Principles and Guidance for a Trauma-Informed Approach**

MS. SARA AFAYEE: Okay. Okay, thank you.

So what I'm understanding is that some folks might not be able to see the slides right now. Is that correct?

FEMALE SPEAKER: Yes.

MS. SARA AFAYEE: I just want to be mindful of that. Okay. Thanks for letting me know.

Well, good afternoon. It's a pleasure to speak with you all today. My name is Sara Afayee, and I work in the Community Support Programs Branch in the Center for Mental Health Services at SAMHSA. I am also part of the internal SAMHSA Women's Coordinating Committee, and I have had the pleasure of attending the ACWS meetings around five or six times over the years. So it really is a treat to present for you all today.

I want to acknowledge that some of the ACWS members have contributed to some of the feedback in the trauma concept paper and may have a good understanding already about this and the framework. In addition, the work of the trauma and justice strategic initiative here at SAMHSA is led by Dr. Larke Huang, and the work that you will see today was from contributions of several SAMHSA staff, and I want to acknowledge them for their work.

And actually, Becky Flatow is also on the phone. During the Q&A, she'll jump in if necessary. Thanks, Becky.

Okay. So I tried to advance the slides. I don't see anything there. But we'll just wait for that to come up. But in the meantime, I just wanted to give you an overview of the trauma and justice strategic initiative. It's one of the eight strategic initiative priorities. And on the slide, it's pretty much to give you a 30,000-foot view of how SAMHSA looks at the integration of trauma-informed approaches.

And the intent is really to integrate trauma-informed approaches in behavioral health, of course, but also in other health systems and other related entities in order to decrease the effects of trauma and violence in communities for individuals and their families. With reducing this impact of trauma, there can be innovative strategies for reducing the involvement of individuals with trauma and behavioral health issues in the criminal justice system, as well as the juvenile justice system.

Okay. So for those of you who can see it, I have put up a slide of just the front page cover of the concept paper. I wanted to give you a glance of what the paper actually looks like. It's currently in clearance in the Office of Communications here at SAMHSA, and the expectation is that it will be out for public viewing in the next few months. But this is just a little bit of a taste so you can see that.

This is a timeline about the evolution of trauma-informed care. Before we get into the nut and bolts of the actual trauma definition and some of the highlights from the paper, I wanted to give a brief overview of how SAMHSA began to develop the concept and receive input. And I think it's really critical to acknowledge that the trauma-informed care movement has been growing and thriving in the field for decades.

And the next two slides are pretty much just showing you a timeline of the robust movement that has been growing in the field and in the local, State, and Federal arenas. And a wonderful team at SAMHSA put this evolution of the movement together, and on this slide, it just highlights just a few items. There is quite a few as you go along, as you might imagine, since there's decades of work.

But, you know, kind of we started from the feminist movement. And just back in 1995, SAMHSA had its first national trauma conference, Dare to Vision, and that brought together over 350 consumer/survivors, practitioners, and policymakers. And it was one of the first of its time. And in 2001, Creating Cultures of Trauma-Informed Care, the core values came from Roger Fallot and Maxine Harris, which was a pivotal point, too.

And the next slide, it just continues to talk about the evolution of trauma-informed care, and what's important here to mention is that we had the second national conference. We had the one in 1995, and then in 2004, we had Dare to Act, again trying to look at trauma-informed care not only at the policy level, but also at the research and practitioner and survivor levels.

And the other thing I want to highlight that's important for our evolution here at the Federal level is that the Federal Partners Committee on Women and Trauma is an interdepartmental workgroup, and they have held two roundtables in 2010 and 2011 that focus specifically on women and trauma.

It also sort of gives you a sense that the timeline, you know, that there's a lot of moving parts in the field right now and in the Government related to trauma-informed care work, and we acknowledge that.

Okay. So why did SAMHSA set out for a concept of trauma and guidance for a trauma-informed approach? Some of the reasons are here on this slide, and that is to gain a shared understanding of what we mean by trauma and trauma-informed approach. And as you notice, I'm using "trauma-informed approach" versus "trauma-informed care."

We noticed as we were doing some of our feedback that the word "care" within "trauma-informed care" didn't resonate with some folks because, you know, they're not really doing direct practice or care types of work. So trauma-informed approach is what I'll be using throughout the presentation.

Another reason why SAMHSA went about having a concept of trauma was to get an agreement to enable discussions of trauma and trauma-informed approaches across different service sectors that SAMHSA also interacts with. And also it's important for measurement to have a basis for measurement for us to come up with a definition or a concept and to provide the basis for training and technical assistance moving forward.

And overall through the process, we have found that, you know, this has had a common ground and common language for other partners that we work with, both local and Federal.

Okay. So SAMHSA developed a concept paper in concert with experts in the field -- people in recovery, people with lived experience, practitioners, researchers, and other Federal agency partners. We've had a lot of feedback, which is important in this process.

One of the ways that we collected input was through an expert panel. In May of 2012, SAMHSA convened an expert panel related to the trauma concept paper. On this slide, I included some of the experts that were at the meeting, and the framework for a trauma concept paper started to be hashed out during some of

these meetings.

Another way that we collected input was through a public comment period, and SAMHSA received comments through a SAMHSA blog, where we posted the trauma definition and the guiding principles. We had an overwhelming response.

We had over 20,000 comments or endorsements written on the blog as a new way of us trying to collect feedback and a great way to hear from people with lived experience.

Okay. So thank you for allowing me to take a few minutes to just talk about the background and the evolution of trauma-informed care in the field as well as the process that we used for collecting input. But we're finally at the meat of the paper. You know, what is our concept of trauma?

So here in front of you, which I'll read in just a moment, there is a SAMHSA concept of trauma, which is still being draft -- it's still in draft form until it is released for the public or able to finally be out for you all to see. The concept is often referred to as the "three Es." So here is the SAMHSA concept of trauma.

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning or mental, physical, social, emotional, or spiritual well-being. That's quite a lot, which is why we call it the "three Es" sometimes to have people remember and recall about "event, experience, and effects."

Okay. So, on that slide, we had the three Es as a part of individual concept of trauma. Here on slide 9, I talk about the four Rs of trauma-informed approach. And a trauma-informed approach is really distinct from trauma-specific services or trauma systems. And you know, the trauma-informed approach is inclusive of trauma-specific interventions, yet it also incorporates key principles into the organizational culture.

So the four Rs is realizes widespread impact of trauma and understands potential path for recovery. Recognizes signs and symptoms of trauma, clients, families, staff, and others involved in the system. Responds by fully integrating knowledge about trauma into policies, procedures, and practices. And seeks to actively resist retraumatization. So realizes, recognizes, responds, and resist are the four Rs.

Okay. So keeping the three Es in mind and the four Rs, SAMHSA has also provided six key principles of a trauma-informed approach. Excuse me. Just as the picture on the slide suggests, the six key principles are critical essential elements for a trauma-informed approach and often overlap and build upon one another.

So we have safety; trustworthiness, transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; culture and the historical, gender issues. From SAMHSA's perspective, it's also critical to acknowledge and promote the linkage between recovery and resiliency for those impacted by trauma.

Okay. So I'm not going to read everything on the next two slides, but it is really important to let you know that we have principles. These principles also have a lot of meat to them in the paper. So as far as the --

DR. CAROLE WARSHAW: Can you send the slides so we can -- those of us who can't get on could see them while you're talking.

MS. SARA AFAYEE: Is that possible, Sharon?

MS. SHARON AMATETTI: Yes.

DR. CAROLE WARSHAW: Thank you.

MS. KANA ENOMOTO: Could we email the slides? Carole is not on the Web.

MR. JOSH SHAPIRO: Carole, they were in that email I sent on Monday, yesterday.

MS. SARA AFAYEE: Do you have access to that email, Carole?

[No response.]

MS. SARA AFAYEE: Are you there, Carole? Okay. Maybe she's looking for it.

DR. CAROLE WARSHAW: I'll find it. I'm sorry. I put myself back on mute.

MS. SARA AFAYEE: Okay, no problem.

DR. CAROLE WARSHAW: Thanks.

MS. SARA AFAYEE: Okay. Yes, I apologize if you can't see the slides, but I'll try to read as much as I can, and I'm on slide 11. And the six key principles of a trauma-informed approach. Safety is really kind of cross-cutting between all of them, and throughout the organization, staff, and the people that they serve, whether it's children or adults, should feel physically and psychologically safe.

With trustworthiness and transparency, organizational operations and decisions are conducted with transparency, with the goal to mind of building and maintaining trust.

With peer support, peer support and mutual self-help are vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their story and lived experience to promote recovery and healing.

Collaboration and mutuality. Importance is placed on partnering and the leveling of power differences between staff and clients among organizational staff and clerical and housekeeping personnel to professional staff, to administrators. Really just keeping everyone in mind when it comes to a trauma-informed approach.

Empowerment, voice, and choice. Throughout the organization and among the clients served, individuals' strengths and experiences are recognized and built upon. It's really important to give people a vehicle to have a voice and a choice there in their organization.

And lastly, cultural, historical, and gender issues. The organization actively moves past cultural stereotypes and biases and offers access to gender-responsive services. And it really acknowledges and addresses historical trauma as well.

So I'm moving to the next slide. I'm on slide 13, the 10 domains that you see on this slide, and I'll read them out loud, are guidance for implementing a trauma-informed approach. So governance and leadership; policy; physical environment of the organization; engagement and involvement of people in recovery; cross-sector collaboration; trauma-specific screening, assessment, and intervention; training and workforce development; progress monitoring and quality assurance; financing; and lastly, evaluation.

And this is not meant to be a checklist or a prescriptive step-by-step process for an organization. These domains have appeared in both organizational change management literature, as well as models for establishing trauma-informed care. In the concept paper, we actually have some sample questions to consider when implementing a trauma-informed approach that aligns with these 10 domains, and I wanted to offer you 2 examples from the paper.

Under the engagement and involvement domain, we have one question that would ask how do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes? And another example, under the financing domain, there's a question that asks how does the agency's budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development? So we have some questions to consider that are a really great way to think about the guidance for trauma-informed approaches in these 10 domains.

So that's the bulk of the trauma concept paper. It's in four parts that we mentioned. So it's a lot of great work that has gone into that, and I just wanted to

mention one connected initiative under the trauma and justice strategic initiative.

As Kana mentioned, we didn't receive funding for GATSBI, but we decided to call it General Adult Trauma Screening and Brief Intervention strategy development. And what we decided to do was convene an expert panel in this past March in 2014, and really we wanted to bring together some people from the field to talk about innovative approaches for using trauma screening and brief intervention used in various settings, and specifically primary healthcare, and to engage in a facilitated dialogue around those key issues and challenges.

Out of that meeting, we decided to do six virtual discussion networks, or VDNs. There are three in each category. So we decided to have one on brief intervention and one on screening, and they're actually currently going on right now. And I want to acknowledge Carole because she's on, actually, both of them, and she's been a great participant. So we appreciate that.

So I just wanted to mention that this is also being done, but you know, in collaboration with the trauma concept paper. Everything aligns with the trauma and justice strategic initiative and the current concept paper. So the brief intervention virtual discussion network, the goal is really to have something concrete at the end of it, and we really want to come up with a list of brief interventions that are being currently used in trauma in primary healthcare settings.

And the second one that we're focusing on is the screening, trauma screening decision aid that we would like to come up with. And the goal is really to develop a decision aid used for primary care and other healthcare settings to help them understand and put in place essential elements necessary to integrate screening into their practices and approaches.

So that's the bulk of what the trauma concept paper is, and my information is on the last slide. And I look forward to hearing the questions and comments that you have around the trauma paper.

## **Agenda Item: ACWS Discussion**

MS. KAREN MOONEY: So this is Karen Mooney in Colorado. I'd like to go ahead and open up the discussion for general comments about the paper or responses.

MS. KANA ENOMOTO: Thanks, Karen. I want to let you know that we have a surprise guest in the SAMHSA building. Johanna, you want to say something?

MS. JOHANNA BERGAN: Can they hear me?

MS. KANA ENOMOTO: Yeah.

MS. JOHANNA BERGAN: Hi. This is Johanna Bergan. I'm with Youth MOVE National, attending a different council meeting downstairs with SAMHSA. So here for a little over an hour or so to join in in today's conversation. So thank you.

MS. KAREN MOONEY: Thanks, Johanna.

Are there comments or responses to the presentation about the paper?

DR. YOLANDA B. BRISCOE: This is Yolanda. And the questions that I had were answered throughout this talk. I was concerned about what kind of tools for quality assurance to make sure that organizations were following whatever the model is determined to look like, and the self-assessment for an organization to look at and really look at the organization itself to see if they fit the model. And it sounds like that's being developed.

MS. SARA AFAYEE: Yes. This is Sara. So there are questions to consider. We didn't want to put anything too prescriptive inside the paper about this is exactly what your organization should follow. We wanted the paper to be general enough that people could really adapt the trauma concept into their organization or into their work, but specific enough to know that this is kind of SAMHSA's perspective.

And your question around an organizational self-assessment, there are quite a few tools out there that we make reference to in the end notes around organizational self-assessment tools that people can use.

MS. KAREN MOONEY: I guess one of the questions that I had -- this is Karen Mooney again -- pertains to the concept paper as a whole and the applicability of these concepts to women's gender-responsive services. Not whether or not they're applicable, but in what way they can be adapted to be specifically gender-responsive?

DR. CAROLE WARSHAW: This is Carole. This is sort of responding to your question, Karen. I meant to respond before and then realized I was on mute. We have an agency self-assessment tool, trauma-informed agency self-assessment tool that incorporates domestic violence, incorporates gender and culture into it that I think an adaptation of it was referenced in the SAMHSA's trauma concept paper that was adapted for peer support programs.

So it's really -- it's not hard to do that. We're also working on adapting it for primary care settings so that I think as people understand the basic concept and then think about what it means in a particular setting or what other layers you

want to add in, it's pretty easy to do. And I think the ways you've made it both simple and accessible and added in some new dimensions into it I think are really great.

So we're happy to share our tool with people if they want to look at it, but it's like one iteration. So people can do other ones pretty easily. And we include some things about substance abuse as well.

MS. KAREN MOONEY: Yeah, that sounds very interesting.

DR. CAROLE WARSHAW: Like parenting and kids, you know, because it's -- yeah, so.

MS. KAREN MOONEY: Yeah, I think the part -- the piece of the paper that excited me the most or the piece of this concept that excites me the most is the discussion around implementation. There are certainly lots of theoretical and sort of principles and ideas that are batted around a lot on a daily basis. But to be able to put those into some kind of a framework to look at implementation and to -- I don't want to use the word "fidelity" because this is not a specific protocol, but to be able to look at whether or not the principles are being followed in a specific way I think is going to be very helpful.

DR. CAROLE WARSHAW: We're also working with -- we're supporting [inaudible] developing a trauma-informed practice tool for DV programs to assess that would be some -- used by people who participate in the program by survivors and to assess whether the program is trauma-informed. And we're developing a trauma-informed outcome measure.

We're doing -- in the process of doing focus groups with -- across cultures of survivors about what kinds of outcomes would be meaningful to them based on having -- being involved in a program that's trauma-informed. So those are all in the works. But they're just one little piece of this. So I can send our tool. It's a draft. We just revised it, and we're going to go back into it. So I'm happy to share it if you want to see what it looks like. So --

MS. KAREN MOONEY: That would be great. Other thoughts or comments regarding the presentation and the paper?

MS. SARA AFAYEE: This is Sara. I just wanted to give Becky Flatow a chance, if she had any comments that she wanted to add.

MS. REBECCA FLATOW: No, Sara. I think you did a great job. Thank you.

MS. KAREN MOONEY: Thank you very much for the presentation and for your work on the paper. It's very exciting.

MS. SARA AFAYEE: Thank you, and we'll surely let you all know what we actually have at final as a PDF. Thank you.

MS. KANA ENOMOTO: Great. Thank you, Sara. Thank you, Karen.

We are -- yeah, SAMHSA is really looking forward to having this, the working definition out and the principles out because we find that as a policy tool, as a leadership piece, it's very helpful as so many people are sort of jumping into the trauma fray to have a touchstone to say "and this is how we define it" or "this is what we're talking about." So that we have a common point of reference.

Whether or not it's definitive for anyone else, at least we all know what we're talking about. Because I think we find ourselves sometimes, you know, everyone sort of touching a different part of the elephant when they talk about trauma. And so, this allows us to sort of put it out there and say here's a common framework. You could agree with it or disagree with it, but at least it's common, and it's a starting point for other conversations.

And for many people in the field are -- I think from the public comment that we received, I think many people are quite sort of willing and ready to embrace it and move on. So we're very excited of the work Larke and the group, and the working groups.

So we are --

MR. JOSH SHAPIRO: Brenda has something to say, actually.

MS. KANA ENOMOTO: Oh, Brenda, did you have a comment?

MS. BRENDA V. SMITH: I actually did. When I couldn't get through, I actually just sent an email, and I wanted to again say that I thought that the framework was really good and was interested in the comments that Sara had received from people who were doing work in criminal justice settings. And I guess my other question was about how the model related to when we talk about gender, not only talking about women, but men and also gender nonconforming folks as well.

So those were my two comment/questions.

MS. SARA AFAYEE: Okay, great. I will take the second part around gender, and then I might ask Becky to chime in around the criminal justice piece.

MS. BRENDA V. SMITH: Thank you.

MS. SARA AFAYEE: Those are really good questions, by the way. And actually, your second piece is more around gender, and then you were also talking about nonconforming gender folks, right?

MS. BRENDA V. SMITH: Yes, LGBT, actually.

MS. SARA AFAYEE: Yes, okay. So, yes, we actually have -- there's a lot going on within the trauma and justice strategic initiative. And as a part of that, we've been including just a focus on males in trauma. And so, when we say "males," we're thinking about both men and boys. And Sharon, actually, has done quite a lot of work around that.

But, yes, so we do actually think about both boys and men when we're thinking about our trauma definition and our concept paper. And so, that's a good point to bring up. And we have actually convened twice a group of experts around males and trauma in the last year or two, and they have access to and have provided feedback on the trauma paper as we move forward.

But, Becky, did you want to chime in around the criminal justice part of the question?

MS. REBECCA FLATOW: Yeah, and can you just repeat whether it's just how we incorporated criminal justice or how we work with criminal justice, or was there a more specific ask?

MS. BRENDA V. SMITH: Well, I guess in looking at the framework, one of the criteria -- I don't have the document in front of me now -- but was sort of to look at organization, right, and how the organization itself can deal with trauma. And obviously, there's a lot of trauma that gets situated in criminal justice settings, but those environments themselves can be traumatizing, right?

MS. REBECCA FLATOW: Yes.

MS. BRENDA V. SMITH: So it was sort of the thinking about sort of gaming it out, I guess, about how you might acquire this or employ this approach in a place that sort of replicates trauma.

MS. REBECCA FLATOW: All right. So I'll say, first of all, that one of -- at least one, maybe two of our experts on our original panel when we were developing our concept for trauma came from criminal justice, came from a criminal justice setting. So Hank Steadman is one example off the top of my head, and he provided -- so at the end of our paper, we provide a matrix that shows how you can actually implement this guidance, and it asks specific questions an organization can point to and to really think about how they can bring this paper to life.

And we also reference -- Hank Steadman provided us with one that -- an example of how a criminal justice setting might take these principles. So, and I believe that is referenced in the paper.

And our hope is that since we kept -- kept the concept pretty broad in the paper that we would start seeing examples moving forward of how different sectors are applying it to their work.

MS. BRENDA V. SMITH: Yeah, and I think that would be a great idea and how they're applying it and sort of what are the opportunities and also what are the challenges in that -- in that space? A lot of my work is around sexual violence in custodial settings, and you know, obviously, those kinds of issues are really hard in the community. They're doubly hard in institutional settings, where so many of the very scarce services are not available or either people are afraid to access them, right?

DR. CAROLE WARSHAW: You know, the --

MS. REBECCA FLATOW: Yes. Sorry. Go ahead.

DR. CAROLE WARSHAW: I could send our NCDV TI tool, the new version of the older-version format, but I also sent two documents from our trauma-informed legal advocacy project that Rachel White-Domain, who's a young lawyer on our staff, developed. So it's trying to help people -- it's for DV, but it's really to try to help people negotiate the legal system when trauma may come up in their -- as they're trying to access an adversarial system in their legal case.

So that might be something to think about, you know, in other ways, you know, for other kinds of settings. So I sent them out as examples of things people might want to do.

MS. KANA ENOMOTO: So this is Kana. Thank both of you for the comments and, Carole, your offer for a resource.

I did want to say, and I think Becky sort of touched on this a little bit, is that we had some consideration about whether or not this document was meant for the entire sort of the world of human services, or whether this was meant to be focused beginning with behavioral health. And because it went a little bit in and out of different domains. It went into law enforcement, went into criminal justice, went into child welfare.

And it seemed like that could expand forever, and yet they were also a little bit out of our -- the SAMHSA footprint. We certainly touch on all those things, but the Administrator felt like we should start in our own backyard and then make a document that other folks could then apply and adapt to their settings but not try to make a document that was definitive for all the other fields.

DR. CAROLE WARSHAW: This makes a lot of sense, but so -- but adapting it, you know, when you have the kind of foundational principles really isn't that hard

to do, so --

MS. KANA ENOMOTO: Right. Right. I think it was -- it was just that, you know, it started to get very replete with examples from all these different places, and you weren't quite sure how it all hung together. So is this for child welfare?

DR. CAROLE WARSHAW: Yes.

MS. KANA ENOMOTO: Is this for DV? Is this for law enforcement? Is this for military families? You know, who is this for? Is this for CJ, JJ? And I think each one of those disciplines or fields could do their own document in a way. So I think we tried to -- because sometimes it talked about providers and sometimes it didn't, and you know, are we doing this for, you know, primary care? Who is this for?

So I think we tried to keep it generally that way, with the assumption, Carole, that it could be lifted and adapted, and we were happy to partner with others. And I know the folks over at DOJ are very eager partners to continue the work in different lanes.

MS. BRENDA V. SMITH: Right. And Kana, when you -- sort of in terms of the distribution, will there be sort of, you know, an explicit sort of distribution, you know, to sort of the key people at places like justice and child welfare and so on and so forth?

MS. KANA ENOMOTO: Absolutely. I mean, we have a Federal Partners Working Group on Trauma, and so that it's everybody, everywhere is -- anyone who is anyone is on the group. So --

[Laughter.]

MS. BRENDA V. SMITH: All right.

MS. KANA ENOMOTO: All right.

MS. SHARON AMATETTI: This is Sharon. I just -- I wanted to add one thing. You might remember this, Kana, that a few years ago, we took the Advisory Committee on Women's Services to the -- we had our meeting in Chicago, and we went to the Cook County Women's Prison.

MS. BRENDA V. SMITH: Jail?

MS. SHARON AMATETTI: Yeah, and Stephanie Covington was one of our advisory committee members at the time, and so she was with us. And it was -- it was quite moving. We visited a women's group that was working on her Beyond Trauma curriculum while we were there. And we had a chance to speak

with them, and what I remember is that some of them said that this was the first time anybody had ever asked them about their trauma experience.

So, you know, they were using a program, a trauma-specific program, but the organization, of course, really hadn't looked close at trauma principles for being trauma-informed. So I do think that this guide does add something, an additional resource that we'll have.

MS. KANA ENOMOTO: And for those of you who know Joan Gillece, I mean, Joan Gillece also worked really --

MS. BRENDA V. SMITH: Yes, Joan is great. Yes.

MS. KANA ENOMOTO: Yeah. So way before we went to Chicago, we also went out I think to Dorchester or Eastern Shore, Maryland, and went to go visit the detention center there. And it was a trauma-informed jail. And so, we've -- yes, this has definitely been a high intersection area.

But I do want to move us on because we're running late, even after we're running late, to our conversation about high-risk/high-need girls and young women. I would also point out to our members that we did take a vote, and you guys identified for us what your priority topics were. The number-one vote getter was trauma.

The number-two ranking vote getter was what does gender-specific look like? And number three was what are the needs of high-risk/high-need younger females? So because we like to please, our two major topics today are the high-risk/high-need girls and the trauma.

So, with that, Jeannette is unable to be with us, as you know, but Danielle Tarino, who's a public health adviser here at CSAT, will be -- will present similar to, I think, what she did for her webinar for Sharon's series on the impact of technology and young women. And Johanna is here as our discussant for that.

Danielle, thank you.

## **Agenda Item: High-Risk/High-Need Girls and Young Women**

MS. DANIELLE TARINO: Thank you. Good afternoon, everyone. Thank you, Kana, for that introduction.

I'm Danielle Tarino, and I am with the Center for Substance Abuse Treatment's Health Information Technology team. And I want to just start by saying that, A,

it's an important opportunity for me to be presenting to this committee today on a topic that's very close to my heart and to the work that I do. And also to reintroduce the idea of health IT as not a scary, wordy subject, like sometimes it's often interpreted as.

I'd like us to look at health IT through a different lens today and maybe as an opportunity, to look at social media as an opportunity for engaging young women in health IT. But also social media as kind of an anti-health information technology and how we can use it to target young women, specifically high-needs young women.

And so, the first image here is of a pro-MIA/ANA site. And so, this is one perspective of technology's impact on the girls. I'm going to go from the negative to the positive today. And so, these sites have existed for well over a decade. They're from the time before Facebook, Twitter, Instagram, and all of the social networks that we're all more familiar with today.

And on these sites, young women and men have met and communicated as a community of bulimic and anorexic people who provide support to one another, but not support in a therapeutic or healthy way. MIA stands for bulimia and ANA for anorexia. And oftentimes, users will refer to these two concepts as if they were people, MIA and ANA.

These sites act as forums for members to exchange dangerous dieting and fasting tips, such as strategies on how to prolong periods of time with no food. You can find these tips on how to cover up the physical signs of anorexia and bulimia, such as fixing green teeth caused by excessive vomiting, how to hide the smell of vomit in bathrooms from those you cohabitate with.

Oftentimes, you will find graphic boards on these sites called "thinspiration boards." So that's "inspiration" with a "th" added to the front, which are more or less collages of pictures of body image role models, which are usually fellow pro-ANA/MIA members who are emaciated with bones showing through their skin or fashion models with no body fat.

And I started with this slide today again to introduce the concept of social network beyond what we typically think of social networking. There is more lurking on the World Wide Web beside social networks that we need to be aware of in identifying these high-risk/high-need young women.

Another important concept now raving all over the Internet are called "Am I pretty?" sites. These are used for peer rating. Am I pretty? forums come in a couple of different types and shapes. There are individual Web sites for peer rating built exclusively for this purpose. A user can post a picture and then allow anonymous people to comment on their faces and bodies.

Or a girl can put what we call "an ask" up on Facebook. For example, they post their photo and say "like," which is the thumbs up symbol, "if you think I'm pretty." And in this forum, users can receive peer ratings from their own friends, which can sometimes be even more dangerous than receiving the anonymous postings. And both can lead to either an ego boost or a traumatic online experience.

Online predators. So this data comes from a 2010 Journal of Adolescent Health, which states that 82 percent of online sex crimes against minors, the offender uses the victim's social networking site to gain information about a victim's likes and dislikes. And the purpose of this slide in my presentation today is to emphasize the importance of privacy, privacy, privacy.

Online predators can target and hone in on specific information in a girl's profiles that they use as conversation starters or create the illusion that the predator already knows the girl. I've included this slide to touch on the importance of privacy in teaching girls about cyber ethics and privacy settings.

Myself and others that refer to us as the cyber ethics community have come up with a pretty important concept that we like to call "thoughtful sharing." And that's the thoughtful sharing of personal information online that we believe not just young women, but all people should have a little bit of education on, and that we're a generation of young women that tend to give too much information about ourselves, information that causes us to become vulnerable and victimized.

Types of information shared that can be dangerous include posting what school I go to or what town I live in on my Facebook and allowing all profile viewers to see my list of friends. So a common way that an online predator will use to engage in conversation with a young woman is, "Oh, you know so-and-so. I also know so-and-so."

Using the check-in function on Facebook can be dangerous because it allows people who are friends with you to see not only exactly where you are, but it will give you a Google map to get them there. When girls, sorry, talk about having a bad day, being lonely, being sad, or certain dramas which inevitably occur in the life of our young women, allows an opportunity for conversations that play on our vulnerabilities.

So now that we've discussed some of the scary and negative real consequences of how young women interact with social media, I want to talk about what are the solutions? How can we repurpose social media and online tools to assist girls in healthy development?

So it's important today -- it looks like I missed one there.

MR. JOSH SHAPIRO: Go back one?

MS. DANIELLE TARINO: Yes, please. It looked like it was flipping around while I was talking. There we go.

So how do girls use mobile devices? And I realize that this is a trick question because this generation uses mobile devices for everything. But these are kind of the three main points that I'd like to highlight.

So interpersonal communication. We talk to our parents, and we talk to our friends, and we talk to our caregivers. And there is a false belief that text and email conversation has stunted relationships or stopped a certain amount of intimacy from occurring without that face-to-face contact.

And I would like to challenge that today. Coming from the same perspective of the cyber ethics community, especially in regards to this upcoming generation of girls who have grown up in the mobile world, the girls are in constant communication with each other, all the time, all day long. We're talking millions of text messages are sent between young women and their friends every day.

This nonstop communication may actually be allowing girls to become closer to each other in their peer groups than ever before. We are long beyond the days of friends calling the house, just an example from my life. "Hello? Mrs. Tarino?"

[Laughter.]

MS. DANIELLE TARINO: They have to, you know, communicate with an adult. "I'm good. How are you?" Useful sentences and punctuation. "Is Danielle home?" And then your mom yells, you know, "20 minutes, and then you have to do your homework."

You know, we're beyond these days. The boundaries of space and time between how young people interact with technology are long gone, and this is something that we need to take into consideration as we learn how to interact with these young women. Boundaries have been diluted between how we communicate with young girls and how they communicate with each other and how technology ties in.

You know, we weren't allowed to be on the phone and do our homework at the same time when I was a kid, but now you can be texting and doing your homework at the same time. So what does that mean for your academics? What does that mean for your ability to concentrate?

And then, of course, context and tone. Despite the fact that we believe that intimacy is being increased by technology today for young women, context and tone are still lost.

I want everybody to imagine that moment when you get that email from your boss, but you can't read the tone of it. And it says, "I need to speak to you today at this time." So that could either mean something really bad, or that could mean absolutely nothing. But already the panic and the anxiety and the stressfulness of this interpersonal relationship that's important to you is starting to affect you negatively. Like I run through the list of like "What have I done wrong?" What did I do today? Did I leave early? Did I leave late? What did I do?"

And so, now imagine this 20 to 50 times a day, which we think is the average amount of time that young women with cell phones interact with their friends, 20 to 50 times a day encountering this lack of context and tone panic because they don't know what their friends, the most important people in their worlds, think of them.

And of course, there are educational -- oh, no, defining one's personal identity, and I've talked about that a little bit today that we use Facebook, Instagram, and Twitter as a source of not only comparing ourselves to other women and other girls, but also as allowing -- as setting our social standing in our society. My amount of "likes" on my Facebook picture creates my self-worth and self-esteem.

And then, of course, educational purposes. Our days of 400-page textbooks are looking like they are also almost behind us. Wikipedia and Google have become the things that hold life's every question. You can look up everything from the War of 1812 to "How do you know if he likes me?" and get some pretty solid answers, I might add.

[Laughter.]

MS. DANIELLE TARINO: You can get some really bad answers, but you can get some really solid answers, too. And so, this generation will learn from behind the screen.

And so, how do we use all of -- there we go. And so, knowing all of this, how do we leverage technology to reach young women? We know that this is a different generation of learners. And we also know that the number of women pursuing sectology -- science, technology, engineering, and math degrees has declined since the mid 1980s. So where are all of these women in technology?

And for whatever reason, enter means go back. So how do we build confidence in girls and this concept of cyber ethics that I've spoken about a couple of times today? So there is a new -- are new camps out there. Summer camp for girls that focus on apps. So we're not knitting and learning arts and crafts and making s'mores by the fire, although that is important. But we're learning how to design interfaces and write Xcode. And these are instructed and mentored by successful female designers and developers.

So campers learn firsthand experience on participating in the software world and brainstorming ideas and learning how to build iPhone apps. And they're also being taught about cyber ethics and use cases, which is, quite frankly, something I think that needs to be brought into the public school system as a whole. You know, we don't need to learn I don't know if anybody remembers the typing classes, where they covered up your fingers, and you know, your pinky had to be over here and you had to be over there.

Computers have become such an intricate part of how young people are growing up that we don't need to be taught how to type. But we do need to be taught about privacy. We do need to be taught best-use case scenarios. We do need to be taught what is and is not appropriate to post online.

How much of a no bikini is naked? Is it appropriate to text a boy that I just met pictures of me without a top or without a bottom? The Internet doesn't forget. It is a constant, never-ending machine brain that no matter how badly you try to delete something, it will find you. It will come back to haunt you.

Young boys going to jail and being sentenced all the time for sexting is now being looked at as a harassment and child pornography of a minor. And sometime as innocent as sharing pictures at the moment seems like, oh, it's just a kid thing to do. But then, all of a sudden, you're sitting in front of a judge, and your parents are paying significant legal fees because you've done something illegal.

And so, when we talk about what needs to be brought into the world of engaging young women and young men, quite frankly, to prevent high-risk behavior, cyber ethics becomes a very important part of this conversation.

I don't know why I bother. Back one?

And so, now I wanted to talk a little bit about technology and mental health. So we know that age-old effective engagement strategies in providing mental health services to children and adolescents include journal writing, practicing of mindfulness, mental and physical activity. I'm going to let you hit it.

And there's an app for that. A cliché phrase that we see all of the time, but it is actually very appropriate for what we're talking about today. There are a number of applications in the marketplace, and I'd like to note that slide, that this is not an endorsement of any specific brand or type of application. These are the most readily available with the highest ratings on Google and Android and iPhone playstores when you look it up.

And I do want to encourage anyone that's interested in using mental health applications that the process for evaluating the health value of these is still foggy. A lot of work is being done in the Federal arena around this, but there really is

no standard of care as far as we're concerned yet. So we do, as the health IT team, advise that you pay really close attention to the consumer reviews, to the number of downloads, and to what people are commenting and saying about these particular products online.

And I would also like to take the opportunity to highlight that there are very few apps on this market designed specifically to work with young girls' mental health. There are many general apps for adolescents and children, but the specific niche of girls' mental health is a very small list of usable apps, and I've provided some here.

I put Fashion Math on there just because I found it to be extremely interesting that it was a math product designed specifically for girls, to engage girls in a community that generally is looked at as more of a boy thing. And I've played with Fashion Math before, and it's helped me to fix some skills that I lost from my high school, college calculus days. So it's helpful for adults, too.

Divorce App was a big hitter for young women dealing with parents who are in midst of a divorce, and then there is a quite large market on self-esteem building. And that's the next slide. So --

DR. CAROLE WARSHAW: Can you send these slides? This is Carole.

MS. DANIELLE TARINO: Yes. And so --

DR. CAROLE WARSHAW: Okay, thanks.

MS. DANIELLE TARINO: -- Self-Esteem Building Guide receives four stars in the iPhone store, and these are apps that are designed for self-esteem building and for the practice of affirmation, self-affirmation. I've listed two of the highest downloaded scores in the app stores here. Facebook also has a variety of pages dedicated exclusively to self-esteem that provide girls a community with daily affirmations. It's girls encouraging other girls and inspirational readings and quotes.

Next slide.

So responsible social networking is taught. I can't emphasize this enough. Similar to the development of social skills and family environment theories, there is a new body of literature coming out on children learning online social skills from their parents as well.

Occasionally, there's a buzz in the news about online bullies who happen to be parents, and so that's what teaching our girls -- so who is teaching our girls to behave the way that they do online? Are we sitting around Facebook in front of our kids judging pictures of old friends and making nasty comments about

people? Or are we role modeling proper behavior for our online interactions?

From personal experience, I have noticed -- and in my academic experience as well from studying this stuff, I have noticed similarities between how certain members of the same family behave online. And there are strong similarities between mother-daughter trios. Not only in the language that they use, but the types of pictures that they post, the types of comments that they add, whether those comments be political, negative, positive. Political being its own animal, of course.

And then I also need to recognize that, you know, my generation, we are the first girls on Facebook, and we still behave the same way that 13-year-old girls on Facebook behave. There is not much of a difference between my peers, who are in their early to mid twenties, and my sister, who is 14 years old. We are still interacting the exact same way online. The exact same way.

Whether it's adding Zs in places were Ss should be or not completing full sentences or putting way to many "xoxoxo" emoticons, and also on how we judge one another. I see my 14-year-old sister, you know, unfortunately I hate to say, make the same judgmental comments about girls on Facebook that women my age make about each other. So we are not advancing in the world of social responsibility online.

Arguably, we're getting worse because my generation was not taught a proper way of how to deal with these tools and how to incorporate them into our lives. So we're continuing to pass down kind of what I like to call it's an illness, so to speak. There is a little bit of a pathology in how we use these tools, and it's being passed down now to this new generation of girls.

And finally, last slide, shameless plug. SAMHSA does a lot in the space of using technology to help young women and help young people, and this is the Talk They Hear You campaign.

I would like to thank you all for your time today in listening to my spiel, and that's all I have.

## **Agenda Item: ACWS Discussion**

MS. JOHANNA BERGAN: Well, thank you very much. I was worried I was going to have to lead a discussion on a presentation that didn't happen. I've been trying to think about how to do that for the last hour.

So this is great. One of the things I wanted to just thank -- again, I know Sharon shared at our last meeting information about the Girls Talk webinar series, which

has been amazing. And the one that I was just relistening to this weekend was the technology one. So this is -- falls in line here.

I guess I'd open it up first for questions or initial comments on this technology presentation.

OPERATOR: We will now begin the question and answer portion. If you'd like to ask a question, you can press \*, then 1 from your touchtone phone. Your name is required to introduce your question. So make sure your phone is unmuted and record your name clearly when prompted. One moment for our first question.

MS. JOHANNA BERGAN: Should I say something about that or --

MR. JOSH SHAPIRO: Kevin, it's not public comment. It was just given to the members.

MS. JOHANNA BERGAN: The people on the phone, yeah.

MR. JOSH SHAPIRO: People who are on the phone.

OPERATOR: I apologize.

MS. JOHANNA BERGAN: So I have a question. Although you did a very good job about not like saying one thing is better than the other, but are there people, organizations that are doing online -- or training for girls online in a positive way? Like, are there good examples that we can look to?

MS. DANIELLE TARINO: Unfortunately, I have not had a lot of interaction with ones that are specifically geared towards young women. There are, for example, coalitions, community -- one that's in the D.C. area is called TechnoTherapy.org. And they have a very large concentration of scientists, researchers, app builders, and consumers and people in the behavioral health community that are working to incorporate cyber ethics and the psychology of computer use into the practices of providers.

And they also take a pretty decent look at how all people, not just young women, are interacting with technology. But as far as like I was saying, there is no niche dedicated to girls besides the Dove self-esteem apps or the Facebook online groups that are really concentrating on building up women. There is a gap.

DR. CAROLE WARSHAW: The National Network to End Domestic Violence in its staff workshop has a whole thing on safety and technology, and I don't know how much that addresses -- focuses specifically on girls. But it does talk a lot about cyber stalking and some of those kinds of things. So at least you could look at it and see if there's anything, and I'm sure they would be really interested

in partnering to develop something for girls since there was, you know, an interest.

MS. JOHANNA BERGAN: So something that has been striking me as I kind of wrote out my notes and listened to the presentation and how you started with the negative space that is very much online and moved to the positive. I wonder in our work about that balance and that we -- it seems so easy to scare potential partners just out of the room. And once you're scared, you go offline. I mean, you don't have an online presence.

And the flip side of that is the, you know, full-on embracing everything we need to do needs to be tech friendly, and then you alienate an audience that has either opted out of this sort of presence or doesn't have access and how each of us balances that in our work.

MS. DANIELLE TARINO: Sure.

MS. JOHANNA BERGAN: And I find that in the youth engagement work is that we duplicate our work frequently. So here is the easy, fast online version. Here is the wait for 2 1/2 weeks for me to get someone to type all that out and get you this information, and there is a disconnect in how people can connect whether based on how much they buy into online professionally.

MS. DANIELLE TARINO: Absolutely. And I appreciate you bringing that up because we talk about the balance in our work a lot. How do we embrace the nontech community and maybe what we refer to as the Luddite community. But when we're talking about young people and girls, it needs to be made clear that no amount of scare tactics, like Just Say No or DARE to keep kids off of drugs, is going to keep kids away from wanting to interact online and wanting to have that community with their peers.

And so, you know, the solutions that my team talks about and that we work towards on a daily basis is bringing providers into that space, providing them training that allows them to use the technology at their own speed, but also recognize the impact that it's going to have on our patients and our clientele. And at the same time not overwhelming them so much with like words and Twitting and buzzing and feeding and really breaking down the lexicon and using common language that everybody is able to understand without emphasizing technology gaps or generation gaps.

MS. KANA ENOMOTO: So this is Kana. Danielle, you talked about sort of technology and mental health. But are there not communities supporting recovery for young women or even young people using mobile apps?

MS. DANIELLE TARINO: Many. There are many. Thank you for that question. There are quite a lot of online groups, specifically on Facebook, Twitter, and

Instagram forums, that are communities of young people in recovery. There are plenty that are exclusively communities of young women in recovery that support each other online and provide each other with inspirational daily quotes, online supports. Having a hard day, someone gets on Gchat with you.

There has been quite a lot of hashtagging movement around sobriety for women, and "I do it because I'm sober" was a big one of those. And "I am not anonymous" is a big one of those. Yeah.

MS. KANA ENOMOTO: Okay. And also like to write "love" on her arms.

MS. DANIELLE TARINO: Yes.

MS. KANA ENOMOTO: And so, there is either, I guess, in the self-injury or suicide prevention space, there is definitely stuff for young women. I don't know about the survivor, and Carole, you may know more in the -- whether child abuse or domestic violence survivor world there is more social media for young women?

MS. DANIELLE TARINO: There are survivor networks that I've seen, like usually they're private groups. And so, one has to seek them out and join and, you know, speak with them before getting on it. And those are less public, but yeah, I've seen. And then on the opposite of the pro-MIA, pro-ANA, there is quite a lot of online forum focused on survivors of anorexia and bulimia.

MS. JOHANNA BERGAN: One of the requests that the young people in Youth MOVE chapters made to us national organization was to create an app space for them to interact, and so we're kind of in that development. Still a process right now. And their request -- and we've had a pushback. We're like, really? Do you want us to design another piece of technology? Here's all of the ways you can access us online. Explain why we're not meeting your need.

And the kind of immediate response we've been receiving is that at least some understanding of what we put on Facebook might not be the way we want the world to see us, and their request was, well, my Facebook is for this part of my life, right? My Facebook I interact with these types of people. I do not interact with people who I want to be seen in a more professional light, although they don't use that language. And so, they want to kind of re-create their profile and have it in this new space, a new way to share this is who I am as I represent my Youth MOVE chapter and how I interact with other youth advocates.

And so, there was a request don't make an app that links to my Facebook page. Give me the chance to kind of re-create that profile. So I think we're going to listen, although it's a pain. And that kind of brought me to a question that I have heard people say before that young women are constantly exploring who we are and who we aren't and trying on different clothes and different ways of talking,

and that's a natural developmental process and that social media allows us the opportunity to do that like on a much more massive base.

MS. DANIELLE TARINO: It's a larger audience, yes.

MS. JOHANNA BERGAN: Yeah, right?

MS. DANIELLE TARINO: Mm-hmm, absolutely. And we would never want to downplay the importance of that kind of soul searching, but there is a boundary. There is a line that's crossed with some young women, particularly the high-risk populations that I was referring to where the line gets crossed between having an audience that encourages the soul searching into an audience that provides more vulnerabilities and high-risk situations.

And you know, there is not a whole lot -- there is a lot of literature on cyber ethics and teaching these things to children. There's not a whole lot of community collaboration built around how are we teaching our children to responsibly interact with the Internet. And I think definitely the Youth MOVEs, the young people in recoveries in this space could definitely provide context and a healthy, safe atmosphere to allow people to kind of explore that space and learn that not everything is Facebook postable if you want to get hired.

And there are private areas where you can express that online, where it's not going to come back and hurt your career later in your life.

MS. KANA ENOMOTO: I do think they're starting with kids much earlier. So fourth grade? Fourth grade they're talking about using social media and cyber bullying and how to respond and what you put online. So I think kids are -- kids are learning those things much earlier. So the next generation of online users may be a little bit more savvy.

MS. DANIELLE TARINO: Savvy, mm-hmm.

MS. KANA ENOMOTO: Also the preventing of the exploitation and the online predators. So they're learning more about the need for privacy and discretion.

Okay. All right. So, Carole, and just so you know, I believe that these slides were also emailed out in Josh's email from yesterday. So you should --

MR. JOSH SHAPIRO: Today.

MS. KANA ENOMOTO: From today. So you should -- you should have them, we hope.

## **Agenda Item: ACWS Priorities for SAMHSA**

MS. KANA ENOMOTO: Okay. So we have a few minutes before Administrator Hyde gets here, and I wanted to just review with you. I did mention that the two topics that we talked about today were a result of the prioritization that the members had sent in, and I wanted to check back with you as we think about our next meeting about what you would like to see.

Thank you, Danielle. I'm sorry. That was great. That was very helpful.

So what would you all like to see for our next meeting, and how would you like to see us carry out these themes over the next couple of years? So I'll remind you again. We had the number-one ranking priority theme was how does trauma impact women? Number two is what does gender-specific look like? It might include features related to the PPW program. And number three, what are the needs of high-risk/high-need younger females? This could include a focus on young mothers as well as young females in the juvenile justice system.

So I guess my question is what you all see as next steps on these? If there's -- I mean, I imagine we may ask Jeannette, if she's able to come, to do her presentation there. She suggested that we might just walk through her slides, but I don't think they quite lent themselves to that since they were -- involve sort of individual stories and sort of a narrative that we didn't have.

But are there other things, since we'll have a full meeting, that you guys would like to see us do in pursuing these topics?

MS. KAREN MOONEY: This is Karen Mooney. I would be interested in further discussion related to gender-specific versus gender-responsive, what this looks like. And maybe some of the outcomes or process related to the pregnant and parenting women program.

MS. KANA ENOMOTO: Okay. And are you saying PPW outcomes relative to nongender-specific programs?

MS. KAREN MOONEY: Actually, that would be very interesting.

MS. KANA ENOMOTO: Okay. I don't know if we have that comparative data because I don't know how much other residential treatment we're paying for through our grant programs.

MS. SHARON AMATETTI: I don't think it would come from SAMHSA programs necessarily.

MS. KANA ENOMOTO: Yeah.

MS. SHARON AMATETTI: But we could ask Chris Grella to share her work.

MS. KAREN MOONEY: Yeah, that would be great.

MS. KANA ENOMOTO: So is there other conversations that we want to have around -- we haven't talked about young mothers, although they are included in the PPW. They aren't -- been necessarily called out. Or is there anything else that we wanted to do specifically about juvenile justice or trauma?

[No response.]

MS. KANA ENOMOTO: So several of you, I think, raised the gender-specific or how does the trauma concept affect women or how would we roll this out or that kind of thing. And I think there is this possibility that this group could be a little bit more, I guess, proactive. So rather than listening to a presentation, we may -- we might have more of a strategy session in terms of hopefully by April, the trauma concept paper will be out. In fact, I'll make that more definitive. It will be out by April.

And so, it could be that the ACWS advises SAMHSA on what it could do with the paper with respect to either dissemination or next steps on tools or, you know, some further analysis of the paper with respect to its impact or importance for women. Is that something that the group would be interested in?

MS. KAREN MOONEY: Yes. Yeah, this is Karen Mooney again. And as you were talking about that also reminded me of the block grant application and the opportunity perhaps to incorporate information about what are gender-responsive services within the context of this particular strategic initiative. I think it would be great to do some work on that.

DR. CAROLE WARSHAW: And also I remember, Kana, when we talked about this a couple years ago about the setup for women's services on the substance abuse side, but not on the mental health side. And if there's any opportunities to infuse that more?

MS. KANA ENOMOTO: So what does gender-responsive look like on the mental health side?

DR. CAROLE WARSHAW: Yes.

MS. KANA ENOMOTO: Okay. Gender-responsive/gender-specific. Okay, and then, Karen, I'd like --

DR. CAROLE WARSHAW: Because the trauma piece, that's part of why gender-responsive is important is because of the sense of trauma women

experience, and it's one layer of it.

MS. KANA ENOMOTO: Okay. So I think if we do a gender-specific versus gender-responsive conversation, we would look at it both from the substance abuse and the mental health perspectives to allow a little bit more comparison there and to identify where there is work that -- to be done. Does that make sense?

DR. CAROLE WARSHAW: Yeah, because developing a whole, you know, something that could happen differently based on that would be great, you know, if we could contribute to something like that [inaudible].

MS. KANA ENOMOTO: Okay. All right. I see that.

So, Karen, I want you to hold. The Administrator has just joined us, and so we'll transition to that conversation, but I'd like you to bring up your suggestion relative to the block grant application because that's something that she's quite involved in. So I think it's -- and that probably won't hold until April. So that's good for this next session.

And then I just want to let members on the phone know that Brenda has had to leave. She sends her regrets and good-byes. So we're glad that she was able to join us for the time that she did.

Okay. So thank you, Johanna, for facilitating our session on young women and technology.

## **Agenda Item: Conversation with Administrator Hyde**

MS. KANA ENOMOTO: And now we have Administrator Hyde joining us for a conversation. This is a little bit more of a free-flowing dialogue. We've had her join us before about specific topics or during sessions where we had presentations, but this is really an opportunity for our members to talk about or raise questions on issues of concern.

Let's just do a quick round of intros, just so that Administrator Hyde knows who's on the phone, and we'll let her know who's in the room as well. So starting with the phone?

DR. YOLANDA B. BRISCOE: Hi, this is Yolanda.

MS. KAREN MOONEY: Hi, this is Karen Mooney in Colorado.

DR. CAROLE WARSHAW: Hi, this is Carole Warshaw in Chicago.

MS. KANA ENOMOTO: Okay. And in the room? And actually, we probably didn't do this earlier, but we'll just go ahead and start. This is Kana.

MS. NADINE BENTON: Nadine Benton.

MR. JOSH SHAPIRO: Josh Shapiro.

MS. KANA ENOMOTO: And you might want to just say what you're --

MR. JOSH SHAPIRO: I'm Capital Consulting.

MS. SARAH JURA: Sarah. I'm the transcriber.

MS. IRENE GOLDSTEIN: Irene Goldstein. I write the minutes.

MS. JOHANNA BERGAN: Johanna Bergan.

MS. NEVINE GAHED: Nevine Gahed, SAMHSA.

MS. SHARON AMATETTI: Sharon Amatetti.

LT. HOLLY BERILLA: Hi. This is Holly Berilla. I'm SAMHSA's new CMO. I'll be taking over for Geretta Wood.

MS. GERETTA WOOD: And Geretta Wood, outgoing.

[Laughter.]

MS. KANA ENOMOTO: Okay. Great.

MS. PAMELA S. HYDE: And hi, this is Pam Hyde. Good to see you all and hear you all.

MS. KANA ENOMOTO: So, so are there -- Karen, would you like to start with the question or the suggestion that you just raised?

MS. KAREN MOONEY: Hi, Administrator Hyde. In the course of our conversation just for the previous session talking about priorities and things that this group could focus on, one of the things that comes to mind for me is the importance of the SAMHSA leadership in the sort of definition and support of women's gender-responsive services through the women's set-aside.

And in the current block grant application or the application as planned, there really isn't a specific section to talk about the use of that set-aside as well as the services that are designed to, you know, promote women's gender-responsive

treatment in general. And I'm wondering whether it would make sense or whether this would be something that SAMHSA would take on incorporating perhaps a little more specific emphasis on women's gender-responsive services in, for example, the strategic initiative related to trauma and justice and whether there might be another initiative as well or two that that might fit into?

MS. PAMELA S. HYDE: Well, I'll say one thing about that and then ask something back from you about it, which is we're going through the block grant application right now for Fiscal Year 2016 and '17. So we're in the process of it takes months to go through the process of developing the application because we have to draft it, and then OMB has to look at it. And then we have to go to public comment, and blah, blah, blah, blah. It goes on forever.

So we're in that process right now, and we're sort of finishing up our part of it, or at least our initial part of it. So it's good timing. I think that's what Kana was alluding to. And I am personally reading every word. So it's helpful to know what your thinking is about that.

There is a section about pregnant women in the set-aside in there, but it may not be sufficient based on what you're talking about. We also have some general language about trauma in there in the sense of these are the kinds of things -- because of the stuff it looks on your agenda like you've been talking about, that you heard from Larke or whoever they heard from about our trauma-informed work. So, hopefully, I will go back and look again to make sure the trauma stuff is in there in a sufficient way.

But if you have -- here is the ask. If you have something specific that you think we should say, I can't promise you that the sentences you give me will exactly end up in there exactly the way you write them. But if you would send to -- who is the right person to send? Nadine? If you would send to Nadine a couple of sentences that you think it ought to say, we'll see if there's a way we can incorporate either the concepts that you give us or even, to the extent that we can, the words that you give us.

Now the caveat here is our lawyers have a lot to say about what we're allowed to do in the block grant, and they are -- there are many places where we can encourage or suggest to States that they do things. There are much fewer places, many fewer places where we can actually force them or tell them they have to do certain things.

But we do use the block grant application to talk about our philosophy or our values or our direction or our proposals or our suggestions for them. So if you want to give me a little language, we'll see what we can do with it.

MS. KAREN MOONEY: Thank you very much. I appreciate the opportunity. I know that in our -- you know, in our process, one of the things that happens is

that the question or the information isn't asked for, isn't focused on. And if it isn't focused on, those things that are explicitly asked for in the applications end up taking precedence in time, attention, resources, staff over those things that are more silent in the application.

So I really appreciate the opportunity to contribute in that way.

MS. PAMELA S. HYDE: Okay. And I really would encourage you to do it very quickly because we're right at the point of trying to finalize that language to send it off to OMB. So if you can get it to us by early next week, that'd be great.

MS. KAREN MOONEY: Beautiful. Thank you.

MS. PAMELA S. HYDE: So this is free-flowing. So whatever else you all -- it's not like I have things to tell you. It's I'm here to listen and hear from you. So tell me what you're -- what's on your minds.

MS. KAREN MOONEY: Well, this is Karen again.

MS. PAMELA S. HYDE: Okay, keep going.

MS. KAREN MOONEY: And the other topic that I was interested in sort of bringing forward is the topic of IMD exclusion and the challenges that we're facing in trying to bring residential programs for women and children online. In light of that IMD exclusion, currently residential treatment is not covered for any population other than pregnant women in Colorado. But we are in a position at this point where we simply don't have capacity, even if more funding does become available, because of that 16-bed limit and the limited number of programs that are able to function with that limit.

MS. PAMELA S. HYDE: So the IMD exclusion is a Federal law. It's not something that we set or that Medicaid set or that HHS set or that the President set. It is congressional law. So it would take Congress to change that.

If they changed it, the -- every time anybody has looked at changing it, the cost across the country is humongous. And here is what the worry is, is there's not a real easy way to separate in the law an exclusion for one thing, say, State hospitals, for example, versus something else, like residential treatment for women. The Medicaid program doesn't allow distinctions based on populations like that.

So it's a very tricky thing to do without opening up tons of costs. And let me tell you, it's more than just congressional cost. I'm not trying to defend this so much as I'm trying to explain it. The issue is if you open it up and State-run facilities, which are some of the biggest ones that are excluded, or hospital inpatient beds are excluded, and those are now opened up for public money or for Federal

money, the history has been that the States don't turn around and use their freed-up money for more services.

What they do is they use that freed-up money for more schools or for -- and teachers or more prisons or more roads or more something else that the State finds is a pressing priority. So it's not only a cost issue, but the tradeoff in what you get if you actually muck with that is a big issue.

So we find ourselves 50 years later, this has been in place for 50 years, and historically, how to fix it or how to undo that is very difficult. CMS has been talking with us and with others about the possibility of waiver programs. But that's also really tricky, and I don't mean to get into the details here too much, but because the waiver process has to show neutrality, cost neutrality, and because those beds aren't currently funded by Medicaid, then it's very difficult to figure out a cost neutrality way of covering that.

And it's also just the -- it's -- again, it's hard for CMS to figure out a way to say we can open that up for pregnant and parenting women, for example, which meant as a priority population for residential, and not open it up for a bunch of other populations, which may or may not be the priority. So it's a very complicated issue.

I just came from the Tribal Advisory Committee, and they have the same issues. So it's a struggle. So I think what CMS has been looking at trying to do is see whether or not there's a way to incorporate it into some community-based programs or demonstrations. And frankly, then having now told you all the Federal side of this, the fact is there are some things that States can do, and some States have just chosen not to.

So sometimes the advocacy is at the State level. So, for example, residential treatment for children, for young people, is not excluded by the IMD exclusion, and residential treatment in numbers less than 16 is not excluded. So there are things that States can choose to do, and a lot of them, unfortunately, just choose not to. I know the State I came from, New Mexico, we covered some residential treatment for children, but not for anybody else. And we could have. We just didn't because of the cost and limitations that the program and the legislature wanted to put on it.

So that's a long story to say it's a tough issue. It is a struggle. I don't think we have a simple way around it. And obviously, in this budget environment, the PPW program, for example, which is a drop in the bucket to the need, has not been -- not seen expansion either. I think we've prevented it from seeing major cuts, but we haven't been able to expand it in any way.

But I am totally supportive of residential treatment for pregnant and parenting women. I just want to see our -- our program be able to do the whole gamut of

community based as well as residential treatment for this population. Does that -  
-

MS. KAREN MOONEY: Yeah, thank you.

MS. PAMELA S. HYDE: It's just a reflection. It's not much of an answer. It's just a hard issue.

I think -- I think didn't CMS already go ahead and put out the -- didn't they just do the residential treatment info bulletin, or is that still in the process? Do you know? I'm looking at Kana, but I don't -- I know they were working on some information bulletins, which is a way they -- it's sort of like our block grant. It's the way that they encourage States to do things that they can't force them to do.

They've been working on several information bulletins. They put out one just recently with us about substance abuse for adolescents and how they could fund it. But they were working on one about residential treatment, and I don't know if that one is out yet or not.

MS. KAREN MOONEY: Thank you very much.

MS. PAMELA S. HYDE: So I guess -- I guess the point there is we know it's a problem. We're sort of looking at it and trying to think about how we can do it best or deal with it and don't have a quick and easy solution.

So what else is on your minds? Yolanda, you run a residential treatment center that's not -- that's excluded by IMD, right?

DR. YOLANDA B. BRISCOE: Yes, we do. And it is excluded, and so we look at other funding sources that's not Medicaid. We could break it up and say this is a 16 here and there is a 16 there, but we're not going to do that. But, yeah, that is an exclusion from Medicaid. Not for our outpatient or for our suboxone program, but definitely for our residential.

MS. PAMELA S. HYDE: So, yeah, you do bake sales, right?

DR. YOLANDA B. BRISCOE: Yes.

[Laughter.]

DR. YOLANDA B. BRISCOE: Lots of them.

MS. PAMELA S. HYDE: Yeah.

DR. YOLANDA B. BRISCOE: And other things because I'm not really a good baker.

[Laughter.]

DR. YOLANDA B. BRISCOE: I did want to make a comment that although this is my last meeting, just to continue to remember about aging population and women and aging. And PTSD and women and aging, and so just to keep remembering about women as the population continues to age, more and more of an aging population.

MS. PAMELA S. HYDE: You bet. I'm there. I am one of them.

DR. YOLANDA B. BRISCOE: Me, too.

MS. PAMELA S. HYDE: Yeah. So, actually, thank you for the question because we get this a lot about why we don't do more about seniors and the aging population. And let me just -- it's a little bit like IMD, except not quite as complicated. And that is most services for seniors are funded through Medicare or Medicaid and private insurance. The vast majority are funded there.

Medicare doesn't have parity yet. Medicaid does, but it's a little complicated, and we are working on a -- CMS is working on the Medicaid parity reg. And some of the States have done the duals program where that would be more people, seniors or otherwise, people with disabilities because of behavioral health issues.

Nevertheless, most of the dollars for seniors are there. That, and through the Administration for Community Living, which houses the Administration on Aging. So that's the Title V program and all that. So there's a lot of money that goes to serving seniors' health and behavioral healthcare that is not in SAMHSA. And if you look at SAMHSA's programs, they are vastly on the kids side.

We have lots of funding specifically for children's mental health. We have funding that's specifically for SMI and SED youth and adults, but frankly, SMI adults, they certainly can go into the aging ages. But just the nature of the disease and the nature of the early mortality and others is there's not quite as many older individuals who fit those criteria proportionately. So those dollars have a tendency to go to people under 65, and then the Medicaid and Medicare has a tendency to serve the older, over 65.

So, and then you put on top of that the IMD exclusion. So the under 65 don't get Medicaid and Medicare. So a lot of the block grant dollars -- I mean, the State dollars go into the services there. So, again, I'm not saying this very articulately. But the bottom line is SAMHSA's dollars are way disproportionately on the young people and adults side.

So what we try to do on the seniors, we do have some materials about seniors.

We have some small programs about seniors. We have been trying to do more work with the Administration on Aging, and in fact, we gave them some money one year because we had some year-end money. We gave them some money to do some prevention programming around depression and suicide and prescription drug abuse.

And actually, Kathy Greenlee, who's the head of that Administration, and I are right in the process right now of writing a blog -- we just, I think, finished it this morning -- on suicide. So that we're going to put out together. So we're trying to do things we can. But I think sometimes people -- we really try to be and SAMHSA wants to be the agency that advances behavioral health for all of the Nation.

Our funding is uneven, however. And to the extent that our funding is targeted to certain populations or certain age groups or certain prevention kind of efforts, as opposed to -- or treatment for people with serious illnesses, as opposed to different kinds of illnesses that seniors may experience like depression and other things that may or may not rise to the level of a serious mental illness. We are constrained on some level by our funding.

Given that, I personally, and I'll take responsibility for it, given where our funding is, given where the priorities are, given where the resources are and what the Affordable Care Act and others has meant to seniors, and there's been a lot of work at the departmental level to get seniors covered and to get them into insurance -- either Medicaid, Medicare, or private insurance -- we have hung back. And I have made a decision to focus more of our efforts on the younger ages because of that.

It's not that they're not important. God knows I am one of them. It is really just a matter of there's only so many dollars, and we're trying not to duplicate the wheel. We're trying to support our partners in the Aging Administration and the work that they do. And I can tell you, Kathy is very, very interested in behavioral health issues and is trying to do what she can within the constraints of her dollars as well.

DR. YOLANDA B. BRISCOE: Well, thank you for that. And more specifically, not as much about funding or starting programs, but just an acknowledgment. I'll give you one quick example. We are seeing more and more grandmothers raising their grandchildren --

MS. PAMELA S. HYDE: Right, yep.

DR. YOLANDA B. BRISCOE: -- than ever before. And so, the support around the grandparents because they don't get Medicaid.

MS. PAMELA S. HYDE: Yep.

DR. YOLANDA B. BRISCOE: Because the child is not -- they don't get tax allowances, none of that because they're not in their name, and the child would have to give up parental rights. And that's not always something a parent, even though they're in their addiction or severe mental health issues, are not willing to do.

MS. PAMELA S. HYDE: Yeah.

DR. YOLANDA B. BRISCOE: And so, just the acknowledgment that as women are aging, and when we're talking about parents and just a little bit about that education about the technology, that's something really new. We have some counselors who talk about "I don't know how to help them with their homework. I have no idea. I haven't done homework in 30 years, 40 years."

[Laughter.]

MS. PAMELA S. HYDE: I do homework every day. I don't know about you guys. But, yeah.

DR. YOLANDA B. BRISCOE: Yeah, so just a reminder of that.

MS. PAMELA S. HYDE: Yeah. No, that's very fair, and I actually personally ran into that issue much more when I was responsible for TANF and child support, the issue of grandparents raising grandkids and getting no support for it because of the nature of the relationship or because of the disconnect. It's a huge issue. It's a huge legal issue as well.

So I totally understand that, and I think we can think about ways to keep that in our minds as we go forward. Thanks.

DR. YOLANDA B. BRISCOE: Thank you.

DR. CAROLE WARSHAW: This is Carole. I don't know if you, Administrator Hyde, were on when we were talking about gender-responsive services on the mental health side, but it's more developed on the substance abuse side and how to infuse some of that into maybe the block grant. Just even thinking about what that would mean or what that would look like, especially as part of the trauma and justice, you know, maybe something around trauma that people being in the standard settings and that type of thing.

I mean, there's lots of ways that plays out around those gender issues, but also around the way settings are structured. So that was one thing, and another thing was we've been doing some work around privacy concerns and EHRs, and we've submitted comments on the 42 CFR. But that comes up around domestic violence and privacy and an abusive partner having access to records and how

that plays out.

And part of our thinking was around really there is so many -- so much money going into the development of electronic health records and that there should be some money going into having a really robust informed consent process so that people actually can think through not just having that HIPAA thing that you sign in fine print that, you know, what are the implications and who might have access? And you know, how to think through making those decisions in an informed way.

So one of the things we think about are like the psychiatric advance directive. There is the attorney-in-fact, someone who's got an abusive partner and how to provide guidance around those issues. And there are lots of areas that aren't focused on gender issues, but having that lens could make a difference. And the stigmas around behavioral health integration and health homes, you know, where would gender issues, trauma issues come into those? What are things that people might be thinking about differently?

So the things that aren't specifically focused on gender, but that having that lens would be important.

MS. PAMELA S. HYDE: Yeah, that's -- I came in right as you were talking about that, sort of the tail end of when you were talking about that is when I came in. So that I only heard part of it.

DR. CAROLE WARSHAW: That was all I said. I'm just trying to think about where are the places -- there is like more issues that are specific to women and girls, and then there are more generic issues where having an infusion of how you would think about what you would layer in is important. Like on the committee, the DV Suicide Prevention Committee, but thinking about what would you layer in, the crisis calls that would be different?

So it's all those places that we could be thinking about that wouldn't be like major initiatives but would just add, you know, a lens.

MS. PAMELA S. HYDE: Uh-huh. Well, I assume, since I saw people writing that down when you -- when you were saying it as I came in. So I'm assuming that Kana and others will think about what's the right way to get Paolo and others involved in that discussion.

MS. KANA ENOMOTO: Well, there was the first part that she did mention when you were coming in, which was the gender-responsive -- what do gender-responsive mental health services look like? So that we do have. I think the latter thing that you brought up more around the HIT, the privacy, that's slightly different, sort of how do you think about gender across the behavioral health policy landscape? Which is a slightly different and bigger question.

I think with respect to the 42 CFR Part 2 stuff and having a more robust informed consent process, I think those are a little bit separated issues. What we're talking about with respect to the "to whom" and the redisclosure, I think some of that is trying to keep technology and try to keep the regulation and the law apace with technology and the way the world operates now, regardless of gender.

But I agree that -- and the consent issues, I think we talk about needing those to be more robust for everyone. And I agree, there can be a gender lens on that. What does this mean about if you have an abusive partner? Or what does this mean about if you have a trauma history?

But it also, you know, relates to HIV, psychotropic medications, a lot of other things when you sign a consent.

DR. CAROLE WARSHAW: Right.

MS. KANA ENOMOTO: And think it's acknowledged that we, each of us, regardless of our what medical concerns or health concerns we have, often goes into a doctor's office and signs pages and pages of forms with fine print without actually having arrived 45 minutes before your appointment to read all of it.

MS. PAMELA S. HYDE: Yeah. Yeah, it's a good point that we are in the middle of, right, again good timing, the 42 CFR Part 2. We're reviewing what proposals we might make about changing that reg. And the context for the reg is really about how to share or whether to share data about drug abuse or alcohol issues among treating providers. It doesn't really address the issue head on about sharing it with other family members or not.

So the bigger issue I think that you're raising is like we've been doing some work with the Office of the National Coordinator for Health Information Technology, or it's called ONC, around data segmentation, they call it. And we've actually done some of the pioneering work about how to do the technology about that.

And the theory being it would matter for us around substance abuse issues and, frankly, on the mental health side, which tends to be State by State. It's not a Federal law, but it tends to be varied State by State. But the issue is how do you segment anything?

So if I want my neurologist to have some information, but he doesn't need the information about my knee replacement, or at least I think he doesn't -- now there's a bigger issue about whether or not your doctors need all that to know what kind of medication you're on or what kind of body trauma you've had or whatever. But that's a different issue. The issue is, is there a technology way in a technology world, of letting a person make their own decisions about which part of their health record, including behavioral health, do they want shared and

with whom?

And it's a, as you might imagine, a thorny issue. But I think if you -- I always think of it this way. If you can imagine and if you can remember, if you're old enough, and I certainly am, back to a time when you couldn't get online and go buy a plane ticket and figure out where you were going on different planes and different places and check in online and walk through and show it on your iPad and everything else. There was a time when all that was by paper and phone calls.

And so, in my lifetime, that has shifted. So I think the technology on health information and sharing is going to shift in our lifetimes as well. And so, I think we probably should go back and think about in that data sharing thing or data segmentation work, we've really thought about it more as how to segment your data from one provider to another, not so much from other family members or whatever. I don't know that that lens has been on it, and we probably should just go back and think about that and look at it.

DR. CAROLE WARSHAW: I think, you know, in conversations with Dr. Clark that he said he was able to kind of open source the technology for data segmentation and that the big vendors said they couldn't do it, but in fact, you can do it. They just need the motivation to do it. And that people need to -- you know, we're hoping that there could be some Federal guidance, you know, or some criteria for vendors to actually provide that technology for segmentation and for good informed consent and think about unintended potential consequences, you know, in a variety of ways.

So I think that SAMHSA really has a leading role in that, which is going to be really important.

MS. PAMELA S. HYDE: Yeah, and Kana may know the answer to this. I just don't know whether our data segmentation software that's open source software allows you to say you can give this to my podiatrist and my sister, but not my husband or my heart doctor. Do you understand what I mean?

DR. CAROLE WARSHAW: Yes.

MS. PAMELA S. HYDE: It's been -- in my head, I acknowledge in my head, it's been more about which treating physician gets it or not and which -- so it's sort of in the healthcare arena, and my head has also been wrapped around not letting it outside that box of healthcare because we do have, obviously, certain circumstances in which people want to use that data for things like child welfare issues or for law enforcement issues or others. And we don't want them to do that. Absolutely. We want them to not be able to do that without consent, no matter what.

So that's where my head has been, and I'm just acknowledging I haven't thought about it as much in terms of the segmentation around a particular family member you don't want to have it or a particular person who's been causing you domestic violence or stalking or anything else.

MS. KANA ENOMOTO: Yeah. I think the data segmentation is a technology solution to the problem of releasing in the context of EHRs and HIEs and networks of --

MS. PAMELA S. HYDE: Right. Right.

MS. KANA ENOMOTO: -- providers that are sharing information electronically. It's not meant to be the solution to -- because I think probably the paper solution works just as well, or the individual consent to this information can go to this employer, or this information can go to this family member. Please send my record.

I think those, your employer, your family member, is less likely to be part of the health information network, and so that's -- that's what the segmentation is sort of the traffic cop or the air traffic control to say because the way the 42 CFR Part 2 is, it says you must, you have to name the provider to whom you're releasing information. But if you -- the way healthcare is structured now and with substance abuse services getting integrated into mainstream healthcare or mainstream health systems, you know, if I release -- if I am going to a provider, but they're part of this broader network, can my records go into that health information network? And can it go to the podiatrist so that if I go to a podiatrist who is my treating provider, they can access that record if they need to? Or I can decide that they can't.

But I think it wasn't necessarily intended to permit sort of people who are outside of the network to have information. Now is there a way that you could use data segmentation to flag your record to provide consents to others and which consents is probably the same technology, but it's not -- it's not what this was designed for.

MS. PAMELA S. HYDE: Right. Right. So where my head was going about this was on the other hand, there are two other things. You know, HIPAA, when it first came into play, was really operated to prevent people -- like a mom could not call up and say, "Is my 19-year-old son in the hospital?" The hospital wouldn't tell them. And that got very frustrating. So there has been some pressure, especially in the behavioral health world, some pressure to ease that a little bit.

And I think you find now hospitals are not quite so strict about that, for example. I'm just using one example. And so, there's pressure in the behavioral health, especially in the mental health world, about family members wanting access to

information about their mentally ill family member's record. So there's that pressure to open it up more to family members.

And then, on the other hand, there is pressure to keep it away, as you said, from family members you don't want it to have. And yet the LGBT issue has raised issues of making it more possible for a person to identify who they do want in the room with them or having information about them. My sense is that what's happening with that is less questions about family members getting access to information, just in a hospital setting at any rate, and that may play against the protections you're talking about.

So, again, I'm getting kind of complex with you. But there are so many aspects of this and so many pressures that are coming at this in different ways that I think it does bear us thinking a little bit, well, what are the gender implications of that?

DR. CAROLE WARSHAW: I'll send you our comments so you could see how we were thinking about it.

MS. PAMELA S. HYDE: Yeah. Yeah, well, you're clearly raising things that are making me scratch my head a little bit because we haven't thought about them quite that way. So it's helpful. It's very helpful. Thank you.

MS. KANA ENOMOTO: Johanna?

MS. JOHANNA BERGAN: I wanted to take a minute to thank you for having the time to talk about youth issues in the April meeting and with the joint councils, and I really enjoyed that. And I was wanting to follow up to see if there had been further conversations or work at SAMHSA to continue to include the youth voice within your work, which could include other people on councils, as this is my last meeting with the ACWS. So thinking about how that will continue.

MS. PAMELA S. HYDE: I'm curious about whether or not you got a chance to read the Leading Change 2.0 when it came out for public comment?

MS. JOHANNA BERGAN: I did.

MS. PAMELA S. HYDE: Did we capture enough of what you said, or did you give us some feedback? Because we were very conscious of wanting to try to capture some of what the panel told us. Whether we did that adequately or not is still for you to tell us, but we were at least so you know, we were very conscious of that and went back a second time to the notes from that.

And I don't know. I don't know if we captured it all well enough. But if we didn't, we'd like to hear now. So, hopefully, you can give us that feedback because we're also trying to finalize that document.

MS. KANA ENOMOTO: Also by Monday.

[Laughter.]

MS. PAMELA S. HYDE: Yeah, also by Monday. On the issue of councils, I think we had a commitment, and you know, we always have to figure out who's going off and who's coming on, but I think our commitment was to try to have youth presence on all of the councils. So as that turns over, we'll have to figure that out.

We always have to balance everything from geography to gender to --

MS. KANA ENOMOTO: Discipline.

MS. PAMELA S. HYDE: -- youth to discipline --

MS. KANA ENOMOTO: Mental health, substance abuse, prevention.

MS. PAMELA S. HYDE: Yeah. So we're having to always balance that. But, yes, I think our commitment is there to do that.

We also did a little bit of work. Larke actually did a little bit of work and one of our OPPI folks did some work on how to make sure youth voice is incorporated into SAMHSA. I can tell you, just frankly, as a person at my point in my career, the amount of discussion about youth involvement is humongous compared to the past, and it's growing. So I think you can -- you can rest assured that your voices have been heard in that sense.

I think there's no going back and not having that youth voice. And in fact, some of us -- me, for one -- are very excited about the youth voice because we're getting tired. So some of you come on with your fresh ideas and fresh energy. It's just wonderful to me. So I think there's a lot of commitment to that.

So a lot of the centers are doing that work now just naturally, and there's a lot of just conversations with youth advocacy groups and other things that, frankly, weren't there before. A lot of times that voice came from family members or from other people. So I think you can rest assured you've made that mark as a group, and I think it will only continue to grow.

But if you have ideas about people who want to serve on our councils, you can let us know that, and we'll go from there.

MS. KANA ENOMOTO: We're also engaged in an exciting effort around Native youth. So following the President's and First Lady's visit to Standing Rock and their commitment to address behavioral health for Native youth, we've been

engaging with IHS and our other partners and through HHS and the administration about what more can be done for the young men and women in our tribal communities. So we're strong -- I think a strong voice there as well and look forward to really engaging Native youth in that process and in that work.

MS. PAMELA S. HYDE: Yeah, and I know the issue of Native or -- Native -- youth programming and youth voice is not the same thing. So let me just acknowledge that in what I'm about to say. But having said that, this earlier conversation about how much of our programming is really focused on young people I think is a recognition, certainly a recognition on my part that the facts are there. If we don't address these issues in young people, we're going to have a bigger problem when they become middle-aged adults.

So I think it's an investment in both adults and young people to invest in young people. So that's really what we're trying hard to do, and I think you can see that with what new money we have gotten. And it hasn't been a lot. But to the extent we've gotten new money, it really has been focused around youth.

And that's unfortunate because it's a tradeoff. There's a whole bunch of other populations, but again, when you have to make tough decisions, I think our commitment is let's invest in the youth. Let's invest in the programs for them, the prevention, as well as the treatment and recovery.

And I'm also really pleased, literally 5 years ago when I started in this job, people were not willing to talk about recovery among youth. There was this whole big issue about you could only talk about resilience among youth. And finally, the kids said, you know, whether you like it or not, we did become addicted or we do have mental health issues, and we are in recovery, in addition to needing risk and resiliency and risk factors dealt with in resiliency and stuff.

So I think the youth voice there has also made a really huge difference in our thinking about stuff. So keep up the good work and don't lose that youth voice. It used to be when you got to over age 30, you couldn't trust people. I don't know what the age cutoff is now.

[Laughter.]

MS. PAMELA S. HYDE: What is it, do you think? You're not going to go there. That's a set-up, right?

MS. JOHANNA BERGAN: Yes.

MS. SHARON AMATETTI: I'd also just like to point out that we had presentations today by two SAMHSA staff, younger SAMHSA staff. Both of them identify as women with lived experience, and we have made some great hires here, too. So that's another way to get to youth.

MS. JOHANNA BERGAN: Yes. And that's a request that we get, and we were downstairs talking about the same thing, that so you get us motivated and passionate and excited and listen to us. And then we don't know what to do. We're excited, and we want a job, and where do we go? And so, how do we -- well, both the need for young people to have employment to connecting them to the needs of our fields.

MS. PAMELA S. HYDE: You know, we just lost, if you want to think of it that way, the year just ended. We have a whole group of interns that come in, and we don't have a -- we don't have jobs for them at the end of the time. But I was just thrilled. Number one, I got more connected to this particular group of interns because of the shutdown in October because it was the Commissioned Corps, maybe 40 people or so, and these 15 interns and me.

[Laughter.]

MS. PAMELA S. HYDE: There wasn't anybody here for 2 1/2 weeks. So we really got to know each other, and they got to know each other, and they're just a great group of young people.

And I tell you, if you look at where they got jobs, I mean, some of them, they're in FDA doing this incredible stuff and then off in the CDC and these other places. They're getting jobs out in the community. So I feel like we've sort of, you know, seeded them out there.

And one of them in particular, who I was -- because she was connected to the OA, said she was going to go off and do this thing for a couple of years. And I said, "Well, then you come back," and she said, "Oh, I'm going to. I'm going to."

So we think we're investing there a little bit, and maybe they'll come back for us and find jobs as they -- as they get into that part of their career where we can get them into our jobs. So, but they were just fantastic. Their energy, their smarts. Oh, my God, they're smart. And just their perspective is just so good, and their willingness to jump in, it was just terrific. They were doing all kinds of things.

So, and they did, I think again because maybe in part because they bonded a little bit more around this shutdown thing, they did a luncheon for the rest of us. So they did a luncheon because we had people here from Nigeria and from all kinds of places among that group, and so they all kind of did their own food. Although one young man is from Louisiana, so he went to Popeye's.

[Laughter.]

MS. PAMELA S. HYDE: Brought this great food.

MS. KANA ENOMOTO: We've also had a number of young people coming from recovery schools that were from recovery campuses.

MS. PAMELA S. HYDE: Yeah, yeah.

MS. KANA ENOMOTO: That is something that we've also really encouraged and I think have had great results from.

MS. PAMELA S. HYDE: Yeah. And actually, one of them started a recovery group here, just among some of the employees and stuff. So it's cool.

MS. KANA ENOMOTO: So, Pam, I just want to check in if we have any public comment?

MR. JOSH SHAPIRO: Kevin, can you ask if there's any public comment, please?

OPERATOR: At this time, if you have a public comment, please press \*, then 1. Once again, if you have a public comment, please press \*, then 1.

DR. YOLANDA B. BRISCOE: May I say something real quick before the public comment? This is Yolanda.

MS. KANA ENOMOTO: Yes, yes. We'll go -- I don't think we have any public comment. We don't have a lot of public. We've had a lot of problems with the sign-in to this call today.

MS. PAMELA S. HYDE: Oh, really?

MS. KANA ENOMOTO: Yeah. But, so, yes. Why don't I let the members do a last word, and then I'll have Pam do a last word. Go ahead, Yolanda.

DR. YOLANDA B. BRISCOE: I just wanted to acknowledge that years ago, Administrator Hyde was encouraging providers to pool their resources, and that was something that was really resounding in my -- the back of my head, and so I just want to say that you never know when you say something that someone's actually going to listen. As a parent, I know that all too well.

And, but we are this weekend breaking -- opening a new facility that we are sharing with another organization. So we get a bigger, better place with share the copy machine and share the telephones and share everything, and so we get more bang for our buck. And we don't have to have another bake sale, so to speak.

[Laughter.]

DR. YOLANDA B. BRISCOE: So thank you for that, and we are actually going to do it.

MS. PAMELA S. HYDE: Good for you, Yolanda. Who are you sharing with?

DR. YOLANDA B. BRISCOE: With the Mountain Center, who works with adolescents. We don't work with adolescents.

MS. PAMELA S. HYDE: Oh, cool. Fantastic, yeah.

DR. YOLANDA B. BRISCOE: The ASAM book talks about it's not a good idea to have adolescents in the same facility with adults. Well, out in Espanola, it's not a carpool population. Mom doesn't drop off the kid to get services while she goes to the groceries. And so, we figured that if maybe mom or dad could be engaged in services with us, kids would then be able to be with the other organization and perhaps meet on Wednesday nights for family night.

MS. PAMELA S. HYDE: Yeah, great. Good.

DR. YOLANDA B. BRISCOE: So thank you for that.

MS. PAMELA S. HYDE: Yeah.

DR. YOLANDA B. BRISCOE: And thank you for the ability to serve these years, and it's really been very, very meaningful, and I've learned so much. So thank you to all of you.

MS. PAMELA S. HYDE: Thanks for participating.

MS. KANA ENOMOTO: Carole, did you have anything closing you wanted to say?

DR. CAROLE WARSHAW: Not that I can think of. We'll miss you, Yolanda.

DR. YOLANDA B. BRISCOE: Thank you.

MS. KANA ENOMOTO: And Johanna.

DR. CAROLE WARSHAW: And Johanna, yes.

MS. KANA ENOMOTO: Johanna?

MS. JOHANNA BERGAN: No. Just thank you. Yeah.

DR. CAROLE WARSHAW: Yeah, I learned a lot from both of you, so we'll have to stay connected.

MS. PAMELA S. HYDE: So do you guys have any last-minute thoughts about this format? I know we've tried to balance this issue of onsite meetings and virtual meetings, and I know it's hard to be on the phone for a long time, as I've done that in my life in consulting and other things. It's really hard. But it also prevents you from having to take a whole day traveling and a whole day traveling back.

So I'm just curious. We're definitely going to do face-to-face in April. I think we have a date, the 7th, 8th, and 9th or something like that -- 8th, 9th, and 10th, whatever it is. That Wednesday, Thursday, and Friday. But do you have thoughts about this virtual approach, or did you guys talk about that already?

DR. CAROLE WARSHAW: No. I think in person is always better. I couldn't get on to the Web part and it took a lot -- but the phone works when it's a small group because you could actually have a conversation, you know? When it's a bigger group, it's harder to do back and forth as much.

MS. PAMELA S. HYDE: Okay.

MS. KAREN MOONEY: This is Karen. I really do miss the participation of the other people who couldn't be there because of the technological difficulties that they had.

MS. PAMELA S. HYDE: So there were actually some members who couldn't get on?

MS. KANA ENOMOTO: Eventually, we got everybody. But Karen was on the line for a half an hour waiting for everyone.

MS. PAMELA S. HYDE: Oh, bummer. Sorry about that. That's always the problem. Technology seems so cool until you start trying to use it for something like this.

MS. KAREN MOONEY: So this is worth waiting for. So I didn't mind the whole time.

DR. CAROLE WARSHAW: You guys had some Web meetings for the GATSBI group, and those worked pretty well. You know, where people could raise hands and do back and forth and chat at the same time. So it's not the same as when you're face-to-face, but actually, they were productive. So --

MS. PAMELA S. HYDE: Well, it's always a tradeoff. It's a tradeoff of cost and a tradeoff of your time and energy and wear and tear on your body and all that kind of stuff. But we're trying to get the right mix here of face-to-face and virtual and length of time. So not so much time on the phone and stuff like that.

DR. CAROLE WARSHAW: Yeah, that's much better not spending the whole day on the phone.

## **Agenda Item: Public Comments**

MS. KANA ENOMOTO: We do have one question from the public, I guess?

OPERATOR: Yes. The public comment comes from Curtis Oliver. You may make your comment.

MR. CURTIS OLIVER: [on telephone] Yes, good afternoon, everyone. I apologize for coming in late. I had difficulties getting on the line.

My question is that will the audio enhancing the PowerPoint presentation be available later?

MS. PAMELA S. HYDE: The PowerPoints are available later.

MS. KANA ENOMOTO: The PowerPoints will be on the SAMHSA Web site, and the audio is not.

MR. CURTIS OLIVER: The audio as well?

MS. KANA ENOMOTO: The audio will not be posted online.

FEMALE SPEAKER: But a transcription will be available about 4 to 6 weeks.

MS. KANA ENOMOTO: And a transcript will be available, a written transcript will be available.

MR. CURTIS OLIVER: Okay, great. All on the SAMHSA Web site. Correct?

FEMALE SPEAKER: Yes.

MS. KANA ENOMOTO: Yes.

MR. CURTIS OLIVER: Okay.

MS. KANA ENOMOTO: And thank you for joining.

MR. CURTIS OLIVER: You're welcome.

OPERATOR: We have no further questions.

## **Agenda Item: Closing Remarks and Adjournment**

MS. KANA ENOMOTO: All right. Well, I just want to thank everybody for your time this afternoon, for your patience with the technology, and for your active participation and great advice. I want to acknowledge the folks that brought us together; Josh, Irene, and Sarah, who staffed the meeting. Sharon Amatetti, Nevine Gahed, and Nadine Benton, who are the SAMHSA staff who really pulled the agenda together and got us going.

Geretta Wood, who is retiring as our chief -- our committee management officer, and Holly Berilla, who will be coming onboard as our committee management officer. We thank you guys for the role that you will play now and in the future.

And Administrator Hyde, thank you for joining us.

MS. PAMELA S. HYDE: My pleasure.

MS. KANA ENOMOTO: And great timing on the conversation. Johanna, Carole, Brenda, Karen, Yolanda, those were really good questions. You got some homework assignments. So we'll see if we can turn those around and make your input really actionable here at SAMHSA, and we'll look forward to seeing you in April.

We're going to focus, I think, on looking at gender-specific and gender-responsive programs across mental health and substance abuse, including maybe some more data on PPW program outcomes. And then perhaps some action planning regarding the trauma concept paper and how it applies to women and girls so -- and how we can get it out there.

So thank you very much, and with that, the meeting is adjourned.

[Whereupon, at 3:53 p.m., the meeting was adjourned.]