Department of Health and Human Services
Substance Abuse and Mental Health Service Administration
Advisory Committee for Women's Services
April 25, 2023
Rockville, Maryland
Minutes

Committee Members Present:
Kelly Andrzejczyk-Beatty, D.O.
Tanisha L. Frederick
Octavia Harris
Le Ondra Clark Harvey, Ph.D
Kathryn Icenhower, Ph.D.
Jill Mays M.S., LPC
Lavita Nadkarni, Ph.D.
Joanne Nicholson, Ph.D.
Judge Duane Slone

SAMHSA Leadership:
Valerie Kolick, M.A., Designated Federal Official (DFO)
Nima Sheth, M.D., M.P.H., Assistant Administrator for Women's Services/Senior Medical Advisor

SAMHSA Staff:
Somer Brown, Center for Substance Abuse Treatment (CSAT)
Karen Gentile, L.C.W.S.-C, J.D.
Martha Kent, Office of Behavioral Health Equity
Amy Smith, CSAT
Nancy Kelly, M.S. E.D., CMHS
Jennifer Treger, MHP, CMHS
Nikhil Patel, MD, MHP,CMHS
Yosselin Turcios, Office of Behavioral Health Equity

Guests:
Nicole Owings-Fonner, M.A.
American Academy of Pediatrics

Call to Order

Valerie Kolick, Designated Federal Officer (DFO), called the meeting of SAMHSA's Advisory Committee for Women's Services (ACWS) to order on April 25, 2023 at 9:00 a.m. The Advisory Committee was conducted as a hybrid. Ms. Kolick noted that the meeting had a committee quorum.

Adoption of the Minutes from the September 6, 2022 Meeting

Kathryn Icenhower motioned to approve the minutes and it was unanimously approved.

Maternal Mental Health & Substance Use Subcommittee
Nima Sheth, M.D., M.P.H., SAMHSA

Nima Sheth shared that this year's Budget Omnibus has established a national task force dedicated to maternal mental health which also incorporates substance use disorder (SUD) concerns. Specifically, the task force is charged with identifying best practices across the following areas: screening, diagnosis, intervention, treatment, equity, and community-based practices.

The first report, which is anticipated for release in January 2024, will be a comprehensive review of existing services and programs across government agencies. It will also incorporate research on best practices and a literature review.

The task force will also solicit public stakeholder input including through an FRN announcement. Co-chaired by SAMHSA and the Office of the Assistant Secretary (Admiral Levine), the task force is

creating a subgroup of the ACWS which will meet monthly. They will also convene listening sessions over the summer.

Le Ondra Harvey advocated that the task force be intentional in terms of identifying public stakeholders to ensure there is diversity beyond the academic and professional association communities.

Maternal Mental Health & Substance Use Discussion & Brainstorming

Dr. Sheth then led a facilitated session with guided questions related to maternal mental health. The feedback from the brainstorming session is provided in Appendix A.

Behavioral Health of Girls Grant Programs
Nancy Kelly, M.S. E.d., CMHS; Jennifer Treger, M.H.P.,CMHS

Nancy Kelly provided an overview of Project AWARE, a grant program that funds capacity and partnership building for State Departments of Education, as well as schools, to address behavioral health needs. She also mentioned three Centers of Excellence: the National Center for Eating Disorders; the Social Media and Mental Well-Being Center of Excellence, the Infant and Early Childhood Mental Health Consultation Center of Excellence.

Another program is ReCAST which is a program to respond to community violence and collective trauma. In particular, it is focused on high-risk youth and family exposed to violence.

In terms of data, Dr. Kelly noted that youth report increased rates of helplessness and suicide ideation and these are rates are higher among young women and the LGBTQI+ youth.

Questions and Comments

ACWS shared the following questions and comments:

- **Evidence-Based Curriculums** – Tanisha Frederick noted that evidence-based approaches may be too costly and not appropriate for some cultures. Dr. Kelly stated that SAMHSA is looking at "evidence-informed" curriculums as well.
- **Minority Populations** – Dr. Harvey emphasized that these programs need to reach out to marginalized communities (e.g., Hmong, tribal women). Jennifer Treger agreed noting that grant announcements now include disparity impact statements.
- **Child Welfare** – Dr. Icenhower stressed the importance of recognizing the intersectionality with child welfare entities and to incorporate wraparound services into the discussions.
- **Sustainability** – Lavita Nadkarni expressed concern about sustainability. Dr. Kelly noted that because Project AWARE is built into the school system, it is able to be maintained. She added that there is a national movement to get schools the ability to bill and be reimbursed for services.
- **Connecting with Community-Based Organizations (CBOs)** – Ms. Frederick advocated for school-based services to have connections with CBOs, as services are needed over the summer and after-school hours. SAMHSA staff agreed but noted that there are some privacy barriers (e.g., FERPA and HIPAA).

The Impacts of Social Media with the Center of Excellence on Social Media & Mental Wellbeing (SMMW-CoE)

Nicole Owings-Fonner, Center of Excellence on Social Media and Mental Wellbeing (SMMW-CoE); American Academy of Pediatrics (AAP) Center of Excellence (CoE); Ashley Horne, Program Manager, SMMW-CoE; Jamie Poslosky, SMMW-CoE, AAP CoE

This Center of Excellence was opened last year and serves as a centralized trusted source of evidence and support on youth navigating social media. The Center of Excellence has three main goals:

- Improve pediatric mental wellbeing by reducing the risk and leveraging the benefits of social media;
- Build the capacity of individuals who work with youth to promote health social media use; and
- Synthesize and promote evidence-based and practices related to health social media use.

It was noted that social media use in youth has both benefits and risks. Those who use it a lot or hardly at all are most at risk of mental health concerns. And extensive parental use (e.g., eight hours or more per day) is also a risk factor.

One aspect that the Center is working on is to change the current narrative which is predominantly focused on the negative aspects of social media use which creates a fear-based culture. Rather, they are hoping to redirect the conversation to a more hopeful and curious approach with a focus on solutions. This positive and strength-based mode parallels other public health approaches. This framework focuses on five critical points:

- Center on the child/adolescent agency and digital citizenship/literacy;
- Recognize that there is s developmental lens;
- Stress the important of context;
- Appreciate that there are individualized differences; and
- Address the digital ecosystem with policy.

In terms of activities, the Center of Excellence has convened a Technical Expert Panel to candidly discuss ideas for creating a positive digital space for youth. They are also creating an interactive digital portal so that clinicians, educators, parents, and youth can ask specific questions about social media and mental well-being.

<u>Questions and Comments</u>

ACWS shared the following questions and comments:

- **Youth Advisory Panel** – It was noted that the Youth Advisory Panel does include representation from marginalized communities. The youth leaders are college students and the panel includes younger students (e.g., 13 to 18 years of age).
- **National Federation of Families** – Jill Mays recommended this resources as a helpful partner.

- **Dove Commercials** – Ms. Kolick shared a series of commercials by Dove focused on the impact of social media on contributing to eating disorders. She noted that it could serve as a powerful conversation starter.
- **Evaluation** – The Center is working on data collection criteria and an evaluation plan.

Gender-Based Violence and the Mental Health of Women
Karen Gentile, L.C.W.S.-C, J.D., Director, CMHS

Karen Gentile noted that, in the last year, the White House has been working with an interagency group to develop a national plan to end gender-based violence. The report, which covers domestic violence, dating violence and sexual assaults, will be released soon. It will also incorporate child sexual abuse, sex trafficking, and a gamut of other interrelated interpersonal violence.

The pillars of the report will include prevention; supportive healing; safety and well-being; economic security and housing; and trauma-informed care of survivors. SAMHSA is looking to not just improve current programs but identify new innovative approaches and perhaps new grant programs. Other partners engaged in this include the Administration for Children and Families, most particularly its Family and Youth Services Bureau, as well as its Office on Trafficking in Persons. Ms. Gentile was interested in feedback from ACWS members on how SAMHSA might fit in this work, specifically in identifying gaps in capacity that they can support.

- **Native American Women** – Kelly Andrzejczyk-Beatty noted that one in every three Native American women have been sexually assaulted. As a clinician, she shared the story of having referred a woman but then never being able to follow up to see if the woman actually went to the safe home and was being helped.
- **Child Welfare** – Dr. Icenhower noted that society punishes women who are victims by taking their children away from them. This needs to change.
- **Training Judges** – Dr. Nadkarni would like to see Judges better trained on the issue. For example, a woman may not be physically beaten, but rather isolated which is another form of abuse.
- **Traumatic Brain Injury** – This is a risk for victims of domestic violence. It would be beneficial to screen on this.
- **Housing** – Octavia Harris noted that a main reason women are unable to leave is that they don't have housing. Partnerships with HUD are important.
- **Restrictions on Teachers** – Ms. Kolick shared that her husband is a teacher and has seen things in the school hallway that he felt were abuse signs. However, if it isn't open physical abuse, a teacher is unable to intervene.
- **Harm Reduction** – Dr. Icenhower noted that some couples choose to stay together and that there should be harm reduction efforts (e.g., preventing intergenerational trauma), if separation is not an option.
- **Intersectionality** – Joanne Nicholson noted that there is intersectionality with abuse and women with disabilities. Ms. Harris added that there is sometimes a correlation between abuse and teenage pregnancy.
- **Data Collection** – It was noted that data collection can be difficult with States not wanting surveys with the word "sex" in it.
- **Block Grant** – Unfortunately the block grant's carve out for women is only treatment-based. Ms. Gentile noted that SAMHSA is looking at 988 and warmlines to provide support and resources for individuals experiencing abuse.

- **Homeless Shelters** – Shelters need to be more trauma-informed. They often have strict rules and women coming from abuse are sensitive to that as it is usually an aspect of their abuse.
- **Animal Abuse** – There does seem to be a correlation between a household that has human abuse also having animal abuse. Talking to a child about pet abuse might be an indirect way to screen, as the child might be more open to talking about that concern.

SAMHSA Priorities with Assistant Secretary of Mental Health and Substance Use

Miriam Delphin-Rittmon, Ph.D., Assistant Secretary of Mental Health and Substance Use

Assistant Secretary Delphin-Rittmon provided a review of SAMHSA's priorities from its strategic plan. She noted that workforce was originally a cross-cutting principle but has now been categorized as a core priority, given the sense of urgency and challenges in addressing this concern. She added that this modification will allow SAMHSA to dedicate more resources to addressing the workforce shortage. Cross-cutting issues include data, trauma–informed approaches, and equity.

Other salient points updates she shared include the following:

- **Language Change** – Some of the language related to children and youth have been updated as well as the inclusion of resiliency as a focus.
- **Harm Reduction** – SAMHSA is focused on fentanyl strips and wound care. Dr. Delphin-Rittmon noted that there is an innovative program in Kensington, Philadelphia where staff do outreach at a public restroom facility to engage individuals on harm reduction efforts.
- **MAT and Naloxone** – The x waiver requirement for prescribing medication-assisted treatment (MAT) has been removed. Students are also able to carry naloxone. .
- **Suicide Prevention and Crisis Care** – While last year was focused on the launch of 988, the effort is now focused on increasing awareness of these services. SAMHSA has a partner toolkit to assist State and community entities. With regard to suicide, SAMHSA will be convening a policy academy focused on young African-Americans risk for suicide. There is also a new grant that is geared towards addressing suicide prevention and interventions for individuals 25 and older. Target populations are older adults, adults in rural areas, and American Indian and Alaska Native adults
- **Certified Community Behavioral Health Centers (CCBHCs)** – Currently, there are over 500 centers which aim to facilitate a no-wrong door approach towards meeting the needs of individuals with behavioral health conditions.
- **Office of Recovery** – SAMHSA will soon release its plan for peer recovery standards.
- **The Tribal Behavioral Health Agenda (TBHA)** – SAMHSA is working with tribes to update the TBHA which is a collaborative tribal-federal blueprint for improving the behavioral health of American Indians and Alaska Natives.

The Assistant Secretary also noted that there is an internal initiative (SAMHSA Strong) to increase staff engagement, agency, and voice within the Administration. Efforts include having no-meeting times, improving communication, and providing better career advancement.

Questions and Comments

ACWS shared the following questions and comments:

- **Women Veterans** – In response to Ms. Harris' concerns about the unique needs of female veterans, Dr. Delphin-Rittmon noted that SAMHSA has reconvened a task force with the Department of Defense (DoD) and the Department of Veterans Affairs. Particularly, the task force is looking at 988 support and working with at-risk groups, which includes female veterans.
- **Sustainability of CCBHCs** – Dr. Delphin-Rittmon noted sustainability of the CCBHCs is high on her radar. She added that many States are working on some model, even if not a full-fledged CCBHC. Even if a State does not pursue certification, SAMHSA grants can still be used as demonstration sites, though the funding matches may differ. In the long run, States will be the entity that will have to provide financing whether through Medicaid or other braided funding sources.
- **Transition to Medicaid Models of Care** – Dr. Icenhower noted that in California, numerous program have closed because their particular services isn't funded. Often these closed programs are the ones that reach high-risk populations. She encouraged Dr. Delphin-Rittmon to reach out to Mayor Karen Bass of Los Angeles to learn more about this concern.
- **Block Grant for non SMI/SED** – Ms. Mays noted that there are individuals who don't have an SMI/SED and it is difficult to get the block grant to cover these services (it is not exactly prevention). They have been able to use the crisis set-aside for substance use disorders, but not for pure mental health prevention.

Public Comment

There were no public comments.

Closing Remarks/Adjourn

Ms. Kolick thanked everyone for their participation. She adjourned the meeting at 4:10 p.m.

Certification

I hereby certify that, to the best of my knowledge, the foregoing minutes and the attachments are accurate and complete.

_____ _____

Date

Nima Sheth, M.D., M.P.H.
Associate Administrator for Women's Services,
SAMHSA

Minutes will be considered formally by SAMHSA's Advisory Committee for Women's Services at its next meeting, and any corrections or notations will be incorporated into the minutes of that meeting.

Appendix A

The following is feedback from ACWS members in response to guided questions related to maternal mental health and substance abuse.

Best Clinical Practices

What are essential factors to consider as we review best practices for prevention, screening, diagnosis, intervention, and treatment?

- Barriers to access (e.g., transportation).
- A workforce that is culturally and properly trained/cross-trained.
- Outreach engagement and creation of a safe place/environment.
- Integrating services with primary care
- Collaboration across resources (e.g., beyond just co-locating with primary care).
- Ability to incorporate trans-diagnostic processes.
- Task-sharing opportunities, particularly for refugee population and with community-based service providers.
- Barriers related to licensing, certification, insurance.
- Labeling services (e.g., what is early intervention peer support)?

Do you have recommendations for best practices in referral and implementation?

- Use the FQHC or CCBHC model. CCBHC should have criteria for maternal mental health.
- Address the needs of women with intellectual disabilities (have a double stigma).
- Provide integrative care (e.g., pre-conception counseling, prevention support).
- Support providers in how to have specific conversations (e.g., with young pregnant women, mothers over 40).
- Leverage referral systems (e.g., care coordination and family resource centers)
    - Have a maternity coordinator/navigator from conception to birth and then a warm handoff to community provider or pediatric care.
- Address diagnosis and treatment issues
    - Misdiagnoses
    - Post-partum depression should be normalized without pathologizing it.
    - Treatment tends to focus on pharmacological solutions but should also incorporate holistic and cultural approaches.
    - Need behavioral health providers in OB/GYN settings, especially in rural settings.
- Allow billing for Medicaid for care coordination services (e.g., State waivers)

Community-based practices

What are the various community-based models and practices that you have known to be successful?

- Grassroots organizations are already working on this. Need to find them and bring them to the table.
- Need to elevate these programs and bring them to scale.
- Home visitation and screening programs (both pre and post natal).
- Healthy Start Program.
- VA Maternity Coordinator Program which has been good in reaching out to homeless populations.
- No wrong door model.
- Reduce fear, stigma and consequences (e.g., CPS involvement) around services.
- Crisis services need to incorporate an OB at least on call..
- Providers need to have next steps, resources if screening identifies a need.
- Incorporate into parenting classes.
- Have a behavioral health provider in labor and delivery doing rounds.
- A Health Start program for women with older children.
- Provide family and partner support. Issues with partner can often be the reason that will bring/motivate a mother to come in for counseling services.

What are some of the non-traditional spaces behavioral health needs among pregnant/post-partum women can be identified? And what types of interventions within those spaces yield a higher result in treatment engagement? For example (churches, schools, online communities)

- Pediatricians need training and resources to identify and screen.
- Photographer/Lactation specialist/Nurses have access to mother and might see warning signs.
- Triggers such as child born with a disability, delivery trauma, loss of child services, miscarriage and infertility.
- Adoption agencies as adopted children may have special needs.
- Examine the history of a mother (prior pregnancy/childbirth) as they may fall into multiple need categories.
- Outreach (using students) in libraries and children-based museums.
- Barbershops and salons.
- CBOs host events that highlight resources (learning community model).
- California has a non-clinical model which focuses on hiring nonclinical support helpers on screening and linkages.
- Behavioral Health Coaches in the ERS. Already exist in Child ERs.
- Need to weave in trauma-informed approaches.
- Look at existing trainings programs and increase awareness by clinical providers.
    - Case conceptualization model and reinforcing interdisciplinary approaches (Dr. Harvey has an example).
- Focus also on jails, probation and other places where mothers who are criminally-justice involved.

- Daycares.
- Sensitivity Training for practitioners.

Equity

What are things we need to review from an equity lens?

- Terms document

How do we ensure implementation of best practices for special populations, such as immigrants, those experiencing GBV, prison, etc.?

- Mothers with intellectual disabilities – Special doulas, OB accessibility.
- Mothers in Prison.
- Immigrants/Refugees.
- The Black woman's experience with incarceration (Dr. Nicholson mentioned resources).
- Native Americans.
- Lift up existing models that work.
- Collaborate with HRSA (e.g., Healthy Start).
    - Screening for mental health and also screening for parenting.
- Research and disaggregated data.
    - Where are current research gaps in this field?
        - The voices of those with lived experience.
        - Clinical trials don't exist for many.
        - Women who have infertility issues and were in the military (any correlation with PTSD).
        - Impact of mental health issues on children removed from their parents.
        - Maternal Health for teen girls.
        - Human trafficking.
        - Homeless women.
        - Women in corrections.
        - Registries where women can add their own information.
    - What are essential types of disaggregated data to include?
        - GPRA parenting data
        - Non-medication options (e.g., holistic options)
        - Mental health warmlines.
- Racism/Implicit Bias Trainings (Medical Schools, Harvard Implicit Bias Test).
- Normalizing (e.g., reduce stigma, fear for mom and family).
- Address cultural norms and values.
- De-incentivize the pricing structures
- More opportunities for the consumer voice in systems (e.g., Amish).
- Clinicians are trained to "be" a provider. What about training to "be" in the community?
- Understand the inequities patients face outside the office.
- Provider self-care (and concerns expressing stress will result in loss of license).
- Respect Institute trains individuals with lived experience on how to tell their story.