

**Department of Health and Human Services
Substance Abuse and Mental Health Service Administration
Advisory Committee for Women's Services**

**August 14, 2013
Rockville, Maryland**

Minutes

The Substance Abuse and Mental Health Services Administration (SAMHSA) Advisory Committee for Women's Services (ACWS) convened at SAMHSA headquarters in Rockville, Maryland, on August 14, 2013. Ms. Sharon Amatetti, Women's Issues Coordinator, SAMHSA, chaired the meeting.

Committee Members Present: Johanna Bergan; Jean Campbell, Ph.D.; Vincent J. Felitti, M.D.; Harriet C. Forman; Shelly F. Greenfield, M.D., M.P.H.; Velma McBride Murry, Ph.D.; Starleen Scott Robbins, M.S.W., LCSW; and Carole Warshaw, M.D. (see Tab A, Committee Roster)

SAMHSA Administrator: Pamela S. Hyde, J.D.

SAMHSA's Women's Issues Coordinator: Sharon Amatetti, M.P.H.

Acting Designated Federal Official: Nadine Benton, M.B.A.

Representatives of the Public Present: (see Tab B, Public Attendees List)

Call to Order

Ms. Nadine Benton, Acting Designated Federal Official for ACWS, called the meeting to order on August 14, 2013, at 9:00 a.m.

Welcome and Adoption of Minutes of the ACWS Meeting of April 10, 2013

Ms. Sharon Amatetti, SAMHSA's Women's Issues Coordinator, welcomed participants, and committee members unanimously approved the minutes of the ACWS meeting held on April 10, 2013.

Opening Remarks

Ms. Amatetti described recent legislative highlights. Though the Senate Appropriations Committee had passed a Fiscal Year (FY) 2014 budget for the Labor and Health and Human Services (LHHS) Departments in July, that budget did not come to the full Senate for action. The committee's bill included \$3.62 billion for SAMHSA, including \$95 million for the President's new "Now is the Time" initiative to protect children and communities from gun violence. The House did not consider a FY2014 budget, and SAMHSA is expected to operate under a continuing resolution with a budget reduction of 2%. Mr. Brian Altman, SAMHSA Legislative Director, explained that sequestration amounts would increase slightly in FY2014 to meet lower discretionary spending limits. Two bills related to women's and girls' issues were introduced in Congress, Federal Response to Eliminate Eating Disorders Act and Access to Substance Use Treatment Act.

The White House's June 2013 National Conference on Mental Health was attended by faith leaders, youth-serving agencies, mental health service providers, congressional representatives, business leaders, and other stakeholders. The President and Vice President challenged the nation to join in the conversation on mental health and to help those individuals who need it to access treatment. The White House issued a fact sheet highlighting public- and private-sector partnerships, established the MentalHealth.gov website,

and developed a toolkit to guide community conversations about mental health. Ms. Amatetti welcomed feedback from Council members on the toolkit and noted that several conversations on mental health have taken place in communities with support from private organizations. Former National Football League player Tony Edwards has taken on the role of informal ambassador for emotional well-being.

Ms. Amatetti announced staff changes at SAMHSA. Ms. Geretta Wood, Ms. Elaine Parry, Mr. Richard Kopanda, and Dr. Anna Marsh have retired. Ms. Nadine Benton is acting as contact for ACWS. Ms. Anne Herron now serves as Acting Director, SAMHSA's Office of Policy, Planning, and Innovation, and Mr. Mike Etzinger has been appointed Director, Office of Management, Technology, and Operations. Ms. Mirtha Beadle will serve as CSAP's Deputy Director.

A new TEDS (Treatment Episode Data Set) report on trends in substance abuse among pregnant women shows that the proportion of pregnant female substance abuse admissions remained stable, but shifts took place in the substances used. The percentage of pregnant admissions reporting alcohol abuse declined, but drug abuse rose. A SAMHSA report on fetal alcohol spectrum disorders was forthcoming in anticipation of September's FASD Awareness Day. The National Survey on Drug Use and Health (NSDUH) showed that as many as 20% of pregnant women consume alcohol during the first trimester.

The ACWS will meet again on April 2, 2014, and SAMHSA's Joint Council meeting will take place on April 3, 2014, at SAMHSA headquarters. The August 2014 meeting will take place via conference call.

Discussion. Dr. Jean Campbell suggested that SAMHSA use email to publicize the Center for Mental Health Services' (CMHS) wellness promotion initiative in order to expand the agency's emphasis on health and wellness. Dr. Velma McBride Murry expressed interest in tracking and evaluating impacts of the nationwide community conversations on mental health. Ms. Ingrid Donato, Chief, Mental Health Promotion Branch, CMHS, stated that the activities are tracked, but the federal government has decided that evaluation would be the province of local communities. Dr. Campbell noted the importance of learning whether negative attitudes increase or decrease as a result of public awareness campaigns, and she pointed out that the Missouri Institute of Mental Health has conducted a statewide survey of stigmatizing attitudes using a new tool. Ms. Donato stated that the community conversations website might support and help organize community-initiated evaluation of the community conversations.

ACWS Member Updates

Dr. Campbell described her new interest in integrating science, especially data, and the arts. She and other ACWS members expressed concern about the erosion of women's rights and diminishing availability of women's services. She asserted that advocates for women's issues must engage in activism rather than pursue softer approaches. Dr. Murry has begun to develop a new prevention/intervention program to address depression among inner-city African American girls via a mother/daughter program designed to enhance that relationship and to empower them to seek protective settings in high-crime areas. She also noted her interest in the mothers of participants in her study of rural young people in light of their emerging high incidence of HIV/AIDS diagnoses and increased substance use as a coping mechanism.

Ms. Scott Robbins explained that the National Association of State Alcohol and Drug Abuse Directors' (NASADAD) Women's Services Network (WSN) provides a supportive environment in which states' women's services coordinators can learn from each other. Ms. Harriett Forman called attention to the turmoil in the New Mexico mental health system. She stated that her current interests lie in supporting marriage equality and countering sexism in health issues. Ms. Johanna Bergan supports 68 chapters of young people nationwide in Youth MOVE National, which works to create national standards for peer-to-peer services among young people and to initiate conversations among young people and compile knowledge about their views, for example, on sensitive language such as *stigma* and *transition-age youth*.

The group coordinates a National Young Leaders Network whose members make presentations on mental health in communities and often incorporate a focus on overall wellness. Ms. Bergan stated that most of the organization's work is gender neutral and that many young women are leaders.

Dr. Shelly Greenfield stated that she continues her research on evidence-based treatments for women in addiction and has directed the Women's Mental Health Initiative at McLean Hospital, which soon will launch a comprehensive women's division. Dr. Greenfield continues to chair the Gender Special Interest Group for the National Institute on Drug Abuse (NIDA). She expressed concern that binge drinking among young women does not receive sufficient attention. Dr. Greenfield's involvement with integration of behavioral health with primary care includes devising user-friendly ways to integrate screening, brief interventions, and referral in order to enhance patient outcomes without excessive administrative burden.

Dr. Vincent Felitti described his work on the Adverse Childhood Experiences (ACE) study, of which he was co-principal investigator, and his subsequent efforts to incorporate trauma-oriented questions into a comprehensive, general medical history questionnaire despite significant resistance among practitioners to using the data in such a questionnaire. He asserted his belief that if great numbers of people use the North American Health Index, a free downloadable questionnaire that he is developing, would benefit from access to the person-generated, trauma-oriented information typically unavailable due to time, shame, secrecy, and social taboos. In practice, Dr. Felitti pointed out, once set down on the Internet or on paper, this sensitive information has been found to be willingly discussed by individuals in face-to-face encounters. Ms. Amatetti added that a number of key federal agencies have acknowledged the need for enhanced screening for trauma and mental health issues in childhood; SAMHSA, the Administration for Children and Families (ACF), and Centers for Medicare and Medicaid Services (CMS) issued a joint letter to state directors on the ACE study in the context of screening for adverse childhood experiences.

Dr. Carole Warshaw, Director, National Center on Domestic Violence, Trauma, and Mental Health, described her study and tools related to mental health and substance use coercion in the context of treatment planning. She also has worked with family court judges about their perception of these issues and is devising strategies and tools to reduce negative attitudes and generate better resolutions. She noted that the Americans with Disabilities Act may offer opportunities for supports to help women parent more successfully and maintain custody of their children. Dr. Warshaw also is engaged in capacity building with domestic violence coalitions to promote trauma-informed approaches, and she is piloting a capacity-building curriculum for trauma-informed domestic violence services on what it means to be supportive and inclusive of women who are parenting and who have co-occurring disorders. She is involved in a project to train consultants to help states implement trauma-informed domestic violence programs that provide ongoing supervision, and another project to pilot trauma-informed outcome measures. Dr. Warshaw focuses on culturally relevant and culture-specific interventions for domestic violence. She also is working on community-based models for agencies that might use holistic healing strategies to address historical trauma's effects and more complex trauma-informed approaches for people who continue to be under siege. Dr. Greenfield called attention to a study published in the *New England Journal of Medicine* on a scalable group intervention implemented by lay health workers in Congo for women who had been sexually assaulted or raped.

Updates from SAMHSA's Women's Coordinating Committee

Ms. Amatetti explained that SAMHSA's Women's Coordinating Committee, composed of internal SAMHSA staff, convenes monthly. The committee sponsored an in-service program in May 2013 for Women's Health Week, at which committee member Rosalind Wiseman presented on "Navigating New Realities of Girl World and Boy World." The committee is helping to plan release of a SAMHSA Spotlight for FASD Awareness Day concerning alcohol use in pregnancy by trimesters. In addition, with

the help of the committee, SAMHSA will design a webinar series and environmental scan on adolescent girls. Ms. Amatetti requested input from ACWS members.

Ms. Mary Blake, Public Health Advisor, SAMHSA, described the Department of Health and Human Services (HHS) Coordinating Committee on Women's Health's subcommittee's work to develop a research symposium on screening and counseling on interpersonal violence. The symposium will review the evidence base in order to strengthen it for screening in the context of primary care settings and to stimulate thinking at HHS about future directions. Dr. Campbell suggested that SAMHSA stream this and other meetings on the Internet and enable Twitter responses for wider dissemination of ideas, noting that the Patient-Centered Outcomes Research Institute has adopted this strategy.

SAMHSA Block Grants and Health Reform with a Focus on Women's Services

Ms. Deborah Baldwin, Branch Chief, State Grants, Eastern Branch State Planning and Systems Development Branch, CMHS, explained that the mental health block grant is a formula grant to 59 eligible jurisdictions that include states, territories, and the District of Columbia. The block grant mandates recipients to implement community-based services, with specific restrictions, for individuals who have serious mental illness and children with serious emotional disturbance. The block grant is a flexible funding source, and SAMHSA recently has added more accountability. Requirements include involvement by consumers and family members on planning councils to guide states' service delivery across public mental health systems, and data reporting. In FY2012 the mental health block grant amounted to more than \$459 million, representing approximately 1% of SAMHSA's total budget.

SAMHSA set new goals for states for the FY2012 block grant. States are expected to foster increased participation of individuals in recovery, access for underserved populations (including women) to promote recovery and resilience in the community, and coordination with behavioral health and primary care. More than 30 states submitted combined mental health and substance use plans for FY 2012. States are expected to set funding priorities on individuals who lack insurance or for individuals whose coverage is interrupted. Where services are not covered by Medicaid, states are expected to emphasize prevention. SAMHSA's staff now collaborates more, has consolidated and leveraged its technical assistance to states, fostered integrated systems at the state level, increased combined Behavioral Health Planning Councils, and provided resources to the combined planning councils.

Ms. Baldwin stated that SAMHSA's revamp of its data systems will produce better information on women's services. Data for FY2012 showed that more than half of consumers served were females. Young people have high usage rates, but usage drops off among transition-age youth. The majority of women consumers were served in community settings, but counts are unreliable for women in institutions. Women in community settings are competitively employed at a higher rate than their male counterparts, though 31% of all women were unemployed. Evidence-based practices were used to serve the nearly 19% of women who had serious mental illness and only 2.3% of children.

Dr. Olinda Gonzales, expert on SAMHSA's data system, explained that states have begun client-level reporting in recent years on several indicators. By FY2013 all states will report on client-level measures, and reports on diagnosis soon will be available. As funding for mental health data moves to the Center for Behavioral Health Statistics and Quality (CBHSQ), SAMHSA is planning data integration strategies.

Mr. John J. Campbell, Chief, Performance Partnership Grant Branch, CSAT, explained that a requirement for women's services were added to the Alcohol Abuse, Drug, and Mental Health Services block grant in the 1980s when Congress added a 5% set-aside. Several years later Congress raised the set-aside to 10%, with the intent that states would serve pregnant women and women with dependent children as a priority population. A 1992 statute specified an explicit set-aside for services for pregnant women and women

with dependent children, ended the prerogative of states to interpret the statute, and required the Secretary to write regulations for a block grant. The current statute requires states to provide gender-specific treatment for women, therapeutic services for children, case management, transportation, linkages to primary and pediatric care, and other services. In addition, states must publicize the priority that women have in admissions. Mr. Campbell stated that Congress has added to the set-aside requirements over the years. While the targeted statutory populations include pregnant women and women with dependent children and intravenous drug users, HIV and tuberculosis services have been added.

To guide states toward implementation of the Affordable Care Act, SAMHSA offered a new uniform application beginning with the FY 2012–13 block grant application. The application requires states to engage in a detailed planning process with an emphasis on women who are pregnant and have a substance use and/or mental health disorder, and parents with substance use and/or mental disorders who have dependent children. Regional administrators and SAMHSA program staff office monitor block grant expenditures, and stakeholders have opportunities to comment on the plans during the planning process.

Ms. Anne Herron, Acting Director, Office of Policy, Planning, and Innovation, SAMHSA, described the block grant's future and how SAMHSA uses it to communicate to state agencies about SAMHSA's emphasis on full implementation of ACA. Block grants will be used to fund treatment and other recovery support services for people without insurance or whose insurance does not cover the services; to fund primary prevention efforts; and to collect performance and outcome data. SAMHSA wants states to have plans that ensure that anyone eligible for insurance receives and accesses it, and that coverage pays for the services offered. The block grant is to be used only in the absence of insurance coverage.

Some states, such as Massachusetts and Vermont, which have undergone health reform, have found that many behavioral health clients churn in and out of, or cannot access, insurance coverage, or their insurance does not cover the needed services. SAMHSA wants to ensure that people understand that the block grant fills gaps and holes, and is not duplicative. SAMHSA also emphasizes its support for state substance abuse and mental health authorities in implementing ACA, including in such areas as essential benefit design, involvement in health information technology systems, and monitoring services usage.

Discussion. Ms. Scott Robbins emphasized the block grant's value for family-centered and women's treatment, and for filling service gaps. Despite dated language, the block grant helps states to focus on minimum standards. Mr. Campbell responded to Dr. Campbell's question that states that opt out of Medicaid expansion nevertheless must contribute funds toward maintenance of effort in prevention and treatment services. Ms. Herron added that states have addressed behavioral health disorders in different ways and will continue to do so under ACA. Dr. Greenfield inquired about the block grant's support for women with treatment needs who are not pregnant or parenting, and Mr. Campbell responded that states must do what is explicitly prescribed, abstain from doing what is prohibited, and have flexibility otherwise. Ms. Baldwin stated that upon submission of states' FY2014 block grant applications, states' thinking about women's services will be more evident.

Appreciation Ceremony

Ms. Amatetti acknowledged SAMHSA's appreciation for the dedicated service on behalf of ACWS retiring members Harriett Forman, Velma McBride Murry, and Starleen Scott Robbins.

NASADAD Women's Services Network

Ms. Sarah Wurzburg, NASADAD's Women's Services Network lead, explained that NASADAD's membership is composed of state and territory substance abuse agencies. NASADAD's National Prevention Network and its National Treatment Network, within which reside the Women's Services

Network (WSN) and the National Opioid Network, provide technical assistance and facilitate information sharing to states and territories.

Ms. Starleen Scott Robbins, Past President, WSN, explained that 46 states plus Guam currently have women's services coordinators who manage the jurisdictions' women's set-aside block grant funds. After several years of coordination by CSAT and with CSAT's encouragement, in 2007 the coordinators met as a group, developed by-laws, and joined NASADAD under NASADAD's National Treatment Network. In 2013, with amended by-laws, WSN became a voting member of the National Treatment Network. WSN addresses the unique treatment and prevention needs of women and children across the lifespan, works to expand and improve publicly funded programs, and facilitates collaboration with other public and privately funded service agencies and stakeholders.

Ms. Scott Robbins stated that WSN meets annually to review goals and outcomes, and its executive leadership interacts with other NASADAD networks. Its Criminal Justice Committee works on treatment for women who are incarcerated, and training tools and resources to educate judges. WSN's Outcomes Data Committee considers how states' outcome data can help support treatment and services, particularly therapeutic services for children. The Pregnant and Parenting Women's Committee educates policy makers and legislators on substance use during pregnancy, with particular emphasis on opioid dependence in pregnant women and fetal alcohol spectrum disorders. This committee also works on a protocol for neonatal abstinence syndrome. The Recovery-Oriented Systems of Care for Women Committee is dedicated to states' integration of gender-responsive prevention, early intervention, treatment, and recovery services for women and their families across the lifespan.

Ms. Scott Robbins explained that CSAT recently helped the WSN begin a strategic planning process. A survey of members elicited topics of broad interest: trauma-informed systems of care, opioid addiction and pregnancy/neonatal abstinence syndrome, new opportunities in financing women's substance use disorders services, reducing punitive measures and promoting recovery for pregnant women, and gender-specific treatment. WSN has established a new work group on trauma-informed care as part of the planning process. Though most states use trauma-informed evidence-based practices, they may not have necessarily considered moving toward becoming trauma-informed organizations. WSN is working to help states that lack systems of care to address that issue in their planning and implementation processes.

WSN's Members Services listserv facilitates communication among members. Compiled in partnership with NASADAD, CSAT, and some federal partners, WSN's *Guidance to the States: Treatment Standards for Women with Substance Use Disorders*, which is based on CSAT's Comprehensive Substance Abuse Treatment Model for Women and Their Children, provides guidance to states seeking to develop or enhance treatment standards for women. WSN's *Therapeutic Services for Children Whose Parents Receive Substance Use Disorder Treatment* describes how nine states defined therapeutic services, determined which services were provided, established criteria for receiving services, and ensured that children have access. WSN's Data and Outcomes Committee helps states refine their data efforts and hopes to derive more information from that process.

WSN has participated in planning for the National Conference on Behavioral Health for Women and Girls and also has participated in other conferences. Ms. Scott Robbins described the important outcomes of participation in the Women's Addiction Services Leadership Institute, including personal leadership skills development and support of others in their leadership. She stated that several WSM members participated in the American Society of Addiction Medicine's field review of patient placement criteria, and other members helped develop the Core Competencies for Working with Women and Girls.

Ms. Wurzburg added that WSN's guidance for women inspired NASADAD's State Youth Substance Abuse Coordinators Committee to develop guidance for building youth systems in states.

Discussion. Dr. Murry suggested the need for academic institutions to educate new behavioral and general health professionals about the WSN, noting that the American Psychological Association may be a willing partner. Ms. Scott Robbins responded that the *Guidance* document was designed with academic and licensing boards in mind. Ms. Wurzburg added that NASADAD’s treatment and prevention networks workforce development committees work to influence curricula in graduate education programs.

To Ms. Harriett Forman’s inquiry about whether WSN addresses lesbians’ needs, Ms. Scott Robbins noted that the Core Competencies do address the needs of lesbians, but Ms. Scott Robbins acknowledged that WSN has not championed the needs of that population. Dr. Campbell suggested that someone with lived experience should serve as an advocate for LGBT issues in WSN. Ms. Wurzburg noted that NASADAD has a workgroup on LGBT issues.

Ms. Scott Robbins stated that WSN will help SAMHSA consider how to address treatment issues in light of new sentencing guidelines for nonviolent substance use violations. Dr. Warshaw suggested integrating knowledge about domestic violence and substance abuse coercion into WSN’s work. Dr. Murry urged SAMHSA to enhance public awareness of WSN to leverage knowledge and promote women’s and girls’ issues. Dr. Warshaw stated the need to apply WSN’s lessons to the mental health arena and to work on parenting, prevention, and trauma-informed care. Ms. Scott Robbins responded that many women’s services coordinators wear multiple hats, which permits cross-training across fields. Ms. Bergan and Dr. Murry agreed to share knowledge with NASADAD about work with young people.

Etiology of Behavioral Health Problems

Dr. Felitti suggested that the term *substance abuse* is misleading: Substance use is an “unconscious attempt to cope with problems”—an issue that is absent from the discussion. He posed questions about the benefits of smoking or use of alcohol or crystal methamphetamine, and the relevance of the fact that use of methamphetamine, the first successful anti-depressive medicine, lasted for 15 years. Dr. Warshaw observed that trauma as an underlying issue should be raised to a higher policy level. Dr. Greenfield advocated for a multifactorial approach to the etiology discussion that incorporates both genetic predisposition and environmental stressors. Dr. Felitti suggested that detailed developmental histories can help determine the etiology of behavioral health problems.

SAMHSA of the Future

Ms. Pamela S. Hyde, Administrator, SAMHSA, set SAMHSA’s context for the future. SAMHSA will operate under the Affordable Care Act and parity, and millions of people will be newly insured, have enhanced insurance, or be enrolled in Medicaid or Medicare. Nevertheless, behavioral health still will represent a small slice of the healthcare financing pie. Ms. Hyde explained that behavioral health care is becoming increasingly integrated with general health care, and sentiment is growing that behavioral health matters. Against the backdrop of behavioral health’s increasing importance, however, funding is dwindling. SAMHSA’s key activities include voice and leadership, grant making, surveillance and data collection, practice improvement efforts, public education, and regulatory matters.

To Dr. Murry’s question about potential for competition and/or opportunities to leverage resources with other agencies in SAMHSA’s future, Ms. Hyde responded that the Department of Veterans Affairs (VA) has increased its behavioral health work, on which SAMHSA collaborates to a significant degree. SAMHSA also collaborates with experts in CDC, ACF, the Department of Justice, and other agencies.

Ms. Hyde asked committee members to share their opinions on the nature of SAMHSA’s unique contributions. Dr. Campbell pointed out SAMHSA’s 20-year history of sensitivity to the lived experience

and individuals' voice, and development of the recovery-based model. Nevertheless, in its work with data, SAMHSA still focuses on clinical aspects of behavioral health rather than wellness. Dr. Campbell asserted that people might rely on SAMHSA for knowledge about positive health, psychology, and health effects. Ms. Hyde responded that some view SAMHSA as spending too much effort on recovery and not enough on treatment. Ms. Starr Robbins observed that no other agency would claim to be treatment and recovery experts; this expertise is SAMHSA's brand and value. Ms. Hyde concurred, noted that other agencies have begun to emphasize trauma-informed approaches. Other Council members enumerated unique aspects of SAMHSA's work, including community-engaged approaches and expertise to develop and set standards for evidence-based approaches to complex behavioral health and systems issues.

Dr. Warshaw described her vision of SAMHSA as a public health agency: SAMHSA would focus, on a higher level than merely issuing grants, on well-being, prevention, trauma, supporting children and parenting, and economic disparities. SAMHSA would have a firm presence when economic policy decisions are made regarding investments in public health and mental health. Dr. Felitti asserted that because SAMHSA's work reaches such a small percentage of people, SAMHSA should adopt the goal of primary prevention and exploit mass media. He asserted that the greatest public health advance would be improving parenting skills across the nation, particularly among people who may never have experienced positive parenting. He suggested that parenting could be taught via a serial program on broadcast television. Ms. Hyde responded that SAMHSA has begun to use social media to broaden its influence.

Dr. Greenfield suggested that SAMHSA should serve as the expert in translating evidence into practice for behavioral health, including scaling up, dissemination, and diffusion of knowledge. This approach would enable economists to conceptualize the economic impact of making investments in behavioral health care. Ms. Hyde responded that, with input and some funding from SAMHSA, several units of the National Institutes of Health have begun to do that translation, and the agency intends to do considerably more. Dr. Greenfield also suggested that comprehensive, systemic services research should reflect downstream outcomes, take a public health approach, and use a gendered lens. Dr. Warshaw noted the importance of SAMHSA's strong role in building capacity in the field to implement evidence-based practices, and Ms. Scott Robbins observed the need for ongoing training, supervision, and technical assistance regarding evidence-based practices to inform cost-benefit analyses.

Ms. Hyde asked Council members which activities they might reduce or eliminate in order to tackle new approaches. Council members suggested re-targeting the block grant to address new ideas, for example, scaling up evidence-based practices, and not just filling in gaps. Dr. Murry posed the question of whether expanding SAMHSA as a public health institution might further its mission. Dr. Greenfield stated that the way a mission is visualized fosters partnerships with other agencies around that mission. Ms. Hyde stated that her sense of the conversation was that SAMHSA should provide more leadership and voice, enhance practice improvement, set standards, and provide information to the public and the field. Council members concurred, noting that those types of activities also will have salutary effects on other SAMHSA activities. Ms. Forman suggested that education departments are SAMHSA's natural allies on parenting issues. Ms. Hyde described the tension among SAMHSA's constituencies over the value of grant awards directed to a locality versus SAMHSA's preferred approach to take lessons learned from grants to inform the broader field. She also described tension surrounding SAMHSA's current focus on early childhood and young people, versus the view held by some that SAMHSA should focus on issues across the lifespan. Ms. Hyde asserted that SAMHSA, in conjunction with its federal partners, covers the lifespan. Dr. Campbell suggested the need for a professional development initiative, featuring mentors and including peers, to move to a public health culture and a focus on wellness and recovery.

Dr. Greenfield pointed out the importance to the field of SAMHSA's NSDUH survey. Ms. Hyde responded that SAMHSA is poised to publish a data barometer that offers a snapshot in time of the behavioral health of the nation and each state. Ms. Bergan suggested that SAMHSA use its leadership and

voice to influence private organizations, such as foundations, as well as individuals. Dr. Greenfield encouraged SAMHSA to continue its focus on the needs of women and girls.

Council members discussed points to be reported out at the next day's Joint Council meeting. Rough draft language was proposed for the report: SAMHSA should continue to use multiple lenses, such as trauma, women, recovery, and gender-specific services. The SAMHSA of the future is a public health organization uniquely representing the need for a continuum of services for behavioral health. In representing these needs, SAMHSA will support and implement the translation of research to practice, diffusion, and scalability, and will partner with other organizations to leverage resources to accomplish its mission of diffusion of evidence-based practices from primary prevention to treatment to recovery in order to facilitate the health of the public. SAMHSA will provide education at the organization level to ensure that initiatives include behavioral health.

Women's Recovery Group Study

Dr. Shelly Greenfield, Professor of Psychiatry, Harvard Medical School, and Chief Academic Officer and Director, Clinical and Health Services Research and Education, Division of Alcohol and Drug Abuse, McLean Hospital, Boston, described her Women's Recovery Group (WRG) study. Given women's heightened vulnerability to the adverse consequences of drug use and general avoidance of treatment compared to men, Dr. Greenfield sought to learn about gender-specific substance abuse treatment for a heterogeneous group of women in the community. The rationale for women-only treatment relates to individual differences and certain women's preferences to access substance abuse treatment in women-only settings; the effects of gender on group processes, such as increased cohesiveness due to certain types of homogeneity; enhanced freedom to speak openly; and the ability to address gender-specific topics such as reproductive health and parenting and family relationships. Data show that these topics are important to women in their recovery.

Dr. Greenfield stated that effective treatment programs are gender responsive; address women's treatment needs; and take into consideration co-occurring psychiatric disorders, trauma exposure, the central role of women's relationships; and often provide adjunctive services that are especially relevant to women's outcomes. The plan was to develop a manual-based group treatment for women with content relevant to women in recovery, and to pilot test the model for feasibility, acceptability, and client satisfaction.

The study featured structured, relapse-prevention, group-therapy sessions with a different general or women-focused topic discussed at each session, plus skill practice as homework. Researchers hypothesized that the women in the study group would have better outcomes than the women in mixed-gender groups that used the Group Drug Counseling structure. This trial revealed that all women improved during the 12 weeks of treatment, but subjects in WRG continued to improve 6 months after treatment, while in the mixed group, women's outcomes worsened. All participants expressed client satisfaction, but WRG participants reported enhanced satisfaction. Results also showed that women with high self-efficacy sustained their gains best. Exit interviews revealed that the women in the WRG could focus on gender-relevant topics and more frequently felt safe, endorsed all aspects, had their needs met, and felt intimacy, empathy, and honesty in the group setting.

The researchers conducted the second phase of the study at two sites to replicate its conditions, but this time with a rolling-enrollment format typically seen in practice instead of limited enrollment. Women had dependencies on a range of drugs, plus a variety of psychiatric diagnoses. Dr. Greenfield pointed out that few such studies measure personality disorders. This phase of the study found that women in WRG experienced a significant reduction in mean days of any substance use, not significantly different from the mixed group but sustained throughout the study and 6 months afterward. Researchers concluded that WRG is a new manualized therapy that constitutes effective treatment for women with substance use

disorders who are heterogeneous with respect to their substance use and co-occurring disorders. Able to be used in a rolling-enrollment group by community organizations, WRG is a gender-responsive, women-focused group therapy that also can be delivered in a mixed-gender setting.

Discussion. Dr. Greenfield emphasized the importance of supervision and fidelity, and noted that the manual can guide replication of the treatment program with fidelity to the model. Drs. Campbell and Warshaw concurred, and Dr. Warshaw added that building capacity to deliver supervision is critical. In response to a question from Dr. Warshaw, Dr. Greenfield responded that much study data has yet to be analyzed. Ms. Scott Robbins noted that the WRG study has implications for gender-specific meetings for Alcoholics Anonymous and Narcotics Anonymous. She inquired whether supervision is built into manualized treatment, and Dr. Greenfield responded that the book soon to be published addresses how to measure adherence by a therapist or counselor. Dr. Greenfield stated that supervision skills can be taught to counselors without advanced degrees. Dr. Campbell explained that she is field testing a fidelity tool for peer practices and plans a continuous quality improvement process for study sites that would include adherence, which is a component of supervision and mentoring.

Dr. Greenfield stated that she will run a pilot test of WRG for women with co-occurring eating and substance use disorders, and a colleague will launch focus groups with men to develop a male-specific group treatment on this model. She noted that women prefer the single-gender format, while men preferred a mixed group. Dr. Warshaw noted that in batterer interventions, men will be more honest in sessions with just men.

Public Comment

Time was set aside for public comment, but no one chose to speak.

Closing Remarks and Adjournment

Ms. Amatetti stated that we might explore a focus on wellness and health for the agenda at the next meeting. Dr. Campbell suggested inviting an expert to speak to the committee.

The meeting adjourned at 5:05 p.m.

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

11/8/2013
Date

/s/
Kana Enomoto
Chair, Associate Administrator for Women's Services
Principal Deputy Administrator

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

Attachments: Tab A – Roster of Members; Tab B – List of Attendees

Advisory Committee for Women's Services

Public Roster

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**ACWS Meeting – August 15, 2013
List of Attendees**

0 Non-SAMHSA Federal Attendees

22 Public Attendees representing 22 Constituent Organizations

Amanda Archer	The National Center Substance Abuse & Child Welfare
Suzanne Carrier	Dept of Behavior Health Kentucky
Alfenzo Dorsey	State of Kansas House of Resources
Dan Dubovsky	FASD
Jennifer Foley	Oregon Health Authority Addiction & Mental Health
Lewis Foster	Multiple Family Therapy Resource Center
Catherine Freidman	REM
Chris Gaskill	Alderson Reporting
Vivian Gettys	Capital Human Services District
Sherri Green	University of North Carolina Chapel Hill
Erin Hall	Children & Family Futures
David Han	Hans Pharmacy
Palmer Johnson	SRA
Vanessa Johnson	National Women and AIDS Collective
Jennifer Keyser-Bryan	JBS International Inc
Karen Mooney	Colorado Department of Human Services
Margaret Murphy	Advocates for Human Potential
Lisa Ramirez	DSHS Texas
Marilynn Teel	University of Colorado
Michele Tilotta	Depart of Public Health Iowa
Christine Ullstrup	Meta House
Rita Webb	National Association of Social Workers