Resources
Transcript

Addressing the Intersection of Intimate Partner Violence and Substance Use in Maternal Health Care

November 7, 2024, 2:00 – 3:00 pm EST

Resources

Resources Shared by HRSA's Maternal and Child Health Bureau

- Task Force on Maternal Mental Health Resources
  - National Strategy to Improve Maternal Mental Health Care
  - Maternal Mental Health Report to Congress
  - Task Force Leads
    - Substance Abuse and Mental Health Services Administration
      - Dr. Nima Sheth, MPH, Associate Administrator for Women's Services (AAWS), Senior Medical Advisor, Nima.Sheth@samhsa.hhs.gov
      - Madonna Green, LICSW, Public Health Advisor, Madonna.Green@samhsa.hhs.gov
    - Office of the Assistant Secretary for Health
      - Dr. Dorothy Fink, Deputy Assistant Secretary for Women's Health and Director of the Office on Women's Health, Dorothy.Fink@hhs.gov
      - Cyntrice Bellamy, Psy.D, M.S., M.Ed., Senior Public Health Advisor, Cyntrice.Bellamy@hhs.gov

- Hotline Resources
  - National Maternal Mental Health Hotline call or text 1-833-TLC-MAMA (852-6262).
  - National Maternal Mental Health Hotline Promotional Toolkit
  - National Domestic Violence Hotline which providers can also contact for treatment guidance at 1.800.799.SAFE (7233) | Text "START" to 88788.
  - National Human Trafficking Hotline at 1.888.373.7888 or help@humantraffickinghotline.org.
  - StrongHearts Native Helpline at 1.844.762.8483.

- HRSA-supported Resources
  - Training and Technical Assistance for Health Centers through the Health Partners on IPV and Exploitation.
  - Freely accessible training recording through the Survivor Health Connection Project.
  - Toolkit resource for Preventing and Responding to IPV: an Implementation Framework.

- Connect with HRSA
  - www.hrsa.gov
  - Sign up for the HRSA eNews newsletter.

Transcript

Helenka Ostrum: Hello, and thank you all for joining today's webinar, "Addressing the Intersection of Intimate Partner Violence and Substance Use in Maternal Health Care."

Helenka Ostrum: My name is Helenka Ostrum, and I am a public health analyst with the Health Resources and Services Administration also known as HRSA.

Helenka Ostrum: Please take a moment to introduce yourselves in the chat with your name and organization.

Helenka Ostrum: In today's webinar, we will discuss initiatives that are addressing the intersection of intimate partner violence and substance use in maternal health care.

Helenka Ostrum: You will learn about the National Strategy to Improve Maternal Mental Health Care and Health and Human Services' Violence Against Women and Substance Use Prevention Initiative.

Helenka Ostrum: We also have a Q&A, a question-and-answer feature on this webinar. Use the Q&A box to drop your questions to our presenters.

Helenka Ostrum: I will now turn it over to Bethany Applebaum, the senior advisor in the Maternal and Child Health Bureau.

Bethany Applebaum: Good afternoon and welcome everyone. My name is Bethany Applebaum, and I'm a senior advisor in the Division of Women's Health, in HRSA's Maternal and Child Health Bureau.

Bethany Applebaum: This webinar was developed in collaboration with our colleagues at the HRSA Maternal and Child Health Bureau and the Department of Health and Human Services Office on Women's Health.

Bethany Applebaum: Before we get started with today's speakers, I want to briefly share a bit about my agency for those of you who may be unfamiliar with our work.

Bethany Applebaum: HRSA is a component of the U.S. Department of Health and Human Services.

Bethany Applebaum: We support a broad range of programs to provide health care to people who are geographically isolated and economically or medically vulnerable.

Bethany Applebaum: Every year HRSA programs support tens of millions of people, including those with low incomes, people with HIV, pregnant people, children, parents, rural communities, transplant patients, and other communities in need as well as the health workforce, health systems, and facilities that care for them.

Bethany Applebaum: Intimate partner violence is a public health issue. It affects nearly half of all women and 44% of men.

Bethany Applebaum: IPV has disproportionate impacts on many individuals, including women, lesbian, gay, bisexual, transgender, queer, and intersex people, and people who are pregnant.

Bethany Applebaum: A majority of individuals first experience IPV before age 25.

Bethany Applebaum: Homicide deaths among pregnant women and new mothers are more prevalent than deaths from hypertensive disorders, hemorrhage, or sepsis.

Bethany Applebaum: IPV can impact a person's physical health, behavioral health, and economic and quality of life outcomes.

Bethany Applebaum: IPV can impact maternal health. There is an elevated risk of IPV in the perinatal period.

Bethany Applebaum: An estimated 324,000 pregnant people in the U.S. per year experience some form of IPV.

Bethany Applebaum: While IPV is more common among pregnant women than other conditions. They are routinely screened for, few providers screen pregnant patients for violence.

Bethany Applebaum: Women who experience IPV during pregnancy are about three times more likely to suffer perinatal death than women who do not experience IPV.

Bethany Applebaum: Maternal exposure to IPV is associated with significantly increased risk of low birth weight and preterm birth.

Bethany Applebaum: And women who experience IPV are more likely to receive no prenatal care or delay care.

Bethany Applebaum: Now let's look at data for substance use disorder and IPV.

Bethany Applebaum: Individuals with substance use disorder are at an increased risk to experience IPV.

Bethany Applebaum: Experiencing IPV also increases the risk of substance use disorder.

Bethany Applebaum: Physical and sexual trauma that can often occur in IPV increases the risk for injury that can result in chronic pain and traumatic brain injury, which, if untreated, can contribute to substance misuse and substance use disorder.

Bethany Applebaum: Substance use coercion involves coercive tactics targeting a partner's use of substances as part of a broader pattern of abuse and control.

Bethany Applebaum: And substance use coercion is common among individuals impacted by IPV and creates major barriers to safety and recovery.

Bethany Applebaum: During this webinar you will learn about initiatives that are integrating prevention and care for IPV, substance use, and maternal health.

Bethany Applebaum: I'll now turn it over to Helenka, who will introduce our first speaker.

Helenka Ostrum: Thank you, Bethany.

Helenka Ostrum: I am excited to introduce Melodye Watson. Melodye Watson is the Behavioral Health Lead and a Public Health Analyst in the Division of Healthy Start and Perinatal Services. Melodye supports Healthy Start and the Catalyst for Infant Health Equity Programs. She is a licensed clinical social worker and psychotherapist. She is also the acting co-chair for the Pillar Four Work Group for the Task Force on Maternal Mental Health. Melody, I'll turn it over to you.

Melodye Watson: Thanks so much for the introduction Helenka. Greetings everyone.

Melodye Watson: Today I'm going to discuss the Task Force on Maternal Mental Health, the National Strategy to Improve Maternal Mental Health, and share information about HRSA's Maternal Mental Health Hotline. Next slide.

Melodye Watson: The Task Force on Maternal Mental Health was authorized in the Consolidated Appropriations Act of 2023.

Melodye Watson: The task force consists of nearly 120 representatives of federal agencies, individuals and entities representing diverse disciplines and views, including people with lived experiences.

Melodye Watson: Its purpose is to identify, evaluate, and make recommendations to coordinate and improve federal activities related to maternal mental health programs.

Melodye Watson: The task force prepares, and updates reports that analyze and evaluate the state of maternal mental health programs at the federal level that identifies best practices with respect to maternal mental health.

Melodye Watson: The task force also develops and regularly updates a National Strategy to Improve Maternal Mental Health.

Melodye Watson: It does so by soliciting public comments from stakeholders and develops reports for Congress, and eventually we'll have one for governors.

Melodye Watson: This task force kicked off in October of 2023. Its first deliverables were a report to Congress, as well as a National Strategy, which was released in May of 2024,

Melodye Watson: The task force will continue its operations through 2027. Next slide.

Melodye Watson: So, the primary audience for the National Strategy is the federal Government meaning Congress, the Executive Branch, and the federal departments and agencies that provide health and human services in our communities. Next slide.

Melodye Watson: The vision of the task force's National Strategy is one in which maternal mental health and substance use care is seamless and integrated across medical community and social systems.

Melodye Watson: The vision includes models of care that are innovative and sensitive to the individual's experiences, culture, and community. Next slide.

Melodye Watson: The task force's National Strategy and report to Congress are an important part of broader federal efforts to address women's overall health, including their mental health, and maternal health in particular, across this nation.

Melodye Watson: The National Strategy aligns with initiatives you see here on this slide. And please note that the initiatives highlighted in red have significant HRSA investments. Next slide.

Melodye Watson: So, this slide here depicts the covers for the National Strategy and report to Congress.

Melodye Watson: And if you'd like to access these reports, we have put links in the chat so that you can download and read these reports for yourself.

Melodye Watson: And I'll just kind of go through and give you like an overview of what the report to Congress entails.

Melodye Watson: So, the report to Congress presents findings on maternal mental health conditions and SUDs, substance use disorders, in the United States, related federal programs, and best practices.

Melodye Watson: It describes current data on the prevalence of maternal mental health conditions and substance use disorders and pregnancy related deaths linked to them, highlighting the subgroups that are most impacted.

Melodye Watson: It features a subset of best practices, highlighting ones that advance access, trauma-informed approaches and culturally relevant services and supports.

Melodye Watson: It covers best practices that are evidence-based, evidence-informed, and promising.

Melodye Watson: The report details federal programs related to services, describes current coordination efforts, and points to gaps and opportunities for improved collaborations among agencies.

Melodye Watson: The report describes the overarching themes from listening sessions with people with lived experiences and opportunities for state and local partnerships.

Melodye Watson: Finally, it includes a summary of the state of national policies and programs related to maternal mental health conditions and substance use disorders along with the best practices that might be leveraged to implement recommendations from our National Strategy.

Melodye Watson: Next slide.

Melodye Watson: Right so on to the National Strategies and its pillars. So, the National Strategy is built on five big pillars. The first pillar is to build a national infrastructure.

Melodye Watson: The second pillar is care should be accessible, affordable, and equitable.

Melodye Watson: The third pillar is to use data and research to improve outcomes and accountability.

Melodye Watson: The fourth pillar is to promote prevention and educate and partner with communities.

Melodye Watson: And finally, the fifth pillar is to lift up lived experiences.

Melodye Watson: These five pillars interweave several cross-cutting expectations, which is to increase equity and access, improve federal coordination and collaboration, elevate culturally relevant supports, use trauma-informed approaches to bolster maternal mental health, and enhance care for perinatal mental health conditions and SUDs.

Melodye Watson: So, before I get into some of the recommendations just wanted to note that our National Strategy to Improve Maternal Mental Health includes 29 recommendations. Today I'll only discuss the recommendations that have a specific call to action related to what we have termed gender-based violence, or what we also know as intimate partner violence.

Melodye Watson: It is important because we need to connect the dots between gender-based violence, maternal mental health conditions, and substance use disorders.

Melodye Watson: Experiencing gender-based violence has a significant impact on maternal mental health and substance use and is a major contributor to maternal mortality, suicide, overdose, and homicide. Next slide.

Melodye Watson: Alright, so recommendation 1.2.1 under pillar one calls on Congress to expand, enhance and increase funding for federal programs serving perinatal populations.

Melodye Watson: The goal here is to ensure that mental health substance use disorder and gender-based violence screening and preventive services linkages to timely holistic treatment and resources and referrals to community-based recovery supports are embedded within a national infrastructure for maternal mental health care.

Melodye Watson: And I just want to point out, like the information that you see in the brackets is really HRSA programs that have the potential to act on these recommendations. Next slide.

Melodye Watson: Recommendation 2.1.1 asks that we establish comprehensive pathways to improve the routine culturally relevant and trauma-informed screening and preventive services for the presence of and assessment of risk factors related to developing perinatal mental health conditions and substance use disorders along with gender-based violence, trauma, social determinants of health, with the provision of appropriate resources, referrals and linkages to timely intervention and all relevant care settings. Next slide.

Melodye Watson: This next recommendation is for the creation of a federal mechanism to fund and develop infrastructure that supports innovation and care delivery models for mental health conditions, substance use, substance, use disorders and gender-based violence during the perinatal period to reduce barriers to more accessible, holistic, and multigenerational dyadic care. Next slide.

Melodye Watson: Recommendation 2.3.1 requires all relevant, federally funded training curricula and technical assistance programs to incorporate how to prevent, screen, assess, and treat perinatal mental health conditions inclusive of substance use disorders and gender- based violence. Next slide.

Melodye Watson: So, this next recommendation calls on Congress to allocate long-term funding, to establish, expand, and sustained perinatal mental health, substance use and gender-based violence,

consultation programs for medical mental health and substance use, nursing, allied health providers, as well as nonclinical community-based workers.

Melodye Watson: Next slide.

Melodye Watson: This recommendation calls on Congress to allocate long-term funding to establish expand and sustain perinatal mental health substance use and gender-based violence consultation programs.

Melodye Watson: Oh, I'm sorry. I just read that one.

Melodye Watson: Sorry. So, I'm under Pillar three, excuse me.

Melodye Watson: This recommendation is to create mechanisms to pair implementation guidance and dissemination strategies with research, scientific and surveillance findings on perinatal mental health, substance use disorders, and gender-based violence for wide use, application, and adoption of the most up-to-date interventions, guidelines and data. Next slide.

Melodye Watson: And we're on to our last gender-based violence recommendation from the National Strategy under pillar four, and it states that our federal agencies should support a nationwide approach to clarify the messaging and target audiences of all mental health, substance use disorder, gender-based violence and crisis support warm lines and hotlines for the public.

Melodye Watson: So, I've gone over those recommendations that are specific to gender-based violence or intimate partner violence in the National Strategy.

Melodye Watson: And I really hope that you've taken the time to you know, download the links that we put in the chat so that you can review all of the recommendations in whole. If you have questions about these recommendations, the task force, the report to Congress, or just the National Strategy as a whole, please add them to the Q and A. We will have some time to respond to your questions.

Melodye Watson: Next slide.

Melodye Watson: So here in this slide you have a list of the participating federal agencies that were engaged to inform the National Strategy, and as you can see, it really was, and is a hold of government approach.

Melodye Watson: Next slide.

Melodye Watson: So, we do have leads from our, for our task force and our leads are based at SAMHSA. The Substance Abuse and Mental Health Services Administration, and out of the Office of the Assistant Secretary for Health. And the leads contact information is here for you if you have the inclination to reach out to them.

Melodye Watson: Next slide.

Melodye Watson: So now I'm going to give you a quick overview of the National Maternal Mental Health Hotline, and just want to say thank you to my colleagues in the Division of Women's Health for sharing information about the hotline for me to share with you today.

Melodye Watson: Next slide.

Melodye Watson: So, the National Maternal Mental Health Hotline is a 24/7, 365 day per year, free and confidential service that provides connections to qualified and professional counselors that are licensed and certified in supporting pregnant and postpartum individuals facing mental health challenges.

Melodye Watson: The task force, I'm sorry, the hotline officially launched in May of 2022. In fact, it was May 8th of 2022, which was actually Mother's Day.

Melodye Watson: Through ongoing operations of the hotline, we are gathering valuable information about the implementation of best practices to strengthen services delivered via the hotline.

Melodye Watson: Next slide.

Melodye Watson: So, what does our hotline for maternal mental health offer? So, our counselors provide immediate psychosocial support, evidence-based information, brief intervention and resources and referrals for treatment and recovery support services to pregnant and postpartum persons and their loved ones.

Melodye Watson: Next slide.

Melodye Watson: Services are provided in English and Spanish. The hotline serves speakers of 60 additional languages, including, but not limited to Mandarin, French, German, Polish, Portuguese, Tagalog, Vietnamese, Hmong, Hebrew, Creole, and Arabic.

Melodye Watson: Next slide.

Melodye Watson: So, what to expect when one calls a hotline.

Melodye Watson: Our callers can expect to receive real time, emotional support, resources, and referrals that are culturally and linguistically relevant.

Melodye Watson: The hotline counselors gather information on social factors related to transportation, housing, food, insecurity, and childcare, and they do this in order to provide resources and referrals to local, state, regional and national support services.

Melodye Watson: Hotline counselors may also conduct warm transfers to the 988 Suicide and Crisis Lifeline, the Disaster Distress Hotline, and the National Domestic Violence Hotline.

Melodye Watson: Next slide.

Melodye Watson: So, by directly connecting patients with the national Maternal Mental Health hotline providers can bridge the gap between their patients and expert support, especially during moments of acute mental health crisis.

Melodye Watson: Through the hotline, providers who may not specialize in maternal mental health have access to a team of experts who can offer insights and recommendations on the unique psychological, emotional, and physical challenges that arise during pregnancy and postpartum periods.

Melodye Watson: The hotline offers a support system and comprehensive resources, such as educational materials and provider toolkits.

Melodye Watson: Next slide.

Melodye Watson: So just want to go over a few things that you can do to help raise awareness of the National Maternal Mental Health Hotline. First of all, connect your patients, clients, those that you know who are in the pregnant or postpartum period seeking support to the hotline number, which is 1-833-TLC-MAMA.

Melodye Watson: You may visit the National Maternal Mental Health Hotline website to access their partner toolkit and promotional materials.

Melodye Watson: And you can also amplify the hotline via your social media. Just remember to like comment, share, and repost.

Melodye Watson: Next slide.

Melodye Watson: And to learn more about the hotline and access the promotional toolkit, you may scan the QR code here on screen or click the link in the chat which will take you directly to our website for the hotline.

Melodye Watson: We'll stay here for a second while folks are clicking on the QR code.

Melodye Watson: And if you can't access it through the QR code, the link is in the chat.

Melodye Watson: Let's head to the next slide.

Melodye Watson: So again, please share info about the National Maternal Mental Health Hotline as widely as possible. It is an excellent resource.

Melodye Watson: You can text, call, or chat.

Melodye Watson: So, thank you so much for your time and attention and I will turn things back over to Helenka.

Helenka Ostrum: Thank you, Melodye for sharing all of that are really valuable information.

Helenka Ostrum: It's my pleasure to introduce Gage Dalton.

Helenka Ostrum: Gage Dalton (he/him) is a Public Health Analyst in the Division of Policy and Performance Management at the Department of Health and Human Services Office on Women's Health.

Helenka Ostrum: He is the lead on much of OH's violence-related portfolio and the intersectional issues that commonly overlap with gender-based violence, including projects focused on domestic violence, intimate partner violence, maternal deaths due to violence, substance use, and human trafficking.

Helenka Ostrum: Prior to coming to OWH, Gage worked as a paramedic serving rural populations while he completed his graduate coursework. Gage, I'll turn it over to you.

Gage Dalton: Thank you Helenka and good afternoon, everyone. Thank you for the opportunity to present on the Violence Against Women and Substance Use Prevention Initiative, a grant created by the Department of Health and Human Services Office on Women's Health, or OWH, to bring together substance use providers and mental health stakeholders with those working to prevent violence against women.

Gage Dalton: Like Helenka said, I am a Public Health Analyst at OWH, and I'm also the project officer for this grant.

Gage Dalton: And now heading into the 3rd year of this grant's performance. Our grantees have been making some great strides to address the intersections of intimate partner violence and substance use disorders, or IPV and SUD respectively, through their projects. And we have been incredibly encouraged by the progress they are making.

Gage Dalton: So, on the next slide.

Gage Dalton: This has already been touched on this afternoon some, but for some background on why OWH has a grant focusing on the intersections of SUD and IPV.

Gage Dalton: It is well established that violence in general is a major risk for pregnant and postpartum women with estimates that approximately 324,000 pregnant women are abused each year in the United States.

Gage Dalton: However, in addition to that, IPV and SUD are deeply interconnected issues with data showing that up to 90% of women who access SUD treatment reported that they were victims of violence in their lifetimes and up to 67%, reporting that they suffered violence within the last year.

Gage Dalton: This is particularly worrisome, as IPV and SUD can have severe health effects on women with both contributing to an increased risk of complications during pregnancy, fetal injury, preterm, delivery, and low birth weight.

Gage Dalton: And even though there's a significant overlap between IPV and SUD, the two are often treated separately instead of together, and there's a gap in provider training to prevent and treat the co-occurrence of IPV and SUD, specifically among SUD providers who are not adequately trained to identify IPV.

Gage Dalton: And recent studies have demonstrated this with findings that most providers successfully screen for IPV in their patients but fail to screen for SUD as well. And only around one third of outpatient SUD treatment services offer violence-related services as well.

Gage Dalton: Next slide, please.

Gage Dalton: So, in response to this issue, OWH created the Violence Against Women and Substance Use Prevention Initiative.

Gage Dalton: Where the goal of this grant initiative, as outlined in our initial notice of funding opportunity, is to fund projects that create evidence-based statewide pilot interventions to train SUD treatment providers on IPV. And address the intersection of IPV and SUD during pregnancy and postpartum.

Gage Dalton: Grant recipients have been expected to address this intersection through a variety of approaches, including training SUD treatment providers to recognize and address IPV with patients.

Gage Dalton: And training IPV treatment staff on recognizing and addressing SUD, especially among pregnant and postpartum patients.

Gage Dalton: The training is also encouraged to strengthen relationships between IPV and SUD programs to build better cross referral systems between the two. To ensure buy-in and adoption of the trainings being developed, recipients are expected to incentivize providers through approaches, such as offering continuing education credits. And recipients are also expected to identify, utilize, and disseminate best practices for addressing, evaluating, and managing the co-occurrence of IPV and SUD among pregnant and postpartum women through innovative training and delivery methods.

Gage Dalton: Then those best practices for managing IPV and SUD are expected to be integrated into medical practice across multiple health care settings that overlap with these issues, including settings such as OBGYN, primary care, pediatricians, and family medical practices.

Gage Dalton: Additionally, recipients are expected to integrate perinatal and postpartum programs into existing substance use programs to address the lack of substance use programs currently designed for pregnant and postpartum women.

Gage Dalton: Then, finally, recipients have been expected to develop and implement process and outcomes evaluations to determine how effective these approaches are in achieving these goals with a focus on whether underserved and disadvantaged populations are being reached through these approaches.

Gage Dalton: And we ended up funding six grantees, a total of 3.9 million dollars in September of 2022. And since then, our recipients have been working to develop their curricula and implement those trainings across the populations they serve.

Gage Dalton: And moving on to the next slide.

Gage Dalton: You can see on this slide, and the next one, a list of our grantees and highlights from the progress they have made in the first two years since the Violence Against Women and Substance Use Prevention Initiative launched.

Gage Dalton: At the top here is the Domestic Violence Action Center, with its safe, strong, and sober project located in Honolulu, Hawaii.

Gage Dalton: Their approach is centered around partnering with the communities across their state to provide cross-sectional training on SUD and IPV.

Gage Dalton: And through the collaborative relationships they established, they have successfully launched training programs for IPV, SUD, and other providers on every island in Hawaii, and began providing training to them focused on the screening of prenatal and postpartum patients they encounter that is tailored to their specific populations and needs.

Gage Dalton: Interestingly, they have found that 100% of SUD providers and 59% of IPV providers they trained stated that they had never received any training on the other issue, or the intersectional risks they pose for pregnant and postpartum patients they serve before they received the trainings delivered by this project.

Gage Dalton: And through the implementation of these trainings, they have begun to move the needle on cross-referral between the two specialties in their state.

Gage Dalton: Then we have Hektoen Institute for Medical Research, which is working to address IPV and SUD in West Virginia.

Gage Dalton: So far, they created and launched a statewide stakeholder advisory board and health care task force. Using both, they performed a needs assessment for IPV and SUD providers in their state that helped inform the development and launch of their training curricula that their project is centered around which is now piloting in two sites in their state.

Gage Dalton: This has resulted in the delivery of this training to a wide variety of providers, including IPV and SUD providers, social workers, licensed professional counselors, addiction and prevention professionals, and domestic violence advocates with CME credits for the training series being offered for each of those professions.

Gage Dalton: And we also have the Pacific Institute for Research and Evaluation with their project titled focus on Integrating Response, Screening and Training, or, FIRST for short, for women in Kentucky.

Gage Dalton: Their approach began with the forming of a regional community of practice that links IPV and SUD providers across the state of Kentucky with an emphasis on reaching providers in rural counties, which has reached 12 out of 15 regions in Kentucky, so far.

Gage Dalton: Much like Hektoen, they are using this group of providers in their state to perform an analysis of the needs and opportunities for targeting training efforts in their state and have utilized that information to develop a training program that emphasizes screening and referral.

Gage Dalton: However, in addition to this, they are also utilizing these relationships established as part of the community of practice to build linkage points between IPV and SUD providers and other health care providers to ensure proper care is provided to women once they screen positive for IPV and/or SUD, through the development of an individualized approach for each site they are delivering their intervention at.

Gage Dalton: So far, they have delivered their intersectional training intervention at seven CMHCs. With the participating sites, helping decide what approach would be most beneficial for their providers, based on the needs assessment held at the outset of their project.

Gage Dalton: The early results from this intervention have included increases in self-efficacy and skills related to screening and referral for IPV and SUD.

Gage Dalton: Nearly 3,000 pregnant and postpartum women have screened positive for IPV or SUD that would not have been caught before, and the integration of IPV and SUD best practices into protocol in their state's Department of Public Health.

Gage Dalton: And on the next slide are our next three recipients. The first one here is Texas A&M's Health Science Center, out of College Station, Texas, with their project titled Safe Mothers in Texas.

Gage Dalton: Similar to the two previous recipients I just discussed, this grantee has built a consortium of IPV and SUD providers, as well as stakeholders who intersect with pregnant and postpartum women, and those who are at risk of suffering from IPV and SUD to identify gaps in care in their state, and what best practices have proven effective in bridging those gaps, specific to the populations they are serving.

Gage Dalton: Also, using this consortium, they have developed a resource map for their state for IPV and SUD providers to easily access tools and resources for their patients in the communities they serve.

Gage Dalton: Something unique and exciting about this grantee, though, is how they are developing scaffolded multiform education modules that employ a wide array of platforms, including podcasts, interactive online learning sessions and in-person education, delivery. And they are using this varied approach to education as a way to engage as many providers in their state as possible.

Gage Dalton: These education modules are being piloted in 20 sites across their states and are seeing some positive results already.

Gage Dalton: Next is the University of Mississippi Medical Center in Jackson, Mississippi, and their project, titled SUD and IPV Among Mississippi's Moms Initiative to Prevent and Treat, or the SIMM Initiative for short.

Gage Dalton: They have worked with their partners to develop a statewide registry of professionals and community groups offering supportive services to pregnant and postpartum victims of IPV.

Gage Dalton: Using that registry, they have delivered their training at 21 CMHCS. Thus, reaching IPV service providers in their state and delivering the SUD training program, they developed to equip them with the tools to properly screen pregnant and postpartum women they treat for SUD.

Gage Dalton: They're also utilizing their position at a university to institutionalize this knowledge and fold the trainings developed as part of this project into the educational requirements for graduate nursing students to ensure intersectional IPV and SUD approaches are incorporated into future practice.

Gage Dalton: And lastly, is Virginia Commonwealth University's Project, Recovery in Motion: Treatment, and Prevention Across the Intersection of Violence, Substance Use, and Pregnancy in Richmond, Virginia.

Gage Dalton: They are working to enhance the capacity of their health system to better screen and respond to those with SUD, who are at risk of IPV, and they are doing this by delivering training on IPV and SUD and pregnancy to all providers who interact with pregnant and postpartum patients with a focus on trauma-informed practices and using lessons learned from their trauma center.

Gage Dalton: And next slide, please.

Gage Dalton: As our, apologies.

Gage Dalton: As our recipients' evaluations are still ongoing, we do not have finalized data or outcomes from their projects quite yet.

Gage Dalton: Although we are expecting more detailed outcomes in the coming months.

Gage Dalton: Nevertheless, there are some common threads across many of the recipients' projects that are potentially promising practices and are showing some great signs of success.

Gage Dalton: The first of these is using cross-sectional and multi-form training materials on IPV and SUD for providers.

Gage Dalton: Several of our recipients are reporting that using a variety of platforms to deliver the trainings they developed has served as a way to encourage participation and decrease the burden of joining the training for providers who are already stretched thin from their workloads. And this has been especially reported among our recipients, who are getting great results from using shorter form modules that enable providers to take the curriculum and at a pace that fits their schedule.

Gage Dalton: Another practice that is showing promise after the first two years is how recipients have collaborated with providers and community organizations in their states.

Gage Dalton: All of our recipients are doing this to some degree, and they have all indicated that they have been better able to better understand the needs of the providers and communities they are looking to partner with because of this. And it has equipped them with the information needed to develop curricula and resources that are specifically tailored to their populations.

Gage Dalton: This has also helped connect providers and professionals in usually siloed sectors to establish linkages that may aid in the referral process for victims of IPV and SUD to receive the care they need.

Gage Dalton: Then, along the lines of the first two practices here is the inclusion of incentives for providers.

Gage Dalton: All our recipients are using continuing education credits as a way to incentivize participation in their training programs which has been a great practice in and of itself, especially with the inclusion of continuing education credits for health care professionals that are not doctors or nurses.

Gage Dalton: However, through listening to the providers they are collaborating with, many of our recipients also realized that the multiform and easy to access trainings that were highlighted in the first point here, served as incentives themselves to participation as well.

Gage Dalton: Then, finally, is the inclusion of those with lived experience related to violence and substance use disorders from their states, and the collaborative networks they are forming and partnering with them as they develop their materials to better serve those populations.

Gage Dalton: Next slide, please.

Gage Dalton: Now the next steps for our recipients as they continue moving forward in their efforts, are fairly similar across all the projects.

Gage Dalton: Each of them will be working in year three of the grant to build on the collaborative networks they formed in the first two years and use them as platforms to continue expanding the reach and content of the trainings they have developed.

Gage Dalton: And on those trainings, they all will continue delivering those cross-sectional curricula they created and have plans to amplify them.

Gage Dalton: The curricula they already have, through further developments and additions based on the feedback from providers they have trained so far.

Gage Dalton: Then they will also continue working the best practices for addressing IPV and SUD in pregnant and postpartum women, they identified through their partnerships and built into their curricula into medical protocols, with a few of our recipients already doing so through relationships with state agencies and education systems.

Gage Dalton: This effort will ensure this program is not just a flash in the pan but has lasting impacts on how providers identify and address IPV and SUD in their pregnant and postpartum patients.

Gage Dalton: Then, finally, our recipients are working to finalize the evaluations for their projects to ensure outcomes and results from their approaches can be reported to the field at large.

Gage Dalton: And all of this has been incredibly encouraging work. I'm excited to see where each of these projects land as we come toward the end of this initiative's lifespan and look forward to the results of the groundwork that is being laid here and sharing any future updates with you once we receive more outcomes related to these projects.

Gage Dalton: And next slide.

Gage Dalton: That is all I have for you today. Thank you for the opportunity to discuss the Violence Against Women and Substance Use Prevention Initiative.

Gage Dalton: Please feel free to reach out to me if you have any questions about the work we are doing.

Gage Dalton: Thank you.

Helenka Ostrum: Thank you, Gage, for sharing those real-life examples of what your grantees are doing to integrate IPV and SUD prevention and response efforts across the country.

Helenka Ostrum: Now we are shifting into our Q&A portion of the webinar. I do want to mention that anyone who registered for this webinar, you will receive an email with a recording of this webinar and the resources that have been shared. So, you will be receiving that once that is available.

Helenka Ostrum: And turning over to our Q and A, Melodye, I have a question for you to kick us off.

Helenka Ostrum: Why is there a need for a National Strategy to Address Maternal Mental Health?

Melodye Watson: Okay, just one sec. Can everyone hear me?

Helenka Ostrum: Yes.

Melodye Watson: Okay, thank you.

Melodye Watson: Thank you for that question. And when I'm done answering that there was also a question that I saw in the Q and A that I just want to read out to everyone. And so, I think that you know the thing is like in the U.S, we have, like more women dying during pregnancy in the year following pregnancy than in any other developed country.

Melodye Watson: And tragically, mental health conditions are one of the leading causes of maternal mortality, accounting for almost like 23% of maternal deaths.

Melodye Watson: And so having a National Strategy and an infrastructure to address mental health, maternal mental health, as a part of reducing overall maternal mortality is imperative.

Melodye Watson: And our agency, as far as HRSA is well positioned to support that mandate along with the other federal agencies. So, I mean, the need is there because we have pregnant people and people in the postpartum period, having severe consequences by not getting the support.

Melodye Watson: And so, I just want to go to the Q and A because I wanted to just respond to a question out loud. Someone asked, does the strategy include a mandated supporting approach in order to mitigate potential punitive consequences and family separation.

Melodye Watson: So, thank you to whomever posted that question, and just wanted to state that under Pillar One of our National Strategy we do have a recommendation that is put forward to address those punitive responses, and that's recommendation 1.3 which you can find on page 21 of the National Strategy document.

Melodye Watson: And it reads that we will establish policies that support non-stigmatizing and non-punitive approaches to screening for SUDs, mental health conditions, and suicide in pregnant and postpartum individuals ensure access to culturally responsive, evidence-based trauma-informed family-centered care.

Melodye Watson: And this was put forward because we are concerned about providers' requirement to be mandated reporters, and in some states, there are severe consequences in terms of family separation. And so, the recommendation really addresses that by having less stigmatizing policies and non-punitive approaches put forward.

Helenka Ostrum: Thank you, Melodye, for addressing both of those questions. Gage, my next question is for you.

Helenka Ostrum: What are some effective ways to link substance use providers with violence prevention organizations that your recipients have noticed?

Gage Dalton: Yes, thank you for this question. I highlighted this some in or quite a few times actually when I was talking about our recipients' projects. But many of them have found that having statewide communities of practice, consortia, and task forces just having a place where they can come together and communicate and organizing that at a community level has shown that these specialties are looking to interact with each other and are open to it and excited about it.

Gage Dalton: It's just establishing that and inviting those parties to it so they can start cross-collaborating and breaking down those silos between IPV and SUD providers.

Gage Dalton: And I see a question in the Q and A as well.

Gage Dalton: And I can address that real quick. Will this OASH initiative happen again? Or is this the only cohort for this funding stream?

Gage Dalton: At this time, there is not, there are not any plans for a second cohort of the Violence Against Women and Substance Use Prevention Initiative.

Gage Dalton: However, the Office on Women's Health has a continual focus on violence against women, and as we have future initiatives coming out, we will be sure to share those out using grant forecasting and grants.gov to announce our work in the violence space.

Helenka Ostrum: Thank you for addressing those.

Helenka Ostrum: Melodye, one more question for you.

Helenka Ostrum: Does the Maternal Mental Health Hotline link callers to local resources?

Melodye Watson: It absolutely does. And so, the counselors that are staffing the Maternal Mental Health Hotline are able to not only provide emotional support and resources, but they do link to local resources, regional resources.

Melodye Watson: They also provide that warm handoff to other warm lines and hotlines like I mentioned before, the 988, and the National Domestic Violence Hotline. So, our counselors are trained to, you know, provide resources at the local level.

Helenka Ostrum: That's great.

Helenka Ostrum: Gage, pivoting back to you.

Helenka Ostrum: What are your recipients, hearing from providers working to address these intersectional issues?

Gage Dalton: So, providers are saying that they do not have enough training on these areas that to feel fully comfortable for screening and referring the opposite specialty, which is not surprising from what we were expecting from the outset.

Gage Dalton: So, our recipients are hearing some great feedback from providers as they are delivering these trainings.

Gage Dalton: And in addition to that, providers are also saying that the varied approaches they are finding that some providers need that in person, style, training because of how their workflow is. And some are finding they need the short form online training.

Gage Dalton: So, what they're hearing from their providers is they can't have a one size fit all approach in delivering these cross-sectional trainings.

Gage Dalton: It needs to be tapped into directly what your community is needing. And even across or within a single state, they're finding that providers have varied needs for these types of approaches.

Gage Dalton: So, having those consortia and communities of practice that I discussed before has helped our recipients really know the needs of providers in their communities.

Helenka Ostrum: Thank you.

Helenka Ostrum: And Melodye, if the audience for the National Strategy on Maternal Mental Health is Congress, why should others be aware of this strategy?

Melodye Watson: That's a great question. Thank you. So, I think others should be aware, especially anyone that's working in the field of maternal health or researchers, administrators, providers, folks in the mental health field, and advocates need to be aware of how the federal government is responding to this concern.

Melodye Watson: I think it's important to become familiar with the National Strategy in order to have collective impact in addressing some of these concerns, especially as it relates to driving policy and systems change within our communities and places of work, the local, state, and federal levels.

Melodye Watson: So yeah, I mean, it's important because this is an issue impacting more than half of our population.

Melodye Watson: And the recommendations, I think, even though, since our audience is Congress, but the recommendations will require, let's say, a public private partnership to really be impactful. Since we're really talking about building a national infrastructure, and the government can't do it alone. So, this is for everyone in the field, and for those who are impacted, I mean, we have a specific call out to people with lived experience to have a voice in this work as well.

Helenka Ostrum: And as a follow up to that Melodye, is there identified data available regarding the National Maternal Health Hotline, such as the number of calls, texts, etc.?

Melodye Watson: Yeah, so we do have data, some data available. In terms of the demographics like at this point, like, I don't have access to, or there isn't public access available to like, you know, racial demographic type data.

Melodye Watson: But we do know, like the types of calls based upon like the you know, mental health concerns as far as like its anxiety or depression. We also have like information about the reach of the calls in terms of text, how many contacts.

Melodye Watson: And that information is actually being accounted for by quarter since it's released in 2022.

Melodye Watson: So, every quarter we're gaining more information we know information about, like, if the reason they're calling, if it's for themselves, another person, on behalf of someone, or if it's the provider. I would say, like the majority of the calls are the person, you know, calling for themselves.

Melodye Watson: And again, like, we know, like the help seeker type, so like are they in the postpartum period. Are they pregnant? Sometimes, you know, we have to categorize it, based upon just not able to determine, and we also know if it's a partner or caregiver that's calling, so that's the information that's publicly available right now.

Melodye Watson: And I could put a, let me find a link that I could put in the chat to share with everyone who wants to take a look at that.

Helenka Ostrum: Thank you.

Helenka Ostrum: And Gage, there's one more question for you in the Q and A box. Do these OASH recipients work with Futures Without Violence regarding the limitations of disclosure-driven screening practices?

Helenka Ostrum: Do these projects address those limitations? They said they'd really love to learn more about this work.

Gage Dalton: Yes, I don't know the specifics on the limitations of disclosure-driven screening practices among our recipients for this project, but I do know that we have multiple recipients that are working with Futures Without Violence, and I would be happy to look more into that and answer that later on, if you reach out to me.

Helenka Ostrum: Thank you.

Helenka Ostrum: Well, in our remaining time I'm going to share some additional resources. I want to thank both of our presenters so much for being here and sharing everything with us today.

Helenka Ostrum: And as we heard throughout today's presentations, everyone can contribute to preventing and responding to IPV. Here are some resources for you and your community partners to use to get started.

Helenka Ostrum: These resource links will also be posted along with the recording of our webinar, and everyone will be emailed a copy of these if you've registered for the webinar.

Helenka Ostrum: Some hotline resources that I want to call your attention to. We have the National Domestic Violence Hotline, which providers can also contact for treatment guidance at 1-800-799-SAFE. You can also text "START" to 88788.

Helenka Ostrum: The National Human Trafficking Hotline at 1-888-373-7888, or help@humantraffickinghotline.org.

Helenka Ostrum: And Stronghearts Native Help Hotline at 1-844-762-8483.

Helenka Ostrum: We also have some HRSA-supported resources.

Helenka Ostrum: Those include a training and technical assistance for health care centers through the health providers on IPV and exploitation, my apologies, health partners on IPV and exploitation.

Helenka Ostrum: We also have a freely accessible training recording through the Survivor Health Connection Project. And we have a really great toolkit resource that is Preventing and Responding to IPV: an Implementation Framework and that is freely accessible.

Helenka Ostrum: And we will be sharing those resources with you.

Helenka Ostrum: We invite you all to connect further with HRSA.

Helenka Ostrum: The link to the webinar will be emailed to all who registered and posted on HRSA's website. We also encourage you to visit www.hrsa.gov and sign up for HRSA's E-news, which is a bi-weekly newsletter of comprehensive HRSA news. Thank you all so much for your time today. Thank you again to our presenters and have a nice afternoon. Thank you all.