SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

ADMINISTRATION

ADVISORY COMMITTEE FOR WOMEN'S SERVICES

2:07 p.m.

Wednesday, July 29, 2009

Room 8-1070

1 Choke Cherry Road

Rockville, Maryland 20857

C O N T E N T S

ATTENDANCE

KANA ENOMOTO, Acting Chair

NEVINE GAHED, Designated Public Official

(participating by videoconference)

SUSAN C. AYERS

STEPHANIE S. COVINGTON, Ph.D.

ROGER D. FALLOT, Ph.D.

GAIL P. HUTCHINGS

AMANDA MANBECK

BRITT RIOS-ELLIS, Ph.D.

P R O C E E D I N G S

CALLING THE ADVISORY COMMITTEE FOR WOMEN'S SERVICES TO ORDER

MS. GAHED: Good afternoon, everybody. This is Nevine Gahed. I'm the Designated Federal Official for the Advisory Committee for Women's Services and I hereby call the meeting to order.

Ms. Enomoto.

WELCOME AND OPENING REMARKS

CHAIR ENOMOTO: Welcome to the members of the SAMHSA Advisory Committee for Women's Services, our panel of presenters from the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the National Institute of Mental Health, and members of the public, and SAMHSA staff. We thank you for attending and we are very excited for our first net conference meeting of the Advisory Committee for Women's Services and I think the first net conference meeting of any of our SAMHSA National Advisory Council.

You have the instructions to access the virtual meeting and we have with us today Mr. Ed

Hieronymus, a representative from Verizon, who will help us make sure that the technology works smoothly. I really must give kudos to our Designated Federal Official, who has done yeoman's work to pull this off successfully for the first time for us at SAMHSA, and we're excited to be able to make this meeting happen in as short turn-around as we have, based on feedback from our last May meeting.

As a reminder, members of the public are going to be placed on mute and will remain so until approximately 3:45 Eastern Time, when we will open the floor for public comment. If you wish to speak, the operator has indicated to press star-1 on your telephone you'll be placed in a queue, and you'll have two to three minutes to make your comments.

To our members of the Advisory Committee, you're also placed on mute until the end of each presentation. At that time you'll have several options. You can press the star-1 and then the operator will call on you to speak. Or you may raise a virtual hand by clicking the "raise hand" icon under the participant's box in your Web-X site, and we'll

learn at the end that you have a question and you can direct the operator to open the line. Or you may send an instant message from the chat box. If you don't have the strong need to express it orally yourself, if you just type in your question during the presentation, we'll go ahead and ask it here in person.

Before I begin the meeting, we're going to start with a roll call of members to ensure that your presence is recorded in the transcript. Operator, please open the lines for the members only.

OPERATOR: Just a moment for the lines to open.

CHAIR ENOMOTO: As I call your name, if you would just say "Present."

Susan Ayers.

MS. AYERS: Present.

CHAIR ENOMOTO: Jean Lau Chin.

(No response.)

CHAIR ENOMOTO: Stephanie Covington.

DR. COVINGTON: Present.

CHAIR ENOMOTO: Roger Fallot.

DR. FALLOT: Present.

CHAIR ENOMOTO: Gail Hutchings.

MS. HUTCHINGS: Present.

CHAIR ENOMOTO: Amanda Manbeck.

MS. MANBECK: Present.

CHAIR ENOMOTO: Britt Rios-Ellis.

(No response.)

Britt?

DR. RIOS-ELLIS: Present.

CHAIR ENOMOTO: Wonderful.

Thank you, operator. Please mute the lines again.

Two members are not with us today, but they are with us in spirit. Renata Henry, who together with Ms. Hutchings had the idea to invite the Institutes to give us these wonderful presentations, is out of state at a meeting; and Ms. Jacki McKinney is not able to join us.

As I referenced earlier, in our May 11-12 meeting our members requested to hear from the Institutes regarding research specific to women's and girls' addictions and mental health issues. You all indicated that the knowledge of the available research

is essential to you, especially emerging research is essential, as we review, discuss, and advise the agency about the programs and services that we undertake.

As the issues of women and girls take a front and center position nationally, we're looking forward to maintaining our ongoing relationship with the Institutes. I have to say we were so pleased and honored that the three Institutes responded so quickly to our request for speakers, and I believe that it speaks to their active interest in fostering relationships and in making sure that the information that they work is producing is getting out into the field. So it's greatly appreciated and I think very promising for the future.

I'll give you an overview of the three speakers that we have today or just mention their names. We have Dr. Vivian Faden from the National Institute on Alcohol Abuse and Alcoholism, who is joining us by net conference. Here in the SAMHSA offices we have Dr. Kevin Conway from the National Institute on Drug Abuse and Dr. Catherine Roca from the National Institute of Mental Health.

The format for today will be that each panelist will have 20 minutes to present the emerging research coming from their Institute related to women and girls, and then we'll have an opportunity for the members of the committee to ask questions and have a discussion for about ten minutes each.

So are there -- I don't want to ask if there are any questions because then we would have to open the lines. If you have a question, raise your hand virtually and we'll try to address it.

(No response.)

Dr. Faden will be the first of our presenters today. Vivian Faden is the Acting Director of the Office of Science Policy and Communications at NIAAA. She began her career at NIH in 1974 and, after working for the National Institute of Child Health and Human Development, the National Institute of Mental Health, and ADAMHA, Alcohol, Drug Abuse, and Mental Health Administration, she joined NIAAA in 1984.

Since 2002 Dr. Faden has served as Chair of NIAAA's Data and Safety Monitoring Committee and also leads the NIAAA Under-Aged Drinking Research

Initiative, and served as one of two scientific editors of the Surgeon General's Call to Action to Prevent and Reduce Under-Aged Drinking.

Currently she serves as NIAAA's representative on various government-wide and NIH-wide committees, including the Inter-Agency Coordinating Committee on Preventing Under-Aged Drinking, fondly known as ICCPUD. This committee is charged with formulating a federal response to the IOM report on preventing under-aged drinking.

Dr. Faden has published in peer-reviewed journals in the areas of prenatal alcohol effects, under-aged drinking, and alcohol epidemiology. She received her Ph.D. in psychology from the University of Maryland in 1978, is a licensed psychologist and a certified school psychologist, and has done clinical work with children and adolescents in a variety of settings.

Thank you, Dr. Faden, for agreeing to join us today and we'll look forward to your remarks.

## OVERVIEW OF CURRENT AND EMERGING RESEARCH SPECIFIC TO WOMEN AND GIRLS

PRESENTATION OF VIVIAN FADEN, PH.D., NIAAA

(participating by teleconference)

DR. FADEN: Am I supposed to start talking?

CHAIR ENOMOTO: Yes, Dr. Faden.

DR. FADEN: Okay. This is a new experience for me, too, doing a talk from my desk. So let's all hope for the best.

Anyway, I'm very pleased to be here with you today to tell you a little bit about the research in the area of women and alcohol abuse. Now I'm supposed to go to next slide, right?

MS. GAHED: That's correct.

DR. FADEN: Okay.

MS. GAHED: Remember, I gave you actually presenter rights, so if you choose the arrow that is next to that little box that says "01" you are able to actually move the slides.

DR. FADEN: Where is the little box that says "01"?

MS. GAHED: Under --

DR. FADEN: Oh, I see, okay. Got you. Sorry, everybody.

(Slide.)

DR. FADEN: Here we go.

NIAAA's mission is to understand the effects of alcohol on health across a person's lifespan. NIAAA has taken that developmental approach and that helps us focus on salient alcohol-related issues at different stages of life. You can see that in this slide. Whatever happens across a lifetime reflects a combination of genetic and environment, and the little wiggly red line is to indicate that alcohol can interact with that development across a person's life.

So at different stages of life direct problems are more salient. For example, in adolescence binge drinking is a particular concern. This is just an example, not an exclusive list. You can see that when you start thinking about organ damage, that's not really occurring very much until middle age.

But today we're going to talk about women. So what I have done is show you on the next slide how we might think about this differently when we think of women's drinking and health. So we may adjust our focus. We may identify different salient issues.

For example, for adolescents, sexual abuse and assault for adolescent girls is of particular importance. Also, for women there might be different connections. For example, the link to depression may be more salient for women, and the effects of alcohol on the development of disease is also different in women.

(Slide.)

But first what I'm going to do is tell you a little bit about the epidemiology of women's drinking and of alcohol-dependent women. More than half of women in the United States drink. Based on the NIAAA's epidemiologic survey on alcohol and related conditions, we know that 2.6 percent or about 2.8 million women had abused in the past year, the past year from when the survey was taken, and that 2.3 percent or approximately 2.5 million women were alcohol-dependent.

(Slide.)

This next slide shows you a comparison between men and women and their drinking for adults 18 and older. You can see that about 50 percent of women drink, are current drinkers. That means they had 12 or

more drinks in the past year, according to that same survey I just mentioned. For men that percentage is higher. The number of former drinkers is about the same, but there are more women who are lifetime abstainers than men.

(Slide.)

If we look at dependence across the lifespan, and this is a combination of data from SAMHSA's NSDUH survey for those 12 to 17 and from the NESARC for those older than that. You can see that dependence does occur more frequently among men than among women across all ages.

(Slide.)

So of course the U.S. government is weighing in on what's an appropriate amount of alcohol for men and women to consume. You can see here the U.S. Dietary Guidelines for moderate drinking. Moderate drinking is defined as no more than one drink per day for women and no more than two drinks for men. There are some nuances in the guidelines that says, you know, no drinking at all for pregnant women and those under-aged.

(Slide.)

So why are the guidelines for men and women different? This is very important to understand as you consider the effects of alcohol on women's health. Well, there are two important reasons: women are generally smaller than men and weigh less; and also, pound for pound women have less water in their bodies than men do.

(Slide.)

So what does that mean in terms of when a woman drinks? When alcohol goes through a woman's system and is dispersed in the body, the same amount of alcohol becomes more concentrated in a woman's body than a man's, since a woman has less body water.

So that plays out into in a woman typically reaching a higher BAC level than a man for the same amount to drink. It also plays out in similar levels of consumption making women more susceptible to alcohol-related damage to various organs because those organs are then exposed to a higher concentration of alcohol.

(Slide.)

So that's a little background, a little epidemiology, a little on the physiological differences between men and women that are important regarding alcohol. We're now going to just list a few of the risk factors for problem drinking among women. If you look at the first bullet, it's greater than seven drinks a week. What you can see there is that means if you have more than one drink a day you've exceeded that moderate guideline, or greater than four drinks on any given occasion, and that is the definition of binge drinking for a woman.

Genetics plays a role, of course, and this is true for men as well. Parents or siblings who are alcohol abusers or people who have that in their family are at greater risk.

A partner who drinks heavily is also a risk factor for heavy alcohol, as is depression, and for women in particular a history of childhood sexual or physical abuse is an important risk for problems with alcohol later in life. We also have relationship problems listed here, and obviously developing tolerance to alcohol.

Of course, these also hold for men, but there are nuances and some important differences.

(Slide.)

What I'd like to do now is go a little more into detail about some of the risk and protective factors for alcohol-related problems as a result of drinking among women. For example, we know that heavy drinking is more common among women who have never married, are living unmarried with a partner, or are divorced or separated.

A woman whose husband drinks heavily is more likely than other women to drink too much. Many studies have found that women who suffered childhood sexual abuse are more likely to have alcohol problems, as I already mentioned.

(Slide.)

Also, we know that depression is closely linked to heavy drinking in women and that women who drink at home alone are more likely than others to have later drinking problems.

Older women, more than any other group, use medications that can affect mood and thought, such as

those for anxiety and depression. These can interact with alcohol in harmful ways. If you recall the rainbow that I showed you in the beginning, particularly in later life medication interactions has been identified.

(Slide.)

I'm going to do a little more on a number of key issues that are related to women's drinking. These are fertility, fetal alcohol spectrum disorder, violence, and relationship of drinking to chronic disease, and returning veterans. While we always pay attention to gender and race -- gender and racial and ethnic differences as we consider alcohol's effects across the life span, I want to spend a little more time on that.

(Slide.)

When you consider alcohol and fertility, we know that women who have a clinical diagnosis of alcohol abuse have been found twice as likely to have experienced three or more spontaneous abortions.

We also know that lower levels of alcohol consumption may be associated with infertility due to

ovulatory factors, endometriosis, and decreased fecundability. So there is more of a problem of just not becoming pregnant in women who are drinkers.

We also know that alcohol in women of early reproductive age reduces their immune responses that are more robust than those found in men.

And mothers who drink during pregnancy are more likely to give birth to low birth weight newborns.

(Slide.)

FASD is very important and we're going to spend a little more time on it. Fetal alcohol spectrum disorder describes a continuum of permanent birth defects caused by maternal consumption of alcohol during pregnancy. The most severe of these is fetal alcohol syndrome and it's also the most common preventable cause of mental retardation.

Babies with FAS have certain distinctive changes in their facial features and they may also be born small. The brain damage that occurs with FAS can result in lifelong problems with learning, memory, attention, and problem solving. What we know too is that you can get alcohol-related changes in the brain

without the characteristic facial features that are related to FAS.

(Slide.)

Of course, there's the Surgeon General's Advisory on Alcohol Use in Pregnancy and you have some of the language from that in front of you. The Surgeon General advises that there is not known to be any safe level of drinking during pregnancy, at any stage of pregnancy. So the advice is that pregnant women should not drink at all during pregnancy and a woman who has already consumed alcohol should stop to minimize further risk, and a woman who is considering becoming pregnant should abstain from alcohol.

This last thing is new, is a relatively new advisory. The third bullet there is especially important in light of the fact that half of all pregnancies are unplanned and that alcohol-related harm could occur before a woman even realizes that she's pregnant.

I also want to spend a little time talking about issues of violence. Drinking makes young women in particular more vulnerable to sexual assault and

unsafe, unplanned sex. For example, on college campuses assaults, unwanted sexual advances, and unplanned and unsafe sex are all more likely among students who drink heavily on occasion, and that's for men five drinks in a row and for women four, as I mentioned earlier. In general, a woman when she drinks a lot is more likely to be a target of violence or sexual assault.

(Slide.)

Now, this next topic is very important. Alcohol is related to chronic disease, especially over a lifetime, for both sexes, but the way it plays out is a little bit different for women. When we look at alcoholic liver disease, women are more likely than men to develop alcoholic hepatitis and to do from cirrhosis. This is because of that greater exposure drink for drink.

In terms of brain disease, most alcoholics have some loss of mental function and brain changes. Some research suggests that women may be more vulnerable than men here.

In terms of heart disease, we know that

chronic heavy drinking is a leading cause of cardiovascular disease, and that here again women are more susceptible than men to alcohol-related heart disease, even though they drink less over a lifetime than men do.

(Slide.)

In terms of cancer, alcohol is linked to various cancers, including those of the digestive track, the head and neck, and the risk is especially high in smokers who also drink heavily. That is generally true for men as well as women.

There's been a lot of research in the area of alcohol and breast cancer, with many studies reporting that heavy alcohol increases the risk of breast cancer. Research also suggests that as few as one drink per day slightly raises the risk of breast cancer, particularly for women who are especially vulnerable, those who are postmenopausal or have a family history of breast cancer.

(Slide.)

In addition, when we consider alcohol abuse in women we have to underscore that alcohol can

exacerbate the course and complicate the treatment of other things, including hypertension, diabetes, or infertility, the type of noncompliant or biological interference.

(Slide.)

I also want to highlight frequently the issue of returning veterans and their families, because alcohol is a problem both among the women who have served and the women that soldiers return to. That is true for the children and the whole family.

(Slide.)

So, for the future what we would like to work on -- and we always adjust our thinking based on emerging priorities and emerging research. But for today, if I can mention: increased outreach to women of childbearing age. We still have not successfully communicated with all women the risks that alcohol during pregnancy -- or at least, if we've communicated we've been unable to accomplish all women not drinking during pregnancy. We'd like therefore to increase screening and intervention for pregnant women.

We also are working hard to improve alcohol

treatment by getting it into primary care. We feel that getting alcohol screening, intervention, and treatment into primary care will affect the lives of many women and their children as well. That's because the women will get treated, but also because the partners will get treated as well.

We're also working toward increased understanding of that relationship of alcohol consumption and chronic disease. I alluded to some of the things that we do know, but there's much more to know in that arena.

We're also working on children and adolescents, for adolescent girls, because we know that alcohol during adolescence is basically normative in this country and that, while girls don't drink quite as much as boys, they do drink quite a bit and often they binge.

We also want to understand biologically what underlies the sex-related differential in alcohol-related risk for various cancers. While there's not much available on this, it will also be important to understand how our different treatments work

differentially for men and women and the different rate at which women access treatment and why that is.

(Slide.)

There's some information on our web site and you can access that at this address.

Thank you.

CHAIR ENOMOTO: Operator, can we open the lines now for the members for a question and answer session?

OPERATOR: At this time if you would like to ask a question, please press star, then 1. To withdraw a question, press star, then 2. Once again, to ask a question please press star, then 1.

One moment for the first question.

(Pause.)

Stephanie, your line is open.

DR. COVINGTON: Somehow, something changed on my computer.

But anyway, the question was, I think it was around Slide 5 and it was data I think from 2001 showing the difference in alcohol patterns between males and females.

DR. FADEN: Yes.

DR. COVINGTON: Has this been increasing, women's alcohol increasing? I mean, I've heard that, that women are drinking more like men, girls are drinking more like boys. So I was wondering if there is a difference? Is this difference, is the gap between them decreasing?

DR. FADEN: As far as I know, I think the gap is probably decreasing somewhat.

DR. COVINGTON: Okay. Now, does anyone know how I get back? What's supposed to be on my screen, on my computer? Right now I have something on an article on women and drinking.

Ah, now I'm back again.

DR. FADEN: That's what you get to of you click on that web site. It's a publication of ours. It's meant for the general public.

DR. COVINGTON: Okay. When you said press star 1, do we do that on our phone or on our computer?

MS. GAHED: On the phone.

DR. COVINGTON: Well, that's what I did and it didn't seem to change things.

CHAIR ENOMOTO: We changed that.

DR. COVINGTON: You changed it. Oh, okay. Sorry. How is all this happening?

Okay, thank you.

OPERATOR: Once again, to ask a question please press star, then 1, on your phone.

We do have one more question. Your line is open. If you'd press star, then 1.

Okay, your line is open.

DELIA: Hi. This is Delia from California Department of Alcohol and Drug Programs. I was hoping to print the Powerpoint presentation. Is that possible?

DR. FADEN: We're certainly willing to share it, so I guess the leader of the meeting could do that, on my behalf anyway.

DELIA: Okay.

DR. FADEN: What is your name?

MS. GAHED: Delia, we're going to have that Powerpoint on our web site. But I'll be happy to send it also to you if you'd like to just email me, and I'll be able to just return it to you.

DELIA: Thank you.

MS. GAHED: Thank you.

OPERATOR: Once again, to ask a question please press star, then 1.

(No response.)

CHAIR ENOMOTO: If we have no other questions, then thank you very much, Dr. Faden, for that very informative presentation. It helps us to understand the nuances of the differences between men and women in the area of alcohol use.

DR. FADEN: You're very welcome.

CHAIR ENOMOTO: Our second presenter today is Dr. Kevin Conway, Deputy Director of the Division of Epidemiology, Services, and Prevention Research, the National Institute of Drug Abuse. Dr. Conway was previously Associate Director of the Division of Clinical Neuroscience and Behavioral Research and Deputy Branch Chief and Program Director for the Epidemiology Research Branch.

He's held faculty positions at Portland State University, Yale University School of Medicine, the College of New Jersey, and Temple University. He's

received numerous awards for his scholarship and leadership in research and is a fellow of the American Psychopathological Association. Dr. Conway received his M.A. and Ph.D. in experimental psychology from Temple University in 1998.

Thank you very much, Kevin.

PRESENTATION OF KEVIN P. CONWAY, PH.D.

DR. CONWAY: It's my pleasure to be here. Can everybody hear me okay?

CHAIR ENOMOTO: They can, but they can't talk.

DR. CONWAY: Okay.

CHAIR ENOMOTO: We have the slides up right now.

DR. CONWAY: Thank you.

(Slide.)

DR. CONWAY: I lost my mouse.

MS. GAHED: One second and we'll fix it. We'll fix that in a second.

(Pause.)

DR. CONWAY: That's the last slide. If you could go to --

Okay, here we go. Thanks again for the invitation. It's a pleasure to be here. I'm going to present some information about NIAAA research specific to women and girls. Some of the information, one or two pieces of information, will be reiterated from what Dr. Faden said, but I will also provide some different information concerning drug use in particular.

(Slide.)

First I'd like to talk about epidemiology a little bit about drug use, with a focus on sex differences in the prevalence of use. So these are slightly outdated data, but relying on the household survey data. What you see across different drugs of abuse is that, as Dr. Faden has said, the rates are pretty consistently higher in males than females for drug use.

But what's interesting to keep in mind is that boys versus girls also have greater opportunities to use. So once you control for the opportunity to use a drug, which means you go and try to find the drug or someone offers it to you, the sex differences appear to go away, which is shown here on the far right-hand side

of this slide.

That means that, once given the opportunity, girls and boys appear to use drugs at the same rate. I think that's an important point to keep in mind.

(Slide.)

As was raised in one of the questions earlier, we do see for drug use that rates of use, for marijuana use in this slide, are becoming more similar over time concerning males and females. So if you look on the left-hand side of both graphs you'll see that the rates are usually higher for each of these -- for marijuana across these different ethnic groups, in males and in females. So if you focus on this dot here (indicating) and compare it to the one over to the left, it's routinely higher in males versus females across the different groups, but those rates are becoming more similar as you move from the 70s into the more recent information. So it does appear that the rates are converging.

(Slide.)

We also have some important sex differences to consider in terms of rates of drug use disorders.

So here relying on the same data source that Dr. Faden referenced before, the NESARC data, which is a nationally representative epidemiologic survey, here this slide shows rates of drug use disorders, which is drug abuse or drug dependence, by different specific drugs. It's stratified by sex.

You can see across each of the specific drugs there is a higher rate of disorder in males versus females. You also see that -- and this is an identical slide presented slightly differently here than Dr. Faden presented, showing rates of drug dependence by sex and by age separately. This importantly shows that there is this pretty systematic effect of higher rates in males than females, but it's not dissimilar among adolescents. That's an important point to keep I mind as I continue through the slides.

(Slide.)

An important point to consider is that, despite overall prevalence among males both for dependence, abuse, and for drug use, evidence points to greater risk of dependence among female users. So once females start using, they may be at greater risk of

progressing to problematic consumption of drugs.

(Slide.)

Here this is a re-analysis of what used to be called the household survey. What you see here for cocaine use is that, whether you're focusing on the left, the number of days used cocaine, or the amount you used in the past month, again cocaine, you see that the rates of dependence are systematically higher for females than for males.

So again, this is sort of conditional dependence upon use.

(Slide.)

In a different way of looking at the same kind of issue, this slide shows that for cannabis that there's a shorter length of time from the progression, if you will, from abuse to dependence among females than males.

I'm going through these quickly as they're circulated. I have references on all of them, so you can spend more time combing through them.

(Slide.)

Here, this is a little bit of a complicated

slide. What it shows is that essentially there's individual variability in withdrawal severity after someone quits smoking. These individual variability profiles seem to cluster in this study into three different groups, cluster 1, 2, and 3, and they're depicted here by the different looking lines.

What you would hope to see perhaps is that the withdrawal goes down pretty readily and steadily with time. But there are some groups where you have a lot of volatility in withdrawal severity. Interestingly, in those two groups up top, the dotted or the dashed lines, those that are highly volatile and do not show an overall decreased level, they happen to be predominantly female, which would suggest that females who quit smoking may suffer greater withdrawal symptoms.

(Slide.)

This potential increased risk for dependence among females appears to emerge in adolescence.

(Slide.)

Again another complicated slide, but I put some highlights on here to draw attention to some

things. First of all, the things that are circled are showing higher dependence rates on the left for marijuana and alcohol in males relative to females and, conversely, a higher overall rate for dependence for nicotine in females than in males. So we're seeing sex differences in prevalence of these two substances by age.

But what's interesting is that you do see a younger peak age of dependence for cocaine in females. That's a significant gender by age interaction, which would mean that this is a reliable finding that female girls have a greater risk of cocaine dependence than males once they start using cocaine. So I think that's an interesting thing to keep in mind.

(Slide.)

Interestingly as well, female adolescents begin daily smoking about two years earlier than do males in this epidemiologic study. This is not the NESARC. It's another study, but it's epidemiologic.

(Slide.)

Then when female adolescents do smoke, they tend to smoke at higher rates. You see this is

particularly the case at ages 18 or younger, whether you look at number of cigarettes they smoke per day or the number of days they smoked in the past year.

(Slide.)

Here in -- it's about the best epidemiologic study we have for adolescents. What you see here is that the years from drug use, sort of the passage of time, the number of years since first use to dependence is shorter for females than males. You see it for nicotine, you see it for marijuana, and you see it for the "any illicit drug." You do not see a reliable difference here for alcohol abuse disorders.

(Slide.)

So that's sort of depicting a pattern of a greater risk for abuse or dependence among females who do begin using. There's lots of reasons you could hypothesize why that would be the fact, and there's some evidence pointing to the important role of comorbid psychopathology, particularly behavior disorders, as being potentially more prognostic of drug dependence among females relative to males.

(Slide.)

So here, going back to the NESARC data, here we're just showing lifetime prevalence of different psychiatric disorders. You see higher rates for alcohol, any drug, and antisocial personality disorder in men relative to women. That's not a surprise. And you see higher base rates for women for mood and any anxiety disorder, for females rather than males. So those are the base rates. That's not terribly surprising.

(Slide.)

What is interesting, though, is how these comorbid psychiatric disorders may or may not play a role in the etiology of drug disorders. What this slide is showing is the population attributable risk of drug dependence due to prior mental disorders. What this means essentially is that, how much of the rates or the risk of drug dependence could be due to prior mental disorders.

This is a fascinating study from Ron Kessler. It's an international psychiatric epidemiologic study across multiple different sites. On average, shown in this green line going across relative to the blue line,

the population attributable risk is higher for females than males. So what this would suggest is that the risk of drug dependence, given psychiatric disorders, is more elevated in females rather than males. It's not the case across every single location, but it is the average.

(Slide.)

Focusing back toward the U.S. epidemiologic survey of the NESARC, we can drill down into specific psychiatric disorders that may play a role in risk for drug dependence. So I show this rate of comorbidity for the antisocial personality disorder, for anxiety disorders, and for mood disorders. What you see is that, as I showed you before, the base rates for anxiety and mood disorders are higher for females than males and they're lower in antisocial personality disorder.

What you find here is that rates of antisocial personality disorder are significantly and consistently higher in women than males across any of the specific drug use disorders that are available for analysis in the NESARC. We do not see that for mood or

for anxiety disorders.

(Slide.)

So it could be, as this slide would suggest, that behavior disorders are more comorbid with substance use among girls. You see this again in Jane Costello's study.

It's an important point to make that those are all averages. Those are all means across groups. Of course, not every individual is at equal risk for drug disorder given a psychiatric condition.

(Slide.)

So what this slide suggests is that it could be that those girls who are the most -- have had the highest rates -- have the highest scores, if you will, of misbehavior early in life, those are the individuals that are the most likely to go on and having drug problems. Here we're seeing that those girls who in the fifth grade had the highest rates of misbehavior in school were the only ones at an increased likelihood of tobacco dependence at age 21.

(Slide.)

There's a budding and growing literature on

lots of reasons why this might occur, and this slide simply suggests the possibility that in females relative to males, those who actually are addicted, their brains react differently to cues for cocaine addiction. Here you see a typical male response, which is very much involving the amygdala, in contrast to the female's, which does not necessarily involve the amygdala, but may involve more frontal activity.

So it could be that for females craving and recovery may involve more inhibitory regulation capacities in terms of controlling the impulses from subcortical regions.

(Slide.)

So, as Denise Kandel said a long time ago, it could be that young women are particularly vulnerable to alcohol and drug use problems. We don't know why. We don't have a lot of causal models per se, but it's a hypothesis that needs further delving into.

(Slide.)

This etiology research then can lead to indications for gender-specific treatment and has also led to an emergence of science that looks at gender

responsivity in terms of treatment. I'll just quickly walk through that because I know that part of the Advisory Committee's role is to translate this etiology information into treatment and services.

(Slide.)

What we're seeing here over time, if you track treatment admissions by gender from 1994 to 2004, the rates are going up slightly higher for females than for males. When they come in to treatment, they're presenting with drug disorders that differ in some ways from males. Males is heavily marijuana and there's an increasing portion devoted to methamphetamine. We do not see the methamphetamine as a major player in females, and you see more equal diversity of what they're coming in for in terms of their primary substance of abuse.

(Slide.)

When they come in to treatment, men and women tend to be motivated by different reasons. Men might come because their spouse is opposing their drug use and they're suffering consequences both at the family level and at the work level. In women there are

different motivating factors here: exchanging sex for drugs or money, referral by a social worker, antisocial personality disorder, and things that are specific to raising children, especially being a single mother.

(Slide.)

Not surprisingly, what you find is that when you offer treatments that suit the needs of women, such as providing child care or providing women-only concentrated treatment, you get better retention. If we've learned anything about recovery, it's the longer you stay in treatment the more likely it is to sort of stick.

(Slide.)

But the bad news is that these specialized treatment services aren't readily available. SAMHSA has shown that only roughly 40 percent of the treatment facilities that accept women as clients provide specialized treatment for women.

(Slide.)

Here this slide just shows that gap between what's needed and what's received across the different types of domains requiring assistance.

(Slide.)

The good news is that when recovery groups are either all-women composition or women-focused groups, you get enhanced outcomes for women in these kinds of settings that involve greater cohesiveness, greater focus on triggers and relapse, focus on different types of consequences. So they're highly specialized and tailored, and that seems to increase probability of remission.

(Slide.)

We're also seeing, very briefly, that the criminal justice system is becoming increasingly important in terms of the role of drug use.

(Slide.)

Here you're seeing over time from 1985 to 2005 there's an increasing proportion of offenders, here in California, incarcerated for drug-related offenses across all years. That rate is higher for females relative to males. I haven't tested, but I would argue that the slope is actually increasing more so for females than males.

(Slide.)

Once you have a client who comes from the criminal justice system, here this slide focusing on juvenile detainees in Chicago, you're getting a picture of complex and extensive psychiatric comorbidity.

This is a great slide. It's actually very hard mathematically to produce this. It's proportional, it's beautiful. But the point to make is that in females about 27 percent of the females in this setting have none of the disorders listed, so it's really dominating the clinical picture. That's even more so than in males.

(Slide.)

The criminal justice system has lots of intervention points which could be taken advantage of in terms of referring to treatment, and they're listed here. There's a lot of research at NIDA going on to try to capitalize on these entry points for access to treatment services.

(Slide.)

So just to summarize, there are sex differences in the prevalence of drug abuse and those may be explained by greater opportunities for drug use

among males. So it could be that this overall trending of greater similarity in use in males and females over time could be due to greater opportunities afforded to females, which is not a good thing.

Two, patterns of male and female drug use are converging over time, as I said. It could be that female drug users may be more vulnerable to addiction. These indicators of vulnerability appear early in adolescence and possibly earlier in terms of preexisting psychiatric conditions, which may be in fact more prognostic of drug dependence among females. So those are opportunities for intervention.

(Slide.)

Swinging to treatment just a bit, treatment among women may be most effective when it addresses issues that are specific to women's needs for treatment.

From a public health perspective, referral and treatment for substance use disorders is increasingly embedded within many other service systems, like the criminal justice system, as opposed to a stand-alone substance abuse clinic.

It's important to note from a science perspective that evaluations of many of these gender-responsive approaches is just at an early stage. So we have a lot to learn to have some firm conclusions about what works and how to keep it sustained.

(Slide.)

I won't go through this, but this is a listing of different links on our NIDA web site that focus specifically on sex or gender differences. We have two individuals, Cora Lee and Samia, who are our dedicated coordinators for this sort of topic. Neither of those were available to come today, so I had the pleasure of representing this program.

Thank you.

OPERATOR: Once again, to ask a question please press star, then 1.

CHAIR ENOMOTO: I'll ask a question while we're navigating the technology. I noticed during Dr. Faden's presentation she had sort of a childhood sexual abuse as a common predictor for alcohol use and dependence for girls and women, and I didn't see that so much in your presentation and you're really linking

to behavioral disorders. Has there been a lot of thought about or is there work going on to look at actually trauma being the sort of precipitating factor for the behavior disorders and then, with the Kessler research saying that mental disorders are showing up earlier and that may be just an indicator of the process?

DR. CONWAY: We do have an active portfolio in that area. It's certainly a risk factor. I think that the challenge is sort of entangling, or disentangling, the causality here, as well as the challenges with understanding -- challenges associated with a retrospective recall that is common in that kind of research. Longitudinal research that has to be done in that area -- I don't know that there's a lot of studies that follow individuals early pre-trauma into the period and through the period of drug abuse disorders.

I know that Cathy Williams' data has sort of been a little mixed in terms of its predictive -- the role of sexual abuse predicting drug use disorders, because when she does it retrospectively, if my memory

serves correct, you find that strong association, but then as these kids have aged into the period of risk the prospective relationship doesn't appear to be very specific.

So it's an area that we do find quite a bit of science on. The clarity for me isn't quite there yet.

OPERATOR: We have a question from Stephanie Covington. Stephanie, your line's open.

DR. COVINGTON: Thank you.

Actually, the first part of the question did have to do with the mood and anxiety disorders, the comorbidity with the trauma. So thank you for answering that.

Then I have a question on Slide 23. The slide said first grade behavior, but you said fifth grade, and I wasn't curious if it was first or fifth.

DR. CONWAY: Sorry. Yes, it's first grade. In my mind I must have thought about five year olds.

DR. COVINGTON: Oh, okay. First grade sounds really young to me.

DR. CONWAY: It's first grade.

DR. COVINGTON: Yes. Well, I thought -- oh, it is first grade?

DR. CONWAY: Yes. It's the good behavior game.

DR. COVINGTON: Remarkable. Okay.

Let me ask you this since you're so well versed in all this. The Cathy Williams research, what about the research that talks about -- this is tangential to your presentation, but that talks about early childhood abuse being a risk factor for later violent behavior? Is that research -- because I know you're questioning the research having to do with, her research having to do with early trauma and substance abuse. But I was just wondering if you're also --

DR. CONWAY: So let me try to take a quick stab at that question.

DR. COVINGTON: Okay.

DR. CONWAY: So our Institute's mission is to focus primarily on drug abuse.

DR. COVINGTON: Okay.

DR. CONWAY: To that extent, if such an application were to come in that would focus on the

link between child abuse and subsequent violence only, it's not something that we would necessarily fund.

DR. COVINGTON: Got it, right.

DR. CONWAY: But if it were to look at this, this important and fascinating drugs, crime, violence nexus, then yes. And we do have a robust portfolio in that as well. I was a little cherry-picking in terms of what to talk about.

DR. COVINGTON: Sure, sure. I was just curious about the other thing.

DR. CONWAY: Yes. We do have almost half a program devoted to that complex dynamic.

DR. COVINGTON: And that'll be accessible via the web site?

DR. CONWAY: Possibly, but if you want more detailed information you can email me directly and I'll try to get you some information.

DR. COVINGTON: Okay, great. Thank you.

OPERATOR: You have one more question.

Dr. Rios-Ellis, your line is open.

DR. RIOS-ELLIS: Hi. This is Britt Rios-Ellis.

I have a question related to race and ethnicity and also class as to have any of these data been -- I'm sure they have -- been extrapolated in any way, looking at race, ethnicity, class?

DR. CONWAY: Yes. One of my slides did show that. It was one of the Kandel studies looking at the cohort effects over time in terms of convergence of males and females. You do see some ethnic differences.

I could have given an entirely different talk if the charge were to look at it sex by race or ethnicity kind of interactions. So we do have an entire office that focuses on that sort of issue, as well as individual program officers in our division as well as other divisions who take that on as their charge. So that's a longer story, but yes, there's an awful lot of information on breaking these things down.

Just as an example, that one slide that I highlighted and just talked about, the people at greatest risk for all of these things are Native Americans. We have great collaborations with other agencies to try to do that really, really difficult but important work of getting into those reservations and

collecting information. That's just an example.

MS. GAHED: Do you remember the title?

DR. CONWAY: Of that slide?

MS. GAHED: The title.

DR. CONWAY: We're going to try to find that slide, just to highlight it.

(Pause.)

DR. CONWAY: There you go. So this is just a snapshot of race by sex by cohort for marijuana use among twelfth graders. So this is breaking it down by sex and by racial and ethnic category as responded to in the Monitoring the Future study.

MS. GAHED: One of our members, Gail Hutchings, has just written us and I'm just going to quote: "Excellent presentation. Thank you. I particularly appreciate your discussion on smoking and nicotine addiction and its particular relationship to girls. Is there further work expected from you on this?"

DR. CONWAY: So the issue is smoking and tobacco dependence among girls. Yes. Tobacco use is one of our flagship priorities at NIDA. In fact, Nora

has on record and it's on our web site that she wants to eradicate smoking. So it's a very bold and aggressive agenda.

If you look over time at the surveillance data, there's good news about smoking in the sense that it's at lower rates among youth than it has ever been since we started collecting the information, in part because of regulation, increased taxes, and so forth. So these environmental interventions have made a dramatic effect.

There are, interestingly -- and I can't remember what they are off the top of my head. There are interesting sex and race-ethnicity differences in those slopes. If someone wants, I can try to dig that up and share it with folks. So it is -- it's a very important program for us and certainly there will be more to come.

CHAIR ENOMOTO: Well, thank you very, very much, Dr. Conway. We appreciate --

OPERATOR: We do have one more question. The name wasn't recorded, but your line is open and if you press star, then 1.

Hit your mute button. Your line is open if you'd press star, then 1.

We do have a question from Roger. Roger, your line is open.

DR. FALLOT: Thank you. Hi, Kevin.

DR. CONWAY: Hi, Roger.

DR. FALLOT: I wanted to follow up on that very interesting slide that you had here on evolving treatment approaches. I wonder if you could just say a bit more on what NIAAA is currently examining in terms of priority and gender-specific and gender responses.

DR. CONWAY: I don't know how much specific detail that I can give you about particular -- this very specified program. But we do have an active portfolio. There are several investigators who we fund who are, one, doing randomized controlled trials that address the very issues you've raised. Some of them have written seminal reviews of the topic. In fact, those slides that I showed at the end concerning treatment were borrowed from one of our funded investigators or two of our funded investigators.

So there is an active research agenda on

looking at gender-specific treatment, gender-specific response to treatment, as well as keeping an eye at the 30,000 foot level of reminding us this is early stage research. We need replication. So I think that program is particularly savvy in both looking at the details, but sort of important questions and keeping in mind that things have to be replicated and proven before they're rolled out at scale.

And I know that that topic is something that is a focus both of our treatment branch as well as our services branch. Those two are different branches. One focuses on treatment modification, treatment development, and the other, the services branch, focuses on the delivery and the sustainability of those sorts. Both have an active interest in this topic.

DR. FALLOT: Thanks.

OPERATOR: No other questions at this time.

CHAIR ENOMOTO: Thank you very much, Kevin. We appreciate it.

Our final presenter today is Dr. Catherine Roca, the Chief of the Women's Health Programs at NIMH. Dr. Roca works in the Office for Special Populations at

the National Institute for Mental Health. Previously she served as Deputy Clinical Director at the NIMH Intramural Program and Medical Director at the NIMH Clinical Core, a group developed to protect patients participating in clinical trials.

Dr. Roca completed her research fellowship in reproductive psychiatry at the National Institute of Mental Health. She served as a principal investigator on a number of studies on sex differences in stress response and reproductive hormone-related mood disorders. She received her medical degree from Northeastern Ohio Medical School and did her fellowship at Cleveland Clinic.

So thank you, Dr. Roca.

PRESENTATION OF CATHERINE ROCA, M.D.

(Slide.)

DR. ROCA: Thanks. It's nice to be here.

When I spoke with Nevine when she was talking about doing the presentation, it sounded like members had a couple of different requests. One was to sort of highlight cutting edge research, as well as there was, it sounded like, a request to go through the web site

so that members could make better use of the information that we have.

So what I'd like to do is at the beginning sort of give some highlights of research results from the previous year, and then, hopefully if there's time, go through the web site so that people feel comfortable being able to locate information for themselves that comes up as research is being published and as initiatives are coming out.

(Slide.)

So our mission is to transform the understanding and treatment of mental illness through basic and clinical research, with the purpose to prevent and help patients recover and ultimately cure mental illness, which is, as mentioned before, a bold agenda.

(Slide.)

For those of you who are familiar with NIMH -- and I know Renata was involved in this -- NIMH has recently gone through a strategic planning process that has come up over the last year. I thought I would just highlight the top objectives for people because I think

it gives you an idea of broad priorities of the Institute.

The first is to promote discovery in brain and behavioral sciences. The purpose of this is really to understand the causes of mental disorders. We also are taking a developmental approach. We want to chart the trajectories to determine where, when, and how to intervene, to hopefully prevent or at least ameliorate the effects of mental illness.

The third is to develop new and better interventions. Obviously, we do that by understanding better the causes, and then we want to be able to incorporate the diverse needs of different groups of people in different circumstances with mental illness.

Then finally, we want to strengthen the impact of our research. We're doing this in partnership with a number of other federal agencies like SAMHSA.

(Slide.)

So how does this translate into research for women and girls? Well, one of the ways the Institute is trying to coordinate research across divisions is

through these cross-divisional teams. NIMH is set up so that there are five different research divisions. They encompass everything from basic neuroscience and behavioral science all the way through to interventions and services research.

We have members of all these research divisions as part of our cross-divisional women's team. One of the things the women's team has done is to sponsor a couple of research initiatives. I wanted to highlight these two in terms of talking about cutting edge research that's occurred over the last year.

(Slide.)

There are two. One is women's mental health and sex-gender differences research. This is over and above the requirement that people have who do our clinical trials to do sex-gender analysis. So this is really looking very broadly across the basic sciences through to epidemiologic research, interventions and services in terms of what works better for women, what may account for some of the sex differences in prevalence and so forth.

Then the second initiative is related to

women's mental health in pregnancy and the postpartum period, because this has been an area that has been largely understudied. Historically the research in this area has not been very robust and we're really trying to get better quality research in this area.

Like I said, again with the other PA, it is a very broadly written program announcement so that it covers everything from basic science animal models through to treatment during pregnancy and the postpartum period and accessing services.

(Slide.)

One of the reasons we're interested in sex differences, as has been pointed out by the other speakers, there are significant differences in prevalence of mental disorders in women compared with men. Most notably, you see that eating disorders are much more prevalent in women, depression and anxiety disorders more prevalent in women, particularly PTSD. Then even in disorders where the prevalence is roughly one to one, there are differences in the course and severity of illness. For example, in bipolar disorder you have a greater prevalence of rapid cycling bipolar,

usually considered to be four to one in women compared to men. In schizophrenia, which is slightly more common in men -- depending on the study, you'll get like 1.4 to 1 men to women -- the premorbid functioning is actually better in women, the age of onset is later.

(Slide.)

So these sex differences are interesting and important because they can also be teased apart to kind of understand mechanism of illness. So this is an area we're very interested in.

So what I'm going to do is just highlight a couple of examples of research that have occurred in the last year that illustrate examples of sex differences work. I'm going to highlight a couple of studies that look at underlying neurobiology and affective circuitry and sort of understanding mechanism of risk and resilience between men and women, differences in severity of illness, and then highlight differences in treatment response research that have happened in the last year.

(Slide.)

Now, this first study was actually a study

done out of England, but our intramural research program participated in this. This is interesting because it's the first study that's shown a gene association with increased risk in schizophrenia in women only. Reelin is a gene. It's on chromosome 7. It's actually involved in neural development. It's actually involved in development of the cortex. So it's an interesting gene that may contribute risk to schizophrenia.

(Slide.)

When the researchers looked at their population, which was initially evaluating an Ashkenazi Jewish population, they found significant association of one polymorphism, this GG genotype, in women but not men. So they wanted to replicate this finding, which they did in a U.K. population, and then wanted to look at it across other groups.

We see that it's in the same direction in both Irish, the NIMH, and the Chinese populations, but not statistically significant. But overall it looked like it was associated significantly in women compared to men.

Why is that important? Well, you know, none of these genes convey -- in other words, it's not a single-gene defect. But it may confer risk. The interesting thing about this is that if this does in later studies show to be associated in female compared to male schizophrenics, this is a gene that is modulated by hormones, so it's a gene that's more active in women compared -- in females compared to males, I should say, because these are animal studies. And hormones do play a role in this gene's function.

It may be helpful in sort of then teasing apart why there are sex differences in schizophrenia.

(Slide.)

Again, that's farther down the road, but it just gives you an idea that there are some researchers looking in this area to try to tease apart these differences.

(Slide.)

On a separate note, one of our intramural research groups has been looking at affective circuitry. In other words, sort of looking at what are the biological underpinnings of emotion that are

different between men and women, girls and boys, that may confer greater risk, as I mentioned, to girls and women. Girls after puberty, I should say, and women are more likely to develop depression and anxiety compared to boys after puberty and men.

Puberty is the point where this separation takes place. So one of the groups in the intramural program has been looking at anxiety disorders in kids through using MRI and some fear conditioning paradigms and have shown that, as has been mentioned in previous talks, that obviously the amygdala is involved in kids that have more anxiety disorders.

(Slide.)

This time they wanted to look at clues as to whether there are differences between unaffected girls and boys, and so they used a paradigm where they brought in kids, did an MRI, told them that they would be chatting with some peers later on. So they showed them pictures of happy kids -- there were no fear or hostile faces -- of kids that were roughly their age and asked how interested they were in interacting with that person.

So this was really sort of looking at anticipation of peer interactions. Why look at that? Well, this is a time in life when peers are very important and some kids, for example kids with anxiety disorder, social anxiety, will have some fear response associated with that. The other reason they wanted to look at it is to see is there a difference in kids who are younger -- and their youngest age group was 9 -- compared to older teens, and the oldest was 17. So that they looked at it by age as well as gender.

Two weeks later they brought them in and said: We're going to do the MRI. We want to see which kids do you think would be interested in interacting with you. Again, same faces, and they would rate. So they were anticipating then chatting with these kids right after the MRI on the Internet.

So this is again sort of this social stressor test. What they found was that there wasn't really any difference across the age groups with boys, and in younger age groups there wasn't a difference between boys and girls, but the older girls were more likely, instead of having any kind of a fear response, which

you might see in someone who was anxious, they actually activated this reward pathway, so that it was as if they were positively anticipating peer relationships.

The investigators viewed this as sort of a sign of resilience in normal girls, that peer relationships were important. It's sort of an interesting biological backup to other psychological studies where they've shown that positive peer relationships in girls is somewhat protective against depression and stress and goes along with this sort of "tend and befriend" stress response that women have been described as having.

(Slide.)

So as an example of differences in risk and severity of illnesses that have occurred in the last year, a study from the National Survey of American Life which is looking at black youth ages 13 to 17 found that black teenage girls are at high risk for suicide attempts. African American girls were the most likely to attempt suicide, followed by Caribbean girls, and then African American teen boys, and lowest risk was Caribbean teen boys.

The reason why this was an interesting study I think was that previous data from the CDC had shown that African American women were at lowest risk for suicide. The other interesting thing about this was that the suicide attempt rate was rather high. It was 7 percent by age 17. And while mental disorders were obviously highly correlated with suicide attempts, about 50 percent of the kids who had had suicide attempts had never been diagnosed with a psychiatric disorder.

So the take-home for this was that really they need to be doing screening in sites other than mental health facilities and thinking about doing some screening at school or whatever to kind of pick up these kids that may have undiagnosed mental disorders and intervene before they actually get to the point of attempting suicide.

Again, this is another one of those studies that's looking at ethnicity, which I think is very important, and sex and trying to ascertain what's going on. I think that further studies are really going to be focusing on why this risk is so high.

(Slide.)

Then finally as another example of sex differences research that's been in the last year is looking at differences in treatment response. This is a study that was part of the STAR-D, which is, as you know, a large study looking at sequence-treatment alternatives for treatment-resistant depression. The first step of that study involved treatment with citalopram in this showed an increased response and remission in women as compared to men to citalopram treatment, even though the women had a greater baseline severity and had more comorbidity.

This study supports some earlier work that had been done that suggested that women did better on serotonin reuptake inhibitors compared to men. That was a study that was done a number of years ago and hadn't been replicated, and this study nicely now supports that data.

(Slide.)

As I mentioned, the other initiative, research initiative, that is being sponsored by the women's team is looking at mental health during

pregnancy and the postpartum period. As I mentioned, it's a very broad announcement. One of the things that's been a real area of interest for the Institute has been to develop animal models to understand the physiology behind postpartum depression, because obviously it's difficult to do studies in people and animal models can also provide a way of not only understanding mechanism, but looking at different potential treatment targets.

In addition, there's been a number of studies looking at the effects of mental illness and treatment of mental illness on mother-infant outcomes, and then a number of studies we have ongoing on treatment.

(Slide.)

I jus wanted to highlight this one study on animal models because this is something that we don't really have a lot of animal models in this particular area. This was considered to be a very important study that occurred about this time last year. Pregnancy has been considered to be protective against depression. That has been sort of the clinical lore and data really have not borne that out. They have shown that

depression really does not remit during pregnancy, and in the postpartum period a number of women are very vulnerable to depression. Again, it is not protective.

So they've been looking at trying to develop some animal models to look at the hormone contributions to postpartum depression. Now, obviously in people there are many, many things that contribute. It is not just a physiologic response. There are many different psychosocial stressors that occur with having a baby. But this is really just looking obviously at a physiological area.

What they found is that the GABA-A receptor is known to be responsive to changes in progesterone, and that it fluctuates during pregnancy and the postpartum period because of that. There's a sub-unit in the receptor called the delta sub-unit that contributes to this ability to fluctuate with hormonal changes.

(Slide.)

So what these investigators did is they engineered mice who lacked that delta sub-unit of the receptor. What they found was that these genetically

altered mice showed depression in a number of different aspects, like the forced swim test and some animal models of anhedonia. Importantly, postpartum they found that these animals were really inattentive to their pups. They did not develop nests and also at times cannibalized their pups.

What this slide shows is that the normal mouse builds a nest, keeps their pups together, tries to keep the pups warm, and these genetically altered mice don't even bother forming a nest, the pups are all over, and this poor little pup has been partially eaten.

They're using this as a model of animal model infanticide. One of the interesting, probably the most significant part of this study is when they gave TIHP, which is a GABA-A agonist, all this behavior reversed. These altered mice actually performed as the Wild type.

So while this is obviously an animal model, it does sort of give some leads as to potential targets for treatment. It's important because in terms of women who've required pharmacological treatment, in

other words therapy hasn't been successful in treating their depression, things have been largely focused on serotonin. This is a way of looking at a new target for treatment development in this population, obviously way down the road, but it's important for that reason.

(Slide.)

As I mentioned, we've had a number of studies looking at mental illness and mother-infant outcomes. This is a study that is very recent by Kathy Wisner and it looked at pre-term delivery in women who had untreated depression. It was a naturalistic study, that they followed prospectively these women. Some were depressed and did not want treatment. Some had taken medication partially through their pregnancy. Others were well, they were a control group, didn't have any depression. And others had been on medication through their whole pregnancy.

What they found is that the risk of pre-term delivery was the same in the untreated depression group as well as the serotonin reuptake inhibitor-treated group, and it was much higher than the group of women who were neither depressed nor treated with serotonin

reuptake inhibitors, about 20 percent in both of these groups.

So I think the take-home from this study is that we really need to tease apart the effects of depression from the effects of treatment, because obviously untreated depression is a risk in addition to treating with medication. So we need to take this information and really do some further studies to understand what's going on.

(Slide.)

Untreated depression in a recent study last year also showed that infants are affected by mom not being treated in terms of their stress response. Obviously, there are many studies looking at mother-infant bonding with untreated depression, but this was one of the few that have actually looked at physiological stress response in infants whose moms had not been treated.

(Slide.)

We have a number of treatment studies ongoing. As most of you know, cognitive behavioral therapy and interpersonal therapy have been shown to be

effective in postpartum depression. Now a number of investigators are looking at modifying these therapies for different groups, people who are at high risk for postpartum depression, trying to see if these therapies can be used to prevent postpartum depression, using it with high-risk groups such as adolescent mothers, as well as adapting these therapies for group therapy, for example, because not everybody can come in to have weekly therapy, as you know.

(Slide.)

Then there are a number of studies -- we have a center that has finished its funding down at Emory that was looking at antidepressant and anti-epilepsy medication use through pregnancy, again a prospective observational study examining placental transfer of these medications, effects on infants and pregnancy outcomes. We're starting to get some of the results from those studies.

Then finally, as I mentioned, it's very complicated to tease apart effects of illness from effects of treatment in pregnancy and we funded a study that's looking at stress, both depression and anxiety,

and importantly anxiety because I think it's an area that during pregnancy and postpartum has not been evaluated as much as depression, and looking at both the effects of treatment as well as stress on infants.

(Slide.)

That is just an overview from two funding initiatives. I just wanted to let people know that research in women's health is very broad, so there are a number of initiatives that don't -- that aren't female-specific. But for example, we have a number of program announcements related to trauma. They're not just related to abuse, but also are looking at trauma related to natural disasters, trauma related to service in the armed forces, which of course is a big issue now with women returning home from Iraq and Afghanistan. There are also some initiatives related to eating disorders.

So there are a number of other ongoing initiatives that, if people are interested, you can go to our web site. Sorry, they're going to try to connect me to the web site so I can show you where to look yourselves.

(Pause.)

MS. GAHED: We have to click for you. Sorry.

DR. ROCA: Oh, you have to click for me, oh.

CHAIR ENOMOTO: You can come here.

MS. GAHED: Yes, you're welcome to come here.

DR. ROCA: For example, to find --

(Pause.)

DR. ROCA: So if you want to look at some of our other initiatives, for example under our program announcements, there are a number related to trauma, because I know that that's an area of interest for this group. Like I said, they're not specifically geared towards women per se, but they do obviously look at early childhood abuse.

(Screen.)

Here it is, mental health consequences of violence and trauma. This kind of goes to what people have been asking about related to what are the consequences in terms of developing depression, anxiety disorders, PTSD, and the like. So this really supports research in this particular area.

There also have been a number of requests for

applications that have dedicated funding with them and there have been in the past some related to treatment, particularly of anorexia, which has been a very difficult disorder to treat, with a very high mortality, the highest mortality of any of our mental disorders.

I apologize, I just did something. But anyway, if you go to the web site you can search for these different funding initiatives. The other thing you can do is search under -- when you look at general information, there's a tab for women and it can lead you to information for clients, brochures that you can download for women on different issues that could be helpful.

So I guess we could open it up to questions.

CHAIR ENOMOTO: Do we have questions from our committee members or the members of the public?

OPERATOR: Once again, please press star, then 1, to ask a question.

CHAIR ENOMOTO: While we're waiting, I have a question. Related to trauma, the mental health consequences of trauma and violence, is that also

available for services or intervention work?

DR. ROCA: I believe that it's -- I'd have to look at the announcement because I'm not directly involved with that particular one. But I think it does involve looking at services, certainly interventions and causality.

Services is an area that's been sort of a difficult area for women because even, for example, in perinatal depression, where -- Kim Yonkers has done some work where they've actually offered services for free for women. They haven't taken them up. People haven't actually showed up for treatment even when they've been screened positive and offered treatment without charge. So it is an area where people are trying to figure out what are the barriers. It is a real issue.

Now, with perinatal depression, postpartum depression, obviously there are a lot of logistical things -- getting kids, babysitting, transportation. But it seems that some of the research I think is showing that also calling it stress makes it a little more acceptable for people to come in and get treatment

as opposed to coming in for depression.

CHAIR ENOMOTO: Do we have any questions from our participants on the line?

OPERATOR: Once again, to ask a question simply press star, then 1.

(No response.)

CHAIR ENOMOTO: If there are no further questions, I'd like to thank all of our presenters. I feel like we really got a primer on the emerging science for women and girls around drug abuse, alcohol, and mental disorders. It was kind of you to dedicate the time to give us a peak into what's coming out now, what we already know, and I hope that we can document the presentations. At least they'll be available on line. Those that want to access the resources that you've highlighted and the references and the articles that you've referenced, the data, will have that available to them and we'll make sure that all of our members on the ACWS have the presentations as well.

So really a wonderful foundational presentation, so I appreciate it very much. Thank you to all of our presenters.

And at SAMHSA we're going to clap.

(Applause.)

PUBLIC COMMENT

CHAIR ENOMOTO: There's virtual clapping going on all over the country.

We're now going to open the line for public comment. Panelists may -- I guess it's Dr. Faden may log off, and our panelists here, we would appreciate you staying, but you're not required to stay. This is part of the formality of our Advisory Committee.

Do we have any public comment today?

OPERATOR: Again, please press star, then 1.

(Pause.)

COMMITTEE ROUNDTABLE

CHAIR ENOMOTO: If we have no public comment, then we do actually have some work of our Advisory Committee looking at our agenda for our August meeting in conjunction with the National Association of Community Health Centers. So our committee members, if you would take a look at our draft agenda I would appreciate it.

To our panelists, again thank you very much

for joining us.

Operator, are the lines now open?

OPERATOR: At this time would you like all the lines open?

CHAIR ENOMOTO: Yes, please.

OPERATOR: Okay, I'll open all lines. And that's just for your panelists or the public also?

CHAIR ENOMOTO: Just for our panelists.

OPERATOR: Okay.

CHAIR ENOMOTO: I'm going to go ahead and ask Nevine and Debby to kind of walk us through the agenda on where we are.

MS. GAHED: At this point we've got a confirmation for Chicago. We are going to be there for the 25th --

(Musical interruption by phone.)

VOICE: You will now be piped into conference.

VOICE: You're planning amongst yourselves.

CHAIR ENOMOTO: Are our members, are we all there still?

VOICES: Yes.

CHAIR ENOMOTO: Wonderful. Thank you very much.

Nevine is walking us through the agenda and we'll go ahead and have a discussion on where it's headed.

MS. GAHED: It's a general thing. I had already sent you a copy of the agenda, the proposed agenda for August. We did get a lot of your feedback, so we thank you so much for it.

We actually are confirmed for the 25th and the 26th. We are going to be at the -- I'm just going to give some of the logistics to get that out of the way. But we are going to be at the Farmer House. Travel requests, if I could ask some of you who have not sent them to me to please do so.

CHAIR ENOMOTO: You know who you are.

VOICE: I have mine filled out, ready to fax. And I am coming, so I was able to make that decision.

CHAIR ENOMOTO: Excellent.

MS. GAHED: The first day is going to be an actual meeting, except that it's going to be held in two different spaces. The first one is at the Farmer

House because we could not get room at the Hilton, where the NACHC is having its conference. So we are planning to finish around 3:15, to be able to get to the other hotel and do the listening session on women and trauma.

We were very, very pleased to find that we have presenters who have accepted. We have three of the community health centers in Chicago, Access Community Health Network and the Asian Human Services Family Health Center. we're also having -- and Terry McGinnis is going to also be coming in, that's right. Terry McGinnis is going to be talking about medical home models. So that's the morning session.

The afternoon session, we are going to go -- this is going a little bit too fast one way or another. We're going to be having a panel discussion also, and it seemed to develop itself in an interesting setup where we have Pamela Rodriguez, who is the president of CASC, and she's been invited. I haven't heard back, so I'm going to follow up with her.

Linda Teplin is a professor of psychiatry at Northwestern and she actually was our lead to get into

the site visit the next day, so we thank you her for it. She's going to come in and also speak.

Are you seeing any movement on your screens?

VOICE: No.

MS. GAHED: That's what I thought.

They've got to do it themselves. You've got to scroll down, apparently.

CHAIR ENOMOTO: Really? They have to scroll?

MS. GAHED: You can scroll down at the same time to see all this.

The third presenter is --

CHAIR ENOMOTO: Carol Warshaw.

MS. GAHED: Carol Warshaw, exactly, on domestic violence. She's going to be talking about domestic violence and the issue of mental health.

The next day is going to be a half a day at the Cook County Jail, and it is being set up with Dr. Selina, who is going to host us. It isn't on the agenda, that part, because that's really the public agenda right there. And I am going to be in contact with her to actually get some more details about how that's going to run and who it is we're going to be

meeting. It's going to be set up in a way that we do the introductions, then we'll do the tour, and then a Q and A at the end.

That's that part. Do you have any questions on this, any comments, any feedback?

VOICE: I have a question. On the Cook County Jail, are we going to the treatment program as a side visit or are we going to their work program, or where are we actually going?

MS. GAHED: We are actually going to see the whole totality of the program that they do that is gender-responsive. So I think it is the treatment, the substance abuse treatment as well as the mental health piece. So I'm going to get some more details as soon as I've talked with Dr. Selina on that.

VOICE: Great. That sounds interesting.

MS. GAHED: We certainly hope so, yes.

MS. HUTCHINGS: Nevine, this is Gail. Nice job. Thank you very much. I appreciate hearing from everybody.

First I want to apologize for not commenting sooner, but I'm wondering -- one of the things that we

want to do, I think, is capitalizing on the great job you've done in getting the agenda together for Chicago, is trying to engage HRSA and the sort of brain trust at the community mental health centers as well. So in addition to the local program operators that you've done such a great job on, is there any way that we could try to engage with a very senior HRSA person and-or somebody from the association that represents the community health centers, maybe to have them on a panel for some kind of global engaging remarks? I hope it's reciprocally engaging.

MS. GAHED: Certainly. Let me see how we -- do you have somebody in mind in HRSA?

MS. HUTCHINGS: No, but I'm happy to do some of the research to find out. I'm happy to do that. I'm curious if the other Council members agree as well. But I think it's sort of like the difference between us going out and speaking to Roger on behalf of Community Connection, which is phenomenal, but it doesn't get us to all of the grantees of SAMHSA. So it's the same idea applied to HRSA and the community health centers.

MS. GAHED: Okay.

CHAIR ENOMOTO: I think that's a great idea, Gail. We can try to arrange that. I think at least inviting Michael Marjila, who has been NACHC's primary mental health, community health person.

MS. HUTCHINGS: Wonderful.

CHAIR ENOMOTO: He was the connection that helped us get the SAMHSA day or get the SAMHSA sessions at the NACHC meeting. So starting there and seeing how far we can go.

MS. HUTCHINGS: Yes, perfect.

MS. GAHED: I think the other thing we may want to speak about right now is actually the listening session and how that particular session will be developed.

CHAIR ENOMOTO: We actually wanted to throw it out to you all. We have an hour and a half. We have no idea how many people we would get. It is the 4:45 to 6:15 session on the second day of a two-day conference and we are running up against three other SAMHSA sessions at the same time. So it's not ideal, we recognize that. But it is what we have.

We understand that NACHC -- Michael has

assured us that he's really trying to get the word out and do a lot of marketing for this set of sessions, because he's very interested in getting his NACHC members there. So at least NACHC is being as supportive as possible. They do have a packed agenda. If you look at it, you see that they didn't have sufficient space available on their agenda and it had already been set by the time we started having our conversations.

We've titled it a women and trauma listening session. It's sort of a theme that runs throughout what we do, and I think it's also a topic that would be of interest to many of the community health centers because it's something that they see and I think a lot of them aren't sure what to do about it.

The question is whether we do it solely as a conversation. There are those of you who were in Florida and we really just sort of opened up the floor. But we have a little bit longer time this time and so we thought we could also take advantage of the folks that we have as our members and do a little bit of presentation. It's sort of up to you all, what you

think would be interesting, a good use of your time, a good use of the opportunity.

MS. HUTCHINGS: This is Gail. I'll jump in -- I'm sorry.

DR. COVINGTON: Go ahead, go ahead.

MS. HUTCHINGS: Just a brief reminder. I'm wondering -- Connie might be the best person to do this or another member, but we all worked hard a year ago putting that framework together and the key priorities for our group and the matrix that we did that in. I wonder if some sort of expression that this is, to the people in the room, this is the sort of thing that we thought were the biggest issues and the way that we should approach it that resonates from the issues that they see in their day to day work. That might help lay a little bit of foundation on who we are, what we are as a group, in addition to individually.

DR. COVINGTON: This is Stephanie. I guess my suggestion was in an hour and a half if we titled it something on trauma, I think there's some value to having some kind of brief overview presentation that sets the stage so people will think about what

questions they may want to ask, versus -- I think what we did in Florida worked well. I'm just wondering if maybe setting the stage might enhance the experience.

CHAIR ENOMOTO: Right, right. Again, Florida was a little more -- any presentations we did would have been more preaching to the choir.

DR. COVINGTON: Right.

CHAIR ENOMOTO: Because it was already a conference about women and substance abuse.

DR. COVINGTON: Exactly.

CHAIR ENOMOTO: Many of the topics that we would cover were already covered elsewhere in the agenda, whereas with this NACHC meeting I guess I did think of it as a little bit of an opportunity for us to be on our soap box. So Gail, I think that's a great suggestion about kind of the overview of what the committee has prioritized overall. Then I don't know if we wanted to just do every member or those members who are interested do ten minutes on their specialty, or if a couple of you wanted to offer to do something.

Just logistically, I'm not sure what makes the most sense or what would be -- because each of you

has a perspective on this topic that's I think really valuable.

Another thing we could do is everyone could have a ten minute, five minute presentation in their back pocket and if we have lots of time we just present it, and if we have not very much, we have 75 people show up with burning issues at the tips of their tongues, and we just talk.

Thoughts?

DR. RIOS-ELLIS: I think it might be a good idea to refresh -- this is Britt -- to refresh on what we all do and to be able to see what each other, what all of the rest of us are doing. So maybe five to ten minutes would be wonderful if we have that chance.

DR. COVINGTON: Well, do we want it to be on what we do or do we want it to be on women and trauma?

DR. RIOS-ELLIS: Well, I think it could be on what we are specifically doing regarding that.

DR. COVINGTON: I think that would be an important focus.

DR. RIOS-ELLIS: And I don't know if I'd do that -- well, with HIV-AIDS I guess I do. But my work

would obviously be related to HIV-AIDS and mothers and daughters. But I don't know if that's a principal -- I think it is, but some of you are working more directly with some of the issues that might be more -- I'm not sure. But I think it might be a really good thing.

DR. COVINGTON: Well, we do a lot of work here with the guidance center. We've done a great job with this program. It's sort of what happens on the ground in our community, in a community setting, with more often moms and their children who are coming out of or are in, trying to get out of, an unsafe situation.

MS. HUTCHINGS: I'm wondering if we can, given that it's an audience of community health center people, I wonder if we could try to focus on what our individual and collective experiences are in trying to engage with the world, not being engaged with them, what service barriers might be in trying to share clients, if any of us have any positive experience with them. I think we need to try to customize it to this particular audience and the things that are working and not working and maybe try to get a dialogue going.

DR. RIOS-ELLIS: Gail, thank you so much for eloquently saying what I tried to. We work a lot with a lot of NACHC members, specifically working with the community and HIV-AIDS, some of which is just for women and girls. But I think that's really important because I think a lot of these agencies, especially within the Latino community, are emerging agencies. They may not have worked -- they're working with the umbrella, obviously, with NACHC, but they may not be working with federal agencies as directly as they would want to. I think we have a lot to learn from them and they have a lot to learn as well. But that reciprocity might be very engaging.

MS. HUTCHINGS: For example, Roger, does Community Connection have any linkages, strong linkages, with D.C.-based community health centers, and how is that going? I think that might be sort of a point for the conversation if we could, I think.

OPERATOR: This is your operator. I wanted to make sure. Do you want to be in a special conference for speakers only or is it okay if you have participants that are listening to you at this time?

CHAIR ENOMOTO: It's an open meeting.

OPERATOR: Okay, so I'll open the lines.

DR. FALLOT: I can think of a couple of things. Certainly, we do have relationships with primary care settings. They range from health care for the homeless to the Washington Hospital Center. The relationships have been different, frankly, in various settings.

I'm reluctant to give up the (inaudible). We think of this forum here and the importance of whatever sorts of setting we're working with (inaudible). So if people are interested in spending five minutes on that, I'd be glad to talk about it.

VOICE: Yes, I second Roger's. I'm wondering if there can be something on Roger talking about being trauma-informed and what that means, regardless of the agency. Perhaps I could say something about some gender differences, and we could have other people who then talk about the challenges of interfacing with various agencies.

But I think the theme through this should be the women and trauma piece, if that's the title of our

session. I think, Roger, you also can speak to the trauma piece in terms of having to develop something that's gender-responsive for men, so that whole concept of trauma-informed and gender-responsive.

MS. HUTCHINGS: This is Gail. I'm all for that. I mean, we know they see perhaps even more trauma-experienced individuals than we do collectively, just given that they've got a bigger book of business, quote unquote, if you would. I love the idea of doing that, the trauma-informed, as well as if they get more community health center expansion grants they get into the business of mental health and addiction services, there's huge opportunities for us to be the experts that have worked on this for years, and how can we do that collaboratively instead of risking what's going on there and is out there in some places now, where they're stealing staff, they can't get fees, they can't afford to pay them as much, they get reimbursed at a higher rate, etcetera, etcetera.

I think this is falling together nicely, I think.

VOICE: Certainly the whole thing is

interesting. Actually, where I am, though, we don't have any federally qualified health centers in my immediate geographic area.

CHAIR ENOMOTO: I think you could also broaden the conversation to what are the health issues that you're seeing, even if you're not directly partnering with a CHC.

VOICE: Well, I'm interested, though, because I know a lot of people are teaming up with these. In Massachusetts there is a movement for the providers who are close to a federally qualified health center to be joining forces. So I know that is where the world is going. So it would be interesting, that dialogue that you're talking about between this group and the professionals. I think it would be certainly interesting to listen in to and participate in.

CHAIR ENOMOTO: How about this as a suggestions? Perhaps just to get everyone on the same page, I might prevail on Roger and Stephanie, and perhaps Jacki if she's there, to do a quick -- after we do an overview of the ACWS and give the basic primer on trauma-informed and gender-responsive services, and

then if each of you would be prepared with sort of a five to ten, or maybe sort of a question preceded by a five-minute sort of statement of issues as you see them, because again Amanda has a tribal perspective, a prevention perspective, Britt with the Latina HIV, and Susan with the child and mother, and Gail with national policy and Renata at the state services level.

I think each of you has a great perspective. I don't think it would be a good idea to walk in there with 75 minutes of presentation planned, but if we had maybe 20 minutes of presentation sort of establishing the baseline of what we're talking about, trauma and how it relates to women's health and services. Then as the conversation evolves we can take advantage of specific opportunities.

Would that make sense? I think in Florida we asked each of you to kind of be prepared with a provocative question or statement to encourage the audience if the audience was reticent. So we might kind of approach it that way to allow for flexibility, but also be prepared.

MS. HUTCHINGS: This is Gail. It works for

me wonderfully, because I think with you doing the priority matrix, Stephanie and Roger -- I'm happy to hold back and have one of those five-minute ones in my pocket just sort of about what we're learning locally and nationally about collaboration sort of at the organizational and state level. And I'm sure Renata -- as you were saying, everybody can contribute greatly to all of those.

So it works for me, so good.

DR. RIOS-ELLIS: This is Britt. Is there room in the conversation about this whole, we're going to get a national health care brand, universal health care for everyone, and what is that going to mean for whether it's a community-based health clinic and trauma-informed care? A lot of us are talking more about that, and it's got to be what everybody's talking about right now with all the activity.

Is that going to pop up anywhere in our day and a half?

CHAIR ENOMOTO: I think that's sort of -- I think at 10:30, the morning session the day before, when we're talking to the CHCs, and-or if we can get a

session with NACHC and HRSA, I think that would be the time to talk about what that might look like. Let's see, we'll be in the middle of the August recess. I hear the House bill -- we're going to know what that looks like finally before they leave, so we'll at least have that for a conversation.

I guess I'm looking at the NACHC agenda. There's not a whole lot in there -- there's not a whole lot in there on health reform. I think it's a little bit shooting fish in a barrel, so it's hard to put it on an agenda per se.

DR. RIOS-ELLIS: Yes, right.

CHAIR ENOMOTO: Just because we could all sit and project or read tea leaves.

But I guess I see that to be on the first part of the agenda. But I'm flexible. Again, Susan, you may put that in your five minutes: So if we get universal health care, how are we going to deal with all these things together.

DR. RIOS-ELLIS: Thanks.

CHAIR ENOMOTO: Are there other thoughts? Amanda, you're very quiet.

MS. MANBECK: I was just listening to everybody. Yes, I'll put something together regarding cultural competency and how it relates to probably more young people. I would be more than happy to get something together for that.

CHAIR ENOMOTO: That would be great. I definitely think a perspective on youth. When we saw the high risk for youth for both addictions and mental illnesses, and they're also the same group that's least likely to seek health care. Yet if you want to prevent disease later on, that's when you've got to catch them. So that would be wonderful.

MS. HUTCHINGS: This is Gail. I wonder if I could just suggest two quick ideas for our subsequent meeting, not Chicago but the one after. I would love to hear from Laura Kwan about her experience going to CDC, given Laura's background as it applies to children.

The other, I think sooner rather than later it's going to be time for us to as a group visit our major priorities and do a self-assessment of have we made progress, how are we doing, where do we need to

be, probably meeting some of the SAMHSA staff a little bit more closely. I'm just recommending some stuff for some reflection.

VOICE: Has a decision been made whether for that next meeting whether it's going to be on conjunction with some other conference?

CHAIR ENOMOTO: I think the plan is that our next meeting would actually be on site. The whole idea was to alternate. So I think that's a great -- because the plan is to have it on site, I think it's a great idea to make that really a working meeting. For example, we had criminal justice as a priority on our matrix. We're going to go do a criminal justice site visit. We don't really have a lot going on in the women's criminal justice area. At least we don't have any of our small women's projects focusing on that, although it may be in our broader grant portfolio to get data on women. But perhaps do we want to do -- we could go do a listening session or do a meeting at the National Institute of Corrections.

VOICE: When is our next meeting going to be? Do we have a date at all or a time of year or a month?

MS. GAHED: Yes. We're meeting in August.

VOICE: Well, I know, but the one after that.

MS. GAHED: Some time in April.

VOICE: It's in April, okay.

MS. GAHED: Right.

VOICE: And that's going to be on site, so that will be in D.C. It's the one after that you're suggesting maybe thinking about something connected with criminal justice?

CHAIR ENOMOTO: Well, I'm just throwing that out there as it could be with criminal justice, or it could be with HIV, it could be with youth. It could be with CDC.

But it could be with one of our own kind of constituencies, National Council or SAS or whoever.

VOICE: Right.

CHAIR ENOMOTO: But I like the idea of bringing, the next one, really bringing it home. We've been out in the field, we've talked about health reform, we've done some site visiting, we've done a few projects. We'll have our core competencies for women and girls done. We'll have the Women's Tip out. We'll

have hopefully our trauma-informed organization draft going by the next meeting. So what's next, you know, work-wise?

VOICE: Right. Can I ask you a quick question? Where is the Women's Tip that's coming out?

CHAIR ENOMOTO: We are now in -- in terms of getting printed, they're waiting to do it together with the Men's Tip. The Men's Tip is at the Department for clearance.

VOICE: And why are they waiting for the Men's Tip?

CHAIR ENOMOTO: It's Dr. Clark's preference to release them together, to do any media and marketing of the two documents together.

VOICE: How funny. You mean the Women's Tip wasn't worth going first? We've waited longer. Very interesting gender response. So the Women's Tip awaits the Men's Tip. Great, and we've waited. That's very funny.

Well, you can tell I'm pleased with that response. That's funny.

CHAIR ENOMOTO: Well, I think we just kind of

struck a middle road between getting it out and cleared and resuscitated.

VOICE: Exactly.

CHAIR ENOMOTO: I think that's just sort of the deal.

VOICE: Well, we're all happy for you getting it out and resuscitating it, etcetera.

So how long will it take for the men's to get clearance?

CHAIR ENOMOTO: Well, there's been some -- there aren't complicated issues. It's relatively straightforward, but it might just take a little bit more time updating the document. I don't think it'll take long. It's not --

VOICE: Is that a six-month "long" or a three-month "long"?

CHAIR ENOMOTO: I think maybe a couple month "long." Maybe we'll get it out by September.

VOICE: That's great.

CHAIR ENOMOTO: I think just there were some outdated references.

VOICE: Oh, yeah, right. I'm sure.

CHAIR ENOMOTO: The last I heard.

So we've already moved on to our April meeting. Do we feel like we're good? Roger, Stephanie, and if Jackie comes perhaps Jacki also, are you guys feeling okay to do that beginning overview on trauma, so that at least everyone who comes knows what we're talking about?

DR. COVINGTON: Sure. Roger, why don't you and I do some emailing back and forth to sort of make sure we're complementary and not repetitive.

DR. FALLOT: Fine. Also, the other thing that wasn't clear in terms of the differences in the cultures between the Institute presentations we heard today was around their relatively traditional model of ways of thinking about diagnosis, disorders, then treatment. That entire approach is really quite different, I think, than most of us who are working in this field (inaudible).

It strikes me that the AIDS study, for instance, might be a nice linkage between the two different worlds.

VOICE: I fully support that, Roger. I think

one of us should include that, and I would even suggest we have the audience open for questions themselves.

DR. FALLOT: Yes, exactly. That's been very effective and it's exciting. That's something I would recommend also.

CHAIR ENOMOTO: Great. I think they were excellent. I really appreciated the presentations. Thank you to Debby and Nevine for setting all this up. Debby says it's mostly Nevine. Thank you, Nevine.

There certainly are different cultures across the Institutes, and yet their willingness to come and their responsiveness to the questions we asked I think shows great promise. But we have to each know -- we have to be culturally competent.

MS. HUTCHINGS: Exactly.

DR. FALLOT: Exactly. We need some training in cultural competency.

CHAIR ENOMOTO: So if we have no -- do we have any additional questions? I'm sorry, before I assume. Additional questions or comments?

(No response.)

CHAIR ENOMOTO: So Nevine, I'll let you close

things up. But before I sign it over to Nevine, I'll say thank you to everyone for your participation, your good questions, and your thoughts about the meeting and ideas. I think they're all contributing to a greater and better and bolder product.

VOICE: Thank you, Kana.

CLOSING REMARKS AND ADJOURN

MS. GAHED: Thank you all. What I am going to do is I'm actually going to be sending you the honorarium form. You can just fax that to me, so we can put that through, if you don't mind.

If there are no other questions, I think the meeting is concluded. Thank you all.

(Whereupon, at 4:16 p.m., the meeting was adjourned.)