



Gender Matters:

Building a System of Services and Treatment for Women in California

Conference Proceedings and Recommendations

December, 1999

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Introduction

In December 1998, 250 women and men came together at the *Gender Matters: Building a System of Services and Treatment for Women in California* Conference to begin to transform California's mental health system into one capable of effectively meeting the unique needs of women. As conference participants we included mental health consumers/survivors, practitioners, advocates, policy makers, and other system stakeholders. We also reflected the full scope of California's diversity: race/ethnicity, culture and language, sexual orientation, age, ability, socio-economic status and gender.

Conference participants validated the variety of ways that "gender matters" in the mental health of women. We identified relevant research findings and told personal stories of trauma and abuse and their impact on mental health. We focused on social and biological changes related to the unique stages of life experienced by women. We explored the interaction of gender and race/ethnicity and the adverse impact of racism and homophobia on the lives of women. We examined the roles that women fill today: leader, mother, caretaker, employee, and how these roles are affected through interactions with California's mental health system. And we documented how these considerations are discounted and marginalized in the delivery of mental health services.

Our examination of mental health services led us to consensus on the need to *fundamentally change California's Mental Health System to ensure the provision of effective gender-specific services to women throughout the State.*

Our discussions generated a clear vision of a gender-appropriate mental health system that:

- Employs a woman-centered approach that takes into account the impact of trauma, life transitions, and life circumstances on the mental health of women.
- Eliminates financial barriers to services.
- Provides culturally appropriate services absent racism and homophobia.
- Presents to women a well-integrated system of care.
- Demonstrates openness to the voices of consumers.
- Supports the full variety of roles that women adopt in our society.
- Promotes gender-specific education, training, and research.

These recommendations represent the product of all of us who participated in the Gender Matters conference. It is clear that it is not the end of a process but rather one of many midpoints along a continual path of learning and advocacy. These recommendations are intended to serve as a roadmap and an ambitious target for those consumers and advocates, practitioners and researchers, administrators and policy makers who are seeking to create change and bring our vision to reality.

Our Goals – Our Vision

Create an Inclusive System of Care Responsive to the Full Diversity of Women

- A woman's language, culture and ethnicity are respected and considered in any treatment and intervention.
- The definition of cultural competence includes lesbian-sensitive services. Homophobia does not express itself in service and treatment systems.

Develop A Woman-Centered Approach to Mental Health Services

- Women have access to services that are structured to reflect and meet their needs. Services are gender-appropriate. Gender-linked barriers no longer prevent access to needed care.
- Trauma, abuse and violence against women are recognized as factors in the lives of many women and important considerations in the assessment and treatment of their mental health needs.
- Mental health services incorporate respect and consideration for the age of women.
- Ethical standards for mental health care are based on the relational psychology of women, human rights, and social justice.

Create a Mental Health System without Financial Barriers to Services for Women

- Insurance coverage for mental illness achieves parity with coverage for physical illness and provides sufficient benefits for treatment of depression, eating disorders, Post Traumatic Stress Disorder, and other conditions prevalent among women.
- There is universal coverage for health care.
- Managed care as practiced in California recognizes the unique mental health needs of women.

Create an Integrated Approach to the Complex Needs of Women with Multiple Mental and Physical Health Problems

- Seamless services are offered to women with multiple problems regardless of their origin or place of diagnosis. Mental health, substance abuse, domestic violence or physical health systems are fully integrated without barriers, obstacles, and duplication.

Promote Change through Effective Advocacy and Consumer Involvement

- The mental health system works in partnership with advocates for gender-appropriate care.
- A woman's right to participate in and determine her treatment is recognized and supported.

Creating a Mental Health System that Supports the Multiple Social Roles of Women

- Mental health services are respectful and supportive of women who act as caregivers.

Promoting Gender-Based Education, Training and Research to Improve Mental Health Services for Women

- The public health approach to prevention teaches all women to value healthy bodies in all their variety.
- Research and evaluation are gender-, as well as culture- and ethnic-specific and relevant.
- Mental health provider training incorporates an understanding of the needs of women.
- Primary care physicians recognize mental illnesses in women and make appropriate referrals.

I. Developing A Woman-Centered Approach to Mental Health Services

Vision

- Women have access to services that are structured to reflect and meet their needs. Services are gender-appropriate. Gender-linked barriers no longer prevent access to needed care.
- Trauma, abuse and violence against women are recognized as factors in the lives of many women and important considerations in the assessment and treatment of their mental health needs.
- Mental health services incorporate respect and consideration for the age of women.
- Ethical standards for mental health care are based on the relational psychology of women, human rights, and social justice, not solely on medical model ethics.

Issues

Issue 1.1: Women experience a mental health system with a severe shortage of gender-appropriate services. Current practice frequently discounts the significance of gender-linked issues such as abuse and trauma, and allocates insufficient attention and resources to mental health problems most prevalent among women, such as eating disorders, depression, and post-traumatic stress disorder (PTSD).

Issue 1.2: Abuse of women has serious ramifications because of its prevalence, the effects on children in the household, its physical consequences for women, and its strong relationship with many symptoms of serious mental illness. Given the large numbers of women exposed to violence – estimates range from 9 to 220 victims per 1,000 women – the failure of therapists to actively and sensitively screen for trauma reduces the effectiveness and prognosis of intervention. In the recent Commonwealth Fund Survey of the Health of Adolescent Girls, 21% of female high school respondents reported being sexually or physically abused. Forty-eight per cent (48%) of girls reporting abuse also reported depressive symptoms compared to 18% who did not report abuse. Women with severe mental illness are not likely to reveal a trauma history unless they are sensitively assessed over a period of time and achieve a high level of trust with their therapists. Furthermore, failure to identify trauma may lead to re-traumatization, especially through involuntary treatment.

Issue 1.3: Women have different psychosocial needs across physical and social developmental life stages. Mental health services often fail to address the complex interaction among the biological, personal, and economic changes in the lives of women and the social environment in which they live.

For example, girls face challenges to their self-images from an early age. Social definitions of physical beauty displace portrayals of healthy bodies. These images coupled with physical

changes and social pressures contribute to a sharp increase in the onset of eating disorders, depression, anxiety, and substance abuse for girls at adolescence. The Commonwealth Fund Survey of the Health of Adolescent Girls reported that 26% of female high school respondents reported depressive symptoms compared to 17% of boys. Other studies have shown that the loss of self-esteem for girls at age 12 is twice that for boys.

Older women with mental disorders are more likely to be poor than their male counterparts and to be living alone. The combination of poverty, isolation and failing health can often lead to institutionalization. Seventy percent of the chronically mentally ill in nursing homes are women. Rates of depression in women actually decrease with age and depressed older women respond well to mental health treatment. Older women are, however, susceptible to alcohol and drug abuse and make up the majority of persons suffering organic brain syndrome and dementias.

Issue 1.4: There is a need for a more woman-centered standard of ethics for mental health services that is based on a holistic view of the needs of women and promotes their empowerment.

Recommendations

1. Mental health systems should recognize the importance of and develop procedures for the sensitive assessment of trauma and abuse experienced by many women.
 - Public mental health services should support trauma/abuse recovery services for women.
 - The California Department of Mental Health and Department of Alcohol and Drug Programs should require all funded mental health and substance abuse service providers to incorporate an assessment of current and past trauma history and treatment.
 - Institutions should avoid or reduce re-traumatizing women through involuntary treatment and the use of seclusion and restraint.

2. Adolescents and older adults have special needs and face obstacles to care. The mental health system should initiate programs and system changes to meet the special needs of adolescent girls and older women while reducing the barriers to services they face.
 - The California Departments of Health and Mental Health and county mental health departments should adopt a public health approach for prevention that teaches young women to value healthy bodies rather than current media images. Prevention strategies should begin in elementary school with positive role models.
 - County mental health departments and schools should develop early identification and intervention strategies designed to reduce development of more serious mental health problems. These efforts should focus on prevention and early identification of abuse as well as eating disorders and depression.
 - The California Department of Mental Health, county mental health departments, and schools should give higher priority to addressing the mental health needs of adolescent girls through their health education, sex education and other programs.

- School programs should provide gender-specific education about mental health/substance abuse issues for women. Education should begin in elementary school and address gender differences and women's strengths and health issues.
- Mental health services should recognize that severely emotionally disturbed adolescent mothers have additional needs that require support.
- Primary health care and mental health providers should ensure older women have access to:
 - √ Appropriate treatment for depression, substance abuse and other mental health related problems
 - √ More service alternatives that do not require institutionalization

3. Mental health programs should set an ethical context for services planning and priorities based on a framework accepted and supported by women.

- All mental health programs should have ethics committees with consumer, clinical, fiscal, and program representatives, so that the discussion is comprehensive and ethics drive care and finances.
- Ethical contexts should view consumers/survivors as whole persons.
- Insurance plans should establish advance directives for mental health services.

II. Creating a Mental Health System without Financial Barriers to Services for Women

Vision

- Insurance coverage for mental illness achieves parity with coverage for physical illness and provides sufficient benefits for treatment of depression, eating disorders, PTSD, and other conditions prevalent among women.
- There is universal coverage for health care.
- Managed care as practiced in California recognizes the unique mental health needs of women.

Issues

Issue 2.1: Many women lack health insurance altogether or have inadequate coverage creating severe barriers to mental health care. Although women utilize health services more than men, they tend to face the following barriers related to inadequate insurance coverage:

- Women are more frequently insured as dependents of spouses or other relatives.
- Women more often undertake part-time employment, where insurance benefits are limited.
- Women, and particularly poor women, spend more out-of-pocket for health services.
- Although Medicaid is a key source of insurance for women, about one-third of poor and near-poor women remain uninsured.
- Women without health insurance tend to use services infrequently, do not receive preventive care, and are less able to sustain extended treatment required by some mental conditions.

Issue 2.2: Mental health services are often inaccessible because of inadequate insurance, gaps in coverage and inability to pay for treatment. When compared to physical health coverage, mental health coverage offers lower maximum benefits, higher deductibles and co-payments, and smaller percentage reimbursement. Neither private insurance nor public programs cover sufficient outpatient therapies or inpatient days to meet the needs of women who face trauma, severe depression, eating disorders, or other psychological disabilities.

Issue 2.3: The limited funding of public mental health programs has an important effect on services for women. Resource limitations have led to the rationing of inpatient services through the setting of admissions criteria. These criteria give priority to the most visible and aggressive manifestations of psychiatric problems, thereby giving relatively lower priority to conditions most prevalent among women and reducing their access to services.

These priorities may also reduce the relative availability of outpatient services to adolescent girls compared to services for boys. An evaluation of California's pilot programs targeting seriously emotionally disturbed children indicates that the majority of children they serve are

boys. Although data are not available to confirm the underlying cause for this imbalance, researchers have theorized that these programs focus on externalized aggressive behavior more likely to be exhibited in boys, resulting in a bias against services for girls.

Recommendations

1. Health insurance reform and managed care reform should include provisions to eliminate barriers to mental health care for women. Specifically:
 - Mental health insurance coverage should be brought to parity with physical health insurance coverage.
 - Health insurance should provide sufficient mental health benefits to address the needs of women with trauma, depression, eating disorders, and other conditions.
 - Managed care plans should develop cost-effective methods for long-term treatment of women with problems such as PTSD and eating disorders.
2. State policy makers should include conditions prevalent among women and related to co-occurring trauma and abuse among the diagnostic criteria given high priority for access to publicly funded services. These conditions include eating disorders, depression, and complex PTSD.
3. Funding for publicly provided mental health services should be increased to remove financial barriers to care for poor women and reduce the rationing of services.

III. Creating an Inclusive System of Care Responsive to the Full Diversity of Women

Vision

- A woman's language, culture and ethnicity do not create barriers to care. Her culture is respected and considered in any treatment and intervention.
- Homophobia does not express itself in service and treatment systems. The definition of cultural competence includes lesbian-sensitive services.

Issues

Issue 3.1: The mental health system is not prepared to access quality services for all women from diverse ethnic and racial backgrounds. Each ethnic population has unique cultural mores and beliefs which impact women and, therefore, must be taken into consideration if access to quality care is to be guaranteed.

Women from diverse communities face a variety of barriers to needed care. Clinicians frequently do not fully understand the cultural overlays that sometimes accompany the mental health problems of women. They also fail to recognize the adaptations of women from diverse cultural backgrounds to majority cultural patterns or to take into account the gender-related cultural values and beliefs of the women they serve. Language barriers continue to exist and mental health systems are seldom proactive in adopting outreach and therapeutic strategies that ensure access to women from diverse communities.

Lesbians face barriers to mental health services created by the conscious and unconscious homophobia of staff; institutional barriers such as intake procedures, forms, and assessments; and the attitudes and lack of understanding by some individual therapists.

Issue 3.2: Access to treatment is difficult for many poor women. The lack of transportation, childcare, and extended or weekend hours for service creates access burdens for working women and mothers.

Recommendations

1. Mental health services should provide consumer focused individualized care that considers culture, age, sexual orientation, religion and economic status. There is a need to expand access for women who face barriers related to language and cultural views of the role of women.
2. Mental health systems should expand the definition of cultural competence to incorporate lesbian/gay sensitive and appropriate services. Service providers should develop specialized services for lesbian and bisexual women.

3. Mental health services should improve access to care for women by providing enabling services, such as interpreters, childcare, and transportation.

IV. Creating an Integrated Approach to the Complex Needs of Women with Multiple Mental and Physical Health Problems

Vision

- Seamless services are offered to women with multiple problems regardless of their origin or place of diagnosis. Mental health, substance abuse, domestic violence or physical health systems are fully integrated without barriers, obstacles, and duplication.

Issues

Issue 4.1: The co-occurrence of mental disorders with substance abuse has been reported in a number of studies. For women, the consequences of substance abuse include increasing likelihood of incarceration, homelessness, and child abuse and neglect. Major depression, anxiety disorder, and post-traumatic stress disorder are the most common mental health problems related to substance abuse. Moreover, use of stimulants, marijuana, and opiates has been correlated with eating disorders, particularly bulimia.

The fragmentation of funding, administration and delivery of mental health and substance abuse services leads to many dually diagnosed women “falling through the cracks” or receiving inadequate treatment for their illness and addictions. Dually diagnosed women face a number of serious barriers to care:

- There is a scarcity of programs that address both substance abuse and mental health needs.
- Few substance abuse programs will accept clients who are on medication.
- Women have difficulty obtaining medical clearance for admission into simultaneous treatment for substance abuse and mental health.
- Entering a residential treatment program may require relinquishing custody of children. Few residential treatment programs permit children to live with their mothers in the facility.
- Most substance abuse programs are built on models designed for men and have predominantly male service populations.

Issue 4.2: There is a lack of integration of mental and physical health services. On the one hand, a psychiatric diagnosis puts clients into a “mentally ill” category and their medical needs do not get adequate attention. On the other hand, the medical care system is woefully inadequate to address the mental health needs of women. Recent studies have shown that only 25% of all patients with mental disorders receive care from mental health specialists, another 25% receive mental health care solely from primary care physicians, and 50% receive no treatment at all. Of the 50% who do not receive mental health care, 80% will seek medical care for physical ailments that are linked to their mental disorder. Primary care physicians cannot always recognize whether the underlying condition of a visible problem is a psychological disorder, a physical disorder, or has elements of both. In addition, CPS,

Mental Health, Probation, and other programs affecting the lives of women with mental illnesses have incompatible goals that preclude full coordination of client services.

Issue 4.3: Women who are homeless and mentally ill live with unrelenting stigma, fatigue and poverty. Homeless women have experienced higher rates of childhood physical and sexual abuse than other women. Notwithstanding the underlying cause of their homelessness, they are in continual threat of assault, rape and sexually transmitted diseases, and have high rates of pregnancy and poor birth outcomes. Many also abuse substances and suffer symptoms of emotional distress and mental illness. However, few of these women access and receive treatment for these symptoms or are able to access other services that would reduce their exposure to risks associated with life on the streets. Most women who are homeless have inadequate medical insurance coverage and suffer from poor mental health follow-up and continuity of treatment.

Furthermore the survival demands of homeless women can inhibit their ability to seek services. They often must choose between treating their mental health issues or simply surviving one more night. Their lack of trust, level of fear, mental health status, or the needs of their children may restrict their ability to request assistance.

Women who are homeless also face an uphill struggle to leave the streets. Patterns of homeless women reflect that 75% leave the streets temporarily but return, about 13% never leave the streets, and about 12% make a permanent exit to stable housing. The reality reflected in these statistics is related to their mental health condition. Lack of housing inhibits the ability of homeless women to stay clean, keep paperwork, master timelines, and meet other requirements for accessing public treatment or finding homes or employment. Often, housing environments maintain rigid guidelines for women using the facilities, guidelines that may not be attainable if the women have children in their care or other problems.

Issue 4.4: Women who are mentally disabled appear to be under-served by rehabilitation services. Only 40% of people with mental illness who receive rehabilitation services are women and only 25% of those with substance-abuse diagnoses are women. Women with mental disabilities also have a lower employment rate than mentally disabled men.

Recommendations

1. Mental health services should take the lead in increasing access to and coordination among physical health, substance abuse treatment, rehabilitation, domestic violence, HIV/AIDS and other services required by women with mental illnesses. Better coordination of both funding streams and the policies and programs of individual agencies is needed.
 - Parity for substance abuse coverage is needed. The Mental Health Parity legislation should also include funding support for substance abuse treatment.
 - The Departments of Mental Health and Alcohol and Drug Programs should expand integrated treatment services designed specifically for dual diagnosis patients. Barriers to existing services should be removed.

- Each county mental health department should develop a clearinghouse for women's services to promote better linkages between county mental health systems and other services.
 - Women need to be able to get treatment that includes their children. Service providers, especially those providing residential treatment should include sufficient facilities to allow mothers to keep their children with them.
 - The Department of Mental Health should develop policies and oversight protecting institutionalized women from being re-traumatized by sexual abuse from care providers.
2. The mental health system should take steps at all levels to better meet the needs of homeless women:
- County mental health departments should develop effective outreach programs.
 - The California Department of Mental Health should provide support to more community agencies that have already gained the trust of women who are homeless to provide transitional residences, screen jails for referrals, and help women leaving welfare.
 - Programs for people who are homeless should provide readily accessible supportive housing, rather than hotels. This approach would improve living conditions for homeless women with mental health problems and increase their access to mental health treatment.
 - The housing environment should reduce restrictions that present barriers to women with mental illness. Resources should be more user-friendly. Utilitarianism and respectful treatment are more effective than strict rules in ensuring livable environments.

V. Promoting Change through Effective Advocacy and Consumer Involvement

Vision

- The mental health system works in partnership with advocates for gender-appropriate care.
- A woman's right to participate in and determine her treatment is recognized and supported.

Issues

Issue 5.1: There are currently no advocacy organizations or advisory groups in California with a dedicated focus on the mental health needs of women. The Office of Women's Health in the Department of Health Services and organizations such as the Women's Health Collaborative have been important voices in the field of physical health by drawing attention to the needs of women, educating policy makers and other stakeholders, and representing a women-centered perspective. They could provide useful starting models for parallel work in mental health services for women.

Issue 5.2: Women with psychiatric disabilities have emerged as powerful leaders in mental health consumer organizing. They have demonstrated a unique and critical perspective on the public mental health system's failure to address core issues such as trauma, abuse, and parenting. The ability of women to build relationships has created peer support programs that are significant elements of the therapy for many women (and men). Their values tend to be values of women's empowerment. Yet, consumers/survivors face a variety of barriers to their opportunity to contribute to the design of mental health services. Women consumers/survivors still have to prove their value. Many therapists don't want to recognize or hear experiences of abuse and trauma shared by survivors. Consumer leadership styles, strength, anger, and conflict related to gender may be reinterpreted, discounted as invalid, or viewed as a symptom of mental disability. In some instances women may discount their own skills, strengths, and contributions.

Recommendations

1. The Department of Mental Health should create an Office of Women's Mental Health to provide a focal point for women's issues within the Department.
2. The California Elected Women's Association for Education and Research, in cooperation with other stakeholders, should establish an advocacy organization dedicated to improving the ability of California's mental health system to meet the needs of women.

3. The mental health system should recognize and value the participation of consumers in the design, provision, quality assurance and evaluation of services. Barriers to consumer involvement and influence should be reduced. Mental health programs should:
- Support consumer leadership and promote the effectiveness of self-help organizations through funding and training in negotiation and mediation.
 - Establish job/career ladders with credit for life experience.
 - Recognize that the client voice is different from the voice of the family advocate.

VI. Creating a Mental Health System that Supports the Multiple Social Roles of Women

Vision

- Mental health services are respectful and supportive of women who act as caregivers.

Issue

Issue 6.1: Women place enormous importance on their roles as caretakers in the family. They are unlikely to access treatment for themselves if their ability to care for these dependents is threatened. This is especially true if their institutionalization results in the loss of custody of their children, whether as the result of their illness or the lack of facilities that allow children to remain with them during their therapy. Yet studies indicate that mental health agencies do not consider the mother-child relationship as an essential focus of psychiatric care, nor do they define parenting as a mental health issue. It is clear that service-receiving women with children require caretaker support systems ranging from childcare to legal services.

Recommendation

1. The mental health system should support the role of women caregivers and facilitate their retention of custody of their children when they seek treatment. Mothers with psychiatric disabilities should not fear the loss of their children when they seek psychiatric treatment.
 - Mental health services should be responsive to the needs of parents, e.g., flexible hours of operation, residential and day services that young children can attend, available childcare and transportation.
 - Mental health service providers should expand the availability of housing and residential treatment that allow children to remain with their mothers.
 - Legislation should reduce the risk of loss of custody of children when women access mental health services.

VII. Promoting Gender-Based Education, Training and Research to Improve Mental Health Services for Women

Vision

- The public health approach to prevention teaches all women to value healthy bodies, not the images created in the media.
- Research and evaluation are gender-, as well as culture- and ethnic-specific and relevant.
- Mental health provider training incorporates an understanding of the needs of women.
- Primary care physicians recognize mental illnesses in women and make appropriate referrals.

Issues

Issue 7.1: There is a significant body of research developed in recent years that indicates that mental illness is experienced differently by women. Women have different reactions to medication than men. Pregnant and lactating women have critical concerns that have not been adequately addressed in research into the efficacy of pharmaceuticals. Women are more frequently subject to abuse and violence and experience different patterns of major mental illnesses.

A significant barrier to the development of gender-sensitive mental health systems is the lack of practical research about the implications of treatment modalities on women. Published evaluations of pilot projects and client outcomes do not raise gender as an issue. The pilot programs funded by the California Department of Mental Health contribute greatly to the direction of public mental health policy, but do not currently contribute significantly to the body of knowledge to assist the development of gender-sensitive mental health programs. Furthermore, research has not satisfactorily addressed the intersection of gender, women's diversity, and mental health services.

Issue 7.2: Education is an underutilized resource in preventing mental illness and promoting early interventions. Mental health issues are not addressed effectively in health education curricula in schools and there is insufficient public education or attention provided by the media. Girls are provided little information about mental health problems and services or women's health issues. Many girls therefore do not develop an understanding of the nature of mental disability and appropriate responses to life crises such as domestic violence, substance abuse, and sexual harassment.

Issue 7.3: Current training practices for mental health professionals under-emphasize the role of gender in the onset, nature, and treatment of mental illness, leaving many mental health professionals with insufficient knowledge about and sensitivity to gender and consumer/survivor issues. Primary care providers need more skill in identifying women's psychological problems, while psychiatric providers need more information about innovative

and effective mental health treatments. Providers of all types of services would benefit from education on the benefits of improved referral and coordination.

Recommendations

1. Mental health research and evaluation should be gender-conscious and specific, focused on issues critical to women, and sensitive to issues of ethnicity, age, and sexual orientation.
 - The Department of Mental Health should add gender-specific analyses and criteria to its evaluation of demonstration projects.
 - California's health foundations should support the development of a mental health "think tank" dedicated to women's mental health issues. The think tank would support research and policy education and disseminate information on mental health issues for women. This think tank should give early priority to consumer/survivor involvement and issues. It should also focus on identifying best practices and developing standards for mental health services for women.
2. The Department of Mental Health, in cooperation with consumer/survivor groups, should undertake a public education campaign, similar to smoking cessation efforts, designed to elevate the consciousness of the public and policy makers. The campaign should incorporate the following objectives:
 - Reduce the stigma associated with mental illness.
 - Encourage early interventions.
 - Reduce discrimination against the mentally disabled.
 - Disseminate information that eating disorders occur at all ages and in males as well as females.
 - Educate media.
3. The Department of Mental Health should establish a Blue Ribbon commission similar to the Families and Children Commission established through Proposition 10 to address the mental health needs of women.
4. Mental health providers need to receive more gender-oriented training and education.
 - Professional training programs and licensing bodies should develop and standardize training and continuing education requirements for medical practitioners, psychiatry, other counseling/psychological professions that better address eating disorders, sexual abuse, domestic violence intervention, trauma and other conditions that affect women disproportionately.
 - Provider organizations should institute cross training among providers of mental health, physical health, substance abuse, and related services.
 - Providers should be trained to work effectively with consumers/survivors.
5. Primary care physicians should be trained and encouraged to assess the mental health needs of women during primary care visits. Managed care plans should develop quality of care

measures that assess the quality of mental health-related services provided in medical settings.