



GENDER matters

ISSUES/CONCERNS

Mental Health Checklist for Women

History

The original *Mental Health Checklist for Women* was developed in 2004 as a result of the California Elected Women's Association's (CEWAER)¹ research and policy paper *Women and Mental Health: Ensuring Access in a Reformed System*. That paper determined that women were underserved throughout California's publicly funded mental health services, both in hospital-based and community-based services. The CEWAER paper explored a number of possible reasons for insufficient or inadequate services for women and provided policy recommendations for providers and program administrators.

As a result of the policy recommendations, Kern County CEWAER and the Kern County Mental Health Department jointly sponsored a Women and Mental Health Conference, where private and public partners worked together to determine service gaps, and to develop plans for future change. The work resulted in the *Mental Health Checklist for Women*²; reviewed by County Supervisors, and Mental/Behavioral Health Directors and staff, providing a flexible tool for use in local review and planning for women in need of mental health services.

The California Women's Mental Health Policy Council (WMHPC) was founded in 1999 as a statewide non-partisan membership organization with a mission to ensure effective, gender- and culturally-appropriate mental health services for women. It is the only such organization in the state. The WMHPC achieves its mission through training, research and advocacy, which it implements throughout the state with information for front-line providers, position papers, and studies encompassing topics that intersect with the needs of women and girls who are living with mental health issues.

Overview

Since the time of the initial findings, little has changed for women's mental health services in California. Anecdotal evidence shows that mental health services for women and girls are often the first to be eliminated in lean economic times. In this unprecedented fiscal crisis, the need for low-cost or free mental health services are more important than ever.

The purpose of this updated *Checklist* is to stimulate a creative review of mental health services for women. It is not intended to establish an artificial one-size-fits-all standard in which one model fits all communities, but rather to serve as a guideline for services to women, and should be adapted and modified according to local needs and resource availability.

How To Use This List

Each section provides an overview of mental health challenges for a particular population of women, followed by a checklist of specific questions or tasks for providers. Each section also provides references to agencies in California that work with each population.

Mental Health Access for Women

Women tend to struggle with “quieter,” less externally observable, mental health diagnoses than men. Women live with depression, anxiety, post traumatic stress disorder, and somatic disorders, as well as post-partum depression. For all chronic mental health conditions, gender differences have been reported in age-of-onset of symptoms, frequency of psychotic symptoms, course of these disorders, social adjustment and long term outcome.^{iv}

There are multiple gender-specific risk factors that are related to age and severity of onset of these disorders, many of which impact women more disproportionately than men. These risk factors include gender-based violence such as rape and molestation, which often lead to post traumatic stress disorder; socioeconomic disadvantage; low income and income inequality; and unremitting responsibility in the caregiver role.^v For women experiencing even one of these risk factors, the more likely their need for holistic services.

- Is staff training provided to ensure awareness of gender differences in prevalence, course of treatment, and outcome of psychiatric disorders; as well as medication dosages and responses?
- Do crisis services have the means to assess internalized as well as externalized symptoms?
- Are there crisis service linkages to women’s self-help groups, family planning, teen pregnancy, domestic violence shelters, restraining order legal clinics, and other women-specific programs?
- Are services provided in an atmosphere that is welcoming and accessible to women? Is there childcare available? Are there service hours for women only?

Resources

California Women’s Mental Health Policy Council:
www.wmhpc.org

Mothers

Women will frequently forego treatment for themselves if it interferes with caretaking responsibilities. Additionally, if custody issues are present, a mother may eschew treatment so as to not jeopardize her status as primary caregiver. New mothers may be struggling with post-partum depression.

- Does the intake service consider caretaking needs in assessments and service planning?
- Are linkages available with services to assist with caretaking, for example, child care agencies, respite care, and home health care?
- What services are in place that support mentally ill women in parenting their children? Are extended family members involved? If no family or other network is involved, are standards in place to support the mother in establishing such a network?
- Do treatment services address concerns of child custody and loss of custody? Are fathers and extended family involved when appropriate?
- Is there strong linkage with Social Services departments concerning children under jurisdiction of the Juvenile Court?

Resources

California Center for Research on Women and Families:
www.ccrwf.org

Women Who Are Survivors of Violence and Trauma

There is a correlation between trauma, victimization, and the onset of mental illness.^{vi} However, pressure on the public mental health system to respond to perpetrators rather than victims may create an unintended direction limiting access for women.

- What services are available for women who have been survivors of violence and trauma?
- Women who are abused are often fearful about seeking services. What outreach or public information programs are available to assist these women?
- Are there facilities or homes available to provide shelter for abused women and their children?
- What interagency agreements or collaborative efforts exist that provide services to this population?
- Are support or self-help groups available for women who are survivors of violence and trauma? Are support services available for their children?
- Have efforts been made to inform judges, social services, law enforcement, attorneys and service providers of programs available for families in which abuse occurs?
- Do services for *seriously* mentally ill women address issues of violence and trauma? Is staff trained to identify history and impact of abuse on women with serious mental illness??

Resources

California Partnership to End Domestic Violence:
www.cpedv.org
San Francisco Domestic Violence Consortium:
www.dvcpartners.org

Women of Color

The demographic landscape of California is changing, with non-Caucasians accounting for 40.1% of California's population.^{vii} Despite this major shift, however, significant racial and ethnic variations in access to mental health services remain prevalent. African-American, Hispanic, and Asian women are significantly less likely to use specialty mental health services than white women, and Hispanic and Asian women are less likely than white women to report perceived need, even after frequent mental distress has been taken into account.^{viii}

- Do system-wide standards or protocols reflect a fundamental goal of providing culturally relevant services?
- In situations where a women presents herself and does not speak English, is there meaningful effort to provide services that are linguistically proficient?
- Are direct service providers trained to identify and understand culturally derived behaviors in women of color who experience mental illness? Are services sensitive to the roles of women in families and social networks in different cultures?
- Are direct service providers aware of stigma's role in the course of providing care?
- Is cultural literacy a system-wide goal for all providers of mental health services?
- Does the system employ an administrative process that audits to ensure services and programs that are culturally and linguistically reflective of the community?

Resources

UC Davis Center for Reducing Health Disparities:
www.ucdmc.ucdavis.edu/crhd/
California Black Women's Health Project:
www.cabwhp.org
California Institute for Mental Health, Center for Multicultural Development:
www.cimh.org
National Asian Women's Health Organization:
www.nawho.org
Latino Coalition for a Healthy California:
www.lchc.org
Hispanas Organized for Political Equality:
www.latinas.org

Older Women

Older women living with mental illness are more likely than men to be poor and living alone. The combination of poverty, isolation, and failing health can often lead to institutionalization.

- What services are currently in place that specifically address the mental health needs of older women?
- At initial contact, it can be difficult to determine whether the primary presenting problems are related to physical health deterioration, mental health issues, and/or concurrent problems. Is there communication with, or assessment services available to, physicians who care for older women?
- Older women sometimes have limited physical mobility as well as inadequate transportation. What “in home” mental health services are available?
- Older women respond extremely well to psychotropic medications. Are there linkages with nursing homes or other facilities where older women with psychiatric symptoms are likely to be found?⁹
- What interagency protocols or agreements exist to facilitate collaborative service delivery with other programs or organizations providing care to this population?
- What therapeutic processes exist to help older women with mental illness establish a social or support network? Is family outreach available?

Resources

Area Agencies on Aging, California Department of Aging: www.aging.ca.gov/aaa/
National Alliance on Mental Illness: www.nami.org

Women with Physical Disabilities

Women living with a physical disability, defined as having a health issue that requires the use of a cane, wheelchair, special bed, or special telephone,^x face multiple mental health issues, including increased prevalence of depressive symptoms.^{xi} While it is difficult to know whether the physical disability is at the cause of the mental illness, or whether the mental health issue is a concurrent-yet-separate diagnosis, the combination of issues often lead women with physical disabilities to mental health providers.

- Is the physical layout of the agency’s waiting room and program areas easily accessible to women with physical disabilities?
- Are providers knowledgeable about the intersection between mental health and physical disability, and the possibility that one may compound the other?
- What interagency relationships exist to streamline services for this population?
- Do providers understand that a physical disability has no impact on mental capacity?

Resources

National Center of Physical Activity and Disability: www.ncpad.org
California State Independent Living Council: www.calsilc.org

Adolescent Girls

While adolescent girls are less likely to experience suspension and expulsion than their male counterparts, and are therefore possibly less likely to come to the attention of school administrators, they are also more likely to experience depression than boys,^{xii} that can lead to a feeling a vulnerability and isolation.^{xiii} Adolescent girls also are more likely than boys to suffer from eating disorders, such as anorexia nervosa or bingeing,^{xiv} which can lead to serious health issues.

- Do referral source assessment protocols include assessment of internalized symptoms as well as externalized symptoms?
- Are providers aware of the mental health issues that are at the root of an eating disorder? Are there existing partnerships with physicians and/or therapists that are specialists in treating these disorders?
- Are parents, who may be more likely than school or public agencies to recognize the seriousness of girls' problems, included in referral assessments?
- Are there linkages with crisis teams and Emergency Rooms that specifically address girls' episodic use of crisis?
- Are there collaborations with programs for pregnant or parenting teens?

Resources

California Youth Empowerment Network:
www.ca-yen.org

Alcohol and Other Drug Services for Women

Co-occurring substance abuse and mental illness are so interlinked that it is best to integrate mental health and substance abuse services, providing dual diagnosis treatment. Women living with mental illness are more likely to use alcohol (46%) than any illegal substance, such as cocaine, marijuana, stimulants, and other drugs.^{xv} Additionally, women with co-occurring disorder (COD), mental illness and substance use disorder, are less likely to seek services from a COD provider, but rather from one or the other. In order to treat a woman living with COD, it is important that there be linkages between mental health providers and substance abuse providers.

- Are there facilities available that recognize and address the special needs of women requiring dual diagnosis treatment?
- Are direct service providers able to link women with housing, employment, or educational services to achieve meaningful recovery?
- Do existing programs provide for medically supervised substance abuse services for women, including pregnant women?
- Is there an alcohol and other drug program that addresses the needs of women who are caregivers to children?
- Are judges, attorneys, and service providers aware of programs available to women in lieu of incarceration?

Resources

Mental Health Systems, Inc.:
www.mhsinc.org
Forensic Mental Health Association of California:
www.fmhac.org
Council on Mentally Ill Offenders, California
Department of Corrections and Rehabilitation:
www.cdcr.ca.gov/COMIO/

Homeless Women

According to the 2010 Annual Homeless Assessment Report to Congress (AHAR 2010), “A typical homeless family consists of a mother and two children,” and people in families experiencing homelessness are more likely to be headed by a woman.^{xvi} Additionally, AHAR 2010 reports that over 92% of mothers who are homeless have experienced severe physical and/or sexual abuse; for homeless mothers, 50% have experienced a major depression since becoming homeless, and 36% are living with post-traumatic stress disorder: a rate that is three times higher than that for their low-income housed counterparts.

- Homeless women may not feel safe seeking help at traditional sites for homeless services. Has the provider modified its agency to make it safer and more welcoming for women?
- Homeless women need access to all primary resources: food, shelter, clothing, and health. What linkages and advocacy exist? Which ones should be prioritized and explored?
- Women living with mental illness being released from jail or prison are often homeless upon discharge. What services are in place to avoid “losing” women at this point?
- Forty-one percent of the homeless population is comprised of families.^{xvii} Are providers working with homeless women within the context of her role as mother? Are services made available to the entire family, and not just to the individual woman?
- Do outreach workers address the issues of violence and trauma? What collaborations exist in the community to address the overlapping challenges of homelessness, violence, and trauma?
- Do programs address high rates of high risk pregnancy and provide necessary referrals to medical services?

Resources

Sacramento Loaves and Fishes, Sister Nora’s Place:

www.sacloaves.org

Project 50 Los Angeles:

<http://cmtysolutions.org/projects/los-angeles-project-50>

Compass Family Services: www.compass-sf.org

National Coalition for the Homeless:

www.nationalhomeless.org

Lesbians and Bisexual Women

Although lesbian and bisexual women do not show any greater manifestation of serious mental illness than heterosexual women,^{xviii} these women do experience generalized anxiety disorder at a rate three times that of their heterosexual counterparts.^{xiv} Additionally, lesbian and bisexual women face unique social stressors, such as violence or discrimination at work, at home, or at school, as well as in public. These stressors can lead to, or exacerbate, a mental illness.

- Do services and programs exist that address the issues of sexual orientation?
- Do providers consider and understand that bisexual women are not confused, but merely represent a different sexual orientation than that of their lesbian and heterosexual counterparts?
- Do advocacy opportunities, specialized services, and/or staff training exist to ensure access and culturally competent services for lesbian and bisexual women?
- Are consciousness-raising programs in place for the education of service providers and the community? Does the agency have a nondiscrimination policy in place for staff members as well as clients?
- What resources exist to support alternative family structures, such as programs and services that work with biological fathers, children, and nuclear families?
- Are there inter-agency partnerships between mental health agencies and lesbian/gay/bisexual/transgender advocacy agencies?

Resources

Contra Costa Health Services:

www.eastbaypride.com

LGBT Tristar:

www.lgbt-tristar.com

Transgender Women

The term “transgender” is an umbrella term for multiple gender expressions, including transsexual: those individuals whose gender identity is in conflict with their anatomical sex.^{xx} Transgender women, those who were born with the anatomy of a man, face multiple stigmas, and have experienced multiple social stressors that can lead to, or exacerbate, a mental illness.

- Is the physical environment of the agency welcoming to transgender women? Are there signs, posters, or symbols indicating this is a safe space?
- Are consciousness-raising programs in place for the education of service providers and the community? Does the agency have a nondiscrimination policy in place for staff members and for clients?
- Do staff participate in regular training to ensure welcoming language, asking about appropriate pronoun use, and asking how the woman refers to herself?
- Are there support groups for transgender women recognizing that their life issues hold different challenges than those for lesbian and bisexual women?
- Do direct service providers feel comfortable discussing the issues related to living as a transgender woman and how those issues impact mental health treatment and recovery?
- Do providers understand that the physical response to medications may be different for transgender women than for those who were born with female anatomy?

Resources

Gender Health Center:
www.thegenderhealthcenter.org
Contra Costa Health Services:
www.eastbaypride.com

Women Veterans

Although women have been involved in military theater for many years, it was only in 1980 that the U.S. Census asked women if they had ever served in the U.S. Armed Forces, at which time 1.2 million responded that they had.^{xxi} The California Department of Veterans Affairs states that currently, there are approximately 167,000 female veterans in California, the greatest number of female veterans in any state. With U.S. military presence in Afghanistan coming to a close, that number is sure to climb.

Female veterans face different issues from those of their male counterparts. More than 40% of female active duty service members have children, and are more likely to be a single parent than male troops.^{xxii} Fifteen percent of women in the Reserve/National Guard are single parents.^{xxiii} While the U.S. Department of Veterans Affairs reports that the overall number of veterans is decreasing, the number of homeless female veterans is on the rise.^{xxiv} Additionally, not only are women experiencing the same stressors associated with serving on the front lines, but they are three times more likely than their male counterparts to be sexually assaulted.^{xxv} Rates of MST in treatment-seeking female veterans range anywhere from 14 to 43.1%,^{xxvi} and this population of survivors of MST demonstrated higher rates of dysphoria and of starving behaviors than their non-MST female counterparts,^{xxvii} which requires a unique focus for service providers.

- For female veterans receiving services from a civilian provider, does that provider have a comprehensive understanding of military culture?
- Can a provider differentiate between symptoms of PTSD that stems from MST, versus PTSD that stems from exposure to serving on the front lines?
- When seeking services from the VA, is the female veteran able to easily access services from a female provider?
- For female veterans who are parents, does the provider work with the entire family and/or make referrals for the children as necessary?
- Does the provider address pre-military trauma, as well as warfare-related trauma, such as coming under fire or seeing colleagues killed?

Resources

Swords to Plowshares, Women Veteran Services:
www.stp-sf.org
Grace After Fire: www.graceafterfire.org
Operation Stand Down; websites vary by geographic location

Resources

- i** CEWAER is now known as California Women Lead.
- ii** The original checklist may be found at www.cimh.org.
- iv** *Gender and Mental Health*. World Health Organization. http://www.who.int/mental_health/prevention/genderwomen/en/. Retrieved on June 27, 2011.
- v** Ibid
- vi** *Adverse Childhood Experiences Study*. Centers for Disease Control and Prevention. 2010.
- vii** U.S. Census 2010.
- viii** Kimerling, R. and Baumrind, N. *Access to specialty mental health services among women in California*. Psychiatric Services (2005 Jun;56(6):729-34).
- ix** *Depression in Older Persons Fact Sheet*. National Alliance on Mental Illness. Retrieved on September 10, 2011.
- x** California Women's Health Survey 2007
- xi** Kimerling, R. and Baumrind, N. *Access to specialty mental health services among women in California*. Psychiatric Services (2005 Jun;56(6):729-34).
- xii** *Mental Health, Substance Abuse, and Dropping Out: A Quick Stats Fact Sheet*. National High School Center. July 2009.
- xiii** *Mental Health: A Report of the Surgeon General*. U.S. Department of Health and Human Services. 1999.
- xiv** *Children's Mental Health Statistics*. Mental Health America. Retrieved November 2011.
- xv** *Women with Co-Occurring Mental Illness and Substance Abuse*. National Abandoned Infants Assistance Resource Center, University of California at Berkeley. May 2005.
- xvi** *Families Experiencing Homelessness*. Homelessness Resource Center. Retrieved on September 10, 2011.
- xvii** *Homeless Families with Children*. National Coalition for the Homeless. July 2009.
- xviii** *Mental Health Issues Among GLBT People*. National Alliance of Mental Illness. June 2007.
- xix** Ibid
- xx** *Transgender Health Story #4*. PRIDE LGBTQI Initiative of Contra Costa County. September 2010.
- xxi** *California's Women Veterans: The Challenges and Needs of Those Who Served*. California State Library, California Research Bureau. August 2009.
- xxii** *Women Warriors: Supporting she 'who has borne the battle.'* Iraq and Afghanistan Veterans of America. October 2009.
- xxiii** Swords to Plowshares, Institute for Veteran Policy, OEF/OIF Reference Guide: www.stp-sf.org
- xxiv** Ibid
- xxv** *Women on the Front Lines*. California Department of Alcohol and Drug Programs. Retrieved September 2011.
- xxvi** Rowe, E., Batten, S. and Davison, E. *Military Sexual Trauma in Treatment-Seeking Women Veterans*. *Military Psychology*, 21:387-395, 2009.
- xxvii** Ibid



California Women's
Mental Health Policy Council
2125 19th Street, 2nd floor
Sacramento, CA 95818