



Gender Matters in Mental Health: An Initial Examination of Gender-Based Data

A publication of the
California Women's Mental Health Policy Council
in affiliation with the
California Institute for Mental Health

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and
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California Women's Mental Health Policy Council

The California Women's Mental Health Policy Council (WMHPC) consists of leaders in mental health. Since its inception in 1999, the WMHPC has been on the forefront advocating for gender sensitive mental health services. The WMHPC mission is to ensure effective, gender-specific culturally appropriate mental health services for women and girls. The WMHPC primarily achieves its mission through a variety of methods including:

- training providers, consumers and family members;
- researching established data sets and evidence-based practices to develop policy and practice reports;
- advocating with other statewide partners to promote effective and promising multicultural women's mental health policies and practices.

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EXECUTIVE SUMMARY

The Women's Mental Health Policy Council (WMHPC) is an independent, nonprofit research and advocacy organization that seeks improvements intended to ensure effective, gender-specific, culturally sensitive mental health services for women and girls in California.

The WMHPC has prepared this report as an initial analysis of readily available gender-based data concerning women's mental health needs and their utilization of public mental health services. The data reveal differences between females and males in the use of mental health services. Most notably, females under age 40 are less likely than males to receive mental health services. Analysis of the data in this report reveals that this finding is consistent for the Medi-Cal population, the population served through the Chapter 26.5 Special Education mandate and the public mental health population as a whole.

“Females under age 40 are less likely than males to receive mental health services.”

In FY 00/01, among Medi-Cal mental health clients under 60 years of age, the average cost per client across all services, including both inpatient and outpatient services, was lower for females than for males. Additionally, female clients are less likely than males to receive medication support services.

Three ethnic specific studies on females and mental health were also reviewed. These studies were: *Unheard Voices: Findings from the California Black Women's Health Project Survey of 2000-2001*, by the California Black Women's Health Project, *Breaking the Silence A Study of Depression Among Asian American Women*, by the National Asian Women's Health Project, and *The State of Hispanic Health*, by the National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)¹. These three eth-

nic specific studies provide some preliminary information on the barriers to access and quality of care for Black, Asian American and Hispanic females.

These examinations of mental health data by gender and ethnicity are the initial steps in learning more about mental health needs, access to services and outcomes for girls and women. Further study is needed to understand the reasons for the gender and ethnic differences identified.

Preliminary recommendations in this report include:

- The Department of Mental Health (DMH), in collaboration with the WMHPC, initiate a program with counties and advocacy groups to increase awareness of the nature and prevalence of girls' and women's mental health issues and examine ways to increase identification, referrals, and services for females.
- The DMH Quality Improvement Council undertake a study to examine the access discrepancies between females and males.
- The DMH use gender as a routine variable in all data that the Department publishes.
- The DMH have gender as a routine variable in the data obtained through the current data matching project with California Department of Social Services (CDSS).
- The DMH pursue or create opportunities for other integrated data projects similar to the CDSS project.
- At the next revision of CSI or as soon as it is practical, DMH add a data element to determine how many clients are raising children or caring for partners or parents.
- The DMH actively participate in population-based women's health studies such as the California Health Information Survey and the Women's Health Survey.

¹ Now known as the National Alliance for Hispanic Health, see: www.hispanichealth.org.

- The WMHPC pursue funding to analyze service and outcome data by gender and race/ethnicity.
- The WMHPC pursue investigation of other studies that have been conducted regarding the state of mental health issues for California Latinas.
- WMHPC pursue collaborative relationships with Latino/a health organizations to embark on a study of mental health issues for Latinas in California.
- The WMHPC work collaboratively to prioritize and implement the recommendations in the ethnic specific studies cited in this report (see appendices for specific recommendations).

BACKGROUND

Research has found that mental disorders affect women and men almost equally. However, mental health professionals generally agree that women and men face divergent mental health challenges. According to the National Institute for Mental Health (NIMH), certain disorders affect women much more commonly than men²:

- Depressive disorders afflict more women (12.0%) than men (6.6%) each year.
- *Major* depressive disorders afflict more women (6.5%) than men (3.3%) each year.
- Approximately twice as many women as men suffer from panic disorder, post traumatic stress disorder (PTSD), generalized anxiety disorder, agoraphobia and specific phobia.
- Almost equal numbers of women and men have obsessive-compulsive disorder and social phobia.



- Women are much more likely than men to develop an eating disorder. An estimated 85% to 95% of people with anorexia or bulimia are female. These two disorders affect approximately 2% of adolescent girls.

The CalWORKs Project³ research interviews conducted in 1999 and again in 2000, with 643 randomly selected TANF single female heads of household in Kern and Stanislaus counties in California revealed that:

- Overall prevalence of any of five mental health diagnoses (major depression, generalized anxiety, PTSD, panic disorder or any of several specific phobias (social phobia or agoraphobia) was 38% in this interview population.
- Twenty-six percent had serious mental health problems at either or both interviews. Of these, 49% had received services by the second-year interviews.
- Thirty-two percent of the women interviewed reported a serious domestic violence issue.
- A serious alcohol or drug problem was reported by 17% of the study population.⁴
- Ten percent had serious difficulties in at least two of the above areas.⁵

²NIMH Research on Women's Mental Health: Highlights FY 1999-FY 2000.

³The CalWORKs Project is a collaborative effort of the California Institute for Mental Health (CIMH), Children and Family Futures (CFF) and the Family Violence Prevention Fund (FVPPF). The Project provides policy and practice-relevant information about CalWORKs participants having mental health, alcohol and other drug, and domestic violence issues.

⁴The CalWORKs Research Project used the following definitions: "serious mental health problem" was defined as a symptom severity score on the BASIS-32 equivalent to that for clients entering treatment at outpatient clinics; "serious domestic violence issue" was defined as physical injury, stalking, threats by the abuser to kill the female victim or to commit suicide, threats to kidnap the victim's children or to call Child Protective Services, and preventing the female victim from working or harassing her at work; and "serious alcohol or drug issue" was defined as a diagnosis of either dependence or abuse.

⁵*Mental Health, Domestic Violence and Substance Abuse*, CalWORKs Project Policy and Practice Brief, Number 1, April 2002, California Institute for Mental Health

“Boys were more likely to be traumatized as observers of violence, while girls were more likely to be traumatized as victims of violence.”

A 1998 study of PTSD among female juvenile offenders at the California Youth Authority School in Ventura found that the presence of PTSD among incarcerated female delinquents not only was higher than in the general population, but it was also higher than the rate of this disorder in the incarcerated male delinquent population. In addition, this study found that boys were more likely to be traumatized as observers of violence, while girls were more likely to be traumatized as victims of violence.

GENDER-BASED DATA

Population Data

According to California Department of Finance estimates, the population of California was 35,802,238 on July 1, 2002. Of this total, 17,818,043 (49.8%) were female and 17,984,195 (50.2%) were male. The California Medi-Cal population in FY 00/01 totaled 5,666,515, of which 57.7% were female and 42.3% were male. The total population eligible

for public mental health services is most closely defined as that population which is under 200% of poverty, including the Medi-Cal population. Based on census data from the Current Population Survey, March 2002 Supplement, produced by the California Department of Finance, females constitute approximately 52% of the 11,386,000 individuals that have incomes below 200% of the poverty threshold.

Public Mental Health Utilization Data

Utilization by Gender and Age

According to the California Department of Mental Health’s Client and Services Information System (CSI), in FY 01/02, the penetration rate⁶ for the total mental health population (both Medi-Cal and indigent) was 5.02 for females, and 5.82 for males. Although this difference does not seem large, it is quite significant. For example, if you take 1,000,000 people, that ratio indicates that 50,200 females would be treated compared to 58,200 males, a difference of 8,000 people. Furthermore, analysis of the data by age reveals that girls are not accessing the system at the same rate as boys are. Table 1 shows that penetration rates of young women and men are not similar until after the age of 17.

⁶ “Penetration Rate” is a term commonly used in managed care to describe the percentage of eligible plan members that use the managed care plan. In this instance, the penetration rate is defined as the number of individuals receiving at least one mental health service during the year divided by the estimated number of individuals with incomes below 200% of poverty for that year.

Table 1. Penetration Rate by Gender and Age Group in FY 01/02 - CSI Data

Age	FEMALES			MALES		
	Population Below 200% of Poverty	Clients Served	Penetration Rate	Population Below 200% of Poverty	Clients Served	Penetration Rate
Total	5,962,000	299,515	5.02%	5,425,000	315,950	5.82%
0-17	2,008,000	70,240	3.50%	2,100,000	113,647	5.41%
18-64	3,187,000	216,214	6.78%	2,889,000	195,634	6.77%
65+	767,000	13,061	1.70%	436,000	6,669	1.53%

In FY 01/02, a total of 616,508 individuals utilized mental health services in the public system. Of the 616,105 mental health clients with a designated gender of either male or female, 49% were female and 51% were male⁷. Of the total served, 268,194 individuals, or almost 44%, were *not* Medi-Cal clients and were funded through county mental health realignment funds or other funding sources such as CalWORKs. Consistent with the overall ratio of Medi-Cal vs. non-Medi-Cal reimbursed services, the group receiving treatment funded by non-Medi-Cal dollars consisted of 44% females and 56% males.

Table 2 shows that in FY 01/02, while females represented just over 52% of the population below 200% of poverty, they represented slightly less than 49% of the total mental health population served. This difference is even more pronounced in figures for utilization by younger women and girls. While females represent just fewer than 49% of the 0-17 age range in the population segment below 200% of the poverty threshold, the percentage of females in the same age range who received mental health services was just over 38%. The percentages of females in this population and females receiving mental health services is the same for the 18-64 age group. In the 65 and over age group, approximately two-thirds of those receiving services are female.



A similar pattern exists for Medi-Cal eligible women and girls. Overall, of the 347,911 Medi-Cal clients served by the public mental health system in FY00/01, 52.5% were female and 47.5% were male. Table 3 shows the Medi-Cal penetration rates for females and males across several age categories and the total number of Medi-Cal clients served. For ages 0-17, 18-20, and 21-39, proportionately fewer females access mental health services. In the 40-59-age category, access to services for females and males is equal. Females ages 60+ have a higher access rate.⁸

This low pattern of mental health access is of particular concern for women ages 18-39 because rates of serious depression in women are highest during the child-bearing years and are double that of men. This data warrants further study, since it appears that when women are at the highest risk of serious debilitating depression and at the most critical time in their childrearing responsibilities, they might not be accessing the services they may need.

Fewer dollars are spent on mental health services for females than for males. Table 4 illustrates that expenditures per female client average 9% less than expenditures for male clients in the 0-17-age group, and 23% less than expenditures for male clients in the 18-20-year age group. While money may not equate with quality, resource distribution is an important indicator of access to services.

Table 2. Percentage of Clients Served Compared to the 200 Percent of Poverty Population, by Gender and Age Group – FY 01/02 – CSI Data

Age Group	Of total below 200% of poverty, percentage who are female	Of total mental health population served, percentage who are female
All Age Groups	52.4%	48.7%
0-17	48.9%	38.2%
18-64	52.5%	52.5%
65 +	63.8%	66.2%

⁷ Four hundred fifty-four individuals' gender was "unknown" and 43 were designated as "other". For the "total served" in this report, we have used the total of individuals with a gender designation of either "male" or "female"

⁸ The penetration rates for older adults may be low because many of them also receive Medicare funded services. This data only shows Medi-Cal funded services.

Table 3. Medi-Cal Penetration Rate by Gender and Age Group in FY 00/01⁹

Age	FEMALES			MALES		
	Aver. monthly Medi-Cal eligibles	Clients served	Penetration rate	Aver. monthly Medi-Cal eligibles	Clients served	Penetration rate
Total	3,268,979	182,753	5.59%	2,397,521	165,158	6.89%
0-17	1,350,246	52,096	3.86%	1,396,546	77,212	5.53%
18-20	165,623	5,663	3.42%	92,449	5,571	6.03%
21-39	814,542	46,296	5.68%	324,254	32,132	9.91%
40-59	417,429	62,409	14.95%	292,050	41,998	14.38%
60-64	69,267	8,353	12.06%	49,099	4,547	9.26%
65+	451,871	7,936	1.76%	243,121	3,698	1.52%
Unknown	1			1		

Table 4. Average Mental Health Medi-Cal Cost per Client For All Services by Gender and Age Group - FY 00/01

Age Group	Females	Males
Total	\$2,978.77	\$3,856.45
0-17	3,871.06	4,257.64
18-20	3,259.80	4,209.75
21-39	2,649.63	3,964.80
40-59	2,711.92	3,375.20
60-64	2,036.56	2,011.44
65+	1,931.19	1,740.24
Unknown		

Access by Gender and Race/Ethnicity

Table 5 shows the percentages of females versus males served in the public mental health system by race/ethnicity for FY 01/02. Caution must be used in drawing conclusions from this data, as the numbers are low in some groups. Of the 616,105 total clients served, 49% were female and 51% were male. Looking at this data by ethnic group, it can be seen that the proportion of Caucasians and Filipinos accessing services is divided equally between males and females. Among the Hispanic, African-American and Samoan populations however, the percentage of females utilizing services is smaller than males. Conversely, in the remaining race/ethnicity groups the percentages of females using mental health services is higher than males. This information highlights some gender differences by race/ethnicity which warrant further study.

⁹ The Medi-Cal penetration rate is derived by dividing the number of individuals utilizing mental health services during the fiscal year by the average monthly Medi-Cal eligible recipients for that year.

Table 5. Percentage of Clients Served by Gender and Ethnicity in FY01/02 –CSI Data

	Total Number of clients	Female %	Male %
TOTAL	616,105	49%	51%
RACE/ETHNICITY			
Caucasian	271,440	50%	50%
Filipino	4,960	50%	50%
Hispanic	137,010	47%	53%
African-American	103,224	45%	55%
Samoan	298	40%	60%
Cambodian	3,772	62%	38%
Laotian	2,318	62%	38%
Other Asian or Pacific Islander	8,011	58%	41%
Guamanian	173	57%	43%
Japanese	1,234	56%	44%
Hawaiian Native	156	56%	44%
Korean	2,169	55%	44%
Amerasian	535	55%	45%
Vietnamese	6,906	54%	46%
American Native	5,304	53%	47%
Chinese	5,098	52%	48%
Asian Indian	668	51%	49%
Multiple	14,858	50%	50%
Other	8,213	50%	49%
Unknown	39,758	51%	49%

“Of the total youth enrolled in CSOC, only 998 (31.2%) were female.”

Children’s System of Care (CSOC) Interagency Enrollee Based Data Program

As a result of the FY 02/03 Budget Act, the California State Department of Mental Health (DMH) is required to provide outcome data on individual children enrolled in the Interagency Enrollee-Based Children’s System of Care (IEBP/CSOC) initiative. This initiative requires counties to identify a specific group of children to be served and specific outcomes to be identified and measured. As of May 2003, the State has information on 3,198 children and adolescents enrolled in the CSOC database. These are youth who are involved in multiple agencies and typically present with the most serious emotional disorders. Approximately 98% of these youth are between 5 and 18 years of age, with approximately 70% in the 12 through 17-year age group. Of the total youth enrolled in CSOC, only 998 (31.2%) were female.



Table 6. Diagnoses of CSOC Enrollees by Gender

Diagnosis	Female	Male	Total
ADHD	7.9%	16.9%	14.1%
Disruptive Behavior Disorders	20.5%	33.1%	29.2%
Schizophrenia & Other Psychotic Disorders	3.1%	3.2%	3.2%
Bipolar	10.3%	8.2%	8.9%
Depression	32.1%	15.8%	20.9%
Adjustment Disorder	8.2%	7.5%	7.7%
Anxiety Disorder	13.4%	10.1%	11.1%
Other MH	2.7%	4.2%	3.8%
Deferred/Missing	1.7%	1.0%	1.2%
Total	100.0%	100.0%	100.0%

Table 6 shows the CSOC youth by diagnosis and gender. Consistent with most research data, this table shows that girls tend to have more internalizing disorders, such as depression, while boys have more externalizing disorders such as ADHD and disruptive behavior disorders.

Mental Health Utilization by Youth Receiving Services Under Their Special Education Plans

An even greater gender difference exists within another subset of the public mental health population. Youth between 0 and 21 years of age served under Chapter 26.5 of the Education Code and need mental health services to benefit from their special education plans were primarily male. In FY 00/01, of the 27,645 youth served under this mandate only 7,210 (26%) were females.



Medication Services for Youth Ages 0-19

Overall, fewer young female clients receive medication support services than young males. In FY 2000/2001, approximately 33% of males age 19 and under receiving services had a least one medication support service as compared to 27% of females. Table 7 shows a more detailed breakdown by gender for several age groupings of girls and boys. Of the total clients under age 15 receiving at least one medication support service, the percentage of female clients is smaller than male clients. Further study is needed to understand the reasons for this gender difference.

Table 7. Young Clients Receiving At Least One Medication Support Service in FY01/02 —CSI Data

Age	FEMALES			MALES		
	Clients with any service	Clients with med support	Percent clients with med support service	Clients with any service	Clients with med support	Percent clients with med support service
Total	78,573	21,364	27.19%	125,027	41,495	33.19%
0-4	3,697	253	6.84%	5,163	604	11.70%
5-9	15,879	3,442	21.68%	29,261	9,834	33.61%
10-14	27,858	7,826	28.09%	45,992	16,976	36.91%
15-19	31,139	9,843	31.61%	44,611	14,081	31.56%

“Of those respondents 40-59 years of age, 90% believed violence negatively affected their health.”

Performance Outcomes

Welfare and Institutions Code Section 5613 requires the Director of Mental Health to report county data to the Legislature using established performance measures. For FY 01/02, the general findings were that females were slightly more satisfied than males on the service satisfaction, access, and appropriateness subscales of the Mental Health Statistics Improvement Project (MHSIP) Consumer Survey, but less satisfied on the “outcomes” subscale which addresses questions regarding quality of life. This finding is corroborated on the Quality of Life (QOL) instrument, where findings indicated that women are less satisfied than men in quality of life areas including satisfaction with living situation, leisure activities, daily activities, social relationships, family relationships, finances, safety and health.

Findings from Ethnic Specific Studies on Females and Mental Health

The California Black Women’s Health Project study, *Unheard Voices: Findings from the California Black Women’s Health Project Survey of 2000-2001*¹⁰, found the following:

- Mental health was a primary concern for respondents.
- Of those responding, 84% believe faith and spirituality influence their health outcomes.
- Respondents reported feeling overwhelmed by the pursuit of perfectionism, meeting goals, mediating family conflicts and challenging the criticisms and doubts of others.
- Respondents reported overwhelmingly that they felt stress and pressure juggling family, work and societal pressures.
- Of those respondents 40–59 years of age, 90% believed violence negatively affected their health.

¹⁰ California Black Women’s Health Project (CABWHP), *Unheard Voices: Findings from the California Black Women’s Health Project Survey of 2000-2001*, 2002.



- Respondents reported that coping with racism and sexism further exacerbates the mental and emotional stress they must endure.
- Physical violence had been experienced by 33% of respondents.
- Respondents identified race and gender of their health care provider as critical in improving communication and quality of care.
- Teenage respondents were skeptical about the conventional mental health system and believe they encounter stigma when seeking treatment.

“Conflicting cultural values can interfere with Asian American women’s sense of control over their lives.”

Findings from the National Asian Women’s Health Organization (NAWHO) study on depression, *Breaking the Silence A Study of Depression Among Asian American Women*¹¹, found that:

- Asian American women who have low self-esteem and perceive that they do not have control over their own lives are at high risk for depression.
- Conflicting cultural values can interfere with Asian American women’s sense of control over their lives.

¹¹ National Asian Women’s Health Organization (NAWHO), *Breaking The Silence A Study of Depression Among Asian American Women*, 2001

- Asian American women often place greater priority on familial obligations than on their personal needs.
- Feeling responsible, yet unable to meet idealized and unrealistic standards set by families and society contributed to low self-esteem among study group participants.
- Asian American women face mental health stigma when attempting to cope with their depression.
- Asian American women witness depression in their families, yet they adhere to the cultural norm of silence and avoid seeking help.
- Asian American women are hesitant about using mental health care not only because it would stigmatize them, but even more so because they believe it would bring shame to their families.

“One in three Hispanic girls report seriously considering suicide, the highest rate of any racial or ethnic group.”

The National Coalition of Hispanic Health and Human Services Organization (COSSMHO) study, *The State of Hispanic Girls*¹², found:

- Hispanic girls are the largest ethnic girls group in the United States and are projected to remain so for the next 50 years.
- Hispanic girls do not constitute a monolithic group, but include Mexican, Puerto Rican, Cuban, Central and South American.
- Hispanic girls lead girls nationally in alarming rates of teenage pregnancy, suicide, alcohol and drug abuse and self-reported gun possession.
- One in three Hispanic girls report seriously considering suicide, the highest rate of any racial or ethnic group.
- Maintenance of traditional cultural values and norms is important in buffering Hispanic girls from high-risk behaviors.

¹² National Coalition for Hispanic Health & Human Services Organization (COSSMHO), *The State of Hispanic Girls*, 1999.

Other Mental Health Data

There are other sources of women's mental health data. Information from these sources is presented in the Appendix. These include the California Health Information Survey (CHIS), the California Women's Health Survey and the California Healthy Kids Survey (CHKS). In addition, the California Board of Corrections produces a quarterly Juvenile Detention Profile Survey by gender that includes not only detention information, but also information about open mental health cases and the numbers of detained juveniles receiving psychotropic medications.



ISSUES AND QUESTIONS

At the present time, only descriptive mental health data is available. Young and adolescent girls are not accessing mental health services at the same rates as their male counterparts. Many factors may account for this. Agencies that refer large numbers of youth for mental health services, such as schools, the juvenile justice system and the child welfare system, refer many more boys than girls. This may be because boys tend to "act out" and be more disruptive, but no information exists to confirm whether young girls need services that they are not now accessing.

Also, very little is known about the reasons for the medication use differences among males and females. This could be due to less need for medication services, lack of identification of a need for such services, an unwillingness of girls to seek or receive these services, or unavailability of services. Finally, there is no information why women between the ages of 21 and 40 who are receiving Medi-Cal are not accessing the mental health system at rates one might expect, given their increased risk for depression during these years and their increased child rearing responsibilities.

Also of importance is the gender-based data that *is not* available. Critical data on the multiple roles women play in society is missing. The state has no data on the caregiving roles and responsibilities of women in the public mental health system. There is no data to show the number of women in the mental health system who are caring for children, who have had children but have lost custody of their children, or who may be caring for their elderly or disabled partner or parents.

WMHPC believes that effective services are integrated services, yet integrated data is not available that provides information on mental health issues for

women and girls across systems, such as substance abuse, primary care, domestic violence, child welfare, CalWORKs, education, and juvenile justice. Data within these other systems are often not presented by gender and are not integrated with mental health data, preventing advocates and policy makers from relating data across systems. The California Department of Mental Health (DMH) and the California Department of Social Services (CDSS) have just begun a data-matching project that potentially could yield cross-system data. Under an initial matching effort, 55% of youth in the Foster Care database also appeared in the DMH database.

In the absence of data documenting the problems of specific groups of people, the people and their problems remain invisible. Without knowing the number of women in the mental health system who have parenting responsibilities, knowing the struggles of these families and the supports they need becomes impossible. Help only comes if their children present with problems in school or child protective services becomes involved. Without integrated data to identify the numbers of women with mental health, substance abuse and domestic violence issues, they remain invisible but frequent users of the public system.

SUMMARY AND RECOMMENDATIONS

The mental health data in this report provides some initial information on access to mental health services by age, gender, and race/ethnicity. Mental health data is not routinely reported and analyzed by gender. This analysis of data by gender reveals several trends:

- Data for the total public mental health population indicate that in the young and formative years of girls' lives they are less likely to access mental health services than boys are.
- Medi-Cal clients show a similar pattern to that of the total population utilizing mental health services. Only after age 40 or above does utilization for females equal or exceed that of men and boys.
- Data on youth served through the Chapter 26.5 special education mandate show an even more dramatic pattern, with boys being served at a 3 to 1 ratio to girls.
- Medi-Cal data also indicate that more money is spent on average for each male served than for each female served.
- While not quite as pronounced as in the special education area, only 37% of the youth in CSOC enrollee based programs are female.
- Data in Table 5 for gender and ethnicity breakouts shows that Caucasian and Filipino females and males receive equal service. Hispanic, African American and Samoan females are served at lower rates than males, while in all other reporting ethnic groups, females are served at higher rates than males.

The initial analysis of available data indicates a need for several responses. Preliminary recommendations from the WMHPC are:

- DMH, in collaboration with the WMHPC, initiate a program with counties and advocacy groups to increase awareness of the nature and prevalence of girls' and women's mental health issues and examine ways to increase identification, referrals, and services for females.
- The DMH Quality Improvement Council undertake a study to examine the access discrepancies between females and males.

- DMH use gender as a routine variable in all data that the Department publishes.
- DMH have gender as a routine variable in the data obtained through the current data matching project with CDSS

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- DMH pursue or create opportunities for other integrated data projects similar to the CDSS project.
- At the next revision of CSI or as soon as it is practical, DMH add a data element to determine how many clients are raising children or caring for partners or parents.
- DMH actively participate in population-based women's health studies such as the California Health Information Survey and the Women's Health Survey.
- The WMHPC pursue funding to analyze service and outcome data by gender and race/ethnicity.
- The WMHPC pursue investigation of other studies that have been conducted regarding the state of mental health issues for California Latinas.
- WMHPC pursue collaborative relationships with Latino/a health organizations to embark on a study of mental health issues for Latinas in California.
- The WMHPC work collaboratively to prioritize and implement the recommendations in the ethnic specific studies cited in this report (see appendices for specific recommendations).

This report is a first step in improving mental health services for the women and girls of California. The WMHPC intends this report to stimulate thoughtful conversation, further research, and action.

APPENDIX

Other Mental Health Data

California Health Information Survey (CHIS)

This is a telephone survey – 2001 current results contain data from over 55,000 adults, 5,801 teens and 12,592 children surveyed. Five mental health questions are asked of adults:

- Of those who had health insurance, do you have coverage for mental health problems?
- Have you seen a mental health professional in the last 12 months?
- Did you need help for emotional or mental health problems in the past 12 months?
- Of those who needed help, did you talk with your doctor about an emotional or mental health problem?
- Of those who needed or received help, did you have difficulty getting the help that you needed?

Adolescent questions are:

- How much of the time during the past 4 weeks have you been a very nervous person? All of the time, most of the time, some of the time, a little of the time, or not at all?
- How much of the time during the past 4 weeks have you felt so down in the dumps that nothing could cheer you up? All of the time, most of the time, some of the time, a little of the time, or not at all?
- Have you felt peaceful and calm? (How much of the time during the past 4 weeks?) (All of the time, most of the time, some of the time, a little of the time, or not at all?)
- Have you felt downhearted and sad? (How much of the time during the past 4 weeks?) (All of the time, most of the time, some of the time, a little of the time, or not at all?)
- Have you been a happy person? (How much of the time during the past 4 weeks?) (All of the time, most of the time, some of the time, a little of the time, or not at all?)
- In the past 12 months, have you received any psychological or emotional counseling?

For the last question, 10.1% of adolescent females under the 200% poverty level (same population used for public mental health) answered “yes”, as did

9.6% of adolescent males. This compares closely to the public mental health system penetration rate for boys (9.25%, but is much higher than the penetration rate for girls (5.94%). The breakdown by race/ethnicity for this question is also very interesting. 17.3% of Caucasian females answered “yes”, as did 10.1% of African-Americans. Only 7.2% of Latinos and 7.1% of Asian adolescent females answered this question affirmatively- a large ethnic discrepancy.

Child questions (answered by “adult proxy respondent”) were:

- What behavioral or mental condition does {CHILD NAME / AGE/SEX} have?
- Did a doctor or psychologist ever tell you {CHILD NAME / AGE/SEX} has attention deficit disorder, ADD or ADHD?
- Does {he/she/he or she} currently take prescription medicine to control {his/her/his or her} ADD or ADHD?

Database can be queried by age group and ethnic categories. More information is available at www.chis.ucla.edu.

California Women’s Health Survey

The survey consists of a core of demographic and health care access and health insurance coverage questions asked over the telephone every year. Data are collected through a computer-assisted telephone survey in which some 200 questions are answered by approximately 4000 women (over age 18) who are randomly selected to participate.

Questions cover topical areas specific to women’s health including breast and cervical cancer, mental health, family planning, breastfeeding, chronic illnesses (arthritis, asthma, diabetes, cardiovascular disease, osteoporosis, nutrition and obesity, sexual behavior, sexually transmitted diseases, health information, care giver responsibilities, hormone replacement therapy). Mental health questions asked are about:

- Attitudes and knowledge of mental health care by race/ethnicity and age
- Desire for and receipt of mental health care for women by poverty status
- PTSD symptoms among women

Most recent data is for 2000 and can be found at www.dhs.cahwnet.gov.

California Healthy Kids Survey (CHKS)

This is a comprehensive youth health and risk behavior data collection support system for school districts. It covers the following areas:

- Use of alcohol, tobacco, and other drugs
- Suicide thoughts and attempts, violence, school safety, gang involvement, and delinquency
- Nutrition and physical activity
- Sexual behavior
- Exposure to prevention and intervention activities
- Risk and protective (resilience) factors

Data is available for 1998-2002. Grades reporting are 5, 7, 9 and 11. Data is not currently available by gender. Website address is www.wested.org.

Juvenile Justice Data

Data is available in the OJJDP Statistical Briefing Book. This data can be found at www.ojjdp.ncjrs.org. The most recent data is for 1999; some is for 1997. The data includes:

- Teen birth rates by age groupings
- Residential placements of juvenile offenders by gender and race/ethnicity
- Offense profile by gender
- Days since admission of detained and committed juveniles by gender

The California Board of Corrections produces a quarterly report on detentions by gender. Their website is www.bdcorr.ca.gov.



Ethnic Specific Study Recommendations

California Black Women's Health Project
Unheard Voices: Findings from the California Black Women's Health Project Survey of 2000-2001

- Create a loan forgiveness and/or loan repayment assistance program for licensed mental health providers who serve low-income, communities of color.
- Organize a corps of licensed mental health providers who would commit to partner with (and serve) faith-based institutions and their members.
- Create a voluntary Certification of Cultural Competence that can be earned by (and conferred upon) health providers.
- Create and disseminate "The 12 Commandments of Good Mental Health".

National Asian Women's Health Organization
Breaking the Silence a Study of Depression Among Asian American Women

- Mental health interventions must promote positive messages about self-determination and create environments conducive to Asian American women's empowerment.
- Services must be tailored and culturally competent approaches are needed to meet their mental health needs.
- This study inform service systems to reduce high risk of depression and rates of suicide.

National Coalition of Hispanic Health & Human Services Organizations (COSSMHO)
The State of Hispanic Girls

- Invest in effective community-based partnerships to promote the health and well-being of Hispanic girls and reduce risky behaviors.
- Support research on resiliency and test innovative ways to promote positive cultural adaptation by Hispanic girls and families.
- Dramatically increase health and mental health care access for Hispanic children, youth and families.
- Reduce the soaring school dropout rates of Hispanic girls.
- Target high risk Hispanic girls and their parents.



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This report was prepared in cooperation with the California Institute for Mental Health, a nonprofit public interest corporation established for the purpose of promoting excellence in mental health. CIMH is dedicated to a vision of “a community and mental health service system which provides recovery and full social integration for persons with psychiatric disabilities; sustains and supports families and children; and promotes mental health wellness.”

Based in Sacramento, CIMH has launched numerous public policy projects to inform and provide policy research and options to both policy makers and providers. CIMH also provides technical assistance, training services, and the Cathie Wright Technical Assistance Center under contract to the California Department of Mental Health.