Surgeon General's Workshop on Women's Mental Health

November 30–December 1, 2005
Denver, Colorado

Workshop Report

This document summarizes the views and issues addressed by invited speakers and discussants at the Surgeon General's Women's Mental Health Workshop. The views expressed in this Report reflect the opinions of the individual participants at the Workshop and do not necessarily reflect the official position of the Office of the Surgeon General, the Department of Health and Human Services, or other Federal entities.

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Surgeon General's Workshop on Women's Mental Health: Workshop Report

Executive Summary

The Surgeon General's Workshop on Women's Mental Health brought together experts from the consumer, academic,

[1] in mental health and to address critical mental health issues affecting girls and women. The goal of this workshop was for participants to develop practical and actionable recommendations for materials (referred to broadly as communiqués) and toolkits that could be produced by the Surgeon General to advance knowledge, understanding, and behaviors regarding women's mental health issues – and ultimately to improve the mental health of our Nation's girls and women.

A rich array of potential messages, materials, target audiences, formats, and dissemination strategies emerged from the day and a half of workshop discussions and presentations. Examples ranged from a Surgeon General's Letter to the American People, to iPod messages for teens, audio materials, story-telling formats, public service announcements, messages on commonly used products (e.g., diapers), and profiles of promising practices or model companies that promote mental health. Also discussed were ways of identifying and harnessing existing resources, such as clearinghouses, assessment tools, studies, self-esteem-building models, and more. The specific ideas and recommendations are described within the chapters of this report.

A series of overarching messages and cross-cutting themes pertaining to the mental

advocacy, health insurance, health care delivery, program management, and public policy communities to explore sex and gender differences

health of girls and women also resonated through the sharing of ideas that took place at this workshop. These messages and themes will serve to inform the development of Surgeon General's communiqués or toolkits:

- **Women's mental health is essential to overall health.** Both mental disorders and mental wellness should be integrated as part of primary and other health care practice.

- **The disease burden of mental illness is enormous.** Among developed countries, mental illness is second only to cardiovascular disease in prevalence and causes nearly a fourth of the disease burden.[2]

- **Women's health matters.** The last decade of research has underscored the importance of sex and based differences in the risk, prevalence, presentation, course, and treatment of mental disorders.

- **Mental disorders must be viewed like other chronic medical conditions and are highly treatable.** This message needs to be further understood to combat stigma and encourage more people to seek the treatment they need. In addition, there is a need for a broader understanding of the variety of treatments available.

[1] Workshop participants defined the terms sex and gender as follows: Sex is a biological construct defined by the organs with which a person is born. Gender is a societal construct that reflects a person's sex as it figures in the context of cultural, family, and social environments.

[2] Murray CJL, Lopez AD, eds. *The global burden of disease and injury series, volume 1: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020.* Cambridge, MA: Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press; 1996.

- **Mental health must be addressed across the life span, from early childhood to the later years.** The types of risk, prevention messages, ways of building resilience, course of disease, and treatments vary according to age, reproductive events, and other life span issues. Thus there is a need for materials and messages adapted to audiences of different ages.

- **There are ways to promote resilience and factors that help prevent mental disorders.** We need to define good mental health and promote prevention. This means building a wider understanding of protective factors that can help girls and women build resilience – including for those who experience mental disorders – and developing effective strategies to translate that knowledge into practice.

- **Culture is an important source of resilience but also of barriers related to the recognition and acceptance of mental health issues.** Girls and women draw great support from cultural connections and identity but also feel the weight of cultural pressures to remain silent about personal issues, not to discuss problems outside the family, or to be strong.

- **Gender must be integrated into disaster training and planning activities.** The lessons of Hurricane Katrina and other large-scale disasters indicate that women are at particular mental health risk due to factors such as family responsibilities, women's higher rates of poverty, their greater risk of depression and anxiety disorders, and their vulnerability to sexual abuse and domestic violence.[3]

- **The importance of trauma, violence, and abuse needs to be recognized by providers, researchers, policymakers, and the general public.** Trauma, violence, and abuse are far more prevalent in the lives of girls and women than commonly thought – and they may lead to serious, long-standing physical ailments, co-occurring conditions, and risky behaviors that, if left unrecognized and untreated, can compromise women's health.

- **Recovery from mental disorders or from the effects of trauma, violence, and abuse is possible.** Following the recommendations of the President's New Freedom Commission, we need to move toward a health care system that is recovery based and consumer focused.

- **Health literacy is a public health and Surgeon General's priority.** It is critical to design communiqués that carry health messages in language that people use and understand. To be culturally competent, materials should be designed with the input and participation of target communities, which may represent diversity in race, ethnicity, age, geographic area, sexual orientation, or health status.

A final message that echoed throughout the meeting was the recognition that women's mental health issues touch everyone, either directly or through the women they love. Recognizing this factor, participants shared an enormous amount of energy, expertise, and commitment to the workshop effort. The rich results of their work are a testament to their substantial and considered contributions.

[3] World Health Organization, *Gender and Health in Natural Disasters.* Geneva, Switzerland; 2005.

Introduction: Background and Purpose of the Workshop

The Surgeon General's Workshop on Women's Mental Health was convened to bring together experts from the consumer, academic, advocacy, health care delivery, health insurance, program planning, and policy planning communities to address critical issues affecting the mental health of women and girls and make recommendations for the production of Surgeon General's communiqués[4] and toolkits. This workshop was part of a broader initiative, the Surgeon General's Women's Mental Health Project, designed to explore sex and gender differences in mental health and gain a better understanding of the role mental health plays in the overall health of our Nation's women and girls. The initiative represents a joint project of the U.S. Department of Health and Human Services (DHHS) Office of the Surgeon General, Office on Women's Health (OWH), Office of Minority Health, National Institute of Mental Health (NIMH), Substance Abuse and Mental Health Services Administration (SAMHSA), and National Institute on Drug Abuse (NIDA).

The Women's Mental Health Project has consisted of several background activities, which have laid the groundwork for this workshop. These have included a concept mapping exercise; key-informant interviews with mental health experts and leaders; facilitated discussions with local providers, consumers, advocates, and decisionmakers; and a targeted literature review. The activities have led to the identification of major mental health issues for girls and women, which are recognized as being both high in importance and in action potential. These myriad issues have been grouped according to eight different cluster areas, encompassing personal, environmental, and health care system-related concerns. The cluster areas include:

- Biological and developmental factors
- Specific mental disorders
- Trauma, violence, and abuse
- Social stress factors and stigma
- Treatment access and insurance
- Identification and intervention issues
- Health system issues
- Protective factors and resilience

Each participant in the Surgeon General's Workshop on Women's Mental Health was assigned to a working group addressing one of these eight topics. Each working group was asked to review and prioritize the issues associated with their cluster area. (Note: A schematic representation of those areas and the issues which fall under them is included in Appendix A). They also were given the charge of developing recommendations for the production of Surgeon General's communiqués and toolkits. For each cluster area, participants were specifically asked to choose three key priority issues to be addressed, describe the key messages, suggest a format for a product or toolkit, identify the audience, and highlight any cultural concerns or other cross-cutting issues.

To set the stage for the workshop discussions, participants were offered several plenary presentations, including a welcome and introduction by U.S. Surgeon General Richard H. Carmona. These presentations underscored the importance of women's mental health not only to their own overall health, but also to the health and well-being of those around them and ultimately of our Nation as a whole. They highlighted the burden of mental disorders on the lives and productivity of individuals

[4] The term "communiqué" was deliberately chosen to represent a broad array of potential products and materials.

and revealed what we have learned about the interplay of sex and gender in the risk, course, and treatment of these disorders.

Participants were invited to become active partners, throughout this meeting and beyond, in the promotion of a mental health system that could address the mental health issues of women with an approach that is more consumer focused, recovery oriented, and focused on integrating all aspects of mental health with mainstream and primary health care.

> "We must truly listen to the stories women tell – turn to women survivors as experts. We must replace the question 'What is wrong with you?' with the question 'What happened to you?'"
>
> *– Rene Andersen*
> *Center on Women, Violence, and Trauma*

Day 1 – Morning Sessions

Welcome, Introductions, and Charge to the Workshop

Wanda K. Jones, Dr.P.H., Deputy Assistant Secretary for Health, DHHS Office on Women's Health, welcomed the meeting participants. She described their task as being to develop recommendations for concrete products and toolkits that could be developed from the Office of the Surgeon General to address key mental health issues affecting women and girls. Dr. Jones explained that each workgroup was comprised of a diverse range of participants (e.g., researchers, advocates, providers, consumers) to ensure that a full range of perspectives would be represented.

Rene Andersen, M.Ed., LCSW, Center on Women, Violence, and Trauma, described her personal and professional experiences with the effects of trauma, violence, and abuse on women and families. She told of her own experience of growing up in a family that appeared to be fun and loving on the outside (the "day stories") but that hid an intergenerational cycle of abuse (the "night stories") filled with cries of despair and terror. Ms. Andersen told how this history led to legacies of depression, addiction, posttraumatic stress, and a host of physical ailments in her life and those of her siblings. She told of being overmedicated and subject to many diagnoses and treatments – all of which overlooked this history of abuse for many years.

Ms. Andersen explained that the experience of trauma is central to the lives of many women and that emotional, physical, and sexual traumas are pervasive. She emphasized that violence is a social disease and not a personal issue. She also stressed the importance of helping the victims of trauma, violence, and abuse to understand that it need be neither unbearable forever nor passed from one generation to the next. Ms. Andersen offered herself as living proof that healing is possible. She noted that there are indeed many "rafts in the river" to offer help and support, including relationships with friends, service providers, recovery groups, and the like.

Everyone knows at least one woman who is a survivor of trauma, commented Ms. Andersen. She suggested that we must turn to women survivors as experts and truly listen to the stories they have to tell. She called for a fundamental shift in diagnosis and treatment founded on the belief that everyone can heal and that the question "What is wrong with you?" should be replaced with the question "What happened to you?"

Ms. Andersen concluded by inviting the audience members to conjure the image of one woman in their lives who has had to survive trauma or mental illness. She asked them to keep that image close at hand during the course of this workshop as a reminder of how closely the issues of mental disorders, trauma, and violence touch everyone directly and through the women they love.

> "I see this work as more than a job. I see it as a tribute to my mother and my grandmother."
>
> *– Richard H. Carmona*
> *U.S. Surgeon General*

Vice Admiral Richard H. Carmona, M.D., M.P.H., FACS, U.S. Surgeon General, shared his experience of being a high school dropout and growing up in an environment of poverty and hardships. He spoke of his grandmother trying to raise her children and grandchildren in Harlem; his father, with no high school education, unable to sustain a life with four children; and a mother trying to instill in her children the value of education and knowledge as a way to escape poverty. The Surgeon General described a childhood living in substandard apartments, being homeless, and moving into the projects with 12 people in a tiny apartment. He talked about the critical roles his mother and grandmother played as the powerful women in his life, who continually battled to sustain their families despite poverty, homelessness, being immigrants, alcohol abuse, and other difficulties. Their continued determination to take care of their families, he explained, taught him about resilience and made him keenly aware of the roles women play in our society.

> "The purpose of this meeting is to bring you all together as parents, providers, scientists, consumers, and so forth to guide the development of these communiqués, whatever they end up being. I welcome the opportunity to argue with you to figure out the right path so that girls and women will say we got it right."
>
> *– Richard H. Carmona*
> *U.S. Surgeon General*

The Surgeon General told of how his mother would say that men have run this world for most of eternity – and are running it into the ground. She would point out that men see the world differently from women and that women tend to be more conciliatory and try to bring people together to resolve problems.

Dr. Carmona turned to the audience of workgroup participants and described their role as the foot soldiers in the battle to address women's mental health and the broader issue of how it fits into their overall health. He recognized the risk they face of being marginalized by other events of the day, but he offered his commitment and support.

Dr. Carmona noted that when he was chosen to be the U.S. Surgeon General, the President described the primary issue to be addressed as that of becoming a Nation that embraces prevention, health, and wellness – because ultimately, we all pay the price for poor health or health care crises. Thus, he explained, prevention and preparedness are the primary areas of focus in the Office of Surgeon General.

In the area of health preparedness, Dr. Carmona stressed the importance of being ready in the face of emerging infectious diseases, such as SARS, mad cow disease, and avian flu, as well as other natural and manmade threats. He pointed to the need to determine how to prepare first responders and other

critical support personnel to be ready to deal with these issues. In addition, he referred to the importance of looking at prevention and preparedness at the household level – where it is almost universally the women who bear the responsibility for taking care of the health of the family, making the health decisions, and being the family health leaders.

The Surgeon General also discussed the importance of the issue of health disparities – noting that he has had personal experience with these disparities and knows firsthand what it is like not to go to the doctor for years. He underscored the need not to lose sight of the fact that ours is still a nation divided as it relates to race and health. We should be outraged, he suggested, to be living in the greatest nation in the world but one where not everyone has the same health care access and outcomes.

> "Those of you taking part in this workshop, you are the foot soldiers. You run the risk every day of being marginalized by the events of the day, but I'll be right with you. My commitment is 110 percent."
>
> *– Richard H. Carmona*
> *U.S. Surgeon General*

Dr. Carmona pointed out that we need a common currency and language to reach into the streets, into the "hood", or among the ranks – and that often those we most need to reach are the ones furthest away from us. He stressed the need to understand that cultural competence is about more than just finding a translator – and that we must figure out ways to translate the great advances we have from science into packages that can reach people. One key factor in this area, he noted, is health literacy – the need to communicate with a language and at a level that people can understand. This is why, explained Dr. Carmona, every time a Surgeon General's Report is published there is also an accompanying "People's Piece" publication that takes the key messages and information from the report and presents it in a clear manner, written at a sixth-grade reading level.

The reason for convening this workshop, noted the Surgeon General, is to help guide the development of any document or materials to come out of the Surgeon General's Women's Mental Health Project. Dr. Carmona specified that he felt these recommendations needed to come from the ground up – from the sample of parents, consumers, policymakers, advocates, providers, scientists, and others represented at the meeting. The Surgeon General said that he welcomed the opportunity to face arguments and disagreements – to figure out the right path ultimately and come out of this together.

Dr. Carmona concluded by re-emphasizing his personal commitment to this project and the important work of this Surgeon General's Workshop on Women's Mental Health.

About the Surgeon General's Women's Mental Health Project

Wanda K. Jones, Dr.P.H., Deputy Assistant Secretary for Health, OWH, gave a slide presentation providing the background of the Surgeon General's Project on Women's Mental Health to help set the context for this workshop. Dr. Jones began by pointing out the long history of supporting reports and documents, starting with the publication of *Mental Health: A Report of the Surgeon General* in 1999, which laid the scientific groundwork for this project. Subsequent supporting documents include:

- *The Surgeon General's Call To Action To Prevent Suicide* (1999)

- *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* (2000)
- *Mental Health: Culture, Race, and Ethnicity*, a supplement to *Mental Health: A Report of the Surgeon General* (2001)
- *Youth Violence: A Report of the Surgeon General* (2001)
- *Achieving the Promise: Transforming Mental Health Care in America* (2003), from the President's New Freedom Commission on Mental Health

She specified the project's four main objectives. The first three include identifying the critical issues affecting the mental health of women and girls, assessing the state of the science, and developing a framework for a long-term strategy to address the issues. The fourth objective is the one most directly related to this workshop, namely to develop additional supporting endeavors and products to increase awareness and activity related to these critical issues.

Dr. Jones described in more detail the background activities of the Surgeon General's Women's Mental Health Project that were undertaken to begin to address the project objectives and lay the groundwork for this workshop. The first of these, she explained, consisted of a concept mapping activity designed to define women's mental health and develop a conceptual framework for addressing the issues that affect the mental health of women and girls. It involved 245 participants representing experts and communities of interest who responded to this statement: "A specific issue that is relevant to the mental health of women and girls is…." Dr. Jones noted that this activity generated 107 issues, which were then rated according to their level of importance and their potential for action.

The next step, she explained, involved the development of cluster areas grouping these different issues according to common themes, which were in turn organized to create a conceptual framework. That framework encompasses individual, environmental, and systemic issues affecting women's and girls' mental health. Because of the central importance ascribed to protective and resilience factors by respondents, these were placed at the center of the framework. The conceptual framework was further refined during the process of two additional background activities. These included a set of leadership interviews with 25 high-level individuals representing governmental, provider, and consumer organizations along with a series of facilitated discussions in three cities with diverse groups of consumers, providers, and the local government staff. The resulting framework is presented below. A more detailed version that lists the specific issues associated with each cluster area is included in Appendix A.

Conceptual Framework of Issues Affecting the Mental Health of Women and Girls

When the eight cluster area topics emerging from this framework were cross-walked with the 1999 document, *Mental Health: A*

Report of the Surgeon General, explained Dr. Jones, there were clear differences in identified priorities, particularly in the research base. While issues such as sex and gender differences in specific mental disorders or developmental factors were referenced in the Surgeon General's Report, others such as "trauma, violence, and abuse" or "resilience and protective factors" barely appeared at all – reflecting the lack of research evidence on these important topics at the time.

The Surgeon General's Women's Mental Health Project's targeted literature review and other background activities revealed several changes or developments since the publication of the 1999 report. Regarding sex and gender differences, noted Dr. Jones, there is a growing body of evidence to increase our understanding of the significant sex and gender differences in the risks, prevention, diagnosis, course, and treatment of mental illness. She added that we clearly need to address these differences not only in research but also in social policies and in the training of health providers.

Another major area that has received significantly more research attention in recent years, said Dr. Jones, is the importance and prevalence of trauma, violence, and abuse in the lives of girls and women. She referenced a new World Health Organization (WHO) study that looks at this issue and its long-term impacts worldwide.[5] Dr. Jones also noted that this evidence further underscores the fact that women need to be screened routinely for trauma, violence, and abuse as part of their regular health care.

One of the important cross-cutting issues to emerge throughout the background activities was the importance of cultural differences and disparities. The issues of culture, race, and ethnicity clearly cut across all of the areas of the conceptual framework, explained Dr. Jones, but the scientific literature is sparse. She mentioned recent research that investigates both the protective factors of culture and potentially deleterious effects of acculturation – suggesting that culture may weigh more heavily than race or ethnicity in terms of our attitudes and behaviors regarding mental health and mental disorders.

Yet another issue to come up consistently and in a cross-cutting way is stigma that keeps families in denial and keeps individuals from seeking care, said Dr. Jones. She pointed to the need for continued education and outreach to providers, to women and girls, and to the general public.

Regarding the issue of resilience and protective factors, Dr. Jones noted that this was clearly a critical topic, in which there is so much more we need to know regarding both protective factors and successful prevention-focused activities.

Dr. Jones concluded that with the combination of the science base, these background activities, and the input from the members of this workshop, we have the potential to create an array of new products. These have been identified as Surgeon General's communiqués – a term intentionally chosen to be broad to reflect the wide array of possibilities. Dr. Jones also pointed out that the term brings together both the words "communications" and "unique." She presented this as a challenge to the workshop participants to debate, discuss, and craft creative ideas for ways we can communicate important issues affecting the mental health and long-term wellness of our Nation's women and girls.

[5] World Health Organization. *WHO Multi-country Study on Women's Health and Domestic Violence Against Women.* Geneva, Switzerland; 2005.

The State of Women's Mental Health – What We've Learned

Richard Nakamura, Ph.D., Deputy Director, NIMH, presented the scientific perspective on the status of what we have learned about women's mental health. Dr. Nakamura emphasized that while critical, research is only part of the picture, and the side that affects individuals on a personal level is equally important. Thus, he noted, the NIMH and the Center for Mental Health Services (CMHS) play complementary roles, with NIMH providing the research piece and CMHS providing the direct service that is informed by the research.

"We are challenging you to help us devise ideas for new Surgeon General communiqués – a word that appropriately combines 'communications' and 'unique'. I invite you to meet that challenge here."

– Wanda K. Jones
Deputy Assistant Secretary for Health
DHHS Office on Women's Health

The mission of NIMH is to address the burden of mental health through research, explained Dr. Nakamura. He noted that worldwide, this burden is considerable, according to data from WHO and World Bank, and it is expected to increase. For example, the data show that within developed countries, major depression is second only to heart disease as the leading source of disease burden, and for women, it is already the number one cause of disease burden. Schizophrenia and bipolar disorder are also among the top 10 causes of Disability-Adjusted Life Years (DALYs). Depression, alcohol and substance abuse, and self-inflicted injury also constitute major causes of disability – and taken together, mental disorders account for nearly one-quarter of the total disease burden in the United States.

"Why focus on women's mental health? Because sex matters!"

– Richard Nakamura
Deputy Director
National Institute of Mental Health
National Institutes of Health

Dr. Nakamura explained that though we commonly speak of the disability burden associated with mental disorders, there is also an important elevated risk of death as well. For example, he noted that 90 percent of individuals who commit suicide have had a mental disorder – and we know that women are four times more likely than men to attempt suicide, though less likely to die from the attempt. This says much about the level of pain and hopelessness these disorders can bring.

Dr. Nakamura then turned his attention to one of the fundamental questions of this workshop; namely, "Why focus on women's mental health?" His simple response was, "Because sex matters!" Dr. Nakamura elaborated on this point and offered a more detailed presentation of the interplay among sex, gender, and mental health issues. His presentation highlighted the following points:

- There are considerable differences in the **sex ratios** for selected mental disorders, with women having much higher rates of disorders such as major depressive disorder, anxiety disorders, posttraumatic stress disorder, and eating disorders.

- There are important **biological differences** related to hormones and brain structure that may affect mental health risks, rates of disorders, and the course of those disorders. For example, research has demonstrated that estrogen and progesterone influence brain function and stress response. These findings are interesting given that at

puberty, the female-to-male ratio for depression rises from 1:1 to 2:1. Some women also experience increased vulnerability to depression during times of reproductive endocrine changes, such as the premenstrual, postpartum, and perimenopausal periods. There also are sex-based differences in the size and structure of the human brain. Men's brains are larger than women's. Women's brains are lighter but more complex, with proportionately larger frontal lobes (attributed to executive functions such as judgment, language, memory, problem solving, and socialization).[6]

"The continued, effective integration of women and diversity in academic medicine and research is essential for ensuring that the research base reflects gender, racial, ethnic, and cultural diversity – not only regarding research topics but also in the interpretation of the findings."

– Richard Nakamura
Deputy Director
National Institute of Mental Health
National Institutes of Health

• Clearly **environmental factors** play a significant role in the risk and prevalence of certain mental disorders. Environmental factors may include both **artifact** (e.g., women may be more likely than men to seek treatment, there may be diagnosis bias) and **psychosocial factors** (e.g., gender socialization, gender roles, lower social status, reaction to social cues, experiences of abuse, gender-related differences in coping mechanisms).

• There is important **overlap** between biological and environmental factors, although the interplay between the two is complex. For example, in the gene that codes for the serotonin transporter, individuals with a short version of that gene seem to have a greater vulnerability to the deleterious effects of a history of maltreatment than do those with a longer version of that gene.

• There is clearly much still to be learned about **social and protective factors** that affect mental health, including the effects of race, ethnicity, and culture. For example, while we see that the overall ratio of female-to-male rates of depression is 2:1, there are enormous differences in range. Rates of depression are higher among Hispanic and Caucasian women compared with African-American women. Similarly, there are considerable differences among women in rates of attempted suicide. Although women are more likely on average to attempt suicide than men, the rates of suicide attempts in African-American women are very low. These differences lead us to wonder if there are social or protective factors at play and underscore the fact that we need to understand more fully what happens with groups that do well.

• New science is rapidly changing our understanding of **lifetime and intergenerational cycles** affecting mental health – and the extent to which environmental manipulations can lead to positive changes. For example, recent evidence shows that when a mother rat licks and grooms her pups, it actually changes their brain function and affects how they themselves parent, producing pups that are better parents.[7] This is supported by other studies that suggest that environmental

[6] Rabinowicz T., Dean D.E., Petetot J.M., de Courten-Myers G.M. Gender differences in the human cerebral cortex: more neurons in males; more processes in females. *J Child Neurol.* 1999 Feb; 14(2):98-107.

[7] Weaver ICG, Cervoni N, Champagne FA, d'Alessio AC, Sharma S, Seckl JR, Dymov S, Szyf M, Meaney MJ. Epigenetic programming by maternal behavior. *Nature Neuroscience.* August 2004;7(8):847–854.

enrichments can change the brain and have long-term, intergenerational effects – potentially through epigenetic effects.

Dr. Nakamura concluded his presentation by pointing to the continued need to integrate more women and diversity effectively into academic medicine and scientific research. He pointed to the slow growth of women in academic medicine – representing one-fourth of medical faculty members in 1995 and one-third today, and still highly underrepresented among associate and full professors in academic medical institutions. Dr. Nakamura emphasized that greater participation of women, including women of color, is necessary to ensure that the research base reflects gender, racial, ethnic, and cultural diversity not only in the types of topics that are being researched but also in the interpretation of the findings.

Like the presenters before him, Dr. Nakamura noted that women's mental health issues have a personal side that touches every family. He dedicated his thoughts from this meeting to an aunt, who was subjected to a frontal lobotomy during the 1950s as a treatment for her bipolar disorder – and shared the hope with the workshop participants that the continued work of this group and others will ensure that no one will go through that experience ever again.

A. Kathryn Power, M.Ed., Director, Center for Mental Health Services, SAMHSA told the workshop participants that it is time to change the way we think about, develop, and deliver mental health services. Ms. Power emphasized that the knowledge exists now to make real headway toward the goal of helping women and girls achieve holistic lives of greater self-determination, power, and self-dignity. She argued that we know from the evidence that recovery is possible and that with the right treatments and supports, recovery can be the expected outcome for every woman and girl in America living with mental health conditions.

In order to promote recovery, she added, it is imperative that the woman herself become the director of her own treatment, since only she knows the truth about the conditions of her life. It also becomes imperative that we move from a model focused on illness, acute treatment and symptom mitigation to one that is recovery-focused and strengths-based, since virtually all behavioral health conditions will require environmental or lifestyle changes as well as biological treatments.

Our current mental health services system, Ms. Power argued, has neglected to incorporate respect for and understanding of the unique histories, beliefs, attitudes, and value systems of culturally diverse populations. Our efforts to bring all of the relevant health and human service components to the table to address the totality of women's health have been haphazard at best – and clouded by stigma and discrimination.

> "It's time we harness the power of these [scientific] discoveries to offer new hope in both treatment and prevention for women and girls. We have the tools. It's time to put them to use!"
>
> *– A. Kathryn Power*
> *Director*
> *Center for Mental Health Services*
> *SAMHSA*

Ms. Power called for an integrated, holistic approach to mental health services that cares for the whole woman. She described this approach as including such things as making routine use of self-administered depression screening tools at primary care clinics, in OB/GYN offices, by breast cancer specialists, and in prenatal and birthing centers to address unrecognized and

untreated depression. Ms. Power also noted that in order to take care of the whole woman it is important to take care of her children and to help keep them from getting caught in a cycle of mental illness themselves. She said that a comprehensive, family-based approach to prevention works. She also noted that there are promising treatment strategies for eating disorders that use cognitive behavior therapy methods and involve family members.

Ms. Power also brought up the need to improve systems of care for women in our nation's jails and prisons, including effective interventions around parenting and child custody issues; services for pregnant inmates; and services and supports to resolve mental health issues related to victimization and violence.

"What do we know about trauma interventions? We know that multi-target, multi-modal treatment approaches and coordinated community responses have had the most positive impacts."

– A. Kathryn Power
Director
Center for Mental Health Services
SAMHSA

As the Director of CMHS, Ms. Power explained that one of her personal and professional priorities is to open the Nation's eyes to the impacts of trauma on women's lives and to the power of recovery. Through the work of its National Center on Women, Violence, and Trauma, SAMHSA is developing leadership networks to spread information about emerging best practices and to stimulate local change. In FY 2006, the CMHS Women's Coordinating Committee – a group charged with promoting the importance of health issues of women across SAMHSA – is planning a series of activities, including trainings focused on the integration of trauma-informed services in public health facilities. CMHS is making a major investment of resources in the issue of women and trauma, explained Ms. Power. CMHS's groundbreaking Women and Violence Study is a shining example.

Ms. Power also cited the Kaiser Permanente/CDC-sponsored Adverse Childhood Experiences (ACE) Study, which provides strong evidence of a causal link between violence-induced neurological damage, the use of self-medicating measures, the adoption of health risk behaviors, and consequent chronic disabling health morbidity and early mortality.[8] She noted that the ACE Study is just one example of the substantial body of research investigating the impacts of trauma, particularly on women. Ms. Power emphasized that what we have learned about the pervasive lifelong impacts of violence and trauma in women and children brings urgency to our need to act now.

She supported that statement by offering the following highlights about what is known regarding the impact of trauma:

- Trauma is no longer regarded as an anomalous experience. It is increasingly seen as a widely prevalent experience of public mental health and human service recipients.[9]
- Addressing trauma is increasingly recognized as essential for recovery for other mental health disorders such as substance abuse. Improvement in symptoms such as depression and

[8] Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) study. *Am J Prev Med.* 1998;14:245.

[9] Tjaden P, Thoennes N. *Extent, nature, and consequences of intimate partner violence: findings from the National Violence Against Women Survey.* Washington: National Institute of Justice and Centers for Disease Control and Prevention; 2000. NCJ 181867.

substance-use disorders will not occur without integrating a focus on an underlying history of trauma.[10]

- A recovery-oriented system is not possible if we do not integrate trauma into mental health services.
- The failure to address trauma results in major and costly human service systems failures, such as seclusion and restraint, self-injury in adult criminal and juvenile justice, repeated failures to maintain housing or employment, heavy use of health care services, and suicide.
- Childhood physical and sexual abuse may lead to harmful coping strategies such as dissociation, self-injury, eating disorders, running away, and substance use that may delay development and create a legacy of lifetime disabilities associated with chronic mental health problems, addictions, and major health problems.
- The intergenerational and historical costs of trauma are being increasingly recognized.
- "Treatment as usual" that does not address trauma results in spiraling costs, lack of reduction in symptoms and misery, and continued cynicism regarding recovery on the part of consumers.

Ms. Power went on to discuss effective interventions for trauma. She noted that multi-target, multi-modal treatment approaches and coordinated community responses have had the most positive impacts. She explained that SAMHSA sponsored a five-year Women and Violence Study, which has provided the most authoritative and comprehensive view to date of what can be accomplished in the public health system with women who have histories of physical and sexual abuse, who are in need of services for both mental health and substance-use disorders. She explained that this groundbreaking study featured a trauma-integrated counseling approach that addressed both mental health and substance-use conditions. Findings suggest that integrated counseling (e.g. group and individual therapy that addressed trauma, mental health, and substance-use disorders issues) was the key element associated with better outcomes, which improved significantly over a 12-month period.

> "The Report from the President's New Freedom Commission on Mental Health challenges us to change the way this nation thinks about, delivers, and finances mental health care. It calls on us to create a new, recovery-oriented national mental health system that meets the needs of every American living with mental illness."
>
> *A. Kathryn Power*
> *Director*
> *Center for Mental Health Services*
> *SAMHSA*

Citing the findings and recommendations of *Achieving the Promise: Transforming Mental Healthcare in America*, the landmark final Report of the President's New Freedom Commission on Mental Health, Ms. Power said that she saw our Nation as being on the cusp of a new evolution in mental health services. *Achieving the Promise*, she explained, calls for the creation of a new, recovery-oriented national mental health system that meets the needs of every American living with mental illnesses.

Ms. Power warned, however, that this change will require true transformation – a revolution, as she described it, in how we do things, how we think, and how we work together. She commented that with this type of change, new sources of power emerge

[10] Rosenberg SD, Mueser KT, Friedman MJ, Gorman PG, Drake RE, Vidaver RM, Torrey WC, Jankowski MK. Developing Effective Treatments for Posttraumatic Disorders Among People With Severe Mental Illness. *Psychiatr Serv* 2001;52:1453-1461.

that create a profoundly different system that is changed in structure, culture, policy, and programs.

Embedded in transformation is the core belief in recovery and the belief that adults with mental illnesses can take charge of their own lives, their own wellness, and their own care, said Ms. Power. It is the belief that systems should help children and their families build on existing strengths, foster resilience, and create promising futures.

She described her vision of a transformed mental health system as one in which:

- Services for women and girls will recognize the complex linkages between biology and environment and the role of violence and poverty in health conditions – and new treatments will grow out of this recognition.
- Culturally relevant, strengths-based approaches, which encompass creativity and spirituality and address the unique needs of refugees and immigrants, will be commonplace.
- The power of technology will be tapped to connect women to, and educate them about, the wealth of effective recovery-focused services that are available to them.

Cooperation and collaboration, noted Ms. Power, are the lifeblood of transformation. She asked the workshop participants at the local, State, and national level to act and to advocate for the comprehensive, coordinated, consumer-centered mental health system that will give women, and all Americans, access to the full range of services they need to recover.

In closing, Ms. Power quoted the American-born Buddhist nun, Pema Chödrön, "Now is the only time. What we do accumulates. The future is the result of what we do right now." She called on participants to act, one person, one program, one community at a time, so that those actions do accumulate and lead to a point when recovery is the expected outcome for all. She challenged them to seize this moment rife with promise and use the power of it to transform the lives and future of millions of Americans.

Cheryl Bowers-Stephens, M.D., M.B.A., Assistant Secretary for the Office of Mental Health, Louisiana Department of Health and Hospitals, described her experience of leading a mental health care system impacted by a severe natural disaster. She noted in her presentation that she was speaking not only as a person in charge of mental health for the State of Louisiana but also as a wife, with a husband who is Director of Health for the city of New Orleans, and as a mother. Through the lens of each of these perspectives, Dr. Bowers-Stephens shared the story and lessons of trying to meet mental health needs in Louisiana before and following Hurricane Katrina.

Prior to the hurricane, Dr. Bowers-Stephens explained, she and others had been planning strategic objectives for transforming the State mental health system to address more fully the need for mental health services. Pre-Katrina State figures indicated that of Louisiana's 4.5 million people, more than 900,000 were estimated to have a mental disorder – including nearly 180,000 adults and 65,000–77,000 children with a serious mental illness. Of these, only 46,000 were being served by the State Office of Mental Health. Thus, even before the storm, there was a great unmet need for mental health services.

With warnings that the storm was on its way, the Office of Mental Health acted to evacuate psychiatric units and hospitals, said Dr. Bowers-Stephens. She noted that though the public heard mainly about those left behind in New Orleans, it is important to understand that 1.5 million people were evacuated from the city through a huge and

largely successful effort. The Office of Mental Health disaster preparedness had included disaster response drills, evaluation plans, disaster training for employees, and a staff callout registry. Prior to and during the storm, multiple command centers were activated; mobile crisis teams and call centers were put into place; Southeast Louisiana State Hospital, Charity Hospital Acute Unit, and New Orleans Adolescent Hospital were evacuated to other systems in eastern and central Louisiana; and special-needs shelters were activated across the State.

Dr. Bowers-Stephens reminded the workshop participants that Hurricane Katrina was the most destructive natural disaster in U.S. history. As a category IV storm with winds of nearly 150 miles per hour, it ripped apart homes, destroyed infrastructure, and toppled hundred-year-old trees like saplings. This was followed by a storm surge of nearly 30 feet, which caused levees to give way and sent people scrambling to rooftops and attics in desperate attempts to avoid the rising water. New Orleans and cities and towns across eastern Louisiana were devastated.

"Women should be considered as a special-need or vulnerable group during periods of disaster. Gender role differences and power differentials between men and women must be integrated into disaster preparedness training and planning activities."

– Cheryl Bower-Stephens
Assistant Secretary
Office of Mental Health
Louisiana Department of Health and Hospitals

The impact of Katrina on the State's mental health system was enormous and far reaching, and Dr. Bowers-Stephens presented some numbers to illustrate its severity. She noted the following:

- An estimated 3.2 million individuals were in need of crisis counseling services.
- More than 1 million registrations were submitted for Federal Emergency Management Agency assistance through local parishes.
- Among those moderately exposed to the destruction, estimates are that 5–10 percent will experience clinically significant mental health issues and an additional 5–10 percent will experience subclinical issues that still will require support.
- Among those in severely exposed communities, an estimated 25–30 percent of the population can be expected to experience clinically significant issues, with an additional 10–20 percent experiencing subclinical ones.

While these numbers are significant, Dr. Bowers-Stephens explained that the impact of Hurricane Katrina was particularly severe for women. She noted that research on gender and natural disasters has found that women are more vulnerable than men in these situations and indeed should be considered a "special population." This is due to a host of historical, social, cultural, and societal factors, such as domestic and economic burdens, lower incomes, lower social status, male flight, and increased risk of violence and abuse. In addition, women face an interaction of biologic and social risk factors, such as a higher baseline prevalence of depression and the risk of adverse reproductive events (e.g., there were numerous premature deliveries during and after Katrina).

Dr. Bowers-Stephens pointed out that the research evidence was indeed confirmed in the case of Katrina and its aftermath, where women were left behind by men to take care of the family, meet immediate survival needs, and face the risks of disorganization and increased violence that characterized the

post-storm situation in New Orleans. Dr. Bowers-Stephens noted that with her husband immediately called to the Superdome, she herself was left to make the family decisions regarding where to evacuate with their three children to meet both her family and professional responsibilities.

Dr. Bowers-Stephens highlighted the fact that there are many important lessons that should be drawn from the experiences of Hurricane Katrina in terms of emergency planning and preparedness. Specifically, she offered the following recommendations:

- Anticipate postdisaster male flight in disaster preplanning, including first responder support. Ensure that there are special supports for women and families (e.g., there were no schools or day care on the cruise ships supplied for evacuees in New Orleans).
- Ensure that specific structures, policies, and procedures are put into place to address postdisaster domestic violence and sexual assault prevention and intervention.
- Institute policies to support the care of children. More than 1,000 children were listed as missing after Katrina and many were separated from their families. Predisaster planning must address the need to prevent family separations and lost children.
- Teach families to be prepared. Incorporate messages into public health policies and messages about the importance of making emergency plans as a family before disaster hits.

Dr. Bowers-Stephens concluded by noting that the lessons of Hurricane Katrina must serve as a timely reminder of the critical need to incorporate gender into emergency preparedness planning and training.

Breakout Group Sessions

Each participant in the Surgeon General's Women's Mental Health Workshop was assigned to one of eight workgroups. The basis for these assignments was not associated with individual specialties or areas of interest; rather, it was designed to ensure diversity and even numbers across each of the workgroup topic areas. These topic areas reflected the eight "cluster areas" identified through the series of background activities leading up to the workshop. As described above, these activities included a concept mapping exercise, key-informant interviews, facilitated discussions, and a targeted literature review. The breakdown of the eight workgroups was as follows:

Group 1: Biological and developmental factors

Group 2: Specific mental disorders

Group 3: Trauma, violence, and abuse

Group 4: Social stress factors and stigma

Group 5: Identification and intervention issues

Group 6: Treatment, access, and insurance

Group 7: Health systems issues

Group 8: Protective and resilience factors

The workgroups were given the task of addressing three major objectives. These included:

- **Objective 1:** Review and prioritize the significant issues affecting the mental health of women and girls within the identified cluster area.

- **Objective 2:** Develop practical recommendations for the production of communiqués and toolkits related to the issues of that cluster area.

- **Objective 3:** Prepare a series of PowerPoint slides highlighting three key priority issues from the cluster area. In addition, for each key priority issue identify the major messages, suggested format, target audience, dissemination strategy, funding sources, and any overarching cultural concerns to be taken into consideration.

Each workgroup was composed of 12–14 participants and facilitated by two individuals, including one Federal representative and one expert from the field. The facilitators conducted introductions, reviewed the workgroup objectives, and conducted a prioritization exercise to determine the highest priority issues within their cluster area. A list of potential communiqués and toolkits, based on recommendations from the background leadership interviews and facilitated discussions, was distributed to the workgroup members to spur ideas and discussions. This list is included in Appendix B.

Workgroup 1: Biological and Developmental Factors At-A-Glance

Priorities

1. Understanding the biobehavioral bases for sex and gender differences as related to mental health
2. Taking a life span approach to mental health – understanding sex and gender differences in etiology, course, and high-risk periods
3. Understanding male and female differences in biobehavioral response to psychotherapeutic and behavioral mental health treatment (including side effects, efficacy, and compliance)

Messages

- Biobehavioral factors underlie sex and gender differences in the way people think and feel.
- Biobehavioral differences between men and women are known through a small but growing body of research.
- Greater knowledge will enhance our capacity to understand the etiology, prevention and treatment of mental health disorders and inform gender-based prevention and treatment strategies.
- Early puberty is a high-risk period for specific mental disorders (for adolescent audiences).
- Research shows that important events and times in a woman's or girl's life increase the likelihood of developing a mental disorder. Gender-specific prevention and treatments targeted to specific events across the life span are more effective.
- Interventions may have different effects on men and women with selected mental health conditions. Women should be aware that a variety of treatments are available and should be encouraged to pursue the ones that best meet their needs.

Products

Fact sheets on sex and gender differences, lists of organizations, summary of scholarly articles, Web sites, TV messages, age-specific videos, and pamphlets

Workgroup 1: Biological and Development Factors

The Biological and Developmental Factors Breakout Group was given the list of issues to prioritize indicated in the following box.

Issues to Prioritize

1. Understanding basic neurological sex differences
2. The need for increased effort to relate biological and genetic mental health research to sex and gender differences in the prevalence and course of mental disorders
3. Sex and gender differences in treatment response (both efficacy and side effects)
4. Factors contributing to the emergence of sex and gender differences in mental disorders in adolescents
5. Sex and gender differences and the effects of psychotherapeutic medications
6. The neurobiology and psychology of sex and gender differences in social behavior and attachment
7. Understanding the biological bases of normative sex and gender differences
8. How the developmental phases of young females affect their mental health status as women

Defining sex and gender

The group began with a discussion of the distinctions between sex and gender, leading to the following definitions: Sex is a biological construct defined by the organs with which a person is born. It changes little over time or across different cultures. In contrast, gender is a societal construct that reflects a person's sex as it figures in a context of culture, family, and social environment.

It was noted that these definitions are further complicated by the need to incorporate lesbian, gay, bisexual, and transgender (LGBT) concerns.

The role of biology versus environment

A major point of discussion for the group was the role of biology and the question of whether biology should be viewed separately or within a social context. The point was made that biological factors often unfold in a way that is influenced by the environment. However, as one researcher noted, some mental illnesses are responsive to medical treatment, so that the role of biology cannot be ruled out – especially since much information has been gained through studies and clinical trials on the role of biology. This raises the issue, which constitutes an ongoing debate between scientists and advocates, regarding who should be the source of expertise.

Taking a life span approach

It was noted that while the morning workshop presentations had focused on adults there also is a need to understand and transmit the message that women and girls are not the same. The importance of looking across the continuum of women's lives and taking a life span approach to mental health issues was highlighted. Workgroup members also commented on the importance of acknowledging that there are critical high-risk periods during a woman's life when mental disorders are more likely to occur. This concept of a life span approach was threaded throughout the workgroup's discussions and ultimately was identified as a priority issue.

Following this discussion, the group was able to synthesize and redefine three priorities from the eight under consideration. Their resulting key priorities are listed below.

Key Priorities: Workgroup 1
Biological and Developmental Factors

1. Understanding the biobehavioral bases for sex and gender differences as related to mental health
2. Taking a life span approach to mental health – understanding sex and gender differences in etiology, course, and high-risk periods
3. Understanding male and female differences in biobehavioral response to psychotherapeutic and behavioral mental health treatment (including side effects, efficacy, and compliance)

Key Priority #1: Understanding the biobehavioral bases of sex and gender differences as related to mental health

Discussion

It was suggested that there is a dearth of research regarding sex and gender differences in the brain and that the brain must be understood before addressing environmental factors. The group discussed the need for a clear understanding of cognitive processes, emotions, and interpersonal functioning.

Audiences

Participants discussed the need to address several different audiences, including the medical research community, the general public, and policymakers. One suggestion was that messages targeting policymakers also could be put into language for the general public. There also was discussion about targeting specific audiences within the general population, such as families, teachers, and researchers. In the end, the group agreed to target two primary groups comprised of:

- The general public
- A combination of policymakers, research funders, providers, and trainers

> "Clinical experience is an essential part of evidence-based practices. What is lacking now is an understanding of the full scope of the existing evidence base. There is a tension between clinical and empirical data. The clinical data on biological differences may be stronger than most suspect, even if there is a shortage of empirical data."
>
> *– Breakout group member*

Messages

The group crafted several messages, adapted to different target audiences. These include the following:

Message to the general public

Biobehavioral factors underlie sex and gender differences in the way people think and feel.

The point was made that the sex and gender differences referred to in the above message would have to be further specified and demonstrated.

Message to policymakers

Biobehavioral differences between men and women are known through a small but growing body of research. Greater knowledge will enhance our capacity to understand the etiology, treatment, and prevention of mental health issues and to inform sex and gender based prevention and treatment efforts.

Message for all audiences

Greater knowledge will enhance our capacity to understand the etiology, prevention, and treatment of mental health disorders and to inform sex and gender based prevention and treatment strategies.

Formats

The group's recommended formats included:

- A report including facts and implications of sex and gender differences that also would include a list of organizations supporting sex and gender specific treatment and awareness
- A pamphlet, which would accompany the report and include empirical data on selected mental health conditions for ethnic minorities and underserved populations

Cultural Concerns

Participants noted the importance of having providers, the general public, and trainers understand that mental health symptoms manifest differently for ethnic minorities. Gaps in care for minorities need to be addressed as well, it was argued, though there is concern that the existing data are uneven. One participant shared the information that several fact sheets already exist on the topic and can be obtained through the Society for Women's Health Research.

Key Priority #2: Taking a life span approach to understanding sex and gender differences in the etiology, course, and high-risk periods of mental health conditions

Discussion

One participant emphasized the importance of examining the ways in which different periods in a woman's life affect her mental health; another added that mental health problems carry different economic, social, and personal costs at various points of the life span. The point was also made that there are sex and gender differences in the etiology, course, and high-risk periods of mental health conditions over a life span.

It also was noted that taking a sex and gender based approach to mental health can be beneficial to both men and women, including understanding more about what causes mental health problems at different times in a person's life.

Audiences

The group worked to identify key periods of the life span, which deserve special attention regarding mental health concerns. Members agreed that in tailoring the message across the life span, the following audiences should be targeted:

- Adolescents
- Postpartum mothers
- Parents
- Caregivers
- Researchers
- Policymakers
- Providers

Messages

The group crafted several messages, adapted to different target audiences. These include the following:

Message to the adolescent audience

Early puberty is a high-risk period for specific mental disorders.

Message for all audiences

Research shows that important events and times of a woman's or girl's life increase the likelihood of developing a mental disorder. Sex and gender specific prevention and treatments targeted to specific events across the life span are more effective.

Formats

The group brainstormed about ways to reach the various age-group audiences. One participant emphasized the importance of bringing the message to the audience, rather than expecting the audience to request a Surgeon General publication. Suggested potential venues for reaching different audiences included:

- Web sites
- MTV and informational programming concerning emotional crises
- Public service announcements that could be delivered through community centers and churches, especially targeting adult women
- 1-800 phone numbers

Cultural Concerns

Participants noted that any materials produced should be translated into multiple languages. Furthermore, they recommended that the message should consider and incorporate cultural concerns and mores and be disseminated in age and culturally appropriate settings.

Key Priority #3: Understanding male and female differences in biobehavioral response to psychotherapeutic and behavioral mental health treatment (including efficacy, side effects, and compliance)

Discussion

Participants noted that there are new treatment models that are person centered and others based on a social model of disability. It is important, they commented, for the general public to know that treatment models are transitioning; women have the right to multiple options and should assert themselves when it comes to their own treatment.

Further points that were raised on this topic included the following:

- There are multiple treatment options, and it is important to understand that what works best for women might differ from what works best for men.
- There are limited data suggesting that the response to a given treatment may differ among men and women. More research is needed that is not merely secondary analysis.
- There are choices for treatment that allow consumers to pursue different options if a particular treatment is not working. Having options is empowering to the consumer.
- An important takeaway is that there are a variety of treatments available that may or may not be influenced by sex and gender.

The group worked to identify health issues germane to women that should be considered when receiving mental health treatment. Their list included:

- The menstrual cycle
- Menopause
- Medications
- Pregnancy
- Age-related hormonal fluctuations

Audiences

For issues related to sex and gender differences, the group identified the following audiences:

- Educators
- Researchers
- Members of the general public
- Providers – with special emphasis being placed on mental health providers

Messages

The group crafted one message for all audiences:

> There is evidence that interventions may have different effects on men and women with selected mental health conditions. Women should be aware that a variety of treatments are available and should be encouraged to pursue the ones that best meet their needs.

Formats

The workgroup identified the following channels for disseminating the message:

- Following the BodyWise Model (developed by OWH) – producing and adjusting a two-page fact sheet to target specific audiences
- Using the 4-Women Web site (developed and maintained by OWH)
- Listservs
- Information Clearinghouse – developing a high-level, government-supported

clearinghouse of information that the public could access.

Cross-cutting cultural concerns

In formatting the message, the group discussed how to incorporate culturally sensitive and accurate material. They recognized that cultural attitudes may cause shame and associate stigma with mental illness. There was agreement that the message should include information regarding different ethnicities' responses to treatment and incorporate and validate the use of alternative healing methods.

Workgroup 1 Participants

Facilitators

Cora Wetherington, Ph.D., National Institute on Drug Abuse

Kimberly Yonkers, M.D., Yale University School of Medicine

Participants

Cheryl Bowers-Stephens, M.D., M.B.A., Louisiana Department of Health and Hospitals

Sylvia Caras, People Who

Nereida Correa, M.D., Albert Einstein College of Medicine

Mary Gee, B.A., Eating Disorders Coalition for Research Policy and Action

Melva Green, M.D., American Psychiatric Association

Phyllis Greenberger, M.S.W., Society for Women's Health Research

Gail Hutchings, M.P.A., SAMHSA

Nadine Kaslow, Ph.D., Emory University School of Medicine

Ruby Martinez, R.N., National Latino Behavioral Health Association

Caroline Mazure, Ph.D., Yale University School of Medicine

Richard Nakamura, Ph.D., National Institute of Mental Health

Eileen Ouellette, M.D., J.D., FAAP, American Academy of Pediatrics

Workgroup 2: Specific Mental Disorders At-A-Glance

Key Priorities

1. Developing communiqués and toolkits focused on children and adolescent girls
2. Developing communiqués and toolkits focused on adult women
3. Developing communiqués and toolkits focused on older women

Messages

- Mental health is essential to health (for children and adolescents).
- Mental health is essential to health. Recovery is the goal (for adult women).
- Mental health is essential to health. Good mental health is possible even in the absence of good physical health (for older women).

Products

Educational kits for parents and educators, toolkits for group facilitation, Web-based tools, iPod messages, visual non-literacy materials, multi-lingual and low literacy print materials, audio materials, videos, story-telling formats, PSAs.

Workgroup 2: Specific Mental Disorders

The Specific Mental Disorders Workgroup was given a long list of issues to consider. They were asked to prioritize 3 from the 20 presented in the box below.

Issues to Prioritize

1. Substance use and abuse (alcohol, illicit prescription use, tobacco, other drugs)
2. Loss, depression, and anxiety across the life span
3. Perinatal depression and anxiety and its effects on the family
4. Adolescent depression, anxiety, and suicide
5. The impact of race, ethnicity, culture, class, sexual orientation, and age on the expression of symptoms
6. The relationship between depression, anxiety, and other negative mood states and substance abuse, especially smoking
7. Recognition of enduring effects of depression and anxiety
8. Comorbidity of mental disorders (depression, anxiety, mood disorders, substance abuse, including smoking, eating disorders, harming oneself, suicide)
9. The impact on children of parental institutionalization (psychiatric, correctional, and military deployment)
10. Understanding why women are more prone to suicide attempts than men
11. The interaction of mental disorders with other illnesses, as both cause and consequence (e.g., cardiovascular disease, diabetes)
12. Eating disorders
13. Obesity and body image issues
14. Research on serious mental illness in women
15. Sex and gender differences in course, pathophysiology, and treatment response in mental disorders
16. Posttraumatic stress disorder
17. Bipolar disorder
18. Schizophrenia
19. Personality disorders
20. Dissociative disorders

Language and stigma

The group began by discussing the consequences, both positive and negative, of diagnosing and assigning a title to an individual's symptoms. Some voiced concerns that certain diagnoses carried a stigma that might prevent women from seeking treatment – especially in some ethnic communities. The question was raised regarding whether consumers were being pathologized by terms such as "disorders". There was a push by some participants to be less label-oriented in favor of being more distress-oriented or reframing issues in a more positive way; for example using terms such as "seeking peace".

> "There is a need for alternative tools besides labels and diagnoses to reach targeted audiences who may already be underserved. Otherwise, if all you have is a hammer, everything is going to look like a nail."
>
> *– Breakout group participant*

Others were in favor of embracing a diagnosis. One participant suggested the creation of a crosswalk that could expand the understanding to incorporate physical symptoms and subsequently a more holistic view of a given disorder.

Another comment was that more consideration should be given to thinking outside the box. The concern was voiced that consumers would not pick up a pamphlet titled "Mood Disorders" voluntarily – underscoring the need for tools besides labels and diagnoses to reach the targeted audiences that may already be underserved.

Ultimately, it was noted that the two approaches were not incompatible in terms of disseminating the message. Emphasizing the importance of targeting particular audiences, the suggestion was made that educational materials could be tailored for primary care providers; an overall piece could be crafted to address mental health in relation to overall well-being; and a third educational piece could target communities with high prevalence. It was pointed out that there needs to be a balance between the two approaches and emphasis placed on disseminating specific information.

Prioritizing the issues

After much discussion about cross-cutting issues, audiences, and what types of tools might be most effective coming from the Surgeon General, this workgroup ultimately identified three major areas of concern:

1.Mood and anxiety disorders, including cross-cutting themes such as culture, faith, family, resiliency, and available treatment options

2.Trauma, including such cross-cutting themes as culture, recovery, and resilience

3.Co-occurrence of mental disorders with medical issues

Overall audiences and messages

The workgroup identified several cross-cutting themes:

- Culture is an essential consideration.
- Promotion of resilience is an important goal.
- Critical life events can challenge coping.
- Mental health is essential to overall health.

Although the workgroup identified three major age groups as their primary focus for the development of communiqués and toolkits, they also noted the need to address multiple audiences with messages regarding each of these age groups. Those audiences included not only consumers and members of the public but also providers and policymakers.

There was considerable discussion about the types of messages to be conveyed to different audiences – particularly for the general public and underserved audiences. The concern was expressed that messages should be crafted in a language that people use and can understand, and that is culturally appropriate. For example, one person noted that most people do not use many of the terms used in the list of priority issues; they refer more to terms such as "illness".

Another participant commented that patients do not care about their Beck Depression Inventory score but rather about whether or not they can get up in the morning. This led to the suggestion that messages be reviewed from the bottom up to ask people themselves in venues such as peer-to-peer interviewing questions such as "How do they understand the message?" and "Do we need to develop different tools?"

Building greater communication between providers and consumers

Another point raised was the need to design tools that could help build bridges between providers and consumers. This was seen as important in helping to move the clinical community to be more responsive and communicative with consumers. It was suggested that this would mean not only incorporating consumer terms into provider materials, but also including clinical terms in materials for consumers. One person added, however, that in order to get providers to pay attention to messages, "you have to come with a hammer" with substantive information and with strategies such as incorporating messages or changes through credentialing bodies or CME credits.

Translating research and best practices into practice

The issue of how information is translated from research into practice was discussed. The point was made that there is a dearth of hard information on knowledge transfer and that anecdotal evidence would suggest that the translation is not occurring. This led to the suggestion that more information is needed on what it takes for people to become comfortable with a tool, what works, what does not, what should be replicated, what type of training is needed, and where information is distributed.

The hope was shared that the bully pulpit of the Surgeon General would offer a greater opportunity to be heard and discuss mental health in terms of whole health. The suggestion was made that messages with the backing of the Surgeon General then could be distributed through the pipelines and networks of existing organizations – including those represented at this meeting.

Looking across the life span

As a result of the discussion of specific mental disorders, cross-cutting themes, and target audiences, members of the workgroup began to move toward a developmental and life course approach. Thus, rather than prioritizing specific disorders from the given list, participants felt it was important to give priority to different age ranges and life transitions, emphasizing how those relate to the risks, course, prevention, and treatment of these disorders.

As a result, the group agreed to prioritize their message, audience, and suggested communiqués or toolkits according to three age ranges, including childhood and adolescence, adult women, and older women. These age groups became the framework for the discussion of specific products and the focus of the group's identified priority areas, as indicated below.

Workgroup 2: Specific Mental Disorders Framework for Developing Toolkits and Communiqués

1. Developing communiqués and toolkits focused on children and adolescent girls
2. Developing communiqués and toolkits focused on adult women
3. Developing communiqués and toolkits focused on older women

The group discussed issues related to particular age groups, such as the importance of focusing on prevention with children and youth. They also looked at issues that cut across different age groups, such as the importance of mental health to overall health. The point was made that this workshop presented an opportunity to get away from the usual silos, defined by funding streams, to make a more integrated, holistic-oriented product.

Key Priority #1: Communiqués and toolkits focused on children and adolescents

Several participants viewed the period of childhood and adolescence as an important one for promoting resilience and prevention. They noted that effective toolkits for girls exist – including tools for at-risk girls – that are designed to help build self-esteem and self reliance. It was noted that these types of toolkits would be given more force if the Surgeon General was behind them.

Another topic that generated discussion had to do with girls and young women who are at risk or already living with mental or co-occurring disorders, including those who may not make it always onto the radar screen (e.g., runaways, the growing population of young women in junior college). Several life events and challenges were identified as being particularly associated with this age group, including the effects of trauma, illness, and family breakup or loss. The positive and negative coping mechanisms that girls employ in the face of the challenges were discussed, including behavioral problems, substance abuse, mood symptoms, and resilience.

Message

The key message for materials focusing on this age group was:

Mental health is essential to health.

Audiences

The identified audiences for this message include:

- Consumers
- Family members
- Health care providers
- Policymakers
- Educators

Dissemination strategies to reach these audiences were mentioned, such as working through schools, teacher associations, and parent-teacher associations.

Formats

The suggested formats include:

- For girls
- Information downloadable to an iPod
- Web-based tools
- Toolkits for group facilitation
- For parents
- Educational kits
- For teachers and parole officers
- Toolkits
- For providers
- Continuing education units (CEUs)
- Board exams

Cross-cutting cultural concerns

The priority cross-cutting cultural concerns highlighted by this group included:

- The need to improve the pipeline of minority providers
- The need to increase the understanding of cultural and age-specific modes of expression among providers, teachers, and others who interact with children and adolescents

Key Priority #2: Communiqués and toolkits focused on adult women

Message

The key message for materials focusing on this age group was:

> Mental health is essential to overall health. Recovery is the goal.

Audiences

A wide audience was identified for this message, including:

> Consumers, families, faith-based organizations, providers, policymakers, employers, community organizations, women's groups, child care providers, criminal justice system, educational institutions, welfare-to-work programs, peer educators and lay home visitors, public housing, vocational rehab programs, AARP, and caregivers

Formats

The suggested formats to reach the identified audiences with the identified message include:

- Visual, nonliteracy materials (e.g., film, video, sound)
- Facilitator's guides (e.g., tool associated with a video) designed with something to deal with emotional reactions that may be triggered through use of this tool
- Self-assessment tools
- Print materials, including multi-language and low-literacy products

Cross-cutting cultural concerns

One focus of discussion on this topic was the need to understand points of intervention for particular groups of women. For example, it was noted that self-determination and self-reliance are key within the African-American community and lack of these can be seen as a real failure. Thus, to break down stigma, it is important that mental health tools be adapted to different cultural groups in ways that address how they view mental health and illness.

The group stressed the importance of ensuring that tools are reviewed and developed by members of specific communities and cultures – and that these reflect knowledge of how individuals can be reached within their cultural context. Examples were shared of materials that successfully bridge different cultures, such as the book Woman Who Glows in the Dark, which was written by Elena Avila, a nurse who practiced both Western medicine and indigenous folk healing.

Key Priority #3: Communiqués and toolkits focused on older adult women

Message

The key message for materials focusing on this age group was:

> Mental health is essential to overall health. Good mental health is possible even in the absence of good physical health.

Audiences

Numerous audiences were identified for this message and this age group. They included:

AARP; employers; nonclinical retirement communities; faith-based organizations; beauty parlors; bingo parlors; adult day care centers; community services for the elderly; areawide Agency on Aging; nursing centers and assisted living centers; and public health services, such as Medicare, SSI, and Medicaid

Formats

The recommendations regarding formats included:

- Large-print materials
- Audio and low-vision materials
- Information that is short and sweet
- Videos
- PSAs (celebrity voices may resonate more with harder to reach populations)
- No acronyms
- Color contrast
- Storytelling and oral histories

Cross-cutting cultural concerns

A number of issues were identified as relating particularly to this group. One set of issues had to do with generational differences, respect for elders, caring for other family members, or being cared for by family members, and end-of-life concerns. Others included issues of poverty and restricted income, privacy, indirect communications, and the use of multiple medications.

Opportunities for collaboration

This topic generated considerable discussion and development of partnering opportunities. Suggestions regarding potential funders and partners included:

- Private foundations (e.g., Kaiser, the Robert Wood Johnson Foundation, the Commonwealth Fund, Pew, Ford)
- National Foundation for Mental Health
- American Psychological Association
- National Association of Mental Health
- Business partners such as Estee Lauder, Ford, The Body Shop, Avon, Amway, and Tupperware
- Interdisciplinary partners, such as the National Hispanic Medical Association, National Hispanic Nurses Association, and faith-based groups, women's organizations
- Accreditation organizations
- Women's athletics organizations
- International groups that have shown an interest in mental health and women (e.g., World Bank, WHO, the United Nations)
- Educational organizations
- Migrant centers
- National Association of Commissioners for Mental Health
- National spokespersons, such as Oprah Winfrey or the head of women's health for Aetna

Workgroup 2 Participants

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Workgroup 3: Trauma, Violence, and Abuse At-A-Glance

Priorities

1. Developmental and mental health effects of trauma
2. Integration of health and mental health
3. Effects of emotional abuse

Messages

- What is trauma and how common is it?
- (Convey the human face of trauma, use everyday language, promote individual and community action to address trauma, violence, and abuse)
- Recovery is possible.
- Mental health is an essential part of physical health.
- There is no separation between mind, body, brain, and behavior.
- There is a need to develop psychological literacy around the mind-body connection.
- Emotional abuse is "soul murder".
- Emotional abuse includes neglect, which is the "violence of silence".
- Emotional abuse negates your existence.

Products

Letter from the Surgeon General; PSAs; toolkits; Institute of Medicine report on trauma; fact sheets on myths and misconceptions about trauma; fact sheets on how trauma and abuse affect the brain; animated version of how the brain works for children; Surgeon General's speeches highlighting this topic; teaching CD-ROM with discussion guide; fact sheet defining trauma, violence, and abuse and their prevalence.

Workgroup 3: Trauma, Violence, and Abuse

The workgroup was presented with a list of seven topics from which to identify key priorities. They are listed in the box below.

Issues to Prioritize

1. Effects of early trauma (abuse, neglect, loss of a parent) on the development of depression and anxiety in women, especially on African-American women. [The group agreed to change this point to read: Mental health and developmental effects of trauma, abuse, neglect, and loss.]
2. Sexual violence against girls and women
3. Childhood abuse, whether physical or sexual, and its long-term effects
4. Domestic violence in heterosexual and same-sex relationships
5. Emotional abuse at any age
6. Effects of bullying, teasing, and sexual harassment in school
7. Sex and gender discrimination, sexual harassment, and violence in the workplace

Defining trauma

There was considerable discussion based on this list regarding the need to broaden the definition of trauma, violence, and abuse to include things such as impersonal trauma (e.g., effects of war, natural disasters) and the impact of trauma, violence, and abuse on productivity, business, and the workforce. Similarly, several participants commented on the need to look at trauma, violence, and abuse within the cultural, historical, and political context of how and where they occur – not just as isolated incidents. They also considered the role of poverty as a context – though the group agreed that poverty was a mediating, not a causal, factor associated with these events.

> "Providers don't want to open that can of worms [assessing trauma, violence, and abuse], because they do not know how to deal with it and don't have the referral services necessary. They need protocols to know how to ask the questions and deal with the fallout."
>
> *—Breakout group participant*

Provider concerns

Another topic that generated a great deal of conversation centered on developing tools for providers to enable them to appropriately assess trauma, violence, and abuse. Participants noted that providers, particularly general practitioners, need a better understanding of how to ask questions about trauma, violence, and abuse and what to do with the answers – especially since they may be the only providers that consumers encounter. Several participants explained that there are many myths and misconceptions about how to deal with individuals who have suffered these events, and providers worry about such concerns as whether consumers will fall apart, how to develop a trusting atmosphere, and whether a provider should show emotional reactions. Participants expressed the need to develop tools and protocols that providers can use to deal with the fallout of a revelation of past trauma, violence, or abuse.

One participant noted that in her experience, it is easier to inform criminal justice workers about trauma, violence, and abuse than it is mental health professionals. Another participant added that it is not possible to train all providers to become trauma professionals. There are three levels of awareness regarding trauma: trauma aware, trauma sensitive, and trauma competent.

The group further reviewed the issues to prioritize to see if some could be eliminated or condensed. They discussed the need to add elder abuse and emotional abuse to the list of issues under the top priorities. Ultimately, the workgroup agreed to highlight the following three priority areas.

Key Priorities: Workgroup 3
Trauma, Violence, and Abuse

1. Developmental and mental health effects of trauma
2. Integration of health and mental health
3. Effects of emotional abuse

Key Priority #1: Developmental and mental health effects of trauma

Message

There was a great deal of discussion about defining a message for this priority area, starting with the need to define trauma. Other points that participants wanted to convey in the message touched on the idea that trauma harms us all, that recovery is

possible and widespread, and that people who have experienced trauma should not feel ashamed or at fault.

Several participants commented on the fact that there is a lot of shame associated with being abused (or being an abuser) and that the message of this key priority would need to be reassuring, empathy building, and presented in a way that victims of abuse will not immediately reject.

The suggestion was made that the goal of the message should be to help change behavior, including for individuals at the precontemplative stage of change (i.e., those who have no intention of changing their behavior in the near future). One individual noted that the message needs to be brought to peoples' doorsteps and shaped to resonate with the target audience. Thus, one angle that was suggested was to talk about safety and how violence, abuse, and trauma affect all aspects of our lives (e.g., how we work, how we learn, how we raise our children). In the end, the group agreed that the message should do the following:

- Define trauma
- Recognize the prevalence of trauma
- Convey the message that recovery is possible
- Use a common language that is directed to the individual and community level to take action
- Put a human face on trauma

Audiences

There was much discussion of potential audiences for a Surgeon General's communiqué on violence, trauma, and abuse. Some of the suggestions included State mental health commissioners or governors, social workers, churches/faith-based organizations, individuals and communities, other sectors (e.g., business), and the general public. Eventually, the group decided to focus on two priority audiences:

- The general public (at the individual and community levels)
- Providers (from multiple sectors)

Format

The workgroup participants proposed that the format of this communiqué take the form of a two-step process:

Step 1: A letter from the Surgeon General to the general public addressing the centrality of trauma, violence, and abuse in women's lives. It was suggested that this letter could go out to every household, similar to the Surgeon General's letter on HIV/AIDS that was disseminated in the 1980s.

Step 2: A series of follow-up activities that could include PSAs targeted to specific audiences, toolkits, an Institute of Medicine (IOM) report on trauma, fact sheets on the myths and misconceptions about trauma, an emphasis on in-service training, and State trauma plans (as integrated into State mental health plans).

Many potential resources and models were cited by workshop participants to help guide the development of communiqués, including:

- The 1986 Surgeon General's letter on HIV/AIDS
- Lessons from breast cancer campaign models
- A domestic violence campaign through hairdressers

- Real Men and Real Depression Campaign
- Trauma certificate program at the University of Maryland
- The Ohio business case on mental health report, soon to be released

> "We never hear of a serious cancer, so why refer to a serious mental disorder?"
>
> *—Breakout group participant*

Key Priority #2: Integration of mental health and overall health

The group discussed the question of how to address what some participants referred to as "a mind/body breakdown" – or the prevailing tendency to separate mental health and overall health in language, financing, service delivery, and common perceptions. The point was made that this separation increases stigma. The group grappled with developing suggestions on how the Surgeon General could address the issue of needing to integrate mental health more fully with overall health and stress the interoperability between the two.

Message

Numerous issues were raised during the discussion of how to frame a message, or several messages, related to the mind/body connection and importance of mental health to overall health. The first had to do with making the case for the connection and integrating the two as part of overall health. There was much discussion on the topic of the stigma associated with mental health. One participant noted the need to explain to people that there is a "range of normal or healthy behavior."

Another suggestion was to look at the use of stigmatizing language associated with mental health issues; for example, one person commented, we never hear of "serious cancer," so why refer to a "serious mental disorder?" Similarly, the point was made that the terms mental and substance use conditions carried less of a stigma than terms such as mental disorder and substance abuse. Ultimately, the group crafted the following messages related to addressing the mind/body dichotomy:

- Mental health is an essential part of overall physical health.
- There is no separation among the mind, body, brain, and behavior.
- There is a need to develop psychological literacy around the mind-body connection.

Audiences

Participants felt that communiqués should be developed for the general public as well as for providers from multiple sectors. In addition, workgroup members highlighted the importance of reaching out to particular age groups that may be traditionally underserved or left out. Specifically, the group proposed to focus on:

- Younger audiences (e.g., through Boys and Girls Clubs, 4H, etc.)
- Older adults, who may be particularly affected by issues of stigma and could benefit from more understanding about the mind-body connection

Format

Several ideas regarding formats were proposed, including:

- Fact sheets on how the brain works – on how psychosocial factors affect the brain and how that affects behavior
- An animated version of how the brain works for children and youth (e.g., the blue part of the brain reacts like this when this happens)
- An interactive video

Resources

The workgroup raised the question of how to leverage other groups that are addressing some of these mind-body issues (e.g., anger management).

Key Priority #3: Effects of emotional abuse

Message

There was considerable discussion regarding how to convey messages about the importance and severity of the consequences of emotional abuse, which some participants also referred to as "soul murder".

Participants shared thoughts and concerns regarding the effects of emotional abuse – how it negates one's existence, damages self-esteem, and can be as damaging as or worse than physical or sexual abuse. They also noted the difficulties of getting people to recognize the importance of emotional abuse; for example, one workgroup member commented that Child Protective Services will respond to cases of physical or sexual abuse but, when it comes to emotional abuse, will say that it "is not really going to stand up." One person cited the work of Maxine Harris (e.g., *Trauma Recovery and Empowerment: A Clinician's Guide for Working with Women in Groups*) as a good resource on the damaging effects of emotional abuse.

Workgroup members also talked about the role of emotional abuse in the context of sports. They discussed the need to train athletes to talk to kids and teach about rules and understandable lines that need to be respected. Participants noted the importance of teaching children and youth that you can act both aggressively on the field and respectfully off the field.

Although they found it difficult to define emotional abuse and craft succinct messages, the workgroup did come up with three key messages regarding emotional abuse, including:

- Emotional abuse is "soul murder."
- Emotional abuse includes neglect, which is the "violence of silence."
- Emotional abuse negates your existence.

Audiences

The following audiences were identified for messages relating to emotional abuse:

- Students
- Parents
- Older adults
- Coaches
- Teachers

Cross-cutting cultural concerns

Several workgroup members grappled with the question of how the definition and concept of emotional abuse may differ across diverse cultures (e.g., effect of spanking) and through the process of acculturation. They noted that there was a tension between what may be accepted in a particular culture and what may be personally damaging. As one participant commented, "Simply because something is accepted by a cultural group does not mean that it is right."

The group discussed the importance of education, helping to identify what is abuse, and giving parents – including those who honestly believe that they are doing what is best for their child – an alternative that might be better. Participants also acknowledged the flip side of this type of awareness and education. For example, one workgroup member explained the risk of having a woman who suddenly learns that what she has been experiencing in her family is abuse but who is then disowned by

her family, because they do not believe that their behavior toward her is inappropriate.

Dissemination

The group came up with numerous suggestions regarding strategies for disseminating messages about emotional abuse. These included:

- Having the Surgeon General include in his speeches that emotional abuse is a serious issue that needs to be addressed
- Developing a fact sheet including a definition of emotional abuse, prevalence, and examples
- Developing a film about emotional abuse
- Developing a CD-ROM teaching tool with a discussion guide
- Developing illustrative vignettes
- Getting these messages into pop culture (e.g., reality shows, Superman, etc.)
- Developing a list of how to identify emotional abuse for different age groups

Workgroup members also cited numerous opportunities that they saw for building on existing vehicles or venues to further disseminate messages about emotional abuse. These included:

- Building on the clearinghouse capacity of the newly formed Center on Women, Violence, and Trauma
- Increasing knowledge about what is already out there, such as existing clearinghouses and resources
- Developing an article (brief summary) about this Surgeon General's Workshop on Women's Mental Health that can be used for developing activities around women's health month
- Developing a cadre of responders for the aftermath of crisis – possibly taking the form of a National Guard of Responders composed of individuals interested in helping to address trauma
- Supporting current leaders and developing emerging ones (e.g., on college campuses, in research positions at the NIH or the CDC) to carry the trauma message forward

Workgroup 3 Participants

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Workgroup 4: Social Stress Factors and Stigma At-A-Glance

Priorities

1. Discrimination and stigma of women and girls who live with mental health issues
2. Depression and anxiety disorders among women and girls across the life span
3. The need to integrate mental health issues in settings where women and girls naturally congregate

Messages

- Discrimination is stigma. Stigma is compounded by factors such as sex and gender, culture, race, ethnicity, poverty, age, and locality.
- Stigma leads to lost opportunities.
- Women and girls have an increased level of suffering from mental health issues, associated with issues of family responsibility, poverty, employment, and access to mental health services.
- Having a mental disorder is not your fault and not something of which to be ashamed.
- It takes strength to reach out for help.
- Treatment works.
- Women and girls face unique risks at specific developmental stages (adolescence, pregnancy, post-partum, menopause, elderly years, etc.).
- Early intervention and identification promote greater success.
- It is important to distinguish between depression and normal sadness.
- Building knowledge helps to enhance access to identification and intervention.
- There is no health without mental health.

Products

Legislative breakfast, briefs with recommendations, PR materials, messages on commonly used products (e.g., diapers), bookmarks, cards, screening for moms when they bring children to the pediatrician, public transportation venues, school health curricula, first-aid approach, community networks, Web sites, workforce development, identifying champions, expanding State and national health weeks

Workgroup 4: Social Stress Factors and Stigma

The group was asked to consider and prioritize the list of six issues pertaining to social stress factors and stigma indicated in the box below.

Issues to Prioritize

1. Increased risk of victimization for all women
2. The extent to which lower socioeconomic status and/or immigrant status relates to mental health
3. The discrimination and lack of social acceptance that those with mental disorders face
4. Internal barriers to seeking and receiving mental health care such as shame and guilt
5. Negative images of girls and women, particularly among minority women, in television, magazines, and film-related media
6. The need for additional research on the economic impact of maternal mental illness on family health outcomes

As the group reviewed the identified issues and addressed the task of trying to prioritize them, the discussion touched on several key themes, including stigma, cultural issues, and social stressors.

Stigma

Much concern was voiced among members of the workgroup regarding aspects of our current mental health system that serve to reinforce issues of stigma surrounding mental health. For example, participants noted that the fragmentation of services, limitations on mental health coverage, and the lack of affordability of drugs to treat mental disorders contribute to stigma. The state of mental health treatment was characterized by one participant as "separate and unequal." Discrimination was referred to as the "big elephant in the room," and the argument was made that discrimination not only occurs in public mental health care but is in fact legally sanctioned in mental health. The resulting stigma and discrimination, it was noted, result in greater stress on individuals seeking help.

Several participants discussed strategies for getting messages out to the public to address and help reduce stigma. One concern specifically was in reaching families, who often expect to confront the challenge of mental illness alone and not discuss it with outsiders. It was suggested that there was a need to explain that mental illness is not just a family affair. One person noted, for example, that the literature on anxiety disorders suggests that these are biologically based illnesses. Explaining this to families helps them to understand that this is a medical diagnosis, just like heart disease, and should be seen as an illness that can be treated.

However, it was noted that describing mental illness as a function of genetics might prove offensive to an older population. The message "You have a real illness" seems to be more effective at addressing issues of shame, guilt, and stigma. Another participant suggested that there might be helpful "people first" language to be gleaned from the Institute for Mental Disease.

Participants also shared examples and ideas of ways to integrate mental health screening with other assessments to destigmatize the issue further. The example was raised of a screening assessment that included two trigger questions for mental illness listed with a series of other health screening questions, which reduces stigma. However, the point was made that once you screen a person for a mental disorder, you need to be able to refer them to appropriate information or treatments.

One participant explained that in Australia, information packets that include a suicide screening are given to every middle school student. Similarly, high school students receive a lunch kit with information on mental health agencies, birth control resources, drug issues, and other information – the point being that the widespread dissemination of this information helps reduce stigma and increase awareness.

Culture

Language barriers coupled with a lack of cultural sensitivity by providers were cited as a significant challenge to overcoming stigma in some communities. Participants noted that it would be important to have some background information on different issues regarding social stress factors and stigma within different cultures. Another related comment was that consideration needs to be given to individuals who are minorities but foreign born – a population which is often overlooked. This may require developing targeted materials for specific communities, as several group members noted, that are not simply a translation or adaptation of materials developed for the

"mainstream" population. It was recommended that materials be developed from the ground up to reflect specific cultures and cultural issues.

Other participants cautioned that diversity should not be focused solely on race or ethnicity, but also on issues such as sexual orientation, geography (e.g., underserved rural or urban environments), and age groups (e.g., children). Several people commented that one consumer may belong to many groups and that emphasis should be placed on starting with one core message that resonates across many sociocultural strata.

Social stressors

The workgroup spent time identifying social stressors that might affect women's mental health, their resilience, their ability or willingness to seek help, and their outcomes. The list of issues they compiled included:

- Poverty
- Homelessness
- Being uninsured or underinsured
- Lack of knowledge regarding mental illness or substance abuse
- Living in a rural environment
- Living in the inner city
- Isolation
- Incarceration
- Living in the projects
- Aging
- Immigration (e.g., guilt, trauma history, acculturation)
- Racism
- Lack of long-term coverage for treatment

After creating this broad list of social stressors, the group turned its focus toward identifying those factors that are of particular concern to women. This list included:

- Women acting as primary caregivers for family members
- Stigma for women associated with substance abuse
- Stigma for women associated with loss of child custody due to mental health issues
- Girls with a mentally ill parent tend to take on caregiver roles
- In the caregiver role women have little time for self-assessment
- Peer pressure for girls (e.g., smoking, the "mean girl" phenomenon)
- High rates of victimization for both women and girls
- Negative images, especially of minority girls and women
- Women and girls having different mental health issues

The power of public health education, it was noted, should not be underestimated. Workgroup members shared examples of positive campaigns or changes that could serve as models. One example given was of a generation of children who have been taught to cough into their arms instead of their hands. Another example that was highlighted was of the effectiveness of the seat belt safety message – largely because it has been translated into law.

Several issues were discussed but ultimately placed in a "parking lot" for future consideration. These included:

- Trafficking of women
- Single-payer systems
- The state of mental health care in the United States
- Parity
- Housing

Based on their long discussion and consideration of priorities, the workgroup identified three priority issues, presented in the following box.

Key Priorities: Workgroup 4
Social Stress Factors and Stigma

1. Discrimination and stigma of women and girls who live with mental health issues
2. Depression and anxiety disorders among women and girls across the life span
3. The need to integrate mental health issues in settings where women and girls naturally congregate

Key Priority #1: Discrimination and stigma of women and girls who live with mental health issues

Message

Following their lengthy discussion on discrimination and stigma, the workgroup members agreed to highlight the following messages:

- Stigma is discrimination. It is exacerbated by factors such as sex and gender, race and ethnicity, poverty, age, and locality (e.g., rural, inner city).
- Stigma leads to lost opportunities.
- Women and girls have an increased level of suffering from mental health issues, associated with issues of family responsibility, poverty, employment, and access to mental health services.
- Having a mental disorder is not your fault and not something of which to be ashamed.
- It takes strength to reach out for help.
- Treatment works.

Audiences

The group members identified the following audiences for this priority issue:

- Policymakers
- General public – including schools, faith-based organizations, etc.
- Primary care providers
- Families
- Service utilization sites

Format

The group noted that the Health Resources and Services Administration (HRSA) is already in the process of developing a toolkit related to women's mental health for primary care settings. The suggestion was made that if resources are limited, it would be important to focus on areas of high risk or service-based programs, such as the Supplemental Food Program for Women, Infants, and Children (WIC).

Some of the recommendations for formats focused on reaching a general public audience. Suggested formats included:

- Age-appropriate pamphlets
- Messages in school planners
- Word of mouth
- Ways to get into the media
- Web-based formats for younger audiences
- Radio-based formats for older audiences

Another suggestion with regard to targeting policymakers was to try to come up with formats and materials that could show the economic benefits or cost-benefit analysis of addressing stigma and discrimination to promote greater understanding, prevention, and treatment of mental health issues.

A final suggestion was to look at existing resources and ways to help disseminate or integrate those further.

Cross-cutting cultural concerns

Participants identified cultural barriers related to discussing "problems" with someone of another culture, race, or ethnicity. They also noted the importance of addressing cultural barriers within a community that contribute to misunderstanding, stigma, and discrimination.

Key Priority #2: Depression and anxiety disorders among women and girls across the life span

Message

The group developed several messages related to this priority area:

- Women and girls have unique behavioral health risks at specific developmental stages. Examples include adolescence, pregnancy, postpartum, menopause, and elderly years.
- Early intervention and identification promote greater success.
- It is important to distinguish between depression and normal sadness.
- Building knowledge helps to enhance access to identification and intervention.

Audiences

The workgroup members focused on several specific audiences for this topic and set of messages, including:

- Primary care family practices
- OB/GYNs
- Pediatricians
- Schools
- Sororities and other college-based organizations

Formats

The workgroup members suggested the following formats for conveying the messages, including:

- Putting messages on commonly used products, such as diapers, formula, etc.
- Bookmarks, cards (high school, college)
- Screening for moms when they bring their child to the pediatrician
- Putting messages on public transportation venues (e.g., bus shelters)

Cross-cutting cultural concerns

Participants identified several cultural concerns. One had to do with addressing the culture of silence surrounding depression and mental disorders generally, particularly within diverse racial, ethnic, or cultural groups. A related issue was the role of traditional practices and values with regard to depression and anxiety disorders. Another concern was the fact that depression and mental disorders are seen as a family issue in some cultures, one that needs to be kept within the family sphere – thus discouraging individuals from seeking treatment.

Key Priority #3: Failure to integrate mental health issues in settings where women and girls are

Message

The workgroup crafted a very simple message to address this priority issue:

There is no health without mental health.

Audiences

They identified numerous audiences:

- Schools

- Primary care physicians
- People in all health-related disciplines
- Faith-based organizations
- Community-based organizations, such as scout groups, the Rotary Club, and the League of Women Voters
- Public education students (pre-K through grade 12)
- Stores, barber shops/beauty parlors, clinics, and local hangouts

Formats

The suggested formats included:

- A first-aid approach (psychological first-aid for children already exists)
- A school health curriculum
- A community-based campaign within social networks
- A Web site
- Workforce development
- Toolkits
- Champions within the community
- Mentors
- Health advocates
- Identified health weeks or health days

Cross-cutting cultural concerns

The group discussed issues of language: how the message is framed, by whom, and whether or not it is in a person's mother tongue. The suggestion was made that diverse consumers should be involved in the development and implementation of communiqués to ensure greater cultural competence. They also pointed out the need to address issues related to persons with physical disabilities.

Workgroup 4 Participants

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Workgroup 5: Identification and Intervention Issues At-A-Glance

Priorities

1. Preventive interventions for the most common and disabling disorders, such as major depression and anxiety
2. The need for screening for depression, anxiety, and other common mental disorders in primary care, schools, and other settings
3. The importance of consumer and provider empowerment, self-determination, and choice in mental health treatment

Messages

- The concept of mental health must be broadened to include other systems (e.g., primary care, education, employment, housing). It also should use a strengths-based approach, highlight prevention as the beginning of the continuum of care, and expand the scope of services across generations and from individuals to families.
- Identify and develop holistic screening tools to assess mental disorders.
- Community involvement is needed to establish a process of empowerment and self-determination.
- Barriers (language, culture, costs) must be removed to empower consumers and providers. Federal agencies (e.g., Health, Education, Justice, Labor) can help remove these barriers.
- A collaborative care strategy is needed to overcome financial and administrative silos.

Products

Community partnerships with health care, employers, schools, managed care organizations, insurers, and peer support groups; community toolkits with examples of effective tools, reviews of the latest science; education protocol on how to use assessment tools; identify champions to promote use of assessment tools; consumer education communiqué; toolkit for advocacy and community mobilization; intergenerational worksheet to manage mental health issues; local mental health care decision making flow sheets (like those of Cancer Regional Centers); storytelling approaches; address issues for immigrant women and families

Workgroup 5: Identification and Intervention Issues

The key priority issues assigned to this workgroup are listed in the box below.

Issues to Prioritize

1. The importance of consumer and provider empowerment, self-determination, and choice in mental health treatment
2. Models for transitioning women from institutions to re-entry into family and community living
3. Preventive interventions for the most common and disabling disorders, such as major depression and anxiety
4. Depression and anxiety that go undiagnosed and therefore untreated
5. The need for screening for depression, anxiety, and other common mental disorders in primary care, schools, and other settings
6. The need to implement the comprehensive nationwide program for suicide prevention previously described in the National Strategy for Suicide Prevention
7. The lack of support and care options for older women
8. Complementary and alternative medicine in relation to self-treatment of mental disorders

As members of the workgroup considered how to identify the top three priority issues they also identified a number of related issues that affect the diagnosis and treatment of women's mental disorders. Those issues are grouped here according to common themes:

Target populations

- Older populations, especially their growing demographics and rising rates of responsibility in raising grandchildren
- An increasing number of women who are foreign born and the lack of a support system for them, especially the elders

Access to and funding for mental health services

- The role of insurance companies in empowering or disempowering providers in their ability to provide care
- Health economics and the waste of health care dollars when alternative practices are not validated
- Access to care – mental health being seen as an additional burden rather than as a critical part of care
- The need for education, interagency coordination, and less fragmentation that contributes to underdiagnosis and mistreatment of mental disorders
- Bringing care into the home (helps address barriers)

Treatment issues

- Choosing one's own path to health, reducing isolation, and increasing networking opportunities
- Treating individuals versus working with the family unit
- The sense that believing in treatment can help to make it more effective
- The need to promote community-driven supports
- Faith-based activities

Prevention

- Preventive efforts are critical to improving health status but are not well funded.

Provider education and training

- Training and education – the need to shift how and whom we train
- The lack of minority health providers

Of the issues presented to the group, the following three were chosen as the top priority issues.

Key Priorities: Workgroup 5

1. Identification and Intervention Issues
2. Preventive interventions for the most common and disabling disorders, such as major depression and anxiety
3. The need for screening for depression, anxiety, and other common mental disorders in primary care, schools, and other settings
4. The importance of consumer and provider empowerment, self-determination, and choice in mental health treatment

Key Priority #1: Preventive interventions for the most common and disabling disorders, such as major depression and anxiety

Message

Members of the workgroup argued that the concept of mental health needed to be broadened to take into consideration other systems, such as primary health care, education, employment, and housing. They emphasized the fact that mental health affects and is affected by these systems.

The group also identified the following attributes of a message for this topic:

- Uses a strengths-based approach
- Highlights prevention as the beginning of the continuum of care
- Expands the scope of services across generations and from individuals to families

Audiences

The identified audiences included:

- The entire health care system, especially the primary health care system
- Schools
- Employers
- Insurers, especially managed care
- Community-level organizations
- Self-help groups

Formats

The group suggested the need to create community partnerships with health care, employers, schools, managed care, insurers, and peer support groups. Participants noted that it would be important to establish a knowledge base within the community to help recognize prevention and resilience issues. Two other suggestions were that treatment must connect women in care to other systems options and that community involvement in the intervention process should be developed and enhanced.

Cross-cutting cultural concerns

The following cross-cutting cultural concerns were raised:

- Recommendations must be community driven and developed by stakeholder partners.
- Consideration of self-directed complementary and alternative treatments should be integrated into the development of communiqués and toolkits.

Priority Issue #2: The need for screening for depression and other common mental disorders in primary care, schools, and other settings

Message

For this topic, the group came up with the following message:

> Identify and develop holistic screening tools for the assessment of mental disorders.

In discussing the message, the suggestion was made that there was a need to create tools that measure the "whole woman." The example was offered of the Medical Outcomes Study Short-Form 36 (SF-36), which has been extensively tested and validated and is a functional health self-assessment measure with physical and mental health scales. It measures mental-component-improved-scores by (1) antidepressants and (2) self-described behavior changes (spiritual growth, dealing with relationships, doing work they are good at what matters, taking care of themselves). It was explained that the process of using a simple tool to identify mental health issues helps patients feel listened to and holds providers accountable to dealing with these issues and suggesting interventions.

Other participants discussed the need to establish functional health measurements that ask the right measurement questions. Also noted was the need to create a structure for mental health measurement and response that can be integrated and standardized into current practices, especially in primary care practice. Group members noted the importance of interpreting the numbers and being able to "translate the numbers back into people." The suggestion was made that

tools be adapted to the unique needs of diverse populations or providers through methods such as demonstration programs, which also would test their functionality in a "living laboratory" or real world setting.

One participant raised the issue of developing broadly based, holistic screening tools that could empower consumers (e.g., self-assessment tools) and promote access to services. These types of tools would need to focus on functionality and quality of life, it was explained, rather than simply on symptom reduction. They also would need to be culturally and developmentally appropriate.

Another key point of discussion was the need for identified referral systems and services to follow up on screenings and assessments. Participants pointed to the importance of education and training to properly use assessment tools – and to avoid bias and discrimination based on health-related stereotypes. As one person noted, "the tool is only as useful as the training on how to use it properly." One suggestion was the possibility of developing a training manual to describe the process of using an assessment tool. As a final comment, one workgroup member noted that assessment tools can be important for securing funding.

Audiences

The suggested audiences for this message were:

- Federal agencies
- Funders
- Schools
- Providers
- Consumers

Formats

The following suggestions were made regarding potential formats:

- **Community-based and tested toolkit.** Workgroup members discussed the need to gather information to develop or find existing assessment and screening tools. As part of this process, they proposed the development of a toolkit that identifies such things as examples of effective tools and reviews of recent scientific research on this topic.

- **Educational protocol.** The group identified the need to train providers on how to use assessment tools tailored to the specific needs of women, especially those of color. The training and curricula would need to be culturally and linguistically appropriate, relevant, and sensitive, and it would need to include training in self-assessment techniques. The training should be field-based and able to highlight how these tools work in real-life settings.

- **Something that gathers information on the importance of using these tools and how it can improve women's mental health outcomes.** This would be designed to inform stakeholders.

- **Champions.** Identifying individuals to champion the use and integration of tools within communities. It was noted that champions can be found often in times of tragedy.

Cross-cutting cultural concerns

The group underscored the importance of community-driven involvement in the development of materials. This was defined as including the active involvement of community-based organizations and individuals from both within and outside of mental health. It was noted that stakeholder partnerships should be established and include a reciprocal communication of ideas. The need for culturally and linguistically appropriate training on the use of assessments was also re-emphasized as part of this discussion.

Challenges

Along with their recommendations, workgroup members identified a series of challenges, including:

- How to respond to the mental health issues that are identified by assessment tools
- How to identify which types of activities and treatments have worked and will work for patients
- How to establish an adequate supply of providers to whom you can refer patients

> "We don't just want to be at the table; we want to *eat* at the table."
>
> *– Workgroup member and consumer representative*

Key Priority #3: The importance of consumer and provider empowerment, self-determination, and choice in mental health treatment

There was some disagreement regarding the phrasing of this priority issue. Several participants expressed the concern that the concept of mental health needed to be broadened to include the wider context in which women's mental health plays out. There was also interest in including the concept of self-directed care. One other suggestion was to include this sentence: "Mental health care strategies include alternative and complementary treatment options."

Ultimately, the priority was left as indicated.

Messages

The following messages were recommended by the group:

- Community involvement is necessary to establish a process for empowerment and self-determination. As one participant noted, "We don't just want to be at the table; we want to eat at the table."
- Health systems and Federal agencies (e.g., the Departments of Health and Human Services, Education, Labor, and Justice) should help remove barriers (e.g., language, cultural, financial) to consumer choices and empowerment.
- A collaborative care strategy (e.g., substance abuse and mental health) is necessary to overcome financial and administrative silos.

Audiences

Workgroup members identified a broad array of audiences for this topic, including:

- The entire health care system
- Schools
- Employers
- Insurers
- The community
- Self-help groups

Formats

The following formats were suggested:

- Consumer education communiqué for consumers, providers, and advocates
- A toolkit on advocacy and community mobilization for empowering women
- Intergenerational worksheets and plans of management for mental health issues, with separate worksheets for different population groups, providers, consumers, and policymakers
- Toolkits for immigrants and refugees about their rights and explaining the basics about the mental health treatment system, making legal provisions accessible to vulnerable populations

• A local mental health care decisionmaking flow sheet, perhaps similar to one developed by the Cancer Regional Centers

• A Surgeon General's Call to Action, to pull in representation from all stakeholders to make recommendations happen

> "Mental health is not an individual issue. It affects whole communities and is partly caused by the broader community. Women are complex, and they require a complex strategy to address all of their nuances."
>
> *—Breakout group participant*

Several comments regarding formats touched on the idea of using nontraditional communication methods, such as a storytelling approach.

Challenges and strategies to overcome them

The workgroup cautioned that communiqué development would need to anticipate challenges and resistance to holistic concepts and the use of terms such as "living laboratories" that are unfamiliar to more mainstream communities, such as policymakers and planners, training institutions, mental health centers or authorities, school districts, and such.

To address these challenges, members of the workgroup proposed the following:

• Invite stakeholders who may be potential sources of resistance to participate in the decisionmaking process.

• Develop clinical Centers of Excellence for Women's Mental Health. These could be national, State based, county based, Tribe based, university based, or special populations based.

• Develop structures to organize community-based groups, including faith-based groups, around women's mental health that operate outside of clinical Centers of Excellence. There may be opportunities to create pilot projects at this level as well.

• Create "living laboratories", pilot projects, or "transitional research" to initiate this process. Start small to see how they work, and expand them if they do well. The ultimate goal is to make new initiatives standard in current practice. An example of a "living laboratory" could be a recovery group.

• Develop a sex and gender focused national effort focused at the State level to address mental health issues (e.g., trauma) by developing State-level leadership (e.g., governors and their spouses, State mental health directors, State Medicaid directors).

• Identify women's mental health champions.

Further priority issues from the group

As a wrap-up to their workgroup discussion, participants went around the table and identified their own priority issues:

Focus on specific women's mental health issues, such as older women's issues, perinatal depression, and substance abuse issues.

• Focus on agencies and organizations (e.g., medical, social worker) that can think about and mobilize on these issues.

• Develop practical tools in a way that makes practitioners, consumers, and others want to grab hold of them and use them.

• Mobilize serious resources to improve training and workforce development as a way to improve quality of services for women.

- Think more fully about how to reach nonmedical providers and providers of alternative or complementary medicine.

- Focus more energy on prevention at early ages with ways to strengthen girls and young women. Remove stigma and begin empowerment regarding mental health early in life. Blend these efforts across generations within communities.

- Use existing leadership and develop future leaders, recognizing the capacity of underutilized advocates.

- Increase the level of communication and build bridges between communities.

- Address mental health issues through a life span approach, and recognize that providers have their own mental health issues.

- Take a serious look at sources from which future funding will come.

- Consider women's mental health within the complex context of their lives.

Workgroup 5 Participants

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Workgroup 6: Treatment Access and Insurance At-A-Glance

Priorities

1. Effects of racial, ethnic, and linguistic disparities in health service access, data, evaluation, and delivery on mental health status
2. Access to appropriate and effective care through primary care providers, mental health specialists, and nonclinical settings
3. Financial and structural barriers – including insurance coverage, reimbursement policies, and mental health parity

Messages

- Include and know your community.
- Disparities come at a high cost to society.
- Everyone can do something to eliminate racial and ethnic disparities.
- Health care providers and lay workers are key to eliminating disparities, but they need specific tools and support.
- We need 100% access and must build capacity for "no wrong door".
- Integrate mind, body, and soul. We should use a holistic approach, based on the biopsychosocial model.
- What every woman should know about mental health care…
- Access to appropriate care is a woman's right.
- Women's health is funda-MENTAL.
- Lack of parity for mental health coverage affects our future human and economic resources and costs society.
- Society gains when effective and accessible mental health care is available.

Products

Toolkits for health care and lay providers; assessment tools; consumer-based DVDs in pediatric offices, nail salons, consumer groups; PSA, profiles of best employers and insurers that promote and address mental health; State Report Cards on mental health; communiqués for employers that make the business case for mental health; Web-based CEUs.

Workgroup 6: Treatment Access and Insurance

The key priority issues assigned to this workgroup are listed in the box below.

Issues to Prioritize

1. Access to appropriate care through primary care providers and mental health specialists
2. The effects of racial and ethnic disparities in health service access and delivery on mental health status
3. Lack of parity for mental health care coverage
4. Insurance coverage
5. Competing demands for women that limit their ability to access care (e.g., taking care of children and other relatives)
6. Better access to treatments for adolescent depression, anxiety disorders, and eating disorders
7. Access to sex and gender appropriate diagnostic and treatment services
8. The lack of culturally and linguistically competent providers and treatment materials

The group considered and commented on each of these issues in order.

1. Access to appropriate care through primary care providers and mental health specialists

Here the point was raised that most people go to doctors, not mental health specialists. Thus, there is a need to learn how to integrate mental health concepts into primary care – creating a seamless system between the primary care physician and mental health services. It was noted that even if physicians know how to help deal with mental health issues, they lack the time in a typical office visit. In addition, appropriate care is not always there – particularly to address sex and gender, culture, and age specific issues, and it is important that care be not only appropriate but also effective.

The need to look at best practices was raised, with the comment that although primary care doctors have the reputation for being uncomfortable with mental health issues, there are models out there for doctors to cover it better. The problem is that these models are not well-disseminated or widely used.

It was noted that consumers do not always have a choice regarding the type of provider they can see. The suggestion was made that we need to look at the full continuum of care, including personal, family, and community roles and resources. Following the continuum to the end, noted a workgroup member, also means caring for the provider, who is vulnerable to stresses and mental health issues as well.

2. The effects of racial and ethnic disparities in health service access and delivery on mental health status

The workgroup members agreed that disparities should be considered as an overarching issue that reaches across multiple topics listed among the priority issues.

3. Lack of parity for mental health coverage

The discussion of this topic began with the question of how to define parity. One comment was that the issue of lack of affordable and effective insurance coverage combines lack of parity for mental health coverage with issues of insurance coverage. There was some discussion about whether these are different issues or should be combined. An additional topic that was raised regarding parity concerned the question of medical codes driving what types of things doctors do during visits.

4. Insurance coverage

One point raised related to this topic was that there is sometimes a lack of understanding regarding insurance coverage – that some people may have coverage but not understand what is covered. This was seen as an issue that needed to be more fully understood at a community level – understanding coverage and how to get treatment. Participants commented on the fact that there are differences in coverage across the country and that within a given State, there are varying levels of access to care among groups such as undocumented immigrants or members of particular racial and ethnic groups.

5. Structural barriers were noted, as were provider incentives from insurance companies or accreditation bodies to use particular screening tools.

Competing demands for women that limit their ability to access care (e.g., caretaking of children and older relatives)

Participants recognized the need for actionable and practical solutions to address the issue of competing demands and sex and gender roles. One suggestion was to focus on nonclinical settings, such as self-care, that may be easier to fit into women's lives. Other ideas included involving schools, churches, Head Start, and similar programs or organizations to fit into women's multiple constraints and responsibilities. One commenter noted that the group should not focus only on mothers.

A further suggestion was to encourage more girls and women to go into health professions to increase the supply of providers who are potentially more culturally competent and sensitive to sex and gender differences.

> "Mental illness does not discriminate, so why does the health care system? As a result, women are disproportionately affected."
>
> *—Breakout group participant*

6. Better access to treatments for adolescent depression, anxiety disorders, and eating disorders

and

7. Access to gender-appropriate diagnostic and treatment services

These two topics generated little discussion other than to consider where these types of services are delivered.

8. The lack of culturally and linguistically competent providers and treatment materials

Suggestions for addressing this topic included looking at how to train providers to deal with cultural stigma, addressing provider-patient communications, and exploring examples of culturally appropriate best practices.

Other topics

Several other topics were considered during this discussion. These included the following:

- Developing tools to address how consumers should talk with providers and what was the best use of time during an office visit.
- The need for more information on what resilience is and how to support good mental health during the primary care visit. The need for wellness and prevention models for mental health was highlighted.
- Further exploration of nonclinical models, such as self-care. For example, patient care management through the Internet has been shown to be effective.
- The need for toolkits to address financial issues (getting health care, including mental health services), integrated care issues (what to expect from a primary care provider on an annual visit), and health disparities/cultural competence.

To reflect the richness of the discussion, the group proposed to highlight several overarching issues as a preamble to their list of top priorities. Those overarching issues include:

• The incorporation and involvement of women, following the theme: for the community and by the community.

• Culture must be considered very broadly, including not only race and ethnicity but also sexual orientation, disabilities, life span, socioeconomic position, geography, and religious context.

• We must make the business case for the high cost of disparities for each priority area.

• We must recognize the importance of public discourse and the media for fostering a national dialogue and use these to create new expectations for women's mental health.

The workgroup members voted to identify the top priority issues and easily identified three as the most important and overarching, with several others seen as fitting under them. Some of the wording was revised to expand or define the issues more clearly, resulting in the three highlighted in the box below.

Key Priorities: Workgroup 6
Treatment Access and Insurance

1. Effects of racial, ethnic, and linguistic disparities in health service access, data, evaluation, and delivery on mental health status
2. Access to appropriate and effective care through primary care providers, mental health specialists, and nonclinical settings
3. Financial and structural barriers – including insurance coverage, reimbursement policies, and mental health parity

Key Priority #1: Effects of racial, ethnic, and linguistic disparities in health service access, data, evaluation, and delivery on mental health status

Messages

The following messages were articulated by the group:

• Include and know your community. Participants emphasized the importance of including experts from the community and of being trained by people from the relevant culture, racial group, ethnic group, or gender orientation. In addition, they argued that there was a need to include the appropriate data and evaluation tools – developed with the input of the appropriate cultural perspective.

• Disparities come at a high cost to society. Emphasize and demonstrate the high cost of disparities to society (e.g., DALY metric).

• Everyone can do something to eliminate racial/ethnic disparities.

• Health care and lay providers are crucial to eliminating racial/ethnic disparities, but they need support and specific tools to do so. Tools exist, as do referral sources and community resources, but they must be more effectively identified and used.

One person noted that mental illness does not discriminate, but the health care system does. As a result, she added, women are disproportionately affected.

Audiences

The group identified the following audiences, noting that these would vary depending on the particular message:

• Providers, including lay providers (messages such as "Know your patients, and know what to tell them")

• Elementary through high school youth

• Policymakers (messages on such topics as costs of health disparities)

• General public (messages such as "Disparities do not discriminate; why does the health system?")

• Consumers (messages that help empower them)

Formats

Workgroup members felt that messages for the consumer should be empowering and help them to talk with their provider. However, the concern was raised regarding how to get people to listen to these messages. This was recognized as the challenge with recommending formats. One participant suggested looking for good models and pointed to the example of the Primary Prevention toolkit that came out about 10 years ago (possibly from the Office of the Surgeon General), which included stickers, folders, and other freebies.

Their suggested formats included:

• Toolkits for providers (supports to eliminate disparities) to be used for provider certificates and training

• Communiqués aimed at businesses, insurance companies, and policymakers highlighting the high costs of disparities

Cross-cutting cultural concerns

Members of the workgroup suggested that culture should be considered very broadly – not just race and ethnicity, but also life span, sexual orientation, disabilities, socioeconomic status, living in rural areas, and religious context (as mentioned in *Healthy People 2010*).

Key Priority #2: Access to appropriate and effective care through primary care providers, mental health specialists, and nonclinical settings

Messages

The group articulated the following messages:

• **100 percent access.** The group's primary message was that access must be universal, which in turn would lead to zero disparities.

• **Integrating mind, body, and soul.** A holistic approach was advanced, using the biopsychosocial model and integrating the delivery of care to address the whole person.

• **What every woman should know about mental health.** This includes a "navigator" theme, which has been used successfully in the cancer community to help consumers navigate the health care system to obtain the services, information, and treatment they need. This message also includes the idea that every woman should have some basic wellness/prevention tools.

• **Access to appropriate care is a woman's right.** Everyone should have access to at least one effective intervention for his or her particular diagnosis, issue, problem, or health care concern.

• **Women's health is funda-MENTAL.** Access barriers to services and care may vary by individual, community, or context, so you need community participation and partnership to identify, prioritize, and rectify barriers. We need an integrated system that connects primary care providers and mental health providers that can offer culturally,

racially, and ethnically appropriate best care practices.

Audiences

Two key audiences were identified for these messages: providers and consumers.

Formats

The group's suggested formats included the following:

For consumers

- An educational DVD offered in pediatric offices, food stamp programs, churches, beauty shops, gyms, and other venues where women can be reached. It would address the life span, contemplate different groups of women, and provide role models. It also would address navigation issues such as how to access treatment, which treatments are available, and so forth.

- PSAs for radio and TV stations

For providers

- CEUs and conferences to build capacity through integrated treatment. Emphasize access to care in clinical and nonclinical (peer support groups, etc.) settings that focus on prevention, wellness, and care using the biopsychosocial model. Dissemination must recognize the challenge of getting providers to read materials, which can be addressed through strategies such as CE courses or Web-based information.

Key Priority #3: Financial and structural barriers – including insurance coverage, reimbursement policies, and mental health parity

Messages

These were the messages articulated by the workgroup regarding the issue of financial and structural barriers:

- Lack of parity for mental health coverage affects our future human and economic resources and costs society.

- Society gains when effective and accessible mental health care is available (e.g., low employee turnover, increased productivity, less need to hire and train new employees).

The point was made that it was important to show data demonstrating the cost benefits of mental health coverage to employers, insurers, and policymakers.

Another issue raised during this discussion was the importance of ensuring that coverage takes into account the caregiver role, primarily played by women, and gives assistance in navigating the system.

Audiences

The identified audiences for these messages included employers, payers (insurers), and policymakers.

Formats

Suggested formats included:

- A toolkit or communiqué for businesses showing the business case for offering mental health coverage

- Media partnerships

- Profiles of employers offering the best mental health coverage and services (e.g., report card, best companies to work for, incentives)

- A report card of State coverage and services for mental health

Workgroup 6 Participants

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Workgroup 7: Health System Issues At-A-Glance

Priorities

1. Medication issues for women
2. Inadequate emphasis on women's mental health issues in education and training for health care providers
3. Family planning and women with major mental illness

Messages

- Additional evidence-based information is urgently needed concerning the safety and effectiveness of psychotherapeutic medications, including sex and gender and reproductive cycle factors and consideration of nonpharmacological interventions.
- Women's mental health needs should be incorporated into all levels of health care curricula, including in the knowledge, skills, and attitudes regarding sex and gender differences and issues of race, ethnicity, and culture.
- Discussions about reproductive health and family planning should be incorporated into the care of all women with major mental illness.

Products

PSA, booklets, proclamation, posters, RFPs, Web-based CEUs, advocacy toolkit, letters to governing bodies of educators, press releases

Workgroup 7: Health System Issues

The list of priority issues to be considered by the health system issues breakout group is identified in the box below.

Issues to Prioritize

1. Lack of information on safety, dosing, and effectiveness of medications during pregnancy and lactation
2. Inclusion of women in clinical trials and pharmacokinetics/pharmacodynamics of drugs
3. Inadequate emphasis on women's mental health issues in academic curricula for physicians and other health care professionals
4. Side effects of medication
5. The role of hormone therapy in symptomatic perimenopausal women
6. Family planning and women with major mental illness

There was considerable general discussion on the topic of health systems issues prior to consideration of how to prioritize the ones presented to the group.

Budget constraints

Budgetary concerns at the State and provider system level were identified as one problem plaguing the health care delivery system. As one provider put it, "Money and budget undercut all of the issues in this group." Similarly, fragmentation in the system itself

was identified as an important barrier along with the lack of agreement on how to deliver mental health care; for example, whether it should be focused more on pharmacology or nonpharmacological issues.

Technology transfer

However, the primary concern for many group participants, which was not listed as a priority, was the issue of technology transfer – or how to transfer knowledge from research and the evidence base into language and tools that would be beneficial to consumers – especially those, like homeless women, who are most at risk. The group suggested several solutions for improving the transfer of technology. One suggestion was to use partnerships to help determine what is working and what is not, based on evidence-based practice. Other suggestions for improving the translation of research into practice included increased advocacy, research, education, and training.

Redefining the issues

Many members of the workgroup felt that the issues listed were not really health system issues and that important issues that belonged under this topic were missing.

It was noted by several in the group that there was heavy emphasis placed on pharmacological concerns within the six priority issues. The emphasis on pharmacology seemed almost in direct contrast to how many participants defined a health system. They were reminded that the topics had been chosen according to both their importance and their action potential. Many other issues identified in the concept mapping might have fit more closely with the group's definition of health system issues but may not have been considered very high in action potential.

By consensus, the group identified three overarching themes that they felt needed to be integrated throughout the discussion of health system issues. Those themes included:

- Safety
- Quality
- Disparities

After much discussion, the workgroup members decided to condense several issues and define the three priority issues as listed below.

Key Priorities: Workgroup 7
Health System Issues

1. Medication issues for women
2. Inadequate emphasis on women's mental health issues in education and training for health care providers
3. Family planning and women with major mental illness

Key Priority #1: Medication issues for women

Messages

Workgroup members noted that the research shows greater rates of unwanted pregnancies among women with major mental disorders, indicating that their family planning needs are not well-met. The group formulated the following message to address this issue:

Additional evidence-based information is urgently needed concerning the safety and effectiveness of psychotherapeutic medications, including sex and gender and reproductive cycle factors and consideration of nonpharmacological interventions.

This message reflected concerns raised by participants regarding the following issues:

- The lack of information on safety, dosing, and effectiveness of medications during pregnancy and lactation
- The need to include women in clinical trials and understand the pharmacokinetics/pharmacodynamics of drugs
- The need to gain further understanding of the side effects of medication
- The role of hormone therapy in symptomatic perimenopausal women
- The need to define sex and gender broadly – across age, race, ethnicity, and transgender issues

Audiences

The primary audience defined by this group for this issue was the research community, including pharmaceutical companies and Federal organizations such as the NIH, the Food and Drug Administration, and the Agency for Healthcare Research and Quality.

Formats

The group identified several means and venues for disseminating the message:

- Proclamation
- Request for proposals
- Web-based continuing education for providers
- Advocacy toolkits
- Congress
- Health care providers
- Advocacy groups
- Consumers
- National Health Policy Forum (for Congressional staffers)

Cross-cutting cultural concerns

The following issues were identified as cross-cutting cultural concerns:

- Race and ethnic disparities
- Class
- Stigma
- Language barriers
- Belief systems
- Trust
- Stereotypes about legal and immigration status

Resources and challenges

The group identified several resources to address this issue, including additional funding, policy changes, and public/private partnerships or collaborations.

In terms of challenges, there were two major areas of concern, including ethical issues and the institutionalization of reporting requirements around race and gender.

Key Priority #2: Inadequate emphasis on women's mental health issues in education and training for health care providers

Messages

The group formulated the following message:

> Women's mental health should be incorporated into all levels of health care curricula, including in the knowledge, skills, and attitudes regarding sex and gender differences and issues of race, ethnicity, and culture.

Other issues that participants felt should be included in health care training included:

- Standards of care and best practices

- Knowledge of sex and gender differences in disease manifestations in response to therapy

Audiences

The group thought that this message should target the following audiences:

- Health care educators
- Administrators
- Students
- Policymakers
- Health care providers
- Professional organizations
- Case managers

Formats

The group identified several means for disseminating the message:

- Communiqués
- Letters to governing bodies of educators
- Press releases for the general public

Cross-cutting cultural concerns

Several overarching concerns were raised:

- Racial and ethnic disparities
- Limited English proficiency
- Cultural competence of providers

Resources

One resource that this group recommended was the development of a multidisciplinary expert consensus group. The suggestion was made that one of the projects it could undertake would be a multidisciplinary needs assessment.

Key Priority #3: Family planning and women with major illness

Message

There was consensus among the participants that the term "family planning" was too narrow. It was agreed that "reproductive health" should be added instead for a more comprehensive message. As a result, the following message was proposed by the workgroup:

Discussions about reproductive health and family planning should be incorporated into the care of all women with major mental illness.

Audiences

The group proposed several audiences for this message:

- Health care providers
- Students and trainees
- Consumers
- Administrators
- Professional associations

Formats

The group identified several formats and venues for disseminating the message:

- Booklets or pamphlets
- PSAs
- Proclamations
- Posters
- Mental health centers
- Drop-in centers
- Correctional facilities
- Professional association meetings
- Advocacy organizations
- Conferences
- Churches

Cross-cutting cultural concerns

The following list was identified as incorporating key cultural considerations for effectively disseminating the message:

- Language barriers
- Belief systems regarding reproductive health
- Treatment disparity
- Stigma
- Stereotypes
- Sexual orientation

Resources

Workgroup members also proposed several resources to inform and develop this topic:

- Funding sources
- Marketing specialists
- Needs assessments
- Focus groups

Workgroup 7: Health Systems Issues

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Workgroup 8: Protective and Resilience Factors At-A-Glance

Priorities

1. Relationships and social and community supports
2. Knowledge and education
3. Culture, spirituality, traditions, faith, and making meanings

Messages

- Every girl needs at least one supportive, safe, trusting, loving relationship to develop resiliency and positive mental health and wellness.
- Protecting and nurturing your daughter means protecting and nurturing yourself.
- The development of more programs in the arts, sports, music, and such can build self-efficacy and self-esteem as prevention and as a form of healing and recovery.
- Communicate the prevalence, impact, and appropriate response to sexual and physical abuse.
- Sexual and physical abuse traumas exist. Here is the damage they can cause, and here are ways people can protect themselves or recover and heal.
- Create a safe environment by recognizing culture, spirituality and traditions. Respect and validate women's voices and the meaning that they make out of their life experiences.

Products

PSAs, pamphlets, Web site, radio TV, awareness campaign, research on resilience with resulting materials in plain language, soap opera and talk shows, curriculum development, certification and licensure, criteria for professional competencies, handbooks, literature for adolescents, training curriculum, peer training, ways to acknowledge negative cultural issues (e.g., trauma assessment tool).

Workgroup 8: Protective and Resilience Factors

The workgroup was asked to pick three priority issues from the list indicated in the following box.

Issues to Prioritize

1. Coping skills for stress and emotional issues
2. Enhancing resilience factors, such as active coping and assertiveness in girls, to prevent emotional problems
3. Lack of knowledge about mental health well-being versus signs and symptoms of mental health problems
4. The relation of physical activity to depression or anxiety treatment
5. Mentoring and positive role modeling

There was considerable discussion surrounding this list, which ultimately the workout group members redefined significantly in order to identify three key priorities for protective and resilience factors.

Numerous overarching issues were raised during the course of this discussion, and they are summarized below:

Starting young

Much of the general discussion around the question of prioritizing the issues began with an emphasis on the importance of starting young. Participants noted that issues of protective factors and resilience, as well as the risk factors that may undermine them, begin in childhood.

Relational perspective

Several group members commented on the importance of thinking about resiliency from a relational perspective – for example, the fact that young girls are still socialized to take care of everyone else and not themselves. It was noted that the early literature on resiliency did not take into account the relational approach. More recently there has been a change to adopt this approach and look at results from a contextual perspective to see why some children will do well in one situation while another will not, or why a child will do well in one situation and fail in another.

It also was pointed out that some literature defines resilience differently, following the varied pathways people take to deal with difficulties. Thus, for example, researchers might look at how different people deal with grief, with some finding a way to use it as a growth experience.

Societal pressures on girls and women

An issue raised by several group members had to do with strong societal pressures on girls and women from the media industry and other social arenas. These pressures change with time, it was noted, and currently reflect the greater sexualization of society, idealized body images, and increased violence.

Violence, abuse, and trauma

The theme of violence was picked up by several workgroup members, who spoke of personal experiences with the issue of unaddressed childhood trauma resulting from physical and sexual assaults – and the resulting mental health and health risk issues that they lead to later in life. Group members shared stories of family members and others they had known who struggled with the effects of the childhood trauma and had not found the type of treatment or support they needed. For example, one person told of the experience of trying to find help for her daughter, a victim of sexual assault at age 4, in a system that was not equipped to meet her needs – and ultimately failed her. She noted that doctors and teachers were caring but did not have the knowledge or training to help. She expressed her frustration at the way money is spent for conferences and physicians but misses the people who are affected and need help.

Suggestions were made regarding the need to inform providers and others who interact with children better to identify signs of trauma or abuse and to know how to refer victims to appropriate services. The concern was raised that these individuals face the temptation to take the path of least resistance or just to treat the immediate symptoms they see without trying to identify a deeper cause, such as child abuse. One person noted that providers need to be taught to "ask the questions".

Similarly, several people raised the issue of needing to offer greater supports to parents, including the grown victims of abuse. As one participant pointed out, the average age for posttraumatic stress disorder among girls is 16 years. These girls grow up to have their own children – raising the question of how to build in supports and stop the cycle of victimization.

Models to build protective factors and resilience

Group members then discussed the importance of protective factors and of creating safe and supportive environments. They spoke of the need for building in supports, such as support groups where people can talk freely, and noted that just one significant relationship can be a protective factor.

There was a call for more models of evidence-based practice and promising practices in all aspects of the mental health system. One person specified that there was a need to change the paradigm from a disease focus to an evidence-based focus.

Participants added that it was important to look at strengths instead of just problems – looking at strengths such as competencies, skills, and abilities. They also noted the protective, strengths-building, self-efficacy developing roles of factors such as sports, physical activity, and good nutrition – though one participant commented that for some children these are not attainable.

Several overarching themes emerged from the group's discussion:

- To talk about resilience, you must talk about risk.
- The goal is to decrease risk and increase protective factors. Resilience surrounds both.
- Regarding trauma, it is critically important to increase knowledge and education on every level.

Reframing the priority issues

Group members agreed that the five priority issues that they had been given presented a mismatching combination of formats, with some representing activities and others representing subcategories of broader issues. As a result, participants discussed ways to reframe and repackage the priority issues.

Within this discussion, the concern was raised that other workgroups had been assigned tasks related to risk factors and issues such as trauma and abuse. Thus, the suggestion was made to focus on how to build resiliency with protective factors, with the understanding that this must be done in coordination with the mitigation of risks (which overlaps with other workgroups).

Identifying protective factors

Participants brainstormed to create an extensive list of protective factors. That list includes safe environment; one or more significant relationships; honoring women's experiences; nutrition; trust; social supports; community connections; supportive relationships; strength-based competencies, self-efficacy; empowerment; knowledge and education; healthy lifestyles; adequate health care access and quality; ownership and informed choices regarding a woman's own body; spirituality; cultural values and traditions; respect for diversity, including sexual orientation and women who are not mothers; awareness and acceptance of trauma histories; and integration of mind, body, and spirit.

Four general categories were identified for classifying these different protective factors:

- Relationships and social and community supports
- Strength-based competencies and self-efficacy
- Knowledge, education, and recognition
- Culture, spirituality, and traditions

There was recognition that more research is needed on what factors affect people of different cultures and races.

Following this lengthy discussion, the workgroup defined its own three priority issues, based to some extent on the original list provided, but refined and condensed to

reflect the knowledge and concerns of the workgroup participants. Their key priorities are listed in the box below.

Key Priorities: Workgroup 8
Protective Factors and Resilience

1. Relationships and social and community supports
2. Knowledge and education
3. Culture, spirituality, traditions, faith, and making meanings

Key Priority #1: Relationships and social and community supports

Message

Members of the group commented on the essential importance for girls of having a relationship or bond with someone and that parents often underestimate its importance. They noted that authentic relationships with transparent communication need to start early and continue throughout life. One person added that to start healing, you just need to have some significant relationship with another person. It was noted that this significant relationship does not necessarily have to be with a parent but can be with a person who has their best interests in mind.

Another issue that was raised was how to help parents, particularly mothers, create resilience in their child even if they do not have it themselves.

Based on their discussion, the group members recommended the following messages:

- Every girl needs at least one supportive, safe, trusting, loving, healthy relationship (may or may not be with a biological parent) to develop resiliency and positive mental health and wellness.
- Protecting and nurturing your daughter means protecting and nurturing yourself.

Another area, which came up later in the discussion but was identified as belonging here, focused on looking at or asking what girls are good at and what makes them strong, instead of focusing on pathology. This led to the development of an additional message:

- The development of more programs in the arts, sports, music, and such can build self-efficacy and self-esteem as prevention and as a form of healing and recovery.

Audiences

Although the group members recognized that there are numerous potential audiences and could be numerous products for this priority, they tried to narrow the focus. Ultimately, the group decided to focus on two audiences:

- Parents (broadly defined to include caretakers and other parent-like figures)
- Girls

Formats

Their proposed formats included:

- PSAs for girls and parents
- Pamphlets
- Research on resilience in girls, including more studies on both what the protective factors are and what builds and destroys resiliency
- Literature for adolescents that reflects lessons from research in plain language

Cross-cutting cultural concerns

The group noted that when preparing products for non-English-language audiences, there needs to be not just a linguistic translation but an adaptation that incorporates cultural translation and considerations as well.

Another issue which came up during the discussion was the cultural tradition – for example, among Latinas – to put others before themselves always.

Culture speaks to everyone, gives a message of hope, and helps to make meaning out of life experiences.

Talk about the prevalence, impact, and appropriate response to sexual and physical abuse across the life span.

Sexual and physical abuse traumas exist. Here is the damage they can cause, and here are the ways people can protect themselves or recover and heal.

Dissemination and resources

The following dissemination venues were recommended:

- Schools
- The Internet
- Radio and TV
- Providers' offices

In terms of resources, the suggestion was made that we need to get youth together (who have not been silenced) to craft the language for girls. Participants noted that attention would have to be paid to ensuring a cross-representation of communities, cultures, and kids who have gone through the good and the bad. The same was recommended for messages targeted to parents.

Key Priority #2: Knowledge and education

Messages

Although they considered more tailored messages, ultimately members of the workgroup agreed that messages for this topic should be aimed at a broad public audience to try to reduce the stigma surrounding mental health issues.

Two similar suggested messages were proposed, though only the first was included in the PowerPoint presentation for the plenary session. While they overlap, both are presented here to capture the full range of discussion and nuances:

Audiences

The primary audience identified for this topic was the general public. The secondary ones include providers, educators, and others who interact with girls.

Formats

The following formats were proposed:

For the general public:

- PSAs
- Soap operas
- Talk shows
- Peer training (especially for targeted populations)

For professionals:

- Integration of messages into degree training (interdisciplinary), CEUs, licensure by professional associations
- Legislation on training for providers in this area
- Handbooks
- Use of real-life experiences and perspectives from people who have been there and experienced trauma or abuse to help educate providers

Cross-cutting cultural concerns

Though it was referred to as a taboo subject, someone noted that in some cultures, incest and domestic violence are acceptable. To address this issue, it is important to use

women from within those cultures who want change.

Another issue that was raised under this category was age-appropriate concerns.

Key Priority #3: Culture, spirituality, traditions, faith, and making meaning

Messages

The group noted that many cultural and spiritual issues were encompassed under the two previous key priority issues. Nonetheless they considered how culture speaks to everyone, gives a message of hope, and helps to make meaning out of life experiences. Similarly, the comment was made that faith helps women and girls to overcome.

Another point was made regarding the need to address the viability of different lifestyles (e.g., gay, lesbian, transgender, bisexual, questioning) without treating them as diagnoses.

A final topic of discussion was the detrimental cultural values in women's lives. As one person explained, when treating trauma, you always believe the woman; in substance abuse, you never believe the woman because of ingrained ideas that substance users are necessarily liars.

Ultimately, the group proposed the following message:

"Create a safe environment by recognizing culture, spirituality, and traditions. Respect and validate women's voices and the meaning that they make out of their life experiences."

Audiences

The following audiences were identified for this topic:

- Providers
- Families
- General public

Formats

The suggested formats included:

- Criteria for professional development
- Handbooks
- Training curricula
- Ways to acknowledge negative cultural issues (e.g., a newly developed trauma assessment for women to be used as a State standard that addresses these issues)

Cross-cutting cultural concerns

Several people commented that it was important to remember that there is a women's culture that has no cultural/racial boundaries: women have many of the same problems and feel the same way about them.

Nonetheless, there was recognition that providers must be made aware and expected to respect the diverse cultural aspects of people's lives and what is important to the individual (e.g., many African-American women feel that they must endure and can carry everything on their backs).

Another concern was related to the conflict between professional values and cultural values (e.g., if a girl does not make eye contact, it may be for cultural reasons).

It was also pointed out that the word "resilience" does not exist in Spanish, but there are other cultural values that can promote resilience.

Finally, participants discussed the negative influences of cultural beliefs and norms that may prevent women from seeking help for mental disorders or may pressure them to stay in situations of There was a reminder, too, about the negative aspects of culture and the need to support women who are trying to escape those negative aspects.

Workgroup 8: Protective Factors and Resilience

Facilitators

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Day 2 – Final Session

Overview of Themes and Recommendations from the Breakout Workgroup Presentations

Rear Admiral Kenneth Moritsugu, M.D., M.P.H., Deputy Surgeon General, greeted the workshop participants and thanked them for their hard work and generosity in sharing their perspectives and personal experiences for this effort. Dr. Moritsugu also thanked the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, and the Society for Women's Health Research for sponsoring the workshop reception.

Dr. Moritsugu expressed Dr. Carmona's regrets regarding not being able to stay for both days of the workshop due to a mission assignment from the White House in celebration of World AIDS Day. The Surgeon General reported that he was very excited and energized by this workshop. He reiterated his commitment to the issue of women's and girls' mental health and to the goals of the workshop.

In his role as Deputy Surgeon General, Dr. Moritsugu explained that he provides oversight and direction for the development of Surgeon General's documents. Dr. Moritsugu assured the workshop participants that he would be recording and considering the outcomes of their discussions carefully – and bringing these back to the Surgeon General.

In honor of the fact that it was World AIDS Day, the Deputy Surgeon General took a few minutes to acknowledge the heavy toll that HIV/AIDS takes on women and girls and how it relates to issues of women's mental health.

He reminded the audience that an estimated 39.4 million people worldwide were living with HIV at the end of 2004 and more than 20 million had died of AIDS since 1981. December 1, noted Dr. Moritsugu, serves as a reminder that action makes a difference in the fight against HIV/AIDS. He added that across our own Nation, African-American and Latina women are at particular risk for HIV/AIDS, and no one is immune to HIV. He noted that the percentage of women being infected with HIV has increased sharply to 27 percent of new cases.

As was discussed within some of the workgroups, Dr. Moritsugu commented that mental health issues can put women at risk for engaging in health risk behaviors – such as injection drug use or sexual contact – that can put them at risk for acquiring HIV. Thus, he said, it is very timely that we have come together to develop messages and communication strategies to better address the mental health issues of women and girls, which also may help protect them from developing other health problems, including HIV/AIDS.

Dr. Moritsugu reminded the workshop participants that the President's Emergency Plan for HIV/AIDS Relief is a $15 billion global initiative to provide HIV/AIDS prevention and treatment services in 15 countries. He added that domestically, the President is working with Congress to reauthorize the Ryan White Comprehensive AIDS Resources Emergency Act, which funds primary health care and support services for individuals living with HIV/AIDS.

However, the battle against HIV/AIDS cannot be won by political leadership alone, warned Dr. Moritsugu. Individuals hold the most important keys to eradicating HIV – prevention and early diagnosis are vitally important.

Similarly, individuals hold the key, both alone and in united forums, for addressing and promoting the mental health of women and girls.

Dr. Moritsugu concluded by saying that he looked forward to hearing the recommendations of the workgroups and working together to set the direction of how to proceed with Surgeon General's communiqués to address the important issues of women's and girls' mental health.

> "The work you have been doing at this workshop and the ideas and recommendations you have generated will be very helpful in setting the direction for how we will proceed with the development of Surgeon General communiqués to address the mental health of our Nation's women and girls."
>
> *– Kenneth Moritsugu*
> *Deputy Surgeon General*

Wanda K. Jones, Dr.P.H., Deputy Assistant Secretary for Health, OWH, invited the facilitators from the eight working groups to present their groups' recommendations. These were offered in the form of PowerPoint slides, which highlighted the three priority issues identified by each workgroup as well as the corresponding major messages, audiences, suggested formats, dissemination strategies, challenges and resources, and cross-cutting cultural concerns described in the previous chapter of this report.

Comments from the Workshop Participants

Following the workgroup presentations, Dr. Jones invited the workshop participants to share questions and comments with the larger group. The following highlights major themes and issues raised in those comments:

Prevention

- If we want to build prevention and resilience, it is important to identify what good mental health looks like (e.g., positive relationships, autonomy). There are plenty of images in the media about bad mental health, but we do not have the picture of good mental health. We need more data on this. It also would be helpful to explore how better to harness innovative technologies that can help boost resiliency.

- We need to pay more attention to the theme of prevention. The mental health challenges of trauma and violence are preventable. We must prevent the intergenerational cycle of abuse. Los Angeles has billboards and other public campaigns designed to address this topic. We also need to educate State legislators about prevention and mental health.

- We need to focus on self-care for the caregivers and nurture the deficit disorder that women face who care for others.

- Prevention needs to include issues such as eating disorders. We see disorders such as anorexia, which affects 2.5 million people in the United States, in children as young as 9 years. Binge eating disorders are not even on the table.

Families

- Families are critical, and they are the first place we learn to heal.

- We need to acknowledge and support the role women play in holding families together in the face of immigration to this country and the traumas that may precipitate or follow that change. Many carry the burden of trauma silently, face language and other barriers, and do not know that they have a right to access services.

Integrating mental health and overall health

• We will never address the issue of parity between mental health and other health unless we have a workgroup specifically designed to address this issue.

• We need to integrate mental health with primary care, but the payment systems do not match. We need to advocate for greater parity and integration with legislators and health care business representatives.

Target populations

• Although aging was mentioned in some discussions and presentations, we need more dialogue on this issue, including with women themselves. We need to talk about conveying the message to older women that they should not give up taking care of themselves. We need to address issues of isolation. The Administration on Aging is in the process of developing a toolkit addressing depression in women over age 65.

• The issues of trafficking and prostitution, which affect an estimated 30,000 to 50,000 women and girls in the United States, need to be addressed.

• Incarcerated women and women with HIV face undue mental health needs.

• Rural women and girls often have no place or no one to whom they can turn. In the past 40 years, there has been no progress in increasing the supply of providers. Moreover, 61 percent of people in rural areas are underserved for mental health. In Nebraska, there is only one provider for cognitive behaviors in the whole State.

• Women in the military now constitute 15 percent of our overseas troops. Some are given only 4–6 weeks' notice before being deployed. Some are four months postpartum. They face issues of trauma, abuse, and secrecy – the "don't ask, don't tell" policy affects these areas, too.

• It is important to look at both sex and gender differences and similarities. Men can be our allies, too.

Developing products and sharing existing resources

The 1980s letter from the Surgeon General on HIV/AIDS is something that people still remember. It can be a very effective tool.

• A document highlighting exemplary practices would be very useful for presenting to legislators; such as a compendium of consumer networks, State standards, and other such resources for mental health issues, such as trauma or eating disorders.

• We need information for parents written at a sixth-grade level and readily available to families. Educate parents and children on why mental health is important and that there are resources out there to help with healing.

• We need to train front-line staff to be mental health savvy and responsive. They well may determine whether a person speaks up or returns to a provider.

• There is a new evidence-based report on eating disorders due to be released in the spring of 2006. Another report is focusing on feedback from focus group participants regarding the use and effectiveness of domestic violence hotlines.

• California passed a tax for mental health services. The next phase will be on identifying innovations so that California counties can incorporate some into their mental health plans.

Closing Remarks

Rear Admiral Kenneth Moritsugu, M.D., M.P.H., Deputy Surgeon General, closed the meeting by reiterating the Surgeon General's personal commitment to bringing hope to those suffering from mental disorders – directly or indirectly through individuals they love – and to a strategy of prevention so that fewer women and girls will suffer in the future.

> "The Surgeon General communiqués and toolkits we develop will be a platform upon which we will build the awareness to move all of the stakeholders – consumers, providers, policymakers, researchers, and the media – to action."
>
> *– Kenneth Moritsugu*
> *Deputy Surgeon General*

The Deputy Surgeon General reviewed some of the major themes heard at this workshop that can help serve as a guide in the development of Surgeon General's communiqués and toolkits. Those themes included the following:

- Mental health is integrally important to overall health, or as one group put it, there is no health without mental health.

- To address stigma, mental health needs to evolve, as cancer has, to be seen and accepted as another chronic condition.

- We must recognize that many families have their "day stories" and their "night stories" hiding secrets of abuse, trauma, and pain.

- Mental disorders touch all of us directly and through the people we love.

- When it comes to mental health, sex matters – and so do gender differences in the causes, course, treatments, and prevention of mental disorders.

- The importance of trauma, violence, and abuse needs to resonate more clearly with the general public, providers, researchers, and policymakers.

- We must continue to spread the word that recovery is possible, and we must transform the mental health services system beyond treatment of acute symptoms to one that is focused on recovery.

- We must look at mental health issues such as specific conditions, risk, resilience, and protective factors across the life spans of women, from childhood through the later years. Products should be designed to target different age groups and life stages.

- Culture is clearly a priority that cuts across all of the areas of discussion related to the mental health of women and girls. Tools must be culturally competent and developed with the participation of diverse consumers and communities.

- Culture also must be considered from a strengths-based perspective and as a source of protective factors and resilience.

Dr. Moritsugu noted that the different breakout workgroups had generated some excellent and creative ideas for concrete products and toolkits, ranging from a letter from the Surgeon General to the American people, to iPod messages for teens, audio and low-vision materials, storytelling formats, PSAs, messages on commonly used products, assessment tools, profiles of model practices or best companies for mental health, and many more.

Everything we do will affect the lives of individuals, commented Dr. Moritsugu. He added that he would not forget the human aspect of the issue of women and girls'

mental health – as expressed by Rene Andersen, Dr. Carmona, and many others during the course of this workshop. Dr. Moritsugu also reminded workshop participants of lessons learned from Hurricane Katrina shared by Dr. Bowers-Stephens regarding the disproportionate effects of natural disaster on women and children. These must be taken into consideration, he noted, as we continue to develop our Nation's disaster planning and emergency preparedness.

The Deputy Surgeon General concluded by assuring the workshop participants that the goal was not to produce just another Federal report that would collect dust on a shelf. He reminded the audience that Surgeon General's publications through the years have been catalysts for action to improve the health of Americans. Dr. Carmona, he added, is passionate about the need for action, not just talk, and committed to seeing that the communiqués have a true impact on the lives of individuals. Dr. Moritsugu finished by thanking participants for their contributions and dedication, saying that everyone has a role to play in this endeavor and that the Office of the Surgeon General will rely on the continued input and work of the people gathered at this meeting.

Appendix A: Conceptual Framework

Health Systems Issues

- Lack of information on safety, dosing, and effectiveness of medications during pregnancy and lactation.
- Inclusion of women in clinical trials and pharmacokinetics/pharmacodynamics of drugs.
- Inadequate emphasis on women's mental health issues in academic curricula for physicians and other health care professionals.
- Side effects of medication.
- The role of hormone therapy in symptomatic perimenopausal women.
- Family planning and women with major mental illness.

Treatment Access and Insurance

- Access to appropriate care through primary care providers and mental health specialists.
- The effects of racial and ethnic disparities in health service access and delivery on mental health status.
- Lack of parity for mental health care coverage.
- Insurance coverage.
- Better access to treatments for adolescent depression, anxiety disorders, and eating disorders.
- Access to gender appropriate diagnostic and treatment services.
- The lack of culturally and linguistically competent providers and treatment materials.
- Competing demands for women that limit their ability to access care (e.g., caretaking of children and older relatives).

Identification and Intervention Issues

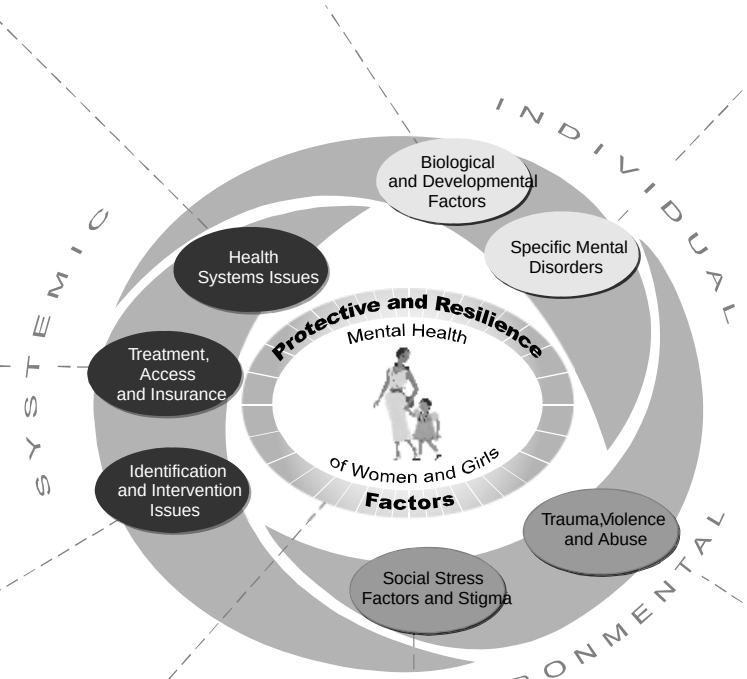
- The importance of consumer and provider empowerment, self-determination, and choice in mental health treatment.
- Models for transitioning women from institutions to re-entry into family community living.
- Preventive interventions for the most common and disabling disorders, such as major depression and anxiety.
- Depression and anxiety that go undiagnosed and therefore untreated.
- The need for screening for depression, anxiety, and other common mental disorders in primary care, schools, and other settings.
- The need to implement the comprehensive statewide program for suicide prevention previously described in the National Strategy for Suicide Prevention.
- The lack of support and care options for female older adults.
- Complementary and alternative medicine in relation to self-treatment of mental disorders.

Protective and Resilience Factors

- Coping skills for stress and emotional issues.
- Enhancing resiliency factors such as self-esteem, coping and assertiveness in girls to prevent emotional problems.
- Lack of knowledge about mental health well-being versus signs and symptoms of mental health problems.
- The relation of physical activity to depression or anxiety treatment.
- Mentoring and positive role modeling.

Biological and Developmental Factors

- Understanding basic neurological sex differences.
- The need for increased effort to relate biological and genetic mental health research to epidemiologic differences in prevalence and course of mental disorders.
- Sex differences in treatment response (both efficacy and side effects).
- Factors contributing to the emergence of gender differences in mental disorders in adolescents.
- Gender differences and the effects of psychotropic medications.
- The neurobiology and physiology of sex differences in social behavior and attachment.
- Understanding the biological bases of normal sexual and gender differences.
- How the developmental phases of young females affect their mental health status as women.



Specific Mental Disorders

- Substance use and abuse (alcohol, tobacco, illicit, prescription use and other drugs).
- Loss, depression, and anxiety across the lifespan.
- Perinatal depression and anxiety and its effects on the family.
- Adolescent depression and anxiety and suicide.
- The impact of race, ethnicity, culture, class, sexual orientation and age on the expression of symptoms.
- The relationship between depression and anxiety and other negative mood states and substance abuse, especially smoking.
- Recognition of enduring effects of depression and anxiety.
- Comorbidity of mental disorders (depression, anxiety, mood disorders, substance abuse including smoking, eating disorders, harming oneself and suicide).
- The impact on children of parental institutionalization (psychiatric, correctional and military deployment).
- Understanding why women are more prone to suicide attempts than men.
- The interaction of mental disorders with other illnesses, both as cause and consequence, (e.g. cardiovascular disease and diabetes).
- Eating disorders.
- Obesity and body image issues.
- Research on serious mental illness in women.
- Gender differences in course, pathophysiology, and treatment response in mental disorders.
- Post traumatic stress disorder.
- Bipolar disorder.
- Schizophrenia.
- Personality disorders.
- Dissociative disorders.

Trauma, Violence, and Abuse

- The effects of early trauma (abuse, neglect, loss of a parent) on the development of depression and anxiety in women, especially African American women.
- Sexual violence against girls and women.
- Childhood abuse, whether physical and/or sexual and the long term effects.
- Domestic violence in heterosexual and same sex relationships.
- Emotional abuse and neglect.
- The effects of bullying, teasing, and sexual harassment in school.
- Gender discrimination, sexual harassment, and violence in the workplace.

Social Stress Factors and Stigma

- Increased risk of victimization for all women.
- The extent to which lower socioeconomic status and/or minority status relates to mental health.
- The discrimination and lack of social acceptance that those with mental disorders face.
- Internal barriers to mental health care such as shame and guilt.
- Negative images of girls and women, particularly among women, in television, magazines, and film-related media.
- The need for additional research on the economic impact of maternal mental illness on family health outcomes.

Appendix B: Communiqués and Toolkits: Ideas from Leadership Interviews and Facilitated Discussions

Breakout group participants will develop recommendations for Surgeon General's communiqués and toolkits on issues affecting the mental health of women and girls. These products might include some of the following ideas suggested in the leadership interviews and facilitated discussions held earlier this year:

- A People's Piece booklet for consumers on women's mental health, similar to companion booklets for recent Surgeon General's reports on smoking and bone health
- A TEN TIPS series for consumers and providers on issues of concern for the mental health of women or girls
- Booklets on what we know about sex and gender differences in major mental disorders, risk factors, violence, stigma, trauma, etc.
- Booklets on best practices and promising models for professionals and policymakers (e.g., "Current Issues in Women's Mental Health")
- Interactive Web-based toolkits for consumers and professionals with links to resources (e.g., OWH's BodyWise toolkit on nutrition, physical activity, and eating disorders), OWH's BodyWorks toolkit on a range of health issues and questions for girls, AoA's new depression self-management toolkit, HRSA's nutrition and physical activity toolkit for Bright Futures, HRSA's new toolkit promoting emotional and spiritual wellness, model programs, and white papers

Other ideas include suggestions for toolkits targeted specifically to consumers and families and to professionals:

Toolkits for Consumers and Families

- Information about specific mental disorders (e.g., prevention, symptoms, treatment options)
- Information about breaking down the barriers for constant re-enrollment for Medicaid (e.g., every 6 months for some States) that includes guidelines about what must be done to access publicly funded services, when, and by whom
- A community-based resource directory
- Information about self-advocacy (e.g., how to ask questions, what questions to ask), patients' rights, confidentiality, and HIPAA
- Information on issues that affect only women or primarily women (e.g., eating disorders, domestic violence, trauma, abuse, depression and anxiety)
- A self-screening tool or checklist

Toolkits for Professionals

- Culturally competent screening
- Community-based resource directory to distribute to consumers
- Community-based resource directory for providers (e.g., who to go to for questions and advice)
- Issues that affect only women or primarily women (e.g., eating disorders, domestic violence, trauma, violence and abuse, depression and anxiety)
- Appropriate waiting room environments (e.g., showing a stress management video instead of Jerry Springer)
- Confidentiality and HIPAA
- Provider empowerment
- Provider support and self-care (e.g., how to deal with one's own stigma, how to seek support for one's own response to people's distress and one's own wellness)

Appendix C: Participant List

The Surgeon General's Workshop on Women's Mental Health Participants List

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