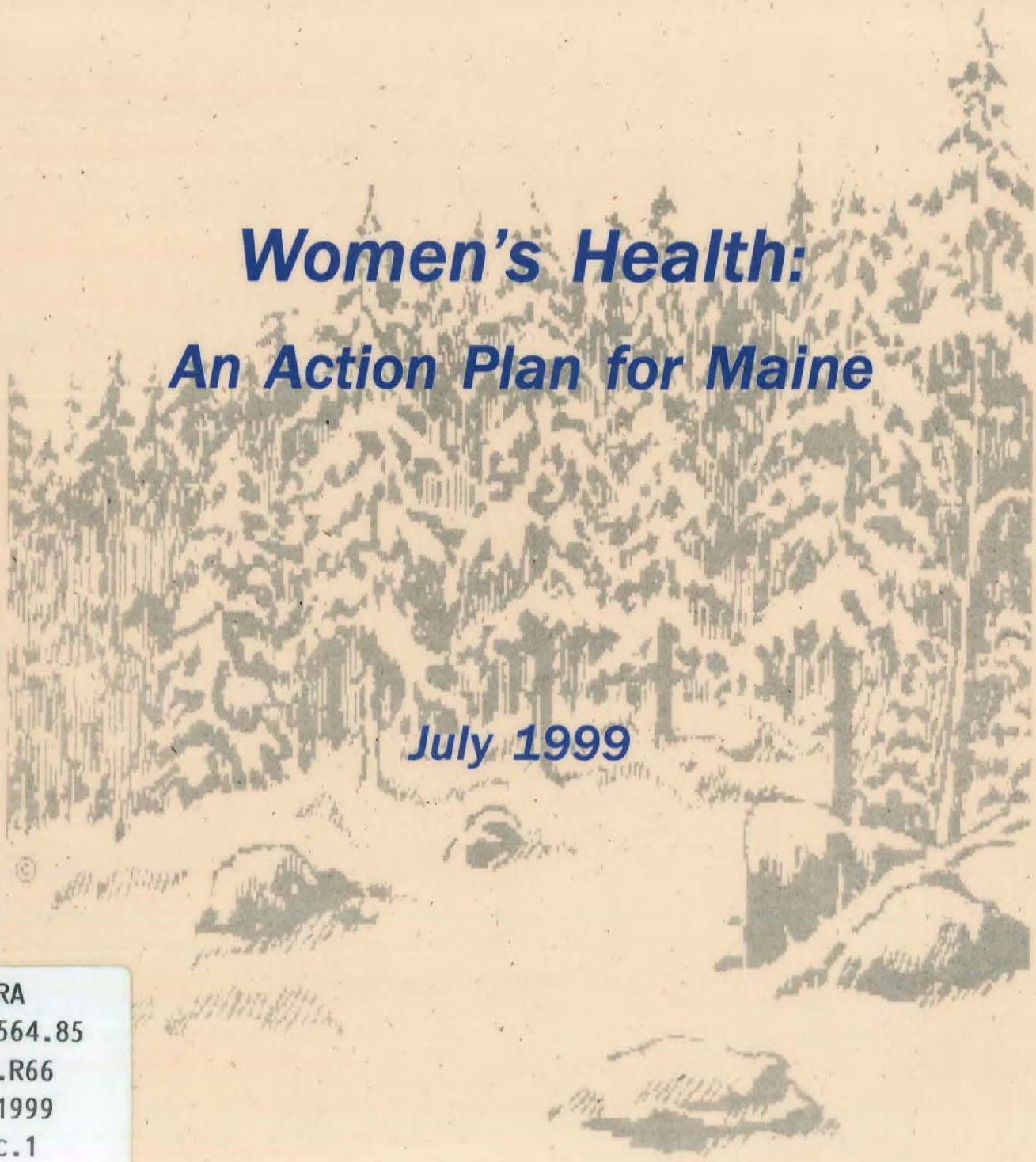
Women's Health:

An Action Plan for Maine



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Introduction

Background on the Maine Women's Health Campaign

First Lady Mary J. Herman, the Women's Health Equity Campaign, the Department of Human Services/Bureau of Health, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and other partners launched the Maine Women's Health Campaign (MWHC) in 1996 to enhance the health[1] of the approximately 500,000 women and adolescent girls in the state. The purpose of the MWHC is to examine the health status of Maine women, foster collaboration, and encourage new initiatives in the private and public sectors. The goals of the Maine Women's Health Campaign include raising awareness of gender as a critical variable in health and increasing access to appropriate health care for all Maine women.

Past inequities in research, training, and clinical practices have resulted in serious gaps in knowledge about the causes, treatment, and prevention of disease in women. For too long, women's health has been focused solely on reproductive issues; an emphasis that, while important, does not encompass the full range of women's health concerns throughout their life span. Traditionally, public and private funding recognized women only within or as members of unserved, underserved, or high risk groups, or for conditions uniquely female. Changes taking place in health care delivery (e.g., managed care and decreased public funding) have serious implications for women's health.

The MWHC has completed two phases of its mission. The first phase included research for and production of a report, Women's Health: A Maine Profile, documenting the health status, needs, and concerns of Maine women. Section I of the report contains data on health status and Section II summarizes the results of ten focus groups which included Maine women of all ages and backgrounds living throughout the state. Phase II began with the Maine Women's Health Summit convened September 17, 1998. At the Summit, nearly 100 persons representing health care policy, advocacy, research, and delivery developed strategies for addressing the health care needs of Maine women. The development of the Action Plan and the distribution of this document, summarizing the recommendations from the Summit, completes the second phase.

[1]Throughout this document general terms such as health and health status, etc., refer both to physical and mental health.

The Development Process for the Action Plan

This document reports on the results of a planning process which involved nearly 100 Maine experts in health care research, policy, delivery, and advocacy. These professionals were invited to attend the Summit to share their ideas on mapping the direction for women's health in Maine. They were asked to make individual and organizational commitments to reach the selected objectives. To the extent possible, the goals and objectives outlined herein are aimed at achieving pragmatic, economically sound, and viable outcomes, including the **expansion and support of existing programs, incremental change, and inter-organizational collaboration**. The proposed efforts focus on seeking coordination and implementation of broad-based strategies at various levels of the public health, behavioral health, and medical care delivery systems. These efforts are intended to build upon existing strengths in Maine, utilizing lessons learned from successful programs both in and outside of Maine.

Participants at the Summit brought a great deal of energy and enthusiasm to this task, and this Action Plan represents the convergence of many voices. This Plan is meant to provide a starting point; the objectives represent the first steps for addressing each priority issue. Because of the time constraints of the Summit, activities were not developed for all objectives. The Plan is a working document, which can be revised and updated periodically. If funds become available, another Summit may be held at which time this review would take place.[2]

Four small group discussions at the Summit focused on:

- Health Resources & Systems
- Health Risks & Prevention
- Health Status & Chronic Disease
- Behavioral Health

These areas are, of course, inter-related and many of the same issues were raised in each group. In order to avoid redundancy, issues that were discussed in more than one group have been consolidated under or within one section.

[2]Because of the limited time at the Summit, the participants were asked to focus primarily on adult women, but it is anticipated that issues related to adolescent girls will be addressed in the future.

Philosophy

In addition to the unique physiological aspects of the female "....gender is a fundamental social variable that affects individuals' social status, access to resources (such as education, income, health care), experiences of health, and interactions with the health care delivery system." (Weisman, 1997) Therefore, the strategies in this Plan are aimed at eliminating gender barriers in the promotion of good health, including the financing and delivery of health care. The MWHC will include advocacy for long-term change for women and girls throughout the state of Maine, particularly low-income or underserved women and girls. As documented in the report Women's Health: A Maine Profile, the status of women's health interacts fundamentally with their economic status and will be an underlying theme in all MWHC activities.

Implementation of the Action Plan

The broad response and number of participants making a preliminary commitment to moving a women's health agenda forward in Maine called attention to the need for a **coordinated response**. In light of the Summit outcomes and the substance of this Plan, the Steering Committee of the MWHC is committed to finding funding for the development of an organization dedicated to enhancing the health of Maine women. While many organizations, agencies, and individuals (see Key Stakeholders section below) are crucial to accomplish the objectives in this Plan, a coordinating body is needed to facilitate the process. (See Health Resources and Systems on page 7.)

Key Stakeholders

The following organizations represented at the Summit, along with others, will play a critical role in the implementation of the Plan.

- Alliance for the Mentally Ill of Maine
- American Association of University Women
- American Cancer Society, New England Division, Inc.
- American College of Physicians, Maine Chapter
- American Heart Association of Maine, New Hampshire, and Vermont
- American Lung Association of Maine
- Bangor – Brewer YWCA
- Blue Cross and Blue Shield of Maine
- Business and Professional Women (BPW)
- Cardiovascular Disease Council

- City of Portland, Public Health Division
- Consumers for Affordable Health Care Foundation
- CrossRoads for Women
- Department of Human Services, Bureau of Family Independence
- Department of Human Services, Bureau of Elder & Adult Services
- Department of Human Services, Bureau of Health
- Department of Mental Health, Mental Retardation and Substance Abuse Services
- Eastern Maine Medical Center – The Women's Center
- Family Planning Association of Maine
- Franco-American Women's Institute
- Harvard Pilgrim Health Care
- HealthReach Network
- Healthsource Maine, Inc.
- Healthy Community Coalition
- Husson College
- League of Women Voters of Maine
- Lesbian Health Project of Southern Maine
- Mable Wadsworth Women's Health Center
- Maine Ambulatory Care Coalition
- Maine Association for Mental Health Services
- Maine Bio-Ethics Network
- Maine Centers for Women, Work & Community
- Maine Chapter, American College of Surgeons
- Maine Coalition to End Domestic Violence
- Maine Dartmouth Family Practice Residency
- Maine Department of the Attorney General
- Maine Health Care Association
- Maine Health Information Center
- Maine HMO Council
- Maine Hospital Association
- Maine Medical Assessment Foundation
- Maine Medical Association
- Maine Medical Center
- Maine Municipal Association
- Maine Nurse Practitioner's Association
- Maine Psychological Association
- Maine State Employee Health Commission
- Maine State Nurses Association
- Maine Women's Lobby
- MaineGeneral Medical Center
- MaineHealth
- Medical Care Development, Inc.
- National Association of Social Workers, Maine Chapter

- People's Regional Opportunity Program
- Physician Specialty Associations
- Planned Parenthood of Northern New England
- Portland YWCA
- Rural Health Centers of Maine, Inc.
- SAFE
- Sexual Assault Crisis Center
- Southern Maine Medical Center
- St. Joseph's Hospital, Bangor
- St. Mary's Regional Medical Center, Lewiston
- Steering Committee of Maine Women's Health Campaign
- University of Maine School of Nursing
- University of Southern Maine
- Veterans Administration Medical Center, Togus
- Western Area Agency on Aging
- Women's Development Institute
- Women's Health Equity Campaign
- YWCA of Lewiston/Auburn

Health Resources & Systems

While health resources and systems issues are incorporated throughout this Action Plan, this section includes recommendations on the broader women's equality agenda and sociopolitical environment. Viewed from a multi-disciplinary perspective, "women's health" means that the social, economic, ethnic, educational, and employment contexts influencing women's lives and health status are considered. Historically, women have often placed the needs of family members above their own, compromising their well being. Policies and programs affecting women's health should be based on an understanding of how these factors affect health on an individual and population basis. For example, the multiple concerns of women whose health is at highest risk due to poverty—welfare reform, lack of pay equity, as well as self-efficacy issues—must be addressed in the effort to reduce disparities in health care access and status.

Goal #1: Develop an Advocacy/Coordinating Group for Women's Health

The need for an organization to advocate for women's health with one voice was identified as an important strategy by several of the small groups at the Summit. This entity would increase awareness of gender specific issues related to health, promote partnerships and collaboration, and provide policy makers, decision-makers, providers, and consumers with information and recommendations for improving the lives and health of Maine women through social and health care policy. Additional issues identified by Summit participants included ensuring health care for all regardless of ability to pay, establishing parity for mental health insurance; supporting efforts against violence and substance abuse; and challenging businesses that advertise unhealthy products (especially alcohol and tobacco).

Objective #1

Seek and obtain funding for an ongoing Maine Women's Health Campaign with permanent staffing to support the goals of this Action Plan.

Activity

- Completion of the Action Planning process, development of a work plan, identification of responsible parties, and creation of a timeline by steering committee members and key stakeholders.

Objective #2

Provide analysis, advice, and information on key women's health issues for government, health, and women's organizations.

Activity

- Collect, analyze, and publish health information, data, and indicators related to women. Gender-impact analysis, including data analysis, by private and public health agencies, will be emphasized.

Objective #3

Build a network to collaborate with state researchers, policy-makers, providers, consumers, and grassroots organizations on an ongoing and structured basis.

Activity

- Conduct a bi-annual Women's Health Summit.

Objective #4

Support the development of a state government-wide Women's Health Advisory Committee.

Activity

- Request that a staff person in the Governor's Office is identified to serve as Women's Health contact and representative to the committee. Establish liaison with legislative leadership.

Goal #2: Improve Health Care Access for Maine Women

Access has been defined by the Institute of Medicine as the timely use of personal health services to achieve the best possible health outcomes. While access to health care is a problem for many Americans, the problem is exacerbated for women because of the organization of the medical care system and the delivery of health care. Rural residents tend to have higher poverty rates, have fewer health resources, and more difficulty getting to services. Limitations in access to care extend beyond financial barriers and include absence of a regular source of care, social isolation, transportation, as well as the acceptability of available services to the target population. Trauma survivors, lesbians, women with disabilities, immigrants, and others with special needs are often unable to find providers who are appropriately trained and sensitive to their needs.

Objective #1

Support and encourage public and private efforts to reduce the numbers of uninsured women, including reexamination of existing programs and health care reform.

Objective #2

Collect and analyze data on key private and public sector policies that affect access to health care for women.

Activity

- Assess the implications of welfare reform and Title XIX programs covering children's health care.

Objective #3

Inventory and assess the extent to which components of women's health care are included in Maine public and private insurance plans (including both managed care and indemnity).

Objective #4

Inventory and promote programs that are designed to improve accessibility for all women (including lesbians, minorities, women with disabilities, trauma survivors, and immigrants).

Activity

- Support and expand outreach efforts to inform women about available programs and to overcome access barriers.

Goal #3: Improve the Economic Well-Being of Maine Women

Women generally continue to be at an economic disadvantage that directly affects their health care status, coverage, and access. Lower wages, disproportionately allocated family responsibilities, lack of political representation, etc., were all identified as barriers to optimum health. Women are more likely than men to be employed part-time, in small companies, or to work in occupations that either do not provide employer-based insurance coverage or, if they do, inadequate coverage. Divorced women are twice as likely as married women not to have health insurance and widowhood often negatively affects access to insurance. High co-payments or deductibles discourage poor women from seeking preventive care or care for managing their own chronic conditions. Efforts to increase income, provide job skills, improve literacy, increase self-confidence in finding work, money management, etc., were among solutions discussed by participants.

It was emphasized that solutions must be economically viable, unlike family medical leave legislation which permits only unpaid time off from work.

Objective #1

With the active participation and support of legislative leadership and the governor's office, develop a "white paper" documenting the link between economic status and health status for women.

Activities

- Disseminate the "white paper" to decision/policy makers (e.g., legislators) and advocacy groups.

- Hold a forum for decision/policy makers on findings in "white paper."

Health Risks & Prevention

The actual underlying causes of most deaths in the US are health problems or conditions with identified risk factors that can be prevented through environmental approaches (e.g., availability, accessibility, policy), behavioral changes (e.g., personal behavior change), or changes in the health care delivery system. Modifiable lifestyle practices for heart disease, cancer, and other diseases include physical activity, decreased dietary fat intake, and cessation of tobacco use. Prevention of many diseases and injuries depends not only on individual behavioral change, but also on community norms that support and provide an environment conducive to positive lifestyles as well as positive health behaviors. These community norms must also include health care provider vigilance through screening and counseling for both personal and environmental risk factors.

Recent studies have contested the assumption that the higher rate of age-adjusted mortality among disadvantaged Americans is solely attributable to a greater prevalence of risky behaviors such as smoking, drinking, and being overweight. Researchers have found that the increased prevalence does not fully explain the higher rate of mortality among those with lower incomes. More important causes may include environmental exposures, occupational health hazards, and differences in access to medical care and information. Increased stress, decreased social support, perceived control over their lives, and self-esteem may be other factors causing differences in mortality.

Discussion focused on:

- Alcohol and other drugs (e.g., including nicotine/tobacco)
- Heart disease
- Abuse and violence against women
- Nutrition and obesity prevention

Goal #1: Reduce the Prevalence of Preventable Risk Factors

Credible sources of health information is essential for informed decision-making. Such information must be age and culturally appropriate and at a literacy level that makes it accessible to the majority of the population. Women need readily available information about healthy behaviors, prevention of chronic illnesses, maintenance of good health, and access to clinical preventive services. This is particularly true as life expectancy lengthens and the number of older women increases.

There are many programs and services currently in place at the local and state levels that address women's health needs. This information, however, is often unavailable to the consumer or program planner. Often, a model exists or experience resides in the state which could be shared with others who are contemplating a similar effort. Programs that provide services and refer women as well as women who are seeking services themselves, would benefit from an easily accessible, ongoing statewide exchange and inventory of information.

Most women do not recognize heart disease and lung cancer as leading causes of death in women today. There is also evidence that health care providers neglect to assess, diagnose, and treat women for these problems. It would be beneficial to raise awareness of the risk of heart disease among women and to increase physician awareness and use of the current research on primary and secondary prevention of cardiovascular disease. Fortunately, the American Heart Association and several national partners are launching a major multi-year public awareness campaign about women and heart disease. The campaign is aimed at building an understanding among women aged 25 and older about the dangers of heart disease and stroke and known preventive measures.

Objective #1

Improve the availability and dissemination of quality health information.

Activities

- Conduct focus groups to identify ways to best address women's health information needs at the local, community, and state levels.
- Create a task force to develop recommendations and standards for meeting women's needs for female-specific health information.
- Develop a resource guide to selected web sites and other health information resources.
- Identify channels for distribution of the resource guide to consumers.
- Support efforts by advocacy groups to provide translation services to women with limited English who are seeking health care services.

Objective #2

Improve the collaboration and coordination among programs that address preventable risk factors.

Activities

- Compile a resource inventory of women's health related public and private programs and services.
- Create an ad hoc committee to guide the development and dissemination of a resource inventory of health promotion programs.
- Establish a clearinghouse for accessing information about local and state activities by program personnel and consumers.

Objective #3

Increase health care provider awareness of and attention to cardiovascular disease and lung and other cancers as the principal killers of Maine women.

Activities

- Support existing statewide efforts to improve the number of health care providers who follow primary and secondary preventive health guidelines for all female patients.
- Develop a curriculum and identify physician faculty for continuing medical education program on CVD guidelines and women.
- Collaborate with statewide efforts to educate physicians about smoking cessation and identify women's specific cessation issues.
- Investigate and support activities on women and CVD sponsored by the American Heart Association and others.

Goal #2: Improve the Capacity of Communities and the State to Reduce Preventable Risk Factors

Social isolation, stressful lifestyles, and inability to find ways to cope are all barriers to adopting healthy behaviors. Supportive communities which offer an environment conducive to healthy lifestyle choices as well as alternatives to traditional models of health care delivery can help to overcome some of these barriers. By building capacity, individual communities can find ways to share information on available resources, help women develop resiliency skills, sponsor peer support groups, etc. It is critical that health care and other organizations develop responses to the need for prevention which are coordinated, comprehensive, and coherent and address the underlying social, economic, and environmental factors that affect the health of women. Alternative

approaches to providing health services to women should include community-based approaches, placing a high priority on prevention, and should involve women in their development and implementation.

Objective #1

Identify and disseminate information on best practices to reduce environmental risk factors in communities such as social isolation and lack of access to healthy activities.

Activities

- Offer technical assistance to community coalitions and other organizations with an interest in developing their capacity to enhance the health of women.
- Respond to requests for information regarding community-based solutions to women's health issues.
- Encourage a coordinated response within communities.
- Collaborate with state programs supporting and funding community solutions to advance women's health issues.

Objective #2

Investigate and disseminate information on best practices for assisting women to reduce stress, improve coping skills, and make healthy choices.

Activity

- Offer technical assistance to community coalitions and other organizations with an interest in developing their capacity to enhance the health of women.

Objective #3

Increase and support state, community, and grassroots advocacy activities which promote policy solutions to improving access to health promotion programs and preventive health services.

Activity

- Build networks and partnerships with advocacy organizations.

Health Status & Chronic Disease

Chronic conditions are the major cause of illness, disability, and death in the US today; they disproportionately affect women throughout their lifetime. They include the presence of long-term diseases or symptoms of physiological, psychological, or anatomical abnormalities including developmental disabilities and impairments caused by injuries. Medical care, rehabilitative care, and personal assistance are the three major components of chronic care but are not well integrated or coordinated through payment mechanisms or the health care delivery system. The current system (of payment and services) often makes it very difficult for women to obtain the appropriate continuum of care required over a prolonged period of time. An ideal continuum of care should ensure that a person receives care appropriate to her condition, when it is needed, and in the right amount.

Arthritis, asthma, diabetes, heart disease/stroke, respiratory cancers, osteoporosis, and high blood pressure are the most common chronic conditions affecting women. The connections between these conditions, mental health and other factors, including violence, are also important but not yet well understood. While strategies in this section are primarily confined to secondary and tertiary prevention strategies, one strategy, regarding the integration of services, is aimed at linking the primary and secondary prevention needs of women.

Goal #1: Improve Access to Services for Chronic Conditions

Because women live longer and experience earlier morbidity, they are the primary users of long-term care services. The long-term care system has developed in a piecemeal fashion and is characterized by multiple payers, fragmented service delivery, uneven access to services, financing and quality problems. Long-term care includes a combination of housing and supportive services that assist persons with chronic conditions, including respite care for the caregiver. According to an Agency for Health Care Policy Review (AHCPR) study, while chronically ill patients in managed care plans have better access to care than patients in fee-for-service plans, their care was not as comprehensive, they waited longer, and had less physician-patient continuity (AHCPR, 1999).

Objective #1

Identify the components of model employer and publicly funded health and disability policies and benefit packages, including health promotion and self-management of chronic disease.

Activities

- Convene an expert panel.
- Advocate for adoption of model benefit package with employers groups (including self-insured businesses) and the Bureau of Insurance.
- Advertise model benefits to consumers/employees to encourage advocacy for adoption.
- Support efforts to develop universal health care coverage in Maine.[3]

Goal #2: Ensure an Effective Care Continuum for Maine Women

Many women are dissatisfied with the way health care is delivered and there is evidence that women receive less aggressive treatment or appropriate care than men with the same symptoms (Wenger, 1997). The burgeoning interest in and acceptance of alternative medicine is one possible indicator of this lack of trust in traditional medicine. Fragmentation of the health care delivery system, which includes the separation of reproductive needs, increases the likelihood that a woman's health status will not be fully assessed over her life span. Women with chronic conditions are likely to need specialists for certain services, in addition to their regular care. Some women who live in nursing homes could live on their own or with a family member at much lower cost if home health care were more accessible and covered by insurance.

The lack of coordination in the medical care system for women with chronic diseases makes obtaining the needed services very difficult, especially for those with multiple problems. In order to make informed decisions regarding their health and well-being, women in Maine need to efficiently obtain scientifically correct information that is culturally relevant, woman-centered, and easily accessible. In addition, there is little information or support for a coordinated self-management approach which maximizes an individual's quality of life and independence. Building alliances with community and professional organizations which serve women should enhance the flow of information into the community and access to interventions.

[3]The King administration does not support univeral health care coverage per se, but does advocate for targeted expansion of public programs such as CHIP, the Child Health Insurance Program.

Much of public health funding at both the state and federal level is categorical in nature, i.e., it supports activities related to specific diseases and conditions such as breast cancer, diabetes, and cardiovascular disease. This does not easily support a holistic gender-specific approach to health. Two major sources of federal funding for state activities are the Preventive Health and Health Services Block Grant and the Maternal and Child Health Block Grant which are somewhat more general in nature, although each has specific requirements. In other states the flexibility in some of these block grants has allowed for funding women's health initiatives through these mechanisms.

Objective #1

Develop a report on possible models for providing comprehensive services (e.g., education, wellness, prevention, diagnosis, outpatient care, inpatient, rehabilitative, funding, and support services) to Maine women with an emphasis on underserved groups .

Activities

- Conduct research including surveys of women and the evaluation of existing services.

- Disseminate the report to communities, providers, hospitals, and policy makers to facilitate the exchange of information on promising practices and systems of care.

Objective #2

Identify opportunities to encourage reallocation of public and private funding to broaden the focus on women's health needs.

Activity

- Advocate for the allocation of MCH Block Grant and Preventive Health Block Grant funds to address women's health issues across the lifespan.

Objective #3

Identify ways to improve surveillance and reporting of chronic illness among women.

Objective #4

Identify and address gaps in the availability and accessibility of educational services, self-management, and patient programs for chronically ill women.

Activities

- Support public/private efforts to develop models to promote a coordinated self-management approach for the chronically ill which might be adopted by providers and payers (e.g., care coordination, ombuds program).

- Identify and disseminate consensus clinical guidelines for chronic diseases that disproportionately affect women (e.g., arthritis, osteoporosis, cardiovascular disease).

- Develop written personal profiles of the social and medical history and status of women with multiple chronic illnesses and disseminate to key decision-makers in government and health care.

- Develop and disseminate an inventory of easy-to-read patient education materials related to chronic disease, which address women's concerns and emphasize self-management.

Issues in Behavioral Health

Behavioral health refers to a broad range of issues including mental illness, mental retardation, and substance abuse. Important gender differences are seen in the prevalence of particular mental disorders; these disorders affect women at different stages of life. Many risk factors are involved, including violence and abuse. Low socioeconomic status has been found to be a contributing factor in the onset of certain disorders. The vast majority of individuals needing mental health services today do not receive them at all. For women, part of the reason may be that service options do not offer support for the families of women in crisis and treatment.

Goal #1: Reduce Environmental Barriers to Recovery

Increased attention is needed to the wide range of social and environmental factors creating barriers to recovery for women with behavioral health issues. Health care services will only be effective if these issues are also addressed.

Environmental barriers include:

- Logistical barriers – access to adequate child care, transportation, etc.
- Structural barriers – separation of health, mental health, and substance abuse delivery systems, impact of poverty on access to services.
- Social and legal barriers – stigma and discrimination against women diagnosed with behavioral health issues, especially women with children, who are at risk of losing custody.
- Financial barriers – lack of insurance coverage, especially for women leaving welfare system (and, perhaps, losing Medicaid).

Objective #1

Develop a plan for addressing specific environmental barriers to recovery.

Activities

- Convene a committee to examine the barriers to recovery and make recommendations.

- Develop criteria for addressing and overcoming environmental barriers (including child care and lack of insurance) in RFPs, contracts, QI plans, etc. Estimate costs and revenue sources.

Goal #2: Seek Parity in Insurance Coverage

Currently, insurance coverage for behavioral health issues is not equal to coverage for health care problems. In particular, coverage for problems which are trauma-based, rather than biological in origin, is insufficient. A full parity bill which ensures coverage for all behavioral health diagnostic categories and which expands coverage to include treatment modalities specific to women with trauma histories should be supported.

Objective #1

Develop/broaden coalition to support parity legislation.[4]

Activity

- Build network with non-profit associations (e.g., Maine Businesses for Social Responsibility) and private businesses.

Goal #3: Address the Connections between Violence and Behavioral Health

Evidence is growing that experiencing trauma, especially (but not limited to) childhood sexual abuse, has a profound effect on mental health in adulthood. Trauma can also occur within the treatment setting, ranging from the unintentional misuse of power to physical abuse and sexual exploitation of clients/patients by staff. The relationship between trauma and behavioral health has been largely ignored in the training of professionals and in the development and financing of services. A comprehensive planning approach is needed to ensure that these issues are addressed throughout the health and mental health systems.

Objective #1

Create a formal linkage between state trauma initiatives (e.g., Trauma Advisory Board) and the Maine Women's Health Campaign.

[4]The King administration supports a variety of mechanisms to assure that appropriate behavioral health services are available in both the private and public sectors.

Objective #2

Provide continuing education opportunities on violence and mental health/substance abuse issues for emergency room staff, other physicians, and jail staff.

Goal #4: Improve Access to Health Care for Women with Mental Retardation/Developmental Disabilities/Mental Illness and Substance Abuse Disorders (MR/DD/MI/SA)

Women with behavioral health diagnoses often have difficulty getting good basic health and dental care, due both to a high incidence of poverty and to the stigma and discrimination associated with behavioral health diagnosis. Often, critical health issues go undetected or untreated, at times causing symptoms which are misdiagnosed as mental illness, at other times contributing to secondary behavioral health problems. Ensuring adequate and caring basic health care for all women with behavioral health problems is crucial.

Objective #1

Determine specific mechanisms for improving access to health care (including dental care) for women with MR/DD/MI/SA.

Objective #2

Develop informational materials to assist women with MR/DD/MI/SA to obtain the appropriate health care services.

Goal #5: Identify Behavioral Health Issues Relevant to Special Populations

Particular attention needs to be paid to women whose needs may not be adequately met within the mainstream health and behavioral health systems. These groups include (but are not limited to) elderly women, especially those who are poor; incarcerated women; adolescent girls; women with cultural or linguistic differences, including Franco-Americans, Native Americans, and recent immigrants; lesbian and bisexual women; women who are deaf or physically disabled; etc. Attention should be paid both to special issues of access and cultural relevance as well as heightened risk for depression, substance abuse, and other behavioral health problems.

Objective #1

Develop an inventory of special populations, including demographic information, and other key issues.

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