

California Black Women's Health Project
Policy Summit 2002: Black Women's Health
February 8, 2002

The Second Annual Policy Summit (the "Summit") of the *California Black Women's Health Project* ("CABWHP"), brought Black women from across the state of California to the Sierra Health Foundation in Sacramento with the intention of discussing this year's theme: Black Women's Mental and Emotional Health.

Familiar faces greeted each other and new faces mingled in reunion fashion before quieting to give their attention the CABWHP Executive Director, Latonya Slack.

I. Welcome and Introduction of Participants
LATONYA SLACK, JD, Executive Director

After a warm welcome, Ms. Slack promptly addressed her organization's decision to make this year's Summit a forum primarily for Black women grassroots leaders, health care providers, government representatives and policy advocates. It was simple. In order to address the systemic realities of Black women's unique health care concerns, it was necessary to create "time, space and a voice" for those who can speak to those concerns the best. Such action could prove life-saving for a community of women whose healthcare needs are not sufficiently being met. Slack painted the sheer reality of the state of Black women's health with mention that, statistically speaking, Black women were disproportionately falling ill – both physically and mentally. To address this crisis, the *California Black Women's Health Project* felt it was time to become more proactive about discussing ways to remedy this and to ensure that the voices of Black women across the state are heard by policy makers.

To focus the Summit and to give each participant a personal charge to carry throughout the day of meetings and discussions, Slack then challenged the participants to consider how they could each impact Black women's health and well-being. In essence, this is what they had come to this year's Summit to do: provide input and analysis to a statewide action plan designed to mobilize policy makers to actively address the disparities in Black women's mental, emotional and physical health.

After allowing each participant to introduce herself, Slack returned to introduce this year's keynote speaker, Dr. Robbin Huff-Musgrove.

II. Introduction of Keynote Speaker by Latonya Slack:

Slack opened her introductory remarks recounting how her organization had recently surveyed Black women throughout California about their health care concerns – about what they needed and wanted. Also, focus groups were conducted with this same intent. The results of the survey and focus groups ultimately served as preparation for this year's Summit by directing the staff of the *California Black Women's Health Project* to focus on the important issue of Black women's mental health.

The research revealed that Black women were simply tired. They were stressed out or were struggling with the effects of "the superwoman syndrome." We must be politically, socially, professionally and personally creative about ways to 'speak' to the growing needs of a community at risk of further deteriorating mental, emotional and physical health.

Slack announced that CABWHP is launching the "Black Women's Mental Health Initiative." The

goal is to make the health care delivery system for Black women in California comprehensive—one that addresses all of their unique mental and physical health needs.

To expound on the importance of such an initiative, psychologist and conference speaker/Dr. Robin Huff-Musgrove was invited to this conference to walk this year's participants through the historical landscape of the physical and mental health of Black people in general and Black women in particular. Such background was meant to act as primer for the working groups to be convened later in the day.

III. Dr. Robbin Huff-Musgrove:

Dr. Huff-Musgrove stepped to the podium somewhat enamored by the small sea of diverse Black female faces looking back at her. She considered it a "luxury" to have the distinct opportunity of addressing a room full of Black women who were also advocates for health.

She began her talk by posing a rather personal question to those in attendance. She inquired specifically how many, of those present, knew women who have been diagnosed with mental health issues. The majority of the participants raised their hands affirmatively. Dr. Huff-Musgrove wanted most to stress the point that the issue of mental health is prevalent and it does not discriminate. The pervasiveness of the issue was not coincidental, Dr. Huff-Musgrove maintained. There is a reason why so many Black women are dealing with this issue. That reason can be found in the annals of American history.

Her thesis, very simply, is that Black women's mental health is linked to Black women's history. More specifically, it is linked to what is called the "peculiar institution:" the institution of slavery. Sharing this information with an exclusively Black audience was a unique exercise for Dr. Huff-Musgrove, who has shared this same material with predominantly non-Black audiences in the past. In Dr. Musgrove's experience, the reactions from the two audiences are usually quite different.

For Blacks in the audience, when this subject is presented, it is affirming and also confirming. Yet for non-Blacks, there is usually some discomfort with addressing the topic. The latter will usually seek to understand why the past is being "relived." Slavery was so long ago. Non-Black audiences today will typically question its relevance to discussions on the mental health of the Black community in these present times. There has even been feedback that bringing up the topic of slavery when discussing the mental health of members of the Black community was an attempt to make non-Blacks feel guilty about the past. But it is never about this. It is, however, about understanding how laws, society, regulations, and rules that came out of the 'peculiar institution' affected those oppressed by it. It is a chance to look at the American "family" history.

Dr. Huff-Musgrove's Workshop Overview:

A. *Slavery - The Peculiar Institution:*

Dr. Huff-Musgrove opened her comments with a documentary-style video presentation on slavery. The video began with a most provocative line of narration: "Don't think you can understand race relations today without looking at slavery." With that, the video's narrator takes us back to the norms of that period in history:

Visual reminders of the Middle Passage – a shimmering body of water, the sun creating a haze – were overlaid with some of the exclamatory remarks familiar to the slave trade: "Negroes for hire!" "Africans baptized as Christians!" The video's narrator explained that under British law, a slave's Christianity meant that they could only be slaves for a limited period of time. In America, those same slave owners would later deny the humanity of the

slaves in order to reconcile that, in fact, they were not ‘sinning’ against God by enslaving Africans.

With stirring visuals, the video went on to explain that the life of a slave encompassed: beatings, the buying and selling of human lives and the lie that human bondage was a part of the "natural order" ordained by God. Slave children were routinely taken from their parents and raised on other plantations. Poor nourishment, inadequate clothing, and sparse living quarters that often had the bare ground as ‘flooring’ plagued them. Moisture and wetness often made living quarters further uncomfortable. In general, life as a slave was highly unstable which gave way to rampant insecurity amongst the slaves.

However, for slave owners slavery was a much ‘friendlier’ institution. The American south came to rely upon slavery economically. Therefore, it was a coveted institution among its supporters.

The movement to spread slavery from the south throughout the rest of America grew. The battle lines were drawn – many states seceded from the Union. The Civil War ensued. The Union won. In his own words, former U.S. President Abraham Lincoln said of this: "The time had come that slavery must die."

Around the room, as the video continued, there was quiet. The Summit participants – diverse in age and professional tenure – remained still and focused on the video as the difficult reality of slavery and its pervasive effects were again etched into their memories.

After the conclusion of the video, Dr. Huff-Musgrove remarked that the video was meant only to serve as a reminder. The past and the present state of Black women's health were linked; and slavery was that link.

Dr. Huff-Musgrove went on to say that slavery and race-based prejudice didn't happen all at once. It really happened “one law at a time”:

- **1641:** *Slavery became legal in Massachusetts*
- **1662:** *In Virginia, state law provided that a bi-racial person's status (as slave or free) would be determined by the mother's (racial) status. Since it was taboo for a White woman to be with a Black man, the law was meant to apply to Black women who had become pregnant by slave masters.*
- **1680:** *It became lawful to kill a runaway slave resisting apprehension in Virginia. This same year slaves were legally considered to be “chattel.”*
- **1691:** *It became illegal to free a Black slave unless they were leaving the colony.*

The way that Black women's mental health history evolved was likened by Dr. Huff-Musgrove to the effects that trauma is known to generate. For instance, a parent who is traumatized promises himself or herself that their children will not suffer that same trauma. However, the “mental personality traits” of that child may still lead them to the very same fate.

This is significant in that there is something unique about the parent-child relationship whereby the emotional wounds of a parent can directly impact a child. Parents can unconsciously transmit a sense of insecurity and predispose their children to this merely by their interaction with their children. It is upon this understanding that Dr. Huff-Musgrove asserts that Black women today have inherited the psychological history of those from slavery.

To remedy Black people's psychological inheritance, humor and music have become coping-mechanisms for Black people today. These mechanisms can be transmitted from generation to generation.

Dr. Huff-Musgrove began to describe some different rationales often used by whites to support and justify slavery.

B. Rationalization:

Rationalization, a psychological defense mechanism, is one method oppressors use to cope with racism. Slavery was in fact rationalized by the English in order to mend an internal conflict with their moral/Christian beliefs. Surely, slavery could not be morally justified. Therefore, the rationalization for slavery was that the slaves were sub-human, beast-like beings that required subjugation and subordination. Such false beliefs made slavery palatable by slave owners and "legal" in the eyes of even the Queen of England – who, herself, owned slaves.

1. Monetary gain:

- ❑ *Protestant Reformation of 17th Century: With the Protestant Reformation, man became directly accountable to God. Every man was also entitled to personal dignity, respect and human rights.*
- ❑ *Greed overshadows humanity and Christian ideals* (The slave owners figured that they were ministering to the "heathens.")

2. Africans were considered subhuman and unfit (and as):

- ❑ *Blackness/physically unusual in appearance*
- ❑ *Beast-like*
- ❑ *Sexuality/sexually deviant*
- ❑ *Heathenish*
- ❑ *Culturally inferior*

Negative attributes, in general, were given because the Africans were different.

3. Slavers were agents of god bringing religion and civilization to the heathen

C. The Societal and Psychological Residuals of Slavery

There are socioeconomic indicators of slavery's lingering effects that can be measured:

1. Population:

- ❑ Dr. Huff-Musgrove asserts that according to The Census Bureau, 12.3% of Americans are Black.

2. Family:

- Historically, Blacks were separated from spouses and children in slavery. Today, there is a high incidence of single-parent households. The statistics now show 74% of Whites live in a two-parent household and only 39% of Blacks living in two-parent households. Dr. Huff-Musgrove makes the correlation between the past and the present circumstances of the Black community directing these outcomes.

3. Education:

- While only 12% of Whites have less than a high school education, 22% of Blacks have less than a high school education.
- Only 15% of Blacks have a bachelor's degree or higher (as compared to 26% of Whites.)

4. **Income:**

- While there is only a 7.5% poverty rate for a White family of four, there is a 22% poverty rate for a Black family of four.
- Blacks are more likely than Whites to suffer from long-term poverty.
- The median net worth of Whites is ten times greater than that of African-Americans.
- 37% of Blacks 18 years or younger live in poor families.

It is important to consider all of these socioeconomic indicators because history has illustrated that they affect the health and well-being of a people.

D. **Responses to Socioeconomic Hardship:**

The hope for progress is thwarted by 'blockades' found economically, socially, politically and otherwise. This, Dr. Huff-Musgrove maintains, leads to other possible hindrances such as frustration.

1. **Frustration:**

Frustration is a deep chronic sense or condition of insecurity discouragement and dissatisfaction arising from thwarted drives, inner conflict or other unresolved problems.

- **TYPES OF FRUSTRATION:**
 - *Personal*
 - *Environmental*
 - *Conflict (choosing between two goals)*
- **REACTIONS TO FRUSTRATION:**
 - *Aggression- (e.g., when you don't get the job and you know in your heart of hearts that it had to do with race)*
 - *Realistic Hard Work – (e.g., when you try to work harder in order to decrease the level of anxiety)*
 - *Develop New Skill*
 - *Reinterpret Situation*

When these issues – of how the peculiar institution still affects Black people today – are discussed in mixed company, non-Black people tend to become incensed. Even when there is a discussion about 'privilege,' there tends to be a misconception among White people. That is, White people understand the concept of 'privilege' to mean the proverbial "silver spoon." But it is far more than that. It is the unmerited favor that a White person is given simply because of their racial identity.

On this issue of racial disparities, there is a video entitled "True Colors." It was created by journalist/commentator Diane Sawyer and it examines the ways Black and White people are treated differently in society – in the same situation. In the video, for example, a Black person responded to an ad about an apartment for rent and a White person subsequently responded to the same ad. The Black person was given less favorable treatment and different information about the apartment's availability than his White counterpart. The video illustrated the concept

of 'privilege' and racial disparities such that racism's existence could not be denied.

Still, critics would say that Black people are constantly pulling the "race card" – using race as an excuse for lack of advancement, lack of financial resources, etc. They would say that they usually do not see a disparity between the way that Black and White people are treated; and that education is "the great equalizer" – putting both Black and White people on equal footing. But if education was what put Black and White people on equal footing then the question remains to be answered: Why then are so many Black people still hindered by a very real (corporate) "glass ceiling?" To deny the existence of inequality only creates confusion and frustration among those whom are experiencing it. Much of this frustration is the catalyst for an interesting conflict wherein a Black person might be forced to choose between two goals.

In addition to this frustration, Dr. Huff-Musgrove asserts that Black people are told that there is "something wrong with them" generally. Black women's hair, for instance, does not 'perform' the same as White women's hair. So the message often sent is that Black women's hair doesn't "act right." So, many Black women attempt to compensate by altering their hair.

2. *Defense Mechanisms:*

Societal standards, generally, send the message that Black people are not measuring up. So to survive as a people, Black people find defense mechanisms – ways, essentially, to protect themselves against racism:

□ *Repression:*

- In repression, a problem is kept beneath the conscious mind. Too much anxiety crops up when attempting to deal consciously with racial issues.

□ *Denial:*

- A Black person might choose to overlook or deny clear racial injustice in order to survive it. Denying that a problem actually exists is just one way that they can protect their sense of self. People generally do not know when they are in denial.

□ *Identification:*

- To survive, others will identify or over-identify with the "oppressor" so that they can be seen as acceptable. Black people will act like and even talk like White people.

□ *Overcompensation:*

- There are some Black people who will set excessive goals -- such as getting advanced degrees in an effort to show that they are "valuable".

□ *Sublimation:*

- People attempt to become 'invisible' essentially. They have received the message that they are not valuable. So their response is to 'fade into the wall-paper.'

□ *Displacement:*

- A person's (usually strong) feelings are expressed to someone in close proximity to them instead of to the proper recipient. For instance, many

direct their anger towards those closer to them – such as other family members.

These coping/defense mechanisms are certainly exhausting to implement. Add to them being Black, poor and mentally ill and the weight of these things combined becomes overwhelming.

3. Religion and Spirituality:

Religion and spirituality have positively impacted the Black community in different and also contributed to its survival. More specifically, religion and spirituality in the Black community provide:

- Recognition of a Power greater than self*
- Instills hope*
- Frustration tolerance*
- Fosters a positive self-image*
- Group support*

4. Acculturation:

Bi-culturalism and code switching are modes of acculturation and are ways in which Black people manage within society today. For instance, a Black person might choose to alter their style of talking/language dependent upon the company (Black or non-Black) they are in. Such actions can cause stress.

Modes of Acculturation include:

- Assimilation: assume majority identity*
- Integration: maintain ethnic and incorporate majority identity*
- Separation: withdraw from the majority society*
- Segregation: forced separation by larger society*
- Marginalization: lack of identity with both ethnic and majority group*

5. Maladaptive Responses:

Racism's psychological and social effects on the Black community have manifest as "disorders of the self":

- Alien self*
- Anti-Self:* People become judgmental of others who are living in a way that feels shameful.
- Self-destructive:* People who have suffered a great deal sometimes turn to addictive behaviors.
- Organic disorders:* Crack/heroin addicted babies are an example of an organic disorder. The illnesses caused by lead painted apartments -- which still exists in some low-income areas -- are organic disorders. Organic disorders are ones that are precipitated by the environment.

E. Black Women and Mental Health

Depression prevalence rates are high for Black women. Depression rates for Black women are estimated to be 50% higher than those for White women. Prevalence rates are higher due to racism, cultural alienation, violence and sexual exploitation. Many Black women are misdiagnosed because they do not speak of their symptoms in the way that doctors can identify them as depression. A Black woman might say, for example, that she's feeling "fatigued", "cranky" or "irritable."

Alternatively, she may come in as a 'stoic believer'. A 'stoic believer' is one who will speak faith-based language when identifying their symptoms – such that they avoid making a negative faith confession. Many stoic believers may be prone to say something like 'if it wasn't for my faith (in God), I would feel sad'. This is not, in itself, a problem per se. But clinicians need to have their ears attuned to what these statements actually mean – as it relates to diagnosing these women.

1. Mental Disorders

The following are examples of mental disorders:

a. Depressive Disorders:

- *Major Depression*
 - Feeling depressed most of the day
 - Significant weight loss when not on a diet
 - Restlessness
 - Feelings of worthlessness
 - Recurring thoughts of death
- *Dsthymia*
 - a low grade depression
- *Bipolar Disorder*

b. Anxiety Disorders:

- *Panic Disorder*
- *Obsessive- Compulsive Disorder:* This usually is 'encouraged' by the need to stave off feelings of pending doom or death.
- *Post Traumatic Stress Disorder*
- *Generalized Anxiety Disorder*
- *Phobias*

F. Disparities in Mental Health Services

1. Black people:

- *Rates of mental illness are similar to Whites (in the community)*
- *Overrepresentation in high need populations (in the following areas):*
 - *Homeless*
 - *Incarcerated*
 - *Substance abuse*
 - *Foster care*

2. Accessibility of Services:

There are barriers that generally impede Black people from getting sufficient care for mental-health related concerns:

- *Lack of health insurance:* Blacks with health insurance still do not have as good health as non-Blacks.
 - *1/4 of Black people are uninsured – which is 1.5% greater than Whites*
 - *Provision of insurance alone does not eliminate the disparities; generous mental health coverage does not increase treatment seeking in Blacks as Whites.*

- *Medicaid funded providers have been more successful in reducing disparities*
 - *Medicaid covers 21% of Blacks*
- *Attitudes towards mental illness: Seeking help doesn't have to be incompatible with faith; although at times it has been. In some cases, faith-based Black people might avoid indicating that they have a mental health concern because it may be viewed as a negative faith profession.*

General attitudes towards mental illness have their basis in:

- *Stigma & spirituality*
- *Personal weakness*
- *Treatment not encouraged*
- *Fear of mental illness in Blacks is 2.5 times greater than Whites*
- *Black women with mental health care concerns tend to:*
 - i. *minimize serious nature of problem*
 - ii. *say that symptoms are 'just the blues'*
 - iii. *not be proactive in changing their condition*
- *Style of service delivery*
 - *Ethnic match: This seems to work because the clinicians share a cultural background with their patients.*
 - *Time spent with the provider: Blacks prefer personal warmth and typically prefer to have a connection with health care providers. Passive clinicians can be off-putting and negatively viewed by Black people. However, this is not a paranoid response. But rather, it is based on history.*
 - *Sense of trust: It is interesting to note that Blacks who are not feeling well emotionally will tend to visit their family practitioner – someone with whom there is a longstanding relationship – instead of a mental health practitioner.*

Generally, when Blacks do seek help it is usually at a much later phase in the evolution of their mental health issues. Conversely, Whites more promptly set an appointment with their psychiatrists, if they perceive a mental health concern.

3. Utilization:

- *According to the National Comorbidity Survey:*
 - *Only 16% of Blacks with mood disorders saw mental health specialists*
 - *Blacks rely on public mental health programs*
 - *Blacks received less care than Whites*
 - *Blacks are more likely to terminate care prematurely*
 - *Blacks are more likely to see their primary care providers*
 - *Blacks are underrepresented in outpatient treatment*
- *Black women:*
 - *rely on other supports (community, family, the religious community) than mental health services*

- *seek mental health care less than Whites*
- *seek help later in life or at later stages of their illness.*

4. *Historic Patterns of Mental Health Service Use:*

There is a disproportionately high rate of inpatient admission among people of African descent. Note:

- *The U.S. admission rate to state hospitals between 1980 – 1992 is 163.6 per 100,000.*
 - *Whites: 136*
 - *Hispanics: 146*
 - *Native American & Asian: 142*
 - *African descent: 364.2*

G. *Quality of Services*

The quality of care received by Black women is inferior to that received by Whites. This inferior quality manifests itself in the ways described below.

1. *Misdiagnosis:*

- *Blacks are diagnosed less accurately for depression when assessed in primary care and emergency rooms.*
- *Blacks are diagnosed with higher rates of schizophrenia and lower rates of affective disorders.*

Example: A Black Christian might use language such as "the Holy Spirit said..." when referring to any kind of decision. But in some circles, clinicians will believe that this is an indication of mental illness and therefore may misdiagnose them as having schizophrenia.

2. *Treatment:*

Many times Blacks aren't given the most current drugs. Instead, they are given older drugs that have more side effects. A person becoming over-medicated is a real concern.

- *Blacks are less likely to receive appropriate care for anxiety and depression*
- *Blacks less likely than Whites to receive antidepressants when their depression is diagnosed (27% versus 44%).*
- *Blacks are less likely to receive newer SSRIs than Whites*
- *A greater percentage of Blacks than Whites metabolize antidepressants and antipsychotic at a slower rate and are more sensitive to medication*
- *Clinicians in psychiatric emergency services prescribe both more and higher doses of antipsychotic medication*

3. *Result:*

- *Slow metabolism and overmedication of antipsychotic drugs in Blacks can yield extra-pyramidal side effects:*
 - *Parkinsonian-like tremor*
 - *Muscle cramps*
 - *Long-term reverse side effects such as tardive dyskinesia*

- ❑ *Tardive dyskinesia is significantly more prevalent in Blacks*

H. Possible Solutions

There are ways to improve the mental health care experience for Black women:

1. Access:

Sometimes clinics are situated within the community. But more often good health care service is a journey away from those in the Black community.

- ❑ Community outreach
- ❑ Community based programs

2. Services Utilization:

Get churches, celebrities, and others with influence in the community to produce public service announcements (PSAs) to educate providers and the community and to de-stigmatize mental health issues in the Black community itself.

- ❑ *De-stigmatize mental illness via:*
 - *Educational campaign*
 - ⊂ *Churches, sororities, CBO's*
 - ⊂ *Celebrity PSAs*

3. Quality of Care:

The quality of care for Black women can be improved through various means.

- ❑ *Set-up mandatory cultural competency training*
 - *Professional guilds*
 - *Board of consumer affairs*
- ❑ *Evidenced based treatment*
- ❑ *Ongoing research*

Dr. Huff-Musgrove closed her presentation by challenging the Summit's participants to allow the past to inform the present – as policies, agendas and campaigns are being launched and pursued to better the health and health care concerns of Black women.

Slack returned to thank Dr. Musgrove and to formally introduce the staff of the *California Black Women's Health Project*. In attendance this year were Crystal D. Crawford, Esq. (Director of Public Policy), Eleanor Brown (Program Manager) and Joy Rayside (Community Organizer).

The introduction of the CABWHP staff was followed by a luxurious lunch that catered to the diverse health conscious tastes of the Summit's participants. As lunch commenced, a rather family-reunion like feel resumed amongst the participants – who shared turns holding one participant's baby, caught up on their respective lives and greeted new faces. Black women – health care advocates, non-profit executives, medical doctors, community activists, lawyers and the like – with all the authority, power, influence and professionalism they each possess mingled without pretense but rather with warmth, honesty and humility.

IV. Legislative Update 2002:

As the staff of *CABWHP* rallied the participants back to the roundtable, Slack again returned to the podium this time offering her sincere thanks to the financial supporters of *CABWHP*: The California Endowment, The California Wellness Foundation and the Ford Foundation.

Slack then segued into an introduction of the day's next topic – the “Legislative Update.” A panel of distinguished policy veterans – now seated on the dais behind Slack – was brought together to lend insight, ignite discussion and offer encouragement on the current legislative affairs of Black women's health at the state level.

Affectionately dubbed the "Sacramento Insiders," Slack welcomed three panelists – each serving in unique capacities in the public policy and health arenas: Holly Mitchell (*CABWHP* Board member; formerly of Senator Diane Watson's staff and the Western Center on Law and Poverty), Angela Gilliard (former Senior Consultant to the Assembly Health Committee and current Legislative Advocate for the Western Center on Law and Poverty) and Ana Matasantos (consultant to the Senate Health & Human Services Committee).

The presentation began with opening remarks from each panelist. To start, Holly Mitchell offered an overview of the representatives that exist at the state level with whom the mantle of advocacy concerns for the Black community rests.

A. Holly Mitchell

California's state capitol of Sacramento, Mitchell began, was a prime location to gather around a discussion of Black women's health advocacy. It is on the state level where change that assists the women in the community begins.

Notably, the first week of February (the week of the Summit) was an important week in legislature. There is a new Speaker of the Assembly who is a Black male. However there are no Black women state legislators in California. Based on this lack of Black women representatives, Black women's health care advocacy could possibly continue to suffer. In light of this, something needs to be done. All of this becomes even more significant of an issue when it is taken into consideration that it has been five years since welfare reform was instituted.

Mitchell's illuminating opening set the stage for her colleague, Angela Gilliard, to entrust even more staggering statistics to the Summit's participants.

B. Angela Gilliard

Just one day prior to the *CABWHP* Summit, there was a meeting in which the state's budget consultants informed legislators and advocates that there needs to be a dollar-for-dollar match in the state budget. That essentially will mean that they must “keep a dollar, cut a dollar,” in order to maintain a balanced budget.

Furthermore, because of the current political climate, community support programs such as the Child Health and Disability Prevention (CHDP) program are actively serving the needs of the community. However, the CHDP was recently on the Governor's list of proposed cutbacks. But advocates, along with Gilliard and her colleagues, are working to keep this program funded.

As active members of the community and as professionals in the health advocacy arena, there are things that can be done through the legislature, the market and administratively to aid the longevity of state programs that specifically support Black women's health needs.

For instance, when it comes to private funding, it is difficult for the legislature to dictate to the provider what to pay. However, there may be some lobbying efforts on the community level that could influence this. In general, Gilliard maintained that there is an issue with getting mental health professionals/practitioners properly compensated.

Another concern with health care professionals and treatment is screening for mental health issues by primary care physicians. The problem is that these physicians really do not have sound criteria for discerning the mental health needs of Black women. This is an issue that legislature has really struggled to address.

With that, Gilliard gave the floor to Sacramento legislative colleague Ana Matasantos. Holly Mitchell first added that Ms. Matasantos is an ally to Black women health care advocates and the closest representative the Black community has in an influential seat in on either legislative health committee currently.

C. Ana Matasantos

There is a serious dilemma on the state level: the most needy communities are being targeted for budget cuts. The support these communities presently receive is already insufficient and it will only get worse if these proposed budget cuts follow through.

Policy initiatives do affect diverse communities differently. The question, generally, is how this happens. One key point to remember in this is that until those in the legislature hear from those who are aware of cutting-edge community issues, then they will remain ill-informed at best. The needs that get legislative attention are the ones about which people inform policymakers. Moreover, the community concerns that affect policy-making are those that healthcare professionals and community activists intentionally make known to the state. Until there is awareness, there is a sense that an issue is not valid or, plainly, does not exist.

Matasantos went on to share that issues of environmental health, access to care and healthcare inequality (between different communities) are key issues to keep on the minds of legislators. The Senate Health and Human Services Committee has a special relationship with the current administration. Therefore, the Summit participants are welcomed to voice their input and assist the committee consultants in staying abreast of the unique advocacy agenda concerning Black women and their communities by calling them at 510.449.5965

At the close of Matasantos' remarks, Angela Gilliard further stressed to Summit participants that Matasantos' offer was to be warmly heeded. Matasantos, Gilliard notes, has the ability to "call the cabinet" members and effectively communicate with legislators regarding key issues. This is an opportunity to be "heard" on the state level. Obviously, there is a tremendous void in Black female representation on the state level. Since legislators often act on what is brought to them, Matasantos' invitation to stay in contact with her becomes invaluable.

Holly Mitchell then added that while some state legislators need assistance in identifying the

areas of need in the Black community, most have no idea that they even lack this information. Matasantos then disclosed that when there is no ‘voice’ speaking the concerns of Black women specifically, then legislators listen to other non-Black voices on the issues.

The panelists then received a couple of questions from Summit participants.

Question 1: *Is there a possibility for more resources for prevention?*

Panelist answers:

- It is unclear what the exact breakdown of budgetary dollars is, altogether. But that figure needs to be consistent in good years and difficult years alike.
- Education and a continuous voice (as previously noted by Matasantos) are key to seeing resources allocated for prevention.

Question 2: *If only five psychologists will even take Medicare, how will a woman who needs care get it?*

Panelist answer:

- Every year to eighteen months, there is typically “turn-over” in legislature. So, every year legislators need a fresh perspective and current information on Black women’s health care concerns.
- Generally, advocates for Black women’s health will need to present their issues without fear of approaching the state or simply not wanting to impose.

On the infectious wings of the “Legislative Update”, many participants were primed to continue to voice many of their concerns and to inquire further about impacting public policy. Therefore, CABWHP’s Executive Director urged Summit participants to focus their invigorated insights on eight probing questions – devised by the staff of CABWHP and the Summit Planning Committee.

With that, Summit participants gathered into four working groups comprised of 5-10 participants per group. After meeting for 1-1/2 hours, the Summit participants reconvened at the roundtable to report back to the entire group.

VI. Working Group Sessions

The working groups were designed to capture the thoughts, insights and unique professional and personal perspectives of Summit participants. The resulting information could indeed lend itself to assisting CABWHP with identifying key healthcare concerns and policy remedies to the same. The participants would be helping to craft a health policy agenda and action plan to impact Black women’s mental, emotional and physical health.

The overall theme that some felt characterized their body of answers was the issue of ‘trust’ – trust between the community and healthcare practitioners and professionals. There was also the prevailing thought that racism needed to be “defined” before the challenges in the relationship (between the community and the healthcare industry) could be addressed. Perhaps, some suggested, the answer was in “decoding” what mental health really means.

The small group discussions yielded the following insights, corporately:

1. ***What are the most effective ways to raise the profile of the issue of racism and how it impacts: (1) Black women's mental/physical health;***

and (2) Black women's inability to access health services?

- Define what racism is and how it is linked to mental and emotional health.
- Create a model developed by Black women of what mental health means for Black women.
- Implement a marketing campaign that would make seeking mental health services socially acceptable.
- Train and recruit more culturally competent providers.
- Re-educate health professionals about what Black women need and the actions that should be taken to meet those needs.
- Create interdisciplinary teams that include community members, administrators and providers. These teams will develop specific action items about which position papers will be written in order to encourage policymakers to take action to meet the needs of Black women.
- Determine the connection between physical and mental health

2. *What challenges keep Black women from accessing mental health services? What outreach or public information programs should be developed to encourage Black women to address their own mental and emotional health? What are the most cost-effective methods of outreach?*

a. *Challenges*

- Being uninsured or under-insured
- Lack of skilled providers
- Stigma attached to mental health
- Myth of the “strong Black woman”
- Mental health services are not linked with primary care services
- There is a trust issue re: disclosing one’s personal business
- Value of silence/secrecy in the Black community about “dirty laundry”
- The separation between spirituality and mental health
- Lack of access to child care

b. *Outreach Programs*

- Activism - on an individual or group level -- can be used address the issue

- Identify providers of color and disseminate the information throughout the community.
- Build outreach and services based on our own cultural foundation
- Outreach must be multi-faceted including consumers, public and private sectors
- Use radio and other media utilizing a holistic ethnic/multi-media approach
- Public service announcements
- Make the connection between mental and physical health
- Create a discussion on the community level where we convene Black women to discuss mental health and what it means to them
- Create a “buddy system” where a buddy would help a peer access mental health services and provide support

c. *Cost-Effective Outreach Methods*

- Regarding cost-effectiveness, we need to determine what the government should fund and what should be privately funded
- Link the faith-based community with mental health
- Make the Black women’s mental health a public health issue so it is incorporated into mainstream public health discussions
- Funding by pharmaceutical companies

3. *How should direct service providers be trained to identify and understand culturally derived behaviors in Black women that impact their physical, mental and emotional health?*

- Understand/identify cultural differences between service providers and patients
- Teach them to identify their own racism
- Develop a glossary of language that will help Black women be helped/diagnosed by service providers more efficiently
- Increase the number of Black providers
- Increase the amount of available educational training by increasing the public

and private money allocated for such training

- Educate children about race and gender and prepare them for careers in the health professions
- Encourage more medical school students to enter the mental health field
- Train consumers to navigate health care issues and interface with health care providers
- Partner with the clergy in terms of helping our community understand the positive effects of putting pressure on providers to have more heightened awareness about psychosomatic illnesses.
- Focus on prevention not just treatment
- Ensure that mental health is discussed along with physical health care concerns
- Train and diversify allied health professionals
- Direct service providers and institutions should reflect ethnic/gender diversity of community -- with management also being reflective

4. *How should direct service providers be trained to address the impact of racism on Black women's physical, mental and emotional health?*

- Educate about the ways in which racism cuts across many aspects of our lives
- Address allied health professionals
- Emphasize cultural excellence, not just competence
- Ensure that providers are sensitized to the fact that racism does exist.
- Providers must address their own racist ideas
- Diagnostic tools must reflect cultural issues
- Begin with medical schools and professional programs

5. *Given the shortage of licensed Black mental health professionals, how can we increase the numbers of Black women mental health professionals? How can we increase the numbers of mental health professionals who service the Black community?*

- Identify resources for appropriate referrals.
- Create a training course for service providers about black women's health –

with a focus on mental health.

- Teach people to be aware of their own mental health
- Don't separate the mental health professionals from the physicians
- Create new models of dealing with mental health within the confines of managed care
- Improve insurance company reimbursements to providers

6. *How can we more effectively link the provision of mental and emotional health services to Black women who are experiencing crisis related to violence/trauma or HIV/AIDS?*

- Assess the true needs and the state of black women's health
- Identify the role of the church in the mental health realm
- Address the state of male- female relationships
- Engage men in women's health advocacy work so they become our allies
- Address how men are linked to the emotional health of black women

- Use individual experiences in a public way – (1) encourage women to tell their stories in person and through video; and/or (2) create case studies using elements of different women's stories in order to protect their identities
- Create a safe place for women and providers to talk
- Try not to operate in a vacuum

7. *In what ways can research and demonstration projects be encouraged to: (1) include race and gender; and (2) address the specific concerns of Black women's mental and physical health?*

- Eliminate communication barriers – use language that is relevant to our community
- Engage in advocacy to ensure that researchers are held accountable
- Provide incentives to researchers who address these issues
- Form a watchdog group re: Black women and research and become part of coalitions of existing watchdog groups

- Look at the HIV and breast cancer movements for examples of what works and what does not work in raising the profile of health issues. Mental health is a taboo topic in the way HIV was 20 years ago.
- Make it safe to participate in research
- Researchers from our community are needed

8. *How should we exert pressure outside of the legislative arena to address Black women's health needs?*

- Encourage insurance companies to get involved with health promotion in general and regarding Black women's issues
- Have a training course for service providers about black women's health -- mental health specifically.
- Teach people to be aware of their own mental health
- Reach out to faith-based organizations to participate in education, information dissemination and putting pressure on providers to meet our mental health needs
- Encourage corporations to be active in fostering the health and well-being of women employees
- Encourage professional associations (e.g., Black physicians, nurses and social workers) to take a stronger stand and become active advocates
- Educate judges about the mental health needs of women in the criminal justice system
- Encourage education and information dissemination through rehabilitation programs and welfare agencies
- Encourage medical and other health professions schools to integrate our issues and concerns into their curricula
- Focus on prevention, not just treatment

At the close of the working group reports, Latonya Slack returned to again thank participants for their collective effort in assisting CABWHP in understanding how it can address Black women's mental health as well as the overall healthcare concerns of the community. At this time, any additional comments or questions were welcomed from the floor.

- One participant passionately called for the healthcare advocates and practitioners in the room to hold drug companies accountable. It is easy to prescribe a "pill" to remedy the mental health concerns of a patient. However, such a reflex could be more

destructive than helpful to a community of women whose healthcare needs are unique.

For final remarks by the organization, Slack again introduced the Director of Public Policy for the CABWHP, Crystal Crawford.

VII. Summit Proceedings: Where Do We Go From Here?
CRYSTAL D. CRAWFORD, Esq, Director of Public Policy

CABWHP is building a Policy Advisory Group (“PAG”) comprised of grassroots leaders, health service providers, government representatives and policy advocates. The input that has been provided by Policy Summit 2002 participants will affect how CABWHP moves forward with the PAG. We will look at Black women’s health in a holistic manner. The PAG will link Black women throughout the state with a commitment to ensuring that the issues of race, gender and quality of care are being addressed adequately throughout California.

Concurrently, we will hold the community and policymakers accountable for addressing the healthcare concerns of Black women.

In order to raise awareness and build this accountability system, CABWHP will train healthcare professionals, community-based activists and other Black women as advocates addressing Black women’s health concerns via our Advocate Training Program (ATP)– focusing on the intersection between mental and physical health. By multiplying ourselves, we will create a more effective movement around the state and country discussing, advocating for and addressing the mental and physical health concerns of Black women.

Participant question: How does this work?

The CABWHP will develop the curriculum for the ATP. The advocates-in-training will participate in a campaign to raise awareness about Black women’s mental and physical health among the community and policymakers. Our first group of ATP members will participate in cervical cancer education and outreach in the community, in addition to mental and emotional health advocacy.

Participant statement: It is important that the healthcare concerns of Black women are being heard on the state level – in the legislature.

Crawford agrees and reaffirms that, as an organization and as a community, it is important that our agenda be proactive and not become reactive.

Participant statement: Linking the PAG to an organization such as the Association of Black Psychologists would lend assistance. Perhaps such a relationship will cause grant monies to be shared, so that the efforts of CABWHP can be structured to succeed.

This is something, Crawford shares, that the CABWHP will definitely consider.

With the same warmth of the morning’s welcome, Latonya Slack returned to bring the day’s discussions to a close. The enthusiasm for the issues surrounding Black women’s mental health have given way to very fruitful exchanges and tangible suggestions that the *California Black Women's Health Project* will be able utilize. In the months to come, the participants will be kept

informed of the organization's progress on the issues discussed during the Summit and their additional input encouraged and welcomed.

With her organization's sincere thanks, **the California Black Women's Health Project Policy Summit 2002** came to a successful close.