NAMI Ask the Expert: Failing Another Test in Addressing Mental Health Disparities
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Presented by
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Due to technical issues, the recording began about 10 minutes into the webinar. The introductions were cut off in the recording and Dr. Stewart had just begun her presentation when this transcript picks up:

Altha Stewart (00:00:00):

… at the time the language was Negro, but the psyche of the black person in relationship to the surrounding social construct left us in a constant state of rage. Today, if someone is seen or viewed to be in a constant state of rage one of the first things that is said about them is they must have some kind of problems, indicating in most cases that there is some mental problem because no one is always angry, or being angry as a symptom of some mental disorders. And so, I think James Baldwin was pressuring in his own way and identifying that very fundamental core emotion at the root and the psyche of most black Americans at that time. Next slide please. And because this is Bebe Moore Campbell Minorities Mental Health Month, I want it in my own way honor Bebe by sharing a couple of remembrances.

I think it is important for those in the audience who don't know the story of how Bebe came to this work and how she surrounded herself with like-minded individuals to take on this major problem in our society. This quote from her, I think epitomizes where we as a community of people who care about people with mental illness and their families, who care about advancing the issues related to stigma and discrimination and all of those things that make challenges for people with mental illness to just survive sometimes. Her call for a national campaign to focus because on the stigmatizing mental illness, particularly in the black community was very important at the time. There was a very clear message in much of the black community. You don't talk about it if it exists. If it exists, you don't and acknowledge it.

And if you have to acknowledge it, do it quietly off on the side somewhere. And for anyone who's ever watched the movie Soul Food, you will recall the character of the uncle where the mother, the matriarch of the family had taken care of her brother all of his life, because he was considered to be mentally ill. And in fact, I think his name was Uncle Joe. Uncle Joe may have been the brightest person in that family, and certainly was not by today's standards suffering from a mental illness, because he knew the

family secret and what was going to keep that family together. And at the right moment, he shared it. So, within the black community there is a tradition of not acknowledging these things and it has caused major suffering over the years.

And it was Bebe who began to articulate and voice for others who felt it that that is not something to be ashamed of. It is something to acknowledge and get treatment for because, as she says here, recovery is possible. Her celebrity and notoriety as an award-winning novelist allowed her a platform and opened up an audience to hearing her that might otherwise not have listened. Next slide please. And so, for those who've not read these two books, I highly commend them to you. Her novel, 72 Hour Hold. And it is a work of fiction where she uses real life experience and understanding of mental illness and mental health systems in a fictional story of a family struggle to get their loved one mental health treatments.

And so the challenges that they face, which is, it's a wonderful read, it's compelling, and people who have read it, who were struggling with their own understanding of mental illness and family and loved ones are comforted, I think, by seeing it not so much first person story, but as the story of someone who was a master storyteller about a topic that is compelling and personal, that resonates with so many people. The other book was one that she wrote for children about a little girl whose mom had bipolar disorder and who had to struggle to understand the ups and downs of that particular illness, and to get help to appreciate the fact that throughout it all her mother who loved her, that her illness prevented her from always showing it in a positive and loving way, which was an important message Bebe knew for many of the children of people with mental illness. Next slide.

These are some of my favorite people. These are the NAMI Mommies. You'll see Bebe in the middle and the four women surrounding her. And actually, there's a fifth woman whose picture I could not find. But these are the friends of Bebe who came together in Los Angeles because of their shared bond of trust children with mental illness. And unfortunately for them, their children as they grew up were having more and more contacts with law enforcement and they banded together and decided that there must be something for people like them. These were accomplished women such as Bebe, actors and doctors and businesswomen and business owners who had professional lives and identities but love their children who were unfortunately suffering with mental illness.

And when they banded together, I think they gave themselves the name NAMI Mommies. But by the time I met them in Los Angeles at some NAMI events, they were a strong bond. Had formed their own chapter of NAMI. NAMI Urban LA to address the specific culturally based issues frequently experienced by families and consumers of color. And so, they set out on a path to identify issues and address those issues in a culturally responsive way. And NAMI Urban LA is still in place today and does some very good work. Bebe's former husband Ellis Gordon is on the board there. And some of these folks are still very active in NAMI. Their children, of course have grown up and had other kinds of experiences and lives.

But these are the women that I credit with bringing to the forefront the issues they think groups of black and Brown people who were families and loved ones and families who needed the kinds of things that NAMI uniquely provide, but they understood that they

needed it to be more culturally responsive than it was at that time. I suggested to them that they write their stories. I think the NAMI Mommy story would be very important in today's world. And hopefully if any of them are listening they will still consider doing that. Next slide, please. Now, in the history of mental illness, we've all heard of famous people who have suffered from mental illness. Most of whom we acknowledged long after they passed but we know these folks. Lincoln and his depression.

Newton had multiple diagnoses, according to historians who have reviewed his life and history. Winston Churchill was not just famous for the cigar and getting England through World War II, but also for suffering from depression. And Charles Darwin, who we credit with so many wonderful things in the science community had his own set of psychological challenges that we've come to know and understand better in today's world. Next slide. But I'm sure you may be don't know some of the faces here. In the top left corner of that slide is Taraji P. Henson, a noted actress and all around great humanitarian, philanthropist who formed her own foundation to combat stigma after her experience with her dad who was a Vietnam vet, trying to get help for his depression and PTSD and finding that the system, the mental health treatment system was failing him.

On the right at the top is someone who some of our younger members of the audience might recognize the Charlemagne the God who has become in his own right a mental health advocate. He's written a book on his own challenges with mental illness. He hosts a widely viewed radio show and regularly talks about mental health, mental illness, advocating for improved mental health services, advocating to reduce the stigma. And at the bottom is a lady who is just fascinating in her own right. Jennifer Lewis, who talks very openly about her own challenges with mental illness. And I was honored, along with Dan, I was honored to be the keynote speaker at the launch of Taraji P. Henson foundation a couple of years ago and was able to meet and talk with all three of these people.

They are wonderful champions and advocates for mental health. They speak openly about their own issues in the mental health arena and the challenges they faced. They have become my personal heroes and heroes in this fight to de-stigmatize mental illness in the black community. Next slide, please. So, let me get down to the root of why I'm here to talk with you today. The title on the slide on my title slide and the title for this talk had to do with the failing system in terms of reducing mental health disparities. Very clearly the pandemic affects all of us. And I suppose on some level, when I came up with that title, I was actually thinking of all of the bad things, all of the things that are going wrong, all of the things that are just heaping trouble after trouble, after trouble on an already overwhelmed system that was having challenges facing its work to reduce mental health disparities before the coronavirus pandemic.

And since then it is almost buckling under that weight. But as life is known to do experiences this week have changed my mindset with respect to having a much better level of optimism about what is possible. Two important things happened this week that make this slide particularly relevant. The elephant in the room around mental health disparities as we all know they exist, but we don't know what to do about them, or we say we don't, and so we don't do anything. That's the elephant in the room when it comes to this particular issue. Bebe understood that, our current day champions

understand that, and I understand it. And so, this week when we've spent a fair amount of time honoring a lion of the civil rights movement, and today are laying his body to rest, I was reminded of things like his phrase, good trouble.

And it dawned on me as I was preparing for this afternoon, as this morning was listening and started to think about this afternoon, that maybe I should reframe my comments today to seeing them as sharing with you opportunities to do some good trouble, because lord knows if any area of our life today needs some good trouble to shake it up, to make change, to push the needle, to force people, to accept our social and just responsibilities in the area of improving mental health systems in reducing mental health disparities, and in working towards equity in our overall health system, that includes our mental health system. It was NAMI that taught me for example, there is no health without mental health. And so, I think if Bebe was here today she would want me to have this as a reframed topic, something about achieving equity.

And John Lewis would say, "If you're going to do good trouble, let's talk about unmasking these mental health disparities once for all so that no one can say they don't know what to do anymore." So, I'm going to try to live up and honor both of those champions in my mind today as I go through the meat of my presentation. Next slide. We have to always start, because I am assigned to some medical person, we have to always start with something that brings the health into the center and the focus of what we are talking about. And so, since I believe that these disparities represent a public health problem I went to the American journal of public health and found this quote, and I've used it several times. And I have to tell you, in one session someone asked me in the Q and A why I thought that discrimination was casually associated with poor mental health outcomes.

And I couldn't figure out what they were saying until I realized I sometimes have a bit of the problem with dyslexia myself. And so, they thought this was casually when it's causally. And so, we have to accept the fact, the science bears this out, discrimination is causally associated with poor mental health and physical health outcomes. And this has nothing to do when it is corrected for income, education levels and everything else. These things matter when it comes to our health and wellbeing and certainly our physical health and wellbeing. Next slide please. So, where do I start? We've got stigma. Yeah, it exists. There are access issues. Everything from, is it available, and am I willing to use it? And how do I define help seeking, and when I need to use it? And is it normal in my culture and my community and my family and my social networks to acknowledge these things? Funding.

There's the formal stuff and then there's the community-based stuff. We get a lot of funding sometimes in those formal institutions that don't always address the real issues of the people we're talking about today. But community-based institutions and organizations and agencies tend not to get the amount of money they need to be resourced well enough to do the good work that they're doing in a much larger way. There's the whole issue of lack of awareness and understanding, and education and literacy. Just understanding when you go to the doctor or when you go to the mental health provider, what are they talking about? We use these words and phrases and acronyms that confuse people. And so, we've got to get away from that. And then there

is that final bottom line when it comes to people of color of, "Is this culturally competent care?

Am I getting something, even if it's good quality that I understand from the standpoint of my culture, that resonates with me from the standpoint of what's acceptable within my culture, my framework, my family, my community, and am I able to translate that into something that says, "This is good for you? Let's do it," and it will work?" So, these are all the things that are part of my starting lineup, if you will. Next slide. And so, now I've got a starting lineup and I need to have something. You know that banner that's over when you run the marathon, there's always a banner at the top that says where you began. This is where we began. Dr. David Satcher, the surgeon general back in 2001 did the first ever, in 1999, actually did the first ever surgeon general's report on mental health and open the door to an understanding by the general public, not just the science and healthcare and medical world, but the general public as to the science base, underlying all of the things that we know about mental health.

He demonstrated there was the science evidence-based for what we were doing, or what we needed to do that we needed to start helping people understand. A couple of years later he published the next report, which was mental health, culture, race, ethnicity. And this quote comes from there. It is familiar whether you've ever heard it or not, because we all know that all of this stuff matters in the context of our family, our community, our society. That we need these positive things in our lives, in our psychological being, if you will, to have good health and that if we have that good health and that good psychological health, we have these other things as a possible outcome. The improvement in our ability to communicate and learn, to have resilience, to have self-confidence and self-esteem.

To be productive, thriving citizens. Next slide, please. But in the context of a society where structural racism permeates even our health and mental health systems, these are the challenges that we've faced. Some would say barriers. Because I'm in that more positive, good trouble mindset I'm going to just call them challenges. We have the challenges of high rates of poverty and unsafe living conditions, lack of access and availability of healthcare, the high levels of trauma that we're exposed to from childhood and even prenatal periods through the end of our lives, lack of access to the opportunity structures, whether that's education, work, movement up in terms of socioeconomics. And then there are these constant nagging, negative interactions with systems directly related to all of those other bullets in education, health, child welfare.

And in my area that I spend most of my working life in criminal justice and specifically juvenile justice. Next slide. So now we've got a frame, we've got a starting point. There's the banner over there. I've highlighted the challenges. Now let's talk some definitions. And I won't take time reading them to you. We'll leave them up for a moment so you can read them for yourself. And most of you already know these definitions. But every organization that is responsible for health, funding health, overseeing healthcare systems has created a definition of disparities. Most of them have some common threads about the incidents and prevalence, how it connects with one's ability to thrive and be productive. That it is somehow tied to environment, economics and other things, but you will know what is missing, and here comes the good trouble.

You will know what is missing is any reference to discrimination, racism, and some other things that we now know, thanks to the good work of many heavy hardworking researchers who are doing the heavy lifting in this area. We now know fundamentally at the foundation at the core of all of these issues that result in disparities is the underlying foundation of structural racism, discrimination, racism, whatever name you want to give it, it is there as the underpinnings. And it's not just the healthcare system. It is throughout our society. It is the basis for how our government, our country was formed. Mental health has a tragic history with respect to how the first practitioners of mental health treatment created segregated environment to assure no mingling of the racist. People who were fighting for their own liberty took a moment to say, "Hey, but if you're insane, got to be in a separate facility from those colored people."

So, the basis of our society, and remember this is good trouble. The basis of our society is one where that is the foundations. Is it any surprise that we are left in 2020 with the level of health and mental health disparities that we have? Next slide, please. And it's not like we haven't had lots and lots and lots of information since the surgeon general support on mental health. In 2003, the Institute of medicine released its report on unequal treatment. And for the first time a major organization actually named it, racism discrimination are at the base of how these disparities have come to be and how they come to thrive in an environment in the world's most powerful country, with the greatest healthcare system, that because of these fundamental underpinnings, many in our population don't get to achieve a level of care treatment and other things that one would expect with the greatest healthcare system in the world.

And there are other reports that documented similar things with respect to disparities and you have to search on whichever is your favorite search engine some of these things, and all of these reports are now available online for anyone who's never seen them and would like to read them. They are filled with science, which is what I love about them, because the argument against this whole theory has been there's no science. Well, there is. And these groups have given us that science and many more are working on even more today. Next slide please. And these are just pictures of the surgeon general's reports. He followed up his first two with a report on children's mental health. And so, all of this stuff is available. It's got reams and reams and reams of reports and articles and citations and references and charts for those who need the data.

It's got lots and lots of that. I encourage you to go and read it if you aren't. If you aren't fluent in the world of mental health disparities, get grounded in some of this stuff as your starting point. Next slide please. So, if there are challenges and barriers, then there must be actions that these barriers are complicating. And I've just listed the four or five that come to mind when I think about them. Ideological, if it doesn't affect me what difference does it make? What does this mean? If it's determined that mine is good and someone else's is bad, am I responsible for that? And if it's not affecting me, why do I care? I don't know enough about it to really understand it. So, I'm not having any problems. So, I'm going to leave that alone. And I won't even go into the political because that's a raging battle right now.

And then institutionally systems and institutional settings have real challenges today because they are the cornerstone of much of the care. And they are struggling to

understand not only what their role is, but once they figured that out, what to do about addressing these things through their role. So, there are some clear challenges to affecting the change we need to see to achieve equity and reduce disparities. Next slide, please. Any discussion of disparities takes me naturally to a discussion of social determinants of health. It's that fancy word that we've created. The concept, actually, that we've created to talk about those things like racism, discrimination, poor housing, lack of opportunity for education and employment. We've given them a name so that we can concretely capture them and then use them as a springboard for getting our action steps together.

And this means, now we're talking about more than an individual's issue. Now we're talking about a community, a population issues, which makes it a big public health problem, which is where I think we want to be with this, because public health problems like car seats and smoking and reducing cholesterol and the risk of strokes and heart attacks are things that people get behind. So, we really want to have a campaign, if you will, of public mental health that people will get behind. Next slide. I often tell people that I know folks who wrote the book on social determinants of mental health, and I actually do. These are two colleagues. Michael Compton, and Ruth shim who wrote the book literally on the social determinants of mental health. It's a great, basic reference point of starting point for some of the stuff that I won't get a chance to talk about today.

And again, if you have not gotten anything else. These are the things for the novices in the audience who want to know more, and so the people who know a lot, but now want to begin to use the science and the evidence to support these things and push policy and practice agenda forward. These are some of the reference books that I would encourage you to take full advantage of and use. Next slide. This is just a cartoon representation of the battle we were about to rage. We have a mountain of social determinants in the river we're trying to roll across in a boat that is now stuck on them, trying to take care of the population of people. We've got a hole in our boat. We're bailing out the water and we're not making much headway. It's time folks for some good trouble. Next slide.

So, I have a couple of ideas that I always like to share with people as examples of how I, and this is strictly me. And as you heard in the introduction, I tend to like to be in charge of things. President of this, chair of that, that sort of thing. So, I acknowledge fully that for me, good trouble means taking charge, being in charge, leading the way. And so, what I'm about to share has to do with how in my day to day work, and many of my programs we look at how we can reduce health disparities by addressing the social determinants of health in three areas. Is there an intervention? Is there some aspect that could lead to policy development? And can we get better at communicating and sharing information so that we build a base of champions like Bebe and like John Lewis to help us carry the message that we can do better. Next slide.

You heard that I work in the juvenile justice area. I work in the community health area. And I work in a department of psychiatry that has a community psychiatry component. And so, for me an intervention that's going to be successful and used and accepted by the people I'm working with, no matter which of those areas I'm in, it has to be evidence-based, it needs to be culturally relevant. It's got to be appropriate to that community, that population, that issue. It always must incorporate family, peer support and recovery

principles. And it has to have strong community collaboration. Examples of that would be for me, working with kids in the juvenile justice system. We do a lot of trauma focused intervention. So, TFCBT, CBITs in schools, PCIT. And I apologize for the acronyms, but that's how they appear in my brain, so that's how they come out of my mouth.

But these are all well researched and studied. They appear in the national database of evidence-based practices. They have been used in various populations with pretty good success in most of them. And they are things that are easy to train people to use and to help people that you're working with to understand why you're doing it. They allow people to hear and see things as opposed to just talking back and forth. They're concrete, they're structured. They can be measured. People can get into it, they can engage, in other words. And the collaboration part is very important because many people create programs based on resources. And when the resources dry up the programs dry up the collaborations with a community, allow you to, from the beginning, create a sustainability framework where people buy into the notion.

They begin to help you get the right resources, whether it's from their local city council person who has discretionary funds, or whether they joined together and go after a sustainability grant, or whether they get the business community to fund a program, because it helped the community create a better workforce. If you get people engaged in the intervention and you show them how that intervention matters in the lives of an individual and a community and a family and themselves, then they began to be your champions. And building champions is what good interventions do. They also help individuals, but they really build champions. Policy development, similar thing. Got to get families involved. You have to help them understand why this policy change will make a difference, not only in their lives, but in the lives of people like them.

And help them figure out how to push for funding, get them involved in evaluating the programs. We often think when we work in communities that people just don't understand this high-level stuff that we're talking about. And if we can't break it down. There are all these acronyms and things. In my experience, when I set out to create a program and I call a community meeting and tell people what I'm trying to do they have a lot of questions, and they challenge a lot of my ideas. But once we've cleared that initial getting to know each other, and I spent patients instead of judgmental, and I've been one amongst them as opposed to up here. And they're down here. Once we clear all of those usual hurdles that complicate the lives of community researchers, I found that most communities want things that will help their community.

They want their children to be healthy. They want their homes and families to be safe. They want their schools to be good. They want productive citizens surrounding them. They want businesses to want to invest in them. They want employment and education. They want to have fun. They want their kids to have fun. And when you can help communities understand that and get them involved in helping you to create better policies, all of this stuff really works well for them for me, anyway. Information sharing, as you can see, as a matter of communicating we have a lot of very heavy-duty science stuff in mental health. We talk about neurotransmitters and enzymes and the names of some of our medications are tongue twisters.

But when you can break this down, as one of my moms in my system of care program told me a few years ago, she said, "Doc Stewart, you're very well-educated woman, and you seem to have a good heart. But you all really talk a different language. And I don't understand it. You all need to break it down for people like me." And I've never forgotten that break it down mantra. And if I'm in a room and someone says something that does not seem to be resonating with the people I'm trying to communicate with, I have to stop them and ask them, "Do you know what the Hudson rule is?" And it's named after the woman who said that to me in the meeting. And she has given me permission to always use her name because she loves getting the credit for it. The Hudson rule was established in our program because we didn't want families to feel embarrassed in asking questions when they didn't understand.

So, all they had to do was raise their hand and say Hudson rule, and whoever just spoke must have said something they didn't understand. So, it was their responsibility to go back and explain it. It's that kind of sharing of information in that context that allows people to feel like you're welcoming them in, as opposed to keeping them out by using language and words and concepts that are hardly understandable to some of us. Next slide please. And then in the institution, because I do work in an academic setting, I have to talk a little bit for a couple of minutes about treatment training and research, as concepts that we've got to get behind, get beyond. Next slide, please. In the treatment arena and in the training arena, this is just one of those word cloud things that I'm just enjoying these days.

Because the concepts that are captured here are all of the things that trip us up in the training environment. We aren't training our new generation of mental health providers in a way that allows them to acknowledge their social justice value system in the context of a heavily now medicalized psychiatric mental health system in a way that allows them to translate and share information without stumbling over things. We also are at a real tipping point with respect to the balance of workforce that engages a primarily minority population by a primarily non-minority provider group. And so, things like microaggressions and micro-invalidation and micro-assault and verbal challenges that come either because of a lack of awareness or lack of understanding, really wreak havoc in the therapeutic setting for many people.

And in the training world, not only do the students come in with certain values, but our training group, whether it's faculty or supervisors or professors in the professional schools, they bring their values there. And each of us carries a value set based on our life experience, our culture and our upbringing. And so we have to acknowledge that, and we have to be aware that in this day, at this time, if we are not sensitive to and aware of those things, that we aren't even thinking of as being triggers and an assault on the psyche of others, then we're not training people to be understanding and aware. We're not modeling for them how you do that. And that means we're not providing the best possible care, but the people who come to us for care.

At the very least whatever we do in the service of helping someone with a mental illness or supporting the family of someone with a mental illness should not hip more assault and trauma onto them and their lives. At the very least, we should not do that. At our best, we ought to be doing everything to avoid that and do something affirming and do something positive and supportive for them as they navigate through the series of

challenges they may be facing with their mental illness. Next slide. I was struck and I show this now just because I'm still fascinated by it. This was a study done of first year residents who were asked these questions and in an online survey first year residents, and these are the percentages who believe these myths about biological differences between blacks and whites.

58% believed that black skin was sicker than white skin. Blacks age more slowly than whites. Now, there is some truth to the black don't crack. So that may not be that far off. But things like that means being less sensitive. This is the reason that when black people with sickle cell go to the emergency room complaining of pain, they're accused of being drug seekers, because the assumption going into this is based on a faulty myth that black people don't experience pain. And therefore, if they're asking for pain medicine they just want the drugs to get high. And this is present in our medical practitioners. These are mental health practitioners. This is medicine, the broader medical arena. And the references there, I won't go through all of them because some of them are actually quite depressing denser, stronger bones, less susceptible, whites less susceptible to certain things.

Whites have larger brains than blacks. It is fascinating that in 19 … I'm sorry. In 2016 that people actually believe these things to be true. Next slide. So, I've talked a little bit already about collaboration. But these are some of the actual strategies that we utilize when we're out in the community, if I'm starting a new program or writing a grant, and I need some involvement from my community to craft the program that they really want. These are some of the things that we do to make sure that people are engaged and involved from the beginning. So, these are just a few ideas that I throw out. Next slide. And you can't talk about doing this work without talking about the sustainability plans. And so, I like to think that if I frame sustainability, instead of saying that word, if I talk to people about. If you think this is good, and this is where you live and work and learn and play and pray. Because I'm in Memphis, in the South, the Bible belt.

So, everything centers around prayer and church and faith. So, we always add that last item. But when I reference it and frame it in this way, people understand exactly what sustainability means and they will get behind it. And it's them getting behind these kinds of things, these innovative programs, these models that they are helping to create because they think this is going to address their need. And they're willing to work with me on it. And they're willing to encourage people to come for the service. That's where we can really reduce the disparities and achieve a level of health and mental health equity. That is a Testament to the folks like John Lewis and Bebe Moore Campbell. Next slide, which should be … This is just a series of pictures demonstrating some collaborations. That top one is a collaboration that I was a part of in South Africa to talk about adverse childhood experiences, a global notion.

The bottom left is one of my juvenile justice seminars, training seminars which was really kind of a community meeting in addition to a training with a mix of professional people and community members and some family members of the kids that we work with. And you can probably tell from the ceiling that it's a church. That's a great place in the community to have these big meetings. It levels the playing field. Most people don't scream, yell or curse in churches in the South. And then the top is David Satcher who was part of that South African group. And it was a major event for us to be part of that

from the US the lady in orange next to me is one of the NAMI Mommies who went on that and presented with me at that meeting. Next slide. This is the final slide. This line of German shepherds with the cat crossing in front of them goes by many names.

But for today, we're going to say, be the cat. Be the cat that accepts the challenge to fight mental health disparities and walk past the naysayers and the evil doers and all the people who will argue against this work. And you see how those German shepherds seem poised to move, but don't move. I want everybody to think of themselves as that cat. Walk proudly. That tail is up in the air. And I know it's a female cat because she's not even looking at them. She knows that charge. So be that cat. Let those dogs have their way on the side. They're not bothering you. They can't stop you. The work that we have to do, the work to honor John Lewis and Bebe Moore Campbell, the work that reflects the good trouble we need to make to shake up the mental health system to eliminate disparities, to achieve mental health equity on behalf of people with mental illness and their families.

That's good trouble. And that cat knows good trouble. So, I think that's my last slide. And thank you for your attention.

Dan Gillison (00:43:17):

Thank you, Dr. Stewart. This is fantastic. We will remember to be the cat and not the dog. And with that said, as I get ready to introduce our nominees director of inclusion and diversity, I just want to mention that as you've mentioned being the cat I also want to share with this audience that two years ago, I had the pleasure of working with you in your role as the president of the APA. And you are a visionary. And you took the leadership team to Memphis for a diversity equity and inclusion retreat. So, you were already on that stack of mail as we see the huge need two years later. So, thank you for doing that. And that is a segue into my introduction of NAMI's director of inclusion and diversity, Monica Villalta. She is a cultural competence expert, diversity leader and public health practitioner with having had roles in both the private and public sector.

And she holds a Master of Public Health from UC Berkeley, and a BS from the university of Maryland. She also leads NAMI's diversity equity inclusion committee. She has an Annie E. Casey Foundation and National Hispanic Leadership Institute fellow with certificates from the Center on Creative Leadership and Harvard University, John F. Kennedy School of Government. With that, I give you Monica Villalta.

Monica Villalta (00:44:45):

Now you do. Hello. Thank you, Dan. Thanks for the introduction. It's such a pleasure to be here with Dr. Stewart. And I want to share that this is a very tough act to follow. In my capacity as the very first director of diversity and inclusion and diversity officer at NAMI I wanted take a couple of minutes to link this fabulous conversation and presentation that Dr. Stewart shared with us today and link it to two things. First to NAMI, and our organizational commitment. And secondly, to what's going on currently in our localities, in our nation and go from there. So, let me get start with linking it to NAMI and our organization briefly. So, if you could show the next slide, please. So, NAMI has gone through a process of redesigning our strategy, and we have identified our roles,

accelerators, goal and the change that we want to create, and we're moving passionately in that direction.

And we know too, next slide. That we will not be able to accomplish this work unless we have a powerful, inclusive, and strong Alliance with the competency to provide an open our doors and provide services to all. To that end, we have started some of that work. We have begun having many conversations like today. We have begun developing resources that you ask us to do. For example, during our last council last week, we shared with you some resources on isolation and COVID-19. Some resources on trauma, historical trauma, and being re-exposed to that trauma via media. And all of you participants today will receive some of these resources later, along with all the resources that we have put together around racial inequality and other important and relevant topics.

I want to say that in the process of creating that inclusive, powerful NAMI with all these skillsets we've been rethinking diversity and inclusion. And I think addressing the things that Dr. Stewart has mentioned today will require that. Rethinking how we do our work around diversity, equity and inclusion, because in a year where we're facing a public health crisis and economic crisis, a racial justice crisis that has opened up our eyes about different experiences and about that trauma. And that's for some of us who thought that the mental health system was already undergoing an emergency in terms of lack of resources, some of us think and know that after these three crisis we are increasingly more effective, and therefore the role of NAMI is more important and more critical, more relevant than ever.

But part of our commitment to diversity and inclusion, which comes from our board cascades toward CEO, and down toward leadership we're already being reframing how we're going to be doing this diversity and inclusion work. We have four core components. I'm not going to go in detail with them. You will see us as we go forward in our mission work and in our resources in the sites, but we're reinvesting in our people and careers and we're building the know-how so we can deliver more products and services that are increasingly more culturally relevant, culturally competent. We're expanding our identity and how we're seeing communities. And perhaps more importantly, in an alignment with what Dr. Stewart said, we are rethinking how we create a partnership.

That powerful, effective, culturally relevant relationships and partnerships with that competence, and also the cultural humility to be able to be effective and reach and deliver so we can accomplish our powerful mission. Again, this work is not easy. It will take time. It takes time. We know that. It takes reflection. It takes compassion, curiosity, and grace. But we have begun this journey with making a long-term commitment and this conversations like today highlight the need. I cannot add much what Dr. Stewart said today because her presentation was comprehensive. And it brings me back to my good old days from the school of public health, going to the basics and the social determinants. And we know that doing the change requires a long-term investment, but we are committed to that. Creating a process of transformative change. We have begun to create more resources, new partnerships.

For example, we just started a partnership with the CDC foundation for their [inaudible 00:50:12] initiative, where we will be bringing more resources in Spanish and English to

members of our communities and the public at large. I'm very proud to be part of NAMI doing this work. And I hope that through your participation in conversations in this through our resources going toward websites and exploring new knowhow we'll accomplish our mission together. These resources like the one that is being shown on this slide right now will be shared with you. And you'll receive an email of the other resources I just mentioned. Thank you so much.

Ken Duckworth (00:50:49):

Thank you, Monica. And thank you, Dr. Steward for a comprehensive and incredibly thoughtful talk. I'm going to start our Q and A with a love note. One of our attendees created the collage that you had with Bebe Moore Campbell. That's Ladonna Milner created this collage. She sends her thanks and blessings to you.

Altha Stewart (00:51:15):

Thank her for me. Thank you, Ladonna. It's beautiful.

Ken Duckworth (00:51:17):

And she's right on here. You can than her.

Altha Stewart (00:51:21):

It's beautiful.

Ken Duckworth (00:51:22):

Isn't that lovely? It's a nice note to start on. It's a community, the beautiful community. Let's talk about misdiagnosis. I of course have followed the literature on misdiagnosis, over diagnosing psychotic illnesses, under-diagnosing, mood disorders. Bill Lawson and others have done a lot of work in this area. This question is more about black male children and the over-diagnosis of oppositional defiant disorder. And of course, in juvenile justice you're seeing a lot of this. How do you think about that, this piece of misdiagnosis?

Altha Stewart (00:51:57):

Well, then is an excellent question. And I'm so glad you've asked it, because I don't get a chance to talk about this enough in the general public arena. In the last, I guess, eight, nine years of my career, I have focused primarily on working in the juvenile justice or with justice involved youth, or kids at risk of being categorized in that way. And what I am finding, and I've not done the study yet, but what I'm finding is we did a study of a record review of kids who were admitted to our juvenile detention center over the course of a year. And it was very telling because we are now much more engaged in trauma informed awareness and understanding at work. And so, we are more likely now viewing this through a trauma lens. And by “we” I mean the people that work with me in my center. And so, as we're reviewing the records. We're using the tool that allows us actually really look at measures of trauma that we can find in the record.

Some of it is extrapolating or translating material and information from that record into the language of trauma. But what we are seeing is that most of the children who were admitted, even if they didn't have a diagnosis of childhood PTSD or some reflection of that, they always had one of the disorders. Oppositional disorder, explosive intermittent, explosive disorder, ADHD, ADD. There's always that as the basis for anything that they were having. And it didn't matter their social context, their family structure. They all have those kinds of diagnoses. And that's an incredible coincidence or inaccurate. And so, we began looking in a different way. We began looking at kids who were being referred because of truancy. And in Memphis, if you are absent for more than 10 times, unexcused, you are sent to this truancy meeting, and it's a whole big deal.

And it's kind of scared straight going to school style. And as we begin and to screen kids at that center for trauma, we began to see that same pattern that kids who were truant more likely came from homes or were having experiences in their community that were clearly trauma related. And that people were not recognizing that connection between the traumatic experience, the behaviors that led them to problems in the classroom, suspension or expulsion or entering into the juvenile justice child welfare system. So, there is a clear link in my mind. We just now have to go back and actually do what I said in my presentation. We got to do a study, create the science. And others have done it. But some places want their own data. They want their own evidence. So, we're going to go back and do that.

But I'm certain that what we're going to see because of the situation that many of these kids come from, the communities they live in, the circumstances that they experience in their day to day lives in their homes, in their neighborhoods or in their schools that we're going to see a significant number of kids who score very high on any trauma scale. Once that is taken into account, we'll not be getting these diagnoses of all of these explosive and, and oppositional disorders. And there's the other context that I brought up in the presentation about the assumptions that we make about little black boys. It is fairly well known that law enforcement, when they encounter a 13-year-old black boy, see someone who is much older, who is much more threatening, who is less likely to comply with their rules, and therefore they feel threatened.

That has been proven by many more people than I will ever study about more people than I will ever study by people that I greatly respect for their work. And so, we have this clash of the over representation and diagnostic categories, things that don't fit when you really evaluate that child in the context of not just the diagnosis, but what is going on in their lives. The phrase that everyone in Memphis now says, which makes me so proud is, it is not what is wrong with you. It is what happened to you. The study is now looking at this through the lens of trauma. And that's not to explain bad behavior. It's not to excuse criminal actions. It is to give the child … The whole point of the juvenile justice system was rehabilitation, not punishment. But if we can sign a child to a serious diagnosis, place them in an intensive criminal justice setting, I'm not sure what we expect to get back will change.

Ken Duckworth (00:57:31):

That trauma informed piece is really important.

Altha Stewart (00:57:37):

Very important.

Ken Duckworth (00:57:38):

Part of what happened in restraint reduction. What happened to you and how have you been traumatized as opposed to what is wrong with you? Couple of questions on one topic that we're going to try to put into one topic. I'm a white practitioner and I didn't grow up in this culture. I want to be as culturally competent or perhaps to use Monica's term as cultural humble as I can be. How can I be in better service to my patients as a mental health practitioner who is not of the culture of someone I'm working with?

Altha Stewart (00:58:18):

This is a no brainer for me. And I'm glad that someone felt comfortable enough even setting to ask the question. The word humility is really got to be a priority in the mind of any non-minority treatment provider, working with a person of color. There is no shame in saying words like, "I'm not black." I think that's pretty obvious. "And I want to do the best possible work I can with you, but they're going to be things I don't understand. I hope you'll be patient with me. I hope you'll help me understand it. I'm going to do my own learning. I'm going to read; I'm going to ask questions of my peers and colleagues. I'm going to put myself into the role of students, but I'm going to have to ask for your patience and grace, because I think I can help you, but I need you to understand that I know I don't know everything I need to know to really understand you."

Some variation on that is generally well received because people like it when you acknowledge the obvious. The obvious is, I don't know enough. "Based on what I think you're thinking as you look at me, I probably don't know enough for you to think I can be of help. I want to be of help. I'd like to help you. I think I have something based on your symptoms, based on your condition, I think I'm the right person. I'm just not the right person. So, if you give her some grace, a little patience, let me learn some stuff, help me help you." In the words of Cuba Gooding Jr. Help me help you.

Ken Duckworth (01:00:08):

Open the door to the conversation is really what you're saying. Put it on the table, bring it into the room.

Altha Stewart (01:00:15):

I have done that with white patients. I've done that with gay patients. I've done that with individuals who assumed that even though I was black, I didn't understand their lot in life because I was a doctor and they were on Medicaid. And it's helping to level the playing field treatment environment in a way that may pay off it. It won't always work. So, you are rebuffed by one person. Then you've been rebuffed by one person. The trick is to keep trying and keep learning.

Ken Duckworth (01:00:54):

And keep the conversation part of the clinical work. Because it might up seven sessions later.

Altha Stewart (01:01:04):

You and I are old school. In the old cycle analytic world if something keeps coming up and you hit a wall there's something there. So, start looking on that.

Ken Duckworth (01:01:14):

That's right.

Altha Stewart (01:01:16):

Are we at this place because you've got something that you need to talk about but you're not sure I will understand because of my race? Every now and then the therapist has to have that humility that Monica talked about. And it's not a crime, it's not a sin. It's not a sign that I'm not worthy. That I don't know enough. What it really is, and my mind can, is a sign that I understand where I am at the context of this patient's life. And I represent everything that has been oppressive in the life ... If I'm a white person, I represent everything that is oppressive. I may not recognize my privilege. I may not acknowledge my privilege, but with that patient, I need to accept the fact that if I'm going to be of any help to them, I can't be my usual inside and ignore the obvious.

Ken Duckworth (01:02:07):

Thank you. That it's a beautiful answer. There's a statement here that I want to see if it's accurate, because I have a different understanding. There are just not enough medical students going into psychiatry. My understanding is more students are finding psychiatry compelling than before and are picking it, but demand is increasing very substantially. But the related question. So, I want you to answer that question about people entering the field. There are not enough students of color going into psychiatry. And I want you to talk about making helping to make the workforce more diverse. That's a two-part question, but it's related to workforce in psychiatry.

Altha Stewart (01:02:50):

Well the workforce and increasing the interest in psychiatry is there. We're seeing an increase in the number of students who in medical school are actually getting involved in groups like PsycSCAN, which is the sort of affinity group for kids in medical school who thinks psychiatry is in their future. We're seeing certainly in the academic setting; we're seeing students who are engaging in mental health and psychiatry and setting up projects. The American psychiatric foundation has a program called helping hands grants. And it's for medical students to have projects while they're in school in their area of interest. And I've been encouraging a couple of our medical students to actually apply for that grant because they want to host a mental health, not a clinic, but a mental health program or attach themselves to one of the clinics with mental health treatment.

And I'd love to help them get that started and want them to learn grant writing and other stuff as part of that. So, we are seeing an increase, there are many more pipeline

programs so that students who might be interested can get engaged with other older seasoned mature mentors and sponsors, just to keep that interest. The other question about fewer blacks going into psychiatry is a troubling one. While we are seeing a number of programs that are doing well in their match for students who want to do psychiatry, there are so few medical students, black medical students still that the number of them who are choosing psychiatry still has not risen significantly. Groups like the Black Psychiatrists of America, like the National Medical Association are doing flips, trying to identify early and keep engaged students who show any interest.

But still we have in the pool of psychiatrists in the country, I think we're still hovering around 4% of the total number of psychiatrists. And that's really not enough. That's just not enough. So, think of like, things like this, and during my presidency, of course, of the APA, I went on a major recruitment. Every everywhere I went to speak I managed to talk to medical students and residents to encourage those medical students and residents who were black or Latino to consider psychiatry. Talk to them about how important it is from the standpoint of cultural treatment and aspects of things in the training research and the clinical services arena that are just as attractive as internal medicine subspecialties through equity.

Ken Duckworth (01:05:55):

Thank you. I'm going to call this halftime because I know you like sports metaphors, which I was pleased to see. This question is for Monica. Monica, how can the NAMI affiliates connect to the NAMI national strategy around diversity, equity and inclusion

Monica Villalta (01:06:23):

Perfect. Thank you. It was a bit of a delay. So, this is a very good question. And if you notice, when I talk about this new framework for diversity equity and inclusion, we do begin some components that are internal, such as building capacity and know-how. And the second part of this framework is external. Some of it is through mass media and connections. The other one is through partnership, but significant piece of this work that is around, how do we create linkages and resources to better serve the alliance. So, we're still rethinking how to do that and building the infrastructure within. But part of what we're beginning to do you may have heard Danny in other occasions is exploring pilots and exploring initiative where we can create that kind of compensation.

Especially now in 2020, with this increased use of technology for us to connect, we know that this has been a challenge in the sense that we had to build our capacity to use the technology, but it's also become an open door to explore new ways to connect across distance and boundaries that does no longer require for us to be physically present in one particular place. So, the opportunities are coming down the pike. I want to share with you that as of now, we are in the process of creating a national diversity staff council and the board in the past year has established a board work group and we're reconciling their perspectives and opinions to enhance that framework and figured out how we're going to connect with you directly. We begin with the small pilots and expand.

Ken Duckworth (01:08:16):

Thank you, Monica. That's excellent. All right. Dr. Stewart, several questions and I want to just apologize to people. We have many hundreds of people on this important conversation. So, I'm not going to get to every question. So, I'm doing my best to combine them. You're from Memphis. Memphis is of course where one of our NAMI heroes, Sam Cochran lives who helped to create a de-escalation model crisis intervention team.

Altha Stewart (01:08:42):

CIT.

Ken Duckworth (01:08:44):

CIT. NAMI is a big promoter and supporter. The question relates to both over-criminalization of African Americans. And then of course, a larger question of de-escalation in policing. And what is CIT 2.0 or 3.0 going to need to be? So, I'm combining four or five questions with my own twist, but because you're from Memphis, the center where it all began, this whole idea of police training to deescalate people, dealing with vulnerable people. And of course, the failings that we've seen in police response nationally towards African Americans. I want to know … I know it's a big question, but at least we've covered five or six questions that have come in, even though it's a big question. Thank you.

Altha Stewart (01:09:31):

Well, I'm always proud to talk about anything Memphis and Major Sam is a fixture here. He's a local hero and we're real proud that CIT was born here. So however, many people ask that question. Thank you because I get [crosstalk 01:09:47] on Memphis. The issue of over-criminalization. Let's with that. I think in part what the challenge is that because we are so under resourced in mental health, in mental health crisis services, emergency services, those things that would normally be done for any other health care emergency, we simply aren't resourced well enough, no matter where you are, unless it's a place that I not heard of everybody is struggling with the inadequacy of resources to take care of crisis, emergency kinds of things that often results in the reason why police are involved in the first one.

It's a combination of not having the right kind of services, not having them allocated in the right way. And even though we are the birthplace of CIT, we don't always get it right either. And I know our police director very well. He is very proud of his CIT officers and do as good a job as they can. But I don't know a law enforcement agency that has enough of them to do all the calls that they would have to do based on the kinds of issues that arise on a regular basis. And so, we've got to get a better balance of resources out there. And I think if it weren't for the fact that the politics of defund the police got all confused, I think the spirit of that message was these are getting involved in things they don't need to be involved in or trained to be involved in. Let's put that money where it should be.

We know assertive community treatment works. We know that crisis stabilization works. We know that early onset of intervention with people who are about to spiral out of control cycle, whatever framework you come to this work with, we can recognize when things are about to get out of hand and families have to be better prepared, individuals have to be better prepared. The system has to be better prepared to respond early and appropriately, as opposed to a knee jerk reaction. "You're a threat." "I think you may have a weapon." "You're not listening." "You're not following my orders." Or, "I'm afraid of you." I'm from that generation of people who trained when in the early days, when families would beg, "Can't you do something?" And we couldn't. Because the law said, unless you were a danger to self or others you shouldn't be hospitalized against your will.

And we just didn't understand well enough how the families educate the system, resource the system. And so, we've left ourselves in this place in 2020. I think we get out of it if we can depoliticize the language of shifting allocations and resources. I think we can come up with some of the strategies that we need on the over-criminalization part of this. When we lost our state hospitals and the money didn't come into the community, the resources weren't there. We've got to realign resources with community need. That's the bottom line. And that doesn't mean build bigger hospitals or hospitalize more people. We have lots of recovery programs that don't require any central intensive locked setting. And people [crosstalk 01:13:32].

Ken Duckworth (01:13:33):

You mentioned peer support earlier as well.

Altha Stewart (01:13:36):

People function quite well without bars and locks and other things. Now, the other thing, that's the over-criminalization. And the other part of this is for the … The other part of your question, all of a sudden it jumped out of my brain.

Ken Duckworth (01:13:57):

I was asking a little bit about kind of CIT going forward as it relates to the police brutality we've seen in and the obvious lack of de-escalation thinking and culture in certain places. And I was interested in how you thought about that. Because I think CIT is a work of genius, but clearly something else needs to happen. So, we have to do better going forward. I was interested. The questions relate to that, but also this is partly my question. What could we as NAMI do to support a next generation CIT?

Altha Stewart (01:14:33):

I think the key is the concept of de-escalation. When things get out of control, when they escalate to that point, we know good de-escalation begins with building some kind of rapport. Whether you call it creating the therapeutic encounter relationship, if you've got time for that, or if it's a nonthreatening nonviolent situation. But there has to be some building of rapport. The beauty of CIT at its best is it's a law enforcement officer who comes without the law enforcement personality. They come in that official role, but that's

not who they are at that moment. They're talking in a different way. They're respecting boundaries and personal space. They're not threatening. I think building the model to expand it, to include that being the approach of law enforcement, whether it's police or Sheriff's or school resource officers.

Having that understanding within criminal justice system. Because a lot of the people who wind up in the system are there because they were there, they got out, they saw what in their mind was the image of why they were there. They lash out at that. They go in again. And then they're angry and they … It's a vicious cycle. If we can change the behavior and manner in which we approach people with mental illness, no matter where we meet them, and if we can help the people who are, what we now call first responders in any capacity. And the people who in the business community it's okay to help somebody who's homeless, as long as they're not threatening your customers. If they start getting a little aggressive with panhandling, then you want to shoo them away. Well, that's a mixed message for people who are now comfortable that it's okay and may not recognize that they've gotten a little aggressive.

That's not where they are. So, I think it's about teaching that escalation, de-escalation is a concept that everybody needs to know, including families help with the individual who may need that kind of support to maintain a state of faith.

Ken Duckworth (01:17:04):

Well, Dr. Stewart, I've been told we have to draw to a close. I could talk to you for hours. And we have dozens of questions that we'll have to leave on the floor. We hope to invite you back in the future to continue this essential conversation. I do want to mention in the coming months, we have Megan Walls who will be as a child psychologist talking about kids going back to school and managing that. That's in the end of August. Dr. Uma Naidoo, who's a psychiatrist and a nutritionist will be talking about nutrition in September. In October, Dr. Sarah Lisanby, who's a leader at the national Institute of mental health will be having a conversation with us about the latest treatments for schizophrenia. So, I want to say thank you, Dr. Stewart, and re-introduce our CEO, Dan Gillison.

Altha Stewart (01:17:49):

Thank you, Ken.

Dan Gillison (01:17:52):

Thank you. Thank you very much. And closing out, I just want to, again, acknowledge Bebe Moore Campbell Minority Mental Health Month and the legacy that Bebe Moore Campbell has left us with. And as we're talking about legacy one on this day it's important to acknowledge that advocacy and that work. We want to also remember cultural humility. I think that was critically important in terms of language today. And also, it is not what is wrong with you. It is what happened to you. I think if I could leave you with anything, that's what I'd like to leave you with from Dr. Stuart's incredible overview for us. And thank you Dr. Stewart. We also want to thank and acknowledge

our board. Our board is really very supportive of our body of work. We appreciate them and want to acknowledge and recognize them.

So, our NAMI leadership and staff who comes to work every day to make a difference, thank you to each of them. To our presenter, Dr. Stewart, you know. And to Monica Villalta, thank you both. And to our moderator and chief medical officer, Dr. Ken Duckworth. I know that you and Dr. Stewart went to school together. I'm sure the structure is still there. I don't know, but hopefully it's there. Let me also close by thanking our production team, because as I've said before, and I'll always say we all go to events where when the curtains are closed we hear all of these different sounds and all of a sudden the curtains open and we see this great performance. So, that is due to this production team, Elyse Hunt, Elizabeth Stafford and Terrie Brister.

Great job. Thank you all. And we hope that this was seamless every one of you all in the audience that were listening, because this staff and this production team works hard to make sure it's very efficient and effective for you. Any questions that we didn't get to, if you'll make sure that you sent those to us, we will be getting back to you from your questions in the chat. Keep us in mind as we continue to bring you these ask-the-experts. And even though this is a close of Minority Mental Health Month and Bebe Moore Campbell Mental Health Month, this is for everyday we're going to be doing this work? So, all the best. And again, Dr. Stewart, thank you. Thank you. Thank you. Thank you.

Altha Stewart (01:20:21):

Thank you all for the opportunity.