

Stephanie Robertson:

I want to give a huge thanks to Hagen for all of his support in preparing for and supporting this virtual town hall. And I want to welcome all of you to part one of our virtual town hall series, Breaking Barriers to Building Bridges, which is hosted by NAMI's Community Health Equity Alliance, or for short CHEA. Again, I am Stephanie Robertson, director of Mental Health Equity Innovation at NAMI. I'll be moderating today's first session in the series called Adversity to Access: Culturally Informed Mental Health Care. Today, we'll be in moderated conversation around the structural, cultural and systemic barriers that continue to impact mental health access and outcomes for Black African ancestry and other minoritized communities. We will also talk about how we can collectively reimagine and reshape systems of care to be more accessible and culturally responsive. So we'll spend around 30 to 40 minutes going over some prepared questions and then lead the remaining time for questions from our audience, which may include some questions that were submitted beforehand.

I want to level set a little bit before we begin and provide a few definitions that will be important for today's conversation. You will hear us use the phrase minoritized populations throughout. When we say this, we are referring to groups that are historically under-resourced and often face barriers to accessing resources due to race, religion, gender, socioeconomic background, geography, and war. When we refer to something as culturally responsive, like in culturally responsive mental health care, we mean that someone or something actively values and incorporates diverse cultural backgrounds to ensure individuals feel seen, respected, and supported. And at the heart of all of this is accessibility. With this topic we are discussing, accessibility refers to care services that are easy to find, reach, and use regardless of income, language, location, identity, or background in general.

So today, we are honored to be joined by two extraordinary experts and advocates in this space. Dr. Sierra Carter and Dr. Napoleon Higgins. Both have accomplished so much and I won't be able to get to cover all of their biography here, but I'll share a brief overview and we'll follow up with their full bios along with other relevant information after the event. Dr. Sierra Carter is an associate professor and director of the HEART Lab or Health Equity Agency, Racism and Trauma at Georgia State. She's a clinical psychologist whose research focuses on racial health disparities, particularly how stressors like racial discrimination impact mental and physical health in underrepresented communities. Her work integrates clinical, physiological, and bio-behavioral methods to identify mechanisms for prevention and treatment. Using a risk and resilience framework, she explores how factors like racial identity and community context can buffer the effects of discrimination. Dr. Carter earned her BS in psychology from UNC Chapel Hill and her MS and PhD in clinical psychology from the University of Georgia. Welcome, Dr. Carter.

Dr. Sierra Carter:

Thank you so much, Stephanie. Glad to be here.

Stephanie Robertson:

And we have also Dr. Napoleon Higgins, who is a psychiatrist that specializes in child, adolescent, and adult mental health. He is the owner of Bay Pointe Behavioral Health Services and Kaleidoscope Clinical Research in Houston, Texas. He serves as executive director of the Black Psychiatrists of America and holds leadership roles in several national medical organizations. Dr. Higgins is a published author and advocate whose work focuses on trauma, racism, and improving mental health access in underserved communities. He earned his BS from Prairie View, A&M University, and is MD from Meharry Medical College. Thank you for joining us today, Dr. Higgins.

Dr. Napoleon Higgins:

It is great to be here. Thank you.

Stephanie Robertson:

We are also going to talk a little bit about CHEA and then I promise you get to the real meat of the conversation. But the Community Health Equity Alliance is an initiative led by NAMI that is partnering with selected NAMI state organizations and affiliates as well as other national strategic partners to improve access to culturally responsive care for Black African ancestry adults with serious mental illness. CHEA aims to amplify voices, differential barriers, and diversify the mental health workforce. Our goal really is to build trust, reduce stigma, and expand access while creating partnerships that support a sustainable model for broader impact.

The next slide, please. And the Crisis Can't Wait campaign is a part of CHEA, which is dedicated to making mental health care navigation easier. We provide accessible pathways for care, stabilization, treatment and recovery, and really giving power to individuals and their support networks for essential resources. These include Know the Signs, Know Your Care Journey, and Know 88 as you can see here on the slide. But for more information, because again, I want to go ahead and get into this amazing conversation that we're going to have, you can go to chea.nami.org or scan the QR code and we'll also include these resources in our follow-up email.

And so, I guess we are ready to go. Sorry, I had to get a quick drink right there. That's the intro. And just getting really started with this, we're going to go ahead and set the foundation. And I'd like to start off with a question for both of you, which is a bit of a two-parter to really deepen our understanding of mental health and wellness. I'd love for you to share what culturally informed mental health care looks like in practice and what key barriers need to be addressed to make it more widely accessible. So again, can you share what culturally informed mental health care looks like in practice? And what are key barriers that need to be addressed to make it more widely accessible? Dr. Carter, let's start with you.

Dr. Sierra Carter:

Yeah, no, that's a great question and I love it. Thinking about this in practice, I think a lot of us know what culturally tailored, culturally informed mental health means, but in practice, I think it's an important concept to think about. And I tend to think about at the base, culturally informed mental health has a lot to do with curiosity and a lot to do with thinking about the necessity of understanding that there are just multiple ways of knowing. Oftentimes the ways that we're trained is in Eurocentric frameworks of mental health treatments, and there are more ways of knowing than those standards.

And so, culturally informed treatment is a way of valuing people who are at the margins and really listening and learning and being curious about their lived experiences and what that looks like in practice from a therapeutic perspective, but also as a researcher as well, is a lot of cultural humility as a term. So this involves avoiding assumptions and actively seeking to understand a client's worldview, where they're sitting at, where they're coming from, what they bring with them to the table, and not shying away from conversations that may not be aligned with your own personal experiences of the world and world and well-being.

One thing that often gets missed, I think, and I'll just say this briefly in culturally informed mental health, is that it doesn't only involve this interpersonal practice of knowing, which I think is important, but it often involves advocacy and system navigation. So if I'm in culturally informed in mental health, that means if my client is having difficulties with assessing the spaces that I work in, then it's my job to work in increasing that accessibility. That also involves advocating for equity within the institutions that I'm in. That's in culturally for mental health to me.

Stephanie Robertson:

Thank you. If you see me looking down, I'm writing notes because you're saying amazing things and I want to make sure I'm able to take some of this and be able to share with others. I do want to, Dr. Higgins, can you answer that question too, and we'll come back to this kind of, well, you started to talk about the

key barriers that may exist. So Dr. Higgins, again, I'll restate the question. So culturally informed mental healthcare, what does that look like and the key barriers needed that need to be addressed to make it more widely accessible?

Dr. Napoleon Higgins:

Well, not much to add to what Dr. Carter said. I would say that too often we can be in these silos where we hear the same people, we talk to the same people, our friends have our same perspective, our friends have our same background, and these are people that we naturally have affinity to. But realizing that there is a whole world of people out there with different thoughts, different habits, different cultures, and honestly as mental health providers and just as being a good citizen, you should truly be interested in people's stories and their lives and how do they come to think the way that they do? And I think that essentially if you have a love and an interest of people, you'll be more culturally competent understanding that the more you know, the more you don't know.

And so, I tell people that too often in mental health we will act as if we know as to show a weight of competence about a person, but truly interest is shown by asking the question and not making assumptions. And oddly enough, when you ask the question, people are more likely to engage with you because you show interest in who they are and what they do. So being that person who's truly a social scientist, but also beyond that, being interested in individuals and asking the questions for clarity, because I think a lot of people will be a lot more connected with you if they're able to tell you their story.

Stephanie Robertson:

And that actually leads me into the next question, so thank you so much for sharing that. But let's go a little bit deeper into how mental health providers can build that kind of trust to be able to really learn about the individuals that they are working with and encourages the individuals seek more care and support, especially in communities that have historically faced adversity, including racism. I'll let you go ahead and continue on where you were starting from, Dr. Higgins, and I'll go back to you, Dr. Carter.

Dr. Napoleon Higgins:

Well, right now in our nation, it's been a very much a charge racial situation going on. I know my father, who was 86, who was born in the '30s, grew up in the '40s in rural Texas says that how racially charged things are right now are as high or higher than he's ever seen in his entire life, including before segregation. So we have these issues going on that are impacting multiple people across multiple races, and people are feeling, for lack of a better way of saying it, some type of way about a whole bunch of things.

So trying to make sure that we clarify and understand that our way is not always the best way. Be careful of the different silos that we're hearing information and making sure that we engage with the further public in discussing information. And I would say that typically if you talk individuals, they're not so hard and fast on their thinking as you would possibly publicly see on the outward face of when you look at the news or you look at these talking heads or on social media where people are trying to give quick buzzwords to get reactions out of people, to get likes or clicks or to get advertisements. Normally, most people are a lot more so in the middle and making sure that we don't prejudice individuals by the way they look or way they act or talk or where they're from, and having an engaging, honest conversations that will actually allow us to be better able to understand them.

Stephanie Robertson:

Thank you. And I think this piece about really connecting with people on this individual level and being open and trying to get rid of these silos that exist and I feel like deepened recently, I think is really critical

to this conversation. Dr. Carter, I'd love to hear more from you and maybe you can talk a little bit about systems as well, but your thoughts on this too.

Dr. Sierra Carter:

I like everything that Dr. Higgins was saying as well. For me, I think about often when we're thinking about trust building, I think about the historical underpinnings of where mistrust comes from. It's a valid experience, particularly with the mental health for marginalized groups. And I work a lot with black people, and one of the things that I often get when trying to discuss mental health and community settings is how long are you staying? So people think that a lot of clinicians aren't there for the actual community. They're there to do the things that they were trained to do in a clinic. And I say building trust isn't built in a clinic alone. It's built within being in the community. What that looks like is working and partnering with communities, giving them a voice, not minimizing their experiences, and acknowledging the truths that they have told us over generations. That can include things about experiences of racial trauma, experiences of racism, as well as systematic barriers to their own well-being that influences their mental health.

So one of the ways that I also think about building trust is a lot of transparency and consent. I am a very big advocate of telling people upfront, like this is what we do, this is what it looks like. The mistrust is real. We have all these experiments that have been done on Black people, for example, things that can cause mistrust, and with more transparency, this is what I will do, this is what I will not do. What would you prefer? How would you like it? Allowing people to partner with us in this exchange of mental health, again, with this acknowledgement of multiple ways of knowing allows this partnership to build in mental health and whole wellness and to build trust at the same time.

Stephanie Robertson:

I want to continue on with you about informed care, having culturally informed care, really focusing on your research. You've done a lot, and that's how we first met. This is the research that you've done on mental health and the brain and how discrimination and adversity in general can affect the brain structure. So just with your research in mind, how can we really focus on culturally informed care that will help better people understand and response to the long-term effects of racism on mental health, especially in the ways that promote access and healing across generations?

Dr. Sierra Carter:

Yeah, it is a big question, and I think Dr. Higgins made a big point about the times that we are in. But I think generally, we often have a naming issue in our society. And as a researcher, I do, I name what the causes are of mental health inequities and mental health disparities and racism and inaccessibility and social cultural forms of harm are big components of what leads to disparities in mental health care. And so, I say first we have a naming issue and then we have an acknowledgement issue. So often when I see people coming in, they're looking for ways in which people can validate their experiences. And the work that I do often is a validating experience. "Oh, I know I felt stressed out, but I didn't know that that was the reason why." That is a part of it.

And a lot of things about the work that I do is not only saying that racism can affect a lot of the ways in which we think about our mind and body health, how the health disparities that we see related to heart disease and diabetes are related to these types of social injustices, but also that we have treatments that can offset that toll. So the mechanisms driving a lot of the work that I do is mental health treatment. What does it mean to experience oppression? And for children, Black children, the one thing that we see is depression. My identity is being challenged by society, and we as mental health providers have the ability to treat that depression if we acknowledge what is happening to Black children, for example. If we're able to acknowledge what is happening, what is the stressor, then we can use the tools that we have to provide

a culturally informed mental health treatment that can have long-standing effects on people's longevity of health and wellbeing.

And so, I think the work that I do and with racism, racism is multi-pronged in nature, because we can think about systematic inequities, we can think about intergenerational trauma that you mentioned, Stephanie, and so it naturally guides itself into community level change. So what happens in communities when we begin to acknowledge what racism is and how can the systems repair from that harm is also a part of how I think about the work that I do and mental health treatments. How can we work if we understand that these systems have been inequitable for a long time due to oppression, whether that be from redlining practices to voting restrictions to histories of enslavement, for example. How do we take that and understand ways in which we can promote systematic well-being?

And that can look in many ways of how we present ourselves and the clinics that we serve, how we allow spaces and the assessment measures tools that we use that include measures of oppression and uplift, people talking about their identities. There are measures of racial identity development, for example, ways in which people talk about their language and culture that could be already included in an assessment measure that validates people's experience from the jump. So they're not necessarily having to bring these things to you, but they're seeing a space that already validates their experience and is promoted as important work in the research that we do as well.

Stephanie Robertson:

I'd love for you to also go in, and actually both of you to go into actionable community-centered strategies or changes that can improve access to mental healthcare in minoritized communities. So Dr. Higgins, would you be able to respond to that? And then Dr. Carter, if you have more to add as well, that'd be great.

Dr. Napoleon Higgins:

Yeah, one thing that I, a group that I work with is that we talk, we do healing circles in the community where we're able to go through a lot of what is going on and making sure that we use the community resources as they have them. So often as professionals, we want to run in with what we've got and obviously what we've got must be the best thing, but that's not always the community thing, and that may not be the best thing in that particular community. So always being on that side of a listening ear and asking what are the needs in the community, something that we really have to be a part of. Also going into your, I get a lot of invitations for health fairs, going to churches, speaking to groups, links, fraternities, sororities, boys and girls clubs, sometimes even speaking to schools and teens, and whomever is willing to hear my voice are the places that I'm willing to go.

And making sure that we clearly have understanding of what are the needs there. Realizing that obviously you have the individual, but you have the community, and using those community resources are going to be key. Obviously, having some of the community leaders in the area to hear what is going on is also key doing town halls, because so often you could find that can be a moat around some of these medical places or even within the political systems where people really don't truly understand what's going on in their community. So by increasing the dialogue within the community and with our community, I think, is a major step in trying to make sure that we be able to improve individuals' lives.

Dr. Sierra Carter:

Yes, that's beautiful. I don't have much to add. Only thing I would say is in addition to what Dr. Higgins is pointing out is community advisory boards as well. So I think that's a good blend between research and practice and that community advisory boards allow space to partner with community as providers. I think one of the things Dr. Higgins highlights is centering community and the health and healing that they want and desire. And community advisory boards can also tell us what we're not doing great at and what we

might want to change. I think part of the cultural humility that I was mentioning is just having an open mind to things looking differently based on the community's needs. And I think what has been instrumental in the work that I have done is having people with lived experience who are on part of the community tell me, "Oh no, Dr. Carter, that's not what we want." Or, "Oh, okay, yeah, you can come do that, but we know how to do X." And we can partner together to be able to think about what's really going to listen to holistic wellness.

Stephanie Robertson:

On that note, I'd love to, I don't know if this is a bit too logistical for this, but how does that happen? How does a community advisory board even happen? Is this something that comes from the community first? Is this something that as practitioners you bring, it's like, here's a structure, but we want to make sure that it is a structure that fits you so tell us what you need? For folks who are trying to think through ways to engage with community to just community advisory board. Sounds like a great way. How does that even happen?

Dr. Sierra Carter:

It can happen in multiple ways, but I think from my first statement, being in community, sometimes it can happen naturally. Sometimes it can happen through research partnerships. So I'm looking for what people say from people I work with are the leaders in the community. So I'll ask them, "Who's a big person that you respect and love and care about? Who would you go to and trust the most?" And I reach out to them and ask if we can have a conversation, if they would be interested in a paid community partnership where they're helping us discover ways to improve mental health equity in the community. And I think oftentimes this idea of asking is sometimes difficult for us, but I think the biggest thing I've learned is you won't get anywhere if you don't ask people about who are the people who know and who do they trust, and then bringing those people together to have conversations about what you're doing.

And so, oftentimes that can be if you're in community already, but you're doing things in community that he mentioned like health fairs or going into church events. Also, there's a lot of fairs, particularly in the summer that I'm a part of where we're having a lot of talks around like, okay, would you be interested in being a part of a community advisory board, focus on, for example, maternal mental health? And so, I'm looking for people who are particularly interested in maternal mental health, people with lived experience, people who have been pregnant in the community, and they are advisors to the work that we do, both in clinic but also in research practice.

Stephanie Robertson:

Sorry, I was writing all that down as well. But I think this lived experience piece, and you said it earlier to this validation and actually giving space to those who have the lived experience to help shape not just their own individual treatment or experiences, but system-wide as well, I think is amazing. And to be able to do that and the work that you're doing, both of you're doing I'm sure is greatly appreciated, not just on the larger scale, but for each individual person who you are staying, I want to hear your voice and I want your voice to be amplified to others. I know Dr. Higgins, if you wanted to comment a little bit more on that or we can go ahead and go to the next question,

Dr. Napoleon Higgins:

Next question. The lived experience. And oddly enough, a lot of times when we are looking at these communities, I found that when you bring the community stakeholders together, that many of the people who do policies also live in the community and can have blind spots, but also can also recognize that, yeah, I'm having the same problem as well within these communities. So it's important to make sure that

we pay close attention to those lived experiences, realizing also that sometimes those people who are in charge of policy may be missing it as well or understand clearly what is being missed too.

Stephanie Robertson:

Well, then we're going to switch gears a little bit. Sorry, I feel like I was echoing a little. Push gears and really focus on trying to get this lived experience, trying to get the folks who had the lived experience to talk about their experiences to be a part of these communities, these advisory boards. What are effective ways to even help people reduce stigma to get to that point, to be open and to feel comfortable with sharing their stories and also seeking mental health support? So really focusing on how do we get rid of stigma and how do we have people come to the table but also to support and help themselves. And Dr. Higgins, I'd love to start with you on this.

Dr. Napoleon Higgins:

Well, honestly, I've seen in many communities where people are really talking about mental health more so now than they have been before. I think the work that we're doing such as CHEA and Dr. Carter and myself and the organizations we work with are really getting the word out there by having people see individuals with these mental health problems goes a long ways. So far as I wouldn't have never thought that you would've had anxiety or depression or bipolar or whatever it might be, ADHD or that you're dealing with these particular issues on your job. So often, I find that people believe they're the only one. "I'm the only one with this mental health issue. I'm the only one dealing with issues of discrimination on the job, be it racism or sexism or genderism or whatever it may be." We think that we're alone. So by putting a face to these, it can go a long ways. And then, overall discussion by people being open.

Now, I always tell, remember the joke that testifying is good for the soul, but it could be bad for the reputation because when you're putting yourself out there, people may judge you because of that. But I think that becomes from an issue of a lack of awareness by every time we step out and we talk about it, it gives a little bit more awareness. But then also, as we as professionals have to understand that how the community describes issues can be very different than how we describe issues. We use a lot of a psychobabble, a lot of psycho jargon that most people don't understand. The fact is that if you picked up the DSM, which is the diagnostic manual that we use in mental health, if the public picks that up, they can't understand what that says. I mean, it's a science book written very differently than how people communicate.

So trying to be open, trying to talk about it, trying to discuss it, but also using that common word and common language, because when you talk about mental health using common words, oddly enough, it doesn't sound strange. People with these issues, so essentially be it anxiety or phobias, everybody has a little something going on, but if we could talk about it openly in a good way, in a healthy way, I think it can help overall reduce the stigma and let people know you are not alone.

Stephanie Robertson:

Dr. Carter, did you have anything to add to that?

Dr. Sierra Carter:

That was beautiful. I mean, I think to your point, I think there is a position to also think about hiring, retaining culturally representative providers in that space, because I think understanding these lived experiences also means diversifying the field that we have with those types of experiences. And I think when you mentioned healing circles, Dr. Higgins, I think with trust building and reducing stigma, you can embed care in these trusted spaces. Oftentimes we're trying to bring people to us, and I do think there has been a significant reduction in people's disclaimer of mental health services or not wanting or desiring them. But I do think there is a space to also say, "Hey, we will come to you. What does that look like?"

And I think we can have conversations about what do mobile clinics look like? I've seen pop-up therapy. I've seen the ways that they look where the trust is built because you're not asking someone to come to maybe a siloed space that is often considered maybe only a white space, but you're embedding yourself within a community and discovering what they desire in that space as well.

Stephanie Robertson:

And that is something that we definitely are trying to do here. NAMI through CHEA look to diversifying the pipeline of professionals. And starting off young, you had to start off middle school and high school and introducing young people of color, young people from different backgrounds to this profession. And it can be all types of professions, I think is the piece of it as well within the mental health care space. And so, very important, while we are trying to diversify the pipeline, I think if I get the stats right, there are 2% Black psychiatrists, maybe a 4% Black psychologists. While we try to work on that because it's what we're doing, how do we look at cultural humility and how that plays into the practice? What can one do to become more culturally humble, but to have this cultural humility and how does that improve patient engagement and outcomes? I will start with you Dr. Higgins and then Dr. Carter, if you have anything to add, definitely jump in.

Dr. Napoleon Higgins:

Understanding people. Don't go for the stereotypes of what you see on the news or what you hear in the music or see on social media. Realizing people are more alike than they are different. We all have the same desires to raise our kids, take care of ourselves, be able to grow in life, own things, do things, have happiness and joy, have employment that matters in workforce and to be safe. Housing security, food security, job security. These are the basic things that everybody wants. But understand that there are limits and barriers that can impact individuals, be it they're Black, be it even if they're the white poor, all these things, there are other things that impair that advancement in life that impacts your safety. Are they enough as a upper middle class Black family? There are still issues of racism that occur that still impacts you, that we still have to talk about and unpack when we get home.

But you mentioned something earlier, which is the issue of the pipeline. And there are not enough black mental health professionals. Now, luckily we have telemed and things of that sort, and I've seen more Black patients since I've gotten telemed, since I've been able to do this portion of my practice than I have before because I'm more accessible now. But even at that, the number of calls of Black patients or even patients of color, period, looking for a doctor of color is becoming increasingly problematic. One, because of the need and all the issues that are going on that are causing people to want to get help to get healthcare or mental health care. But also, the of there are set up barriers that limits the amount of black psychiatrists that you see. It's thought that we may have about 1 to 2% of Black psychiatrists. We are thinking that those numbers may actually be dropping. That's less than 1,500 practicing Black psychiatrists in the country, which would make us less than that 2%.

So these numbers are startling. They're traumatic, and as you stated, to increase the pipeline, you got to start way back. For a kid to come out of high school and say, "I'm about to be pre-med," and you have not taken the classes to set you up for college, I mean, you could be the smartest person in the world, but the lack of exposure goes a long ways in order to make myself or Dr. Carter, that's at least post high school, 8, 13, 15 years of training that was set up back in the third grade. What were you exposed to? What did you see? So myself, go to college, I was exposed to calculus. I test in the calculus, I already knew some calculus, so therefore I'm ready to go to college and be a science major versus you barely took trig. You may have been an A student, but you did not see those upper levels of math pass geometry because you took something like math models.

I don't even know what exactly that is, but I don't think that sets you up for calculus. So now, you're going to college and you're already being remediated even though you are a top student from where you came from, you have all the desire, all the love, but you're starting so much further back than many other people

are. So this set up to be able to see the stuff to get your training, but also there are so many barriers in the way, and one of the disturbing trends that we've seen in psychiatry is that we have approximately one out of five residents being dismissed in residency out of their mental health programs. So you're losing 20% of the population, and this is a new phenomenon that you're seeing Black residents being dismissed during residency.

So a lot of people will say, "Well, maybe it was they were incompetent," or yada yada. Residency is based upon objective, who's good and who's not good. The thought of putting people out of training while they're trainees because realizing you're actually in training to learn to put them out in that learning area especially when they're near the end, is a traumatic issue that can occur where we are losing a lot of mental health professionals. So realizing this, that the system is not only causing a lack of professionals early, but it's also causing a lack of professionals late. And then, you're looking at the socioeconomics of going to school, it's a privileged few that could stay in school this long, where you really didn't have to go out to work.

My grandfather, he had to go to work at 12 because his father went missing. You look at now, he was able to put one child into school who was able to get a scholarship. And then, from there you have on and on and on where you have more professionals coming out of the home, but so many families are impacted or affected that you can't get through the system. You're not exposing information. How long can you stay in school? Do you have the finances to be in school all the way into well into your adulthood? And then from there, you still have those systemic barriers that impact the amount of professionals who will be out there available to treat.

Stephanie Robertson:

So do you have any suggestions to this? If we start off with the younger population like middle school, how are they being reached? What are ways to be reached? I know that we have developed a few pipeline programs that we're going to be running, but what are other ways? Maybe the people who are on right now are trying to think through ways. I would love to be able to help. I would love to be able to expose younger people to this space and to help them understand that this is so that they can pursue. And then, this other piece of mentorship. So this mentorship for those who may be almost there, and I hadn't heard this before, that is a disturbing trend. And so, who and how can someone become a mentor to help guide as much as possible? And if you don't think that's possible is more of a systemic kind of thing that we need to talk about, then we can talk about that as well.

Dr. Napoleon Higgins:

One, it's systemic issue, so it's not an easy answer. Starting early in school, education, basically the setup starts, well, when mom met dad in the moment of passion is basically what has started the setup. So who are the two people who came together? Now, where can you make the interventions along the way? The easiest way, I do child and adolescent, former school teacher as well, is the parents showing up to that school house and making demands on the school. And two is voting because voting is going to determine where the money's going to be split up and where it's going to go. All right. So those are some very basic things, being involved in your child's school.

Now, this could be very difficult for families, especially if the parent is working two jobs, you have multiple kids. So as stated, it takes a village. So even if it's not the parent, it could be the stepparent, it could be the cousin, the grandma, the auntie, whoever it is, making sure that you used to pay close attention to what's going on in that school and know what resources your child needs. And if the school knows that you're showing up, they're going to pay more attention to your child and what are the needs inside the home. Know what your rights are.

I tell people, ChatGPT you can use for a whole lot of different things. One is knowing how to impact the school to make your child is being educated. So really realizing that all children do about as well. And

oddly enough, many Black kids actually do better up until about the third grade. The third grade is where the split is made on who is going to get certain services and who is not going to get certain services, who's going to get the classes and who is not going to get the classes. Now, in my mind, you should give all the kids the classes. That shouldn't be a split on who gets a higher education in elementary school. What's the point in that? It only makes for a better society if we're making sure that everybody's exposed to information so they can advance themselves. But that's elementary.

The next hit is middle school. Middle school, same thing, staying involved, making sure the child is taking the upper level classes, making sure they're taking advanced English and advanced reading and taking those STEM classes that is setting them up for college and setting up for doing well in high school and then doing well in college. Because a lot of the inability is the issue of a lack of exposure. How you do in school will determine scholarships. All right. So you could beat the plan if you score well with your grades and you do well with your academic testing, that can break the mold and get you into college and get you paid while you're in college or take away some of the burden of the family.

But most of that is an issue of a lack of knowledge, a lack of knowledge of how the system works and how you can actually somewhat, I would say, beat the system at its own game by making sure that you know what your options are. And those options that I mentioned don't necessarily take a lot of money, but it does take time and time can be a barrier as well.

Stephanie Robertson:

To continue on with that a bit, would love to intertwine the systems of health care education and public policy. So voting, getting out there, how do these work together? And Dr. Carter, if you are able to answer this, I would love to hear from you to really improve mental wellness and make more accessible care for minoritized communities, Black communities as well.

Dr. Sierra Carter:

Yeah, I think, and reflecting on this whole conversation, often what I hear when I talk about system level change is it's too hard. We move more to the interpersonal, which is important, but the system level change is like, oh, whoa, it's too vast for us to comprehend. But I think a part of this culturally informed practice, as I said before, is systematic change and advocacy. And advocacy is not as hard as we think it is when it's a part of who we might be. If we see injustice, if we see inequity, one of the things I think about is coalition building. Coalition building is so important and has been a long-standing tradition and the culture that I always grew up in. Building coalition around things around inequity can include things around advocacy and policy building and investing in communities that have the politicians, as Dr. Higgins noted, to speak for them.

So one of the things that I do, for example in my research side is I give my research back to the community and we have a community forum where we invite politicians to that event and the participants from our study can take the information from the research and tell their providers and the policymakers what they're upset about. I, as a researcher, often I think I'm the researcher, I have this knowledge about how I'm going to share. But the most powerful conversations have come from, for me, the participants, Black pregnant women, often telling people about maternal health and mortality and postpartum depression and how that has looked because of inaccessibility of care at the hospitals that they are at. And I'm giving them the information that we have around racism, justices, systematic inequities, voter restriction laws that prevent them from being able to have the politicians that they might desire in their neighborhood.

And so, they have all these information and they utilize them. And it has always been a beautiful experience for me and also recognizing that I wasn't trained in that type of skill. I work a lot across interdisciplinary scientists with political science majors, lawyers and policy advocates to identify ways in which we can think about systematic level of change that is rooted in what I have been trained in mental

health equity. And so, I think some of this has a lot to do with collaboration, just recognizing your own areas of not knowing. If we want to be advocates, there are people who also have particular training and how to do policy level change, policy briefs, how to engage in community forums, things that I hadn't learned before, but as I work more interdisciplinary across disciplines, I think has been really vital and heartwarming to see the ways in which change can potentially happen and has happened in communities because we've given different armor, I would say, and tools to be able to advocate for themselves.

Stephanie Robertson:

It sounds like for both of you, learning and being open is just very critical to this work, especially when you're going to be working within specific communities. I would love to actually ask a couple of questions that come up in the Q&A that more into this as well, but really focus on how do we get the folks who have the lived experience and build this community and how do we get the folks who may not be within this community to understand better what is needed and how to better build these partnerships. I guess as Dr. Carter, you're saying that so you can learn from each other.

But the couple of questions actually that have been presented to us either beforehand or the Q&A go to that, and I'd love to start that. I think we have enough time to go into a number of questions here. So in an emergency situation, let's go into that for example, I mean I think a lot of what we talked about today is about systems, is about the advisory, committee advisories about the prevention or working beforehand, but what happens in emergency situations? So someone asked, how can providers show cultural sensitivity in an emergency department setting versus an outpatient therapeutic setting? And if either one of y'all can take that if you want to.

Dr. Napoleon Higgins:

I'll take that. I will say that working in an emergency room, you're dealing with an acute issue and you're focusing on one issue. And then triage, especially when it comes to mental health. So by being culturally competent, one, finding out what the problem is, but, and when I say problem, normally in mental health is going to be suicide is the number one issue or some kind of substance abuse issue, or we need to be in a hospital inpatient or out, be it admitted to the hospitals and to outpatient services. And so, that is normally what that emergency room is going to deal with. So making sure that you have the relevant community resources for individuals. So be it if they're a Black individual, do you have a list of Black providers, Hispanic providers, do they have insurance? Do they not have insurance? Is the county mental health, do they have resources to be able to help themselves?

So making sure that you understand the different resources that are available, realizing that many times people will make assumptions that can be completely untrue. And in the emergency room, you really don't have that much information. I remember somebody was told, "Well, the guy was homeless, so we got to set him up with, we'll give a bus ticket to Houston and the number for the county mental health." Well, one, he's not from Houston. Two, a bus ticket from Houston actually sends him further away from his home and then it takes six months to get into county mental health. "Did you try calling the home number?" Called the home number. His mom picked up the phone and said, "Yeah, I'll come and pick him up. I could be there in a couple hours." Like what? You assumed that he was homeless, that he didn't have family that didn't have family who was willing to come and pick him up and we've been looking for him for a while.

So those issues, the assumptions can be problematic, but realizing that the emergency room is mighty late to try to get somebody help. And too often when we look at individuals in the emergency room, now you had a reaction where you have limited time, you have limited ability to get into what the story is, and now you're trying to make a quick decision or a triage where essentially you come to me and I'm trying to send you on to the next spot of where you need to go.

Making sure that we ask the individual what are your needs is important as well. But in the overall community, as we were talking about too often, we're reactionary. After this situation has been done, after the money has been appropriated or misappropriated or was where it was not supposed to be and it doesn't help me, now we want to get mad, now we want to go and protest. The issue was did you vote? But also you lobby. Now, lobbying is where you talk to these politicians about what your particular issues are. Do you show up to the town hall because they all have to do town halls? Did you show up to the community center where the person was at?

Because what I've found about politicians and how they split up the money, sometimes they have no clue what your issue is because you never showed up. And I can guarantee you they don't know what your issue is if you don't vote. So if you vote and you show up, I can guarantee you it changes how they think about things. Now, they may not vote the way you want them to, but they know that there's a vote against them if they don't. So being actively involved, and it's funny when doing lobbying, you'll find that some of the people have no clue about what they're talking about and they're literally waiting on you to show up to tell them what that is, and the person who shows up the most will make their decision, but if they don't know, they truly don't know.

So making sure that we vote, we lobby, we do public policy, but also trying to be less reactionary. But at the same time, if we are now in the emergency room, now we got to do what we can do in the emergency room. And I love the quote that says that fight until hell freezes over and once it freezes over, now you fight on ice. So just because you're in the emergency room doesn't mean we can't make a difference. Whether we're in an emergency room or somewhere else, doesn't mean we don't keep fighting, but we've got to make sure that we start the fight early and try not to wait until late when the resources are limited and we're trying to swing for home runs.

Stephanie Robertson:

Definitely was talking well, sorry. Thank you so much for that. I think those are wonderful ideas, especially this piece about being involved with the policies piece. For some though, it might seem a bit lofty, and I do want to say that NAMI, for example, has its programs to help especially those with lived experience, be able to share their story. As you said, they need, sometimes the lobbyists sometimes want to know what they need to be saying and they don't know. But then on the other side, other part of this is the person with the lived experience or the family or the caregiver and how are they able to actually do that, because that sounds like a really big lofty thing to do. And so, there are organizations and NAMI is one of them. There are organizations that are out there that could help you really craft your story and really help prepare you in that process. I just wanted to put that out there. So thank you so much for saying that. I don't know, Dr. Carter, do you have anything else to add to that particular question?

Dr. Sierra Carter:

No, that was beautiful.

Stephanie Robertson:

So to go back actually then to let's try to get to a good place before the crisis happens. What are we doing before that point? For an individual, what kind of advice would you give to one that's seeking a culturally compatible therapist? Again, this is pipeline piece as we're working on it or looking into that. If someone can't find a person that looks like them, that has similar backgrounds, what are other ways or what, I guess we do both. What are ways to find somebody? You started to talk about it a bit, Dr. Higgins, but both of y'all, I'd love to hear to start to find someone who could understand you and your background, your cultural background, and if that is not possible, other ways. How do you end up finding someone who's culturally responsive and able to understand because they learned?

Dr. Sierra Carter:

Yeah, I will say people in my community often ask me, do I know people who they can trust with their mental health care? And I tend to think of it like you're shopping. And so, I tell them to ask these providers all the questions. And so, I often think about myself and I, in thinking about cultural humility, I have a lot of personal work to do consistently. I'm consistently in need of examining my own personal biases. I think Dr. Higgins hit on a lot about assumptions. When you get to the emergency room, those assumptions can happen so fast and if you haven't did your own work, those days can go left really fast. And so, I tend to think about what am I doing to research about different cultures, think about language differences, cultural differences? Have I done the work that someone who comes to me will be able to identify me in that way as someone who could help them? Or have I not? Do I have more to learn than we always have?

Cultural humility is a continuous process, but I think for people to identify those people, I think they're asking some specific questions, particularly now as people are feeling more aligned with noting their mental health difficulties. When it comes to oppression, they're looking to see, have you been paying attention to the news? Do you understand about ICE and what is happening with immigration laws? Do you understand how stressful that could be for me and my family? They're looking for, do you understand at the base something about being, obviously you're not going to know everything. That's not what I'm saying. But people are looking for someone who can at least align and have empathy towards their own experiences.

I often also say is looking at people's websites, looking at when you walk into the room, what does that look like? Do you only see white people on the walls? These are the ways to think about your own spaces. Are your spaces culturally humble or are they Eurocentric in nature? Because people are looking for that. Do I feel like this is a space for me or do I not?

And so, even when we don't have the diverse providers that we desire, there are ways to identify and show that you are in the space of being a culturally informed provider and people are looking for that. They are looking for, is this a space that I would want to be in as a minoritized individual? Is this person asking me about my life and lived experiences? Do they know about some of the things that my culture is going through right now? Because right now, it's a lot going on. So naturally, people might have some questions about that and their own stress levels. Those are the types of things that I have people look for. And those are the types of things that I'm trying to make sure I stay steep in the research literature, but also in the political and social cultural literature. So when I'm seeing people that I'm at least able to embrace this idea of I'm curious about your experiences, I'm curious about what's going on, what might have happened to you on the way here? What might have stressed you out on the way here?

Dr. Napoleon Higgins:

I love that, Dr. Carter. And the thing is, so often we don't realize what triggers that a person can have from another space if we don't understand. So far as example, you walk into doctor's offices, they're going to have the television on. I know in my office space, we're always going to keep on HGTV. That is the only show and shows we're going to show. Because I've walked in the doctor's offices where they're showing a particular news channel and immediately I have a reaction to what is going on on the news and how they're talking about it, which lets me know sometimes is sometimes people are trying to tell me a signal that they don't want me there. And so, you have to understand on whether or not you're giving off a signal that, no, I don't want you in my office and we have a particular point of view or a particular political point that we want to make, and that is without you. And I'm like, "Perfect." That way I can know I need to go somewhere else.

Also, we talk about the issue of racial concordance and I agree a lot, but then that's something I disagree with. It is clearly seen that Black patients have better outcomes with Black doctors on average more so than white doctors. At the same time, when people say racial concordance, that's incorrect because they

found that white patients seeing Black doctors have no better outcome of Black doctors or white doctors. It's only seen in one direction where people have poor outcomes. Now, I tell people, do you feel welcome in the office? Do you feel like you're being heard? Do you feel like people care about you in that office? And if you don't, you need to find another doctor. It's actually your health care. And if they don't feel like you don't feel like they don't care, they're not listening or they're not paying attention, you had questions, they didn't feel like the need to answer, then you definitely need to move on.

Now, I know for us, I'm executive director of Black Psychiatrists of America. We do have the blackpsychiatrydirectory.com, which does have a tab for black mental health providers. We've covered several cities, not enough, not many, but we do have the information on there. But also, we have information regarding many providers, regardless of color on there as well so far as community resources. Ask a friend, all of us got social media put on there. Do you know a good therapist, good marriage counselor, a good child psychiatrist, anyone who can help me? Because if you reach out, I can guarantee you that people are going to respond because there are people out there with your particular issue. Obviously, you have your online searches, which could be helpful. But many people would prefer to have a reference of somebody that they know. I know from myself, I have a waiting list of people trying to get in to see me, many of them Black. Oddly enough, I have a lot of them who are white who want to see me because I am Black.

Understanding that not everybody sees everything the same. So you can't assume that somebody sees something a particular way because there are upper middle class white male who lives in a conservative area. Sometimes what's going on in the world bothers them just as much as it bothers Black people. So you have to make sure that we stay away from those stigmas, but also make sure that we have ourselves out there so that people can try to access us who are trying to see us, but realizing that the resources are poor.

I do know a group, every person that I have is referral for therapy in my office is somebody that I actually trust. So the majority of them are Black, but a lot of them are actually white. I know that they're very good therapists who I've had a good response from my patients, be it Black, white, Hispanic, or indifferent, who have good experiences there. If I have a patient who tells me that they don't feel like they were cared for or listened to at that office, they quickly come off the list. So on my list, I have a range of individuals of color, and honestly, I think all of them are great. So being able to go to someone and ask that question, who you think is good, I think goes a long ways.

Stephanie Robertson:

Thank you so much. I just realized we are at time. I did have one more question before we wrap this up because that was a very wonderful conversation and I really got wrapped up in it. So I apologize for going a little bit over. But I do want to end with this question for both of y'all. What gives you hope right now in the movement toward mental health equity? Whoever wants to go first can go.

Dr. Napoleon Higgins:

Man, mental health equity. All right. One thing that I would talk about is making sure you take care of yourself. So much of mental health is what you are doing. I tell folk, You can see me for 15, 20 minutes, or maybe you saw me for an hour, is 90% of what I did and 10% of what you did when it comes to that assessment. But when you walk away out of my office for the next 30 days or 90 days, it's 90% of what you did and 10% of what I did. So making sure that you learn that one, there are stresses in the world. World can be very much unfair. Make sure that you do the basic things. Get adequate sleep. Your diet matters. Your exercise matters. The people that you're hanging out with matters. De-stressing, de-cluttering your life, learning how to say yes to things that help you and knowing how to say no to people that you need to get out of you, get away from you.

Somebody, a good therapist of mine says that some people in your life are vampires and they will suck the entire living blood out of you if you allow them to. Knowing how to cut those people off, making sure you take care of your finances, going places and getting clean air, taking a vacation, there should never be a sick day or a vacation day left at the end of the year. You need to take all those, realizing if you fell over dead, that place will keep working tomorrow. All right. So you want to make sure that you take care of yourself and doing all those other things that you could do that actually contribute to your overall mental health. Well, outside of what the doctor is doing, what can you do for yourself?

Dr. Sierra Carter:

And I'll be quick. What's giving me hope right now is just the growing power I'm seeing in truth telling, community leadership. We're no longer whispering in the margins about mental health, I don't think, and that gives me a lot of hope. People who have been excluded are now claiming spaces, naming traumas, celebrating, radical healing practices. Those things give me hope demanding that their services be held and not silencing them. I see that on a daily basis, even in the face of a lot of structural inequities. And I didn't see that even a couple of years ago as much as I've seen it now, and I am hopeful for the future that there's this continuous truth-telling and shared power structures where we can come together and continue to break down these silos and break down mental health disparities.

Stephanie Robertson:

I want to thank you both and let you know that you both have given me hope. Being able to meet and get to know you both has been an amazing experience, especially me being new to this space. So just knowing you has given me hope. So thank you and thank you for being a part of this conversation. Our commitment to equity and improving access to mental healthcare for all has just never been greater. And so, knowing that we have people like you both fighting the fight along with us is very critical and really moving forward. So together we know we can make a positive difference in the lives of millions.

And with that, I do want to go ahead and wrap-up. Again, sorry for going a little bit over, but I really wanted to get to that question. I wanted to hear both of you and tell us what you were hopeful about. And so, to learn more about our work on CHEA and to focus on equity, you can visit chia.nami.org and that is the end of our webinar. So thank you again so much for joining us, and thank you so much for our panelists for being a part of this conversation today.