Stephanie Robertson:

I'd like to start off by thanking you, Hagen, for your support and preparing for today's virtual town hall. And to welcome you all to part two of our series, Breaking Barriers to Building Bridges, hosted by NAMI's Community Health Equity Alliance. I'm Stephanie Robertson, director of Mental Equity Innovation at NAMI, and I'll be moderating today's session, breaking the silence, suicide awareness in Black African ancestry communities.

For today's town hall, we'll begin with the moderated conversation for about 30 to 40 minutes, followed by audience Q&A, including questions submitted during the pre-registration. Throughout session, if you have a question, please use the Q&A option, as Hagen said earlier. And before we dive in, I'd like to share a few things, including some key statistics.

Suicide is a growing public health crisis, especially within the Black African ancestry community. In 2021, suicide was the third leading cause of death for Black youth, according to the U.S. Department of Health and Human Services. Research from the KFF, an organization dedicated to health policy, research, and polling, shows that between 2011 and 2021, suicide deaths among people of color increased substantially, with rates for Black individuals rising by 58%. In between 2018 and 2023, the CDC further reports significant increases among Black adults age 25 through 64. So with these stats in mind today, we're joined by experts who bring lived experience, deep expertise, and perspective to this urgent issue. Together, we'll examine stigma, barriers to care and systemic challenges, while sharing culturally-grounded strategies that offer prevention, healing and support, creating spaces where Black African ancestry individuals and families feel seen, supported, and safe.

Our conversation today will include discussion of suicide and mental health, which may be difficult or triggering for some participants. We want to provide the following content warning disclaimer. At NAMI, we believe that sharing personal stories can foster connection, understanding, and healing. However, we also recognize that some topics may be difficult or distressing. The following session contains real stories and lived experiences that may include references to abuse, violence or trauma, racism, suicide or self-harm, death or dying. We encourage you to take care of your mental health and emotional well-being, so please feel free to step away at any time and do know that you are not alone. You can find help in more resources at nami.org or afsp.org, which is the American Foundation for Suicide Prevention. And we will provide these resources afterward as well.

So we are honored to be joined by extraordinary experts and advocates in this space, Victor Armstrong, Dr. Rosalynn Thyssen, and Dr. Sidney Hankerson. They've accomplished so much, and I won't be able to cover all here, but I'll share a brief overview of each of our panelists.

Victor Armstrong is the Vice President for Health Equity and Engagement with the American Foundation for Suicide Prevention, as well as the AFSP liaison for Soul Shop for Black Churches, a suicide prevention training program for faith community leaders. With over 30 years in human services, including working as the chief health equity officer for the North Carolina Department of Health and Human Services, he's nationally recognized speaker on health equity and access to care for marginalized communities. He serves on the National Action Alliance for Suicide Prevention, the College for Behavioral Health Leadership Board, and hosts the Strong Talk podcast. Victor was named 2025's National Social Worker of the Year by the National Association of Social Workers.

Dr. Rosalynn Thyssen is a professor of Southern University School of Nursing and founder of Traeh Thyssen Have a hearT Foundation, created in honor of her son after his death by suicide. She leads initiatives that promote suicide prevention, early intervention, and culturally-competent outreach for Black and brown youth, including the 13-Minute Challenge to encourage listening and connection with young people. At Southern University, she integrates trauma-informed, culturally-responsive practices to nursing education and supports student-led prevention programs. Dr. Thyssen is a nationally-recognized advocate for youth mental health and community healing.

And finally, we have Dr. Sidney Hankerson, who is the associate professor and vice chair for the Department of Psychiatry at Icahn School of Medicine at Mount Sinai. His work focuses on reducing racial disparities in mental healthcare, through partnerships with community, sports, and faith-based organizations. He serves on the New York City Department of Health Boards, the NFL Mental Wellness Committee, and as a second-opinion physician for the MBA. A nationally sought speaker, he's presented at the White House, United Nations, and Aspen Ideas Festival. Dr. Hankerson earned his MD, MBA at Emory and trained in psychiatry at Emory Grady Hospital, and completed a research fellowship at Columbia University. So welcome all and thank you for being here today.

Before we really dive into the discussion, I want to take a moment to talk about NAMI's commitment to mental health equity, which is work interwoven into everything we do and is really at the heart of one of the initiatives that I've been fortunate to lead, the Community Health Equity Alliance or CHEA. CHEA's goals are to expand culturally-responsive care and build a responsible model for equitable mental healthcare and Black African ancestry in other communities, aligning with NAMI's overall mission to ensure that people prioritize their mental health, get help early, and receive the best possible care. We are committed to working alongside our 650 state organizations and affiliates to expand our reach, raise awareness, and ensure that communities facing the greatest systemic barriers have the support they need and deserve.

So within CHEA we have an initiative called the Crisis Can't Wait Campaign, and this is dedicated to making mental health care navigation easier, especially during a crisis. We provide accessible pathways for care, treatment, and recovery, empowering individuals and their support networks with essential resources. To find out more, please go to chea.nami.org. And again, we'll include these resources in our follow-up email.

Sorry, that was a lot, so thank you for hanging in there with me. And we are going to go ahead and get into this conversation, which I'm excited to have today with these experts. And I am going to start off with just kind of setting the foundation. So Victor, I'm going to start with you. Suicide in Black African ancestral communities has risen at alarming rates over the past decade, as was just stated in the stats I gave earlier. So from your perspective, what is one of the most urgent factors driving this crisis and how can we start to address it?

Victor Armstrong:

That's a great question. I think there are a lot of factors, because as we know, suicide is a multifaceted issue. And there's no one single cause for suicide, it's really a combination of a lot of complex things, often including mental health challenges. But from my perspective, I think one of the things that is impacting the rise in suicide in the Black community really has been our reluctance to talk about suicide in our community. I think a lot of what has happened over there... And we're seeing some now, I think some of the results of not having that conversation, because a lot of what has happened in Black and brown communities, and by not necessarily by fault of the community, is that resources have not been historically available in communities where people live, work, and play. And that has allowed stigma in many ways to form in a vacuum.

That's why you'll see that a lot of Black people do not initiate treatment. We know that statistically Black people are 20% more likely to psychological stressors, but less likely to initiate treatment, more likely to terminate treatment prematurely, and more likely to initiate treatment in acute care emergency departments. But I believe a large part it is because we have been socialized to believe that suicide is not a Black problem, that it affects other communities. I grew up in a very rural community, faith-based community. My father was a pastor. But I heard all my life that suicide was not a Black problem, it was a white problem, and that all we need to do was have more faith as opposed to seeking mental health care.

And I think what we're seeing as a result of that is that we have formed these narratives around what suicide is and how it impacts us. And that has also I think led into this thinking among Black men being

socialized that the way we navigate the world is you keep your head down, you keep your mouth closed. You don't show weakness, you don't talk about things that make you appear vulnerable, because we have been socialized to believe that in many ways what is treasured most about Black men is performative. And we have not always been socialized to believe in our own value and our own self-worth, and all of that impacts how we see ourselves in the suicide prevention conversation, I believe.

Stephanie Robertson:

... sharing that. And I do agree, growing up in South Carolina in a Black family, we definitely did discuss not feeling well, you pray to God, you go to church. And talking about mental health just in general it was difficult. And so creating these spaces now has been phenomenal because of what I didn't have. And so I do want to turn to Dr. Thyssen and continue on with this as far as stigma and silence, and how they do prevent families and communities from seeking help as Victor just talked about. So how can we begin to shift that conversation around suicide and mental health in general in ways that are relevant and safe for the Black community?

Dr. Rosalynn Thyssen:

So whenever we're talking about shifting the conversation, that begins with meeting people where they are. So that means culturally, spiritually, emotionally, and then normalizing those conversations about mental health. So we got to frame it as a part of overall wellness, not as a weakness. Especially in communities of color, stigma has been reinforced through generation. So we got to be intentional whenever we are creating those culturally-relevant and safe spaces. So that means respecting those faith traditions, partnering with those trusted community leaders, using language that feels affirming rather than the clinical language, that can sometimes seem a little stigmatizing.

I can say that I've seen firsthand how vital it is to acknowledge the barriers that families of color have, like mistrust of the healthcare systems, fear of judgment, cultural belief that struggles should be handled privately. So again, we got to create those safe judgment-free environments where people can speak their truth, and that's where we start down to break down those walls of silence and stigma.

I also want to that being culturally relevant means representation as well. Representation matters. So when young people of color or just people of color see healthcare providers that look like them, educators that look like them, advocates who look like them talking openly about mental health and about suicide, it normalizes that idea that getting help is not just something that we need to do, but it's acceptable and it's needed. So again, I just want to reaffirm and restate that that means we need to reaffirm identity, honoring those lived experiences, give them that space to express those lived experiences with no judgment, ensuring that whenever we have those conversations about suicide or mental health, that they feel safe to do so, they feel seen, they feel relevant, and it has to be rooted in understanding.

Stephanie Robertson:

Thank you so much. I really appreciate you saying this, but also doing the work. And so we will get back into that later on in the conversation about how you do create these spaces.

Victor Armstrong:

Can I add one point? Because I think Dr. Thyssen hit on a really pertinent point in that a lot of what has happened also historically is that when suicide prevention resources have been prevented, mental health resources in general, they generally are not marketed toward the Black community. And when you create resources that are not culturally relevant or relatable to my lived experience, I don't see myself in those resources. And what that does is reaffirm that narrative that this is not about us, that we're not the target audience. And so it is extremely important that we create resources that are culturally relevant, that speak to the lived experience of Black and brown people. And I think that's also why there's a narrative that, for

example, Black men don't want mental health care, and I don't believe that's true. What Black men want is treatment that speaks to who we are and speaks to what it means to be a Black man in America. And without that, we're not going to engage in those things. So her point about those culturally-relevant resources is extremely pertinent.

Stephanie Robertson:

Thank you for sharing that and pointing that out. I also think that this representation piece, not just with doctors and clinicians, but just everyday people sharing their stories, people that look like us, look like me, that is I think, critical as well. So these resources, and as a doctor, as a professional, yes, that representation is incredibly important, but also everyday human beings who are open to sharing their story, that is critical as well. So thank you both opening the conversation up.

And I do want to turn to Dr. Hankerson now and to talk about this partnership with faith leaders in schools and community organizations, and how vital they are really to mental health advocacy work. We talked a little bit about how the churches and faith within Black communities is very important. So what role can partnerships with these organizations and with faith leaders in schools play in really reaching Black youth and families?

Dr. Sidney Hankerson:

So thank you, Stephanie. And first I just want to say thank you to NAMI for creating this space, to Victor's point, to talk about a topic that we often have not talked about. So I just want to acknowledge that. There's a saying in the Black community that teamwork makes the dream work. Teamwork makes the dream work. And as I think it relates to suicide prevention, no statement could be more true. Traditionally, in our community, we have sought care from our grandmothers, from our seniors, from our barbers, from our beauticians, from our pastors, from our sorority sisters, from our fraternity brothers. And the idea of going to seek care from a mental health professional was foreign to us.

And so I think one of the things that has shaped my work was a study that came out over 20 years ago, which looked across the country and asked people in the United States, "When you're first experiencing a mental health crisis, where do you initially get help from?" They asked, "Do you get help from mental health professionals, like social workers and psychologists, or do you get help from your primary care doctor or even a psychiatrist?" And after social workers and psychologists, the group that most people in this country initially get care from are their faith leaders. So our pastors are frontline mental health professionals. And so in so many times they can be the bridge for getting people connected to care.

And I think it's also important to acknowledge a challenge of engaging faith communities, especially in the Black community, is how faith has sometimes been a barrier to people getting care. I grew up in a Black Baptist church in a small town in Virginia. And growing up, people would say, "Well, how are you feeling today, Sidney?" And people would often say, "Well, I'm too blessed to be stressed," or people would say, "I'm too anointed to be disappointed." And I've heard many well-meaning pastors say, "You don't need Prozac, you just need prayer." And so I think we have to acknowledge this tension that our faith communities, yes, are often sources of emotional support, yes, have been cathartic, yes, have provided tremendous healing, and at the same time have often been barriers to people getting care. And many people have felt blamed, ostracized, or perhaps that their faith was not strong enough if alone through prayer or faith, they were not able to overcome depression, anxiety, substance use or whatever the case may be.

So my work has really been in trying to acknowledge this tension and empower faith leaders, empower ministry leaders, and empower congregations to create caring congregations that increase awareness about mental health problems, that create stories of healing and hope, and that create evidence-based bridges to care so that we create a cycle of positivity and a cycle of healing in these safe spaces that then

people can feel trusted, heard, seen, and really seek out to get connected to care in settings that they normally trust and engage with anyway.

Stephanie Robertson:

Thank you for starting that conversation around faith and how our faith-based leaders can support those mental... those who have mental challenges or those who just need support in general. I think that folks are stepping up. We have our faith net here at NAMI, and so work with a lot of faith leaders throughout the country who want to be a part of the solution, who want to be that bridge. And I do want to turn then with this in mind to Victor. We'll talk about the American Foundation for Suicide Prevention in a second, but I think talking a little bit about the Soul Shop for Black Churches at this point would be great. So the Soul Shop for Black Churches, would love to learn a little bit more about that, how you help Black faith leaders really become trained in mental health and suicide prevention within the Black community. So would you be able to address that?

Victor Armstrong:

Yeah, it's one of the programs that I personally am extremely proud of. I was fortunate, I should say blessed, to be a part of the team that put this training together. It's an eight-hour curriculum that's designed to teach faith leaders in the Black community how to minister to congregants that may be experiencing suicidal desperation. And bringing to the awareness of faith leaders that at any given time you have in your congregation, people who either are suicide attempt survivors, people who have suicidal thinking themselves, people who have lost someone to suicide, or people who are concerned about someone who may be expressing suicidal tendencies or having mental health challenges. And we have historically not had the resources to minister to those people. And so what we have given them is what we have, we offer them prayer.

And so this is not to say, and this is part of how we share with faith leaders, is that this is not to say that your theology is wrong. It's not to fly in the face of your theology. We want to give you resources that you can utilize to help to reach your congregation. So we share stats with them. We share the data, much like you shared coming on. Because part of what has to happen for a lot of our faith leaders and for a lot of people in the Black community is we have to make it relevant, and making it relevant means helping them to understand that, yes, this is impacting us. And one of the things that especially resonates with faith leaders is when we share the data about the impact on our youth. That gets their attention.

We also share, talk about the stigma. The things that have impacted the way and influenced the way that we think about suicide in the Black community, and we talk about it in the context of the Black experience. Which is one of the things that is unique about this program, is that everything is talked about through the context, through the lens of the Black experience in America. And so it allows us to have a conversation about a shared experience. Because what we also find in suicide prevention, as we're having these conversations, not every community enters this conversation having been socialized around suicide the same way. And so this is a way for us to have the conversation in a way that fits the way that we've been socialized to think about it in the Black community.

We teach them how to recognize the warning signs, the risk factors, the protective factors. We give them resources on how to share scripture that may pertain to someone who's lost someone to suicide or even resources they can use for funerals. We share those kind of resources with them. We teach them how to connect with resources in the community. And we talk with them about how not to make this a program, but how can we help you to create what we call a soul-safe community, where we can bring not just churches, but the entire faith community together to talk about suicide.

One of the things that I'm really proud of with this program is back in September... well, November of 2023, we had a gentleman to travel from Cameroon Africa to be trained in Soul Shop, because he wanted to take the training back to Africa. He was a gentleman who oversees some 200 faith leaders in

Cameroon. And so we trained him. He went back to Cameroon, he did a couple of trainings there and realized the need. He wanted to train more faith leaders, but he needed more trained trainers. And so AFSP allowed me to travel with him to Africa, and we spent about 10 days on the ground in Cameroon training 92 faith leaders in Cameroon through this Soul Shop for Black Churches curriculum.

And so it has been extremely effective. It does give us a way, all the things we've been talking about, it gives us a way of meeting people where they are. Faith leaders are trusted messengers. The other thing too is that as we are thinking about how we educate our Black community and how we create resources in the Black community, I'm a firm believer that one of the best ways to create resources in a community and particularly creating sustainable resources in a community, is to invest in resources that the community is already invested in. And so rather than coming into a community and trying to create something brand new, can I come alongside something that the community's already invested in and wrap resources around that entity in the community? And so that's the way we approach this work with Soul Shop.

I tell people all the time, it is a faith-based curriculum, but I don't think of it as a religious program, I think of it as creating access. The church can be a point of access for the Black community because it is trusted space, they're trusted messengers, all we need to do is give them a trusted message. And as Dr. Hankerson pointed out, historically, a lot of our faith leaders have not had the right information to give to their congregants. And what has happened is that while the church has been a source of faith and hope, it has also in some ways been a source of misinformation historically, because again, we have given people what we've had, and what we've had is scripture and prayer, but we have not always known how to apply the science of suicide prevention to that. And so we are marrying the two together.

Because the final thing I'll say too is that what I am seeing is that both in the clinical field, we are becoming more aware of the benefits and the need of incorporating faith into suicide prevention, but at the same time, churches are adopting a more grace-filled theology. And so that message of suicide being the unpardonable sin and that it's a sign of spiritual weakness and moral failure, churches are moving away from that message. And so they're starting to learn that in more grace-filled theology. And as a part of that, we are better able now to partner with a lot of faith-based organizations in giving them this as a resource.

Stephanie Robertson:

Thank you for sharing that, and we will be able to provide that information as well. I think it's important to really look into the programs themselves, but I love the fact that you said come alongside. Many of these organizations, many of the different partners you have, you already have the foundation for this. And so organizations like Soul Shop and American Foundation for Suicide Prevention, not only we're here to aid, but the resources are already there. And so I think that is a really critical point. And just being open to really learning more about this space and creating the space to be able to talk and be, as Dr. Thyssen talked about earlier, judgment free.

And so I do actually want to go to Dr. Thyssen and talk a little bit about your work as an educator and how you work with your students. A lot of the stats that are... all the stats are alarming, but especially alarming are the stats around young people and young adults. And so really focusing on your work, especially with future healthcare workers, specifically nurses, which do face a higher risk of suicide than many other professions. As a professor at the Southern University School of Nursing, how are you preparing students to really talk openly about mental health and build a culture where asking for help is encouraged, especially within an HBCU? Nursing is a giving back profession, so how we make sure that those that are giving back are taken care of and taking care of themselves.

Dr. Rosalynn Thyssen:

Right. Thank you so much. So as a professor, I'm very intentional when it comes to normalizing mental health conversations. In the classroom, in mentoring spaces, I try to be wherever the students are, and remind them that silence doesn't mean that you're strong. Hold on to things doesn't make you strong. That self-care is a professional responsibility to your patients, and you owe it to yourself to have that self-care. It's not a weakness. So we incorporate discussions about stress, compassion, fatigue, burnout right alongside their clinical skills, because they're equally as important.

One of the things that I love that we do in the school of nursing is tea time. Tea time we do every week and we have safe, open conversations about mental health or suicide awareness or anything they want to talk about. We have real brewed tea of all flavors. We have light snacks. And we just encourage students to break through that cultural stigma of talking about mental health by just having normal conversations. And it's a safe space. Like you say, story stay, lessons leave. They don't have to worry about judgment. And I am right there in that circle with them. So it's not them versus you or anything like that. So we're at Southern University, we usually say it's SU, when we flip those two letters, it's about us. It's about us. So we got to join together.

So I'm sitting with them and I'm being just as transparent with them, because again, like I mentioned, that representation matters. So if Dr. Thyssen, who's my nursing professor can sit with me and be vulnerable with me and not judge me, and can share the grief and the pain that she's had, then I can do it, too. So I love being with students, because they show me that as long as we create the spaces, they're going to come. We just have to create those safe spaces. You know the whole if you build it, they will come? If we create those spaces, they're going to come. We just have to help them and meet them where they are.

Stephanie Robertson:

I think that that need for these spaces is just becoming stronger and stronger. And so I had the privilege of being able to be a part of one year tea times, and it was amazing. And again, back to the representation, being open about our own experiences is just very critical to creating that, to being the kind of role modeling the way it can look. And we are these professionals and we are open about our own mental health. I do want to stick with the story theme and stay with you. And talk a little bit about just you sharing your story and different ways you do share your story. For example, you are a part of one of our series that will come out soon, our Stories of Hope initiative, which features recordings of people with lived experience. So let's go a little bit more into why this is important to you and what you hope others, outside of being a professor and outside of just being an amazing higher education professional and educating our future, again, healthcare workers, why is it important for you to share this story?

Dr. Rosalynn Thyssen:

Before I was Dr. Thyssen or anybody mental health advocate, I was a mom to an amazing son. His name is Traeh, his name is heart spelled backwards. And I realized that when I was walking through grief, it taught me that silence isolates, but connection heals. So share my story. Let me know that we need spaces where our pain and all of that can be acknowledged without judgment, and where we can find both practical support and compassionate community. So share my story is deeply personal for me, but I also know that it's necessary. Suicide is often surrounded by shame and silence. So I'm a nursing professor, I read that in the book, suicide is associated with shame and silence. But it wasn't until my son died and I was in different spaces and, "Oh, how old was your son?" "He was 13." "Was he sick?" "No, he took his own life," and then the face changed. It was like, oh, my gosh, what did you do or what did you not do?

So by speaking openly, my hope is to let others know that they are not alone, whether they are struggling themselves or walking through trying to help a loved one or walking through the grief of losing someone to suicide. That shame, you don't have to bear that shame. You don't have to be by yourself. I just want people to know that there is a community of people that are here. And I had to learn that the hard way. I was silent for a little while, not long, but a little while because the looks hurt, the judgment hurt. And so I don't want anybody else to feel that hurt. It's bad enough to lose someone to suicide, but to have that

shame on top of it just makes it like you really fall into the sunken place. And I don't want any other family to feel that shame and feel like they have to be silent like my family and even Traeh may have felt before he died.

Stephanie Robertson:

Again, thank you for your willingness. Sorry, I'm... We connected around this story and when you showed me a picture of Traeh. I was like, "He looks just like it could be my little brother." So I really do appreciate you continuing to share your story and share your story in this space, because you're right, there should be no shame. People should have asked you, how are you're doing and what help do you need? What support do you need? That is what should be happening. And if we can get that started in this conversation here, then we've made a difference. So again, thank you. I have to get a little bit... Sorry. Because again, your story did definitely move me and I appreciate you. Just you. So thank you.

Dr. Rosalynn Thyssen:

I appreciate the space.

Stephanie Robertson:

I'm going to turn to Dr. Hankerson, I'm trying not to cry. But Dr. Hankerson, actually, him and I have already spoken and I've cried in a conversation with him as well, because creating these spaces is important and feeling safe in these spaces virtually is critical. And so our conversations have been great. And I do want to turn to your work focusing on mental health care and community spaces, including faith-based, but also we talked a little bit about sports and being able to reach particularly young people through initiatives like Triumph for the HOPE Center in Harlem. So I'd love you to talk a little bit about what the HOPE Center is and what have you found most impactful about that model. And how do you see it possibly being scaled nationally?

Dr. Sidney Hankerson:

Thank you, Stephanie. First I just want to just acknowledge Dr. Thyssen, just for her vulnerability and transparency in sharing the story about Traeh. I think what you just modeled for us is the power of stories and the power that stories create in unending silence. Because so often in our community, especially around issues around suicidal thoughts, behaviors, and death by suicide, that stigma is pervasive because of our silence. So I just honor you and thank you for that.

So I'll respond to the question about the Hope Center with another story. So I work with a pastor of a large church in the village of Harlem in New York City called First Corinthian Baptist Church, which is under the leadership of Pastor Michael Walrund. So Pastor Mike, as he is called, just a brilliant man. More house man, got his Masters of Divinity from Duke and then came to New York City to lead this church. And grew the church from 200 members, when he started, to membership of over 10,000 now. And over his 15 years of leading the church was tremendously driven to grow the church, tremendously driven to give back to the community. And I think in that growth, recognized that he was struggling with symptoms of anxiety and depression. And he had, at the time, was diagnosed with sarcoidosis. For those who may remember, that's what Bernie Mac, the comedian, died from. So he was in constant pain. Pastor Mike was in constant pain, but felt like he always had to show up for people on Sunday and had to mask that pain.

And there was a moment that he has shared publicly, and he's okay with me sharing this, that he was in Seattle, Washington at a retreat actually, and was on the 16th floor of a hotel. And in that moment was just feeling overwhelmed with everything going on in his mind, and that was the first time that he actually had thoughts of having suicide. And he realized if given all of the academic accomplishments, all of the things that he had done professionally, if he had thoughts of suicide, thinking about folks in our

community who didn't have the resources, the means, the people who were impacted by generational trauma, the people who didn't even have enough money to put food on the table, what must they be going through?

And so that led him to hire a social worker, to start seeing people. Her caseload quickly became full, and that then grew into creating a clinic that was associated with the church called the HOPE Center. And HOPE Center stands for Healing On Purpose and Evolving. And Healing On Purpose and Evolving is kind of his way and the clinic's way of saying that we are in charge of our futures, we are reshaping our narratives and we are going to reclaim our future. And so the HOPE Center provides access to evidence-based treatment free of charge. So we know in our community, finances are often a barrier to getting mental health treatment. The HOPE Center provides care free of charge. Evidence-based therapy like trauma-foreign CBT or interpersonal psychotherapy. And now we have a partnership with Mount Sinai, where psychiatry residents are actually providing medication management.

And our hope is that we will continue to grow the services of the HOPE Center, and we do believe that it could be replicated nationally. And I just want to acknowledge Vic, because we are going to be featured on his podcast next month. So thank you. And I love the collaboration between AFSP and NAMI on this issue to talk more about the HOPE Center next month. So that's what the HOPE Center is. It really emerged out of Pastor Mike's vision to address the generational trauma in our community. And we created a freestanding clinic that provides care, that is culturally relevant, that addresses our people's needs in a way that is therapeutic. And it's been tremendously powerful on the lives of people that we serve.

Stephanie Robertson:

Thank you for sharing that in this space. I mean, we talked a little bit about on the podcast, Hope Starts with Us, NAMI's podcast. And being able to replicate that would be, I think, phenomenal. And so I'm going to have everybody reach out to you, all, what, 692 people? Kidding, kidding. But I do think it's an amazing program that folks should be looking into to see how to replicate across this country. I do want to just ask one more question from Victor about the AFSP, since you brought up the relationship and the partnership that you're developing. I wanted to just learn a little bit more about what AFSP outside of Soul Shop, which is a national leader in suicide prevention. What else is the organization doing to approach suicide prevention in Black communities? And strategies that you've found are most effective in reducing barriers to care, just the work that the AFSP is doing right now as well.

Victor Armstrong:

Yeah. First, I would say in general, and one of the things that attracted me to AFSP, I've been with the organization now as an employee for a little over two years. I've been affiliated with AFSP for about a decade. Served on the board here in North Carolina, where I live for about eight years. And the thing that first drew me really to AFSP was that AFSP was on this journey of being intentional about how we connect with communities. And so when we think about health equity and my role as vice president of health equity, the approach that AFSP has taken is that we view suicide prevention as a population health approach. And that means we want to know how do we make sure that everyone in the community has access to resources where they can be their best self, they can be their healthiest self, and they have their best opportunity not to be impacted negatively by suicide.

And as a part of that, we did partner with a group of people to put together Soul Shop. When we put together Soul Shop, we brought together Black faith leaders, advocates, clinicians, lived experience to create Soul Shop. And we've done a similar thing to create a program that we call LETS Save Lives, and that's an acronym, listening, empathy, trust and support saves lives. LETS Save Lives is a 90-minute program. And the full name of it is LETS Save Lives: An Introduction to Suicide Prevention in the Black and African American Community.

It's based on one of our signature programs. We have for a long time had a program called Talk Saves Lives, which has been basically our suicide prevention one-on-one program. We brought together a group of, again, Black clinicians, lived experience, advocates, policymakers a couple of years ago. And I was fortunate enough to be asked to lead this team, to put together this program called LETS Save Lives. And again, it is a suicide prevention curriculum that's based on the experience of and through the lens of the Black community. So again, by taking this program, people learn how to recognize the signs and symptoms, the risk factors, the protective factors. We share, give the data. We help them to learn how to talk to someone, to ask questions if they think that someone is thinking about suicide.

And the results that we've seen from the LETS Save Lives program have been phenomenal. When we first started a couple of years ago, we did a 90-day pilot, and we piloted it in several different states, and the results have been phenomenal. One of the things that I think has resonated with me that I did not necessarily expect, we've had great results in terms of people feeling like their awareness and their knowledge about suicide prevention has been increased. We've had great results with people feeling like they're better able to talk to someone if they think, and ask the question they think that someone is thinking about suicide. We even, in fact, do a six-month look back and we're finding really good data on people who have actually reached out to someone that they were concerned about, because they now feel like they have been equipped to do that.

One of the things that we did not anticipate is one of the questions that we look at in the survey that we ask audiences is really about their perception of AFSP as an organization. And what we have found is that when we go into communities and we create resources that are created with the community and that are created from the perspective of the community, and not just through the lens of the community, but through the voice of the community, having the community be the ones who are leading us as opposed to us leading them, what we have found is that after going through this training, not only do people say that their knowledge is increased and their comfort level in talking about it is increased, but we have found overwhelmingly that people also now identify AFSP as a trusted resource. And that was not the case before, because our resources weren't speaking to them. We were creating resources and inviting people to find their way to these resources, but now we're creating resources with communities and it really makes it much easier for community to see themselves in it and to learn from it.

But that's been our approach with not just the Black community, but our approach with engaging communities in general is we are really on this learning journey. We feel like the best way to create resources for communities is to engage with communities and allow them to lead us and not show up as experts, not show up as telling communities we have all the answers, because the question that the community is going to ask is, if you've had the answers all this time, where have you been? And so we come to them really saying, no, we don't have the answers. We have missed it. We want you to help us now to fix this. And so it has just been a phenomenal, phenomenal experience.

One of the places that I enjoy doing the LETS Save Lives program the most has been on HBCU campuses. It's been amazing to engage with young people because they are so much more ready for this conversation than a lot of our older groups. And one of the things I also love about taking these programs to HBCU campuses is we're also talking with folks in the 18 to 22, 23-year-old age range who, if they're not already parents, they're about to be young parents. They're also learning resources that they will at the end of their semester or whenever they go back to their communities all across the country, they take these teachings back with them. So spreading these teachings and these resources across the country through these young people. So all of that has been a part of the way that we've been approaching how we can better engage communities and create resources that really are relatable to that lived experience of the communities that we're trying to serve.

Stephanie Robertson:

I appreciate you sharing all of that. And I actually was able to be a part of one of the ways you connected with young people in the campus walks. And so through these campus walks, you actually have students

leading the walk and then being able to really guide AFSP on what is best for that particular school. And so I was able to experience that. And it's amazing, because that is meeting the students where they are.

Victor Armstrong:

I would also add too, that one of our partners in the LETS Save Lives program is Omega Psi Phi. They've been one of our partners in advertising it, in helping us to find places to do the presentations. I say that both to commend Omega Psi Phi for their partnership, but also to challenge all the Divine Nine. We'd love to have partnership with all of the Divine Nine on bridging these gaps and bringing these resources to the community.

Stephanie Robertson:

I'm sure there's some folks on here, so we'll give you information as well. And NAMI also has some relationships, and so we can talk offline on how to really build those bridges too. This conversation has been pretty phenomenal, and we're already at 3:51, so I do want to take some time to put out a few questions that came either from the Q&A or that were pre-submitted. And so I'm going to start with you, Dr. Thyssen, about schools and what they should be doing to protect and promote the mental health of Black children and young adults. Can you talk a little bit about that?

Dr. Rosalynn Thyssen:

So I've been partnering with a lot of schools in the Bed Rose and surrounding areas about, again, just creating that safe space. That is the first step, creating that space. Partnering with parents about how to create that safe space at home. Using the correct terminology. I'm always talking about mental health first aid, offering youth mental health first aid to those teachers, to those parents, so we can reshape the mindset, reshape conversations, because words matter. Words definitely matter. Teaching them whenever they have kids and something's going on with their child, instead of saying, "What's wrong with you?" Reshaping the words and saying, "Tell me what's going on," or sitting down. So just creating those open spaces and creating those trainings, meaningful trainings, not just a video that they have to watch and it's a check mark to say that they did a training, but some really intentional training about how to meet students where they are, how to use their language, how to use language that supports them and supports their mental health, and doesn't create a wall or a barrier and shut them out.

Stephanie Robertson:

And you said that you are helping in these partnerships and there are other organizations dedicated to these partnerships, so you don't have to do alone. So The Steve Fund is an amazing organization focused on young adults of color. We have the Jett Foundation focused on young adults in general. So we have our own youth and young adults team. Phenomenal. So this is not to overwhelm you. This is a way to tell you how to go about doing it, about how to partner with different organizations to do this. So thank you for sharing that.

And I do want... I just muted myself. We have time for maybe a couple more questions. I would love to come to you, Dr. Hankerson, on the mental health field, and training and helping professionals to become more culturally competent. I mean, could you talk a little bit more about what is being done or what should be done in order to better train professionals to be culturally competent? I don't know if I have time to get into diversifying, but let's focus on the training to be culturally responsive.

Dr. Sidney Hankerson:

Yeah, this is a critical conversation. I tell people in the community that 3% of psychiatrists in the United States are Black. 3% of psychiatrists are Black. So if everyone wanted to see a Black psychiatrists, it just would not be possible. So it's critical that we expand access to issues around cultural humility. So I like

the term cultural humility because I think that it really teaches, to Vic's point, about working with community instead of telling community what to do or coming in as an expert and saying, help us. It's really letting community drive us. And so I think cultural humility is really taking hold of certainly across the spectrum of all mental health professionals, across certainly the big three of social work, psychology and psychiatry, understanding that we need to equip clinicians to be able to put their cells in a person's shoes. It's critical for a non-Black clinician to be able to say, "Can you help me understand? When you say that you're experiencing a microaggression at work, help me understand what that means." To open that door for that conversation instead of brushing it away.

I think the reality is that so many Black folks stay away from formal mental health care is because they have not been seen, they have not been heard, and they experience that as a painful act of racial discrimination, which then keeps them out of treatment, which then leads their symptoms to be prolonged and then increases disability and impairment, and increases distrust in the system.

And so I've been doing a lot of work with the American Psychiatric Association Foundation, which is responsible for really developing psychiatry residents. So residency is the period of training when you're learning to be a certain type of doctor. And the foundation has done a tremendous job of sending out trainings, materials and impairing non-Black clinicians with access to Black leaders in the field to increase cultural humility of providers in the field. So it's a critical area, and I just think really speaks to the need of increased access to these services in our communities. We can't have just more providers who are going to do the same thing over and over again, so we have to really increase cultural humility training.

Victor Armstrong:

If I could point out also, Stephanie, and I meant to mention this earlier when you were asking me about some of the initiatives that we were doing with AFSP, because AFSP is also the nation's largest nonprofit funder of suicide prevention research. And over the last few years, we have had emphasis on funding researchers of color and research that speaks to underrepresented communities. And that's part of it. We have to have more research. Because we talk about evidence-based science, most of the evidence-based science is not based on evidence that comes out of Black communities. And so part of it is getting more research and more Black researchers.

We also are focusing on both our policy and advocacy. Where can we impact policy that benefits Black community? So all of that in addition to our programs. And then also, as Dr. Hankerson mentioned, with our media. I have the privilege of hosting the Strong Talk podcast that's supported by AFSP. We have a quarterly, we call it Elevating Voices, which is a Facebook Live event that focuses on historically marginalized communities. So all of those are areas where we are intentionally leaning into it, because if we don't intentionally lean into equity, we are just perpetuating inequity.

Dr. Sidney Hankerson:

If I just can follow up, Vic. You can see we've done a lot of these together. I just want to acknowledge AFSP. I am the proud recipient of one of their grants focused on a church-based suicide prevention project that is multi-generational. So looking at how we can address suicide across generations for youth and then adults who help with youth. So I do want to elevate them in this space, because they have truly been a national leader in providing funding to Black investigators in this space.

And just also want to just highlight this importance of collaboration. We, when we talk about the Divine Nine, and I just want to give a shout-out to Alpha Phi Alpha, I'm a proud brother of Alpha Phi Alpha and anybody else in the Divine Nine, just imagine if all of us joined together and really shone a light on this issue and made 2026 the year that we are all going to work together on suicide prevention. It would be tremendous and it would save lives. And so I challenge us, I encourage us to do that. And I think, Stephanie, we need a part three of this with the three of them.

Stephanie Robertson:

I mean, we are about at time, and I had many other questions actually. But I do want to end this with a question. And I'll start with Dr. Thyssen, but for all of you. And Dr. Hankerson, actually what you just said, for me answers the question of what gives me hope, knowing that there are some new collaborations happening and getting excited about doing more collaborations, because that is how this work is going to get done. So for all of you though, what gives you hope right now? And I'll start with you Dr. Thyssen, and then Victor and then Dr. Hankerson.

Dr. Rosalynn Thyssen:

What gives me hope is the opportunity to speak in spaces like this. I'm going to always just talk about the spaces, because for a while I didn't realize that these spaces existed, even for me when I lost my son. So this gives me hope. And just the number of people that are on this call who value mental health for African Americans and Black and brown people, that gives me hope that people do care and people are coming together to create change and to provide mental wellness for our community. So all in all, this space gives me hope.

Victor Armstrong:

Yeah, I think for me, what gives me hope is our young people. Every time I talk with our young people, I leave filled with more hope, because they are so ready for this conversation and so much more willing to have the conversation than us older people are. And it especially gives me hope because I see in the Black community the suicide rates rising for our young folks. So the fact that they're willing to take this on gives me hope.

Dr. Sidney Hankerson:

Yeah. And what gives me hope is certainly us creating spaces where people can share their stories. And I think if we can create spaces where people can go from pain to purpose, from sorrow to strength, and from hurt to healing, then we will rewrite the narrative of silence and shame that so often makes people suffer. And that really is what gives me hope, is the power of stories and the power of healing.

Stephanie Robertson:

I think that is a wonderful place to conclude. I really do want to thank you all for being a part of this really very important conversation. And our commitment to equity and improving access to mental health care for all has never been greater. So we know that together, as we just talked about collaborating and working together, we can make a positive difference in the lives of millions. And so with that, we're going to conclude this part. Maybe we will have a part three of this. But again, thank you so much all of you for joining. And to learn more about just the work of the Community Health Equity Alliance, visit chea.nami.org. And again, we'll follow up with links to different resources. And I thank you all for joining us today.