**Wisconsin Mental Health Forums**

# The Ethics of Advancing Mental Health Equity Transcript

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BETHANY: All right, let's go ahead and get started. Thank you, everyone, for joining us today. Today we have Dr. Christine Coleman. And she's going to be covering the topic of the ethics of advancing mental-health equity. If you joined us before, you have met Dr. Christine. She is wonderful. And we are honored to have her here again with us today.

So I'll just remind everyone, feel free to put your questions or comments that you have throughout the presentation in the question box. And she will either answer them throughout her presentation or will do it at the end as well. But feel free to interact and respond and ask questions throughout the presentation. So without further ado, let's get started and welcome Dr. Christine.

CHRISTINE COLEMAN: Thank you, Bethany. Thank you, everyone. It's so good to be with you all again. I might be new to some of you. And to those who I've met before or interacted with before previously, thank you so much for having me back. I've truly enjoyed working with this organization. And I'm eager to bring you some hopefully helpful, hopefully insightful content that will help you and all of us better serve our communities.

Today we're going to be talking about the ethics of advancing mental-health equity and behavioral health equity altogether. Again, this is going to be-- this was a really-- actually, if I could share personally, a really important training for me to put together. It's the things that I think we know we know. But then to see them, to absorb them, to really sit with them is so essential for us to continue to uphold best practices and continue to serve in the ways that we should, and I believe most of us do intend, to serve our communities, especially those who need it most.

As a quick reminder, my name is Dr. Christine Coleman. I use she/her pronouns. I specialize in the intersection of mental health and diversity, equity, inclusion, and belonging. I'm a licensed therapist, speaker, consultant, coach, and I founded a nonprofit, which I'll be integrating in my conversation with you all today, called Soul Sisters, where we are attempting to do systemic work and bridge the gap between women across difference.

And so we really focus on mental health, physical health, the arts, and professional development to empower the whole woman. And we primarily focus on marginalized communities, low income, low socioeconomic status. And then we also have this amazing network of women who still seek us out, who are educated, who have resources, but are still seeking community and still love to give back.

So we're doing some research around, how do we continue to serve women as an entity as a whole, but at the same time continue to bridge this gap because there still is a divide. And I think that will show up a lot today as we talk about inequity. My personal mission altogether, everybody, is to create equitable mental health opportunities across communities and organizations. I'm so happy again to be with you all.

A brief overview for what you're going to walk away with today-- we're going to explore, first, some social detriments of health-- determinants, excuse me-- examine the structural, institutional, and interpersonal factors that can support behavioral-health equity. We're going to identify risks associated with inequitable care and then hopefully, again, walk away with opportunities to meaningfully address mental-health disparities.

Thank you again for being here. I will do my very best. I like to watch the chat, everybody. Today is a heavy-content day. So I'm going to do my best to get through all of this, share with you, and hopefully educate you on some things you might know and maybe some things that you'll walk away with, and new discovery. And also, I will hopefully leave some time at the end. Everybody, it's 8:00 AM here. You probably hear my children. And I apologize for that. This is real life. OK, apologies for that, everybody.

Some quick community agreements-- again, this is primarily a webinar format. So I will be running through as if this is a teaching opportunity. However, I will give opportunities for folks to interact as well. So my ask of all of you is to uphold what is confidential.

And that really means, again, if somebody shares on here something really personal or something about a client or an interaction they've had in the community, let's keep those things confidential, not share anybody's personal sharing with outsiders. But if I share something that's-- again, it moves you, it teaches you, it prompts you to take it back to your community, to your family, to your loved ones, please do feel open to sharing that outside of here.

Showing up authentically-- again we're all professionals, people in service roles, people who care. And yet, we're all human beings. And we're touched. And sometimes we are confused. And sometimes we are conflicted with the information and with the things we're supposed to do. And that's OK. We all have opportunities to learn.

I can't tell you how many times I'm like, oh, gosh, I'm Dr. Coleman. I should know everything. And I don't. I don't. I'm learning all the time. And so if we can all, together, show up authentically, ask the good questions, have conversations-- and if I don't know the answer, y'all, I'm going to tell you, I don't know. And I'll open it up to the space and see if somebody else does know and can help. This is, again, I'm here to serve you. I'm here to bring you what I can. And also, this is also the importance of community to come together.

And of course, respect-- so create an emotionally-safe space, respect for experiences and opinions. So what this is, at the end of the day, it is meant to be a safe-- physically-safe, emotionally-safe, psychologically-safe space, an inclusive space, where we all matter, are seen, are heard, and we're also thinking about those in the same way that we serve, as well as supportive and educational. What this is not-- it is not a judgmental space. It is not a space to get defensive and get in conflict with one another. And even though I am a therapist, this is not therapy. This is purely for training and psychoeducational purposes.

If you all are good with that, I'd love to see a number one in the chat box, just to let me know you're here, let me know you can agree to these agreements. It will help our time together flow much more thoroughly. That would be fantastic. Thank you, everybody. All right. Cool. Thank you, everyone.

What is behavioral-health equity? I think that this is an important place for us to begin as we talk about this term as we talk about this concept. What is it? What does it mean?

So a few things here. As a broader term, behavioral health is where mental health and substance-- excuse me-- mental-health and substance-use disorders, life stressors and crises, and stress-related physical symptoms. Behavioral health care refers to the prevention, diagnosis, and treatment of these conditions. So again, this is likely what all, if not many of you, engage in on a day-to-day basis.

And so you are the makeup of what behavioral health is across different communities, across difference, across different individuals, how they interact, and how it shows up on a broader structural level as well. Behavioral-health equity is where everyone, regardless of their race, ethnicity, gender, sexual orientation, income level, geographic location, should have the same opportunities to receive treatment and support for their behavioral-health needs.

I'm not sure if anyone has seen this image here. I like to integrate models or images for those who learn differently, outside of text. I like this one. There are a lot of different models out there. They're all really wonderful. For the purpose of today, I thought I'd bring this one in to really help us just hold the space and lay the foundation down for what are we actually attempting to do as we continue to promote and work towards more equity in behavioral health.

So if you look at this image for just a moment, we see here, m the top left, what visual is of inequality. And the small text says, unequal access to opportunity. So you have two people about the same size. But their tree is leaning left, towards one person getting and one person not getting. And the other person is like, why do I not get this tool, this resource, this opportunity, when they do? That is defined or seen as or visualized as inequality.

Whereas we go down, equality-- and I like that they added a question mark-- Is this really equal? Are we aiming for equality when evenly-distributed tools and assistance might not actually solve the problem? So this tree, that is probably representative-- you probably agree with me-- of the resources, the tools, it still leans towards one person. And they're able to reach it much more easily, even though the one on the right has the same prompting up of the ladder.

So the same, OK, well, we gave everybody equal resources. We gave everybody equal opportunities or on the same playing field. But really, the source, the source, maybe the structural system, still leans towards those with privilege, still leans towards making it easier, even if you or the system argues that there is equality at hand.

So we have to question-- I want you to be thinking about this throughout our time together-- What am I striving for? Am I striving for equality, where we say, everybody gets the same thing, everybody is served the same way, when we know that there are so many issues and inequities across the people we serve, just by basis of structural and systemic oppression?

When we go to the top-right here, where we talk about equity, which is I think what we're all aiming for together, is custom tools that identify and address inequality. So this tree is still leaning because at the root, our systems are still unparallel. They are still uneven.

But on the right, that person has a taller ladder. That person has more thought around how they are receiving the services, how they are receiving what is given. And so they are given-- again, this is where things get really conflated. I want to make sure we hold.

And they're not handouts, y'all. They're not poor thing or pity or here they go again, using these resources when they can just go get a job. These are the things we hear in our communities. Or they should just work harder and they wouldn't have these things. There's so many systemic, structural issues that we have, that we'll walk through together today, that causes this shift in that tree, that causes shift in systems and who gets what.

So equity is saying, there's a problem with the system. There's a problem with the structure. But we, as behavioral-health specialists, as people in the community who care, are going to try to increase and solve for the issues to make sure that folks who do not have the initial access can still have the access they deserve. And I love that we can integrate justice here, which I know are things that really are at the root, the things that need to truly change are-- that we do the work on the system, we do the work on that tree.

If you can see there, the tree is propped up to make it even, so that we could have equality, so that it could be because at the end of the day, yes, equality is fair. Equality should be accessible across all differences. But as of right now, that's a really hard feat that we're all attempting to try to fix. So justice is fixing the system to offer equal access to both tools and opportunities.

I hope this is a helpful grounding point for us as we move forward in talking about behavioral-health equity, what we're working towards, and ultimately, to envision what justice could look like, where we are actually continuously working to fix the systems that affect our people around us, maybe even ourselves in this space, in negative ways. Thanks, everybody. Let's keep this moving.

I want to talk a little bit about social determinants of health. This comes up a lot in the research that I was doing. And I want to make sure that we ground ourselves, again, in, What are we focusing on behavioral-health equity? What is related to behavioral-health equity? A lot of social determinants of health.

So what I want to prompt us all to think about is, this goes beyond health care. This goes beyond health care. And I hope that many of us are aware of that. I might have shared in the last session that when I first started my career in mental health, I was placed at a high school for my internship. It was an all-girls college-preparatory high school in the Mission District of San Francisco. Shout out to anybody who's from the Bay or has visited the Bay.

I was there as a new therapist, learning a lot, didn't know a lot about what I was doing, and was in a school-based setting where a lot of these students-- most of the students were low income, low socioeconomic status. And their families were eager to have them come and receive high-level education, have opportunities to get them into college and so forth.

So I was a new school-based counselor there, learning about all the different issues that these young people had. Their families would come in. I'm there to learn and teach about mental health. And I'm listening. And I'm like, oh, you're falling asleep in class because your parents worked three jobs, they can't pick you up until 7 o'clock, you live an hour and a half away because you can't afford to live in San Francisco in these times.

And then you get home at 11 o'clock, have to take care of your brothers and sisters and do your homework at 12:00 and have to leave home at 5:00 AM. And then you're telling me that the teachers are getting you in trouble because you're not paying attention. And you're telling me that you are stressed. You're telling me that you're anxious. You're telling me that you feel like you are not doing good enough.

Your parents are saying, keep on going, you're the first one in the family to accomplish this level of education. So you need to push harder, but also not giving them the resources or don't even know where to give the resources to help them get a tutor, help them figure out how to get more resources at the school, to help them stay after school there, in a safe place. Some of my students were living in cars, y'all. Some of my students were experiencing severe levels of violence in their neighborhoods and having to come back the next day, clearly traumatized about what they saw and interacted with.

So we have to think about the social determinants of health, how they impact mental health, behavioral health as a whole, physical health, and so forth. So I want us to think about that example that I laid out. Maybe you have your own examples around how behavioral health can show up and where it is integrated. It is integrated in economic stability. It is ingrained, as I mentioned, in educational access and quality health care in the neighborhood and the built environment around them, and social and community context.

Quick stat for you-- estimates show that those of the lowest socioeconomic status are up to three times more likely to have a mental-health condition. So when I talk about my nonprofit and what I'm seeing, I'm studying women from-- working right now, more so at my private practice, and then as I've become an executive coach, I have had the pleasure of serving women who are CEOs, executives, in the C-suite, directors, people leaders, people who are climbing, climbing, climbing.

And they're primarily women of color. And they're dealing with so many mental-health stressors. But they have access to me. They can pay my fees as a private practitioner. They can go and receive different forms of self-care.

When I work with women through Soul Sisters and I realize, what are the struggles here, a lot of the divide-- and we see this in the research-- is around socioeconomic, cost, and then also access, which we'll get to as well, and also around race, and also around race and ethnicity. And that is not just an observation on my part. It is an observation throughout research that we'll continue to impact together. So let's hold these stats. Let's hold these social determinants and how they show up.

I like this model. I don't want to complicate things too much, to have you look at all the little images with the small text. But I do want to just give those who prefer a visual aspect on the structural inequities model to think about this. So we see how public safety, the physical environment, our social environment, transportation I mentioned-- a lot of these kids that I talked about were needing to be driven.

Some of them couldn't. Some of them had to take multiple buses. Some of them had to, at really young ages, get in Ubers, which maybe city life is more normalized. But it was still sometimes dangerous for them to be getting around. We see this around employment, health systems and services, housing, income, and wealth.

And at its core-- excuse me-- at its core, I think we're all collectively working to making health equity a shared vision and value. We are increasing community capacity to shape outcomes, which I think is true for all of us. And we're also fostering multi-sector collaboration for the purpose of healthier, more equitable communities where individuals and families live, learn, work, and play.

Let's take pause there to think about the vision that we're all working towards again, towards equity, towards justice, how all of the structures and the social determinants impact health. And we're going to continue-- my goal and the way I structured this time together is to help us get deeper and deeper, to understand from the larger scope to the more interpersonal scope, how we can do this effectively.

There's a lot of text, y'all. So I'm going to just read through this really quickly. And again, take pause-- that's what I invite you to do-- take pause in visualizing, again, this model that I showed you previously, and thinking about what spaces you occupy, which work and roles you are involved in, in thinking about structural, institutional, and interpersonal aspects to these social determinants.

So as a quick review, structural is where a system, where public policy-- so here we're really going to focus on the policies, the legislation, the laws-- institutional practices, cultural representations, and other norms work in various, often reinforcing ways. So they all work together. But they perpetuate oppression towards people groups across social, economic, and political systems, the structure, the systems, the root, the things that when you look at that tree, is like, Why is this tree leaning in the first place?

The history in our country, the history in our world, continues to have this power that ultimately affects marginalized communities, communities who have experienced and continue to experience oppression and different forms of discrimination. Institutional-- these are social arrangements and practices where collective actions are taken. So examples of these are legal institutions, educational, health care, social service, government, media, and criminal-justice systems.

A step further here is where-- the institutional oppression is where the systemic mistreatment of people within these different identity groups, race, class, or socioeconomic status, sexual orientation, and so forth, are supported and enforced by the society and its institutions based on the person's membership in that group. So again, I'm using the example of my dear students when they come in, seeking. These families are seeking better access to quality education. And yet, the institution is still not quite understanding.

The teachers are still reprimanding them. The school itself did a great job-- and I think we really had to put our heads together to solve for a lot of these issues. But when we are looking at the students themselves, the people themselves, who are experiencing all of these social determinants and all these different factors, and yet the institution itself is saying, well, the family's got to figure it out. Well, maybe if they just, again, got some more sleep.

We put it often on the client. We put it often on the people within these systems. And that is something that we have to change. So I'm proud to say that as I was there and all the work that happened all around me, we did. We did think about the resources to help families get from living in their cars to staying in a hotel until they found stable housing.

We did work towards having some more thoughtful after-school programs and opportunities so that parents wouldn't have to stress about their children being unsafe after school. We did think about lunch access and healthy lunches for them. We did think about expanding the mental-health department that was once just me. And now there are multiple therapists there. We thought about a lot of different things to fix and tend to the problem that is within the institution and more deeply, within the structures that uphold this oppression.

I like this quote here. "It is based on the belief in inherent superiority or inferiority"-- that is regarding the institutional oppression we're talking about. "Institutionalized oppression is a matter of result, regardless of intent." And that's where I think a lot of us have to tread carefully, myself included, is, we are navigating complex, difficult, unjust structures and systems.

And we're doing our best to try to tread through them and do our best to serve. And yet at the end of the day, our call, across our different forms of behavioral health, is to do no harm, is to do no harm.

And yet sometimes, our systems, our structures, our institutions, and the individuals within are doing harm to our communities. And we have to be really thoughtful about, What is the result here? What is my intention? But also, my intention is to do good. And I also have to be responsible and thoughtful about making sure that the result is captured in a way that does not do any harm to the clients I'm serving.

And lastly, interpersonal-- communications between two parties is what interpersonal means. But let's think about this in a behavioral-equity context. Examples of interpersonal inequities are-- here we go with thinking about this from an individualized perspective on your part-- talking to the client versus asking for their client input. A lot of times, again, across behavioral health, there is a sense of authority, an uneven distribution of authority. So you're the doctor. You tell me what to do. You're the psychologist. You tell me what to do.

And while there is a responsibility, we have to guide our clients forward in the most responsible and positive ways, we also want to make sure that we are asking the client for their expertise and their experience within their own selves, and maybe even, if they're willing, within their own communities of what they're witnessing and what they're experiencing, without necessarily putting it on them to solve for what you can actually be educating yourself on and what your workplace can be solving for as well.

We also see language barriers. This can go across verbal as well as material, and not always being inclusive or thoughtful around the language barriers that can keep the institutional and structural power in place. We also see literacy barriers. Sometimes we're like, here's a pamphlet, here's this long document, this long document or this big packet to read through. Good luck.

We don't realize that sometimes there are literacy barriers. What are we doing in our behavioral-health practices to help with that, to be thoughtful about that? I had a colleague once shared that her mother is from a small Indigenous town in Mexico and is now in the US, given Spanish materials translated into Spanish, which is fantastic.

However, she didn't read that type of Spanish, the type of traditional Spanish. She had an Indigenous language. And it was very difficult for her to understand. And then the doctors the people who were caring for her also didn't know how to translate that.

So we have to be thoughtful about-- again, translators are great. Interpreters are fantastic. We need more of those. Those are all good goals. But also let's think about the vast populations and demographics that we are serving too. And depending on where you are today and where you serve, some of our towns and cities are going to be more equipped to be able to have these tools.

Some may be more rural-- excuse me. That's a hard word to say for me-- rural towns have a difficult time getting those access to resources. And yet, people who have immigrated, who have become refugees, et cetera, find themselves there. And the tools and resources they have are not always able to be best served to them.

Interpersonal also includes not considering the entire client experience. I saw in the research I was doing where we are thinking about-- from the time they step into the building, y'all, to how they're interacting with the janitor, to the check-in desk, to the form filling, to getting in the waiting room, to interacting with the doctor. It's not just, I'm going to see the doctor. Are we thinking through the entire client experience and how behavioral-health equity can actually show up in small ways, in minuscule ways, but yet can mean so much to the client?

We also continue to see a lack of cultural responsiveness-- we'll get into that as well-- and an overall dismissal of the history of mistrust in the health-care system. A few years back, I was presenting at the American College Health Association Conference. And I did a presentation on racism within the within the health-care system. And it was-- ooh, that was deep, y'all. That was hard to immerse myself in, to just really, truly dig deep, read, process the deep roots of racism.

And it goes beyond just the history of the United States. The history of health care is rooted in white supremacy. The history of health care is rooted in believing that Black people and people who have melanin, which goes across various races and ethnicities, were less human. Therefore, the studies that were done on their bodies, on their minds, were harsh, were inhumane, were unethical.

The assumption that people are not as smart because of their skin color continues on today. And everything around scientific racism or an attempt to base on science has been proven false. And yet it is still upheld. And we still see that today.

And I want us to think about, How do we still see racism? How do we still see different forms of discrimination and oppression in the health-care system that we navigate? And let's think about how difficult it must be for clients to come in.

The time they parked their cars or get off the bus or find their transportation there to how much it took for them to get there, to walking in those doors, to interacting with staff on the main floor, to getting in the door to see you as a therapist or to see you as a nurse or to see you as an aide or to see you as a paraprofessional, et cetera, what are we doing to help them? And are we thinking about the history of mistrust that can show up consciously or unconsciously?

Let's look at the impact. Here's a quick example. So let's take the example of schools. I know I'm leaning a lot on schools today. But I know there's a variety of ways this can show up. For the purpose of today, let's just use an example of a K-through-12 school that is segregated based on-- again, usually race and socioeconomic status is what shows up the most.

Again, there are other forms of inequities across social identities. We're going to use this one because the research says it's most prevalent as well as something that can be used just for this time alone. But it does not denounce the fact that other forms of oppression still exist and still factor into health inequities.

What is the result that can happen to these children? And I want us to think about that. Some of us work with kids, adolescents, adults, and elderly. The result can be, on a systemic structural level, all the way up to the institutional level, all the way up to the interpersonal level, limitations to treatment, shortened life expectancy, adverse childhood experiences, divorce, various forms of trauma, et cetera, likelihood to be immersed in the school-to-prison pipeline which can lead these adults into workplace discrimination.

Whether they went to prison or not, they are still likely, from childhood, to experience, from the beginning, these various forms of limitations to health treatment, to opportunities, to have a voice and get their families involved, to the experiences they have all around them in school and otherwise, in their communities and their families and their homes, leading them up to adulthood, where they're going to likely experience workplace discrimination because of those institutional and structural aspects.

They're going to have prevented opportunities to building wealth and assets. And then at the very top, they're going to lack the access to influence policy change, which includes things like voting, which includes things like using your voice, that all of us have the right to do.

And yet with these limitations, when we think about health inequities, it's not just about what happens in the doctor's office. It's not just what happens when you're going to see a mental-health provider. These are social determinants that show up. And we can see how they can start from the school system, from a young age, all the way throughout adulthood.

Another interesting graph here, when we talk about racism for a moment-- I'm not going to spend the entire time together today on racism. But this is again, I think, an opportunity for us to hone in on social identity in the form of race and what racism can show up as. So let's think about this on a systemic level.

We have immigration policies, incarceration policies, predatory banking that affect people across oppressed races and ethnicities. At a community level, we have different differential resource allocation, racially or class-segregated schools, as mentioned.

At an institutional level, we have hiring and promotion practices, under or over evaluation of contributions, on an interpersonal level, overt discrimination and implicit bias, and on an interpersonal level, internalized racism, a stereotype threat, and embodying those inequities, start to believe I'm not worthy. You start to believe, I'm the stereotype. You start to enact the stereotypes. We start to dislike or even hate ourselves because of our skin color, our gender, and so forth.

So let's summarize the risks here. What are we working with? Again, we're giving a few examples. You might have your own examples swirling in your mind as you think about those you serve, where you walk through, what kind of environment you are serving in and working in.

Some of the risks that we can see here in our clients and those we serve can be worsened health, mental-health conditions, like anxiety, stress and depression. We see an increase in social isolation, poorer overall health outcomes. We see likelihood of intergenerational trauma because if we're not solving for, healing, providing for the generations past, this generation is going to inherit that trauma.

We're not going to be able to disrupt the trauma. So we're going to continue to pass that on. And it's going to show up in different ways, as well as holding on to the root of the trauma from the generations past. We're going to continue to see forms of discrimination at school, in the community, in the institutions, in workplace environments, and so forth.

We're going to see the continued upholding of cultural stigmas. This can go from a structural level in the broader community. This can also happen at an interpersonal level, where we start to see, oh, you're just crazies in our communities. Oh, don't go with that crazy stuff. Don't go see a therapist. I'll only go to the doctor if I'm dying.

We hear these things in our communities. And instead of being able to provide preventative options and opportunities, we're seeing this carry out because a lot of what is internalized and what is learned interpersonally and what becomes interpersonal is rooted in some of these stigmas.

Reduce self-esteem, acceptance of violence in our communities, physical and sexual harm, and a higher likelihood for suicide and even murder-- so we see this here, y'all. Again, I can't say it enough. It is beyond health care. It is beyond treatment. It is beyond diagnosis. This is a collective, holistic approach to the individual and to the community at large that we have to be thinking about.

And if we're not thinking about behavioral-health equity and not practicing it in our workplaces and our environments and our institutions and so forth, these are the risks-- and there are likely so many more. These are the risks that are at hand for the people we care about and we serve.

Looking at the time here, I'm doing good on time. And I see the chat going. And I promise you I'm going to get there. Otherwise, I end up talking to you all for so long, I don't get through all my slides. So please forgive me for not going to the chat box as much. And thank you so much for your grace and patience.

How to address behavioral-health inequities-- there are three main barriers in the research that I want to offer all of you. And these are the ones where I want you to-- again, if you have a piece of paper that you're taking notes on or if you're typing notes out, these are the ones I want you to be thinking about and take as you need, to take for yourself, take back to your workplace colleagues, take back to meetings within your city and within your state, to be thinking about,

How do you, as an individual, create change? How do does your workplace create change? How does your collective community create change? How do we continue to influence policy and so forth?

The three main barriers that have been identified in the research for behavioral health inequities, that are most impacted, I should say, are cost, accessibility, and stigma. Let's start with cost. The ways in which we can solve for the inequities across cost to services start at the policy level, which I know for some of us are like, great. How am I supposed to influence that?

Maybe that's not your calling. And maybe it is. And I have to think about that for myself too when I think about the nonprofit that's continuing to grow and evolve. I didn't start off as a non-profit expert, everybody. I still am not one. I just wanted to help people. I wanted to create more empowering tools, resources, events, services to help women, to help-- also now that I know more, bridge the gap where we can start to see some institutional and structural change so women are not divided across socioeconomic status, across race, across sexual orientation. We can come together.

But yet, that's a hard feat. And to walk around and just say, let's just all get along and let's all get together is not just. It's not accurate. But it is possible. But we have to get at the root of the structures.

So we talk about things like cost, policy. Are we working towards having conversations with our city leaders, with our government leaders? Are we perhaps applying to the grants that are available to ensure that the money that we have access to can help serve others and help them not think about cost because there is money already available for them to receive the health-care services that they need and deserve.

For some of us who are in private practice, perhaps a sliding-scale approach, or perhaps designating a certain percentage of your caseload towards clients who cannot afford you-- I usually tend to allot for one to two sliding-scale or pro bono clients.

I've been a part of different platforms that ask for donated hours from clinicians. I've donated 10 hours here and there, that I can do with one or two clients. And then I give them a proper treatment plan for them to think about where they want to go from there, if they'd like to continue with me or if they'd like to go elsewhere. We talk through that as well.

Telehealth is also showing that is actually becoming-- again, when you're talking about access, more accessible, but also more cost effective because sometimes again, transportation, sometimes child care, that doesn't allow for particularly adults, let's say, to be able to receive services can actually-- so the option of telehealth and virtual health care can actually solve for some of these cost issues.

There's a wonderful nonprofit here that I learned about in the Bay Area-- I learned about it last year-- that works with migrant farm workers. And migrant farm workers deserve proper-quality health care, particularly mental-health care, as well.

And so this woman I met, who is just a phenomenal leader, she created this model within her nonprofit to have mental-health providers go out on the field with them. And they can't stop working. If they stop working, they don't get paid. So they would walk with them, talk with them casually, be able to hear about their life's challenges, be able to serve them and see them.

Then she got some funding. And this is so cool. She got some funding. Out here in the Bay-- I'm not sure if you have these in your different cities-- we have a lot of tech companies out here. We have a lot of double-decker buses. And often I'll see them. I live in Oakland. So I'll see these double-Decker buses taking people, let's say, into the city or different cities outside of the major city of San Francisco, double-decker buses, stacking all the tech workers to go in and then get to work.

A company donated a double-decker bus to this nonprofit. And they converted it into a space where these people can take pause from their work, whenever they have a lunch break or some kind of pause, to be able to get on the bus and see a provider in person or log on to laptops in a confidential way to be able to have virtual care.

How cool is that? When I heard about it, I was crying. And I was so moved. And I thought, this is where we can get creative. So let's think about that when we talk about behavioral-health inequities and transferring that into more equitable opportunities and services. Let's get creative. Let's put our heads together. Let's think about, How do we transform the way that health care is done? So I love that story.

We're also seeing, in terms of being cost effective, whole-person care. Have you all heard of that? Whole-person care is where we're training and getting more buy in from people like primary health-care providers, paraprofessionals who might not have the licensing or the training, but they're certified or have different forms of training where they're able to still provide the basics of health care, still provide some form of care that is still quality, that is still professional, but it is focused on the person that can have access to a variety of services. And maybe that does also integrate mental-health professionals, psychologists, nutritionists, and so forth when we're thinking about the whole person.

And this is what we're seeing a lot of models occur as well. And it's showing that it is more cost effective than, you go to that person over there, you go to that provider over there, you pay this fee for that person and that fee for that person. If we can focus on the whole person and think about this holistic approach to providers, that also can be a cost-effective approach.

We're also seeing that Medicaid is the largest payer of behavioral-health services in the United States. So we can be called to lean more on Medicaid and Medicare as well. A quick stat for you-- US respondents with mental-health needs, particularly Black and Hispanic Americans, were most likely to report cost-related problems accessing health care. So again, there continue to be problems that are related to our social identities, primarily race and socioeconomic status.

However-- excuse me-- however-- looking for my tissue. I think it fell. Excuse me. We know that there are opportunities for us to provide some support. Accessibility-- we want to be thoughtful about making access to our services easy, detailed, inclusive. So we talked about, again, language barriers.

I think I saw in here, even closed caption. So we can use things, even technology tools, to our advantage, that have closed captioning, that have a variety of languages available for folks to be able to sign in on.

We can provide free Wi-Fi or things of that nature to help people be able to access. That's something we did at the school as well, was provided the students laptops and also access to Wi-Fi and internet at home because that was proven to be a problem, maybe in your communities as well. Again, paraprofessionals, as I mentioned before, can be really helpful in helping people access what they need and what they deserve.

Transportation continues to be an issue. So can we be thoughtful about stipends or passes or reimbursements, things of that nature for transportation? Can we also be flexible with our time? Of course, we want people to honor our time. We want people to be respectful and responsible towards what they have committed to. However, let's think about that journey that people often have to take. Let's think about the different challenges that come with just getting there, just seeing you, whether it's virtual or in person.

Can we be flexible with the times that we have there? Can we think ethically, but then also broaden the aspect of how am I going to get to you, this nonprofit that is going to the community versus expecting them to come and oh, you're late, OK, well, now we only have 5 minutes versus your 20 minutes and so forth? Can we be flexible and understanding and offer a lot of empathy and compassion?

And also, there is still a shortage of behavioral-health professionals. So continuing to create opportunities for continued generations of behavioral health professionals is really important. And we also want to continue to make our fields attractive to people, paying people equitably as well, to do this work, and also reminding folks that this is hard work. This is community work. This is impact work. And this is really important for us to think about and root ourselves anytime we get frustrated, anytime we are-- with a system, with a client, with a patient, et cetera.

More than half of all rural-- there goes that word again-- counties report that they do not have any behavioral-health professionals. And nearly 3/4 of all US counties report serious shortages. So there's a quick stat for you, regarding the need for behavioral-health professionals, especially in different parts of our country.

And last but not least, there still remains a stigma. We want to address our own stigma. We want to think about, OK, I'm offering all these services. But what do I think about them? What do I think about-- what was I taught about mental health? What was I exposed to regarding conversations about how to take care of myself? Do I only go when I am in deep, dire need of health care? Am I doing preventative work? Am I eating the foods that I tell other people to eat and so forth? Do we have our own stigmas around mental health, physical health, and all different forms of health?

I don't know if Dr. Jones is on the call today. But Dr. Jones is a colleague of mine and introduced me to the idea of listening sessions, which sounds straightforward. But I really was moved by psychologist Dr. Jones introducing this approach to listening sessions within staff and being able to allow staff to be heard, to share their experiences of what it's like, especially if they're working as ambassadors or representatives of their communities, going out and inviting people in who might not otherwise trust people like me or maybe some of us.

And so we want to listen to, What are our staff carrying? What are our ambassadors carrying? What are they holding? Where are they getting stuck? What are their stigmas? What are their needs? How can we not only train them, but also listen to them and make sure that they're getting access to health beyond just, here's your benefits package? Are we really tending to and prioritizing the health-care needs of our staff, especially those who are directly interacting with our clients and communities?

Normalizing mental-health across your institution, for instance-- and obviously health care as a whole is really important. Hiring staff representative of the demographic and population you serve is also key. We want to think about, again, the history of mistrust. How do we bridge that gap? Let's hire people who understand the community, who know the community, who can not only teach you, but also be that bridge that can bring communities together.

But that does not mean that if you are not-- you can't relate or you've never lived that experience, that you're not trained, that you're just saying, well, I don't have a say in this, you all go do that hard work. I'll just be over here on my are doing my executive thing or my doctor thing or so forth. We want to continue to lead with cultural humility and responsiveness and responsibility, which we'll get to as we continue to close that.

The last thing I want to leave you with is, I want to leave us with thinking about an emphasis on belonging. When Soul Sisters, my nonprofit, started out, we were doing these service events. We were partnering with different existing organizations who already had access to the clients we wanted to serve. We gave them really beautiful tools and resources, days of pampering, days of empowerment, workshops and so forth. We were so proud to see our community come together and see the joy and light and celebration that these women had, who were getting this attention and these services.

And then we started holding our own events and inviting these women and asking them to come. Come on over. We're having this event here. And then all of our-- peers and women who had access to resources would come because they loved Soul Sisters. They wanted to be a part of our event, have a good time, and be in sisterhood.

And we would invite them. And we would provide things like transportation stipends, child care, and so forth. And while some of them did take advantage, most of them didn't come. And this was earlier on. And when they were there, they were often siloed within just them. And they wouldn't--

And all of us were so friendly. Come on. Come on over here. Let's come on. And I didn't understand at the time because I was younger. I didn't know. I've learned so much more in my own growth journey and along with my colleagues.

If you don't feel like you belong-- think about that from the entrance to coming in. If you don't feel like you're safe there, in your mind, in your heart, in your physical being, it's not going to work. All these efforts are not going to work. So you fixed the accessibility. You fixed cost. OK, they're here. We gave you these resources. Why are you not happy to be with us? We need to emphasize belonging.

So that's why the representation among staff, that's why training us, who maybe have no real-- many things in common with you, let's find the things we have in common with our clients. Let's find some ways to help them feel comfortable and safe and exercise compassion and empathy, but not just at a limit, truly seeing them as people and who they are and thinking as a team within your workplace.

How do we continue to emphasize that they feel like they belong here, that we're not just giving them handouts like these models make us think that we are, or these people say, you're just not working hard? They hear these messages every day. They're treated this way every day. When they come into our treatment, our services, our community within mental-health and behavioral health, this is an opportunity for us to say, you're safe here. You're good with me. I see you. Tell me more about yourself. I value you, just like we would hope that people would treat us.

Finishing up here, for clinicians, I might have some clinicians in the house, like me. Hello. I shared this slide at the last training. I did I want to bring it up to surface because I think it's still relevant. We want to continue to conduct an intersectional self examination. I have that model-- there it is-- here, which I'll go back to.

Thinking about all the social identities we have, how they intersect, how they show up, and how our power and privilege shows up, as well as our forms of oppression show up, and how they actually impact the people we serve. So we always want to look inward and think about, How do I navigate the world? What are my stigmas? What are the areas I have easier than others? What are the areas I struggle with maybe more than others? And how does that impact the way that I show up for my clients and my patients?

Consider issues of discrimination and the connection to mental health. So let's think about this. This goes into that cultural, responsive care we'll talk about at the slide after. Our clients are experiencing various forms of discrimination, covert and overt. And how do they affect their mental health and emotional health? Continue to keep that top of mind. Ask the questions. Think about it. And do not be afraid to bring that part in.

They'll actually probably-- let me say this. They're more likely to feel more relief that you're able to name it versus them feel uncomfortable to say it. So some might say it and might just bring it up in session or bring it up in group. But if you're able to confidently sit and say, tell me more about any forms of discrimination that you have experienced in your life, and I want to hold that with you and let you know how unfair I think that is and how wrong I think that is, and I want to work with you to make sure we help you protect yourself, heal yourself, tend to yourself so that you can continue to go out and face these unfortunate systems, but also know that you are not deserving of that. How powerful to hear it from you?

Recognize and celebrate differences across clients, explore the history of racism and scientific ideologies-- I mentioned that. So doing your own reading, your own research. Lead into decolonize psychology frameworks. Even if you just do a Google search, there are many, many resources, many research papers out there, lots of peer-reviewed articles out there. The American Psychological Association has many as well, if you want to go there. Really important for us to start thinking about how colonized the field of psychology and the field of health care is.

Again, it traces way back. Even if we're doing our very best not to practice it, it's inherent. So we have to start deconstructing that work and making sure that we're thinking about best practices moving forward.

Educate yourself on culturally-responsive mental-health approaches. Extend appreciation for the Indigenous science. I think I shared this prior, where I went to a conference and there were Indigenous healers there, doing these beautiful ceremonies.

And I loved that this conference, that was focused on mental health, was able to integrate that to show that we have our way of modern medicine, but there are many, many medicinal and health-care approaches across the world. And one is not better than the other. Can we use them together, perhaps, especially with the communities that we serve? Again-- I mentioned this earlier-- consider sliding scale. And also providing additional resources that they can use, as well.

I won't spend too much time on here. I already mentioned this. But again, culturally-responsive care is a philosophy that guides mental-health providers towards seeing and valuing clients fully for their aspects of their lives, so again, not being afraid to ask. Call in all aspects that they carry here, just like we all carry. And also leading with cultural humility, knowing that you're not always going to get it right, you're not always going to have all the answers.

However, this does not mean that we lose sight of doing no harm. Remember our good intention versus the result. We want to be educated enough, trained, thoughtful, look interpersonally in our own selves, to make sure that we're not just accidentally saying something wrong or doing things that we didn't know. We're human beings. We're going to make mistakes. And we have to really think critically about ensuring that we're doing our very best to do no harm.

So let's reflect. And I think we have time for just a few questions if there are any there. We have to think about the historical aspects to behavioral health and equity and how that influences current inequities. They're there. It's been happening for a long time. And folks like you, who show up on a call today, are part of the change.

And that's what it says here. Community groups are agents of change. You are an agent of change. Collectively, we can do so much more. So who do you need to partner up with? Who do we need to collaborate with to work on policy, to work on how our workplace does things differently, to how our community, across different organizations, can do things differently? How do we collaborate together to create more change, to infiltrate the system in a positive way, to shift that tree to straight, to fix and make things just?

And let's always keep in mind the social determinants of health. It's not just, this person has high blood pressure. What else? What else is going on? Can we have a holistic approach to think about all the different influences of one's mental health and one's physical health and one's behavioral health and so forth?

I'm going to ask you, How will you put what you have learned today into practice? What is one step-- that's usually how we do things, right-- what's one step-- if you have a moment to write it down, absorb what we talked about today, if you could write one next step you're going to have is x. Maybe it's emailing me. Maybe it is staying in touch with me and having me come to your organization. Maybe it's let's just do a consult call. Maybe it's, I'm going to go do some more of the research that Dr. Coleman told me about. Maybe it's, I see somebody on the call that I haven't talked to in a while. I want to, perhaps, reach out to them. There's lots of things that you can do.

So let me stop my screen. Bethany, if you'd like, I can give you these slides in case anybody would like them. And then you have my contact information here. And I can also share it. So thank you so much, everybody. It's so wonderful to be here with you all. And I think I'm going to go back here, to look at these questions. And let me just take pause here, if anyone would like to say anything while I'm looking at these questions.

And I apologize. I see some of those come through, that your chat box was disabled. That is my error. Thank you so much. All right. Any other questions coming through? Let me see on this chat box, as well.

BETHANY: Hi, Dr. Christine. We have a question here that says, "What is your opinion on referring individuals to inpatient and residential facilities for behavioral health?"

CHRISTINE COLEMAN: That's a really good question. Thank you so much for asking that. That's a really good question. I'm reading it again. This is something that I think is an important question, that maybe I'm not going to be able to answer in a few minutes. But I want us to just think about, again-- it also is very much dependent upon what is going on in their lives.

Are we doing full assessment on what is going on, again, with those social determinants? That's what I would prompt for you, in thinking about, What are the impacts of the differentiated aspects of their lives? Some folks would benefit from inpatient. Some folks are hesitant because of cost. Some folks can't because of access.

Sometimes there is stigma because we know that if you're put in somewhere-- we have all these different terms for going to these places. But sometimes it can be incredibly helpful. But I also want to urge us all to be thinking about, Is that the only option? Are there other options prior to that?

Can we work with the individual, the family, the community, to ensure-- again, I want to think also about that-- whole-person care. Do we also integrate a team of folks to assess and consult and so we can offer to the client or the patient a release to talk to other providers, to determine, is this the approach here?

So sometimes, often-- I don't know if this is a case for you, my friend. But if it is something where it's like, I don't know what I'm supposed to do, I offer you to consult. I offer you to ask your client or patient to ask for a release, if they're comfortable with that, to consult with, maybe, other health-care providers to have a holistic approach to what might be going on to determine if this is good for them or not. So I hope that helps.

"What should we be thinking about as we continue learning about behavioral-health equity and incorporating this understanding into our work? High levels, key takeaways." Absolutely, so yeah, I want to make sure that we're thinking about this on a holistic level. That's something that I think is embedded in each of us, and yet sometimes just not brought to conscious.

So that's something I want to really emphasize, is thinking about this person came to you or this family came to you or this couple came to you, et cetera. What are they facing? What are they going through? So there's the root cause that we often have. And so we go into treatment mode. We think about what is at hand. But are we thinking about all the different social determinants that they're navigating, including their social identities?

So the intersectional model is also going to be really important to determine, How is the stress of racism impacting my client? How is the stress of being a woman or maybe being an LGBT person from the LGBTQ community impacting them, and so forth?

And if you need to, maybe reassess around your intake forms, your assessment forms, to think about, What are we asking? What are we looking for? Are they culturally responsive? Are we leading with cultural humility? That's going to be really important for you.

And again, I'm trusting that many of you already do this. But I think it's really important to think about, What are you, as an individual provider, offering? And also, what are you doing as a team? When you're in your team meetings, how are we thinking about how we're going to do this collectively so we can work together?

That's the one part about-- I'm in a private practice. And I joined a consulting group because oftentimes, it's a little bit isolating to be able to try to figure out, What do I do with my clients? How do I best serve them?

Being in community for US is also incredibly helpful. And we can think about, What tools are in place? What do we need to assess for? What do we need to modify and so forth?

"What can peer specialists do to maintain equitable services in the community?" And I know that we're at time here. So let me just end here. I think this is a wonderful question as well. I think similar to what I've shared, we want to be thinking about the interpersonal. We want to be thinking about the institutional and the structural. And so when we can think about, What is going on within our communities?

You're a peer specialist. You're in, I'm imagining, in the company of folks who are sharing their hearts with you, who are sharing their struggles with you. And it's an honor, I imagine, to be able to hear it. And it's probably also a lot for you. So doing some inward work along with ensuring that you are taking back what you are learning, telling your team, your colleagues.

Are you equipped for this or not? What are additional trainings that you might need? Where are additional spaces that you need to really just think through critically, to ensure that these are equitable approaches I think, would also be really helpful-- and when working with-- OK.

So I have-- OK, thank you. I know that we have to hop, everybody. But thank you so much. And I'm sorry I couldn't get to all the questions. But these were fantastic. And if I'm able to, I will send some of my responses in written form if that's helpful. But otherwise, thank you so much for having me.

BETHANY: Thank you, Dr. Christine. We really appreciate you being here with us today. Thank you, everyone, for joining us. It's been an honor to do this webinar series and to cover all of these important topics. We are going to do a surprise pop-up final bow on this webinar series.

We're going to be doing one February 22nd with Dr. Christine again, talking about the importance of nurturing success with personal and professional self-care. So we hope that you all join us for that. Please go to the community of practice to continue to talk about the topic today. And with that, thank you so much for everyone, for joining us.