DISMANTLING STRUCTURAL RACISM IN PSYCHIATRY: CHALLENGES AND OPPORTUNITIES

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DISCLOSURE/DISCLAIMER

- THIS IS A DIFFICULT AND UNCOMFORTABLE TOPIC
- COMPLEX FEELINGS OFTEN EMERGE, INCLUDING GUILT, ANGER, RESENTMENT, AND DEFENSIVENESS
- YOU MAY PERCEIVE ME OF ACCUSING YOU OF BEING RACIST/SEXIST/ETC.
- YOU MAY FEEL I HAVE A SPECIFIC POLITICAL AGENDA OR THAT I LACK OBJECTIVITY

“I’M NOT INTERESTED
IN ANYBODY’S GUILT.

GUILT IS A LUXURY THAT WE
CAN NO LONGER AFFORD.

I KNOW YOU DIDN’T DO IT, AND I DIDN’T
DO IT EITHER, BUT I AM RESPONSIBLE
FOR IT BECAUSE I AM A MAN AND
A CITIZEN OF THIS COUNTRY AND
YOU ARE RESPONSIBLE FOR IT,
FOR THE VERY SAME REASON.”

TALKING ABOUT STRUCTURAL RACISM IN PSYCHIATRY

- **WE HAVE BEEN SOCIALIZED TO BELIEVE THAT IT IS NOT POLITE TO TALK ABOUT RACE**

  This begins early, as children in the US (and elsewhere)

- **PHYSICIANS HAVE NOT BEEN TAUGHT ABOUT THE CONNECTION BETWEEN RACISM AND HEALTH**

  Medical school has a long tradition of teaching biological determinism

- **ARE THE TIMES A-CHANGIN'?**

  Some feel that there is an overemphasis and over-correction happening now

THE PROBLEM WITH RACE-BASED CLINICAL CARE

- RACE IS A SOCIAL AND POLITICAL CONSTRUCT
- RACE IS A ROUGH AND IMPRECISE PROXY FOR CULTURE, GENETICS, AND SOCIOECONOMIC STATUS
- RACE CANNOT BE ACCURATELY BIOLOGICALLY CATEGORIZED
- YET, WE USE RACE TO CONFIRM ASSUMPTIONS/PREJUDICES/BIASES ABOUT OUR PATIENTS

HOW DID WE GET HERE?


THE
AMERICAN
DREAM

HISTORICAL ORIGINS OF PSYCHIATRIC PSEUDOSCIENCE

DRAPETOMANIA

"If any one or more of them, at any time, are inclined to raise their heads to a level with their master or overseer, humanity and their own good requires that they should be punished until they fall into that submissive state which was intended for them to occupy. They have only to be kept in that state, and treated like children to prevent and cure them from running away."

DYSAESTHESIA AETHIOPICA

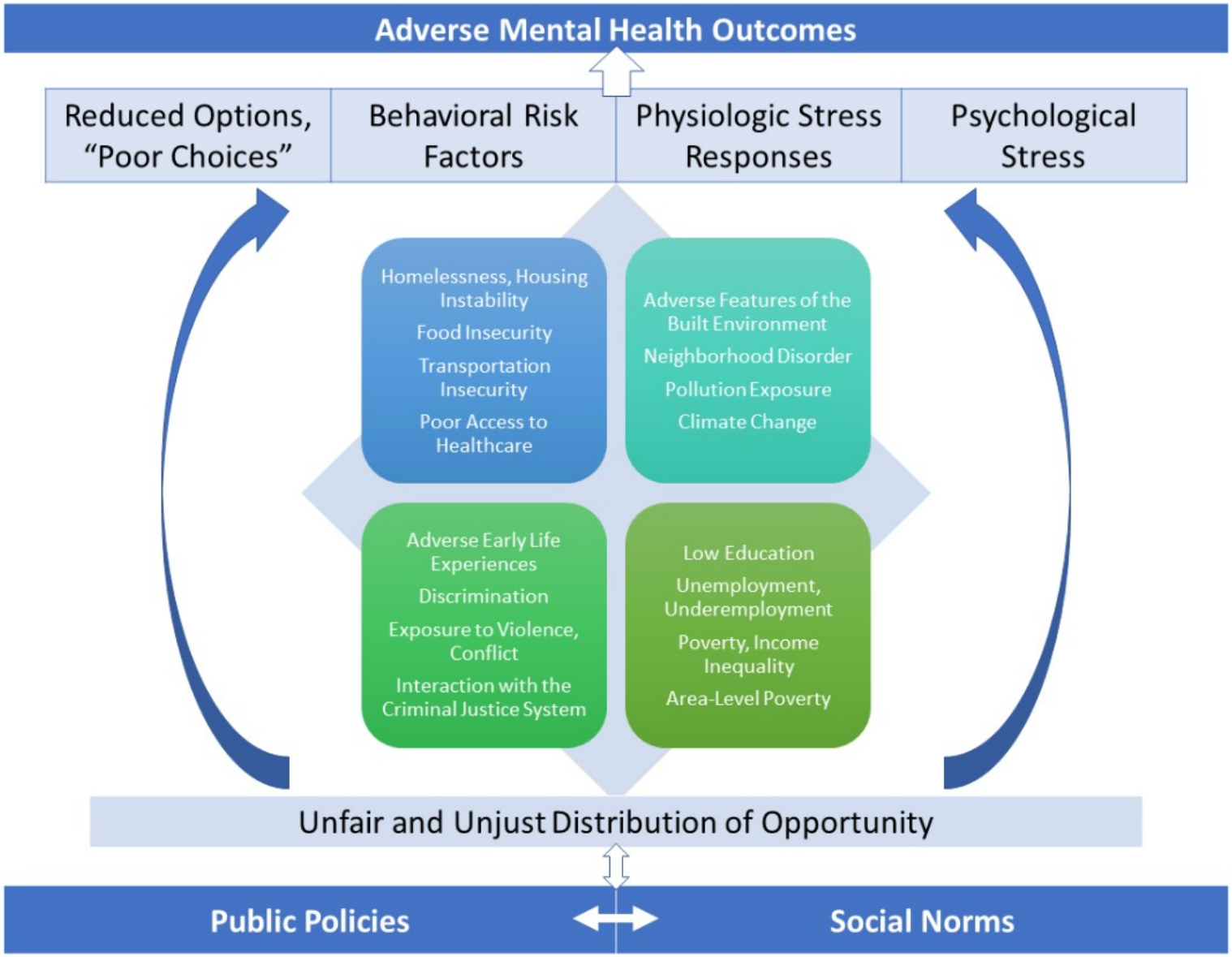
After the prescribed "course of treatment" the slave will "look grateful and thankful to the white man whose compulsory power...has restored his sensation and dispelled the mist that clouded his intellect."

HEALTH DISPARITIES:

DIFFERENCES IN HEALTH STATUS AMONG DISTINCT SEGMENTS OF THE POPULATION INCLUDING DIFFERENCES THAT OCCUR BY GENDER, RACE OR ETHNICITY, EDUCATION OR INCOME, DISABILITY, OR LIVING IN VARIOUS GEOGRAPHIC LOCALITIES

HEALTH INEQUITIES:

DISPARITIES IN HEALTH THAT ARE A RESULT OF SYSTEMIC, AVOIDABLE, AND UNJUST SOCIAL AND ECONOMIC POLICIES AND PRACTICES THAT CREATE BARRIERS TO OPPORTUNITY


Adverse Mental Health Outcomes
Reduced Options, "Poor Choices"
Behavioral Risk Factors
Physiologic Stress Responses
Psychological Stress
Homelessness, Housing Instability
Food Insecurity
Transportation Insecurity
Poor Access to Healthcare
Adverse Features of the Built Environment
Neighborhood Disorder
Pollution Exposure
Climate Change
Adverse Early Life Experiences
Discrimination
Exposure to Violence, Conflict
Interaction with the Criminal Justice System
Low Education
Unemployment, Underemployment
Poverty, Income Inequality
Area-Level Poverty
Unfair and Unjust Distribution of Opportunity
Public Policies
Social Norms

KEY CONCEPTS

TYPES OF DISCRIMINATION

LEGAL

ILLEGAL

OVERT

COVERT

INTERPERSONAL

(Individual)

INSTITUTIONAL

(Organizational)

STRUCTURAL

(Systemic)

PRINCIPLES OF SOCIAL INJUSTICE

- **ESSENTIALISM**

  The belief that there are distinct, unchanging, and natural characteristics that define social groups and facilitate their categorization

- **ERASURE OF CONTEXT**

  Failure to consider sociohistorical context when seeking to understand the etiology of inequities

- **BIOLOGICAL DETERMINISM**

  The false belief that racial groups are biologically and genetically different

- **CULTURAL DETERMINISM**

  The false belief that differences in racial groups are the result of cultural factors (e.g., ethnocentrism)

Shadravan S, Barcelo N: Social Injustice and Mental Health Inequities. In Social (In)Justice and Mental Health, Washington DC, APA Publishing. In Press.

TYPES OF OPPRESSION

EXPLOITATION

The unequal exchange of one group's labor and energies for another group's advantage and advancement

CULTURAL IMPERIALISM

Establishing the ruling class culture as the norm; othering of groups that are not part of the dominant culture

POWERLESSNESS

Oppressed groups lack power and are blocked from routes to gaining power

MARGINALIZATION

Expelling specific groups from meaningful participation in society

VIOLENCE

Threats and experiences of physical and structural violence

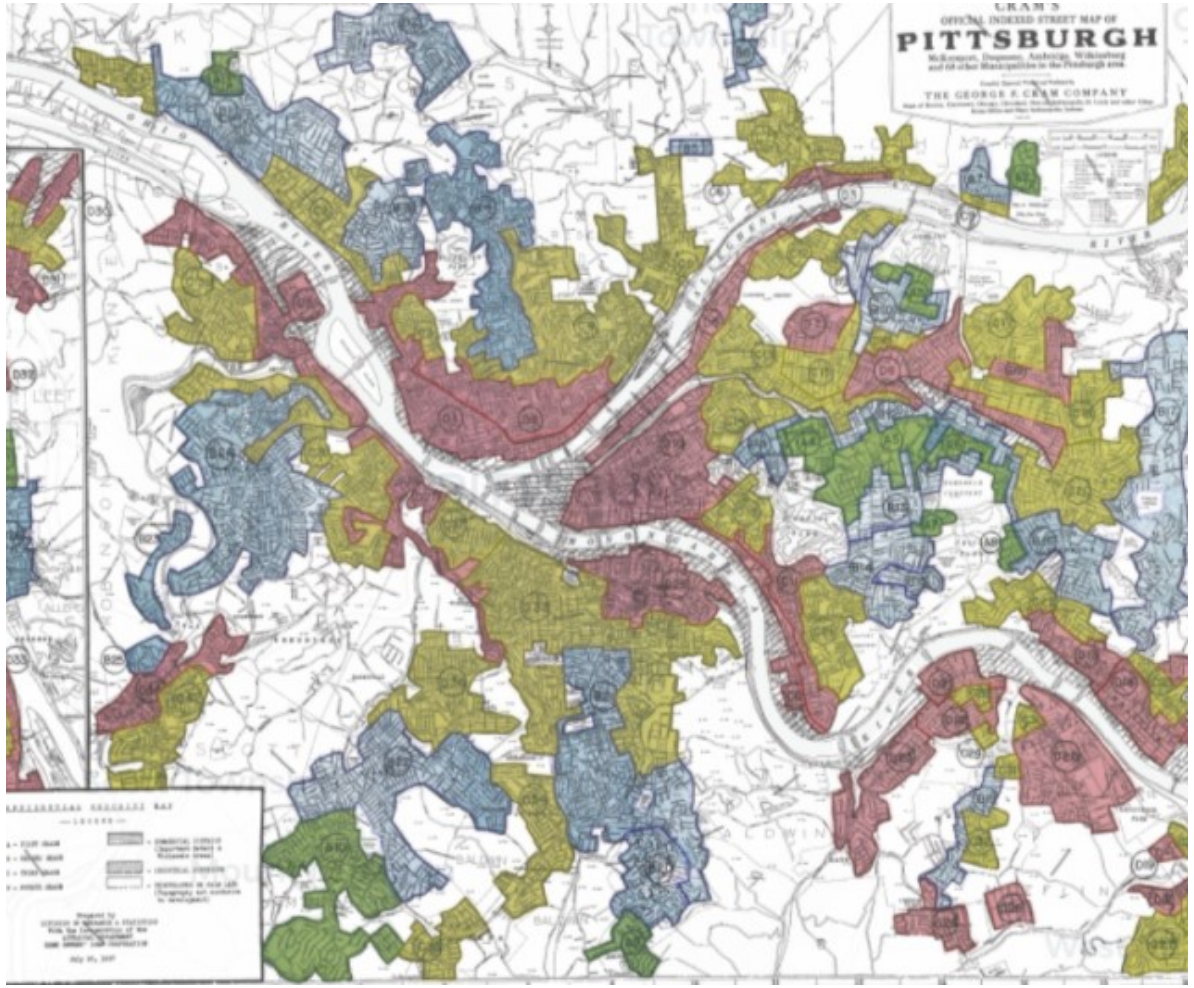
Young IM: Five Faces of Oppression. In Justice and the Politics of Difference. Princeton, Princeton University Press, 1990, pp 39-65

STRUCTURAL RACISM

A SYSTEM IN WHICH PUBLIC POLICIES, INSTITUTIONAL PRACTICES, CULTURAL REPRESENTATIONS, AND OTHER NORMS WORK IN VARIOUS, OFTEN REINFORCING WAYS TO PERPETUATE RACIAL GROUP INEQUITY.

https://www.aspeninstitute.org/blog-posts/structural-racism-definition/

THIS SYSTEM IDENTIFIES DIMENSIONS OF OUR HISTORY AND CULTURE THAT HAVE ALLOWED PRIVILEGES ASSOCIATED WITH "WHITENESS" AND DISADVANTAGES ASSOCIATED WITH "COLOR" TO ENDURE AND ADAPT OVER TIME



https://www.aspeninstitute.org/blog-posts/structural-racism-definition/

STRUCTURAL RACISM IS NOT SOMETHING THAT A FEW PEOPLE OR INSTITUTIONS CHOOSE TO PRACTICE. INSTEAD, IT HAS BEEN A FEATURE OF THE SOCIAL, ECONOMIC, AND POLITICAL SYSTEMS IN WHICH WE ALL EXIST

STRUCTURAL MECHANISMS DO NOT REQUIRE THE ACTIONS OR INTENTIONS OF OTHERS

https://www.aspeninstitute.org/blog-posts/structural-racism-definition/

EVEN IF INTERPERSONAL DISCRIMINATION WAS ELIMINATED TODAY,

RACIAL AND ETHNIC INEQUITIES WOULD REMAIN DUE TO PERSISTENCE OF STRUCTURAL RACISM

STRUCTURAL RACISM IN PSYCHIATRY

HOW STRUCTURAL RACISM IMPACTS HEALTH

"THE WAR ON DRUGS"

RESIDENTIAL SEGREGATION

IMMIGRATION POLICY

SOCIAL SECURITY ACT OF 1935

MENTAL HEALTHCARE

Gee, G., & Ford, C. (2011). Structural Racism and Health Inequities: Old Issues, New Directions. Du Bois Review: Social Science Research on Race, 8(1), 115-132.

PRIOR TO THE EARLY 1960S, PSYCHIATRISTS ASSESSMENTS OF SYMPTOMS OF MENTAL ILLNESS AT IONIA STATE HOSPITAL INCLUDED:

"WASN'T ABLE TO TAKE CARE OF HER FAMILY AS SHE SHOULD"

"CAN'T DO HER HOUSEWORK"

"TALKED TOO LOUDLY AND EMBARRASSED HER HUSBAND"

"PERHAPS [SHE] REBELLED AGAINST A PATRIARCHAL SYSTEM, AND A PATRIARCHAL DIAGNOSIS, THAT ALLOWED WHITE MALE DOCTORS AND HER WHITE MALE HUSBAND TO BE THE ARBITERS OF HER MENTAL HEALTH.... HOWEVER,THE MOST IMPORTANT ASPECT...IS THAT [HER] DEFIANCE WAS INTERPRETED AS A **SYMPTOM BUT NOT AS A THREAT.**"

Metzl JM: The Protest Psychosis: How Schizophrenia Became a Black Disease.Boston, MA, Beacon, 2010

"AT THE TIME, COMMON CONCEPTUALIZATIONS OF SCHIZOPHRENIA DID NOT INCLUDE SYMPTOMS OF PARANOIA, AGGRESSION, OR HOSTILITY. INSTEAD, SCHIZOPHRENIA WAS CONCEPTUALIZED AS A DISEASE RESULTING FROM EARLY-LIFE PSYCHOLOGICAL TRAUMA, OFTEN COMMITTED AT THE HANDS OF A SCHIZOPHRENOGENIC MOTHER."

Bolden K, How PC, Rao S, Anglin DM: Social Injustice and Schizophrenia, in Social (In)Justice and Mental Health. Shim RS and Vinson SY, Eds. APA Publishing, in press.

The "Protest" Psychosis

A Special Type of Reactive Psychosis

Walter Bromberg, MD, and Franck Simon, PhD, Brooklyn, NY

THE PURPOSE of this paper is to identify a specific type of reactive psychosis related in part to recent social-political events. It is well known that of the external stresses that trigger many psychotic reactions, the content of the clinical picture may be colored by or formed of political events of national or international import. Thus, delusional schizophrenics complained of Bolshevik persecution in the 1920's and interference by space figures in the 1960's. In the reactive psychosis particularly, a close relation exists between external stresses and the explicated clinical syndrome.

criminal trial, or following conviction and sentencing in a criminal trial. The particular symptomatology we have observed, for which the term "protest psychosis" is suggested, is influenced by social pressures (the Civil Rights Movement), dips into religious doctrine (the Black Musslim Group), is guided in content by African subcultural ideologies and is colored by a denial of Caucasian values and hostility thereto. This protest psychosis among prisoners is virtually a repudiation of "white civilization."

The cases to be presented characteristically arise among American Negroes who

TERM COINED TO DESCRIBE A REACTIVE PSYCHOSIS ARISING IN BLACK MALES AS A RESULT OF "THE STRESS OF ASSERTING CIVIL RIGHTS IN THE US."

BROMBERG AND SIMON (1968) LIKENED SYMPTOMS TO SCHIZOPHRENIA, PARANOID TYPE, BUT ALSO DESCRIBED HALLUCINATIONS OF AFRICAN THEMES, ADOPTION OF ISLAMIC DOCTRINE, AND PROMOTION OF ANTI-WHITE MINDSETS

Bolden K, How PC, Rao S, Anglin DM: Social Injustice and Schizophrenia, in Social (In)Justice and Mental Health. Shim RS and Vinson SY, Eds. APA Publishing, in press.

THE PROTEST PSYCHOSIS, BIOLOGICAL DETERMINISM, AND ERASURE OF CONTEXT

- RESEARCHERS CLAIMED THAT BLACK PSYCHIATRIC PATIENTS HAD HIGHER MEASURES OF HOSTILITY THAN WHITE PSYCHIATRIC PATIENTS, STEMMING FROM "DELUSIONAL BELIEFS THAT THEIR CIVIL RIGHTS WERE BEING COMPROMISED OR VIOLATED."

- LARGE-SCALE PATHOLOGIZING OF THE TENETS OF THE CIVIL RIGHTS MOVEMENT BY EQUATING THESE IDEAS WITH PARANOID DELUSIONS ALLOWED CERTAIN SECTORS OF SOCIETY A MECHANISM FOR REMOVING THREATS TO THE STATUS QUO IN THE NAME OF SAFETY AND MENTAL HEALTH

Bolden K, How PC, Rao S, Anglin DM: Social Injustice and Schizophrenia, in Social (In)Justice and Mental Health. Shim RS and Vinson SY, Eds. APA Publishing, in press.

PHARMACOEPIDEMIOLOGY AND DRUG SAFETY 2015; **24**: 1197–1206
Published online 1 July 2015 in Wiley Online Library (wileyonlinelibrary.com) **DOI**: 10.1002/pds.3819

ORIGINAL REPORT

Persistence of racial disparities in prescription of first-generation antipsychotics in the USA

Thomas B. Cook[1]*, Gloria M. Reeves[2], James Teufel[1] and Teodor T. Postolache[2,3,4]

[1] *Department of Public Health, Mercyhurst Institute of Public Health, Mercyhurst University, Erie, PA, USA*
[2] *Department of Psychiatry, University of Maryland School of Medicine, Baltimore, MD, USA*
[3] *Veterans Integrated Service Network (VISN) 5, Mental Illness Research Education and Clinical Center (MIRECC), Baltimore, MD, USA*
[4] *Rocky Mountain MIRECC, Denver, CO, USA*

ABSTRACT

Purpose The aim of this study was to estimate the prevalence of first-generation antipsychotics (FGA) prescribed for treatment of psychiatric and neurological conditions and use of benztropine to reduce extrapyramidal side effects (EPS) by patient race/ethnicity in a nationally representative sample of adult outpatient visits.

Methods The study sample included all outpatient visits ($N = 8154$) among patients aged 18–69 years where a prescription for one or more antipsychotics was recorded across 6 years of the National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey (2005–2010). Use of FGA was compared by race/ethnicity using multiple logistic regression models accounting for patient and clinical characteristics stratified by neighborhood poverty rate. Frequency of EPS was determined by use of benztropine to reduce or prevent EPS.

Results Black patients were significantly more likely than White patients to use FGA (odds ratio = 1.48, $p = 0.040$) accounting for psychiatric and neurological diagnoses, treatment setting, metabolic factors, neighborhood poverty, and payer source. Black patients were more than twice as likely as White patients to receive higher-potency FGA (haloperidol or fluphenazine), particularly in higher-poverty areas (odds ratio = 2.50, $p < 0.001$). Use of FGA, higher among Black than White patients, was positively associated with use of benztropine to reduce EPS.

Conclusions Racial disparities in the pharmacological treatment of severe mental disorders persist 30 years after the introduction of second-generation antipsychotics. The relatively high frequency of FGA of use among Black patients compared with White patients despite more Food and Drug Administration-approved indications and lower EPS risk for second-generation antipsychotics requires additional research.

KEY WORDS—antipsychotics; racial disparities; prescribing patterns; pharmacoepidemiology

Ethnicity and Diagnosis in Patients With Affective Disorders

Stephen M. Strakowski, M.D.;
Paul E. Keck, Jr., M.D.; Lesley M. Arnold, M.D.; Jacqueline Collins, M.D.;
Rodgers M. Wilson, M.D.; David E. Fleck, Ph.D.; Kimberly B. Corey, M.A.;
Jennifer Amicone, M.S.W.; and Victor R. Adebimpe, M.D.

Background: Clinically, African American psychiatric patients are disproportionately diagnosed with schizophrenia compared with white patients. Why this occurs is unknown. Extending prior work, the authors hypothesized that first-rank symptoms distract clinicians so that they fail to identify affective disorders in African Americans.

Method: 195 African American and white patients with at least 1 psychotic symptom (delusions, hallucinations, or prominent thought disorder) at admission were recruited from January 1, 1998, through May 31, 2001. Each patient received 3 independent DSM-IV diagnoses: a clinical diagnosis, a structured-interview diagnosis, and an expert-consensus diagnosis. The expert-consensus diagnoses were derived from the structured interviews, which were audio-

Received July 11, 2002; accepted Nov. 12, 2002. *From the Bipolar and Psychotic Disorders Research Program, Department of Psychiatry, University of Cincinnati College of Medicine, Cincinnati, Ohio (Drs. Strakowski, Keck, Arnold, Collins, Wilson, and Fleck and Mss. Corey and Amicone); and the Department of Psychiatry, Rush Medical College (Dr. Wilson) and Mercy Providence Hospital (Dr. Adebimpe), Pittsburgh, Pa.*

Supported by National Institute of Mental Health award MH56352.

Dr. Keck is a consultant for Abbott, AstraZeneca, Bristol-Myers Squibb, Eli Lilly, GlaxoSmithKline, Janssen, Ortho-McNeil, Pfizer, and Shire and has received grant/research support from AstraZeneca, Bristol-Myers Squibb, Eli Lilly, Ortho-McNeil, Merck, Pfizer, and UCB Pharma.

The authors thank Mary Fariello, who organized the data collection for this project, and Kelly Wilder-Willis, Ph.D., for help with some diagnostic assessments.

Corresponding author and reprints: Stephen M. Strakowski, M.D., Director, Bipolar and Psychotic Disorders Research Program, Department of Psychiatry, University of Cincinnati College of Medicine, Cincinnati, OH 45267-0559 (e-mail: strakosm@email.uc.edu).

In 1980s and 1990s, Black men were diagnosed with paranoid schizophrenia at a rate 5-7 times that of White men

A Naturalistic Study of Racial Disparities in Diagnoses at an Outpatient Behavioral Health Clinic

Michael A. Gara, Ph.D., Shula Minsky, Ed.D., Steven M Silverstein, Ph.D., Theresa Miskimen, M.D., Stephen M. Strakowski, M.D.

Objective: The authors examined electronic medical record (EMR) outpatient data to determine whether African Americans with schizophrenia or schizoaffective disorder were more likely than non-Latino whites to screen positive for major depression.

Methods: EMR data for 1,657 patients at Rutgers University Behavioral Health Care certified community outpatient clinics were deidentified and accrued for 9 months starting July 1, 2017. A Fisher's exact test was used to compare differences in the proportion of patients with positive screens for major depression (cutoff score of ≥15 on the nine-item Patient Health Questionnaire) among African-American and

($p<.003$) to screen positive for major depression. The between-group difference in positive screens was not significant among patients diagnosed as having schizoaffective disorder.

Conclusions: The results are consistent with findings from a large body of literature suggesting that racial differences in the diagnosis of schizophrenia in the United States result in part from clinicians underemphasizing the relevance of mood symptoms among African Americans compared with other racial-ethnic groups. If the results are replicated, a case could be made that routine screen-

TODAY…BLACK PATIENTS ARE MORE LIKELY THAN WHITE PATIENTS TO BE:

- HOSPITALIZED INVOLUNTARILY
- ADMINISTERED HIGHER DOSES OF ANTIPSYCHOTICS
- ADMINISTERED MEDICATIONS AGAINST THEIR WILL
- SECLUDED AND RESTRAINED

Bolden K, How PC, Rao S, Anglin DM: Social Injustice and Schizophrenia, in Social (In)Justice and Mental Health. Shim RS and Vinson SY, Eds. APA Publishing, in press.

IN 2018:

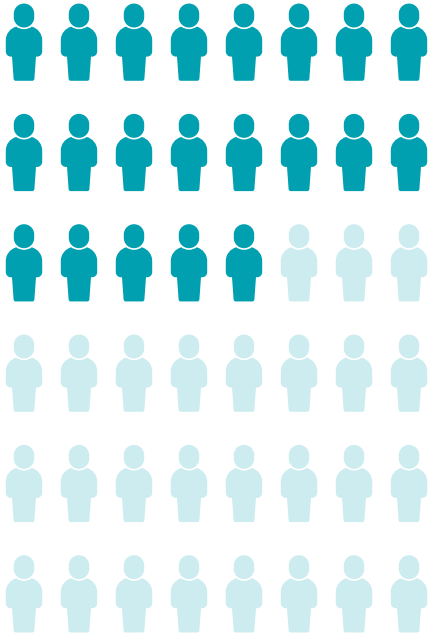
69%

OF BLACK ADULTS WITH ANY MENTAL ILLNESS RECEIVED NO TREATMENT

67%

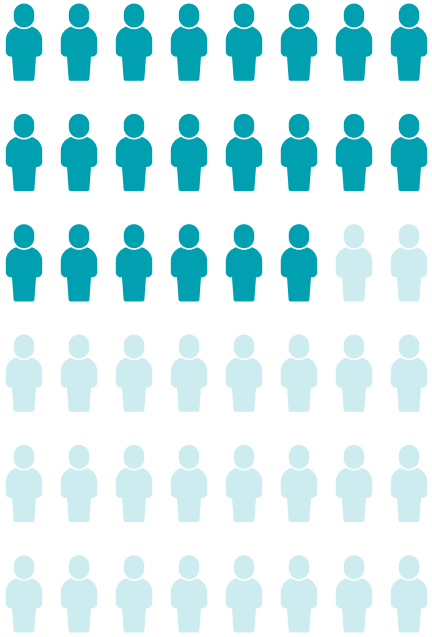
OF LATINX ADULTS WITH ANY MENTAL ILLNESS RECEIVED NO TREATMENT

42%



OF BLACK ADULTS WITH SERIOUS MENTAL ILLNESS RECEIVED NO TREATMENT

44%



OF LATINX ADULTS WITH SERIOUS MENTAL ILLNESS RECEIVED NO TREATMENT

89%

of Latinx adults with substance use disorders reported receiving no treatment

88%

of Black adults with substance use disorders reported receiving no treatment

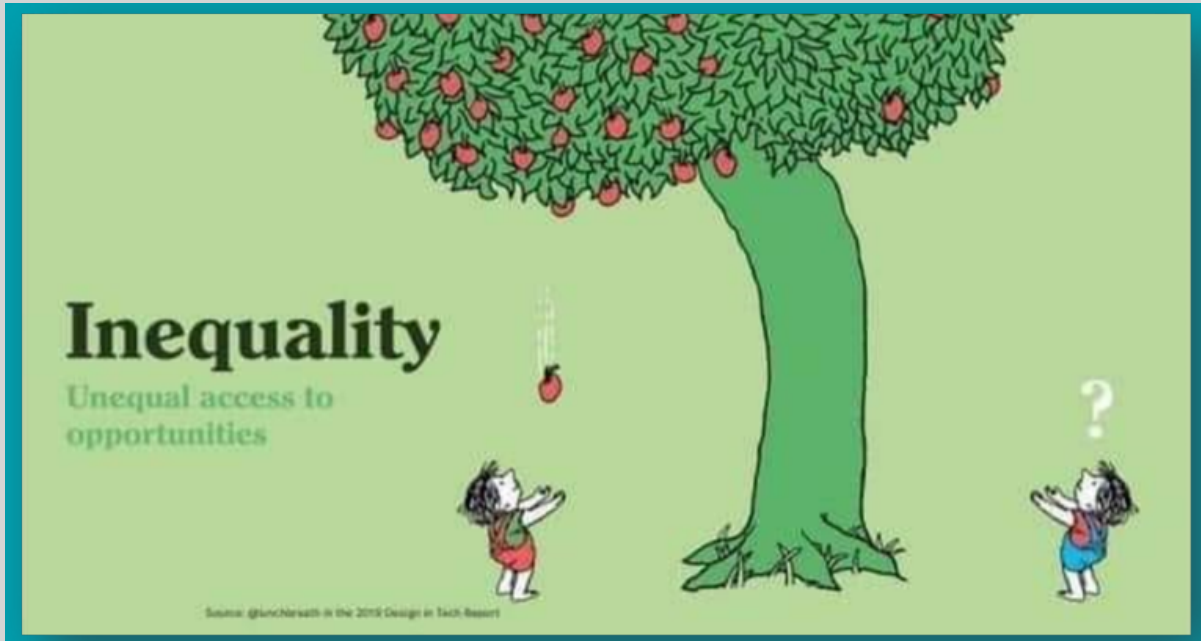
Substance Abuse and Mental health services administration: Key Substance Use and Mental Health indicators in the United States: Results from the 2018 National Survey on Drug USe and Health. Rockville, SAMHSA, 2019

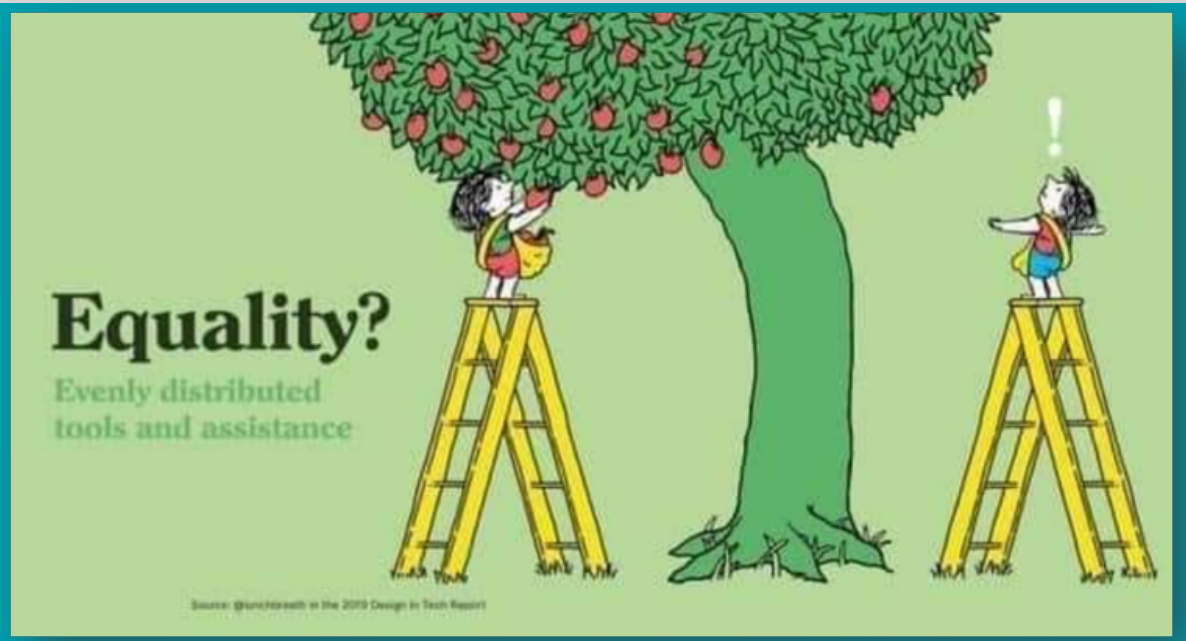
COST IS THE MOST COMMONLY CITED REASON FOR NOT SEEKING CARE

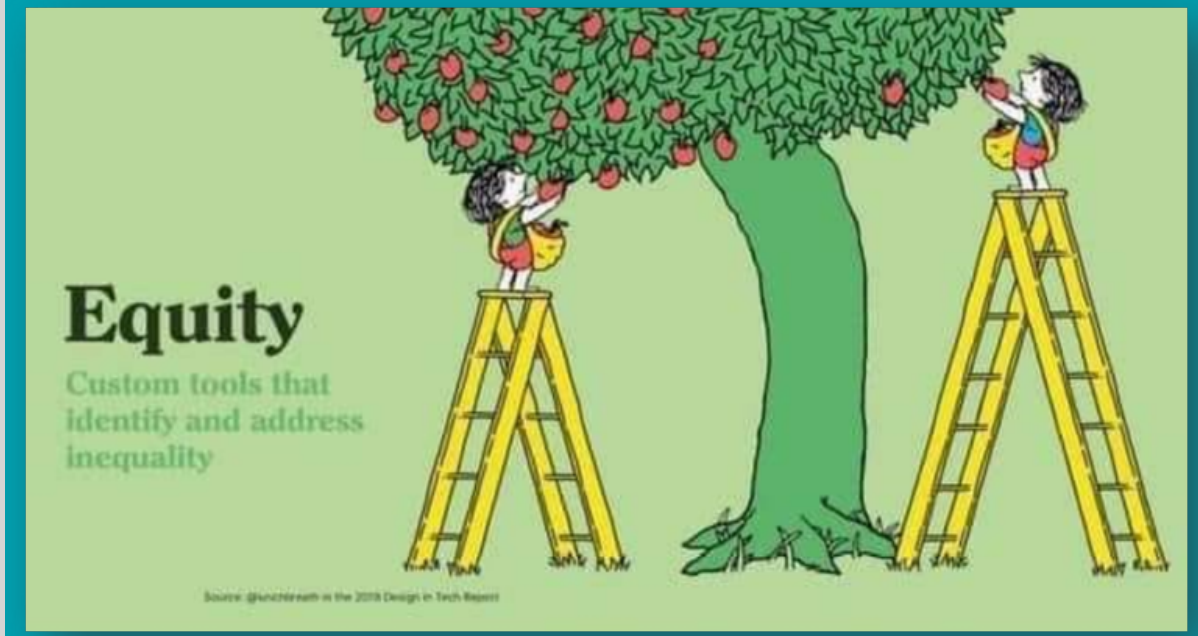
TWICE AS OFTEN AS **MINIMIZATION OF SYMPTOMS** AND **NEARLY FIVE TIMES** AS OFTEN AS **STIGMA**

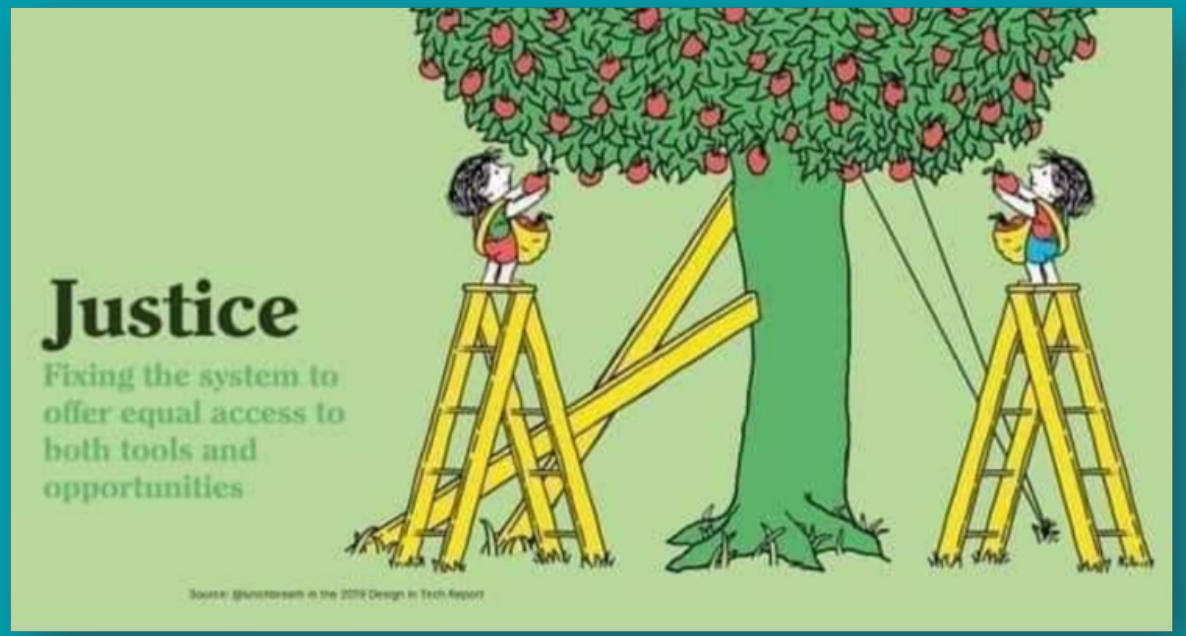
Alang SM: Mental health care among blacks in America: Confronting racism and constructing solutions. Health Serv Res 54:346-355, 2019

WHERE DO WE NEED TO GO?


Inequality
Unequal access to opportunities
?

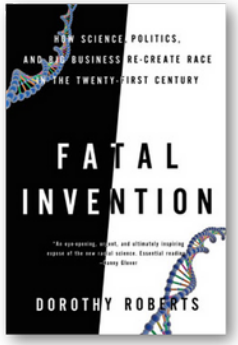

Equality?
Evenly distributed tools and assistance
!

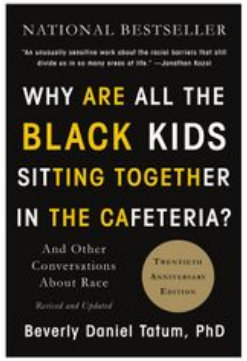

Equity
Custom tools that identify and address inequality

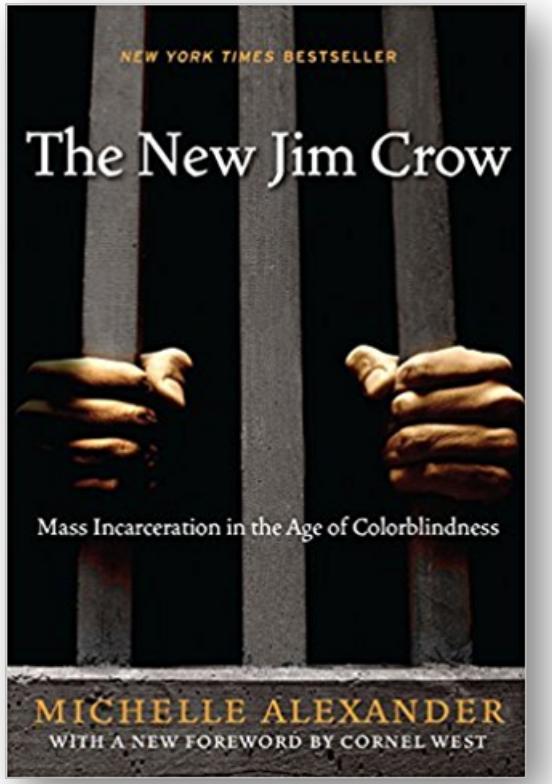

Justice
Fixing the system to offer equal access to both tools and opportunities

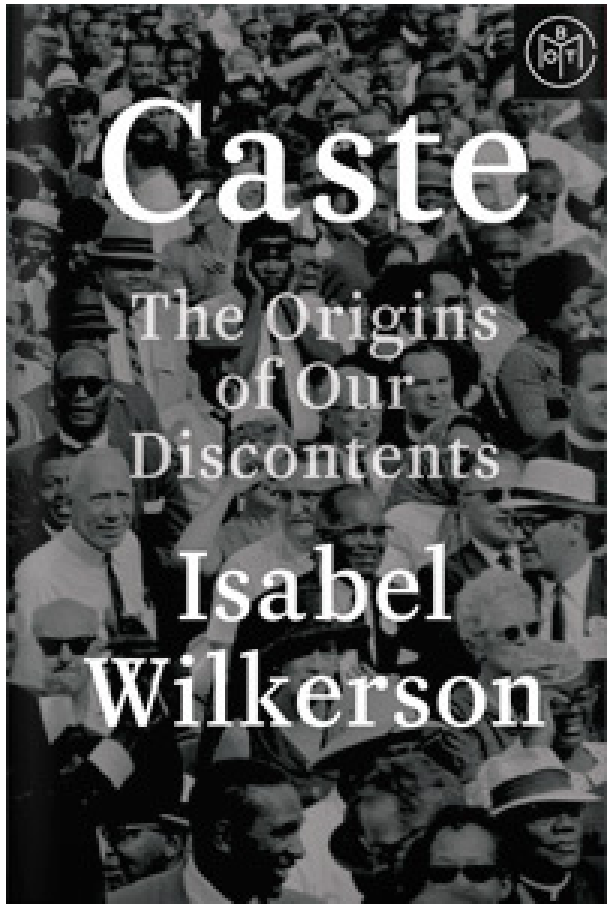
DISMANTLING STRUCTURAL RACISM AND SOCIAL INJUSTICE IN MENTAL HEALTH

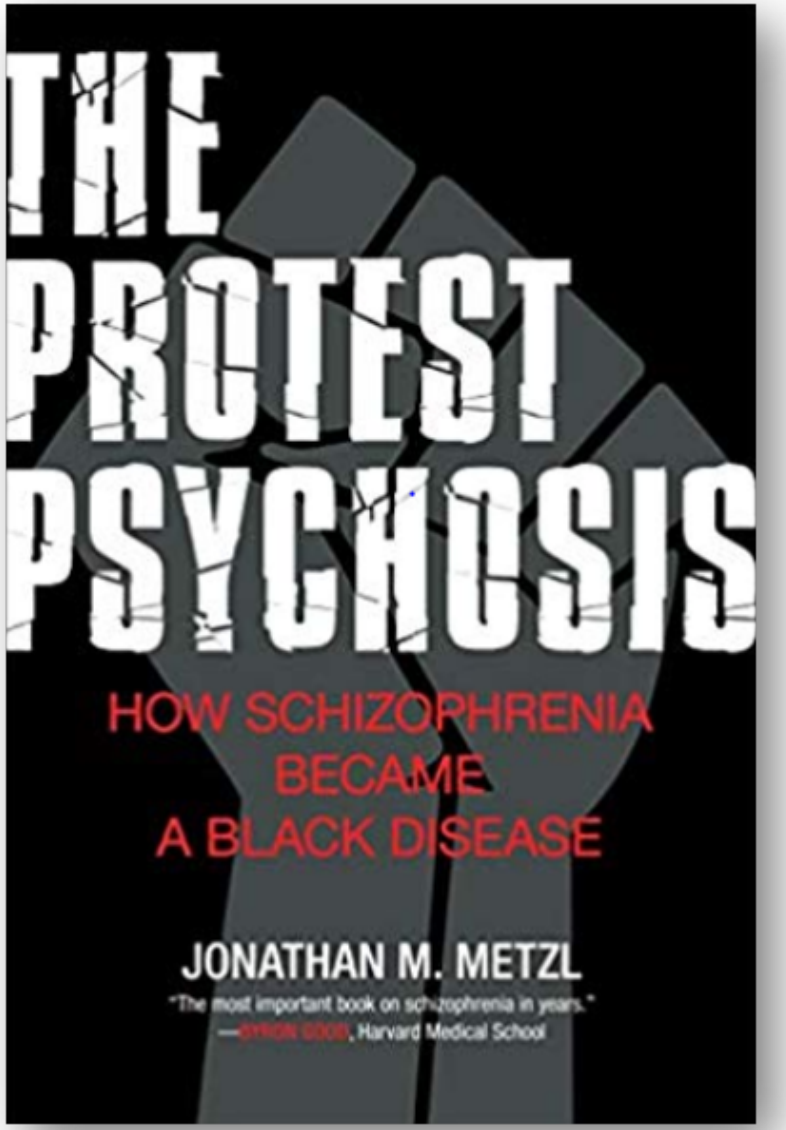
EDUCATION AND SELF-REFLECTION


FATAL
INVENTION
DOROTHY ROBERTS

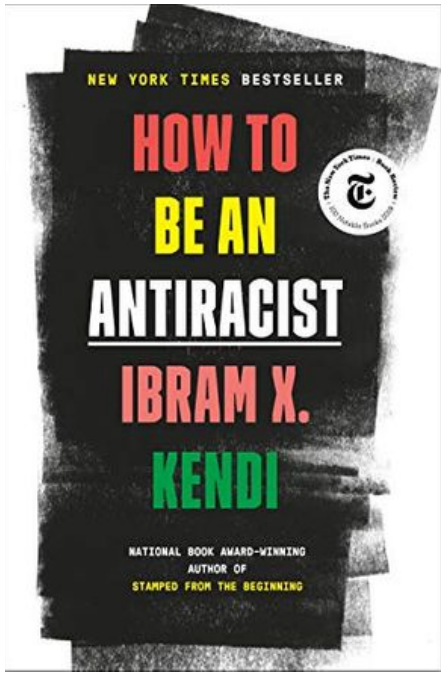

NATIONAL BESTSELLER
WHY ARE ALL THE BLACK KIDS SITTING TOGETHER IN THE CAFETERIA?
And Other Conversations About Race
Beverly Daniel Tatum, PhD

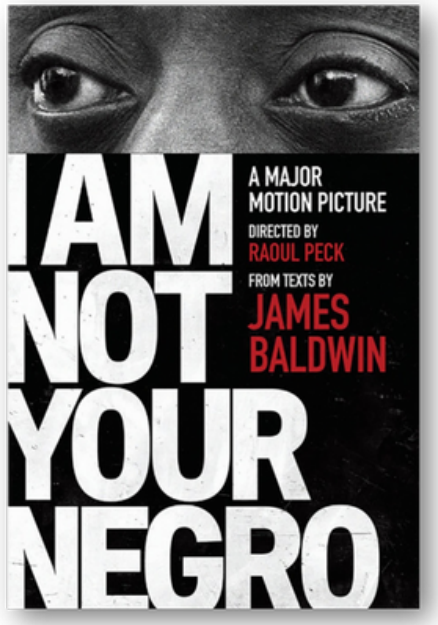

NEW YORK TIMES BESTSELLER
The New Jim Crow
Mass Incarceration in the Age of Colorblindness
MICHELLE ALEXANDER
WITH A NEW FOREWORD BY CORNEL WEST


Caste
The Origins of Our Discontents
Isabel Wilkerson

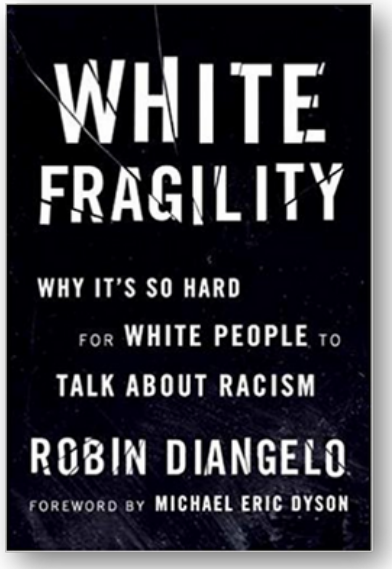

THE PROTEST PSYCHOSIS
HOW SCHIZOPHRENIA BECAME A BLACK DISEASE
JONATHAN M. METZL
"The most important book on schizophrenia in years."
Harvard Medical School

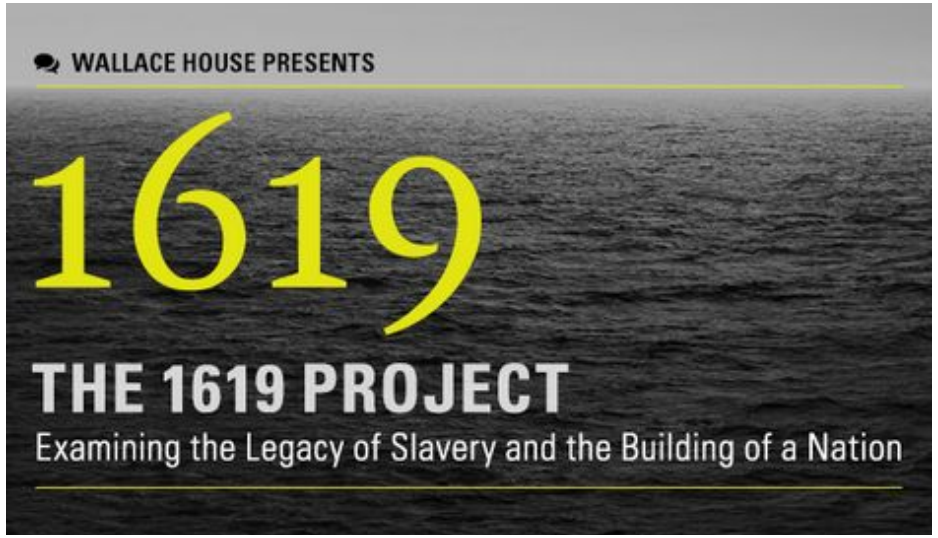

SCENE ON RADIO
Seeing White
A 14-part documentary series exploring whiteness in America—where it came from, what it means, and how it works.


NEW YORK TIMES BESTSELLER
HOW TO BE AN ANTIRACIST
IBRAM X. KENDI
NATIONAL BOOK AWARD-WINNING AUTHOR OF
STAMPED FROM THE BEGINNING


I AM NOT YOUR NEGRO
A MAJOR MOTION PICTURE
DIRECTED BY
RAOUL PECK
FROM TEXTS BY
JAMES BALDWIN


npr
CODE SWITCH


WHITE FRAGILITY
WHY IT'S SO HARD FOR WHITE PEOPLE TO TALK ABOUT RACISM
ROBIN DIANGELO
FOREWORD BY MICHAEL ERIC DYSON


WALLACE HOUSE PRESENTS
1619
THE 1619 PROJECT
Examining the Legacy of Slavery and the Building of a Nation

PRACTICING CULTURAL HUMILITY

- COMMIT TO A LIFELONG PROCESS OF SELF-EVALUATION AND SELF-CRITIQUE
- DESIRE TO FIX POWER IMBALANCES BETWEEN PROVIDERS AND CLIENTS
- DEVELOP COMMUNITY PARTNERSHIPS TO ADVOCATE WITHIN THE LARGER ORGANIZATIONS IN WHICH WE PARTICIPATE

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Undeserved, 9, 117-125.


PUBLIC POLICIES


SOCIAL NORMS

PROMOTE SOCIAL NORMS OF INCLUSION, EQUITY, AND RESPECT

“WE CAN DISAGREE AND STILL LOVE EACH OTHER, UNLESS YOUR DISAGREEMENT IS ROOTED IN MY OPPRESSION AND DENIAL OF MY HUMANITY AND RIGHT TO EXIST.”

-James Baldwin

PROMOTING SOCIAL NORMS OF INCLUSION, EQUITY, AND RESPECT

1. ENFORCE SOCIAL NORMS OF INCLUSION AND EQUITY
2. EDUCATE OR LEGISLATE TO CHANGE SOCIAL NORMS
3. OBSERVE AND CHALLENGE YOUR IMPLICIT BIASES
4. EVALUATE AND BREAK DOWN UNNECESSARY HIERARCHIES

ADVOCATE FOR RACIALLY EQUITABLE PUBLIC POLICIES

"MEDICINE IS A SOCIAL SCIENCE, AND POLITICS IS NOTHING ELSE BUT MEDICINE ON A LARGE SCALE."
-RUDOLPH VIRCHOW

“ALL POLICIES ARE HEALTH POLICIES”

1. TAKE ACTION BEYOND THE WALLS OF CLINICS, HOSPITALS, AND TREATMENT CENTERS
2. ADVOCATE FOR POLICIES THAT ADDRESS SOCIAL DETERMINANTS OF MENTAL HEALTH
3. COMMUNICATE WITH ELECTED OFFICIALS AND PROMOTE EQUITABLE REPRESENTATION
4. FORM CROSS-SECTOR COLLABORATIONS AND COMMUNITY COALITIONS

“IF YOU SEE SOMETHING THAT IS NOT RIGHT, NOT FAIR, NOT JUST, YOU HAVE A MORAL OBLIGATION TO DO SOMETHING ABOUT IT.”