



NAMI Ask the Expert: **Promoting Mental Health Equity in Black Churches** *Featuring: Dr. Sidney Hankerson*

Sherman Gillums, Jr – Chief Strategy & Operations Officer (00:00:00):

Thank you, Dr. Brister. Good evenings to all of you who joined us for this timely discussion on the intersection of faith and mental health in black and African American communities. On behalf of our Board President, Shirley Holloway, and our Chief Executive Officer, Dan Gilson, as well as all the staff of volunteers who help NAMI meet its mission, welcome.

The state of our society today and the collective challenges we face have forced many of us to examine a critical decision points in our lives, such as how we cope and how we hope. For members of the African descendant community in America, hope is often linked to a belief in a higher power, a tradition that dates back to a time when there were no healthcare practitioners around to help them cope with lives permeated by suffering at the hands of an oppressive race-based social order. That pain still resides with the DNA of many who are taught that salvation is not the science, offered the pathway to healing, whether it involves a broken bubble or a broken spirit.

But as we're finding out it's not an either or proposition that communities of color must now overcome a legacy of mistrust in institutions in order to get the help the many need and deserve, particularly as it relates to some of the most stigmatized mental health conditions seen across society. We'll talk about this during today's Ask the Expert session as we focus on promoting mental health equity in black churches. I will now turn it over to my esteemed colleague, NAMI's Chief Medical Officer, Dr. Ken Duckworth, to introduce our amazing guest expert to get us started on this important discussion. Ken, over to you, my friend.

Ken Duckworth, Chief Medical Officer (00:01:40):

Thank you so much, Sherman. We're very blessed to have a remarkable speaker today. Dr. Sidney Hankerson, is an MD, MBA. He earned both of those degrees at Emory University. He is now at Columbia and it's the first guest on Ask the Expert to have spoken at both the White House and the United Nations. This work on addressing racial disparities in mental health care is incredibly timely, as Sherman mentioned, and important.

Dr. Hankerson trained in Emory, was the Chief Resident at Grady Hospital and still practices at a federally-qualified health center in Harlem. Dr. Hankerson, it's a great pleasure to welcome you, and I want to thank you for everything you do and for giving your time to the NAMI community today.

Sidney Hankerson (00:02:34):

Thank you so much, Ken, for that tremendously warm introduction and I'd also like to thank Dr. Teri Brister for the invitation to be here and thank all of NAMI. It's truly an honor to be here in honor of Bebe Moore Campbell BIPOC Mental Health Awareness Month. During our time together today in honor of BIPOC Mental Health Awareness Month, the focus of my talk is about promoting mental health equity with a specific focus on partnering with black churches to promote mental health equity.



Sidney Hankerson (00:03:19):

The next slide. I'd first like us to just do an exercise. It's the end of the day, we're all probably tired, we're all Zoomed and Webexed out. And so I just wanted to take a few seconds, 30 seconds to be exact just to center everyone for our time together today. I'm going to set my iPhone for 30 seconds and over the next 30 seconds I'd like you to think about what has this last year meant for you? What feelings have you had? What have you experienced? How have those feelings changed from the beginning of 2020 until now? So I'm going to set my timer and begin.

Sidney Hankerson (00:04:32):

(silence).

Sidney Hankerson (00:04:32):

Okay. If everyone would take a deep breath and come back. Thank you for participating in that exercise. Certainly a lot has happened. Probably the most impactful thing that happened to me over the last year was that my second daughter was born. She was born on April 24th, 2020, and it has been a joy of my life and also because of a lot of sleep deprivation, so that is certainly one of the things that I thought about over the last year. But certainly as we're thinking about promoting mental health equity and Minority Mental Health Awareness Month, certainly two things come to mind.

Next slide. First of course is the COVID-19 pandemic. And we know certainly by now that as the country is opening up and we've been through the worst hopefully of the pandemic although there are various variants that are certainly causing hotspots throughout the country. We know that African Americans were nearly four times more likely to die from COVID-19 compared to Caucasian Americans. And so this pandemic has highlighted just tremendous cracks and gaps in access to healthcare as well as mental health care so that's certainly one of the huge things that's happened over the last 18 months.

Next slide. And then of course the murder of George Floyd, which we recently just had the anniversary for. And we talked a lot about... There was a lot of discussions about community trauma and the impact of police violence on the black community. And I'll be the first to say that I have family members in law enforcement and so I certainly honor and respect and am grateful for the role that our law enforcement officers provide. At the same time, I have to acknowledge the scientific evidence which shows that African Americans exposed to police killings have worse mental health outcomes, more depression, more anxiety, more stress, more symptoms consistent with post-traumatic stress disorder than when our Caucasian Americans are exposed to a white person being killed by the police.

So certainly COVID and George was murdered and that result that increased awareness around racial injustice in this country have caused so many feelings. And the feelings that I progress to over the last year... Next slide. Went from feelings of despair, feelings of despair. I live in New York city and being the epicenter of the COVID-19 pandemic Manhattan was hit so hard by the virus. I live very close to New York Presbyterian Hospital and it was literally like a war zone. In March and April literally every five minutes we heard an ambulance leaving and going to the emergency room.,So I just had tremendous feelings of despair.



Sidney Hankerson (00:08:02):

And then that despair transmitted to a rage, the anger and frustration with continued injustices in this country. And then now I feel hopeful. I feel hopeful that we are moving towards a more perfect union, that as people are getting vaccinated, as policies are changing, that there is hope for a better tomorrow. The next slide. I love this picture because I think this is what we're all after. We're all after multiple generations of our families being healthy and happy. We're after a world free of stigma around mental illness, we're after a world where people who need support for depression, anxiety, psychotic disorders, and drug use can get those services and quality services in a timely fashion. And so I'm so delighted that NAMI has been such a central and a central player in promoting mental health increase in awareness and providing supports for families and communities as we are trying to continue this march towards hope.

Next slide. I've broken our talk today together down into three main sections. First, I'm going to talk about racial disparities in depression care, and some of the factors that contribute to African Americans having lower rates of depression treatment compared to other groups. And then why I've decided to partner with faith-based organizations as a way to try to promote mental health, promote mental health equity, and increase access to care, and then go over this notion of community-partnered service delivery, which I feel can be disseminated throughout the country.

Next slide. My clinical and research focus is depression and several years ago a really landmark study by the World Health Organization showed that major depression is the number one cause of disability in the world. So more people are suffering, are impaired, are not able to work and function and live their best lives from depression than any other medical condition.

Next slide. The relationship between race and depression is actually a complex one. This is data from a large study that surveyed people across the United States, and they asked people over the course of your life as well as over the last 12 months, if they had symptoms of major depression. And you can see that African Americans had lower rates of lifetime depression compared to non-Hispanic white Americans, as well as slightly lower rates of depression within the last year.

Next slide. But the prevalence or how common depression is, is only half of the picture. African Americans with depression are actually more severely impaired or are sicker compared to non-Hispanic white Americans in virtually every category that is assessed. This is another survey that was conducted across the United States which looked at depressed African Americans and depressed Caucasian Americans, and African Americans with depression were more impaired as it related to their ability to work, in terms of their relationships, and social functioning as well as in overall impairment.

Next slide. In some, depressed African Americans have more severe symptoms and are sicker for a longer period of time. So you would think that because of how impairing depression is in the black community that African Americans would have tremendously high rates of seeking mental health services and there would never be an open slot in my schedule because people would be so eager to get mental health care. Next slide. We know that's not the case. In fact, African Americans and Mexican Americans have the lowest rates of depression treatment in the United States. And so you may be wondering what contributes to these low rates of depression treatment especially in light of how impairing depression is in the black community. Well, I'm so glad you asked.



Sidney Hankerson ([00:12:44](#)):

Next slide. Well, there's certain factors, many factors that contribute to these low rates of depression treatment but I'd just like to highlight two. First, we as healthcare providers and physicians and many on this call may have experience with misdiagnosis by physicians or other mental health professionals. I show this slide to illustrate the fact that... It's an advertisement from a medical journal where you see the tagline assaultive and belligerent, and then an Afrocentric man who to me looks just like James Brown, and then cooperation begins with Haldol. Again, this was in a medical journal from the 1970s.

And I show this slide to illustrate the fact that African American and Latino men with psychotic symptoms, so people who hear voices, who may have paranoia, are more likely misdiagnosed with schizophrenia compared to white men who have the same psychotic symptoms who are more likely diagnosed with depression, with psychotic features or bipolar disorder. So there's a tremendous amount of distrust with healthcare professionals and mental health professionals in particular that contribute to low rates of mental health treatment in the African American community.

Next slide. And certainly as we've witnessed over the last year, structural racism is a huge contributor to disparities of care. This is probably the most well-known framework that outlines three levels of racism, institutionalized or structural racism, which are policies that are enacted to prevent people to have access to goods or services based on their race. And a lot of talk has been about what is structural racism over the last year? And so I'll share a personal example of what structural racism looks like.

My mother grew up in a town in South Carolina called Aiken, South Carolina. When she was born, black adults were banned from delivering babies in hospitals. As a result black women had very low rates of being able to get access to prenatal care. So my grandmother, my mother's mother, actually gave birth to my mother in a house. And my mother was very fortunate to make it out of infancy because my grandmother had seven children where three of her children died within the first three months, in large part because she didn't have access to good prenatal services and she was not permitted to deliver her children in a hospital. That is an example of institutionalized or structural racism, policies enacted to prevent access to good, or in many cases, health services because of race. Individual racism is what people probably think about when we hear people talk about racism as discrimination or prejudice because of someone's affiliation with a particular racial or ethnic background. And then internalized racism is probably the most insidious aspect of racism. That's where people of a racialized group who are subject to these policies have self-doubt, have low self-esteem, and have low self-worth because they are on the receiving end of these structures and these policies. These structures, the institutionalized, individual, and internalized aspects certainly contributed to disparities in care.

Next slide. That's a very big picture overview of some of the challenges and barriers that contributes to low rates of mental health seeking in the African American community. And next I'll talk about one of the solutions to try to provide increased supports and access to care. Next slide. There was a really landmark study that came out almost 20 years ago that asked people across the United States, when you're first experiencing symptoms of depression or anxiety, when you're first struggling with substance use, where do you go get help? And throughout the United States, regardless of a person's racial or ethnic background, regardless of where in the country they live, people said they first were most likely to go get help for mental health professionals who include psychologists and social workers for the sake of this study.



Sidney Hankerson (00:17:46):

But next, the group most secondly sought after for help when people first experience mental health problems are clergy. So our faith leaders, our pastors, our rabbis, our monks, are really frontline mental health professionals and are sources for people to seek help when experiencing a mental health problem more frequently initially than they are to seek help from their primary care doctor or from psychiatrists, so clergy are truly frontline mental health professionals.

Next slide. And the role of faith-based organizations in the African American community is especially significant. Sherman mentioned in his introduction often in the black community people talked about the notion of salvation not science and getting healing. By all accounts, African Americans are most religious group in the country. 87% of African Americans belong to a religious group, 79% say that religion is important, and 53% attend church at least once per month.

Next slide. At the same time although churches are places where clergy are frequently sought after by people experiencing mental health problems and given the high rates of religious importance in the African American community, I had to acknowledge the fact that many faith traditions have been tremendously harmful towards people with mental health conditions. And many of the reasons for that is because in some faith traditions, people with mental health conditions are told that they have those problems because of either personal sin or because of lack of faith. Well, you may be depressed because you're not praying enough or your faith isn't strong enough.

In addition, we have to acknowledge that many faith traditions have been especially harmful towards people who identify as LGBTQ. And so as I try to think about strategies to increase access and supports for African Americans with mental health conditions, we thought that churches could be a viable place to support people because it's where they naturally go and it's accessible and the trusted role of the church, but at the same time we had to acknowledge and account for how faith traditions have been harmful towards people with mental health conditions.

Next slide. One of the first things that I did was to try to see if it was possible to engage houses of worship to promote mental health. I conducted focus groups with pastors at a large church in New York City. 21 pastors participated, most were women, a very highly-educated group, nearly 90% had a master's degree or a doctorate. This is a huge church, so over 20,000 members so by no means a typical church, but this is where we did this particular study.

Next slide. And I want to share with you a few of the findings that the pastors shared with us that really have shaped how we have engaged communities and houses of worship. One of the key things that the pastors talked about was how racism impacted mental health in the black community. This pastor said, "The effects of slavery, white supremacy, institutionalized racism, and all the things that we talk about in the black community can cause depression." In this highly-educated group of pastors, they acknowledged that depression and other mental health conditions certainly have a biological component, but they also made it clear that in their minds depression and mental health conditions are a social component and it was important to acknowledge that as well.



Sidney Hankerson (00:21:36):

Next slide. Another important finding was that there was this notion of stigma and that therapy and counseling and psychiatric care was just not something that African Americans did, that counseling is just not for us, so addressing that with something that we needed to do. Next slide. And then probably the most important thing, and I think NAMI has done such an amazing job at this, is forming strategic partnerships, forming partnerships with people and organizations where they are and where they naturally get care. One of the pastors said, "Dr. Hankerson, we like you. You seem like a nice enough guy, but you're not just going to drop in here and do some study and then fly out of here. Well, you have to partner with us. You have to partner with us and form a committed partnership for there to be any chance of working with churches long-term." So this notion of partnerships was extremely important.

Next slide. In light of the focus groups that we conducted with the pastors the next thing that we did was to try to identify, would it be possible to identify people in churches who may be are suffering from depression? So we conducted the first ever church-based study in which we screened people for depression. Next slide. And the screening measure that we used is called the Patient Health Questionnaire-9, many of you probably have seen this when you go to see your primary care doctor or if you're getting therapy or counseling. It's a commonly used brief nine-item questionnaire that asks people, over the last two weeks how often have these nine symptoms of depression been bothering you?

Next slide. And so this describes a little bit of the people who we were able to screen. We conducted these screenings, we passed out this survey at three different churches in different parts of New York City, and in total we were able to screen 122 people. Nearly 50% of those we screened were men and the average age was 54 years old. Next slide. And I show this slide just to show that there was a very wide range of incomes truly emphasizing the fact that churches are really centers for the entire community. Next slide. Similarly, in terms of educational levels, 48% of the people that we screened had graduated high school and 47% had some college or technical school, and nearly 90% of those we screened had any type of health insurance.

Next slide. And so just to give some context of our overall results and the potential impact of partnering with churches to promote mental health equity, when we screen the general United States population with that nine-item survey, with the Patient health Questionnaire-9, roughly six to 8% of people will be clinically-depressed, so less than 10% of the general U.S. population, if we go out today and screen them with those nine items would be actively depressed. In our sample of 122 people, in total 20%, so nearly three times the amount that you would see in the general population were actively depressed in these three churches.

Another important finding was that in this sample a higher percentage of men were depressed than women. And this showed the possibility of engaging men in mental health care who traditionally have tremendously low rates of seeking mental health care. That was really the important finding of this study. It showed that we were able to work with pastors to identify and show a high need of services in these three different faith-based settings.



Sidney Hankerson ([00:25:57](#)):

Next slide. That covers the first two sections of our time together. We've talked about some of the factors that contribute to racial disparities and depression and mental health care. We talked about the focus groups with the pastors that we did and the high rates of depression indicating the high amount of unmet mental health needs. And then lastly we'll talk about strategies to partner with organizations and partner with communities to increase access for people, especially those people in under-resourced communities.

Next slide. The core principles of this notion of partnering with communities to provide mental health services really focuses on four things. One is community partnered participation. That's where I as a physician working at a medical school am on equal playing field with every person from our local community. We don't bring our IDs, we don't bring our backgrounds, we just bring ourselves, so this notion of truly forming equitable partnerships.

And then the notion of implementation science, that's just a fancy way of saying, "How do we get high-quality programs and treatments and supports from clinics or from medical settings into community settings?" And that's what the notion of task shifting is, how do we train peers? There's a huge peer movement, so how do we train peers to be able to support people and provide evidence-based supports? And our ultimate goal is really to build capacity and lift up the strengths of the local community.

Next slide. And so this is just a schematic of what community partnered participatory research does. When I worked in partnership with folks from our local community, when we embrace the four key themes of community engagement, of empowerment, of planning, of equality, of respect for diversity, we know that participation and engagement goes up. That trust goes up, the capacity, the community's ability to solve problems and be resourceful goes up and that disparities go down. And so this particular method of partnering with academic health centers and leveraging the trust of the local community and really letting the community drive and inform what services are needed and how to get those services into trust settings is really the essence of at least one strategy that's been demonstrated to decrease disparities and promote mental health equity.

Next slide. In the spirit of community partnerships we created a community coalition for mental health. And this is a group of people with lived experience with mental health conditions. We have people on our coalition with a history of heroin use, we have people with a history of depression, we have people with a history of PTSD, we have people with a history of schizophrenia, all working together on this coalition in partnership with clinicians, in partnership with pastors, in partnership with people from our local health department.

And this group, this community coalition that we've formed over the last six years that we've been in existence put our heads together and came up with three goals that we wanted to tackle. One is to promote mental health equity, two, was to reduce depression stigma, but stigma generally around mental health conditions and, three, was to really build and increase partnerships between community-based organizations and academic medical centers.



Sidney Hankerson (00:30:15):

Next slide. And so probably the crowning jewel, one of the things that we're most proud of as a coalition is that one of the churches that we work closely with several years ago opened up a free-standing mental health clinic. This is a picture from the ribbon-cutting ceremony where the First Lady of New York City, Chirlane McCray came out to cut the ribbon to the opening of this clinic. First Corinthian Baptist Church in Harlem opened this clinic and we have worked very closely with them to provide free psychotherapy, free wellness retreats, free mindfulness, and meditation, and yoga and all things that folks in our community say they want. And so we're so excited about the opportunity and the thought of being able to replicate this in other cities across the country.

Next slide. And so another thing that we've tried to do is really leverage the strength and the knowledge and the expertise of peers, of people with lived experience with mental health conditions, with chronic health conditions, to really be our boots on the ground in supporting people through their emotional challenges. And so we created an institute for training outreach and community health that has recruited through a network of churches in New York City, recruited and trained people from churches to become certified community health workers.

Next slide. These community health workers, again, many of whom are our peers and have lived experience with mental health problems, most commonly depression and post-traumatic stress disorder, are really trusted members of their church in their local community that we have trained them how to screen people for blood pressure because we know there is definitely an association between stress-elevated blood pressure and depression, especially in the African American community. They're taught skills and motivational interviewing. They help people struggling with health conditions and with mental health problems to navigate through the complex healthcare system.

And they're registered with the New York State Office of Mental Health to enroll uninsured New Yorkers into health insurance. And many of these, just again emphasizing the importance in the peer-based network of this, many of these community health workers did not have prior health care experience but their experience is their lived experience and their connection to the community.

Next slide. Just a little description of who these community health workers are, all of them identify as black or African American. The overwhelming majority are women and the average age is 61, and as you can see a very, very wide range of educational backgrounds, which we think is invaluable in being able to connect with people from our target community. Next slide. This is just a picture of two of our community health workers at our wellness center learning how to take blood pressure.

Next slide. And so all of this, all of this work, all of the work with our pastors in terms of doing the focus groups and then doing and identifying people with high unmet mental health needs, and then creating the community coalition, and then creating this peer-based community health worker training program, when we took a step back and looked at how we actually did all of this we came up with this model of community engagement called FAITH. And it's something that I hope that everyone on the call, these five principles can take with you back to your local communities to continue to expand upon the work that I'm sure you're already doing and expand your networks.

And so the five steps of our model of community engagement are first forming a strong partnership, I think that's the most important part. Again, going back to what the pastor said, "You have to partner with us." So partnership looks like going to church dinners. I've gained a lot of weight spending time in the community and meeting people. But again, spending time is the essence of partnership, so forming a strong and committed partnership.



Sidney Hankerson (00:35:03):

And then the A stands for assessing the community's needs. Maybe you live in a community that's been rocked by the opioid overdose epidemic, or maybe you live in the community that's impacted heavily by eating disorders. Maybe you are surrounded by people who struggle with schizophrenia or other psychotic disorders. Whatever the case may be we think it's important to assess truly what the community's mental health needs are, whether are its strengths as well as what are its weaknesses and how capacity can be built. And then the I stands for identifying leaders who will support the program. In the churches of course it means you have to have a strong relationship with the pastor, but maybe in your community someone else is a leader that people need to partner with and identify with.

And then the T stands for taking time to set the context. And what this means is, we know that there's so much stigma around mental health conditions. That is important to contextualize the importance of promoting mental health and especially promoting mental health equity. So when we have a mental health event at one of our local churches, we don't talk about depression in the title, we don't talk about mental illness in the title, we call it something about stress or overcoming or wellness. And that again came from our community coalition in terms of inviting words to set the states to draw people in because certainly everybody in New York City is stressed. Everyone in the country now is stressed because of COVID and all of the issues around racial injustice that we've seen over the last year and a half. And so taking time to set the context in your local community we think is important.

And then lastly is honoring the community's culture. Whatever racial or ethnic background members of the community are, whatever sexual identity or gender identity people have in the local community, whatever the primary mental health condition that people have, honoring the culture and expectations of that community is vital. That's our steps at least of trying to engage communities to promote and advance an equitable playing field as it relates to mental health.

Next slide. We're really excited to be partnering with NAMI and thinking about new directions. One of the exciting new initiatives is something called the Weekend of Faith for Mental Health. This is something that was started out of the New York City thrive, a New York City initiative that has really become a national initiative. That in the month of May, which we all know as Mental Health Awareness Month, that across a particular community, all houses of worship regardless of their religious affiliation talk about mental health.

And so we have gone into synagogues, we have gone into mosques, we have gone into churches, and have helped these faith leaders talk about mental health and empower people in these settings to promote mental health. And we hope that this will become a national movement. And so if you haven't heard it I encourage you to Google the Weekend of Faith for Mental Health and hopefully you can participate in it in 2022. And certainly NAMI FaithNet is expanding its reach to partner with faith-based organizations throughout the country to do some of similar and complimentary things of promoting mental health.

And then the NAMI Family to Family program is one of my favorite programs and my dream is to have a NAMI Family to Family affiliate and program in every church and faith-based organization in America, because I think it's so impactful and it's so much more powerful for someone and a family to be struggling with a mental health conditioning to hear another family's experience. So I absolutely love the NAMI Family to Family program and I'm eager to work with NAMI to help disseminate it far and wide.



Sidney Hankerson ([00:39:30](#)):

Next slide. We've covered a lot of ground today but I just want to leave you with three key takeaways. As we saw in the first section where we talked about some of the many factors and the complex relationship between race and depression, reducing racial disparities in mental health care, it's a complex issue. I don't think there's any one silver bullet but hopefully today you've seen a little bit of the complexity and the nuances that contribute to disparities in care. I believe and I feel we have demonstrated that that churches and faith-based organizations are ideally suited to promote mental health equity. Given their trusted role, given the fact that faith leaders are frequently first contacted when people are experiencing mental health conditions and given that they're easily accessible.

At the same time, we acknowledged that faith-based organizations at times have had a very troubled history as it relates to people with mental health conditions. And so churches may not be the answer for everyone and certainly are not the answer for everyone, and so thinking about other naturalistic settings in which to promote mental health equity, whether it's barbershops, or beauty salons, or schools, wherever the case may be is important.

Then lastly, this concept of partnering, community-partnered service delivery, working together, building coalitions, and building upon principles around empowerment, around building capacity, around equality and respect for diversity, we feel like can be embodied and disseminated and broadly shared across the country and hopefully across the world to make sure that people have equal access to quality mental health services. And with that, I conclude my presentation and we'll open it up to Q&A. Thank you.

And for additional information I do want to highlight this, when this comes out there is a video that we created. I would love if everyone on this call could post it on your social media page and highlight some of the work that we're doing in New York. And it's about a federally-funded study that we have call TRIUMPH, Transforming your Mental Health through Prayer and Healing, which emphasizes the role of the community health workers and peer workers with whom we are partnering to try to identify people with mental health conditions, support them, and get them connected to treatment. So we'd love if you can share this with your networks. Thank you.

Ken Duckworth ([00:42:19](#)):

Dr. Hankerson, a great talk, incredibly important topic. Let's start with a couple questions. An individual said they tried to do this in their community but the pastors were resistant to talking about mental health. Now, I understand you have solved for that, but how would a non-academic person who recognizes the same concern, how might you advise that person to work this problem in their local black church?

Sidney Hankerson ([00:42:50](#)):

I think that's a wonderful question. And I just want to be clear that we have certainly worked with some churches who have flat out told us, "We're not interested in talking about mental health conditions." And so there's still a tremendous amount of stigma around mental health conditions in some faith-based settings and so I certainly acknowledge that. We now have been very strategic to rely on the community coalition to help identify churches who both speak openly about mental health conditions. And so the pastors in many instances actually speak from the pulpit about going to therapy and the importance of getting mental health supports.

Ken Duckworth (00:43:40):

Thank you. You're describing a culture that's evolving, so it's not across the board, it's not acceptance across the board. You're finding it's a culture you can help to drive.

Sidney Hankerson (00:43:51):

Absolutely.

Ken Duckworth (00:43:53):

A couple of questions about the pastors. When you met with them, what were their biggest concerns that you were an academician coming in to study and leave, that you were an outsider? Are you a member of any of these churches I think is a related question? Are you an academic, an insider, an outsider, part of the community? Have you become part of the community? I think people are trying to figure out how you were so effective in trying to make sense of that.

Sidney Hankerson (00:44:22):

Yeah, well, I think all those are great questions. I am not a member of any of the churches with whom I partner and I think there are pros and cons of that. The first church that I presented today where we did the focus groups, there was tremendous skepticism, I think, initially. I think the thing that got me in the door to be honest was the fact that my dad is a deacon, which basically means he has... Not at that church but my father is a deacon at the church where I grew up.

And when I was able to share that and tell people that I was not just there as a psychiatrist and as a researcher but was there because my faith is very important to me, I think that put their guard down. I think the pastors respect people who are willing to share a little bit of themselves and be vulnerable before they're willing to be vulnerable and open up their congregations to these types of initiatives.

Ken Duckworth (00:45:22):

Thank you. A couple of questions about your community health workers and the related question of community nurses. And I think one question in terms of scalability, how are they funded? Is that Medicaid money, is that a federal grant? Because obviously community health workers have been shown to be effective in many spaces around the world and one of the questions of scalability is how are they paid for?

Sidney Hankerson (00:45:55):

That's a great question. Right now our community health workers are funded by two primary sources, one, through Columbia University, so we do have intramural funding from the university. And two, we do have a federal grant from the National Institute of Mental Health and so that's the sources of funding right now. The intervention that they're doing right now is called SBIRT or Screening, Brief Intervention, and Referral to Treatment. And so they're using motivational interviewing and SBIRT is a billable service by Medicaid, so we are going to be collecting cost data to try to create a business plan so that their services can be scaled and reimbursed.



Ken Duckworth (00:46:38):

Yeah, we're back to the falter in the churches. So questions related to their approach to alcohol or drug use or autistic spectrum disorders, are they having a AA meetings or Autism Speaks meetings in the church basements? Before mental health, is that parallel to mental health or is that the next thing that you see happening?

Sidney Hankerson (00:47:06):

I think that's definitely the next thing. I started this work in 2009 and we've come a long way as it relates to depression. I think that churches still think that there's a separation between depression and anxiety and drug use disorders. We actually just got a wonderful score on an NIH grant to do a church-based Naloxone study. Churches will be partnering with us to help people administer Naloxone to reverse people experiencing an opioid overdose. That was a much harder sell. So for the current study with the community health workers on depression we have 30 churches, for the Naloxone study for opioids we just have four. That shows you where we are as it relates to substance use.

Ken Duckworth (00:48:04):

Have kids on the autistic spectrum come up in any of your conversations?

Sidney Hankerson (00:48:09):

Issues around childhood mental health are probably the biggest challenges that people in the church are facing right now, not specifically autism spectrum but certainly people are aware of the high rates of suicide, the rising rates of suicide in black and Latino youth and boys. So childhood mental health is probably the most pressing concern for members of the coalition right now.

Ken Duckworth (00:48:37):

Yeah. One question is how are you going to try to work with NAMI's FaithNet and Family to Family and how can we help? How do you like that? That's very NAMI.

Sidney Hankerson (00:48:48):

Well, I'm actually I'm really delighted to be speaking at Doug Beach's conference in San Antonio next month. He and I have worked together at a previous conference and so I just think any ways that we can work together to... My dream is to put a Family to Family program in literally as many houses of worship that want it, because I've seen personally how powerful it is and it is really life-changing.

Ken Duckworth (00:49:19):

Here's a compelling one. I am a pastor and I have run mental health seminars at my church and other locations, however, it has been difficult to get the community involved. So this is the idea that the culture is bigger than the pastor, that the resistance to this idea might not just be in the leadership. Can you develop that because the question ends with how can I increase community involvement in my church in mental health, which is a brilliant question?



Sidney Hankerson ([00:49:52](#)):

Well, first of all, let me just say to the pastor, I applaud your efforts or hosting mental health programming at your church and really being a leader in doing that. I think that right now across the country, because of COVID and the depression and anxiety around the virus, and now the grief, especially in communities of color that, we're seeing stigma around getting services and talking about mental health is actually at an all-time low. If you personally have already tried to have workshops, one thing that you could try to do is maybe engage people who would be willing to share their story publicly or talk about their experiences of seeking care and having good experiences and getting better, and maybe partnering with your local NAMI affiliate. Those are just a couple of ideas.

Ken Duckworth ([00:50:51](#)):

A question comes up about access to that video. My understanding and it will come to your email with the slide set, that because of the platform we're using we're not that good to be able to use a video but you will have access to your TRIUMPH video when you get the email in the next couple of days. I think that's the answer to that question. Let's talk about seminary, somebody is thinking ahead. In terms of the next generation of pastors, do you anticipate engaging pastors who are training for this world and have you had any exposure to that question?

Sidney Hankerson ([00:51:36](#)):

That's a wonderful question and I think that that really is the next step. We are working with New York Theological Seminary and we have relationships with Union Theological Seminary which is both are large seminaries in New York City, to do just that, to train seminary students how to become more sensitive towards mental health problems, how to identify people and connect them to mental health professionals. I absolutely think that's the next step.

Ken Duckworth ([00:52:04](#)):

Oh, that's excellent. Let's talk a little bit about the clinic. People are interested in what does that look like? Where is the clinic? How is it integrated into the faith service? Is it adjacent to the church? In the church? Are there resources and times for people after they attend services? Can you come on a Tuesday? How does that clinic look and feel and operate?

Sidney Hankerson ([00:52:39](#)):

The clinic is literally half a block away from the church, so it's not located in the church it is a separate physical building. It has clinic hours Monday through Saturday. Now all of the services are free and they're all conducted virtually. And so what services are provided right now it's for adults 18 and above as well as couples can get up to 12 sessions of evidence-based psychotherapy. The therapy they provide is CBT or trauma-focused CBT, interpersonal psychotherapy, as well as psychodynamic psychotherapy. And so they're social workers and psychologists and they get excellent care to the community, that's how the clinic works.

Ken Duckworth (00:53:39):

Got it. Another interesting question again, these audiences make this so fantastic. There's a person, Charlotte, North Carolina, they're still doing Zoom faith meetings. In their last Zoom faith meeting one of the members of the faith community gave a talk on mental health and there was tremendous interest in this. And the question is, is that a safer more private space in a way? Does a Zoom transaction break down some of the barriers, is the question the person's asking you to think about because they're experience is that seemed to go absolutely fabulously and trying to make sense of that.

Sidney Hankerson (00:54:22):

I think that's a wonderful observation by that person in Charlotte. One of the advantages of Zoom of course is that you can turn your camera off so you could be anonymous, which I think many people like when talking about a sensitive issue like mental health conditions. So, yeah, I think that Zoom can be a wonderful platform to engage people and create a safe space for folks.

Ken Duckworth (00:54:50):

Well, it's just a very interesting observation, isn't it, in terms of people's engagements? The person basically said they want more sessions like this-

Sidney Hankerson (00:54:59):

Yeah, absolutely-

Ken Duckworth (00:55:00):

And so now the membership is demanding to talk about mental health.

Sidney Hankerson (00:55:04):

I think that's fantastic.

Ken Duckworth (00:55:08):

It's just interesting. Let's talk a little bit about refugee populations. Have you looked at refugee populations in the churches you're collaborating with and do you have any observations about that population or engaging the population?

Sidney Hankerson (00:55:26):

It's a wonderful question. One of the churches that we work with is a Catholic parish that actually served... I don't know if it was say a refugee site, but it definitely served as a site for people who were undocumented to find refuge, a safe haven type of site. And so I don't think that we have worked directly or interacted directly with people who would identify as refugees but it's definitely something that we're aware of and I think that any way that we can provide support for those folks is really important.

Ken Duckworth (00:56:00):

A question about black men. You noticed that black men in your survey had higher rates of depression. And was that just in your survey or is that also in the literature more broadly? That was a direct question about-

Sidney Hankerson (00:56:18):

Yeah, now, a wonderful question. Sorry, I didn't mean to cut you off. I get excited-

Ken Duckworth (00:56:22):

It's all right.

Sidney Hankerson (00:56:22):

... About black men and depression. But that was unique and that was a surprise because in the literature it's very clear, throughout the world, women have two times the rate of depression compared to men, throughout the world. And so the fact that we found that men... It wasn't statistically significant, so our statistician couldn't say that there was a real difference but numerically there was, and so that was very, very surprising. And when we dug a little bit deeper the men in our study were more likely to be on disability or more likely to be not working, had lower income and lower education levels compared to the women and so we suspect that some of those factors contributed to it.

Ken Duckworth (00:57:23):

Thank you. Another question is a note of hope. Lutheran seminaries are now actively training people in mental health alongside their faith work. Is this something that you find is growing in terms of the awareness within the field?

Sidney Hankerson (00:57:45):

I think it absolutely is and I think that people are really understanding that as a field, as mental health professionals we can no longer expect people to come to us but we have to meet people where they are. And so I think there's tremendous interest in engaging faith-based organizations to promote mental health.

Ken Duckworth (00:58:10):

Here's a comment from another pastor. I want to say it is so fantastic because we have parishioners, church members, pastors, I mean, and mental health practitioners, so, Dr. Hankerson, you attract a wide audience, it's wonderful to see. It says, "I'm a pastor and I've gained certification in mental health first day. I teach at the theological seminary and I offer other pastors to partner with me as well as in the local schools. But the resistance is very real particularly in the low-income community. And how do you stay encouraged and continue to encourage when you meet this kind of resistance?" I think there's two questions there. Is it your observation about the low-income community having more resistance and then how do you stay with what is clearly a long-term mission that may not always be gratifying?

Sidney Hankerson ([00:59:10](#)):

Yeah, great question. To address the issue around income and stigma, or not buying into mental health, we actually find that there's no associations with income which is surprising because in the literature there is some evidence that especially among African Americans, African Americans who may make less money maybe less likely to seek traditional mental health resources and more likely to pray or read scripture when dealing with an emotional problem. But I think this issue around socioeconomic status really cuts across race because we're seeing certainly in other racial and ethnic groups that especially very conservative parts of the country, that there's a distrust in many houses of worship of science and of mental health conditions in particular.

I think it's a really complex and complicated issue. But to the point about hope and persistence, I would just encourage this person to continue to believe in his calling, to use scriptural parlance of it and to have faith that if he continues his message that attitudes in minds and hearts eventually can be changed.

Ken Duckworth ([01:00:50](#)):

Here's a question that I'm going to put a twist on. We don't have enough representation of BIPOC mental health practitioners, and I know there are several initiatives to address that. But one thing that I heard you say is that you can create community health workers who will have capacity from that community. And so I wanted to ask you to develop both the idea of the licensed practitioner and the community mental health worker or community health worker.

Sidney Hankerson ([01:01:24](#)):

Yeah. Well, I first want to just acknowledge that, Dr. Altha Stewart, who was past President of the American Psychiatric Association just did an amazing job leading programs to try to increase the number of black and other underrepresented people of color going into psychiatry and mental health fields in general. And I think that there has to be a continued concerted effort that starts way before graduate school, that's starts in middle school and high school to really increase the number of folks of color who are mental health professionals.

Sidney Hankerson ([01:02:01](#)):

And then to the point around building capacity with community health workers, you actually said it, Ken, that community health workers have been shown in multiple settings to be effective. And so our hope is that we're able to do that through the church-based community health workers.

Ken Duckworth ([01:02:21](#)):

Well, Dr. Hankerson, this was a fantastic hour. Your work, your mission, your engagement is inspiring. And now I'm going to turn it back over to our Chief Strategy Officer, Sherman Gillums.

Sidney Hankerson ([01:02:33](#)):

Thank you so much.

Sherman Gillums, Jr ([01:02:36](#)):

Thank you, Ken, and thank you, Dr. Hankerson, for that very compelling case you make for ensuring that our faith-based communities become intersections for care instead of barriers. And I do have a couple of questions before I close out. Going back to your slide if I recall it correctly, you said that 80% of those involved in that faith model were women, and we just talked about how prevalent depression is among black men. Do you have any insights into why so many women are involved in this work and not more men and does it suggest that the patriarchal impact that some of these churches often bear in many communities where you see the barriers to this process of faith and cure?

Sidney Hankerson ([01:03:26](#)):

I think you're absolutely right, Sherman, it's a complicated issue. I think, just to be clear, most churches, the majority of people in churches are women. In general, 60 to 70% of churches tend to be women. Men tend to be in leadership positions so it does create this dichotomy of some people call it inequitable power structures. That's a whole nother topic, but it does create this dichotomy of gender and roles, et cetera. And so I think that in general that's been pretty consistent in terms of higher numbers of women being in health ministries, serving as community health workers, and so we really have to make, I think, very specific strategies to try to engage men in this work because I do think that men would respond more favorably to other men.

Sherman Gillums, Jr ([01:04:26](#)):

Thank you for that. And I have what's a philosophical question for you. The power of faith is unexplained whereas medicine and its power is an empirical evidence and data that explains sickness and things like that. Do you think that faith-based care coordination, at least in the minds of some, a quest to diminish the power of faith, instances where people are being asked to make room for what mankind can do instead of what God has done for a lot of people in their minds?

Sidney Hankerson ([01:05:01](#)):

I hope that it will augment the role of faith in that. And when people bring up the question of either/or as it relates to faith or science or for faith and mental health care, I tell people quite plainly that in scripture there are people who are physicians and that it's important to acknowledge the fact that people are gifted with the ability to diagnose, treat, and support those with mental health conditions just like people are gifted to diagnose and support those with cancer or any other medical condition. So I certainly encourage people to try to see the both ends instead of either/or.

Sherman Gillums, Jr ([01:05:44](#)):

Thank God made all the medicines and doctors, they empower medicine, right?

Sidney Hankerson ([01:05:51](#)):

Indeed.



Sherman Gillums, Jr ([01:05:51](#)):

Well, first of all, thank you, Ken. And thank you, Dr. Hankerson, first for lending us your time, talent, and expertise for today's presentation, but more importantly you've dedicated your life to healing the mind and spirit of others and for that we are truly grateful.

Sidney Hankerson ([01:06:07](#)):

Thank you so much, Sherman, for those kinds of words and it was certainly a pleasure to be able to present with you and spend time with you in this space.

Sherman Gillums, Jr ([01:06:15](#)):

Thank you. And to our attendees, we hope that you come away empowered and enlightened as a result of what Dr. Hankerson shared with us. As we look ahead, our next Ask the Expert is set for the 12th of August. We will have, Dr. Judith Cook, and then in September, Dr. Christine Moutier, to help us wrap up the third quarter of the year. Be sure to block out those dates because you don't want to miss the valuable, potentially life-changing wisdom that experts like Dr. Hankerson bring to each session.

Also NAMICon 2021 is right around the corner, July 27th or 28th. You can still register at www.nami.org/convention. At NAMICon you'll hear more about what NAMI is doing to help our country reimagine crisis response, empower youth, net communities of color to the best care possible, and destigmatize mental health and illness in our justice system. We'd love to have you be a part of these important discussions so you can take them back to your communities and help make a difference.

Please keep in mind this webinars series is not intended to provide medical advice. It is intended, however, to help you find the right questions to ask the expert who provides medical care for you and your loved ones. With all that said, we could not do this without our amazing Ask the expert production team. In front of the camera that's Dr. Ken Duckworth. And behind the scenes, Jordan Miller, Leah Wentworth, Allison Byler, Christina Bott, and the enumerable Dr. Teri Brister. Thanks to you for your steady excellence, we cannot do this without you, and I mean that.

We also could not carry out our mission without the kind generosity of those who support and believe in our work, our donors. Your investment in us shows up in the livelihoods of those we serve in your community and across the nation. Thank you. We look forward to seeing all of you at our next Ask the Expert in August. Until then, take care everyone.