REPRESENTATIVE JOE ARMSTRONG (TN): Yeah. And I want to bring up our Chair of our Health Committee, the Honorable Senator Connie Johnson, who is a 33-year veteran of the Oklahoma General Assembly. She worked for 24 years as a Legislative Aide and was elected. She is currently in her eighth -term -- eight-year of service as a senator in Oklahoma. She's involved in a number of things and, you know, Nate really described who she is and her family if you -- her resume is in the bulletin - but she's the big mama of her family in Oklahoma, and the big mama for the Oklahoma Black Caucus Delegation. Let's represent -- let's give a welcome to our senator, to our Chair of the Health and Human Resources Committee, Senator Connie Johnson. Thank you.

SENATOR CONSTANCE JOHNSON (OK): Thank you, President Armstrong, for such an interesting introduction. Now, you know, women don't like to be called big nothing so. But, yes, we want to try to get…(laughter)

REPRESENTATIVE JOE ARMSTRONG (TN): Please.

SENATOR CONSTANCE JOHNSON (OK): But I appreciate that. Good morning, everyone. How are you doing?

AUDIENCE MEMBER: Good morning.

AUDIENCE MEMBER: Good morning.

SENATOR CONSTANCE JOHNSON (OK): We are going to try to get back on schedule and I talk kind of quickly so, I do first want to thank President Armstrong for that introduction. And also thank Nate Miles and Joe Kelley. After 20 years, I think Joe qualifies as a member of the family. Alright.

AUDIENCE: [APPLAUSE]

SENATOR CONSTANCE JOHNSON (OK): I'm Senator Connie Johnson, Chair of NBCSL, Health and Human Services Committee, and I'm delighted to have the opportunity to serve as your moderator for this, the 20th Annual Black America's Dialogue on Health Policy Symposium. Thank you again, Senator -- I mean, Representative Armstrong for allowing me to chair such an integral issue area in our -- in our -- in our organization. And for me, it's truly a crowning moment for my 33-year career to be named Chair of the Health Committee and I want to just say that I was here 20 years ago for the very first conference, so full circle is real good. NBCSL's Black America Dialogue on Health Policy Symposium represents a 20-year long partnership with Eli Lilly focused on improving health outcomes in our communities. With Lilly's mission to improve quality of life by developing innovative medicines and NBCSL's mission to protect underserved and vulnerable populations, our organizations come together each year to examine how to raise our nation's health status. Over the past two year -- two decades, we have focused on topics such as research in pharmaceutical innovation, overcoming cancer, and healthy eating and lifestyles. This year, we're happy to shine a bright light on depression. Allow me for just a moment to put today's discussion in context by backing up a little and beginning with healthcare reform. Even before the

Affordable Care Act was enacted, passed by both chambers of Congress, signed into law by the president of 2010, and upheld by the Supreme Court in 2012. The National Black Caucus of the State Legislatures-Legislators banded together to call for most of the provisions that ultimately became law. Since 2010, we have intently studied how to -- okay. How to implement -- how to successfully implement the law in order to lead these efforts in our respective states. We've gone to battle in our states to increase the number of people who could get insurance and who could get coverage. Overwhelmingly, though, people whose employers do not help -- offer health insurance and who can't afford to buy it on their own. And so we fought for basic protections against the worst insurance industry abuses such, as denying coverage to children who had preexisting conditions like asthma and discontinuing coverage in a catastrophic incident. Over the past couple of years, since the ACA became law and with the support of Lilly, NBCSL has held forums to identify new opportunities under the ACA to address current health disparities. We've looked at various aspects of the act from expanding insurance access to ensuring all Americans receive quality care and treatments. If you recall this past summer in San Francisco, we held a session where we talked about how to get in where we fit in. And interestingly, a lot of the states in the room where non-exchange states. In other words, we are not offering state exchanges. And we concluded that our best opportunity was to look at the behavioral health and substance abuse areas. So it's very timely that we should be here today talking about depression. Even now, on the cusp of as many as 30 million Americans, including children, finally being able to access health care, something that is integral to both quality and length of life, partisanship in Washington threatens this whole concept. We cannot let this happen. We have fought too hard and too long. And we must do everything in our power to ensure that nothing and no one weakens this promise that is now finally in our grasp. During the same two-year period, our nation has experienced several high profile acts of violence, the roots of which have been attributed to mental illness. Examples such as the tragedy in Newtown, Connecticut, the averted tragedy with the school shooter outside Atlanta, Georgia, or the case last week of the Connecticut mother who had been diagnosed with postpartum depression with psychosis who was shot by the police in our U.S. Capitol. All of this -- all of these incidents bring us to our meeting today and the need for this timely and critical dialogue. Of course, these are worst case scenarios. More typically, depression is experienced in ways that are much less public. Perhaps not as dangerous to others but in ways that can wreak havoc on one's relationships with family and in the work place. Today, our experts will help us understand how this disease works and come up with real, practical legislative solutions to address it. As a taboo issue, depression is not a disease we often talk about, and though we may all be familiar with the term and we may even know someone who has suffered from the disease, we may not be fully aware of the lasting impact that this disease has on families and communities. So in the next few hours, we're going to talk about aspects of African-American culture and experience that can heighten risks factors for depression. We're going to talk about manifestations of depression in African Americans and how gender, socio-economic condition, or education can affect expressions of the disease, and we're going to talk about effective treatments, diagnosis, and care including reasons for non-compliance, the need for

culturally competent care and instances of misdiagnosis. In addition to walking away this afternoon with legislative ideas, we also hope to use what we learn to change the way this disease is viewed in our communities and carry a message that will help our constituents live more fulfilling, healthier lives. But, before we begin, I have a few housekeeping items to go over. This is being streamed live so please remember that all sessions, all panel discussions, and all presentations will be available in recording later. So please silence all your cell phones. Please keep your side conversations to a minimum. If you need to have an extended conversation please take them in the halls. There will be scheduled breaks during the day, should you need to excuse yourself, restrooms are located outside. Legislators will be given evaluation forms at the end of the day and they're in your packets. Please fill these out as these are useful to staff to help continually improve these meetings. And when we get to the Q & A, please stay on topic. Please don't give a speech. Please keep your questions brief so that we can accommodate everyone and answer as many questions as possible. With that, I'm going to introduce, Dr. Jeffrey Gardere. Known as America's Psychologist, Dr. Gardere is among the most respected mental health professionals in the United States. He has a successful private practice in Manhattan and is an Assistant Professor and Course Director at Touro College of Osteopathic Medicine in New York. An adjunct professor at City College, New York City, an adjunct assistant professor at Touro Graduate School of Psychology, and a visiting faculty at American University of Antigua College of Medicine. He's been featured on several news outlets including the NBC Today Show, CNN, and MSNBC. Today, he will discuss cultural connections to depression, highlighting risk factors and major causes. Dr. Gardere.

DR. JEFFREY GARDERE: Thank you, Senator Johnson. Good morning, everyone.

AUDIENCE: Good morning.

DR. JEFFREY GARDERE: Alright. So let me get myself set up here.

AUDIENCE MEMBER: And you can just go to the next slide by clicking…

DR. JEFFREY GARDERE: Just by clicking here.

AUDIENCE MEMBER: Okay.

DR. JEFFREY GARDERE: Alright. It's wonderful to see all of you, our state legislators, guests, friends of the mental health community, Senator Pugh, good morning. How are you? So, I wanted to start off by telling you first and foremost, I wanted to--it's not going to be about education so much. I've spoken to many of you last night. We had an excellent keynote speech by one of your psychologists here, really gave some great information. This is going to be about sharing information more than anything else because a lot of what I'm going to tell you, you basically know already from the great work that you've done. But let me tell you--let me give you a--what I call a Depression 101, just some information that a lot of people really don't know and I think it's important that we have the basics down. Let's look at the different forms of depression. First and foremost, we have what's called the Major Depressive Disorder or

the Major Depression. You all know what that is. You have a lot of information there before you. I have a lot of handouts that I'll give you. But basically, it's someone who has a depressed mood or agitated mood, lack of appetite, lack of focus, an inability to concentrate. They may have crying, anger, loss of interest in their previous activities. Their whole lives have turned around. These are individuals who just don't have the motivation to even get out of bed in the morning or perhaps may not even have the focus to be able to work. They do need to be on their anti-depressants. That's very, very important but as part of that, they also need to have their therapy and that's one major point that I think everyone would agree. I hope that they do. That if you are on any type of psychiatric medication, that you also must have your psychotherapy. The medications have really done an incredible job of helping to stabilize mood, to keep you from perhaps having the delusional thoughts and so on, that I'll talk about in just a little bit, but they don't cure. What they do is they're able to manage what your symptoms are. The real cure --and I believe there are cures to depression come from--actually the introspection come from the psychotherapy, come from the spiritual work from our houses of worship, come from family support, so that is first and foremost. Secondly, we have as a minor part and it's not on the slide. We have something called the Dysthymia. Dysthymia is a milder, a much milder version of the major depressive disorder. Whereas with the major depressive disorder, we diagnose, it takes maybe two weeks to understand that someone is totally dysfunctional, totally depressed, totally unable to concentrate or work or to go on with their lives. With the dysthymia this is a milder version. We call it a Sub-Chronic Depression. Some of us may experience dysthymia. What does it look like? Well, it's that person who says, "You know what? I don't have a lot of energy, you know. I'd like to go out and go dancing tonight but I just don't feel like I have the motivation to do so. I don't want to get involved in a lot of relationships, or I'd like to go out and get my JD or MBA but I just don't have that drive." A lot of times, I just can't seem to make my relationships work." This is what we see as the dysthymia. The person just does not have that energy and has more of this minor depression. And this takes two years to diagnose because a lot of people with dysthymia aren't even aware that they have it. We call it Egosyntonic. They go along with the symptoms and don't realize that something is wrong and that they can use the help. Now, with the dysthymia, we normally don't medicate. What we do is we do get that person into the psychotherapy, into the spiritual counseling, and that usually helps them to get back on their feet and to function in a more optimized way. Then we have something called Psychotic Depression. It's not like what happened with -- unfortunately, with the woman, the Connecticut mom, that's something else. We'll talk about that in a minute. But this is a person who becomes so depressed, okay? This is almost like a major -- super major depression to the point of where they become psychotic. They have a break from reality. They shut down so much that they’re no longer in the environment that surrounds them but become part of their own environment, become part of their own thinking and are not aware of what's going on around them. So, with that, they also tend to have the issues with hearing voices, seeing things that aren't there that we call the auditory and visual hallucinations. They may have paranoia where they feel that someone is after them or they have ideas of reference that whatever is going on in the environment

somehow is some sort of a message being sent to them. Then we have something called the Postpartum Depression. This is what we saw happened with, unfortunately with the young woman, the Connecticut mom in Washington D.C. By the way, my whole theory about that -- we also had an individual who burnt himself to death if you remember that. It's almost, like, no pun intended, a moth to a flame, okay? They see the shut down of the government and it now begins to play into their own delusional thinking so they feel that this is a connection, this is a message they need to make, either come after the president or make a message where they literally go out in flames. A lot of people have asked me, "Well, do you think this person with -- who set himself on fire had some mental health issues?" It was either that or this guy just went through a divorce. I don't know. So, that postpartum depression if it's not taken care of then can become a postpartum psychosis which is where this mom was. Nine to nineteen percent of brand new moms have some sort of postpartum depression. It's not the baby blues. All moms have the baby blues. It's extremely stressful. We know there are hormonal issues and so on. And then one in one thousand perhaps have the postpartum psychosis. Again, these things can be treated. We tend to see that women who get postpartum psychosis also had a predisposing factor, usually some sort of a bipolar disorder or some other schizophrenia from -- that happened from before the birth. And, of course, if you are carrying a baby we don't want to give you anti-psychotic medications. And then we have what's called the Bipolar Disorder. This is where you have the manic depressive illness. And there are two types of bipolar disorder. Again, I hope this is good information for you. You have what's called Bipolar One. Bipolar One is the usual bipolar disorder where we have the very deep depression and the very, very, high mania, okay? Now, this mania will make you think that you're super human, okay? That you can accomplish anything, that you can do fifteen things at one time. And no, none of you are bipolar. I know you all do those things anyway. I know you were thinking about that, senator. No, you're okay. Clean bill of health. Now, if we can only get clean bill for spending, we'd be in good shape, okay? But what we tend to see with this bipolar one is you have to be again, it's all about the medication. Therapy is great. You have to be in therapy but you also have to be on Lithium or Carbamazepine or Valproic Acid. These are the medications that do help and that do stabilize. Bipolar Two, we have the deep, deep depression, but now the mania is not as high as bipolar one. So, you may see the increased energy but you're not going to have the mania that you typically see with the bipolar one. By the way, some of our greatest contributors to world culture have been bipolar one and they have been able to make their contributions when they're in their manic phase. It's considered to be one of the best highs that you can ever, ever have. There's no drug that can give you that high. And because of that, that's why we see a lot of noncompliance with the bipolar illness. As a matter of fact, you'll get people go in to see their psychiatrists and say, "Hey doc, can you give me some medication for my bipolar? Please deal with the depression but leave the mania alone." Doesn't work like that. Okay. So, what are some of the causes of depression? Well, we know genetics. It runs in the family. We talk about this situation of genotype versus phenotype. Again, you know, depression 101. Genotype is what you inherit. Phenotype is how what you inherit actually now is drawn out by the environment. So, just because you have someone in

your family who may have depression doesn't mean that you're going to have depression. Just because you have someone in your family who has Alzheimer's doesn't mean that you're going to have Alzheimer's, but you may have more, again what we call that genetic predisposition so you need to be very careful and look at the signs and get it taken care of right away. So, now, along with this -- the genetics, it's not necessarily someone having depression in your family that may cause you to have the predisposition for the depression. It could be any mental illness, someone who has schizophrenia, someone who has a bipolar disorder, someone who has extreme issues with anxiety. Those genes that run in the family may then cause you to have a depression. Then we look at the environment. The environment is where you live, how you live, what you are given to live by that may cause that depression, what happens in your relationships. So, you may not even have that gene for depression but you can end up in a depression, and we'll talk about this, if you perhaps are exposed to poverty or extreme stress or some other environmental situation or being Black. Okay. And we'll talk about that. Then we have to look at the hormones, okay? This is something again that we don't typically look at enough because it's not about, "Oooh, is this person depressed because there's some sort of crazy going on?" No, no, absolutely not. Sometimes, it's just the body, what's going on with the body and we learn this in behavioral medicine. For example, with the hormones, we see that estrogen tends to boost what's called serotonin. Serotonin makes you feel better if you go to the biology section here of serotonin, dopamine, and norepinephrine. So, it boosts the serotonin and by boosting that serotonin, it makes you feel good. So, that's a good thing when we see that with estrogen. It increases something called GABA. GABA is a neurotransmitter and has a receptive site. When you hit GABA, you're a little bit more relaxed. A lot of our benzodiazepines, when you take those, they make you more relaxed. And it also raises endorphins. We see a lot of people working out all the time. It's not so much because they want to look like Hercules, okay? Hercules, Hercules, Hercules. It's because of the endorphin that's being released that makes them feel good so they're almost addicted to that exercise. So, when we see with perimenopause or menopause that there is less estrogen, that means there's less serotonin, less endorphins, GABA is not being increased, therefore it equals depression. So, it's totally biological. It's not what's going on in that person's life, it's what's going on in their body. We see the same thing with progesterone which tends to balance serotonin. So, if you're not getting enough serotonin that will lead to a depression. And cortisol and women have a real issue with that because that's a stress hormone, and too much of that stress hormone causes them to have a paunch, it causes them to gain weight, it also causes them to get stressed out and it causes then again the issue of depression. So, these are some of the things in the body that cause a depression. So, what do we know about depression? It's costly and debilitating. The gentleman from Eli Lilly was here and he talked about the lowered cost of medications, but it's not just about the lowered cost of medications that really is helpful but what is harmful is that we have something called the downward spiral, a downward drift in SES, socioeconomic status. If you are truly depressed, you are not going to be optimal. You're not going to work as well. You're going to have more absenteeism, more short-term disability, decreased productivity. In other words, you may as an

African American go to what we call BNB, Black and broke. And we also know that depression can adversely affect the course and outcome of chronic conditions such as arthritis, asthma, cardiovascular disease, cancer, diabetes, obesity, all of the things that we're at risk for in African-American society. Either it lowers your emotional immune system and opens you up to these illnesses or if you have these illnesses, you don't recover as well. It makes it worse. We know that spirituality is so important for people go through surgery, right? I talk to my medical students all the time and they say, "Well, doc, what should I do if a patient asks me to pray with them and I'm really not into that particular religion?" I say, "You pray with them anyway. You can use a little religion in your life. Don't get me started, alright?"

AUDIENCE MEMBER: I agree.

DR. JEFFREY GARDERE: Right? Pray with them anyway because what we've seen, it's yes, you know, there is something coming from up there but more than anything else for the patient, for you as the doctor is this whole idea that spirituality boosts the emotional immune system and therefore they tend to recover quickly or quicker from the surgery. So, if you have depression that means if you get cut, if you have one of these major issues, you're not going to heal as quickly. The body is an amazing thing. It really is a machine but it has to have all of the power working with it. Depression is a drain on that power. Let's look at who tends to get depressed the most. Persons 45 to 64 years of age. We have a lot of youngsters in the room but for those of them, who are around my age, I'm 57 now, I tend to see that anxiety is a bigger problem for me. Sometimes, depression may be a bigger problem. As we get older, yes, we get wiser, yes, we get better, but emotionally, things are a little bit tougher the way that we handle them. We manifest them, we somaticize them more from our bodies, from what's going on up here. So, for people around 64 years of age, we are not so much concerned about the depression but also they may be more at risk for suicide too. Women, because of their hormonal changes, women, because they're treated as third-class citizens always, is one of the reasons that they're more at risk for depression. And if we're talking about women of color, then they're treated as fourth-class citizens and therefore they are more at risk to depression. Black men are at risk for depression too. Problem is we just don't talk about it, okay? As they say, for men, in general, "Men don't heal, men ho." So we just go out there as men. We drink, we get involved in affairs, we do all of the destructive things that we should not be doing, okay? But women tend to talk about what their issues are and that's very, very important. And we as men and we, as African-American men, need to step up more in talking about what our feelings are around depression. Maybe you all need to take a page from Montel, okay? Because Montel likes to cry. You all can cry too, it's alright. Just don't cry too damn much, alright? Alright. Persons with less than a high school education are more at risk. Those who have been previously married because we know that a strong and healthy marriage would -- will lead to better mental health. However, it leads to better mental health for men and does not impact so much the mental health of the women. So…

AUDIENCE MEMBER: Say that again?

DR. JEFFREY GARDERE: Well, I'll just say that men can be toxic to their women in marriages. So, men again, we need to step up in that way. I know some of -- some of our male legislators will be meeting me after this. Stop letting the skeletons out of the closet, Dr. Jeff. Individuals unable to work or unemployed are also at risk for depression. Why? Because work is therapy. Work is good. Work is sanctified. Work keeps you strong. Work makes you want to hustle, okay? Persons without health insurance coverage, major, major, major at risk for depression because they're not monitored, they're not diagnosed. As a matter of fact, African-American women, number one group as far as under diagnosis for depression and of course Blacks, Latinos, non-Hispanic persons of other races or multiple races more at risk. Brief statistics, one in ten U.S. adults report depression. That's a big number, one in ten. We think that there are about 19 million people who are depressed, and that number may even be higher because people don't tend to talk about that they are depressed or even recognize that they are depressed. Major -- okay. So here's the deal, you're going to hear people tell you Black people are more at risk for depression. They really are not, okay? They are more at risk for chronic depression. In other words, the numbers are higher for Whites in depression, okay? Higher than those of African Americans, however, African Americans have major depressive disorder as a chronic disorder. When we get it, we hold on to it forever, possibly because we don't have the insurance, possibly because of poverty, possibly because we're not being diagnosed, possibly because of the stigma, but it stays in our lives a lot longer and we tend to report higher levels of functional impairment versus Whites. So that's where we are more at risk. So, what are the causes of depression in Blacks? Well, we have to look at discrimination. Slavery, still you've heard many people talk about this, what's called Post Traumatic Slave Disorder, Post Traumatic Slavery Disorder and so on. It's a real thing. It's been recognized that slavery is an archetype that continues until today in that -- the trickle down effect in how we view ourselves, self-esteem issues, how we're viewed by others, so that legacy lives on. But even if you get through this PTSD, this Post Traumatic Slavery Disorder, now you have to look at the idea of day-to-day discrimination. Day-to-day discrimination will wear you down. Wear you down to the point of where you will have a depression. And here the problem is, for Black women, they tend to want to protect the family, protect the legacy and therefore will not -- or look at stigma and say, you know, "I'm a strong Black woman," okay? We have many single households with the African-American women. "I don't have time to deal with this. I've got to take care of my children." So that's a major issue. For African-American men, just like men in general, we don't talk about our feelings. I'd talked about this, this whole idea that African-American men sit on their feelings of discrimination, okay? So, if they are not able to get a certain job or not able to get work in general, we know the unemployment rate is extremely high in the African-American population. The problem is that there is additional stress with the stoicism and the emotional control experience, which then leads to more depressive symptoms. Now, something that's interesting and this was in *The Lancet [Neurology]* in October 2012, they found that 79% of people who've been diagnosed with depression also stated they were discriminated against, so that's a double whammy. Here you are where you're discriminated against because of your color and now you have a depression. Then you get this

depression and then you're discriminated against because you have depression. So this then leads to a deeper depression. Then we have the glass ceiling effect, okay? I'm sure this may not be happening at Lilly but we see this in many, many major corporations that we have people like yourselves, like ourselves with their masters and their doctorates and so on who can only go to a certain level and cannot go beyond that. So they may tend to have a ceremonial position but what happens is, once they get in they hit that glass ceiling. There's only so far they can go. I mean, we are very proud of Ken Chenault and Dick Parsons and so on, but they're anomalies at this particular point. And so what we see -- and I talked to a lot of -- you know, I worked with a lot of -- a lot of corporate executives of color, basketball players, celebrities, and so on and all of them say -- even with the basketball players once they go into management, what they see is that they have a frustration and that they're kept only at a certain level. They feel isolated. They feel that they can't be themselves. They're kept to a different standard, okay? What they have done as far as miraculous works are considered to be less than and that can make you not just depressed, but it makes you want to holler, okay? And if you don't believe me, you just take a look at one of the greatest presidents we've had, President Barack Obama, where everything he has accomplished including the Affordable Care Act has been torn down. Okay, they're trying to tear it down. Okay. So he's held at a certainly, a different standard. And let me say this, I've talked to a lot of people and this isn't partisan or anything in the -- in any way. I've talked to a lot of people, lot of young people who had so many hopes and dreams when President Barack Obama ascended to power and they felt that it would change the whole landscape of race relations and race and so on. A lot of those people are feeling very down, very depressed because they feel, "Look at what this man is accomplishing, but yet he is still not given the credit because of his color," that's what it comes to down to in many ways. So that in some ways can cause people some real depression, but I tell them hold on because this is what is part of our culture in America that we have to go through this. We have to have a Black president who is dealing with these issues because it makes us confront what issues of racism happen to be and how we now work through those particular feelings, okay? It's part of our evolution as a great country and as great people. At some point, we will have a female president, a Jewish president, and on and on and on. Hopefully not a Tea Party president but don't get me started. On and on and so, that will get us to realize that we are all brothers and sisters and, in fact, how we get to where we need to go. Now let's look at the idea of poverty. In 2010, 27.4% of Blacks and 26.6% of Hispanics were poor compared to 9.9% of non-Hispanic Whites and 12.1% of Asians. So, what does this mean? Yes, African-Americans, again, more at risk for poverty but what do we see? Poverty translates to depression. Why? Because humiliation from subsidies, okay? No one's proud to tell you that they're on food stamps, okay? No one is proud to stand in line at a supermarket and have their WIC cards or whatever and everyone's looking at him like this, "Would you please hurry up? And how come you're getting these subsidies and I'm not and I have to use my Visa card and blah, blah, blah, blah." No one is proud of that. So when you already have the issues of poverty, again, and people see you as being less than and you're getting handouts, that's a major issue that can lead to depression. Poor living environments, frustrated because they can't pursue

their goals, living in an environment of crime, parents going to jail, a failing foster care system, all of these things lead to depression and lead to depression in our children. Then we have to look at single parenting: 72% of Black children are raised in single-parent households, so what does that mean? Well, it means a lot of stress on women, on those single Black women who are raising those children and that stress, again, translates to depression. They have to do the jobs of two parents, not enough emotional support, tend to be isolated. And I can't tell you how many young men that I work with who are enraged and outraged that perhaps their father may not be in the picture and they're dealing with day-to-day depression. Gun violence and PTSD-- in 2013 Center for Disease Control said nearly four times as many young murder victims in the United States were killed by firearms than by other methods such as stabbing, strangling, poisoning in the past 30 years. So, what does that translate to? Yes, that violence is killing our young people. Yes, African-American males tend to be the victims of this violence. But it's not just the people who are killed. It's the people who view the violence. It's the people who go through and are part of that violence everyday and they have to deal with what we call the Post Traumatic Stress Disorder-- anxiety, nightmares, okay? Avoidance of certain stimuli, trying to avoid police as much as possible, being enraged, being depressed. All of that is a part of the problem that we have and why we need gun control laws. It's not just about being -- people being killed, it's about the survivors and dealing with the PTSD. Body image, I put my girl Mo'Nique up here because Mo'Nique accepts her body image. She knows that this is who she is, this is what she looks like, and she's proud of it, but we have a lot of young women especially in African-American society dealing with obesity. And because of that, they have a lot of self-esteem issues, they tend to get eating disorders, okay? Again, issues with skin color, hair texture, when they're younger, all of these things, again, lead to depression. Incest, major problem in the African-American community. Black women less likely to report it, self-esteem issues again, they tend to have arrested development, PTSD, drug abuse, dissociative disorders where they have multiple personalities, schizoaffective which is depression and schizophrenia, and borderline personalities, again, all of that leading to their depression. LGBT, three times the suicide for LGBT youth and in the Black community, let's face it, we're still in the closet when it comes to gay and lesbians. And so I produced a movie, co-executive produced a movie called "You Are Not Alone" recently was featured at the Montreal Black Film Festival, and we talked about the idea that African-American, depressed Black gay man, they don't have the church to go to, they don't have family to talk to, so what they tend to do is to have unsafe sex which is a form of suicide, drug abuse which is a form of suicide, and all of those things are part of a major depression. Diet, we tend to get too much into those comfort foods. We had a lovely meal last night. Lauren, thank you for planning that. That was great. I now have about three minutes, by the way. But with the comfort foods, with the carbohydrates, what we do see is that this releases that neurotransmitter serotonin. That serotonin gives us a high. So we become addicted to those foods because people don't understand the more we eat those foods -- that's why they make us feel good because it's releasing the serotonin. So, once we stop eating those types of foods or once we become immune to eating these foods, we keep eating and eating and eating it, we're not getting that serotonin

release, that leads to a depression and of course, more obesity. And obesity in itself, having less mobility, will tend to add to a depression. Stigma, therapy is a White thing. "I don't need to see a therapist. I'm not crazy." Okay? I don't know if you saw me on "I Dream of NeNe," I was dealing with Gregg. Gregg was like, "I'm not crazy. What you doing here? What did NeNe say? "Let's see what Dr. Ring can do. Let's see what the little man in glasses can do." So, you know, it was important that we talk about -- it's important that we talk about the stigma. We see it as a weakness. It's okay to be depressed but most importantly, it's okay to get treatment. And, lack of insurance. Lack of insurance means lack of healthcare and under diagnosis and drugs and alcohol. We self-medicate too much in order to deal with the depression. So, what's the good news? And here's the wrap up. Okay. Churches and counseling. Back in the day we used to say, "Let's pray it away." "God helps those who help themselves." If you have a depression, you have to get therapy. And now what we're finding is many of the therapists in the church who did spiritual counseling, many of those people have masters in social work and doctorates in education and in philosophy and so on and now are being trained to actually do spiritual counseling and clinical counseling, okay? And the church and other houses of worship are at the forefront of this in the African-American community. We have a distinct respect for our elders and our elders will tell you in a minute, "Child, you need to be in therapy, okay?" And they are also in their own way helping us into getting where we need to go as far as treatment. I thank people like Oprah. I thank people like Iyanla. I thank folks like NeNe Leakes and Gregg Leakes. NeNe Leakes, okay, who -- yeah, "Oh, she's a reality star, what does she have to do with this?" This woman said at least 15 times in her show, "Gregg, before we get married you going to have to get some therapy. We need couple's counseling, we need family therapy." This is a Black family on major network television saying, "Hey, let's get some therapy. Let's deal with issues." So that's an incredible thing for that to happen in our African-American community. In our schools, we're teaching cultural competence and cultural sensitivity to all of the new clinicians that are coming through including the physicians and then a little further down I talk about osteopathic care. We have these physicians who are DOs, okay? We have the allopathic who are the MDs and osteopathic who are the DOs, both are physicians, both equal. But what we do with osteopathic care, and I'm proud of this at Touro is we're teaching them, look, go into primary care but go at the forefront, go into the community, go into the inner cities and work with these individuals because they need this the most. Work with them around their diet, work with them around the neurotransmitter issues, work with them around their environments, work with them around poverty in order to deal with their depression so you can treat not just from a psychotherapeutic but also from a medical. So they are at the forefront of being there for the Affordable Care Act once it's fully, completely rolled out. Single fathers' programs are proliferating, okay. We're seeing them everywhere. Black men are stepping up like they've never stepped up before. Health and nutrition conscious, we're all becoming that. And it's really a wonderful thing that we have everything on our labels that tell us how many calories and so on, educating us and we, as African Americans, are now into "Okay. Let's go with this program, let's work out, let's be a health and nutrition conscious," because all of these things will tend to bring down the numbers as far as the

depressed. And finally, the change in media images and the focus that Black truly is beautiful. We're finally seeing it. It's finally being appreciated for what it is. And therefore we're not dealing with those self-esteem issues. So there's a lot of good news out there. We are battling this depression, we are battling mental illness, but we have to continue doing it and I certainly believe, once again, that what will turn the tide as far as dealing with depression with the African Americans will be insurance, will be the Affordable Care Act. Thank you.

AUDIENCE MEMBER: Yeah.

SENATOR CONSTANCE JOHNSON (OK): Well said.

DR. JEFFREY GARDERE: Thank you.

SENATOR CONSTANCE JOHNSON (OK): Thank you.

DR. JEFFREY GARDERE: Thank you. Okay.

SENATOR CONSTANCE JOHNSON (OK): Let's -- yes. Let's give Dr. Gardere another hand right quick. And we now have about 15 minutes for Q&A. Those of you who have questions online, we'll have Greg Porter, Representative Greg Porter reading the questions that are coming across online, but, Laura Hall?

REPRESENTATIVE LAURA HALL (GA): Thank you. I just wanted to make sure I had your statement relative to men don't heal, what was the other part of your statement?

DR. JEFFREY GARDERE: Well, I don't know if I wanna say that again. Men don't heal -- men don't heal. They get into situations of where they get to into self-destructive acts such as affairs, such as drinking because as men, we've been so -- it's not that we're, you know, we have this idea that, "Ooh, we have to be tough -- rough and tough," it's this whole idea of we're socialized to be rocks, we're socialize not to talk about our feelings. "Oh, a real man doesn't do this," or, you know, "Boy, stop crying and deal with," no, we need to be socialized to say, "You know, this hurts. You know, what happen here has hurt my feelings. What is going on makes me want to cry and I was able to cry." So that's where I see us going more and I do thank people like Montel who absolutely, we've seen him on the air, has cried. I won't talk about John Boehner crying, that's a whole other thing. So that was -- I didn't wanna give that statement again. That's one of those statements you say it once and then don't say it again, but you get the idea.

AUDIENCE MEMBER: I'd like your thoughts, your opinion on a situation, Congressman Jesse Jackson was doing very well.

DR. JEFFREY GARDERE: Yes.

AUDIENCE MEMBER: Everybody was happy, proud, you know -- concerning in terms of his personal life, public life then all of a sudden seems like everything just started coming down. And the first the thing in mind, there have to be some symptoms that we're developing that we can look for, and I wanted your assessment of that and what kind of symptoms in a lifestyle like that which a lot of us carry right now,

should we look for so that we can start implementing some preventive measures so maybe like that won't end up self-destructing ourselves and like -- your thoughts on that.

DR. JEFFREY GARDERE: Sure. With Representative Jackson, what we did discover, and his dad had spoken about that, was that he was experiencing a bipolar disorder, probably the bipolar one where you have the extreme depression and you have the extreme manic activity. And it seems when he was going out and buying all of those card collections and, you know, doing a lot of things that were kind of “off the chain,” as we say, was a key indicator that he was in a manic phase. Not sleeping, not eating, an extreme amount of energy, and I'm giving you the signs right now to a bipolar disorder, and then he would crash where he just would not be able to function at all. What happen is, you -- you expend so much energy, okay. You feel you can do so many things, that you're this superman or this superwoman, after three or four days of expending that kind of energy, then you just crash to the floor and then you have this extreme depression where you need to sleep for several days. And so hopefully with the medication, with the lithium or some other medication you're able to even out those moods. But certainly what I said from the very early on and I did speak with his dad, I said it was very clear to me that he was experiencing a bipolar disorder. And his father actually did come out and say, "This is what was going on." What bothered me more than anything else in the popular media and as far as the politicians, they were saying that he was malingering. He was making it up. It was an excuse. When you take a look at it, why would someone demolish their career in such a way? Okay. Why would they do something that is--let's even talk about Anthony Weiner. Okay? Here was a person who I believe has some real mental health issues that he's dealing with. This is a person who has the whole world in front of him. Why would you do something like text out pictures of yourself knowing that you're going to get caught? It's not about your own vanity. It's about a mental illness, something going on. So you're not in control of your emotions. You have a very poor impulse control and so that's what we tend to see happens with this -- those individuals. So there was no malingering there with Representative Jackson. He had a real bipolar disorder. And I understand that he is being treated now.

SENATOR CONSTANCE JOHNSON (OK): I ask legislators to please give your name and state when you speak.

SENATOR GREG TAYLOR (IN): Okay. Greg Taylor, State Senator, Indiana. I'm really interested in the cultural competency of the medical profession. One of the things that we -- from last year or maybe it was two years ago, talked about the fact that we still suffer as a community from the Tuskegee experiment. And that a lot of the drugs that are out there in the community that are being given to African Americans have never been tested on African Americans and we might have a different reaction to them. But one of the things that I've seen through personal experience is that the medical profession has been lackadaisical in their cultural competency. For example, how do you explain to an African-American family that a family member has a chronic disease that's going to, you know, eventually take their life? How do you express that? And how do doctors actually say those things? And, you know, we're more, in

our community, more body language focused. So when you see a doctor and they sit there and they're stoic and they have these things, you consider that to be a lack of interest. Is there anything that you've seen from a best practices in your -- in your profession that we can look at as a community to start implementing in the health care, because I think we are suffering not only from the fact that we don't participate in these studies which I don't know what you could do about that, but I also think it flows over into the medical profession. They just don't know how to deal with the African-American community. Most of the time you might have some international doctors…

DR. JEFFREY GARDERE: Sure. Okay. No, no, no. I got it. So what we've seen is, that we have a very low percentage of African-American professionals with regard to mental health specifically but also in the medical profession and so on versus the population that's being treated. So yes, part of the answer is recruiting as many minorities as possible to go into the medical and mental health profession and many other professions. But that's only part of the answer. The other part of the answer is we have some wonderful people with great hearts who happen to not be African American. Who may be Latino, who may be white, who may be Jewish, who may be Asian, and that's a resource that's out there but they're not able to connect with their African-American patients or some other culture because they don't have the cultural sensitivity and the cultural competence. And so, I know at the Touro School of Osteopathic Medicine in New York it is part of our curriculum. I actually run the course of cultural sensitivity and cultural competence for the first and second year medical students where, in fact, we have them meet with African-American patients, educate them about African-American patients, educate them about body language, how to touch, how to speak, the distance between you and the patient, how to bring up certain conversations that let's them know that even though you may not know everything you need to know about the African-American culture but you're there and you're open. How to decorate their offices. It's great to have Picassos and so on but let's have some things in the office that reflects the patient who comes in to see you, what the dialogue really needs to be. All of those things are important. Now, they're being more than anything else legislated as part of the educational curriculum for the medical schools, for the graduate schools, and this is what we need to see more of--making it mandatory. I can tell you that in many of the medical schools, the medical students who come in and you'll say, "Okay. Cultural sensitivity, cultural competence," and they're like, "I'm not thinking about that. I'm thinking about pathology. I'm thinking about histology. You know, this is like lightweights stuff." And then they go -- they don't pay attention. They go out into the medical practice. And then their patients are noncompliant. Their patient's are not coming back in. Okay. Their patient's are getting sicker. So we've actually now have been able to open up their minds to the fact of, if you want to be a better doctor, if you want to be a more effective doctor, if you want to be a more caring doctor, if you want your patient to be much more compliant and you want to have a better health psychological outcome you have to study the culture of your patients. And who your patients are as much as -- and it has as much weight as your histology, your pathology, and your anatomy. So that is now should be a core part of the curriculum.

REPRESENTATIVE LARRY BUTLER (CT): Larry Butler, State Representative from the Great State of Connecticut.

DR. JEFFREY GARDERE: Pleasure, sir.

REPRESENTATIVE LARRY BUTLER (CT): Great presentation. Excellent, and excellent information. My question is about parents that have, let say, teenage youth that have mental issues. Right now they're -- they go through a period where their insurance may cover the therapy for 30 days and then that's it. And the children come back from these institutions, back into the same environment household, same problem, and I know we have other panelists, they're going to be speaking today. I hope they talk about this too because this is a real big problem. What can parents and we as legislators do to fill that gap that after 30 days a lot of this people are left with the same issues that they have to deal with?

DR. JEFFREY GARDERE: Thank you for a great question. By the way I live in Manhattan, but I also have a wonderful little place in Lordship right outside of Bridgeport, Connecticut. So I love the Great State of Connecticut. Your highways are very nice too. So, two things going on, one is that the answer is within the question. For too long a lot of people who actually had insurance, okay, they call it the "privilege of insurance," but I think President Obama calls is a basic right of insurance. They didn't have mental health coverage. 30 days that was it. You only got six visits. It's starting to change now. I know with GHI and Empire, some of those insurance companies are giving many more visits or some are -- as long as the clinician fills out the paperwork, you can get 10, 20 visits, some may even be unlimited visits. But you need to push to make sure that, first of all, these things are not cured in 10 sessions. They're not cured in 30 days. Okay? Having a thousand dollar deductible is going to keep you from going in and getting the treatment that you need. So it needs to be unlimited as in any medical condition that you're being treated for. Depression can last you a lifetime, so you should be in therapy for a lifetime. And therapy is a good thing. Therapy helps you solve the problems of the day. You know, you have someone to talk to. Hopefully we don't want to see you on medication forever. There are alternative treatments out there but the medication does fill that gap. The therapy is there for you to help you get there, so that's one of the things that we need to see. But the second thing that I would love to see our legislators be able to do is work with the hospitals themselves to be able to open up more psychiatric beds. There aren't enough. Okay? So when a parent, by some miracle is able to get a child admitted into a psychiatric ward, and I'll talk about that in a second, I said a miracle, right? They're in, they're out. It's a revolving door. Get them on some medications. Get them out, no aftercare. Okay. And the child goes back out and the child is acting out again. So that's a major problem. So we need more beds and we need for them to be stabilized there, again part of that insurance. The major, major issue and this is what we need, the whole idea -- and we've seen it play out in the media. The shootings in -- the shooting in Connecticut, what has happened in different parts of the United States, and so on. Young people are very much afraid of the stigma of mental health issues specially schizophrenia, depression and schizophrenia. They want to pretend that they don't have it. These are very serious mental health

issues. And therefore they don't want to get help. They don't want their friends to know that they're on medication. They don't want their friends to know that they have a schizophrenia where they're hearing things and seeing things. And, therefore, when their parents try to get them help those kids are completely resistant, parents pulling their hair out. Because unless you're a danger to yourself or others you cannot be hospitalized, and that's what happened with many of the shooters, they were right below that threshold. At the time they were seen, they weren't a danger to themselves or others, but 30 days later went out and killed scores of people. So we have to work with that law to see we can help parents to get their kids hospitalized and stabilized for their schizophrenia.

REPRESENTATIVE LARRY BUTLER (CT): Thank you very much.

DR. JEFFREY GARDERE: Pleasure.

AUDIENCE MEMBER: Thank you doctor for being here. Just a one real quick question.

DR. JEFFREY GARDERE: Yes, Senator.

AUDIENCE MEMBER: Telemedicine, do you see that at all helping in terms of mental health? There's a big advocacy on behalf of advocate groups to expand Medicaid, Medicare coverage for telemedicine in rural areas and we've been pushing for it in the urban environment. Do you see that helping in terms of mental health issues?

DR. JEFFREY GARDERE: Absolutely. Here's a situation of where -- especially with young people who may not want to go in and see a clinician --we could do this through telemedicine. Physicians, psychologists, social workers talking to one another through telemedicine, being able to connect the dots about a particular person. That has to happen. The fact is, even though we should be out there making more one-on-one contact, we're doing everything via computers, we're staying home more, we have our command centers where we are. We have command centers in our school. We don't have to, in our schools, we don't have travel hundreds of miles to get what it is that we need especially if there's not a lot of that service there. So telemedicine is something that is extremely important. And where quite frankly we are headed, we will be there, and it will be just a very basic part of our medical and psychiatric care.

REPRESENTATIVE GREG PORTER (IN): Thank you. Greg Porter from…

SENATOR CONSTANCE JOHNSON (OK): Greg is going to ask a couple questions. And then we're going to end the questioning after my brother from South Carolina because of the timeframe. Oh, I'm sorry. I'm sorry. I'm so sorry. But Chicago will be the last question. The State of Chicago will be the last question. Yes, Donne Trotter.

REPRESENTATIVE GREG PORTER (IN): Thank you. A couple of questions. One of them -- thank you doctor.

DR. JEFFREY GARDERE: I'll answer them very quickly because I know you guys are pressed for time.

REPRESENTATIVE GREG PORTER (IN): Greg Porter from Indiana. This is from the Internet. Are there any positive aspects of Black culture that we can draw on to fight depression?

DR. JEFFREY GARDERE: Very quickly. Positive aspects of our culture that old saying, "What doesn't kill you will make you stronger," we have survived slavery, we have survived discrimination, we have survived poverty, and so I think a lot of these things make us much, much stronger in dealing with our mental health issues and, again as I pointed out dealing with our elders. We listen to our elders. Look, there was a time where we would take old people and lock them away. Now, we know more than anything else that our elders are our most valuable resources and have always been in the African-American community.

REPRESENTATIVE GREG PORTER (IN): Thank you. One more quick question from the Internet. And we have talked about youth in your remarks and a follow up to that. Well, how do we start educating the community, schools, and perhaps even employees to look for symptoms as a respond appropriately to our youth in regards to depression?

DR. JEFFREY GARDERE: One of the things -- I was contacted by CNN yesterday because of they finally did the psychological autopsy on Ariel Castro. And what they determined was, excuse me, that he was now shown a film on suicide. And he should've been shown this film because every inmate should get that. So I take that point to say, here what we need to do in our schools is educate all of our employees. We need to make them junior clinicians. We need to get them to understand what depression and ADHD and childhood mental health issues look like. We need to show them films. We need to educate them and we need to accept their input as to what they see is going on and not say, "Oh, well, you're a custodian. We -- you know, what you have to say is not important," or "Well, you're a teacher, so you should just be teaching." No. All of us need to contribute. All of us need to learn. All of us need to be trained. As we're training one another as to what the aspects of mental health issues are. And so this way we act as a community to deal with the issues.

REPRESENTATIVE JOANNE FAVORS (TN): I am Joanne Favors from -- State Representative from Tennessee. We tend to think of thyroid disorders primarily in females.

DR. JEFFREY GARDERE: Right.

REPRESENTATIVE JOANNE FAVORS (TN): I'd like to know how frequently are you seeing depression and suicidal tendencies in male youths related to thyroid disorders?

DR. JEFFREY GARDERE: Well, first and foremost, I'm not a physician. And so on that particular point I don't think that I would be the best qualified person to address that, but I can tell you not -- with regard to thyroid, okay, but we are seeing an increase in suicide among our Black youth, an explosive number. I don't know if that's based on issues with thyroid. We know that there are many of those issues where we misdiagnose on many women as being depressed and in fact it's a thyroid issue that maybe causing the

depression. So we're treating with antidepressants and not treating for the thyroid condition or where we have a bipolar and we continue to treat and treat and then now the thyroid stops working and that becomes a major issue. But what we are seeing is that increase in suicide numbers among our African-American youth. They don't know why it's happening. Can thyroid be one of those factors? I think that's something that we really need to look at. Thank you.

REPRESENTATIVE JOANNE FAVORS (TN): Thank you.

REPRESENTATIVE KENNETH DUNKIN (IL): Ken Dunkin from the Great State of Chicago.

DR. JEFFREY GARDERE: Chicago is my kind of town.

REPRESENTATIVE KENNETH DUNKIN (IL): Hello. Doc, what we know as legislators -- disproportionate number of African-American and Latino young folk and adults in the penal system in all of our states, unfortunately. We also know that there's a tremendous amount of psychotropic drugs being -- drugs being prescribed to a lot of these inmates. Some from what I understand against their own will, sort of an either or scenario, "If you don't take your medications, you're not coming out of the hole," or, "You're going to the hole." How do we get a handle on assessing the impact of all these psychotropic drugs because again, you know, drug companies like to sell drugs? But it's sort of the best kept open secret of a population that we sometimes want to disregard because we sort of categorize them in our head as they did something bad therefore they're getting whatever they deserve in the penal system. So how do we -- how do we get a sense of what's really going on with the over-prescribing of psychotropics with our imprisoned population?

DR. JEFFREY GARDERE: We also see that happening not just in the prison population but with our veteran population. A lot of veterans have complained that they have basically been told that if they don't take this antipsychotic, psychotropic medication, neuroleptic that they're not going to be -- they're not going to continue with the treatment. They can't keep their diagnosis of PTSD, their disability, and so on and so that's a real, real problem. It's really about the mindset, isn't it? We should -- in Russia, as we know psychiatric -- at times, psychiatric treatment especially people locked away in asylum, it's about a punishment. Okay? You have a political belief and therefore you must be crazy. And we're going to treat you with these neuroleptics that have a lot of very severe side effects. We have to get out of that mindset within the prison systems. And by the way, I work for the Bureau of Prisons for several years. I was the Chief Psychologist at the Metropolitan Correctional Center. First of all, and again, I talked about this Ariel Castro thing. They went ahead and did -- again with this psychological autopsy, they're finding this person was not -- as much as we hated this individual, we've revile this individual for these horrible crimes, the kidnappings, you know, the sexual torture, and so on. It's not our job within the prisons to be judge, jury and executioner, you treat that inmate the way you treat every other inmate. And so what happened in many of these prison systems is they would say, "We need to manage you." If you're acting out, okay, if you're hostile, if you're aggressive, instead of giving them psychotherapy and working with

them and doing behavior modification to find out, "Well, why is this person so angry? Why is there so much rage?" Well, duh, that's what got them into jail in the first place. Okay. It wasn't like they were [MAKES NOISE] on the outside and on the inside they're this animal. Okay. There were things that happened to this individual. We know 90 percent of our prison population had some major family dysfunction. One-parent households, they were physically traumatized, sexually traumatized which is why when someone who is a sexual predator goes to jail, they end up beaten or killed because inmates who suffered that same physical, sexual trauma take it out on that particular individual. That's what they went through. So if we were able to work with these individuals and look at why they behave the way that they do and looking at therapy and yes, psychotropic medications to help them, not to manage them, not to get them to be docile, then you would see that that over-prescribing would suddenly stop happening. That only the person who has auditory hallucinations, who has the break from reality, who has a real schizophrenia or depression is actually -- or bipolar -- is actually getting the medications, not someone who's just aggressive, not someone who may just have a personality or a conduct disorder. So, it's about getting out of that mindset of punishment and more of treating and more of rehabilitation, and I'm afraid we've forgotten that whole idea that when it comes to prisons, that it should be about helping them to be better individuals so that when they do come out, that they are productive citizens. What we're doing is punishing. We punish with fists, we punish with medications, and so when they come out, they end up re-offending and becoming worse than when they went in.

SENATOR CONSTANCE JOHNSON (OK): Let's give Dr. Gardere…

DR. JEFFREY GARDERE: Okay. Thank you.

SENATOR CONSTANCE JOHNSON (OK): Thank you. Let's give Dr. Gardere another hand. You just did it. And so when it comes to who, what, when, where, how, and why of depression, you just got a real quick -- like, he said -- depression 101 seminar. It went quickly but there was a lot of useful information that we want you to marinade on and factor it in as we go through the rest of the day. We're gonna take about a 10-minute break which means we will be back here at…