SENATOR CATHERINE PUGH (MD): Okay. Good morning everybody that's here and on time and in their seats where they belong. Let me just say I am State Senator Catherine Pugh from the great state of Maryland and your President-Elect of the National Black Caucus of State Legislators. It's really great to be here with you all this morning. I'll be moderating this dialogue number two and let me just say, let's give Dr. Gardere another round of applause. He certainly provided us with the kind of information that I think that will help us as we move forward in looking at this whole issue around depression, its manifestations, diagnosis, and treatment. He talked to us about the cultural -- the need for cultural competency in terms of the teaching of our doctors and so forth as they move into treating people in our community for mental illness. He also expanded on the issue of telemedicine that's certainly going to have a great impact on our future as we begin to continue to treat people in our neighborhoods. I must just stop for a minute and let you all know that this is where the rubber meets the road when we talk about what we do when we leave here. This is where we begin to look at some of the conversations that will take place after this about the kind of legislation that we need to make sure puts in place, because when we see the issues that impact our communities from the church level, from our neighborhoods, and our communities and as many of you all know, from our own individual homes. We need to understand what kinds of treatments and supportive systems need to be put in place in order for us to move forward and we've got some great speakers with us this afternoon. Let me just say that our speakers are going to take between five to seven minutes and we're going to pull them back a little bit so that they can give us their brief introductions of themselves. Their introductions are -- their bios are in your folders. So, I'm just going to give you the names of our panelists because you can read them very thoroughly in your folders and I'm sure that they'll provide some introduction as they come to the podium. Dr. Shelvy Haywood Keglar -- is that how I say -- Keglar?

DR. SHELVY HAYWOOD KEGLAR: Keglar.

SENATOR CATHERINE PUGH (MD): Keglar, who we also heard from last night, who shared some very outstanding views as it relates to psychology and mental health and some of the areas that we need to be dealing with. And then we have Ms. Nakaisha -- NaKaisha Tolbert-Banks who's with us and she'll be sharing some information with us as well as Ms. Aja Casey. So, to get us back on time, we're going to move forward and I'm going to invite Dr. Shelvy Haywood Keglar to come to the podium. He's a Clinical Psychologist, Midwest Psychology Center, Incorporated.

DR. SHELVY HAYWOOD KEGLAR: Good morning.

AUDIENCE: Good morning.

DR. SHELVY HAYWOOD KEGLAR: After last night's presentation, you know, when I got home, the first thing my wife asked me was, "How did it go?" I said, "It went okay." And she's, "Did you tell your corny jokes?" I said, "Yeah, I did."

SENATOR CATHERINE PUGH (MD): And you said yes.

DR. SHELVY HAYWOOD KEGLAR: I said, "Yes." She said -- so, she got my iPad and looked at it and said, "You know, do you want me to do your presentation tomorrow?" So, I'm glad to be here this morning. We are in a time crunch and I have some specific information I want to get out to you. First, I want to talk about and start with, "What is a definition of -- what is a mental disorder?" It's very important that you know as legislators that all eccentric behavior is not a mental disorder and you need to know that in order to -- for the Marketplace and the Affordable Care Act to really be of use, you have to be diagnosed to qualify for services in those insurance plans. These are medical plans. These are not social plans. These are medical plans. So, what is a mental disorder? A mental disorder is a condition characterized by a dysfunction in thought, behavior, and mood, which usually causes distress. The condition should not be primarily a result of social deviance or a conflict with society. That is what a mental disorder is. Not a conflict with society, not social deviance. And you have to be very careful when we see some things that are just anti-social behavior or sociopathic behavior, that's not necessarily a mental disorder. A mental disorder is diagnosable and you have to have that to qualify for the services with the insurance companies. So, I want to make that very clear, that you understand that. You've heard a lot of talk about bipolar whether it's bipolar I or bipolar II. I want to just give you the parameters of what constitute a bipolar disorder. A duration of one week is a minimum for a diagnosis of bipolar. You have the manic and the hypomanic. Grandiosity is a major one of bipolar disorder. You heard the previous speaker talk about grandiosity but I'll give you an example of what is grandiosity. We were treating a physician in this city some years ago and she called another physician at 4:00 in the morning and said, '"You know, I have some ideas about how we can take over the Medicaid system and run it better for the state." He, of course, said, "Do you know what time it is? It's 4:00." "Yeah, but I've got this idea. It just came to me tonight how we can take over the Medicaid system and run it better." She had to be hospitalized. That's the grandiosity. Decreased sleep. 4:00 in the morning, she was still up. He's like, "Do you know what time it is? It's 4:00." "What are you doing?" "I'm sleeping." There was this question to it. Decreased sleep. Talkative, another characteristic. Flight of ideas, that means you have all these different ideas, you can't settle on one. Distractibility, easily distracted. Excessive energy, yeah, you got this energy you don't -- don't need sleep. And excessive activity and ideas that have negative consequences. You have a lot of ideas and most of those things if you pursue them will lead to something negative. That's the basis of a bipolar disorder. And we talked about the treatment of bipolar. The first thing that is done usually is the mania is medicated first because the person has to be medicated with something for the mania. Then once the mania is medicated -- that's why you usually have someone -- they're usually diagnosed with bipolar, they have a manic-depressive, Lithium or something, and they also have an anti-depressant. So, you treat the mania first and once they come out the mania then they're going to become depressed so that's why you have a depressant. So, you usually have them on both medications. The depressive disorder is just a highlight of what a disruptive mood dysregulation disorder, the first one -- this replaces bipolar in children and DSM-5. Dysthymia is less severe depression but it has to last for two years duration. Another -- a new diagnostic category in a DSM-5 that just came

out in June of this year is premenstrual dysphoric disorder. It's new. There's been some criticism by females about this, some groups, but it is real because I've dealt with females who experienced this and it was a tremendous problem. They have to show five of these eleven symptoms to have a premenstrual dysphoric disorder and it's due in the final week before their menses and these things are not there the week after their menses. So, that's what this new diagnostic category means. And here they are, sadness, lability, irritability, decreased activities, lack of energy, appetite changes, hypersomnia or insomnia, feeling out of control, and physical symptoms for that diagnosis. A major depressive disorder. You have to five of the following, depressed mood, diminished interest, insomnia or hypersomnia, psychomotor agitation, fatigue, worthless feeling, poor concentration, recurrent thoughts of death, and suicidal ideation for a major depressive episode. And you say, what is, you know, what is depression? Well, I'm going to give you a little quick example, this professor was in his mood class. He was teaching his students and he said, "You know, let's get some parameters together. What is the opposite joy?" And his students said, "Sadness." And he said, "Well, tell me, what is the opposite of depression?" He said, "Elation." And he asked his student from Texas he said, "What is the opposite of woe?" And she said, "Sir, I think that'd be giddy up." I still got my corny jokes.

AUDIENCE MEMBER: Another one you brought.

DR. SHELVY HAYWOOD KEGLAR: Okay. Comorbidity is a real issue with depression. Comorbidity, depression and alcoholism, that's a comorbidity issue you see a lot. Depression and post-traumatic stress disorder, you've heard about all the things that cause post-traumatic stress disorder in our community. Depression and anxiety disorders. Depression and these physical ailments. In our community, we know that obesity is a problem and usually patients who have obesity and are depressed, they're less treatment-compliant, less treatment-compliant. The same goes with diabetes and also COPD. Patients who have the comorbidity issues are less compliant and these are the ones that need to be -- the ones I've listed are the most frequent ones you're going to see that have to be treated. And what -- some of the treatments, most of the major depressions, the first thing you have to be treated with medication and that's the serotonin reuptake inhibitors or the serotonin-norepinephrine reuptake inhibitors. And our sponsor has one that's frequently used in both of those categories that's pretty prominent. They also have the only psychiatric drug that's approved for children. So when you talk about treating depression in our community, one thing that we found recently and I know I have some time limits but our black men coming out of prison. When you have all the -- one of the things of depression is hopelessness and there's a difference between grief and depression. In grief, you long for the person but depression, the difference between grief and depression is when you have depression, you have feeling in yourself of worthlessness and lack of hope. In grief, that is not that case. That is the major difference between grief and depression. And when you have individuals coming out of prison as so many of our men do -- I mean African American men. And they have no avenue for jobs and they have a felony, one thing that our association fought for over six to ten years was to get expungement of the felony records, so that we could have African American men take their rightful place if they could get a better job. You

can't do that with a nine or ten-dollar hour job at the table. And Indiana recently after fighting this for 11 years, Indiana recently has enacted an expungement law and we think -- and folks asked us when we started this, "How is that a mental health issue?" It's a mental health issue because of the hopelessness that our black men were facing when they come out of prison. And that's why our association took it on as a mental health issue and it has finally come to fruition in this state. Thank you.

SENATOR CATHERINE PUGH (MD): I'm going to have NaKaisha Tolbert-Banks come. She spent over 15 years in the field of social work. She has a B.S. and a master's degree, master's from Indiana University in social work. She currently serves as the Director of Education and Public Affairs for Mental Health America of the Greater Indianapolis area. Please come on up. Thank you.

MS. NAKAISHA TOLBERT-BANKS: Good morning, everyone.

AUDIENCE: Good morning.

MS. NAKAISHA TOLBERT-BANKS: I unfortunately do not have any great jokes for you. I am horrible. So I'll just go with what I got here, which is the education part. So this morning, I've heard some good conversation and questions just about various aspects of depression and we talked about the mental health piece and one of the things that I do and have done for probably the last eight or nine years within various positions -- within the state of Indiana is to really look at and address the mental health piece and the mental illness piece and the education within various communities, more specifically focusing on minority communities. One of the things that I always address any time I do trainings, just speaking events, health fairs even, is just to talk about the difference about mental health and mental illness because there definitely is a difference. The way that I generally tend to explain it is when you go to your doctor for an annual checkup, the doctor comes in says, "You got a clean bill of health," you know, you're excited about that. You don't think, "Oh, my gosh. What's wrong, doctor? How long do I have to live? Tell me what I need to do." Because he's saying you have a clean bill of health. When there's an illness that comes into play, that means that there's something wrong, something that needs to be investigated further or something that we need to look at to determine a mode of treatment. So that is the exact same thing with mental health and mental illness. When we talk about mental health, we're talking about and addressing when things are going well. The things that are right, that were on track, that everything is pretty much together. When we look at the difference in mental illness, what we're talking about as Dr. Keglar addressed, are there are some deficiencies. So there are some things going on that need to be addressed. So those are some of the things that I think specifically when we look at the African American community are important to address is just the simple education piece. Other things that are important to address as it pertains to mental illness in the African American community more specifically depression is the fact of stigma. There's a lot of stigma that's attached to mental illness as well as depression. So when we look at men and women, there are some differences but there are some -- a lot more similarities. You know, their shame and disgrace, you know, “What are people going to say about me if I seek treatment?” “What are people,” you know, “how are they, you know, going to feel about me?” “Will

they treat me differently? How will this affect my family if I go and seek help?" Even with children, and we kind of look at children that may be seeking help, as parents we say, you know, "Will teachers look at my kids differently? Will teachers treat my children differently?" So there are a lot of different stigmas that we need to address when we look at mental illness within the African American community. Another factor that I think is important are the treatment barriers. Again, that comes with the education piece. "Where do I go to seek treatment? How do I access treatment? How much is it going to cost? How long do I have to be in treatment if there's an issue?" A lot of these factors are things that people sometimes talk to friends about. Your friends may not necessarily know the specific ins and outs. So again, that's for us as providers to be able to educate the community about how to access treatment, where to go. A lot of times when you don't know, you just don't do. I know it's kind of cliché that knowledge is power but when you're educated, you can then have the means and the access to make better decisions. So I think that that's another very key aspect of the education piece within the African American community is to get that out. To kind of go back -- and I think that this was addressed in the presentation earlier this morning -- depression, when we look at overall depression, is the most common and most treatable mental illness. So, it affects one in four adults and approximately one in ten children. So what I like to do, especially when I'm doing trainings, is to go around and count. One, two, three, four, people raise their hand. One, two, three, four, people raise their hand. Even if we went across this room and looked at that statistic, that's quite a few people within this room. So when we take it out to the greater community, we're looking at the fact that that is a large number of individuals within the African American community. One, who are -- who could potentially have that diagnosis as well as the fact that these numbers may be higher because it's not necessarily reported. Okay. Thank you.

SENATOR CATHERINE PUGH (MD): Thank you. Give a big round of applause. And now I'm going to invite Aja Casey up the mic and again just a reminder to you all, these bios are in your portfolio but I just wanted let you know that she too has a master's in Social Work from Michigan State University. She's an LSW. She does a great deal of work in the Indianapolis community around public health. Please welcome her you to the podium. Thank you.

MS. AJA CASEY, LSW, MSW: All right. Good morning, everyone.

AUDIENCE: Good morning.

MS. AJA CASEY, LSW, MSW: Almost afternoon. So like was said, I am a -- I am currently working as a school-based therapist so majority of the information that I'm going to provide today is on the child and adolescent point -- standpoint. So, if you have any questions, I'll be more than happy to answer those. One of the main questions and we have discussed and we put them all in one category is on children with depression. So, it is true children do suffer from depression. About 2.5% of children suffer from depression and it's not necessarily seen this way that children -- or males younger 10 years old has a higher percentage of depression. It kind of sky rockets in percentage when you go to the 16-year-old female age. Part of that is because -- and when you think of symptoms of depression in children,

aggression and anger is a very large number of our children because they don't know -- they don't have a way to express themselves. They're still learning those words and how to use them and what their body feels like. So, the way for some kids to express themselves is aggressively. Some kids they shutdown, they're very quiet, they're very to themselves. So it -- there's different ways they manifest and it's also in different settings that it manifests as well. So children spend most -- once they're school age, they spend most of their time in school. So that's why teachers tend to see a little bit more things. There are things that are off than the norm of kids, that this kid is doing something a little different or this kid is vocally expressing themselves or crying out loud and they're unsure of how to -- how to address the issue especially if -- parents along with what NaKaisha was talking about, with the stigma -- if a, if a teacher comes to them with this -- with this thing to address then a parent may not -- may not want to discuss that because they don't want their child to be seen a certain way. So some of those -- so another thing that happens in children as well along with adults is the change in appetite, the change in sleep, reducibility of wanting to do extracurricular activities, just wanting to sit on the couch and watch TV. Does not want to go outside and play basketball. Doesn't want to learn or find new friends or be a part of different activities in school. Low grades is also another thing that happens in children as well. A lot of -- a lot children also because, you know, we have the special curricular activities in school so art, music, they don't want to participate in those things because one thing they feel like all of the attention is on them when this is -- when it's not necessarily true. So that's another thing that their grades may not necessarily be lower in math but it may be low in arts, in music because they don't have that interest in that, they don't want to be a part of those things. This can be very stressful for parents and one of the things that Dr. Gardere talked about was the single mother. If you have a child who has aggressive behavior and they are in school, then the principal might be calling the mom every single time something is happening. That can be very stressful on a mom who needs to work and get -- and get bills paid for. So, if she has to go home or has to go to the school to pick them up, that takes her away from her job, that takes her away from the money piece for her. So, that causes more stress on the family because my child is not doing what they're supposed to do. I just need them to do what they need to do so that I can do what I need to do to provide for the family. Some barriers to -- some barriers to depression in children is the lack of knowledge. The lack of understanding that children do suffer from depression, that children do have the symptoms that adults also have as well and some of those are, some thoughts is, you know, we all – “Everyone in our family is like this.” Well, that also may -- that also mean that the family also -- there might be a family history of depression that has been untreated. So that's something to think about. There's also a history of misdiagnosis. And in families if, you know, we all talk and you hear different stories from other family members or different friends that something has happened in their -- with a therapist or a psychologist and they don't want that to happen to them so they don't -- they don't want to seek treatment themselves because of lack of cultural understanding or misdiagnosis. So there's a huge piece of -- a huge stigma in that. One of the things that is very important that -- a consequence to leaving depression untreated is suicide and an increase in drug and alcohol use in children. Typically, over the age of 12 you do -- there

are times where you do see that in -- under the age of 12 where they're using alcohol and drugs. But it's typically used -- there's a higher percentage over the age of 12. And suicide attempts are also very common. In young children, this is more impulsive behavior. They're very angry so they don't want to be here anymore and they impulsively have this -- make this attempt. Girls are more likely to make an attempt as well but boys have been more successful in their attempts. So that's something to really think about. There are a lot of cultural strengths -- excuse me, I didn't mean to sniff on the-- in the mic. There are a lot of cultural strengths, we -- we're -- we rely on our family. We have the idea that it takes a family to raise a child. So, that is a very big piece but the knowledge needs to be there as well of what this actually means, what our child is doing, what does that mean for our family, how can we address this -- address this as a family. So not only is therapy, psychotherapy important for children, it's also important to have family therapy. A lot of families may think, "Oh, it's just the child," but isn't -- this child is a part of a family and how are we going to address it as family not just the child address it themselves, because like we've said they need to -- the child doesn't know how to express their feelings. So being part of that family therapy is very, very important. So like I said, I'm going -- I will be here to take any questions on children and families and how that works and how that manifests in our community and thank you for your time.

SENATOR CATHERINE PUGH (MD): Thank you. Thank you, Aja. Give her another round of applause. Thank you. We've got about 30 minutes for questions so you all can line up at the mic and I think Greg is going to take the internet questions and I just -- I want to start off with one question and that is, does mental illness manifest itself any differently in the African American community?

DR. SHELVY HAYWOOD KEGLAR: Well, I think a very diagnosable mental illness, the symptoms are going to be the same regardless of who it is. The precursors or the causes of some of the things that bring out mental illness will be different. For instance, a bipolar and some of the depressive disorders have a strong genetic base and so does alcoholism and substance abuse. That's irregardless of color, but how those things come out could be triggered by different things because some of these happen between ages of 16 to 24 for instance. So the things that a person experiences in the African American community would be different that would trigger the episode to surface.

SENATOR CATHERINE PUGH (MD): Yes.

FORMER REPRESENTATIVE BILL CRAWFORD (IN) Thank you.

SENATOR CATHERINE PUGH (MD): And don't forget to say your name and your state.

FORMER REPRESENTATIVE BILL CRAWFORD (IN): Yes. Bill Crawford, Indiana. My question would be that we know that many of the issues and concerns that impact our community are driven by -- are resource-driven and with absent resources, people have difficulty navigating through the process. Would the ACA offer us an alternative in that -- I had anecdotal comment given to me earlier this year that a gentleman who was a -- wanted to receive service got an appointment 90 days out from his request for

assistance, is that common in Indianapolis or in Indiana or across the nation and is there a metric that we can use to do a comparative analysis as to effective programs where they are, and can they be emulated, and will the ACA help in that?

DR. SHELVY HAYWOOD KEGLAR: I want to address this.

SENATOR CATHERINE PUGH (MD): Who would like to take a stab at that?

DR. SHELVY HAYWOOD KEGLAR: Okay.

SENATOR CATHERINE PUGH (MD): Doctor?

DR. SHELVY HAYWOOD KEGLAR: Yeah, I will speak to that. I think the issue is if it's delayed in some cases, that's the same as denied. If you have to wait several months for an appointment and that is -- I do work across this state and other states, and it is a problem. The ACA should allow more access and that should help because you have more plans. For instance, if a person calls my office or calls any of the mental health centers, the first thing the person wants to know is your insurance, then they have to call the insurance and find out does it cover mental health. That's the second thing they have to know. Do you have insurance, does it cover mental health? Well, the ACA is going to cure both of those. First of all, the person should have insurance and if the insurance plan is mandated to cover mental health. So there should be more access based just upon those two things because as it is now, we all have to be on certain panels, insurance panels. And all doctors, all psychiatrists or psychologists don't get on all of them. So if someone calls my office, my administrative system has a list of the panels that I'm on. And if I'm not -- I'm not on that panel, I can't see that person. But with ACA, every insurance company will cover mental health. So, there should be more access.

REPRESENTATIVE CHARLIE BROWN (IN): Charlie Brown, Indiana. I have a favorite saying, "If you hear that Charlie Brown committed suicide, call the homicide detectives," because in my -- in my era, suicide among African Americans was already almost taboo. When did this change so that that now you hear more and more about suicides in the African-American community and why?

DR. SHELVY HAYWOOD KEGLAR: You can speak to that.

MS. NAKAISHA TOLBERT-BANKS: I can speak to that. We're looking at an increase overall of suicide and probably within the last maybe 20 years or so we started to see an increase. We're actually starting to see an increase more now with our younger African-American males. We look at stressors. Dr. Keglar addressed earlier we're looking at individuals that are coming out of jails and prisons and the needs that are there that are being -- that are not being met. So, lack of employment, parental stress, you know, whether they're going through problems parenting or not parenting. What's going on within the home, communities that they're living in. A lot of times that stress of the environment. You know, you're wanting to have better and live better but you don't have the financial means to do so. So, I think that there's a lot of different stressors that are going on that are just causing this increase. Again, you know, and I can't

stress enough the lack of knowledge about how to access resources and addressing that stigma that if you, you know, reach out to get mental health services that you'll be labeled as crazy or treated differently. So I think, again, addressing that education piece is important because without that, as Aja talked about, when we have these diagnosable mental illnesses such as depression that gets worse, then we're looking at the ultimate of suicide because it's not addressed.

DR. SHELVY HAYWOOD KEGLAR: And I'll just dovetail on that. Now, we have this saying that "Education must peak at age five, they have all the questions. Seventeen, they have all the answers." If you look at some of the things that are happening with most African-American males and I asked most of them. "Do you know someone who committed suicide?" And today the response is most of them, at least 75 to 80% know someone who committed suicide. And I've been practicing over 30 years but if I asked that question prior to 20 years ago, it wasn't the same response. Most studies show that most African-American men, young men do not expect to live past age 25.

AUDIENCE MEMBER: Right.

DR. SHELVY HAYWOOD KEGLAR: And you've seen that in the media recently. The young men who shot the policeman here just told folks, "I want to just make it to 25." That's what he said, "I just want to make to age 25." If you look at some of the -- some of the other homicidal things that African-American men have done recently, the policeman in California, when you walk up to someone that is -- and your hands behind you and you have a gun, you're committing suicide. So, the expectation -- the life expectancy with African-American males they -- most of them do not expect to live beyond 25.

AUDIENCE MEMBER: Wow.

DR. SHELVY HAYWOOD KEGLAR: And I think when you look at that that life expectancy, you don't value your life, then suicide becomes an option much easier than it was 20 and 30 years ago.

SENATOR CATHERINE PUGH (MD): Yes.

REPRESENTATIVE KENNETH DUNKIN (IL): Kenneth Dunkin from the great State of Chicago.

SENATOR CATHERINE PUGH (MD): Yes.

REPRESENTATIVE KENNETH DUNKIN (IL): Given that right now most psychotherapist are pay fee-for-service today but with the Affordable Care Act, it's going to be sort of come one, come all. How is that going to incentivize you as practicing therapist to diagnose for a treatment, successful treatment given that it's going to be a continual sort of base level of fee? In other words, in Europe they're incentivized and they get bonuses on the health of that patient. How is it going to impact your respective profession or this profession in mental health compared to just being sort of okay--or another like your public defender or prosecutor where they have 35 and 60 cases and they're just, you know, they're blasé about it. How do you see the ACA impacting your profession on treatment?

DR. SHELVY HAYWOOD KEGLAR: You want to speak to that?

MS. AJA CASEY, LSW, MSW: Thank you. This isn't -- Okay. So, in regards to performance-based services, I think that they're -- depending on the -- if people --once people get their insurance, if they decide that they do need the service that they do need mental health services then the number will increase. So, for instance not -- this is not my caseload, because I'm working in a specific area -- there are therapists who have 60 -- there -- 60 patients on there -- on their caseload. So, that number could increase if there aren't any other therapists that are coming onboard in regards to just being a part of -- part of the agency. The -- I don't necessarily know if the care would change because, in my -- in my ethical standpoint, I feel that the care is number one, is always -- is always person-centered. So if they are -- if they want to be a part of this -- if they want to be a part of services and they want the treatment, then it's going to be about showing, you know, being -- to show up for it. If they don't have the drive for it then that's when -- that's the -- that's the piece that's going to be -- that's going to fall or going to be questioned, is what's their drive. Now, someone who has depression, they may not have the drive to get up to go to therapy this time. So, it's finding new ways to get them involved, to keep them to come to therapy that is not -- it may not even look traditional anymore where you're just coming to a therapy office, maybe you're going to them but that's also -- it depends on how that looks in regards to what's provided in insurance and what insurance is going to pay for. So, things could possibly change and we're -- I mean that's a big -- that's a big question mark on what that's actually going to look like nowadays.

AUDIENCE MEMBER: Great. We'll take one of your questions from the internet and then we'll go over here.

REPRESENTATIVE GREG PORTER (IN): Okay. Thank you very much, madam chair. One question is, “How does depression manifest itself differently in veterans returning from the war? And is it -- and is the treatment for veterans different than anyone else?

AUDIENCE MEMBER: Uh-hmm.

DR. SHELVY HAYWOOD KEGLAR: Just as a prelude, I'm a veteran. And we had a conference two years ago dealing with veterans here right around the corner, PTSD and veterans returning with various illnesses. And we're also a part of an agency, the VES. We do evaluations 20 or 30 a week of veterans. Part of the problem with that -- depression, clinically, you're still going to have the same clinical symptoms to -- in veterans as anyone else. But the veterans when they have a whole entourage of obstacles that could trigger when they come back—failed marriages, financial problems. And financial problems with anyone is a big part of depression. You can't meet the -- your needs. So, veterans have all those things stacked against them when they come back. Let's exclude the mental things that they have experienced but just adjusting back in life. So, yes, you have veterans who have job problems and they've gone and served and then they have to come back and they have problems transferring what they did in the military to a civilian job, and that's the number one problem on most of them. You think about it. The ones who

go overseas and fight, how do you translate that to an occupation back here? What does that translate into? It's difficult. And then you have the family problems. So, yes, those are some of the things that veterans face in addition to what they've seen over there, that's a PTSD issue. And when we evaluate veterans, we see depression but most of the time it's a comorbid with PTSD. They are both there in most veterans.

SENATOR CATHERINE PUGH (MD): And just for our audience, PT--I was going to say the initials. You just might want to say that out loud for our audience, for people who didn't -- the acronym, for people who -- we have people listening on the internet that may not know the acronym.

DR. SHELVY HAYWOOD KEGLAR: Oh, PT -- oh, Post Traumatic Stress Disorder. I'm sorry,

SENATOR CATHERINE PUGH (MD): Okay. Alright. Thank you. Next.

REPRESENTATIVE EARL HARRIS (IN): Okay. Representative Earl Harris, State of Indiana. How many kids do you find in their early stages in school that you go through and you find out that they are very bright kids, they're very bright kids and all of a sudden they just shut down in the grades level stop? Would you classify that as a form of depression? And do you really go at those kids to try to get them some kind of mental health treatment? I think most of our kids that we find in school is -- there's few of them that just don't have it up here. But you have so many of them that's just bright and they just make the decision that, "We're not going to. I'm not going to do well in school. I'm going to shut it down. I'm not going for it." So, is there anyway that you -- we could scout that and find out exactly -- is that mental health this -- is that depression and how we make to their -- the level?

MS. AJA CASEY, LSW, MSW: If we're -- if we're looking at children who are bright and they're -- and that are in school, one of the things that a parent could do is bring it up to the principal or the school social worker. School social workers are -- have their -- their degree has it where they can do that initial piece in asking questions and seeing what the -- what's going on. If it's necessary where they feel like they need more in addition to services in mental health, then they can make that referral to the parents and seeing if maybe there was an event that happened in their life where they just feel like there is no purpose, there is no need. And it may not necessarily mean that something in their life that they've seen or that they've -- that it physically -- or affected them, but it could've been something that happened to a friend and they just feel like they don't have the drive or the need anymore. So, it may not necessarily be something -- it's more about the questions that we're asking the child. Once you go from there asking those questions, then we can make more decisions on what's necessary for treatment in regards to a school social worker. Once you get to that -- the -- I mean because they can ask those questions, they're right there, they're in the school, they can see that. If a parent agrees and feels that, "Yeah, they do need -- I think that they do need assistance with expressing their feelings." Then, they can -- they can make that decision in looking into services for their -- for their kid.

MS. NAKAISHA TOLBERT-BANKS: I think -- I'm sorry. I think the other important piece of that too is just making sure that we incorporate the teachers into that as well because the teachers are in the classrooms everyday. So, they're able to look at when they see or notice a decline whether it's grade-wise or behavior-wise. And a lot of times, as Aja said, to address with that child, you know, "What's happened? You know, "I've noticed that your grades are starting to go down." Or, "I've noticed that you don't talk as much as you used to in class." Or, "I know that you're talking a lot more and you're behaving in a way that you haven't generally tended to do before." I think when we see those types of things, then we can begin to ask the questions with the child and then bring the parents in. Because at that point, you're going to need more involvement from all parties to make sure that the needs with the children are addressed.

DR. SHELVY HAYWOOD KEGLAR: I would like to add to that issue with children. Pediatricians prescribe more psychotropic medication for children than most psychiatrists. So, in addition to what they've said, I think that another step you could take with children would be to have them see a physician because with the integrated care we're talking about, you're going to have a behavioral assessment done in the pediatrician or the medical doctor's office. So, they're more likely to follow a recommendation from their family doctor. Most of us in African-American community will follow our doctor's recommendation. So, I would say in addition, once they've done the things with the -- at the school, the social worker and the parents, then you take the child to the pediatrician or the family doctor. Because if they say, "I think you need to refer them to a mental health professional," the family is more likely to do it. Most of our referrals come from pediatricians when we see children.

SENATOR CATHERINE PUGH (MD): Gilda.

REPRESENTATIVE GILDA COBB-HUNTER (SC): Representative Gilda Cobb-Hunter, South Carolina. My question is directly to the two social workers and then to the doctor, goes to the general question about the cost of healthcare specifically mental illness and people who show up in emergency rooms. I would like your thoughts on the conversations that are being held across the country in some respects about a gatekeeper system using social workers and emergency rooms to screen out some of the patients who present with mental illness, some who just can benefit from counseling. What do you think of that system? Are you aware of any such system here in Indiana? And do you think in the long run it would cut down on cost as far as mental illness that presents in hospital ERs? Thank you.

MS. NAKAISHA TOLBERT-BANKS: In Indiana -- well, specifically Indianapolis and I'll speak from having worked for one of the hospital and the community mental health centers that they do actually have -- I'll call it a triage where if people go into the actual ER there is a psych ER, if you will, where individuals that may have psychiatric needs are able to be seen in that regard. I think that that's a good access point to maintain and to integrate as, you know, if I'm going into an ER for psychiatric needs, there's someone there that can assess and determine where I need to go. If I'm at the hospital and it's an inpatient, then I can do, you know, a direct admit, you know, to the -- that inpatient unit. If it's something more of "I'm just

having a stressful day. I've got a lot of things going on," I'm still able to be seen at that point. But then being able to get connected there at the hospital versus saying, "Well, you need to wait for two or three weeks to get in in a different area." So, I think that the social workers or psychiatrists that are actually located in these facilities are able to address those psychiatric needs when somebody comes in through the ER.

MS. AJA CASEY, LSW, MSW: There's also -- if -- even if they're not coming into the ER, they may be calling the emergency line and saying that they need assistance. And/or -- and a police officer comes out. So, one of things that they have here in Indiana and I know that they're -- that it's progressively getting larger in the country is CIT which is Crisis Intervention Trained police officers, who are being educated on what to do with a -- with a call when it's not necessarily a crime-related issue but it's something in regards to the psych -- a psychiatric issue or a suicidal issue and making sure that they get to the proper place rather -- maybe being a psychiatric ER or a behavioral pavilion where they do crisis intervention and not to the ER because they don't have a physical complaint, they just have something else outside of that. So, if they're not walking into an ER and they're calling 911 for an emergency then that's an -- something that they have here and that they're working on across the country is those Crisis Intervention Trained police officers.

SENATOR CATHERINE PUGH (MD): Okay. We've got about five more minutes. So, we're going to have one more internet question and we -- that question we're going to end right over here.

REPRESENTATIVE GREG PORTER (IN): Okay. Alright. Thank you very much. As practitioners and therapists, is there a correlation between bullying and depression? And could you explain on that? Because through country, NBCSL and other, we've done a lot of legislation addressing bullying, so we set the legislation. Now, how do we deal with it from the education's perspective?

MS. AJA CASEY, LSW, MSW: One of the things that we -- in schools, talking about bullying is discussing that the bully does not like themself which kind of stems -- I mean not kind of, it is part of that hopelessness that, depression, I don't -- that low self-esteem. "I don't like myself, therefore, I don't -- I'm going to make someone just as an unhappy as I am." So, there is a -- there is a tie into depression in some cases. That might not be the case for every kid who does bully. They just may think it's funny and they want to do that. But there is also this piece of "I'm unhappy and so I want everyone else around me to feel just as miserable as I do." I saw you reach for the…

DR. SHELVY HAYWOOD KEGLAR: Well, I think there certainly is some correlation between those who get bullied and depression. As you see a lot of kids who are bullied do attempt suicide or a self-destructive behavior. So, there is some correlation with that.

SENATOR CATHERINE PUGH (MD): You're the last one. Okay. Next. And then we'll end here.

REPRESENTATIVE VANESSA SUMMERS (IN): Okay. I really want to go back to…

AUDIENCE MEMBER: Your name.

REPRESENTATIVE VANESSA SUMMERS (IN): The -- my name. I'm sorry. Vanessa Summers, State Representative, Indianapolis, Indiana. I really want to go back to the question before Representative Porter. I'm always under the assumption in Indiana that we didn't have mental health beds, you know, if there was a crisis, if there was a sudden psychotic break or something, that they were not necessarily any beds that you could take, you know, you -- you're in danger. You're -- I had -- I had a family in my church where the young man was -- had schizophrenia. And he always wanted to take it out on his mother. And when he got to the point, you know, she's had to lock herself in a room and double lock herself in a room but there was no mental health. I was always under the assumption in Indiana there was not a lot of mental health beds for us to be able to take people that are in need of help, help. Is that still so? Is it -- if that is so, is it still so in Indiana and across the country?

DR. SHELVY HAYWOOD KEGLAR: Across the country and Indiana, 10 to 12 years ago or maybe 15, there was a serious reduction of inpatient beds. And if you just take our city here, Representative Summers, you had a -- we have a Community North Pavilion, you have Wishard Hospital but we -- Saint Vincent reduced their beds tremendously, Saint Francis closed their psychiatric for a while. So, there's been a tremendous reduction in inpatient psychiatric beds and thus the criteria to be admitted as we -- the bar has been raised somewhat, and that is one thing that I think as legislators when you -- that law comes up for review, you have to look at because a lot of the things that are impeding getting care for some of those what I call more severely disturbed is the commitment loss. But there has been a tremendous reduction in inpatient beds here and most states.

SENATOR CATHERINE PUGH (MD): Okay. We're going to take our final question.

REPRESENTATIVE G.A. HARDAWAY (TN): Thank you. State Representative G.A. Hardaway from Memphis, Tennessee. When we look at the war on poverty, war on crime, war on illiteracy, et cetera, how do we, at some point, get our culturally competent providers, mental health providers such as yourselves, engaged in the development, the initial development and design of public policy to address all of these issues that we've agreed mental health plays a critical role in solving them? How do you involve yourselves in the initial design stage development of public policy on all levels—local, state, federal in addressing issues dealing with violence, dealing with education, dealing with the -- all of other areas?

SENATOR CATHERINE PUGH (MD): Okay. Who wants to take that?

DR. SHELVY HAYWOOD KEGLAR: I'm glad you asked because that's one that is easy one for me. The -- there are national organizations that want to work with organization such as yourself. We have National Association of Black Psychologists, Black Nurses Association, Black Social Workers. We all come together and we want to work with the legislators on the national and state level to address this problem. And in fact, the Association of Black Psychologists is having their first meeting in Indianapolis, Indiana next year in 45 years, we're coming here. And one of the major topics that we talk about, we

were in New Orleans two -- three months ago, is the issue of violence in the community and some of the things that need to happen. Some of our members have done studies in some cities where you have more liquor stores per mile or -- than you do of a health centers in our community. Why is that? That's an issue that you need to look at. In our communities, it's not accidental. It's by design.

AUDIENCE MEMBER: Absolutely.

DR. SHELVY HAYWOOD KEGLAR: And they've looked at L.A., where our president is based. And they have more liquor stores per square miles than other needed facilities in L.A. And we don't feel that's by accident. So, if you want to talk about what we can do nationally, you can get with these organizations that want to collaborate with the Congressional Black Caucus, the National Black Caucus of State Legislators, and your individual caucuses. We want to work with you and we've worked with the Indiana Group on several issues over the years that we've been able to get a -- move forward here in this state. So that would be the avenue to address the problem because no matter what the discipline that we work in, the issues are the same.

AUDIENCE MEMBER: uh-hmm.

DR. SHELVY HAYWOOD KEGLAR: You can take the psychiatrist off, social workers, psychologists, it doesn't matter.

AUDIENCE MEMBER: Uh-hmm.

DR. SHELVY HAYWOOD KEGLAR: The mental health and social issues are the same across professions and we all want to work withy you guys.

MS. AJA CASEY, LSW, MSW: And I just wanted to add to that, that another organization like the ones that Dr. Keglar just spoke of is also the National Alliance on Mental Illness. They are -- they are our national affiliated mental health grassroots organization that does a lot of -- that looks in -- a lot into policy and working with legislators and trying to get things involved. So that's another agency to look into and their national conference is in DC next year, so.

SENATOR CATHERINE PUGH (MD): Let's give our panelists a big round of applause. And just some quick housekeeping, hopefully you'll join us for lunch and that you will think about the things that we as legislators can do with you all. You've talked about your national organizations especially around diagnosis, misdiagnosis, and treatment, and how can we be most helpful. Let me just remind you all when we step outside this room, we're going to take a quick photo and then we're going to go to lunch. This has been a great morning. Give yourselves a big around of applause. Thank you.