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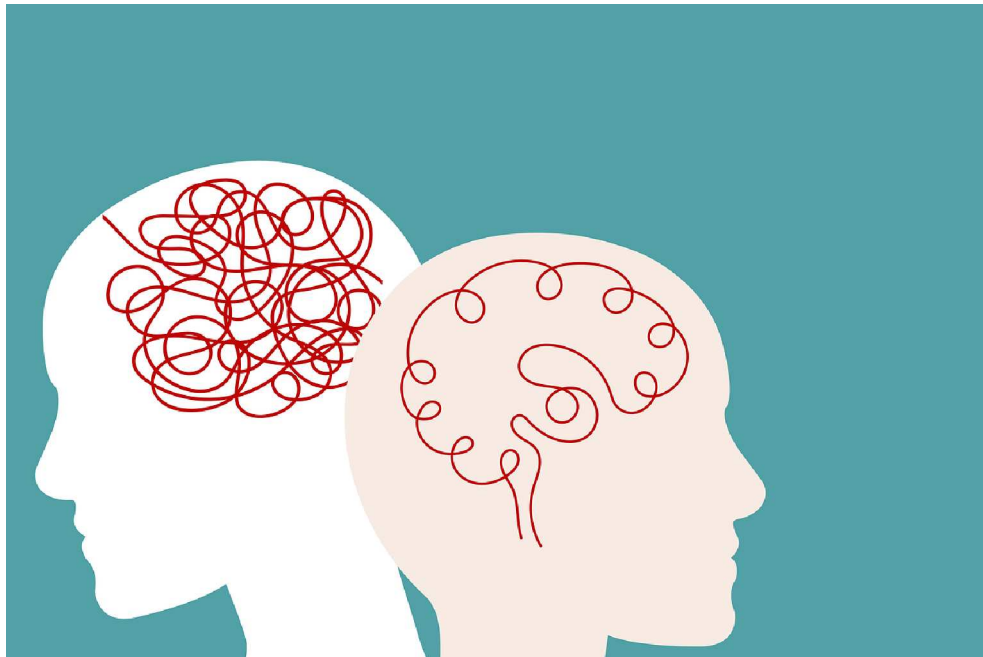
Mental Health Equity: Strategies for Community Engagement and Policy Change

Community Leaders Forum:
Report and Call to Action

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CONTENTS

EXECUTIVE SUMMARY

Intrinsic to our overall well-being, mental health is governed by a complex interplay of multiple individual, social, and structural factors which interact with each other and place us on a continuum in response to stresses and experiences. These factors include biological and psychological aspects, such as access to healthy food, adequate physical activity and sleep, substance misuse, as well broader issues, such as poverty, insecurity and violence, intergenerational trauma, discrimination, and inequalities. According to the World Health Organization (2023), mental health is a basic human right for all people. Beyond personal well-being, mental health is instrumental for communities to thrive and prosper.

While stark disparities in mental health status, determinants, as well as access to services have long existed in the United States, the COVID-19 pandemic further skewed the social and economic factors that shape mental health outcomes. In addition, global conflicts and crises, polarizing trends in societies, and purposeful misinformation have all contributed to confusion, uncertainty, and psychological setbacks. Racial and ethnic minorities, as well as other communities that have been historically marginalized or experience other kinds of disadvantages continue to face persistent inequities in mental health and care, stymied by racism and discrimination, mistrust in the healthcare system, language and cultural barriers, and increased stigma surrounding mental health issues. They are often overlooked and underserved, simultaneously being more vulnerable to mental health issues and challenges, especially when marginalized in multiple ways, and receiving inadequate or unaffordable mental health support. In response to the mental health inequity crisis in the United States, Health Equity Initiative, a member-driven nonprofit membership organization, designed, organized, and hosted a forum in its Community Leaders Forum series. The forum took place on January 19, 2024 and captured

perspectives on (1) the effect of COVID-19 and other global issues on mental health in these communities, (2) strategies to reduce implicit and institutional bias in health and social systems, (3) policies and practices that may help advance mental health equity, (4) suggestions for communities regarding mental health and well-being, and (6) what leaders and policymakers can do to advance mental health equity.

The discussion called attention to several existing and new challenges to mental health equity including an unprecedented rise in domestic abuse, difficulty navigating the healthcare system, digital illiteracy, digital redlining, social isolation, food insecurity, and reduced access to preventive care. Climate change and its various ramifications have also emerged as another source of anxiety for Indigenous communities which will likely heighten the mental health crisis, not only for Indigenous people and other vulnerable communities, but for the broader population. The importance of cultural competence training for healthcare providers and, beyond that, of investing in pathways to medical and mental health service careers for youth from marginalized communities in providing adequate mental, emotional, and spiritual support that acknowledges the dark history of colonization and discrimination was also discussed by the community leaders.

Other themes and strategies that emerged include validating the role of community health workers as trusted and culturally competent members and valuable tools for communities to access healthcare; utilizing routine meetings to start conversations about well-being, and breaking down the stigma surrounding mental health by having open and honest conversations. Finally, community leaders encouraged community members to embrace healing traditions and cultural practices, seek mental health care and report racist or discriminatory behavior through appropriate

channels in the healthcare system, or via community organizations.

This report and call to action includes a summary of the discussion from the Forum and highlights specific recommendations for practices and policy change as grounded in the experience of the community leaders who participated.

Participants

Forum Participants/Panelists (in alphabetical order by last name)

John Davids, Research Coordinator, Black Community Resource Centre (BCRC)

Meritxell Roca-Sales, PhD, Director of Programs, Grameen Promotoras

Kiara M. Tanta-Quidgeon, Keesuk Páhôhtáw (sunrise), MPH Candidate, Columbia University Mailman School of Public Health

Moderator:

Renata Schiavo, PhD, MA, CCL, Health Equity Initiative

Call to Action and Policy Recommendations

The call to action and policy recommendations described below aim to propose solutions for stakeholders who are interested in or engaged around issues of mental health equity. These recommendations emerged from a discussion on January 19, 2024, at Health Equity Initiative's Community Leaders Forum and reflect the organization's commitment to help raise the influence of community voices on health equity. Recommendations are directed at policymakers, organizational leaders, grant-making organizations, and/or other leaders and organizations across professions and disciplines, who can affect much needed change and help address health, racial, and social inequities. Health Equity Initiative may continue to explore each of these themes in future events and resources.

1) Start a conversation with, listen to, and engage with the community you serve, seek members' thoughts, opinions, and concerns, and involve them in designing policy solutions. Heeding the voices of the marginalized and the underserved can help policymakers and leaders better represent the communities they serve. Indeed, one needs to talk, live, and breathe as part of the community to begin to understand and address the mental health crisis. The underserved, uninsured, and newcomers to the country are especially vulnerable to inequities in social determinants of mental health, such as insecurity related to income, education, food, and housing, and facilitating conversations will help leaders understand the needs of their communities. In addition, learning about the historic roots of mental health inequities and the history of marginalization in several communities presents ways to understand current implications for mental health.

2) Take a multidisciplinary approach to tackle the mental health crisis, drawing on the combined experience and expertise of a range of health professionals, social workers, community health workers, community leaders, mental health researchers and others for an encompassing and comprehensive view of the mental health landscape. Explore non-traditional partnerships and the role of community-based organizations to address mental health care access inequities.

3) Increase funding allocated to mental health services. The chronic underfunding of the Indian Health Service is the most cited driver of Indigenous health inequities. Further, the options for free or low-cost mental health services, especially for the uninsured and those with unstable income, are very limited. Making sustainable investments in mental health, including in affordable interventions, training, and research can help yield better outcomes for marginalized and under-resourced populations.

4) Enable policy processes to be guided and led by marginalized voices by encouraging a diversity of voices; including them in all stages of the policy process, from agenda setting and policy design, to decision-making, implementation, and evaluation; and righting power imbalances in the healthcare system.

5) Acknowledge the mistrust and distrust in the healthcare system amongst marginalized groups and the long history of mistreatment and discrimination within and beyond the healthcare system, and approach this as a legitimate and valid way of coping with the long-standing violation of trust that has shaped their attitudes.

6) Authorize coverage of traditional healing practices under Medicaid as a way to provide culturally responsive care to Indigenous communities. A growing body of research is finding

cultural connectedness to be protective for the physical, mental, spiritual, and emotional health and well-being of Indigenous communities.

7) Disaggregate demographic data by race, ethnicity, and other subgroups to provide visibility and representation in data for vulnerable and disadvantaged populations, unmask differences and disparities, inform policy decisions, and help provide care and resources to disproportionately impacted communities. With significant variation within racial and ethnic groups, including linguistically and culturally distinct Indigenous cultures, it is important to disaggregate data systematically and meaningfully to be able to identify gaps in mental health. For instance, non-federally recognized tribe members are often lost in the data.

Forum Discussion

Moderator: Renata Schiavo, PhD, MA, CCL
Forum Participants/Panelists: John Davids, Meritxell Roca-Sales, Kiara M. Tanta-Quidgeon

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Renata Schiavo: Welcome, everyone. It's great to see you all today. Thank you, Meritxell, John, and Kiara for being here. Thank you for the great work you do in your communities. Thank you and welcome to our Community Leaders Forum on mental health equity. Also, thank you to Macy's, Inc., Mission Every One, for their support of Health Equity Initiative's Community Leaders Forum.

We launched the Community Leaders Forum in 2020—it's been already a few years—at the height of the pandemic because we felt that it was important to bring the insights and contributions of community voices. We saw that a lot of forums during the pandemic were primarily focusing on giving space to large organizations, and we wanted to raise the influence of those who actually do the work in our communities.

I'm Renata Schiavo. I serve on the board of directors of Health Equity Initiative as the organization's founder and board president. For the ones of you who do not know Health Equity Initiative, we are a member-driven membership organization. We are volunteers and we are dedicated to building a global community and bridging silos across different professions, geographical communities, and disciplines in support of health equity. We primarily accomplish our mission through community building, both through our membership and other initiatives like our Community Leaders Forum, as well as education and advocacy on the social and political determinants of health, and professional development, capacity building, and training.

We have a number of programmatic efforts to empower other organizations and leaders to bring a health equity lens in their work. We also strongly believe in partnerships, which is another key area at HEI, and the importance of everyone coming together and joining the health equity movement. Since our inception in the Fall of 2011, we have been pioneering a community-driven and multisectoral approach to health equity, and we have actually walked the walk and embedded this approach in all of our endeavors, efforts, activities, and resources.

Mental health equity is an area on which we have worked in the past, not only because we think that this is so intrinsically linked to physical health, but also because we have dedicated special initiatives to mental health equity, including in collaboration with the APHA Health Communication Working Group, and with other organizations. As an example, a few years ago, we developed a social media awareness campaign on mental health equity to bring attention to the disproportionate burden of mental health inequities. We also know that the COVID-19 pandemic has deepened the mental health crisis, especially among young people and people from communities that have been historically marginalized, under-resourced, or experience other kinds of vulnerability and disadvantage.

This forum has been organized really to learn from you all about strategies and approaches for community engagement, and most importantly, policy change to advance mental health equity in our communities, in our cities, and neighborhoods. With that said, welcome again, Meritxell, John, and Kiara!

I'm going to start with my first question, asking you all to introduce yourselves with your name, your title, your affiliation, and any relevant experience or work on mental health and mental health equity, either as part of your current position or past affiliations. Thank you again for being here.

John Davids: Thank you very much, Renata. My name is John Davids, and I am a Research Coordinator at a small nonprofit organization called the Black Community Resource Centre (BCRC),

which is based in Montreal, Quebec, Canada. A lot of the work I do at BCRC revolves around researching community vitality, pertaining specifically to the English-speaking Black community in Quebec. One branch of that research is on health and mental health. Essentially, I'm trying to construct health profiles of this particular population and compare them to the total population more widely.

In addition to that work, I also have a little bit of experience as a patient partner, meaning that I get offered to take part in consultations from time to time from different health researchers across Canada. That's an introduction for myself. Thank you very much.

Kiara Tanta-Quidgeon: Hello everyone, my name's Kiara Tanta-Quidgeon. I'm originally from right outside of the Mohegan Reservation in Connecticut, and I'm a member of the Mohegan Tribe. My traditional Mohegan name is Keesuk Páhôhtáw, which translates to sunrise. I'm currently a second-year MPH candidate at Columbia University's Mailman School of Public Health in the Department of Socio-Medical Sciences.

What brings me here today is that I'm an aspiring researcher. I'm really dedicated to uplifting Indigenous voices in the pursuit of health equity, with a specific focus in my current work on mental health equity. I really started engaging in this work last year with a research internship at the nonprofit organization, United States of Care, as well as with a research fellowship at Harvard Medical School over this past summer.

A little bit more about me, in the past, I served as the Vice Chairwoman of the Mohegan Tribal Youth Council, I'm a member of the Democracy is Indigenous Youth Council over at the Center for Native Youth, and then I was also the Founder and President of the Indigenous Student Union at my alma mater, Quinnipiac University. In general, I've been involved in a variety of community engagement initiatives with Indigenous communities for almost a decade now, which has been a really incredible experience. I'm really honored to be invited today to participate and discuss my experience and recommendations. Thank you so much for having me.

Meritxell Roca-Sales: Good morning, everybody, my name is Meritxell Roca. I'm originally from Barcelona, and I'm the Director of Grameen Promotoras, which is a community health worker and educator program for Grameen America. We are a nonprofit organization providing microloans to women entrepreneurs, mostly Latina, regardless of their immigration status. I believe that this is what really makes a difference and has a tremendous impact in the community we serve. Regarding mental health amongst all the services we provide, we also provide emotional support to our participants, especially after 2020 with the COVID outbreak.

When I say emotional support, I mean we are usually someone to talk to. Our team is not clinicians, we are not doctors, we are not nurses, but we are good listeners. Mostly when we talk about emotional support and mental health in our community, it means talking about domestic violence, helping also with suicidal crises, and system navigation. We will talk about that later on, and connecting them to the services out there, which are very scarce. We mostly serve Latinos, only women, and in several areas of New York City and other states. Thanks for having me here today.

Renata Schiavo: Thank you very much for your introduction. **Moving onto our second question. We know that COVID-19 has deepened the mental health crisis in many of our communities. This has been further exacerbated by the many, many crises in what I would define as the age of emergency, which goes from world conflicts to increased polarization in our communities to infodemic management and all of the misinformation circulating in our communities, including about mental health. This has exacerbated mental health issues for many groups. What kind of change have you noticed, if any, in the community that you serve or belong to? Anyone can start, please.**

John Davids: As you said, the COVID pandemic in particular brought about a real paradigm shift for us in the work we do at the BCRC. An immediate issue we had was that a lot of the people who use the services of the BCRC are seniors and also struggle with digital literacy and a lot of other issues.

Immediately a lot of people became very isolated

because here in Canada; we had some very strict lockdowns, and people weren't allowed to go out even to use some basic services. So that was an immediate thing. Also in my research, I've studied and surveyed young people and people more broadly on the mental health impact of COVID-19, and over time, what I've also found is that there's a sense of resilience that's been found within the community, a newfound sense of resilience, I should say, considering all the breakdown of all these other social things happening around people.

It started with isolation, it started with a very grim outlook, but over time, it also mobilized and rallied the community and organizations such as mine in a way that I hadn't really seen before. I think ultimately, despite all the pain that's still ongoing from COVID, a lot of people have also found a new strength within them. It's not really a good thing, but they found ways to cope with it. That's just one major thing I've observed.

Meritxell Roca-Sales: I would like to talk a little bit about the change in the needs. I would say first, as I mentioned before, the need for domestic violence support after the COVID outbreak. Our community health workers are prepared to deal with these kinds of situations, but the volume exploded, and we had more and more people requesting support because they were close at home with the abuser, and that made it extremely difficult. Then we realized that we also needed to provide emotional support and mental health support to our team because they were dealing with this high volume of situations that was unprecedented.

The second change in terms of the needs and services that we noticed is food insecurity, with more and more people requesting connections for food stamps, food banks, food at shelters, health bucks in the city of New York (which are coupons that can be used in farmer's markets), there was a high demand for that. A third change that we identified was regarding access to preventive care because people had to work more shifts to provide for their families and the free services at hospitals were reduced because they were focusing on emergencies. That also had a tremendous impact on the community we serve.

Last but not least, access to Wi-Fi and cellular

service. Most of our members were cut because they couldn't afford the bill, they couldn't pay for the services, so we had to be creative in our program. We realized that WhatsApp, for instance, was a platform that really worked for us because they only needed a cell phone and access to one of the public Wi-Fi servers. That also was one of the changes that meant we had to rethink our program and how we delivered the information, and we also noticed how the community was communicating with their families in their home countries. That was a very tough moment.

Kiara Tanta-Quidgeon: Thank you both so much for sharing that. I think particularly, COVID really devastated many Indigenous communities across the United States and Canada. I want to echo what was previously said about the need for domestic violence support and addressing food insecurity and many of the other things that were mentioned by my fellow panelists, but when I read this question initially, I was thinking a little bit more beyond COVID and about some of the other aspects of this state of emergency we're living in.

I was really thinking about the impact that the climate crisis is going to have on the mental health of the community that I serve. Indigenous people, although there is an immense amount of diversity within Indigenous communities both globally and domestically, these communities often embrace a sense of interconnectedness between human beings and the environment, the land, and the sea, and so the health and the balance of the human body, for culturally connected Indigenous folks, requires the health and balance of all elements of an individual's connected relational network, which includes the environment around us.

I think, and we know through research, that the environment is a key social determinant of health and well-being for Indigenous folks that is being disrupted by the climate crisis, and so I worry about climate anxiety, I worry about burnout and exhaustion for organizers, and I worry a lot about collective trauma, which is something that we saw a lot in COVID as well. These are the impacts of this crisis that will continue to have impacts on mental health and exacerbate the mental health crisis for Indigenous folks, but I also think for everyone beyond that, and other vulnerable communities as

well.

Renata Schiavo: Thank you very much. I like the fact that you all connected some important social, structural, and political determinants of health, such as food insecurity or digital redlining, or climate change, to the mental health equity crisis. Of course, our concern in relation to mental health equity is always with communities, groups, and populations that have been historically marginalized or experience other kinds of vulnerability, including communities of color, LGBTQI+ youth, people living with a disability, women, and many other groups.

Unfortunately, we also know that social discrimination, and its many 'isms', if I can use that word- racism, sexism, ageism, and other kinds of social discrimination- are pervasive in our society, and this includes clinical settings, unfortunately. What are some of the strategies in your opinion, or that you have seen working, that you recommend reducing implicit and institutional bias in health and social systems? It would be great if you could connect those strategies also to stories to illustrate the importance of such strategies. Please also give examples of strategies that are grounded in the strengths of the community that you serve or belong to. Anyone who wants to start.

Kiara Tanta-Quidgeon: I can go ahead and start for this one. As I mentioned during my introduction, I was a research and community engagement intern at the nonprofit United States of Care last year. We did a big listening work project where I had the opportunity to interview five Indigenous women from various tribal backgrounds. A big goal of our research project was to identify solutions for how the US healthcare system can better serve Indigenous people. I think that two of the solutions that we derived from our findings really encompass how I want to answer this question.

I think the first recommendation I have and the first solution that we identified, was to train culturally competent healthcare providers, but beyond this, also invest in pathways to medical careers for Indigenous youth, so in this context, to mental health service careers in particular. Connecting this to a story, we had a participant in that study who shared with us that she was really hesitant to go to therapy because of the college that she went to, and

as a student, she felt like all of her issues were very central to her identity.

Mental health inequities faced by Indigenous people are often attributed to this legacy of colonization and thus very interconnected with their identity. She knew and felt her university wasn't going to have a provider who understood those issues and who could provide her with the adequate mental, emotional, and spiritual support that she needed. That kept her from seeking mental health care for four years during a very vulnerable time of her life in college, full of a lot of stress and stuff like that.

It isn't just about training culturally competent providers or developing a crash course in indigeneity or just in DEI in general for providers, it's really about having providers who have experience, who are Indigenous, who look like the patients. I think that there are so many barriers to getting to that profession, to getting that education, that we need to unite to change and to indigenize those spaces to achieve mental health equity.

Meritxell Roca-Sales: Regarding strategies that we would recommend to reduce implicit and institutional bias in health and social systems, I think that we need to validate the use of community health workers as a valuable tool for communities to access healthcare. Let's keep in mind that these are trusted members of the community and trust is something very valuable and very hard to achieve, and they are culturally competent, and they speak the language. We are not translators, but we can help.

One is the barrier to access and more importantly, break the stigma. When we talk about mental health and the Latino community in particular, there's a huge stigma. The community doesn't like to talk about it, and it's something you keep at home. Trying to connect that with stories, at Grameen Promotoras, for instance, we started using Facebook. It's the only social media platform we use. We started using that after COVID because all of our participants were in lockdown, so we had to find a way to reach out to them and everybody loves Facebook.

We use Facebook to educate about the importance of self-care and mental health. "It's okay to not be

not be okay and say it out loud," was, and it still is, one of our key messages. A strategy that we have been following, is that we have a Know Yoour Numbers desk here in the office. Know Your Numbers is an opportunity for our participants to come and get their A1C levels and their blood pressure tested.

We are not doctors, we are not nurses, but sometimes it's useful information that can give you an idea. Like do you have diabetes or not, and if you need to go see the doctor right away, or if you can maybe wait for your annual physical. What we have been doing and that has worked, is using that as an excuse to start a conversation about feelings, about your life. Many of our members are grieving the loss of a loved one. During COVID, they couldn't even visit their relatives or send money for funeral arrangements; they had other things to worry about right here at home.

We are using that as an excuse to bring the participant, and while we are checking their blood pressure, start talking about how they are feeling- if they are victims of domestic violence, if they have food insecurity. All of the things that we mentioned before, we use as an excuse to start that conversation, which is very difficult. Also, I think that we need more therapists that are from the community, and that's very hard to find. If we cannot find them, then let's create roles for the community health workers to build bridges between the system and the community; but we need this cultural competency.

John Davids: If I may, on this side of the border, just shortly after the onset of the pandemic, we had a really big story breakout involving an individual named Joyce Echaquan, who was an Indigenous woman who passed away after being abused and neglected at a hospital. What made this case quite interesting, is that she actually recorded her experience. Out of that, there was a big outrage, a big reaction in Canada, even though for decades, we've heard about stories of marginalized people, whether they're Indigenous or Black, or from another historically marginalized group, being neglected or discriminated against in a healthcare setting or in an institutional setting.

This one was quite shocking because people could

see the nature of that abuse. I think one big issue it really pointed to, is that there is still a really big problem with racial discrimination and other forms of discrimination, of course, here in Quebec and in Canada. The big problem is that this issue, particularly racial discrimination, is a taboo topic. It's not something that is really acknowledged by the government here. It's actually openly denied and that alone really sets us up for a culture of denial or a culture where we can't really talk about these things without there being an immediate wall set up and an immediate conflict that comes out of it.

For me, the strategy starts at the very top in this case. If the state doesn't really acknowledge this, it's really hard to move forward socially. I think there has to be pressure put onto policymakers and onto the government to begin to be able to have this conversation because, at the moment, it's such a social stigma to even talk about racism, that it destroys any chance of real tangible change taking place.

One example of race being a taboo subject, is the fact that here in Quebec, we don't collect race-based data explicitly so we don't know the differences between Black communities and White communities and different groups, and the government has made it very clear that they have no intention of changing that anytime soon. It's up to civil society to either conduct the research or to try to pressure the government to change their position.

Last thing I would say, my fellow panelists also made some really great points, but I believe very firmly in representation when it comes to decision-making power. I think different historically marginalized groups need to have some decision-making power that is entrenched in the healthcare system and reserved specifically for that group. I've been to so many consultations so many times when people are speaking with the community, but it never really translates into power and thus, it never really translates into actual change.

Renata Schiavo: Thank you very much, John. I think some of the topics that you mention, including the importance of accountability in the way we work with communities and the centrality of policy change, leads well to the next question because as

you know, policy is an important tool in advancing mental health equity and, more broadly, in advancing health, racial, and social equity. **Is there any policy that each or all of you are currently advocating for at the local, national or global levels, as part of your work, or other activities, including volunteering efforts in your communities?**

Or if you are not directly advocating for any policy change, can you think of any policy solution that may help advance mental health equity, and is also grounded in some of the strengths of your community or policies that you have seen working?

Meritxell Roca-Sales: I can go, even though we don't do any policy in our organization - but I think it's very important to start a debate. That's what I would say. Start a debate on social determinants of mental health. We all know that social determinants include income, education, food, and housing insecurity, but there is significant research confirming the association between income inequality and poor health outcomes. Unstable income can lead to poor mental health, increasing risk and incidents of mental illness and sometimes substance use disorders, for instance, so the underserved, the uninsured, and the newcomers, they're especially vulnerable.
We should start considering, for example, non-traditional partnerships and the role of CBOs in addressing this crisis. I think it's particularly relevant in the US context, where the healthcare system is not universal, it's very expensive and very, very difficult to understand and navigate even for insured individuals. That's my five cents.

John Davids: Maybe I'll just continue from what I was saying before. I did bring up this idea of race-based data collection. Just to unpack it a little bit more, it's a really big problem here because it ends up invisibilizing minority communities, and essentially everyone gets aggregated into one giant population and so the differences that do exist between the Black community and other communities here, are rendered invisible. For me, this really starts as a human rights issue. I don't believe any state can uphold the rights of a minority if we choose to not see what's happening within that community.

Even though my organization doesn't explicitly

advocate for this policy, I personally do, and when I speak at any forum, I'm very open about this because the consequences are pretty dire. I don't believe equity can be achieved across different racial groups unless we're trying to understand what's happening within them and between them. That's my big policy recommendation, beginning to collect race-based data. Just before I end, I'll say there are a lot of arguments against doing so. Some of them come even from within the Black community because there's a lot of hesitation about the misuse of data, and using data to cause harm.

I don't know if this is a fix-all solution, but one of my recommendations or solutions to address that issue is, as I said, to have people from marginalized groups be given decision-making power when it comes to deciding how race-based data will be collected and utilized.

Renata Schiavo: I want to add something to that because, in the United States, we collect only a small percentage of data by disaggregation. As you know, focusing on collecting and analyzing REAL data— race, ethnicity, language-driven data—is not a mainstream practice. A number of people advocate for REAL data to become institutionalized and supported by related policies, so we can capture those differences that you're talking about, John. Kiara, do you want to add anything?

Kiara Tanta-Quidgeon: Yes. Really quick going off of that, if we are collecting race-based data, that we are de-aggregating it. We have that issue I think a lot in Indigenous communities, where data is very aggregated. A lot of the time people who are not members of federally recognized tribes are lost in data, so I think a revisit of how we do data and a decolonization of that, is one of my recommendations. Also, in general, like my other panelists, I don't think my work specifically advocates for any explicit policy, but I'm always thinking about and advocating for policy that can better my community and Indigenous communities broadly.

First, I'll say that we just need to generally increase funding allocated to healthcare services, specifically for the Indian Health Service. When I was working with United States of Care, one of our participants told me that the federal government would have to

double the amount of money per federally recognized tribal member for Indigenous people to have the same healthcare funding that is granted to federal prisoners. The chronic underfunding of the IHS is the most frequently cited driver of Indigenous health inequities in pretty much any publication that you pick up, even if they're not data only on federally recognized tribal members.

It's certainly one I want to call attention to, but it's also important to note again, that these people are not all members of federally recognized tribes. They're not all enrolled, but they may also still identify as Indigenous. They're navigating the more common challenges associated with either being uninsured or being on Medicaid, so we need to address those as well. Before I end this answer, I really want to bring attention to something that I do in my current work with Harvard, where we look at traditional healing.

One of the solutions that we identified at United States of Care, which I didn't have a chance to talk about before, was to promote the acceptance and inclusion of traditional healing. I, like many other researchers and advocates, want to call for Medicaid to improve its ability to provide culturally responsive care to Indigenous beneficiaries by covering traditional healing services. I think that would be really empowering for our communities.

Renata Schiavo: Great. Thank you everyone for some great insights. **Part of this forum is also about looking at suggestions on strategies for community engagement and, in the case of mental health, strategies for community members to find care for mental health issues. Within the current limitations of our health and social systems, what would you suggest to people from the community you serve if they're worried about their mental health or feeling unwell, and/or feel worried about the mental health of a loved one? What should they do? What are some of the action steps or interventions that you see working and would recommend?**

Kiara Tanta-Quidgeon: I can jump in for this one. I think personally as a descendant of traditional healers, and then also after doing the traditional healing research that I've done with Dr. Joseph Gone at Harvard, which I didn't really have the

opportunity to talk much about yet, I definitely tell my relatives and Indigenous people that I meet in general, to start to turn towards or continue turning towards traditional and sacred medicines, healing ceremonies and other culturally based practices. I tell them to continue to or to start engaging in culture in any way that they can.

That's engaging in ceremonies or dancing or eating traditional foods especially, all of these things, because there's a growing body of research by scholars of Indigenous health and wellbeing, that are finding that cultural connectedness can be really protective for physical, mental, spiritual, and emotional health and wellbeing. That engagement, I think, is essential and something that I recommend to the people that I engage with and interact with.

Also, if folks do have resources—because a lot of people that I know in the Indigenous community are members of federally recognized tribes and thus do kind of inherently have some access to health services—if they do have resources but are hesitant to seek mental healthcare because of mistrust, I do tell them stories about the medical doctors and students that I engage with at Columbia, who I really believe are changing healthcare for the better. Although there is a really dark history of mistreatment and thus mistrust in the system and in providers, I do encourage my relatives to take the leap. I interact with current or future providers at Columbia and in the New York City area who for the most part, have given me such a strong hope for the future of healthcare, so I have been trying to encourage my community members to seek those services if they can.

Meritxell Roca-Sales: I would say speak up, let it out, let's talk about mental health. It's not embarrassing, and it doesn't mean that you are crazy. I'm talking specifically for the Latino community, which is a community that we serve. It means that we need to find support to help. Today it may be me, but tomorrow it may be you. The Latino community has to break the stigma, that mental health means loco, crazy, and something that you keep at home, and it means that you are not right.

The Promotoras, the community health workers, can play, and they are already playing, a critical role so that programs like ours and other CBOs should get

more funding to get out there and spread the word—It's okay not to be okay. Listen, our job is difficult. I always say that the Promotoras, we carry that invisible backpack full of stories. Some of them are sad, some are not, but still, there are lots of emotions, and lots going on. As we like to say at Grameen Promotoras, "Together we do better". I would say let's start by being that person you can trust, someone who listens without judging.

We never say it's going to get better, that we don't know, but we will figure it out together and that's a start. I would say, let's go out, let's break the stigma about mental health, and let's create new resources for the community, especially for the uninsured, because currently, the options for mental health services that are free or very low-cost are very, very limited, close to none.

John Davids: Yes, I think that was a great answer and I echo a little bit of it, in the sense of encouraging community members to speak up. Unfortunately, we do have an issue with stigma concerning mental health in the Black community as well. Oftentimes, people put off some preventative things they could do, and then it ends up getting worse, and it ends up going from preventative care to ambulatory care or a crisis. So I'm really trying to encourage people to speak, not just at the healthcare institution, but with community members, with family, with anyone who's willing and able to listen, for us, is the approach we believe in.

Once they do interact—Kiara talked a little bit about the mistrust in healthcare systems—and once they do interact with the healthcare provider, even if that mistrust still lingers a little bit, we also encourage people to document as much as they can about their interactions. It sounds a bit funny, but to complain if something wrong happens. Oftentimes something wrong might happen, and they might not talk about it until later. If something wrong happens to them, we encourage them to speak up and complain, either using the hospital's structures for dealing with complaints or even going beyond and contacting community organizations and people outside of the healthcare network.

I think stigma is a huge issue that communities still need to work on as well.

Renata Schiavo: Great. Thank you very much for your answers. **We're coming toward the end of our forum. I wanted to ask if you had any final thoughts or recommendations or wanted to speak about anything that was not covered so far and is related to the topic of the forum. Most important, we want to leave the organizations, the policymakers, and the leaders who will access the call to action from this forum with some practical recommendations. What do you want to urge them to do to advance mental health equity?**

Meritxell Roca-Sales: I think I made it clear through my answers, but my main recommendation is to listen to the community. Listen to the community, listen to the community, listen, listen, listen. We don't need policymakers who have no contact with the community they serve. They may write memorandums or laws or price bills, but if they don't really represent the community, what's the point? I think that we can only address that crisis if we truly get involved and talk, live, and breathe as part of the community we serve. Maybe by doing so, we won't like what we find out, but it's the first step.

It's to understand what's going on, to make an assessment, and then work as a community to figure it out. We will figure it out. I think that the only way to do that is to listen to the community and have the community be part of the process of getting involved.

Kiara Tanta-Quidgeon: I really want to echo what was just said about listening to community. I also want to urge those who are listening to this or reading this just to educate themselves. I know that seems a little silly just to throw out there, but there's so much out there, a growing beautiful body of literature about the historical and root causes of mental health equity, specifically in the context of Indigenous people. Any of the publications by my mentor, Dr. Joseph Gone who I mentioned, are great resources for people to learn more.

I also want to recommend just that no matter what approach or approaches are taken, that they're multidimensional, that they're interdisciplinary, and that they're complex because I think that mental health inequity in this country and across the globe, I think that we're experiencing, are very multidimen-

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sional and complex issues that are going to require very interdisciplinary and holistic and comprehensive approaches to solve them. I think we have too many separate spheres trying to tackle this issue.

We have the medical system, we have researchers, we have nonprofits, and I think having a sense of unity between these kinds of players in this is really crucial and something that we should really consider going forward.

John Davids: For me, I already discussed the decision-making power quite a bit, so I'm not going to go over it again. Basically, out of the many solutions, one that stands out to me is the fact that there is a long history of abuse in the healthcare system, particularly towards specific communities. Mistrust in itself, for me, it's a public health issue because it drives people away from wanting to go to the healthcare institution or the healthcare provider. I think that's something that's going to stay until it's addressed. Just like the story I told you about Joyce Echaquan, when these stories happen, of course, the mistrust grows, and the divide grows even more.

I think it's very, very, very important that healthcare providers and healthcare institutions more widely acknowledge the harm that has historically happened, and has historically been caused and put upon certain populations. I think that's the only way to even begin to have a conversation about repairing that relationship. Until that happens, I think a lot of mistrust towards the healthcare providers to some degree has some justification. I don't blame people for holding that view, even though in the end, it's not really going to lead to a solution.

I think one way to start that conversation is for healthcare providers to really acknowledge their part in some of the harm that's occurred. That's the only way I think they can try to improve themselves.

Renata Schiavo: Thank you, everyone. I just wanted to say this was an extraordinary forum with a lot of great ideas that emerged for both policy and intervention design, and range from the importance of community health workers to looking at data disaggregation across race, ethnicity, and language to inform policy, to the importance of addressing community mistrust and making sure that we

understand the root causes of such mistrust, to the importance of educating oneself on the history of marginalization of different communities. Most importantly, the forum clearly and unanimously confirmed the importance of engaging communities in designing policy solutions and promoting cultural connectedness. Thank you very much, Meritxell, John, and Kiara for being here today, and sharing your experience and your work.

Thank you very much for the work you do in our communities. Thank you again to Macy's, Inc., for the support of the Community Leaders Forum series. Thank you all for these wonderful insights.

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Participants
(In alphabetical order by last name)
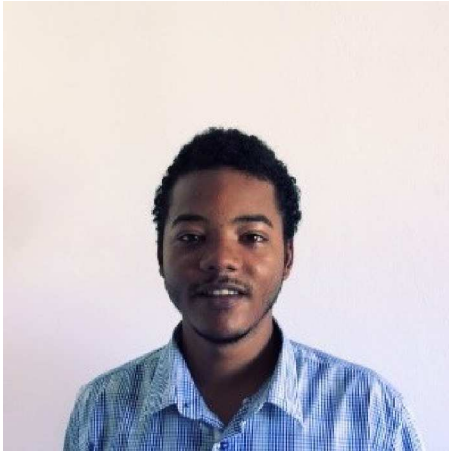
John Davids

John Davids is a Political Scientist whose focus hovers around Global North-South dynamics, the relationship between citizen and state, and the development of Civil Society. He currently works in Montreal, Canada as a Research Coordinator at the Black Community Resource Centre where he studies the well-being and vitality of Quebec's Black communities. He has been part of an ongoing research collaboration with the Human Motivation Lab at McGill University that has studied the impact of COVID-19 on the mental health and well-being of Black Quebecers since 2021.

Meritxell Roca-Sales

Meritxell Roca-Sales is Director of Programs at Grameen America - Grameen Promotoras. She holds a B.A. in Journalism and a Ph.D. In Communication and Humanities. At her current position, she manages a CHW program servicing over 30,000 participants, mostly Latino women. The program she oversees does extensive work on mental health and emotional wellbeing by connecting participants to existing resources, like government programs for low-income families, FQHC clinics and CBOs. In addition, her team also provides 1:1 emotional support and guidance in cases of domestic violence, helping victims to navigate the system and find assistance.

Participants
(In alphabetical order by last name)

Kiara M. Tanta-Quidgeon,
Keesuk Páhôhtáw (sunrise)

Kiara Tanta-Quidgeon is a mixed white/Indigenous (Mohegan) graduate student at Columbia University Mailman School of Public Health in the Department of Sociomedical Sciences and a scholar of Indigenous health and well-being. Through her research and advocacy work, Kiara is dedicated to promoting Indigenous mental, emotional, spiritual, physical, and community health and well-being. In the past, Kiara has served as a Pre-Doctoral Research Fellow at Harvard Medical School, the Vice Chairwoman of the Mohegan Tribal Youth Council, and in other roles.

Moderator

Renata Schiavo, PhD, MA, CCL

Renata Schiavo is the Founder and Board President, Board of Directors of Health Equity Initiative. She is a passionate advocate for health equity and a committed voice on the importance of addressing and removing barriers that prevent people from leading healthy and productive lives. She has 20+ of experience working across sectors and disciplines to improve the health and well-being of vulnerable, marginalized, and underserved populations, including communities of color, Indigenous and immigrant communities in the United States, and low-income groups, refugees, and patients from underserved areas in global settings. Renata is a Senior Lecturer at Columbia University Mailman School of Public Health, the Editor-in-Chief of the peer-reviewed Journal of Communication in Healthcare: Strategies, Media and Engagement in Global Health, and a Principal at Strategies for Equity and Communication Impact (SECI), a global consultancy. She has significant experience in health policy and community, patient, and citizen engagement and has written extensively on raising the influence of community voices on health, racial, and social equity. She has previously led advocacy programs on mental health equity at Health Equity Initiative and has written on mental health in several peer-reviewed publications.

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Health Equity Initiative (HEI) is a member-driven nonprofit membership organization dedicated to build a global community that engages across sectors and disciplines to advance health equity. By bringing together and enlisting the efforts of the public and private sectors, professions and communities that have both a stake and an influence on social determinants of health, HEI advocates for improving conditions and achieving equity in health for all. We focus on championing transformative change to advance health equity, supporting knowledge, engaging communities and leaders, and building capacity to address barriers that prevent people from leading a healthy and productive life.

Bridging Silos, Building ONE Community for Health Equity!