"What we're finding is even sliding fee scales are a barrier to access…"

Arturo Carrillo, PhD LCSW
Mental Health and Family Support Services
Saint Anthony Hospital

Voices of Health Equity in Chicago
Interview No. 8
June 27th, 2017

CENTER FOR COMMUNITY HEALTH EQUITY

DePaul University Rush University

Center for Community Health Equity

The Center for Community Health Equity was founded by DePaul University and Rush University in 2015 with the goal of improving community health outcomes and contributing to the elimination of health inequities in Chicago.

To learn more about the center, please visit us at www.healthequitychicago.org

Voices of Health Equity in Chicago

Our *Voices of Health Equity* project collects the stories of people who have made health equity a central concern in their work. We are interviewing academics, clinicians, public health advocates, community organizers, and others to better understand how different disciplines and professions could work together to eliminate avoidable, unnecessary and unfair health disparities.

Tuesday June 27th, 2017
Interview by Amber Miller and Celie Joblin

Background: Arturo Carrillo is the manager of the Saint Anthony Hospital Community Wellness Program's Mental Health and Family Support Services in Little Village, Brighton Park, and North Lawndale. In 2015, Carrillo received the Community Health Advocate of the Year Award from the National Alliance on Mental Illness (NAMI). In 2017, the mental health program won the Chicago Neighborhood Development Awards - Healthy Community Award. Earlier in 2017, Arturo contributed to a Center for Community Health Equity working paper titled "What is a Healthy Community?". We talked with Arturo about this work and his perspective on health equity in Chicago.

Amber Miller: So we'll start out with who you are and what you do?

Arturo Carrillo: Sure, my name is Arturo Carrillo, I am a Licensed Clinical Social Worker by professional training, I am also just recently a PhD in Social Work… it was a seven year endeavor. I have also been trained, although I've never practiced, as a community organizer. A lifelong Chicagoan, I have had the fortune of also leaving the city and seeing the other parts of the world and country and you know, grew up as a son of a blue collar father and family. Kind of through the years have also seen what privileges we have, what privileges others did not have and also elements of oppression and how that has impacted our lives and other people's lives. So you know I've sat with that question quite a bit throughout my career and now I'm kind of excited to get into a new stage.

Amber: In "What is a Healthy Community?", you mentioned the lessons you've learned, including: "Every community has existing strengths and resources."

Arturo: That is my social work training. I think that that starts with my clinical work and you know, public health maybe I don't know if this part of kind of asset building and asset assessment, that there is the overlap. But for me, it starts from my individual practice. Every person who I work with on a clinical level, you know just to give some context, I entered my first year field placement at the very location I'm still at, the Community Wellness Program, and it was in that space that I learned in practice. I was also learning theory in the classroom, but in practice what strength looks like. What does a strengths perspective look like when you engage with somebody who's been hurt by oppression, by trauma? Who is just kind of for maybe for the first time really giving themselves the space to process this and for us it was very intentional to design a program that addresses all of the barriers, as many as possible to be able to then engage with individuals on a personal level. So one of my first lessons was that.

As people are telling you about the worst things you could imagine, but you're still there trying to find where the strengths lay in that individual, not to disregard, not to discredit, not to impose your belief on their view, but to hold it. To keep it there. To kind of keep it in your back pocket for when the individual is ready to maybe listen to that part of it as well, and not again to discredit, but to also, bring to the surface what often people diminish which is their strengths and their ability to be resilient and survive.

And so you know, I took that mentality - and that's also part of community organizing - to understand my work with communities, right? It's communities [that] are impoverished, communities [that are] dealing with very systematic intentional levels of oppression, right? And you see a high percentage of undocumented individuals, and that is very intentional by design. And for me, still, people are resilient. Still, they are able to thrive.

That being said, there is still a lot of issues and a lot challenges that people face. So, kind of situating yourself in the strengths for me was very crucial. And that goes with community partners. I think community partners, also, non-profit organizations have a lot of challenges, you know? I didn't mention this as one of my identities, but I also helped start a nonprofit and community organization, in the community grew up in. And I know how challenging it is to operate a nonprofit on a shoestring budget. But, that being said, you work with them and their assets and their capacities.

Without trying to impose, I think that the other part, I think that you're always really trying to bring value to their work as well, because it really is about building that collaboration, knowing that they're stretched, and knowing that they're taking it out of their valuable time to support initiatives in the community. But, if it is a mutually agreed initiative, then it works, right? It thrives.

Amber: In the paper you mentioned stigma was the narrative that you were told was the biggest barrier [to accessing mental health services]

Arturo : Yeah

Amber: But then your research shows that it was lowest ranking barrier.

Arturo: Well, it is very intentional. I think, I think it's easy to point to that [stigma] as the main barrier. When you say, "Latinos don't use mental health services because of stigma", and because of, just, you know, very much putting the blame on the individual. This idea of professionals blaming the victim, in any sense, right? Because, when we do our research, we find of course, the biggest barrier is cost. Of course, cultural sensitivity, language, hours of operation, all of those things factor in. But when you look at the response of almost 3,000 individuals, you're seeing that cost is by far the biggest barrier, stigma was in last place out of a list of 11 factors. So as professionals, you know, we incur debt, we incur, a lot of college debt to become masters level professionals.

So in many ways we don't want to address that one, because in many ways, if we aren't getting paid we can't do work. Which that means that, "well let's talk about the rest of them, let's talk about the rest of the barriers." But what we're finding is even sliding fee scales are a barrier to access. So, I always heard another narrative that people should be able to afford to pay something. I always heard that people need to buy-in to come into their therapy session. Which, again, I mean, that makes the assumption that they're not already doing so by just taking the time to be there. To take the time away from their busy schedule. It's very time consuming to be poor. It's really time consuming because you really are having to find how to make a dollar every day. You're having to take care of things that other people can afford to pay for.

I think this is where we as professionals have to kind of accept our bias. Sometimes we have a bias that says, "people can afford to pay", because we can afford to pay. Cost is not a factor because, again, in many ways we rely on this economic model to make our work sustainable. So, again, I was very privileged to come into a space that our financial backing was from a "large" institution. It's a very small community hospital, but a large institution in the community that can offer free services in the community. With that model, we can then put cost aside and focus on the rest of the barriers. As I saw when I was an intern, to this very day we have always maintained a waiting list. There has never not been a demand for our mental health services and the current research shows that stigma is non-factor when you address all other barriers.

Celie: Do you think that partnerships with larger organizations could be a way to address the cost barrier?

Arturo: Absolutely. So we replicated a survey that you are referencing throughout communities. We've surveyed throughout 10 communities, each one of those communities had a sample of approximately around 200-300 in each community. Ten communities on the southwest side of Chicago and the findings were identical. It was the same. Why? Because, again, we would do a 'report back'. We would survey in different communities and then when the findings were completed, we went back to those same communities we surveyed and we gave them the findings back, to community residents.

Sometimes people not only internalize racism, they internalize classism. And, so in that [report back], people were saying, "well you know, people should afford [be able] to pay for counseling services. They should be able to give something" This idea. And then I would say, "Well let me ask you, how much would be able to pay." And they would say, "Well, I don't know, maybe, I would pay $20 to see a doctor. I can pay $20." I'm like, "Great! You know counseling services, especially when we are dealing with trauma is very long-term, and its weekly, and it only really works if its weekly. "So, um, would you be able to pay, say, $20 a session, for a whole year? On a weekly basis?"

And that's when people are like, "Oh, well, no, no", right? And of course people would start saying, "What would you do with that money?" "Well, I would pay for my kid's field trip, I would buy milk", you know?

In many ways, I think it's very intentional to blame every other barrier except cost, because then it almost comes on the professional, on the system, to say, "Well, how do we address cost?" And in this country, you know, even getting free access to health care is a challenge, let alone, mental services. But, for me and my work, I have sat with the question, "How does mental health impact every other social element in people's lives and [what is] that intersection between those issues?" I think it's the biggest health crisis we are not talking about in this country.

Celie: Do you have a mental health specialty? A certain diagnosis that you focus on?

Arturo: [Laughs] If there were diagnosing... you see, the beauty of also not charging and not billing is that you are also free from diagnosing.

And, that in itself is an advantage we have because you're not pinning people into a box. You're not saying, "Let me, let me kind of check off a box in the criteria in the DSM and give you a diagnosis". Because, in "theory", that then provides a framework for treatment, and in practice this medical model is pretty much universally accepted and embraced and there are some diagnoses that require that level of attention and that level of diagnosis. But with the population we serve, which are high functioning adults, most of which have dealt and are dealing with untreated trauma, it is not so simple.

So if there were a diagnosis, it would be it would be trauma. Complex trauma. You know, working with poverty and people who have come from very…people's lives do not start in the U.S., they start abroad and in those spaces, they are very much exposed to trauma. So trauma is the focus of our program, and through that we focus on, again, the strengths perspective. ...it's very much is an empowering model.

For my PhD research, which took me to understanding the structural social work perspective, one that says, "systems interact with one another"; so, we talk about systemic oppression, but structural social

work talks about the interrelation between systems, and how all that has multiplied factors create structural oppression on people lives. To me, working with low-income, undocumented immigrants, you see just the interrelation between different social systems of oppression, and the same goes for the work in North Lawndale and the African-American community. You see just the intersection between different systems of oppression that multiply, already very real consequences of trauma people are dealing with in the worst way possible.

But still, the systems themselves are not equipped or even designed to allow people the access for healing. So people rely on informal methods or supports through their social networks, but for me it was always interesting to see how, you integrate and offer free service that are high quality. That has always been how we teach our interns and teach our staff, we expect the highest level of treatment, and we have always had this saying, if some is well-off, and can afford, you know, the $120 per session here in the Gold Coast, to see that their therapist. They are not going to get a diagnosis, they are going to get long-term trauma focused treatment that really engages people in their space of trauma to promote healing. We expect the same, if not more, for communities that are needing that resource. So that has been our system of design. My big question for us as professionals is, "How do we find other ways of sustaining the level of care for people who are being impacted daily with trauma?"

Amber: Going back to 2005 when you were an intern in Little Village, I was wondering, how much have you seen mental health services change or the system change since then to now, in terms of health equity? What have you seen?

Arturo: It's gone in the opposite direction. It has gone in the exact opposite direction.

You know, it's really been, kind of, a devolving of what that social safety net has, in many ways, been envisioned to be. So there was a moment when our mental health program was faced a question, "Do we apply and attempt to receive state reimbursement for mental health services?" You know, way back when, I'm taking a wild guess here, I would have to look this up, but I might say this wrong, 2009 and prior, yeah 2009-2010, the state would reimburse community mental health agencies to reimburse them for seeing undocumented, unfunded, individuals. Uh, and so, you know, we made a very intentional decision to not pursue that funding. Why? Because we really did not feel that, that really was a fit for our model, right? We found out over time that we were actually right because what ended up happening was as the state was realizing the financial mess was in, that was the among the first item to be eliminated. So, when that happened, we saw that the influx of other community mental health providers, who basically at that point, dumped a lot of these cases, and so we were one of the only programs in town to offer free mental health services at the time. Through this model, not the only one of course, but, we see the influx there.

Over the years, the city of course closed half of the mental health clinics. They were in the process of privatizing one, and maybe others. So, in many ways, you are seeing the dismantling of the social safety net and the state's responsibility for social welfare.

Mental health is one of those issues that affects us all in many ways, and through a system of taxation we could try to, kind of, off-set people's access issues when it comes to cost. So, in many ways, you can see that being dismantled. Nonprofits try to pick up the slack if possible. But the truth is, foundations also don't fund for mental health service delivery, and the same foundations will point to the ACA and say, "Well you know, Obama care, you know, is a requiring for mental health services to be a part of any FQHC and any other health entity". And I think again, it is one of the same, those same people who

point to those services are not going to necessarily send their kids to those services, they wouldn't even themselves go to those services because this behavioral health model, is again, very much going in another direction, and in the direction of embracing the medical model of treatment, which, seems to be very symptom focused, very short term, very kind of educational, and again, the opposite, and it is the opposite of the trauma focused work that requires more long-term, stable, very intentional, psychodynamic treatment that can also can be very pricey if people are having to pay out of pocket or systems have to carry it.

So, for me it has always been very much the challenge to see how new innovative approaches can exist to fill this gap and we are seeing that in the city there has attempts to create local tax districts that can then create, and use that funding to sustain community mental health centers, that's promising. Again, can we scale that? Is that scalable? In a city as large as Chicago? I think we need to keep with this question.

Celie: Do you think that the work that you have done in Chicago and the findings that you have seen here are applicable to other cities? Or do you think that Chicago has such a dynamic history of racism and oppression...?

Arturo: So whenever we present these findings in conferences, I've been asked, "Well do you think it's applicable to other ethnic minority or racial minority groups?" And I'm not quite sure. I would venture to say that for the Black community it's not applicable, in the sense. Cost will still remain the highest barrier, but when people ask that question, they are kind of asking me, "Is stigma not [an issue]". For many professionals these findings are very interesting, maybe it's the first time they're hearing it, maybe they have heard it before, but now they're seeing the numbers, right? And so when we are talking about stigma in other communities, for example, in our work in North Lawndale, we see that stigma is a very big factor as a barrier to mental health access because those communities had generational oppression, they've had systems of oppression that have seen the ugly face of being institutionalized through the criminal justice system and sometimes through the mental health system. And so in many ways, you know, they've also been hurt by involvement of social workers in DCFS cases, and things they've said in counseling sessions gets used against them later. Those levels of exposures are maybe not as clear for newly arrived immigrants. Therefore that stigma may not be as high because they are here actively seeking support and they know they need that level of assistants. They don't how it looks like, or where to go necessarily, or why it works in a way that it does. So education still has a big component for everyone, but I think it's overstated to say that should be the main intervention. Our biggest referral source, and why we have a 6 month, actually, it was 6 month before the election, now it's 9 months after the election, our waiting list. We have always had such a big waiting list. For my entire twelve years at this program, we have always seen a waiting list because word of mouth has been the biggest referral source. Followed by community partners, and so in many ways, I think when you address cost as the biggest barrier, then we can really put in work to address the other ones.

Amber: In terms of politics, because you brought up post-elections, how do you see things unfolding in the next couple years…

Arturo: [laughter] Oh lord. Oh God… I mean, when you hear the Republicans dismantle an already crappy ACA. ...you see how the ACA was a grand compromise. A compromise in the favor of big business, you know, managed care systems that are still trying to wiggle their way out of their responsibility, that is if they even should have had a role in the first place in our healthcare system which was a question that was not even seriously entertained, and you're seeing it go in the opposite

direction. You're seeing it, a president that is very pro-business, treating healthcare as more like a business.

In a paper I just saw, I believe it was the GAO report, it said that the Republican alternative that they are currently working on in Capitol Hill is going to boot 22 million more out of having some level of health insurance, and I've seen this personally. My parents are in that bracket where they're making just enough to not quality for the full subsidies, and still are poor enough to but not be able to afford their treatment. You know, they have children who can support them, other families don't. And that was the best we can do as the richest country in the world? I feel like when we don't consider the role of the state in healthcare. I've of course been a big proponent of the single-payer system. When the government option was not even in consideration in a part of the development of the ACA, and as a result, you are seeing the high level of cost. So this is the one thing that I always think about for us as social workers, as public health workers, we may not be economists, we don't have to be economists, but we do have to try and understand how economy and how the economic theory impact people lives on a daily basis, right? So it's interesting when I started talking about how having at least a government option could have controlled health care cost. People kind of look at you funny, not because you're wrong, because they don't expect you to say that...

Amber: Do you think the Community Wellness program will be sustainable?

Arturo: Yes, I really do because the hospital has committed to this. I mean, it's probably the most stable mental health program in the community, because you know, it dates back 20 years now. And that level of stability is definitely part of what the hospital's intention has been - to invest its community benefits to actually serving community needs, not just researching them, right? And so, for me, Saint Anthony is a leader in that area, and as a small community hospital, it's actually tried to develop different economic model to maintain its operation, because as a small community hospital that's a stand-alone nonprofit, that serves a high percentage of uninsured, high percentage of Medicaid recipients, it really does not need any more charity care to maintain its nonprofit status.

But it has gone farther, we also need to address social need and we have to make them a sustainable part of the hospital system. And moving forward, the new campus that they are looking to develop is going to be mixed used space that will feed different lines of revenue to support the hospital, but also, our Community Wellness programs. Because, again, we do not charge a dollar for anything that we do, and we have close to 25 staff that are all focused to support social emotional wellness in communities for individuals and families.

Celie: Can you tell us about how your institution - Saint Anthony Hospital - has supported this perspective rooted in social justice?

Arturo: It is a very special hospital. I mean, I don't know of any other hospital that has two community centers that are fully staffed to provide support around health and social emotional wellness. We have our Registered Nurse, who is expensive, it is expensive to hire a Registered Nurse that is dedicated to offer free health education in the community to support community organizations to add value to their work and support their health promoters. We have parenting support that assess for childhood developmental delays from the moment they are born through a continuum of services up to providing supports through parenting of 9th graders. This idea that we can really support the family through supporting parenting initiatives that really give the support parents need to be the best care givers of their children. We have, of course, our mental health program that offers free mental health services for

individual, and couples. And very specifically, we've offered free mental health services to those because that has been the population we've served, right?

We really want to fill the gaps. And finally, we also support public benefit enrollment to ensure people have access to the benefits that they are entitled to. You know, we do this out of two community resource centers in predominantly Latino communities, and predominately African-American communities. That is very intentional. It has been very much the hospital saying, "This is our commitment to embracing community needs through service", through delivery of very, very, needed services that support…. and then we are going to make this very stable part of our budget for the next "X" amount of years. Again, it's going back two decades. And this is a very difficult decision for a small hospital to do, right? Because, when it comes to the revenue, we are not bringing in revenue. We are a department that, again, has a $1.2 million operating budget, and is there to be a charity to people and it is very much in line with the mission of the hospital to serve community needs. And, on the contrary, as other hospitals have taken decisions to lay off and close programs, our Community Wellness program has expanded. We've grown, we've doubled in the last 6 years. This is where I am very happy to see that this model has been well established, because it should and it very much needs to be framework for how other hospitals operate. Again, we can only invest in researching social needs so much without actually asking, 'what can we really do? And how can we invest to support those needs?'

Celie: Do you see other hospitals in Chicago shifting to provide more outreach work?

Arturo: Outreach work is one thing, and every hospital has outreach workers and that's one thing. You know, because of the ACA every hospitals are required now to do Community Health Needs Assessments, "CHNAs", and they're required to be done every three years. So our hospital has been doing those for years, for at least, I won't say exactly when they started, but as long as I have been here I will say Community Health Needs Assessments have been a continuous part of our program development. I don't see other hospitals mimicking that next step, and saying, for example, every one of the Community Health Needs Assessments that I have seen from every hospital points to mental health a big issue. I don't see many of them lining up to offer free services in the community in the way that we have [laughs]. And we'd love to see that because then we can start sending our people from our waiting list to those services.

You [also] see people outside of health care trying to find different ways to make it work, right? Brighton Park Neighborhood Council, one of the community organizations that we've partnered with, they very intentionally are integrating school-based counseling into their model of community work. And so, they will try to find ways to creatively fundraising and supporting school-based counselors because Chicago Public School System, also, is a space in which a city and state can invest in accessing community mental health services for youth and their parents. And instead, you are see small nonprofits trying to fill that big void, and, they can only do so much. So it was that partnership where we were able to expand our mental health program within Brighton Park. It was actually through their partnership that we started to do this research, and, it was really through that partnership that we saw, not only….we already knew we what were the needs for the adults, but now we are collectively with Brighton Park Neighborhood Council figuring out how we can also integrate family therapy to bridge the gap. We've already established a strong mental health program that serves the adults, and their program that focuses on youth inside schools. The missing piece here is the family work that has, the therapeutic family work, that goes beyond what we do in parenting programs.

Amber: Do you want to talk a little bit more about the Roots to Wellness initiative?

Arturo: Through my engagement with Enlace Chicago, we were able to then talk “what does mental health look like in Little Village, across the community?’’, And it was really through that initiative that we were able to start this coalition of different service providers, mental health providers, domestic violence organizations, health clinics, schools, to come together to talk about mental health and what the needs are in mental health in the community. And through that, we did some community research, and of course identified that there was a big gap and there were some very clear barriers to access. And, it was great because it was one of those things we were able to bring and almost kind of like, breaking down walls of the silos...

It was 2010 when we started Roots to Wellness, give or take. And it was through that initial conversation that was brought together by Enlace Chicago, we were trying to apply for, if I am not mistaken, a Federal or State grant, it was a very big grant. It was through the process that they brought different stakeholders to the table, it was also through that process we realized how separate we were from one another, we really didn’t even know each other, and didn’t work together, let alone, be able to refer to one another in a way that was very functional. So we were maybe familiar with them, but we didn’t quite know who was there. So, that really was to say that we need to keep this conversation alive, and we did. And over the years it grew, and we were bringing in different partners that were working throughout different communities. And, that’s when we were seeing that limitations of this model that was brought by one community-based organization whose, by definition, their organization focuses on one community, Enlace Chicago, is a community based organization that wants to increase wellness in Little Village. And as a hospital, we saw that Little Village is one of our service areas, but, as we saw in Brighton Park, we saw that there was immense need there and further south, and then in Pilsen. And so, more recently what’s evolved since Roots to Wellness has been for us to convene a new table, the Southwest Side Mental Health Collaborative, that brings providers, and us included, but others, all welcomed to be part of a table that talks about mental health as a regional issue, the south west side of Chicago because, as our latest survey shows, when we replicated the Brighton Park survey that was something that, again, started in 2014 an initiative of Saint Anthony and Brighton Park Neighborhood Council, we replicated that same survey cross ten communities, included Little Village, but going beyond, we saw that these were almost identical. So the collaboration work is when again, I kind of ground myself back to the community organizing model side of work because when you talk about systemic and structural oppression, these are enormous, enormous issues that are very, again, very much designed and made to benefit few, and keep others in certain situations. And those issues of oppression cannot be addressed by one individual, one organization, not even one coalition.

Amber: In What is a Healthy Community?, you wrote “community research is crucial to understanding what is needed for building a healthy community, and this research is done best when it includes the full participation of community residents”.

Arturo: ...in 2014, Brighton Park Neighborhood Council by that point knew really well of the work we were doing in Little Village. And they approached our program, they approached our higher management and asked for a meeting with the CEO Guy Medaglia, and said, “we also have mental health needs in Brighton Park” and our CEO, who is very much community oriented, said “We're willing to support that. I’m willing to invest in that, but I need to see that data. I need to see the numbers”. So we had Mariela Estrada, an amazing organizer, who reached out to me at that point and said “Hey, you’re doing your PhD, help me design this survey - you’re good at this stuff! I’m good at getting the surveys collected. Just design the survey tool, and I will make it happen.” And so I did; I designed this survey to be simple, and be very comprehensive still, and to be able to speak to what the needs are and

the barriers are to mental health services...they then turned it around in 2 weeks, and collected 600 surveys.

And in 2 weeks, you have a big data set, right? Research is as good as your method of data collection. And so it was through that partnership we were then able to demonstrate the needs through that findings of 2014. We've been able it replicate it three years since, and then scale it, more recently, to 10 communities. Very much with the leadership of Brighton Park Neighborhood Council, they really engaged and took on the responsibility to survey in areas in which there was no community-based organization. So they were a big part of the reason why we were able to meet and survey 10 communities. I think they committed to engage in 7 of those communities. So all I have it say is that it was through that partnership that we realized, you know, through this lesson that we speak about, the multiplied power of research when everybody brings to the table their skill set, their strengths, their capacities, their own expertise. These leaders were amazing. They were able to survey and get these numbers that it's not easy to do in public settings. Where you're asking... when a quarter of the respondents are men. Your asking men to say what their mental health needs are in a public settings, and their responses were very revealing.

And what we found in the surveys were that people may not tell you what their mental health needs are, but when you give them an anonymous survey you can just check boxes off of, you get a whole different take on what it is. So, this was to me astounding example of how community based research, the power of community-based research. Because then what happens then, again, what fascinates me and part of our design and very intentionally we said, "Well, we're going to go back to those same leaders. You collect a group of individuals from the community, you bring them together, we're going to present the findings back to them". And then, you see how people learn from the findings. So, these are people who are experts in their community. These are people as leaders who have a pretty good sense of what is happening in the community.

And still, they were being challenged by the findings. So the way I would present it to them, I was part of all of those community presentations. I enjoy that so much, because it was a way as an academic to bring back the findings the community and not just to helicopter in and just take that research with you. It was very intentional to say, "Here is what we found, what do you think?" And a lot of them, there was some moments, you know, when you see minds being blown at that moment. Where we were saying "Wow, I don't know if you guys have realized it, but look at the data. We're seeing that men are responding their number one mental health need is also depression, just like the women." And, some of them were really surprised by it, and some of them maybe knew it, but were confirmed by seeing it. We were also able to see what mental health barriers were for men and women. Or more importantly, for some people were able to say "Well yeah, I didn't think about cost as the biggest barrier." People were having a hard time chewing on that one. Because, it was like they kind of understood it, but they were never told it, but they didn't think it was wrong, but they also didn't necessarily go to it as their first guess. Before I would show them the slide I would say, "What do you think is the biggest barrier for access?, and none would really say cost, that was surprising to me. Until you process that, again, as very much going back to community organizing, you use that same opportunity, not only necessarily to learn, but to drive community action.

Now, how do we challenge the system that's not necessarily serving community needs? And that's the question we are going to pose to everyone to collectively develop a strategic plan to move forward.

Amber: That was going to be my next question, where do you see this going? How do you see it unfolding in the next few years?

Arturo: Yeah, so, you know, I've shared this with… I've just finished my dissertation, and a lot of my community members asked me, "So where do you go from here? You got your PhD?" And a lot of people kind of ask, "Well, ok, you're on the job market, right?" And they're all surprised when I say, "No, I'm going to stay put. I'm going to stay in the work I've been doing. I'm going to really support them in any way I can, now as a PhD to continue to work forward." And people get really surprised by that. You know, I love when, BPNC has their organizational model, "Be the change you believe in", that Gandhi quote. And so, I really commit to that.

Amber: Is there any advice you would give to new public health student, or sociology or social work students starting a career?

Arturo: Yeah, never stop learning. You don't have to go back to do a PhD. I mean, that's a very big endeavor and very personal sacrifice that you really have to be ready for. That's not discourage anyone from doing it [laugh]. But, that being said, there was moments where if I were to start it over right now, I really couldn't do it. [laughter]

...I guess my lesson is, we have a responsibility to learn and continue to learn and not be too narrowly focused that we end up only seeing the world through one lens - having very much tunnel vision. Public health, as in social work, as in nursing, as in teaching education, all of it we have to understand the ties between all these social issues as that pertains to our field. Without it, we end up the perpetuating limited interventions that become very narrow in target, and therefore, very ineffective. And without thinking very comprehensively and engaging in very intentionally, partnerships, building relationships with others who have other skillsets and expertise. That then we can create different possibilities, right? If public health workers only surround themselves with public health workers, you're only going to come up with public health solutions, and those are very limited. Same goes with social work, same goes with education. If we build those bonds. If we support one another in our joint mission for social justice, each of us bringing out skill set and also including community residents and different people at the table, and also arming our own selves with more knowledge and being able to teach that and convey that in or work. Without that, are very limited.

I think that's the lesson I learned and I continue to teach. We have to be very well versed, not necessarily experts, but very well versed in what we have and what the adjacent issues to what we're looking to address. We need to get better at that.