Podcast Episode 48

Words not weapons: A psychiatry expert discusses the impact of gun violence on community mental health, and how prior history of violence, victims of violence, and substance use disorders are far greater predictors of gun use than chronic mental health conditions.

Featuring Dr. Rahn Bailey.

Part 3/4 of our Healing Hate conference series.

Dr. Rahn Bailey discusses how for decades discrimination has played a central role in health disparities, and how gun violence compounds the problem through traumatic experiences, chronic stress and behavioral consequences. Dr. Bailey argues that gun violence against self and others has far greater consequences than suicide and homicide numbers would suggest. Underfunding and misunderstanding of psychiatric services has resulted in people living with unresolved mental health challenges for long periods of their lives. But our understanding of the importance of addressing psychiatric disorders and associated stigmas is changing, with research indicating early intervention and trauma informed care should be central to management of most chronic and comorbid conditions. Some medical schools are integrating education about social determinants of health are making the connection between environment and mental health more explicit, leading to better assessments and better outcomes, and many violence prevention programs are succeeding. With Randall Morgan, M.D., Executive Director for the W Montague Cobb/NMA Institute.

All views and opinions are the participants own.

Dr. Morgan: You are listening to the Health Disparities Podcast from the Movement is Life Caucus. Conversations about health disparities with people who are working to eliminate them. I am Dr. Randall Morgan. I'm an orthopedic surgeon in Sarasota Florida and I am a member of the Movement is Life steering committee. I presently serve as the executive director of the W. Montague Cobb NMA Health Institute which is based in Washington DC. Dr. Rahn Bailey is assistant dean of education at the Charles R. Drew School of Medicine and chief medical officer of the Kedren Psychiatric Hospital. A graduate of Morehouse College, he was the 113th president of the National Medical Association. He is a member of the American Psychiatric Association board of trustees and a board member, past board chair and current chair of the W. Montague Cobb NMA Health Institute. Welcome to the Health Disparities Podcast, Dr. Bailey.

Dr. Bailey: Good morning, thanks for having me.

Dr. Morgan: It's a pleasure to have you and all of the experiences that you have had in your career that have been focused upon health disparities. We are going to start with some quick answer questions then we can explore some specifics in more depth. Our first question is why is this an important conference, right now? We're speaking of the Healing Hate Conference in Charlottesville, Virginia.

Dr. Bailey: The Healing Hate Conference this month of January of 2020 cannot occur at a better time I think in our society, in our community and in healthcare. It addresses the idea that because of health disparities that continue to exist, many individuals are at risk of poor outcomes and very often there are actions that we could take as healthcare professionals to eliminate them and alleviate them. The Healing Hate Conference particularly has addressed this concern that over many decades actually, over a century, the areas of discontent between persons of varying backgrounds have led to conflict being based on discriminatory bias implicit or otherwise. Being based on race or racial ethnicity concerns or racism, gender inequality, discrimination against persons based on their choice of where they pray or who they choose to live their lives with. For a variety of reasons, we see these concerns raising their head again and making it more difficult I think those of us in healthcare to make for a better circumstance for a person's lives. So, Healing Hate I think as a timely entity to address these issues forthright.

Dr. Morgan: Dr. Bailey, there are obvious effects of gun violence particularly when there are homicides or suicides, but there's a ripple effect that occurs in our community that affects many of our citizens and this is something that we at Movement is Life would like to be able to address as well because this is a part of the total human experience that we are addressing in

Movement is Life. So, could you perhaps discuss a few of the ripple effects that you see that occur in communities?

Dr. Bailey: Certainly, I think that there are several. First and foremost, one doesn't have to be a psychiatrist to appreciate that stress and/or anxiety is harmful on our health. And the idea that with ongoing stress leading all the way up to you know the big concern of post-traumatic stress for example, individuals have worsened health outcomes. More hypertension, more diabetes, more worsened cancer outcomes, more pulmonary difficulties, more strokes. A recent autopsy of someone who had a very stressful life who died of a violent act at age 30, in the late 30s, during autopsy it pointed out that the person had a heart of a late 60's age person. So, 20 years more of aging on their heart although violence was actually causing the end of their life earlier on. There are many persons who are still alive who've not been a direct victim of gun violence or other forms of violence who also have these long-term difficulties because of stress that it actually employs. I think the second issue is the conflict or difficulty on families. The conflict of risk of violence has a substantially adverse impact on families for more familiar discard leading up to probably including you know divorce and children being split from both their parents. I think that violence often has the ability as well to cause great deal of adolescent misbehavior.

In psychiatry you often see individuals who if they come from a violent background whether it was in their home or in their neighborhood if they actually knew about it, they may also know about some of it from the media or from entities that are far away from you. You may bring that violence, that dynamic and personal violence if you're an adolescent into your own life experience at school and how you react with peers. A third piece that I think very often is getting a lot more attention now is the conflict between society members and law enforcement. One can put on their local media, their YouTube or whatever and see these increasingly violent conflicts with law enforcement. The law enforcement officer stops someone, and they want to ask regular questions and the persons are challenging law enforcement until the law enforcement reacts appropriately, at times they over act. I think all of this is also part of the so-called ‘ripple effect’ that this ongoing dynamic violence in one area, we've made it to twenty thousand homicides and forty thousand suicides every year but there are millions of people who are impacted adversely because of it. So, we all are affected not just those preaching persons who live in one part of town, in one community or who are direct recipient of a family that lost somebody to death due to gun violence.

Dr. Morgan: In terms of health disparities and health equity, which trends are you most concerned about at this time?

Dr. Bailey: Well, there are several, but I think as a practicing psychiatrist I'm always very focused on the issue of psychiatric disabilities and mental health impairment. Clearly, there's lack of funding appropriately from government and private resources for individuals who have brain disorders as compared to so-called medical disorders and that impairment very often leads to health disparities and adverse outcomes. Early mortality or death and unnecessary unwarranted morbidity or worsened health concerns for individuals who probably could manage or treat much better. One key issue for me has always been that if you have a primary psychiatric illness and a diagnosis before the age of 25, you on average can expect a shortened length of life by over a decade and a half. So, our patients lived to about their mid 60s whereas most individuals in America now live closer to age of 80. Persons are actually dying early because of so-called medical concerns, hypertension and cardiovascular illness and pneumonia and asthma and stroke. But the psychiatric co-morbidity when it occurs early in their life very often is a predictive factor of worse outcomes and early mortality, those issues that we in psychiatry should be speaking about directly.

Dr. Morgan: On that particular issue, is this something that is recent or is this something that has been known for a long time?

Dr. Bailey: We've known this for what I call a long time but it's unfortunate that in psychiatry we've not done as good a job as we should have and we should do better going forward making these points known liberally and generally I think to the entire American populace. All too often, even throughout my 30-year career, I finished middle school in Houston, Texas in 1990 so I've been out 30 years now. We've recognized that many tend to think that you don't concern yourself with the psychiatric issues until it's very late in the game. You've done the full medical workup and you can't find any answer. Then, you call for a psychiatric consult; all psychiatric issues are put on a backburner, a person refuses to take their medications. I often comment about the data that implies that of all years of medicine psychiatry is the area where persons are most likely to go to a physician, receive a diagnosis, we prescribe care and never get the prescription filled the first time. So, the stigma against mental illness or psychiatric disorders is real and it often adversely impairs individuals from doing the things that they need to do to move toward better outcomes and impaired clinical circumstances. We should speak about that much more deliberately in psychiatry.

Dr. Morgan: I think it is of interest that early on in my medical training at Howard University, psychiatry was a part of our education program even earlier than I thought it was necessary. And so, retrospectively, I can understand

why it was introduced so early in the curriculum and I'm wondering if that still takes place in the medical schools today.

Dr. Bailey: Well, I think that you pointed correctly, Howard University School of Medicine was ahead of the curve then and may still be now in addressing psychiatric issues early on. Many medical schools increasingly now get students into the clinic earlier, you don't wait until you finish your second year and pass step two before you finally put on a white coat and engage in clinical activity. Many start early. When I was in medical school we started probably during the second year, some started right from day one getting some clinical experience and clinical exposure. But you're right, very often it does not include a good exposure to psychiatric themes, patients and potential diagnosis, especially, as it pertains to comorbidities. Areas of persons have both a medical problem and a psychiatric problem. If you think about them both collectively from the inception of the diagnostic process, you tend to get outcomes that are enhanced and persons I think who appreciate the value of managing those concerns dually right from the inception of care. I clearly think that some schools have been more aggressive at this, increasingly, there's a wealth of new med schools around the country. University of Houston and University of California, Riverside and some other ones, I think there's one in Illinois that are more focused on social determinants of health. They bring more of a psychological bent into the early considerations regarding diagnosis

and care. That new group of med schools probably are the ones that are increased at the forefront now of addressing these types of psychiatric concerns earlier in the provision of medical education.

Dr. Morgan: And that's something that should be promoted with the traditional medical schools as well because when these disease processes are compartmentalized, it's very difficult to understand how to solve them. And as you mentioned, the social determinants of health has become a major issue today in terms of understanding health disparities. But I didn't think about the connection between psychiatric health and social determinants.

Dr. Bailey: You make a very, good point. I was actually at one of those trainings for this is physician administration at Harvard in Boston January of ’18 and a speaker was speaking about the fact that in countries around the world, most of them have universal healthcare by the way that I think we all in healthcare should probably support, but in countries that focus on social determinants, so put much more proactive resources into prevention early in the process of a person's healthcare they simply have better outcomes. They have the same length of life that we have but less morbidity during the earlier periods.

So, we have in America to take a step back, look at how we actually process the activity of health care and begin to make changes that are

appropriate for current times. I was very clear that in the turn of the century 1900, 120 years ago, persons average ending their life at about age 49. By a century later, by year 2000, that average is almost at age 75 so it increased by about 50%. The length of life with the strategies we employed during that century, 1900 to 2000. We got antibiotics and we left the use of clean water and sewage and we make sure people would wash their hands even in surgery, we had to use accepted techniques and those kinds of things but the next century will be different. Between two thousand and twenty-one hundred, we'll probably have different strategies to find ways to improve the quality and the length of people's lives. And I think this should focus on social determinants of health, addressing more concerns regarding prevention, a huge premium on primary care and early access. Those are the strategies that are likely to work that's why there's just anathema to me, I hope all doctors that we live in a country that's been debating for a decade whether there should be free access to care for everyone. Because if you have healthcare for everyone then persons are much more likely, early on to go for prevention and decrease the need for many of these herculean efforts later when preventative concerns have been addressed.

Dr. Morgan: And we may get back to some of these points in your other questions. In terms of health disparities in health equity, what potential initiatives and remedies are you most optimistic about?

Dr. Bailey: Well, there are several. Clearly, one thing that I'm very involved in now is the issue of preventing violence. I'm a psychiatrist, I've been doing that for 30 years so issues regarding violence and interpersonal dynamic violence have always been an aspect of my career, whether persons are at potential risk of violence to themselves, suicidal thoughts or ideation and we hospitalize them involuntarily against their will or whether there's a dynamic violence against others and a person if you will. All issues with violence come into play but really over the course of the last I'd say five years of my career, I've been much more focused on the issue of firearm violence or gun violence. I'm happy to say that my second book came out on it in 2018; we'll be discussing that I think in the program at Healing Hate in Charlottesville, Virginia, tomorrow Friday, January 31st, 2020. That book addressed I think these five or six key themes of violence prevention that we should all talk about. One, we should acknowledge that the gun itself can be a problem not the only problem, but it is relevant to this discussion about gun violence. So, I would disagree with those in academics or not who would argue, "Well, don't worry about the gun, it's just individual." We can throw the key away and put them in jail or help build more prisons and have more laws and three strikes you out. All those kinds of strategies clearly have not worked in decreasing dynamic violence in America during my career and yours, so we should have a different approach where it's much more likely to be proactive and

effective. Secondly, it goes without saying, most people are very much aware that the guns we have available in America now, they're just too many of them; 325 million Americans, 340 million guns. There's just too many probably more than any other so-called industrial country in the world. I think second only to Yemen in the number of guns per person in the country and the guns are too powerful. The so-called high magazine capacity, everything is a machine gun even a small barrel pistol you can carry concealed not like a long or rifle can fire off many rounds and there's a reason for that. That's done to create maximum infliction of harm to people. You don't use those for hunting and people who are a really good marksman only need to shoot one bullet one time. Those who need to spray an area with multiple bullets or just trying to harm large numbers of persons that's really not beneficial I think for our society. We should speak against it especially in psychiatry. My third point is psychiatrist should also be the ones having this discussion because there's twice as many suicides in this country every year, closer to forty thousand than homicides about twenty thousand by guns. So, follow that focus on homicide prevention of such, many persons want to buy a gun to protect themselves and it's hard to disagree with that concept, but they should at least be aware and educated about the data that implies. You're much more likely to have somebody come to your house and suicide with your gun but often somebody who is known to you, maybe even related to you than for that

gun to be used for defensive purposes which was the reason why it was purchased.

My final point because I've been surprised to find out how much technology already currently exists that we just don't use in America. And I find that to be a missed opportunity and one that I think healthcare professionals should be speaking about very loudly. There's so-called biotechnology now in January 2020 that would make guns safer. A person would buy a gun, it would have to be programmed to only work for that individual based on their fingerprint for example. So, someone else couldn't come with your gun and use it for nefarious purposes to harm themselves, suicide or in a domestic conflict to grab it and use it against someone else even you, the owner. We should use that technology and we should use research to figure these things out. And so, my final point, in this regard, is this so-called Dickey Amendment from 1996, over two decades ago just really has to go. This idea that data and evidence-based research is not to be done on a purpose that politicians would not want to know what the final answer would be which is the underpinning of the Dickey Amendment. It's been harmful I think on the issue of gun violence but I think as a psychiatrist, as a scientist, it's awful on everything we do. You simply cannot have any entity, politicians or otherwise making decisions that are politically based that drive us to be precluded from

conducting research in an empirically based way that might find out different answers for solutions for society's problems.

Dr. Morgan: You've been very involved in the American Psychiatric Association, what is the association's position on the gun violence issue and the importance of psychiatrists in making a difference?

Dr. Bailey: Yeah, I've been on the board, now, since January of, let's see the elections were in January but I began in May of 2020 2019, excuse me and I'm very proud of the fact that the American Psychiatric Association that started in 1850 has always been against rampant, dynamic and interpersonal gun violence. It's had many individual statements, position papers and what have you. What's unique though is that in June of 2016, three or four years ago, for the first time ever, the AMA, the American Medical Association, also came out with a position through their house of delegates, their assembly body, condemning the excessive use of gun violence to harm Americans and indicating that many of the provisions that we should take should be done with a public health perspective. This means that there should be a wide-ranging, broad based perspective of how we develop solutions to these concerns. Entities like the commissioner in health disparities that the AMA jointly sponsored with the NMA and other groups for over a decade I was very helpful because it brought advocacy groups to address these kinds of concerns together as

a more or less a think tank and give them a chance to kind of think, discuss, share ideas and find areas of common interest and common direction to work toward addressing concerns regarding interpersonal violence, that was helpful.

Dr. Morgan: Has there been an opportunity to talk about the rights of individuals in terms of the use of guns versus the health of the community and the nation with regard to guns? Have there been any suggestions that this American Psychiatric Association has given or even AMA for that matter to try to bridge the gap of communication between the NRA, between those that are very strict with regard to the constitution and bill of rights, in terms of gun rights versus a healthy environment?

Dr. Bailey: Absolutely, I think that really is the signature question and the best one that anyone could ask and have answered. I think there's a plethora of information, education, awareness and direction for us to take on just that very point. I think the problem remains currently in today's America that the minority of voices tend unfortunately to be the loudest and the most persuasive in the political arena and they very often tend to have a positive effect and are influential in tailoring the conversation for whether you have gun rights and you should have an unfettered use and access to guns versus you have no rights and the gun’s taken away from you. Nothing could be more disingenuous and untrue.

Our book for example that I mentioned earlier, nothing in my book speaks about taking anybody's gun away. It supports the second amendment, which means you could have access to a gun, and it points out that there are individual rights you have this right. However, within that, there still has to be some restrictions just like we have restrictions on you can have a right to drive a car but if you wreck too many times or if you get too many DWIs or if you have had a seizure, we take that right away. Same with guns, some persons probably should not have a gun it shouldn't be that everybody in America has to always have a gun in an unfair fashion. We do have data which we do on who's most likely to hurt you with a gun we don't use it and that's what's unfortunate, so thank you for giving me this platform because many Americans are not aware that we do know who's most likely to shoot you with a gun. There are people who fall into three categories and very often they're different than the ones that very often we make laws against, make the laws against them and they don't yield and then we're arguing they're not substantially more likely to shoot you with a gun than anybody else, but the three groups that are: A) those persons who've used one before. So, a prior history of gun violence all bid substantially increased likely to future gun violence. B) Those who've been a victim of violence, those persons are much more likely to use a gun against someone else, and third is those persons with substantial SUD or substance use disorders mainly alcoholism. So, we don't say

because you've had a DWI we're going to take your gun away, but we'll say, “Because you've been hospitalized mentally ill, we’ll take your gun away,” or we will say that I think all 50 states in the country have some rules and restrictions against having access to guns if you've had some degree of mental illness. So, we really direct all of our efforts toward gun control in the wrong direction and that's the problem.

Dr. Morgan: And this issue still is a major talking point for many in terms of giving the reason why we have these gun issues.

Dr. Bailey: Well, absolutely.

Dr. Morgan: It is that the people are all mentally ill and so all we need to do is to find who the mentally ill people are and reduce those numbers and then we will solve the gun violence problem.

Dr. Bailey: And the turn of your question is correct. It’s that idea which some others propose or proponents of is remarkably and over the reductionistic approach, you're right. It out misses the empirically based evidence that I just mentioned to you that we know which three groups are most likely to use a gun against you. Those are the ones we should be more conscious of and fearful of. The police will go to your house, there'll be a threat about conflict and violence, there'll be alcohol all over the place and you have a

history of DWIs, and they'll leave and there you are with the precipice of a high risk of gun violence. But if they go to your house or they're called, and you've had history of mental illness then they go looking for guns to take. So, we've been trained, our law enforcement otherwise to think that the wrong group, those with history of SPMI or severe persistent mental illness like a diagnosis of like schizophrenia are the ones that we should be afraid of. They would argue that those groups are probably about four percent more likely than the general population to use a gun in a commission for failing otherwise. So, I can't say that the number is not higher but it's miniscule higher, but the other three groups that I mentioned, those with alcohol or drugs one, those who have been a victim of gun violence two, those have been perpetuate of gun violence three, they're 40 times more likely four percent likely than others. So, it's a tenfold risk. We must get the word out and change, move the needle so to speak on who we address our efforts toward limiting gun violence.

Dr. Morgan: So, just one more point to think about, I’m not sure it's going to clarify anything but there are two categories of citizens who are trained to use guns as a part of their livelihood or as a part of their task. One is the military and the second are law enforcement officers. So. are they included in this? Those who have used the gun before and in the largest numbers of individuals who would use guns?

Dr. Bailey: No, the groups I think who are using guns legally would be excluded. That data really involves individuals who may be free citizens who choose to have a gun in their own personal engagement. But it is a very good point because I think that individuals who actually are trained to use guns, those with a military history or those who are currently in law enforcement are a key group to study. One study that I often like to share with groups is if you think about guns, it is very instructive on who has a gun and why access to guns I think is very, important. They would argue that law enforcement officers, persons who have been trained to use guns and if they were in the military before they were trained twice if you will and those who actually practice, they go once a month, what have you and practice shooting, the marksmanship; they generally hit a stationary target at 50 feet four to five times. A moving target at 50 feet two out of five times and these folks were trained. So, imagine persons who just kind of show up and they have a gun. Because the second amendment said you could have one who never trains, who doesn't practice, who don't have a long prior history; their marksmanship is remarkably poor, so they tend to want to have more guns. Another issue recently was there was an issue in a church where one of the folks pulled their gun out or whatever and very often, they have not been trained to exhibit the professional demeanor that's required when you have a gun or your person. You have to kind of take your own pulse so to speak, you don't act out, you don't act in an impulsive type way. If you're just going to grab a gun very quickly, when I

think about all of the circumstances in a measured fashion, you're more likely to put other people at greater risk than to create any degree of safety, I think. So, we really are going in the wrong direction in America with the overproduction of guns, the allowance of individuals to carry concealed weapons and have weapons on their person. The unwillingness to execute a plan to encourage or require or force individuals who have a gun to be properly trained and have repetitive training over time. And to get the type of psychological emotional overview that's also required to recognizing the high relative degree of risk when there's a gun on your person. All those things that come into play are collectively combined to create a higher risk of gun-related death in America that's unnecessary.

Dr. Morgan: So, we'll just summarize this discussion by asking you what is the one call to action you would like listeners to hear? We'll say related to the health, rather the hate conference but also your involvement in the hate conference related to gun violence.

Dr. Bailey: Well, I think that I'm very appreciative of being offered the opportunity to speak. My comments, you've heard quite a few of those issues regarding the other gun violence book. I haven't mentioned yet that I have a third book coming out later this year, June of 2020 on domestic violence or IPV (interpersonal violence). And that book actually was developed as I was writing the earlier book because so much about gun violence pertains to

the domestic violence interplay. One specific example I'll share with you, I was surprised to find out as I conducted the search that you're more likely if you're a woman to be physically harmed in your own home with somebody's hands or their fists, not with a gun, if there's a gun simply in the home. So, simply having a gun in the home and the other data that supports this raises the ante so to speak or increase the likelihood that persons will respond in a violent way. This is antithetical to psychiatry. We're the main people who should be speaking about and educating society about the need to de-escalate, to use words and not weapons, interpersonal engagement and not physical violence to settle conflict and immediate difficulties that I think people tend to experience. So, just not doing a good enough job being effective I think in that regard; those are all issues I think for this conference. My final point would be this conference also has a timely name, it's called 'Healing Hate' because it additionally addresses where some of this, not all but some of this conflict came from, and those are the racial and ethnically based and religion-based biases implicit and otherwise explicit that existed throughout our society for many, many years and have existed right here in Charlottesville going well back before the event but culminated for many in that event in August of 2017 when the young woman was killed in the middle of the protesting around removing statutes. And the statues represented white supremacy and white male domination over others, over women, over people from different religions, Jews and Islamic and Christians, over individuals who

are ethnically different or African American. All of that combines to lead to the high level of risk that we all experience living in a society where we're with a high access to weapons, a high degree of antipathy and animosity towards persons who are different from us. We think about racism and then a lack of community response that's effective in a preventative type standpoint, it's a volatile cocktail and it can lead to death as unfortunately it did back then, and it has continued to do so in our society over many years. This conference aims to talk about that and address it with some solutions moving forward.

Dr. Morgan: One final question. What would you think would be an appropriate response of a community such as Charlottesville who has been certainly the center of this problem and well even the state of Virginia for that matter because it's become symbolic of this discourse?

Dr. Bailey: I think the four things that must happen from a psychiatric standpoint to heal a community and address a society's problem, first, from the people at the very top, they have to acknowledge and call mistreatment of others for the wrongful behavior that it really is. So, it's astronomically harmful in a society in which we live for the leader of the free world to say publicly that there are good people on all sides, all good people, on all sides. That just was blatantly untrue, and it supports the idea that some individuals who are doing wrongful behavior and exhibiting hate just based on what

you represent. Based on your race or your gender or your sexuality or your religion that that's okay, that's not okay and it cannot come from the mouths of leaders; the president or the governor or the mayor or the chief of police or whoever the leader may be, that's number one. Number two, your professional organizations like the NMA and the American Medical Association, the American Psychiatric Association and University of Virginia School of Law and School of Medicine must take a very active and dynamic approach. Having conferences like this are key, those conferences should actually include all people; people from the community and people from all walks of life and persons who should have a voice, an opportunity to speak their peace, and share what a lot of the historical patterns and historical pains that continue to exist in their current life. Third, you must have some degree of psychological if not physical and financial reparations. And reparations as I understand them speak to the idea that you address something that was wrongful done in the past. Just like if I was a little kid and I had a fight with a neighbor my father made me apologize and do something nice for them. Something nice may not be giving money. It may be providing quality schools and ensuring that the quality of the water is the same. In Flint, Michigan, one part of town there's bad water and in another part of the state is good water. Ensure that there's fairness and equity in how people live their lives. Those are the kinds of reparations that I think are essential to repair many of the historical damages that our society continues to struggle with. Fourth I'd

say there also has to be opportunities for joint interaction. I would encourage on Sunday morning, not just in Charlottesville, Virginia where I'm sitting today but Los Angeles where I live currently and in Beaumont, Texas where I'm from that a church would say "On next Sunday half of our people are going to go to a different church, in a different part of town and worship separately," and that other church would do an evenly exchange. A school would say "one Friday a month, half of our school kids are going to go to a different school in a different part of town and study differently. Another professional entity whether it be a business or another enterprise; you can't continue to live your life regularly in separate isolated vignettes and not think that biases and misunderstandings and stereotypical concerns aren't going to raise their head and at some point, lead to adverse outcome including harmful actions including up to including violence. Those I think are the kinds of strategies that high quality leaders would employ that I think may have some opportunity for improvement of community relations and at the end for better health and less disparities.

Dr. Morgan: So, this has been an excellent discussion. I'm going to recap a few of the points that you have made but I'd like to just ask in summary whether you had any other point that you wanted to raise with reference to your work in particular. And also, in reference to this conference before we try to summarize our discussion.

Dr. Bailey: Well, I thank you for the time. I think that education matters, media-based education can be key. I'm a believer that if we use these venues, these vectors for the positive value that they actually employ that'll be good for all of our goals and improved health outcomes I think for all. Thank you for letting me share a bit about what I do, I'm six months on ground now at a new job in the inner city of Los Angeles, taking care of patients with the most severe forms of psychiatric illness that exist. We call it SPMI or severe persistent mental illness and I'm appreciating there now just like when I was in North Carolina for four years and Tennessee seven years before that, chronic mental illness spares no geographical boundaries. Our patients have the same need where I'm now in fact, or where you are right now to be cared for, appreciated and respected as the human beings that they are. One thing that I would end with is I think that the issue that we often call stigma against patients with mental illness starts at home. Every single individual has to make sure that they're mindful of what they do that worsen it. The telling I think of inappropriate jokes, the other mistreatment, and the schools doesn't want to admit somebody because they've had a diagnosis of psychiatric illness. In fact, the person is afraid to go see the psychiatrist, they don't want to be seen in the waiting room or take those medications; all those things hurt all of us including you, not just that individual. So, I think that as we address education the elimination of stigma and our role to play in it would be helpful.

Dr. Morgan: I think a few of the points that Dr. Bailey has raised that have been helpful for me. And I'm sure will be helpful for the listeners as well, is that psychiatric problems are underestimated in terms of their impact on communities and on our lives and on our abilities to interact with each other. Also, psychiatric problems in general lack funding and at many different levels they are not addressed because of the lack of funding, the lack of education and in many ways patients not being willing to share their mental illness with anyone. Not take their medications, not follow through on the recommendations so that this is a condition that as physicians, we're not solving all of the problems related to psychiatric illness. Then that psychiatric illness has a profound effect on violence and as the studies are becoming more specific, it's more clear that psychiatrists have to be among the leaders in this nation to make a difference as we try to solve the problems with relationship to gun violence and to sort through the political challenges that exist. Someone has to be able to have a rational solution that's accepted by all parties, all geographic areas, and all political parties within our nation. We haven't gotten there yet but you have given us some very good points to work on to try to make that occur.

The five points that you make about gun violence I think are key, that the gun is the problem and not the individual who might be mentally ill or angry on a particular day. If they didn't have a gun they would not

perpetrate gun violence. That there are simply too many guns in America and we're going to have to try to change some of the principles that were stated with the Dickey Amendment, revise that so that there will be a real thrust of limiting the number of guns. And we can see in the state of Virginia even that there's a lot of consternation about the new proposals from the legislature in terms of purchases of guns, how many guns you can have and so forth. So, we're still into that space. Third, that the guns are too powerful, the capacity is more of a military type of instrument and not certainly something that is needed for hunting and not something that should be exposed to populations of individuals who are going to nightclubs or going to other types of public events where they suddenly become victims. I think the other part of this is we didn't talk about, but we all are concerned about the school violence and the fact that students have become very much the advocate in terms of getting rid of guns in their schools and hopefully we will begin to listen. I'm not sure that we have as a nation to this point. Fourth that psychiatrists have identified the fact that there are twice as many suicides related to guns almost 40,000 per year as there are homicides of 20,000 per year. So, we really need to do a better job in terms of identifying those that are likely to commit suicide. Those that are depressed, those that have other types of life issues that come about and finally, there are advances in technology that can make guns safer if we are willing to use those advances.

Dr. Bailey, thank you so much for participating in this podcast and also bringing so many points to our attention in such a short period of time.

Dr. Bailey: Thanks for having me.

Dr. Morgan: Thank you our listeners for joining us on this episode of the Health Disparities Podcast. Please subscribe to us on iTunes and Spotify and you can visit our website at www.movementislifecaucus.com for a full archive of all episodes. Goodbye until next time.

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