KELLE MASTEN:
Alright, we are seeing some people now. Welcome, welcome, greetings. My name is Kelle Masten from NASMHPD and I would like to welcome you to the roundtable discussion for The Intersection of Mental Health, the Corrections System, and Individuals who Identify as LGBTQ+ and to experience serious emotional disturbance and serious mental illness.

This session is to continue the conversation from last week and dive a little deeper into some dialogue with the presenters, Doctor Joan Gillece, Roel Almazar, Randy Killings, Doctor Beth Jordan and moderated by Doctor Lynda Gargan. This is an opportunity for you to ask questions either verbally or in the chat.

Please note that this session is being recorded for those of you who want to ask questions anonymously send directly to me and I will make sure they get asked. If you would like closed captioning, please look in the chat. Thank you again for joining us, and I will now turn it over to Doctor Lynda Gargan.

DR LYNDA GARGAN:
Thank you so much Cal, and welcome everyone to our intimate dialogue as we are calling it, with the 4 presenters that we got to hear last week, and what a wonderful presentation that was. So just a little bit of housekeeping before we get started, I would love it if everybody would turn on that video, if you don't want to understand, but I would love if everyone would just turn on the video because this is going to be a discussion, that's all we are doing here today is giving you the opportunity to ask questions of our marvelous presenters.

Now, we will be able to ask these questions either by raising your hand and I will call on you, or you can put them in the chat and Kelle will share those will get to them. So we are going to get started, relax and get ready for an amazing discussion. I'm going to get us started simply by asking what might be considered a very softball question, but I want to start us off this way.

I'm going to ask our presenters, in thinking about the conversation we had last week, we heard Randy's inspiring story, Raul shared some very important information with us, factually, and Beth shared a compelling story of the work that she and Joan had been doing in the D.C. department of corrections. So presenters, I would like to ask you, of the things we talked about last week, what would be your major take away from that? What one thing you would like to bring to the conversation to get us started from last week?

And I'm going to take people as I see them, Beth, I've got you first on my screen. What was your takeaway from last week?

DR BETH JORDAN:
Everybody, I'm so happy to be here. You know, I'm biased so I think that my-- I guess the message I have is not every correctional facility is the same, and some are really coming from a rehabilitative model, and their hearts and minds are in the right place and they are working with amazing consultants, and leadership is fully on board. And we really want to approach our work from a trauma informed care perspective.

I approach my work in such a way that I want everybody treated in a way that I would want myself and my family members treated. So, I think that there is a lot of bad press. It's unsexy to talk about what not working in correctional health, and I think there's a lot of entertainment value in bashing things that shouldn't be bashed, unfortunately I certainly see that in the area I live in here in D.C., but you know I'm on calls with SAMHSA leadership, it's got a take a lot of time, the contract has be read in a certain way, the vendors in the right place we have a lot of federal money to do things from substance abuse disorder perspective that are having really big ripple effects.

So, I think it's important to, you know, for advocates and family members and friends and loved ones who have people in correctional facilities to do their all to make sure their loved ones are taken care of. But also to know that at least here in D.C., things I think are very different. And I have the data to prove that, because it's not just about feelings and beliefs, it's about data. So I think there's a lot of hope to have.

DR LYNDA GARGAN:
Hope is a nice thing to think about when we are speaking about the Corrections System, isn't it? Joan, I know you've been instrumental in the work that Beth is doing, I know you guys have partnered on a lot of this work and you are doing such amazing things. What would be your highlight from that conversation last week?

DR JOAN GILLECE:
I think my highlight not just from that conversation with the work we are doing is the importance of safety. Really, the importance of folks feeling safe wherever they are, and how can we create that environment or someone, who we are talking about in the LGBTQ+ feel safe, we are in the editing phase is a video we did at Randy's place at rainbow Heights, really asking members and staff, what would make a difference? What makes a difference in what would make a difference? And we were basically focusing on crisis services, but it really kind of morphed into the whole system.

In safety was really the number one thing there, too. What folks are saying, how unsafe they felt and other programs, whether it was community mental health, corrections, whatever it was, and rainbow heights give them a place. Randy speaks in the film, he's fabulous, he speaks in the film saying there might be people that come and sit in the corner for a bit just to have that sense of safety.

There was another individual who said this is the first time I could say I am a gay man and feel proud, you know there were people in the transgender community felt that they didn't even feel like they could go to the bathroom to change clothes before they came to the support. So that safety empowerment, respect, support and actually celebrating. Celebrating people's uniqueness and doing that in a way that makes people feel empowered versus shamed.

DR LYNDA GARGAN:
Alright. Randy, now going to come to you. You just gave the most inspirational testimony when you spoke last week and your voice is so full of hope and it made me smile just listening, but you had a very very important message. My question is, if you were sitting here talking to folks from Rikers and folks from Sing Sing, what would you give them as a recommendation for how they can improve the settings and services that you experience there?

RANDY KILLINGS:
Yeah and thank you again for allowing me to be a part of this amazing training. You know, one of the things I would say, first of all it needs to start with the training of the staff. Jones talked about safety and you can't get that with the inmates, it needs to be something that's enforced, and instilled in the way the prison system is, and the safety isn't there.

It definitely takes away any hope that people have of getting better or changing their life. So, what I would hope is there will be more training to support people where they are in the prison system, and what they deal with on a constant basis. Which is kind of like overlooked. You know, because I listen to Beth and all that amazing stuff that they are doing in Washington, I want that to be waived this way because none of that is happening in New York, and in the prison systems where I've been.

There's no respect, there's no safety, there's no support, there's no dignity in being who you are, even though you are in prison. These things are really important for a person to be rehabilitated. To be rehabilitated you need to be in a safe place to do that and you don't have to result to being a monster, or being abused, and coiled up in the corner.

You know, the thing for me is just to train people on what their job is. I tell people a lot in all my training, your job is this, do it, and I don't think people get it. Sometimes it's just a paycheck, you know? And I get it. But you are there for a service. If you are there to protect people, protect all the people. Make sure that the prison system offers as far as keeping people safe and protected and allow that to happen and to make sure we have somebody looking to make sure that happens.

DR JOAN GILLECE:
Can I ask a follow-up, Randy? I'm interested in your thoughts because I think about this recently in corrections and think about folks within the community who get harassed or hassled by staff. What-- could there be a part of that with the staff where other incarcerated individuals are closing their own sexuality? Is there?

RANDY KILLINGS:
There's always some of that!(laugh)! It's always some of that. In the prison system you have so much of people battling their own demons, this is how they act out, this is how they validate themselves, and it happens a lot. If a person thinks they are any kind of compassion or if they find themselves seeing something in somebody that may resemble something they've kept closeted or deep inside, the thing is let me beat them so this will die.

And that happens with a lot of the correction rules, and thanks for saying that Joan, because a lot of correctional officers have this anger for LGBT people, which is unheard of, like why are you so mad at me for being gay? This is not why I'm here, so why is this the only conversation and the only thing you have to say, and attack me with, is because I'm gay?

So, it does seem like they are battling with some demons inside themselves.

DR LYNDA GARGAN:
Is a really interesting observation, Randy. I don't know that-- I know some police officers, some correction folks, and I have heard a strain of that in conversations. And certainly having lived with those folks for a while you definitely have an amazing understanding of that. I'm going to ask folks, please put your questions in the chat or raise your hand, and I'm going to go to Raul who brought us the factual data on our call last week.

Raul, you had a lot of information there, and trying to unpack that is really-- it's hard. What would you want to emphasize now that we've got a few minutes just to catch our breath and talk to people? Which of that data you really want to make sure people pay attention to?

RAUL ALMAZAR:
I'm going to backtrack and answer your first question and continue the conversation on safety. And for me a part of what really struck me last week is really the concept of cultural safety. That people come from different cultures, whether it's LGBTQ or other parts of ethnicity, or other cultural facets, but really, figuring out ways to create systems that are culturally safe, meeting people where they are at, and I think for me the other piece around the conversation last week is really them as we talk about LGBTQ individuals plus, it's also understanding that there individuals were also not declared.

Shane is actually in the audience, and really, we are looking at individuals who may not publicly declare, but also are in the same vein. But I think in terms of the data, I think the biggest piece of the data is the higher levels of anxiety and the higher levels of suicidality in the LGBTQ population. And really understanding how does that play out in our systems? How does that play out, especially in the justice system?

Part of the work that I've seen really what this is, when we talk about safety often, when we look at - and I think this is really the work that Beth is doing - it's really looking at them in many of our systems structure, regulation, and rules we think provides our safety, but really visualizing, and asking people what makes them feel safe makes the play safer.

Rules and regulations may provide some structure but asking people what makes you feel safe is really the first piece in all of this because especially when we are talking about the amount of anxiety people are carrying and being able to verbalize for us "this will make me feel safe".

DR LYNDA GARGAN:
Raul, that brings up an interesting point. And Beth, and Randy, and Joan jump in here when I put this out here. We want so much to create safe spaces and spaces where people can thrive. But how do we do that without having our folks who identify as LGBTQ sort of moved out into their own group?

Is there any ramification to that? Is there any downside? Do you talk with folks as a group, or is that a problem? How do you go about that? Because I'm thinking about Randy when he was incarcerated, and if someone just told you and other folks who had self-identified into a group to talk about things, would that have cause problems?

RANDY KILLINGS:
Oh yeah. So, me being—I’ve always been out, and as I said my life was really crazy, and I was overly strong entity in jail and on the street, so it didn't bother me, but Raul talked about, people that don't identify. You can't say "We want to talk to all you LGBT people, come over here!", that would definitely be a sign for harassment, abuse, and for people to come at you and so many different ways.

It would definitely have to be sending where people feel safe and asked that question. I love the way that Raul always states, ask people, I think in all situations asking a person their opinion on something is always something they can be a part of, and willingly attest that this is what I want.

But to do that would not be good, and you probably wouldn't get too many people that would say "OK, let's start going over there".

DR LYNDA GARGAN:
Right. Beth, how are you guys doing this? Because you are in real life doing this every day. How do you manage to create these safe spaces without calling attention to people's sexual preferences? Or do you?

DR BETH JORDAN:
Again, I just want to say we are always a work in progress, we are always striving to do better and better, so I want to make that really clear. I know that sometimes leadership, the people in charge, can have really great ideas about how they want services to run, but sometimes if there's a certain officer or a mental health clinician or a provider, and they are not on board, you know, that impacts everything despite our best intentions of how the contract is written. So I just want to be clear about that.

We don't house people-- we don't really house anybody on a certain housing unit based on how they identify. There's no transgender housing unit, nothing specific like that. And I think that just echoing what Randy said, it's because you don't want people to be targeted in a certain group like that.

So, I think part of it is just, we are PRIA certified, there's a coordinator from PRIA around, if there's any kind of sexualized assault, talking in the extreme, or something like that from anyone whose LGBTQ, there are lots of signs there's a PRIA coordinator around, there's an inmate handbook. The invite handbook is called the inmate handbook, there's things about these issues as well.

So the part of it is the optics, the messaging and optics of your facility. What kind of signs you have? Are they in different languages? Do they talk about all kinds of issues, like sexualized assault and things like that? Part of it is just the demeanor of the healthcare providers you encounter when you enter the facility.

So part of it is kind of a, do you feel like there's an energy of empathy? Do you feel like you can say something to somebody? Do you feel like when you put a sick call slip in that the officers-- that no one is going to tamper with it? If you give something to somebody it's going to go in the right box.

Our sick call process… this is how residents get to various types of care. We have 24-7 urgent care. Every day in the housing unit there's what's called a sick call clinic, basically a clinic at every single housing unit, and I think unlike most places we change our processes during COVID so that, bear with me I know this is a little detailed, but in most accredited facilities, and we have this dual accreditation with NCCA and CCA, you have the patience turn into a strip, with what they have, could be a finger infection, or strep throat, it could be medical or mental, and the nurse has 24 hours to triage that sick call slip. Figuring out where to go. And then they have another 24 hours to schedule the appointment and how the residence and.

We turned that whole process on his head, from the time that the patient feels in their sick call slip to the time they are seen as 24 hours, and I don't even think you via that in the community. We have to make sure that was happening in the jail is meeting the community standards, and I would say it really exceeds community standards. And then you know, just talk about COVID.

We did that during COVID so that residents could just be seen quickly even though we were having very vigorous and robust response to any healthcare concerns. But our numbers, if you look at the D.C. department of health website and you compare the COVID numbers sickness versus death in D.C. in general versus the D.C. department of corrections, there was a decreased risk of death from COVID if you were in the jail.

So, six times higher to get COVID and die of COVID in the community than in the jail. So that just speaks to how responsive our healthcare system is. In response to the fact that residents have so many different entry points into our healthcare system.

So, again like I said from the time our residents put in a sick call slip to the time they are seen, that is 24 hours. So I think in an environment where you see certain types of signage, things are in different languages, you get a sense of empathy from the moment you come into the facility, you get a resident, inmate that talks about various issues and you are encountering a healthcare team and a pharmacy team in a dental team that is responsive to the residence needs (indiscernible)--

DR JOAN GILLECE:
You're cutting out. I was also thinking, looking at people's strengths versus weaknesses, looking at the wellness unit versus the--

DR BETH JORDAN:
Yes, and there are so many different spokes which can contribute to things going forward in a strong way. I think of how they healthcare seem, how we set up our healthcare in mental health care is key, residents have to feel that from the moment they come in. There's no-- for transgendered residents if they want to participate in a gendered urinary exam, they don't have to.

So how people encounter the healthcare team is really important. Them feeling like they can say no to things. And then it's about our programming as well, like what kind of programs do residents have access to. Like Joan was talking about there's the women's wellness unit, which is the facility for women with substitute disorder issues and mental health conditions.

In terms of the programming that we have happening in that unit and that we are planning for that unit within the next couple of months, you know, there are these trauma groups that happened that women love participating in this group, it's psychoeducational, it's about stress management, is about mindfulness it's about the role of trauma in our lives and how to manage that.

DR LYNDA GARGAN:
Beth, can you explain to everyone what TAMAR stands for?

ANDREA DURDLE:
TAMAR stands for the trauma, mental health recovery

DR JOAN GILLECE:
Addiction, mental health and recovery.

DR BETH JORDAN:
This is what Joan works on through the country, these TAMAR groups, we have yoga instructors come in, to do mindfulness and yoga, we are soon to start. We also have a Covington curriculum. We're going to be doing gardening, we got this really wonderful woman coming in who's going to be doing gardening inside the facility and out, were going to be doing acupuncture in the coming months. Overlooking a facility in Maryland where people are sent there, I think to the drug courts, instead of going to the jail they go to residential program. Five days a week they have acupuncture for an hour a day.

So, we're going to bring acupuncture onto our program, we are going to the Maryland site in early April and see how they do it, custody, we also have a deputy warden coming with us as well. And that we will do emotional freedom technique which is calming the amygdala and peoples fight or flight response.

So when I was telling SAMHSA about this, they see this as a model for the country, they were really blown away, because they know it doesn't exist. So at least where we are, words about the spirit of the healthcare team, is about the empathy and the services that they convey and have for the residence, it's about signage, is about programs, so I think all of those things work on some level whether people identify as LGBTQI, or not. It speaks to a sense of safety that I hope they will experience whether or not they have to deal with particular issues in the jail.

We also have tablets for most residents, so there are movies, Ted talks, all kinds of things that residents have to be able to communicate, call the family, have entertainment so they're not just sitting in a cell, you know? There's a sense of giving people things that are meaningful while they are in our care.

DR LYNDA GARGAN:
Let's do a quick and dirty poll here. Those of you on the call, please go down to your reactions button, I'm very curious about whether or not your communities Corrections System's often anything close to what Beth is talking about. If they do let's have a thumbs up, if they don't, a thumbs down. Let's just see what we've got here.

We've got some thumbs down. Gee, Beth. It looks like you guys are definitely leaving the country.

RANDY KILLINGS:
Definitely, can I just say this, and thank you Beth for this. When you're talking about just that ticket, and that shows how keen you are on some situations in the prison system. So, right now if you drop a ticket to go to the infirmary, that's kind of determined by the correction officer. And I'm speaking from experience I got into a fight and I was cut, I don't know if you guys can see it.

After that fight, was thrown into my cell. The officer did not take my ticket, I got lucky myself almost 2 weeks, and it wasn't attended. I'm happy I didn't catch keloid, but I worked on that in my cell on my own. Again, another one, I had another fight and I was stabbed in the back of my neck, and because that was a friend of one of the cronies of the correctional officer, I got locked up again and he got to still roam.

So we had to learn self techniques in jail, clotted, store some tape on it, and again I didn't get keloid, you don't see a stitch, you don't see anything because I had to do that in my cell because the ticket is not honored by the correctional officer and it just came out when you said that but that's really important. Because the correctional officer, whether he likes you or wants to take the ticket will just basically do what they want.

So I know you got thumbs down because that just doesn't happen. You can wait a month. A month.

DR BETH JORDAN:
Randy, can I say we have residents during their time out of their cell, they take their sick call slip, they go to a locked box, they put their slip in the box, and the healthcare team comes by twice a day, they pick up all the slips twice a day, and we have an officer sign that form showing that all the slips were taken.

RANDY KILLINGS:
You know how we do it here? When you are locked in, the officer comes around and says, "who has a ticket?", That's how they collect ticket. See you get it on lockdown if they get silly, a dentist ticket, when you're locked in, they walk around.

DR JOAN GILLECE:
This is such a cultural shift. All of this is really about honoring people who are incarcerated, and Beth isn't really talking about anything that costs any money, even though it's really an attitudinal shift. It doesn't cost any money to put that lockbox in there. It doesn't cost any money to have people start to do tapping. It doesn't cost any money to have their clinicians trained in doing TAMAR.

It really is a major attitudinal shift that also the key component to it is leadership, period.

RAUL ALMAZAR:
If I expand on this a bit I see a colleague from Illinois state hospital, and really being able to-- we are not going to talk about the justice system, we are talking about psychiatric systems, you know the psychiatric hospitals, and really for me just listening really to the amount of freedom that your people have compared to people who are in psychiatric hospitals, it's just amazing. To really think about how you have rethought the system, and really that is your main component.

DR BETH JORDAN:
I have to say the Mayor has been so supportive for what we were doing in the jail. Cost a good amount of money to do this, and the Directors, Deputy Directors, the head of unity, everybody has been really supportive of this. I'm completely grateful for that because I sleep well at night because I think are offering all these services to people who have the most extraordinary restrictions imaginable.

DR LYNDA GARGAN:
Lisa said in the chat, this probably saves money in the long run. I know it will be a long time before you can collect that data but you know it doesn't even matter. These conversations about money make me nervous sometimes because I don't think we can do this for the money.

DR BETH JORDAN:
It's interesting, I think--

DR LYNDA GARGAN:
Spending too much time thinking about that, we're talking about quality of life for human beings here.

DR BETH JORDAN:
I was talking with a colleague yesterday who is in a different state, and he's trying to expand NAT services 30 state, and the state of ready has a low recidivism rate, he's dealing with mostly prison population. And he's not sure he can justify financially because the recidivism rate is so low, but we were just talking about the importance of treating substance use disorder, OBR disorder, diabetes or heart disease or hypertension, it's just the right thing to do.

It's unconstitutional to not be able to offer that, right? So I don't know how much it’s going to save, it’s probably going to cost, because the recidivism rate is so low but it still the right thing to do.

RAUL ALMAZAR:
And in Joan and my work for years it continues to be around the same of the systems, you see violence go down, staff injuries go down, workers compensation claims go down, it does save money and many indirect ways.

DR JOAN GILLECE:
You're right, this isn't about saving money, I think the point is a lot of the things we are talking about really kind of boiled down to that how we treat one another. You know, that compassion and that empathy, and human interaction.

I mean, of course we need to do the trainings, we need to take the effort to make that happen, but a lot of that is really that shift, and it is leadership. If Beth wasn't a medical Director this might-- this would be totally different. It’s personality driven.

RANDY KILLINGS:
Thank you Joan. And when Lynda talks about… we talk about money too much, we talk about people's care and lives, and is a part of what can come out of that. And I am that. Because of people stepping out on the edge and thinking about respect and trying to help people with their mental illness and trying to make them feel safe, to feel comfortable enough to go to school and do what they do, it may cost a little bit more but it does, in the outcome, stop the recidivism.

I was in a class of 60 people when the mayor here in New York started his program in Sing Sing, and they still called me because even though there's few, I'm evidence that it can happen, and it is changing people's life. People may not be doing the amazing things that I'm doing now, but they are staying connected, they are trying to stay out of prison, and that's a big thing. That's a lot.

So the money is kind of not; it doesn't matter because you try to keep the blood present is stop that recidivism and get people out of jail to do something else.

DR LYNDA GARGAN:
In the chat Lisa says this definitely is a sticking point. And April brings up, I think she's articulated the point we are talking about well; she says people get caught up in the upfront cost, but then there's the lawsuit, the injuries, all the reactive efforts that wind up costing more in the long run.

But it is a steep climb, isn't it? When you're trying to convince your legislative body that you need more funding when they are also hearing, and rightfully so probably, from their corrections unions and so forth that they need more corrections officers. So how do we balance that? How do we make the case to those in charge of funding that this is as important as adding more corrections officers, or more whatever they typically and traditionally spend money on?

DR JOAN GILLECE:
I personally think, and this is something Beth and I have been working on is, engaging the officers and giving the officers some respect too. I think that's really important too, because oftentimes they are the ones were blamed, shamed, they work the most over time. Maybe it's so hard to get people to work in the system that they aren't screened as well as they could be.

So for us to try, really started working with Officers to explain how trauma affects us, and what happened was that seem to resonate with them as well, because it wasn't us teaching them this how to de-escalate, or what's an evidence-based practice, it is just showing her training in her life affects us in our day-to-day, and the discussions end up being their own life, things and their families.

So I think we have to start with really using the strengths of some of the officers, too. They are always bashed, you know there are bad officers, bad psychologists that should be working there, you name it. But when you hear that all the time, and you are the ones were always blamed, and it's constantly that adversarial relationship, that is a really important place because we can use their strengths and we can use that workforce to help us in this work.

So in the TMR groups that Beth was talking about, what we are doing is officers are going to co-lead the groups, so they are part of this versus separate. And we're doing that so we want, you know, if somebody doesn't get a letter or somebody doesn't get up phone call or cordate or whatever, and they start to feel really upset, that officer can say "what about some of the strategies you learned in TMR today? Some of that mindfulness is, how can you use that?", Versus everyone being in their own lane and separate.

So elevating the officers in terms of their respect ability, being able to interact on meaningful terms, to me is a huge huge part of it.

DR LYNDA GARGAN:
So, ready, can we switch the conversation for just a minute? I would love to hear you talk to us just a little bit about the program you are running now. Tell us about that.

RANDY KILLINGS:
Well, Rainbow Heights is a psychosocial advocacy for LGBTQ people, when seeing psychologist and therapist, we are that human touch to providing them support in the way they want, in a respectful way, listening to them in a way that most psychiatrists even don't. We talk about the old medical model where people have their own agenda, but we help them advocate for themselves and let them know, and Joan taught voice and choice, and we definitely believe in that.

A lot of our clients have been institutionalized a lot, traumatized, multi-traumatizations, and he couldn't speak up for things they wanted or don't want, they were all the same, like robots shuffling like cattle, and now these people are coming to life, and they are speaking, they are getting out of their homes. Some of them are connecting to jobs and schools and doing things that everybody said that they wouldn't be able to do, it was a shift to the quality of their life just being allowed choice.

And our advocacy, because I have nine certified staff that are peers that identify to the LGBTQ and mental illness, so we are role models that there is life after mental illness, there is life after coming out of prison, there is life after addiction, or whatever you're struggling with.

And we work with people in a realistic way, meeting them where they are. Our clients are not here, we call the members, they sign up. That makes it more important to them because they say I want to be here. Whether they're sitting in the corner, or going to a group, the choice is that I get what I need the way I need it, and there is no dictation. And that's just affirming for people. As Joan said, people can come and be themselves in a way they can't be themselves anywhere else, it's going into the house and become Maria and stop being Randy, I can do that without fear that somebody is going to laugh or talk, that kind of thing is just a shift in the quality of their life. And people smile.

In their doctors and therapists call us and say hey, what are you serving in their juice? Because they see that their clients come to life. And it's just an amazing place to be. And it's an amazing place for me to be because I feel that I'm using my lived experience through all my hard time, while it may not be the same as anyone else's, but we all came through a dark place. And with me smiling saying I came out of a dark place and learn to smile, this is what I've done, what you think you need to do? Can help them with that and allow people to paint a picture that stares through their lines, it is so affirming and sorry if I took so long, I get excited.

DR LYNDA GARGAN:
No, I love that!

DR JOAN GILLECE:
If I could add something, if we have the list of everyone that's joined today the video that I mentioned earlier is Almost finished through editing and we can send it to all of you because you are going to hear the voices of people at Rainbow Heights really affirming what Randy is saying, so we are happy to share it as soon as it's finished.

DR LYNDA GARGAN:
How many members you have at Rainbow Heights?

RANDY KILLINGS:
We have three or 400 members, but they, they feel they can so we roughly serve 30 to 40 people a day and also provide a meal.

DR LYNDA GARGAN:
Wow. So, Randy, you have spent time in two of our more infamous correction facilities in the country, it's the ones that are always on television, on all the shows, people talk about Rikers and Sing Sing. And you-- your life is such a wonderful example, but I'm wondering, can you just give us a sneak peek into your life? What is your life like now?

RANDY KILLINGS:
You know, it's amazing. I tell people God has blessed me with a second life in one lifetime. It's just amazing, I don't think of ever ever been this happy, I can't remember a time I was so happy. All the things that I want is as a youngster for myself, I have.

I have an amazing job, I have an amazing partner of 16 years, married seven years coming up, I have a beautiful dog, we have a beautiful home, I have amazing friends that are supportive and my friends are diverse and very supportive, keeping me uplifted even when sometimes I don't feel like I matchup they always help and encourage me and Joan is one of them that always keeps me encouraged and inspired that, you know, every day I get a chance to do something that makes me feel good.

And that's what my life is, and why I'm so happy, because every day I wake up and I say it's like restitution for all the bad things I get. I'm saying Lord, can you give me one more I did another great thing! (laugh) And I wake up happy, no Jones, no ducking, I wake up smiling every day in a way I thought I never feel, it's an amazing life. I never thought I would have this.

DR LYNDA GARGAN:
That's inspirational. Now Joan, you've worked on this from every angle, why don't you give us some wrap up thoughts here?

DR JOAN GILLECE:
I don't think I can but I think Beth and Randy and Raul can also speak to this. Again, as I said earlier, I think respect, helping people feel safe, elevating people rather than looking at their deficits all the time, providing hope in support, leadership, continuing to try to move forward and despite the obstacles when you feel like you're getting beat down, you know?

Sometimes I feel like with us talking about healing and forgiveness and hope, I feel like sometimes people and my peers kind of look at us like we have three heads, you know? That is what we are talking about. But this is what important. But this isn't just compliance and not being treatment resistant, as simply as I can make it, it is just the respect and love we provide to each other, and that's about as simple as it can get.

But I can't think of anything, I can't think of any way to make it more complicated.

DR BETH JORDAN:
And just to add, one of the biggest blessings of my professional and personal life is to have such a colleague and friend like Joan, I think she kind of brought this to the forefront, and I was blown away by somebody who's as beautiful and powerful and savvy and brilliant as she is, I don’t know, just making this work so accessible and being such a stan for.

Because I think we started this work in 2016, we didn't think it was a big listing for it, but now it feels like everyone is talking about it and I credit that to her in the success that comes from this work. You know, for the participants, we started working, Jen and I started working together in 2016, and no offense, I love my job and it's D.C. government and things move slowly sometimes, and part of that is because there's turnover, and a lot of different ways, and I get it and I appreciate it.

But we have been steadfast moving forward, moving forward, moving forward. And I'm really thrilled what was happening right now, but it has taken a while. So, I just want people to know that it is possible, it may not happen overnight, but if you feel like it's the right thing, which we do, just keep that persistence and that emotionally driven desire to do the right thing.

DR JOAN GILLECE:
Thank you, but we also are good friends and really have fun. That's really a big part of it. We all just really have fun together, and we can lay off and we can keep going, but I think that's such a big part of it, we are all colleagues and we are all friends.

DR LYNDA GARGAN:
You know guys I just was to reflect on it, we fuse a lot of weird words talk by the Corrections System's today, words like love and respect, elevating people, trust, yeah Beth, I think you're onto something that the rest of the country needs to know more about.

RANDY KILLINGS:
I just want to also shout out Joan and all of you for the amazing work you do, but I just love Joan, I met Joan in 2014 a presentation here at the park in the mental health and hygiene, I fell in love, she's a fashionista, she caught my eye. And one of the things I love about Joan, and I mean this from the bottom of my heart, I've been working with her so long, she's wonderful lady, she always makes me feel unimportant for what I bring.

And she goes out on a limb because she comes out of that high place and says I'm going down in there, and I'm going to find somebody to talk about what I want to express. And she found me. She is like the Jesus that came out from heaven and went into the dark place and found somebody and wasn't afraid! A lot of people wouldn’t have done that, most people look at the way I was, they were afraid of me, and you should've been.

But Joan caught me at a time and saw something and said, we need to hear you. You know and I know that is possible with some of the things you guys are putting together for people like me that are LGBT's living with mental illness, struggling with addiction, coming out of prison, that there is a chance, we deserve respect and dignity, and how to make that happen. And you guys are freaking awesome.

DR LYNDA GARGAN:
Thank you Randy, well said . Guys, I hate to do this but we've got a wrap up. Thank you, thank you, thank you for being part of this. Thank you to our presenters, what a wonderful group we've had here, I'm going to take this to Kelle and she is going to take us out.

DR JOAN GILLECE:
Thank you Lynda for bringing us all together for this.

KELLE MASTEN:
I echo that, thank you Lynda, and thank you SAMHSA for letting us share this information today. Thank you everyone and thank you all for joining us.

DR JOAN GILLECE:
Thank you.

SPEAKER:
Recording stopped.

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