Introduction to the Wellness Watch

your health. The African-American Wellness Watch. Trusted information for us, by us. Dr. Mike Lenore and other experts from around the country and around world have the latest on how you and your family can get healthy and stay well.

It's time for the African American Wellness watch. Welcome to today's special edition of the wellness watch, I'm your host Dr Mike of having Dr. Ron Kennedy Bailey.

He's a chief psychiatry at Louisiana State University, the chief of the jail cell group of psychiatrists in New Orleans and the assistant dean of community engagement.

Dr Bailey is located in new Orleans, a very special place to talk about mental health. Welcome to our program, Dr Bayley.

New Orleans After the January 1 Tragedy

Well, good afternoon and thanks for having me, Obviously, the events of New Year's Day have changed the landscape across the country, maybe even across world.

But certainly in the city of new Orleans, how is the City of the New Orleans handling that? Well, by definition, your points are correct. The tragedy of January 1st, 2025 will live with us in infamy forever.

My team, our doctors, or our clinical staff, and our entire community, I think was shocked and surprised at the level of vulnerability that we all share.

That's a corner that I've stood on and many New Orleansians have, not just dozens of times, maybe hundreds of time on the corner of Canal and Bourbon Street, next to Big Marriott is a very popular corner in town.

for engagement with people in town, for an activity, a conference. It's just right in the middle of the action and a very fun loving place to be honest with you.

I think that a few things come to mind. First, I acknowledge our relative vulnerability as Americans, as citizens in societies that increasingly are more at risk than we care to believe and initially considered.

I also think that the prospect that more of these issues are occurring may drive individuals to be more fearful of their own safety. They may stay in more and not feel comfortable going out to engage to restaurants, to events, the aquarium, conferences.

but also I think less likely to want to be with their entire family, people they should actually protect. Their children, their spouses will have you in these settings.

So it had a significant impact, I take on all of us, and it may do so for a long time. We really need to get to the bottom of what we can do as psychiatrists to manage these concerns and prevent them going forward.

Yeah, you know, the reason it has had such a resonance around the world and certainly around the country. It's piling on top of so many stressful situations that our populations are having to deal with.

Certainly the election of a new president was, regardless of what you think, a great extension in a lot of people. And then war in Ukraine and the war and in the Middle East.

In fact, today, as I understand it, there is some kind of a ceasefire settlement, which may be calm things down just a little bit.

Collective Stress and Rising Anxiety

And this all becomes a collective stress on the general population, does it not? It does. Clearly, I think that these issues are cumulative. By definition, as you point out, there's a collected stress.

It's growing. Its incremental. All too often, more things happen to add lighter fluid to the fire, so to speak. Very little adds water and douses the So many of us have a growing sense of anxiety and concern, some would call it discernment.

I mentioned earlier, more fear and disbelief than a concept that one might be able to manage these problems and handle it. In psychiatry, we often talk about defense mechanisms, and it's my impression that also often more of these events work toward overwhelming ones, normative defense mechanism.

And at that point, if you can't handle it, you may develop some degree of psychic stress, which can lead to psychiatric diagnoses and problems, anxiety, depression, other forms of affective illness.

These, I think, are our concerns going forward. When I grew up in Texas, obviously we grew with a set of values. and principles. The perpetrator in this attack came from, you're from Beaumont, but I'm from Dallas.

Beaumeont is a small Texas town to me. But we don't need to go into that. He looked so normal. So sensible. Looked like your neighbor next door. What are we missing in our society that we cannot identify and call and strip around the various layers to get to the kind of frustration he had that led to him being, you know, recruited?

Well, it really is an operational term. The reality is, Bowman is middle America, born and raised there, about 100 miles from Houston. But like thousands and thousands of other small cities and medium sized towns.

Regular people do regular things.

Why Violent Behavior Is Hard to Predict

As I understand this individual was a regular person or went to school and maybe worked a job and engaged with persons and didn't show any outward signs of aberrant behavior or violent tendencies or any undue risk.

As I understand, this will begin to see more regularly, not just in that event of January 1st, 2025 here in New Orleans, but in many of these similar circumstances around the country, persons who many others would have deemed as normal.

in their actions, behavior, and past history are engaged in a remarkably abnormal and violent actions. And that's just very difficult, I think, for us to make heads or tails of or make sense of as professionals.

As a psychiatrist, we have an additional responsibility, one that we should embrace to try to get to the bottom of it, as to how we might be able to be much more forward-thinking in our approaches, progressive on our actions and develop strategies that allow society to be preventative in our approach.

Clearly, one thing that does happen is when psychiatrists make a recommendation to limit someone's freedom, society should give us more authority to do so.

I'm not so sure that society would have worked in this case. Nobody took him to the hospital and tried to get him committed. But throughout my career, Dr.

Lenoir and a 30 plus year career as a psychiatrist, it's been more difficult than it had been in the past for me when you try to get somebody admitted to a psych hospital because of perceived future dangerousness for that to

happen.

All too often, the concept has become a person can only be admitted into a hospital once they're already engaged in a violent act. I think that's too much.

That goes too far. And that puts society too at risk. We should, that should change. A question for you. This is a situation that continues to recur. Here's a man, though, however, who's just not mad at his family or mad in the neighborhood, but who was completely converted philosophically.

You know, as pediatricians, for instance, we took on the issue of, let's say, something like cold cough medicine. And we decided collectively that we were going to stop the purchase of cough medicines for young children.

You belong to a number of organizations, National Medical Association. Certainly, I've probably several psychiatry associations. What are these associations saying about what we can collectively do differently in our societies to either identify or prevent something like this from happening because of a change in a mentality of subtlety?

Well, so there are three things that come to mind, and I'm sure there Early in my career, mine and yours, we were trained as physicians that there were four vital signs, temperature and breathing capacity and whether you had any heart rate and your pulse.

At some point in our career we decided to add pain as the fifth vital sign. Now, I honestly believe that violence or violent tendencies should be a sixth vital sign metaphorically.

At every visit, every doctor should ask some questions about the risk of violence.

Mental Status Clues and Paranoia

You'd be surprised how often, unbeknownst to you, a person will admit earnestly and honestly that they are having thoughts toward violence, whether they want to hurt themselves inwardly at a high risk for suicide or somebody else outwardly.

Because we're off the wheel, uncomfortable asking that question, they can linger in harbor for a long period of time before it spills out accidentally.

The kid who does a bad thing in school and then the principal, the teachers and the police ask, did anybody know it? And somebody says that last week he said it's really a A second thing I think is also true that we may be able to do much better is be proactive, not in asking that question, but following up with how does that link to what you would do in a circumstance.

If I ask somebody, are you violent? They may say no or what have you. But if I give them a hypothetical and ask, what would you do if this situation occurred?

Again, I remain very surprised in my current clinical practice. how often individuals don't have the so-called defense strategies or compensatory strategies to work through stresses and problems without resorting straight to violence.

We go from having a good relationship, everything is fine, to violent, without much in the middle. So we have to develop those kinds of ego strengths that help you think through rationally in a normal ego format.

How do you handle problems and conflict and stress? I think more people than we realize fall under that category. The third and final point, I simply argue, is that when we do engage, resources have to be available to treat.

This is an old psychiatric story, but all too often, if you don't have private funds, we can't, and until you've preventatively And if you can't show that you already committed a violent act, where then all the resources show up, then you go to hospital and you're committed and your inpatient hospitalization, medications and management, residential therapy, too much happens.

I'm sorry, on the back end, we should put more on front end for prevention. You know, I want to put you on a spot a little bit. Uh, you read about this guy, and he read his background.

Um, he, read, about his experiences and his transition. to a more active terrorist group. Give me a mental status based upon, I don't expect you to make, you know, a clear diagnosis, but give me mental a status from what you read and what your heard.

The big seven, was he oriented? Yes. So he wouldn't show anybody an overt sign of a problem. He knew who he was and where he, what the date was, basic stuff.

Next, what was his behavior? It was calm and cooperative. I mean, he was able to engage. He wasn't, you know, walking around in a very aberrant or aggressive or agitated kind of fashion.

he didn't show any overt signs. They showed pictures of him riding his bicycle down Bourbon Street a week or two before, so he's able kind to fit in, and that didn t draw any adverse attention to him, which may have sent him to authorities.

Next, we actually move toward mood and affect. In his mood, Prado was a bit sullen. He may have been a little bit distant. Some argued that he may been isolated in some circumstances, but not enough, I think, to draw the average attention of someone who was acutely depressed and crying and sobbing and dysphoric and irritable and angry and moving toward a violent type action.

His affect, how he engaged, again, allowed him to kind of fit in. It may have been a little bit odd to some, but not enough, I think, to draw the overt attention of someone who would want to hospitalize the person going forward.

And the last three are his thought processes. They were probably goal-oriented. It took a lot to kind of think through and plan in a logical fashion. He wasn't illogical or disorganized overtly, having signs of a psychotic disorder, like being having schizophrenia.

And his dark content, although not harboring any overt violence to himself, may have regularly had thoughts that he kind kept amongst himself of homicidal ideation when he heard others.

Too often we tend to see a person who is paranoid. And what are the challenges with the symptom of paranoia, even with a number of status exams?

Primary Care and Early Prevention

is that very often it's the one that's least likely to be detected externally by someone who's not a professional. So your friends and friends around you won't detect that.

Psychiatrists should be adept at doing so much of all of our training, but unless you volunteer and tell someone you're paranoid and fearful, you think that somebody, psychotically, the marshals will come and get you from away, or you may think somebody who lives right next door to you is peeping on you, spying on, if you don't volunteer those things, regular lay people, it doesn't come to their attention, that is gonna be a problem.

So the area I think that should be focused on is the content. It probably was latent with Frank paranoia. And obviously this is not, we wouldn't stamp this as the evaluation.

in terms of its application to him, because you didn't have a chance to sit and talk with him. So I don't want people to misinterpret that you're definitely saying he was paranoid.

But based upon what you've seen, it certainly sounds like a possibility. Here's where I think a lot of this stuff starts. And I take it starts because we as physicians in primary care are not paying enough attention to the four or five things that you mentioned when we see patients.

We're under a lot of pressure, we're in a lotta stress, and we know about the social determinants, We know the psychiatric possibilities, yet we don't seem to be able to incorporate effectively into our histories and physicals enough of the information about mental status of patients, do you think that needs to change?

Absolutely. So I think that you're ahead of your time. The reality is there are some aspects of other disciplines in medicine that I have to consider as a psychiatrist.

We're trained, for example, that before you can make a psychiatric diagnosis, you should rule out medical. A person should have gone to some other doctor at least once a year and got a physical.

and had baseline labs and ensure that we're not missing something. Before I diagnose clinical depression, I should assure you don't have hypothyroidism, for example, which can present exactly the same as clinical oppression.

I think that analogy carries over to psychiatry. We would be wise in our society to have an all hands on deck approach to decrease the risk and increased prevention of these kinds of violent acts.

More clinicians and all physicians should regularly be thoughtful and demonstrative of this concept, as you point out, I think, theoretically, of a mental status exam.

We shouldn't wait until there's an initial consideration of the problem before we send someone as a psychiatrist for a formal assessment. anymore than the psychiatrist.

Somebody walks in my office limping and they said they had a traumatic accident of their leg. Maybe they have a broken leg, I gotta get them to a doctor to manage that.

I shouldn't ignore that and say, well, that's somebody else's area. We all should think that how a person thinks and engages, That's important. And we all shall recognize that we have an opportunity to have blanket of an assessment strategy that is far reaching much more likely, I think, to have a high sensitivity, so to speak, and to catch or capture more persons who may be at some risk.

It's also true that physicians and clinicians who are not psychiatrists are more like to hear a story from an individual rather than a psychiatrist. Of our 30 plus thousand suicides every year, almost 40,000 many years, the data remains that over half have seen a professional within 30 days of committing suicide or the person who is a professional, over half of those persons saw an individual that was not a psychiatrist, a non-psychiatric professional or a physician.

All clinicians should have this as a higher index of suspicion. We should all be very mindful and thoughtful of the problems that are likely to occur overall, incrementally, if we don't capture these problems early and create some degree of successful interventional strategy.

That's not happening enough in our society. And the decision in New Orleans is today's discussion. I'm really concerned about the bigger issue of how often this kind of problem is happening all over the country.

How New Orleans Has Changed

Well, I think one final question. How do you think the city of New Ornans has changed based upon this incident? become much more insular. I think fewer people will want to be out, period.

More persons trying to figure out what they can do to protect themselves and limit their risk. There's been a lot of discussion about putting up barriers and whether the mayor or the chief of police had ordered the barriers.

It's unfortunate, in my opinion, my professional opinion. Those are all professional actions, and I'm not here to criticize any of them. But when someone really wants to hurt large numbers of persons, An individual really does not care about or have disdain for getting caught.

It's remarkably, remarkably difficult to stop it. What would really let you stop a problem is the person trying to figure out their getaway plan. But now with these so-called kamikaze-like actions, going back, you know, 50 years ago to pile as a flight of plane into a ship knowing that they were going to die, or the 9-1-2 actions of some of the years when the same issue was in play, 25 years almost, the reality is it's very difficult to prevent these issues from happening behaviorally once a person decides they're going engage in it, and they don't mind if there's any way that somebody's going get caught.

The way to limit these risks, is for psychiatry and mental health professionals to have more access, earlier access and earlier attempts at individual strategies to capture people with a wide net, a highly sensitive net of persons early on who may be having a problem and then to be able to intervene.

There are people who find these individuals being what we call radicalized, and that can in some settings be linked to some degree of aberrant action.

You gotta sit down and you gotta talk about it. very often these psychiatrists about action and thought and behavior, you have to hear what somebody's thinking.

They've got to tell you, for you to have a better idea what it might better do to limit the risk. We must do that better in America going forward, or my unfortunate perspective is that these problems are likely to continue before they get better.

Dr. Bailey, this was really a unique opportunity for us to talk to someone right on the ground, are able to make some observations, not only about the act itself, but about general reaction of people to the Act and some suggestion about how we as clinicians can get together and cast a wider tent, be more focused in our evaluations and incorporate a better mental status evaluation.

So thank you so much for joining us today, because I know it's a very busy time for you. Today, I think this unique opportunity to Dr. Ron Kennedy Bailey.

Clearly, we need to make some changes in our society. We in the African American Wellness Project are going to continue to try and talk to professionals like this.

Closing Thoughts on Prevention and Health

we know that over the next several years, you're not going have access to a lot of the things that you've taken for granted in area of health. And we're gonna try to supplement and patch that with continued information about what's going on, with analysis of what's happened and some of the ways in which you can take advantage of health care system for you and your family.

So as we always end our program, we say health is our biggest asset. Health is your biggest assets, so protect it.