[The Pointer Sisters' "Yes We Can Can" plays]
Now's the time for all good men to get together with one another.
We got to iron out our problems and iron out our quarrels and try to live as brothers.
And try to find peace within without stepping on one another.
And do respect...
>> Good morning, Virgin Islands. This is "Ability Radio -- You and Your Life."
We're brought to you by Disability Rights Center of the Virgin Islands and its various sponsors, and we have the producer, Amelia Headley LaMont, leading the charge today, as well as Ms. Bermudez, Iris Bermudez, making sure she's the producer and...whatever.
[Laughs] Okay.
And this morning we have a very interesting and helpful guest that's here in the Virgin Islands on our behalf, Mr. Chacku Mathai.
He's with his own consulting services, and he's here to help out with regard to local mental-health services and some various alternatives that will help the entire mental-health system.
Welcome, Chacku.
Welcome back again...
>> Yes.
>> ...I should say.
>> Yes.
>> It's an honor to be back.
>> And give us a little background on your consulting service, but other positions you've held within the mental-health field.
>> Sure. Well, I'll start by saying not only, first of all, thank you and it's good to be

with you, but, most importantly, I am informed by my personal experience as a suicide-attempt survivor, person who struggled with mental-health issues and substance-use challenges as a young person and going through my own challenges and my family going through this with me really launched us towards advocacy in mental health and substance use together.
And, really, our experience with the system and all the things that we didn't get in terms of what we needed and wanted caused us to want to advocate for these alternative supports.
So, that's what informs me, is my own experience, and I can get into that a little bit in detail if you'd like, but that's the first thing I want you to know.
And, from there, I got involved in an incredible community of peer supporters, of advocates, of system leaders, and across my career, I've had the opportunity to really be involved, from community organizing at the very basic level in our community of asking for and advocating for changes to being in executive and board-level management positions in organizations like the New York Association of Psychiatric Rehabilitation Services in New York.
I was their associate executive director for 13 years.
And that's where we modeled a lot of the services and supports that I'm talking about today, even.
[Clears throat]
I, from there, went to become the director of the National Technical Assistance Center, called the STAR Center, both with NAMI, the National Alliance

on Mental Illness, and SAMHSA, the Substance Abuse Mental Health Services Administration with the federal government and, from there, became the C.E.O. of the Mental Health Association of Rochester, and now I'm consulting.
>> Oh!
>> And so the reason I'm in this opportunity with you is because of your great work and all of what you're all doing, but I'm also just noticing that there are so many different aspects of what we're trying to make change that I didn't want it to be limited anymore, and it's nice to be able to offer the various things that are needed by systems around the country.
>> Well, okay. Thank you. Well, one aspect of this-- would you explain your context with the Virgin Islands through our National Alliance on the Mentally Ill and how that came to be in place?
>> Right. So, the STAR Center -- we had an opportunity to work with a number of different regions, and so there's New York, New Jersey, Puerto Rico, the U.S. Virgin Islands.
I worked in Arkansas, Oklahoma, Louisiana, New Mexico, Texas, and from there, a number of other states nationally on building behavioral-health infrastructure that was consumer-directed, and so the idea was that we would be building infrastructure that believed in our ability to recover, that recognized and included the kinds of services, recognized and included the kinds of policies and practices and competencies that really supported people, even those of

us with the most -- kind of what people were seeing as the most serious and persistent mental illnesses or diagnoses to be able to return to what was meaningful to us and live self-directed lives and be able to have health, home, community, and purpose, to be able to live, learn, work, and play wherever we chose.
So, that is the vision, and that's what I got to be involved in.
And so here with USVI, I started around 2014, I think, with some of the earlier efforts and in conversations with several of you and really helping organize, and the real idea was to continue to build the belief among the community of family members and consumers that we could recover and also to organize around the kids of changes that you're making.
>> Well, of course, my aspect of it is I like it because it's grassroots organizing.
And then the persons who have the most stake in the situation, the consumers and their families, have a lot of decision-making process.
Explain some of the things you did in the Virgin Islands in order to build that base of grassroots supporters.
>> Well, as I said and as you just said, the first step in systems-transformation work is to engage the community, those of us in particular who are most relevant to that system, so, in mental health, you need to make sure those of us with mental-health diagnoses are involved or impacted by trauma or those kinds of things -- the families that are engaged.

So, you're right.
It is that grassroots.
The transformation doesn't occur
without our voices involved.
It's that simple statement of
"Nothing about us without us"
that really makes that real.
Now, in terms of what we did is
we really just gathered every
time I came -- gathered
consumers and families.
We talked about these principles
of practice and what was
possible.
We brought in awareness of
models that might be happening
in other states and territories,
as well, and really made sure
people were aware of what, even
from a financing and policy
perspective, could be done.
A lot of times we don't know
because we just haven't heard
about them, and we were just
sharing that information with
you.
So, our work at the STAR Center
at the time was really
infrastructure-focused.
So, what are the kinds of
infrastructure that communities
just don't know about?
So, that was really it.
>> And what was the result of
that contact?
My understanding was at least
one or two training events?
>> Yeah. We had some training
events on practices like
wellness recovery, action
planning, which is an
evidence-based, peer-to-peer,
self-help practice or model.
We talked about -- We had people
talking about, with community,
about what their vision for
community would be, and I think
there was a cohesion that
started to develop among
consumers around what really

they wanted from each other, so that happened on St. Thomas and on St. Croix.
On St. Croix, we had a meeting with the director at the time, Director Burby, and brought her into a training at the Frederiksted Health Clinic with probably 25 consumers on wellness-recovery action planning and how we ourselves can recognize our responsibility for our mental health.
In other words, it wasn't just about going someplace or taking a medication or getting a service.
It was also about the kinds of self-care and the kinds of tools that we can draw on ourselves.
So, self-care had to become primary care.
Primary care is self-care.
That's not my line.
That's from Pat Deegan, one of our colleagues in this work.
So, just to really start to learn about those different strategies that really can be helpful to us, even when and especially when our clinical services aren't available or are no longer needed.
>> And as a result of that, has there been started what we're calling peer-to-peer type of approach here in the Virgin Islands?
>> I think there's an interest in it, but we haven't necessarily -- I mean, I think there are peers gathering.
>> Mm. Okay.
>> However, it's not in a formalized, funded approach yet.
So, that's something that I would strongly encourage and would love to see happen next.
I think there's an opportunity with the strategic plan and the

work that you're doing to embed that into the plan, so I can talk more about what that could look like.
>> No. Yeah. Give some examples of what peer-to-peer services include and how are they delivered.
>> Sure. So, at the broadest level, peer support -- so, in my example, my experience with it, coming into my own process was that I came out of hospital after the suicide attempt and an overdose, and my father met another man who he met at his church, and he just said, "Look, my son's in the hospital.
He tried to kill himself.
He's on drugs and he's on the street.
I don't know what to do."
And this man said, "Me, too.
My son's also struggling."
And that just changed my father's even perception of what was possible.
He immediately leaned in and was interested in what this man had to say, and he said, "My son and I and a bunch of other teens have just opened a center that we call a recovery center, and we've given it to the kids, the young people like your son, to actually support each other through that process.
Maybe your son will go there."
So, we went, and I opened the door, and as I was looking through the door, I saw people who I was scared of, who had bullied me, who I was fighting with, who I didn't feel belonged, that I belonged with, and instead of feeling that way when I opened the door, this one kid turned to me and just welcomed me.
He said, "Hey, do you want to

come over and play some pool?"
in such a welcoming, loving way
that my guard that I had up for
10-plus years at that time -- I
was 15 years old -- just
dropped.
And I walked up to him and
started playing pool and
connecting to that community,
and they got me involved in
other peer-support activities,
so that recovery center became a
safe space, became a place where
we could go on a regular basis,
before school, after school,
evenings, weekends, holidays.
When I got into a fight with my
family, I went there.
When I struggled at school, I
went there.
When I struggled in the
community, I went there, you
know?
When I just wanted people to
connect with, I went there.
>> Well, we'll get right back to
it and your story in just a
minute.
We're gonna take a break for our
sponsors.
>> Now's the time for all good
men to get together with one
another.
We got to iron out our problems
and iron out our quarrels and
try to live as brothers.
And try to find peace within...

>> Now's the time for all good
men...
>> Welcome back, Virgin Islands.
We're here this morning with
Chacku Mathai, and he's talking
to us about alternative services
in mental healthcare, and you
were talking about peer-to-peer
services and self-help,
basically.
>> Yes, exactly, and I was using

that example of my own first experience with a recovery center back in 1985 -- it was in December 1985 -- that supported me to come into my own a little bit more, and we started at that time small support groups.
I would have them in facilities, in residential programs, at the psychiatric center.
It didn't matter where.
We'd have them in the community.
We started to give ourselves spaces to have conversations that we couldn't have in clinical settings.
A lot of times it was feeling like if we said something, somebody would get uncomfortable and think we needed more support than we really did or would misunderstand us, and we had a chance to really talk about what we were going through in a different way.
So, that was one thing.
And then we started actually modeling some services.
For example, just to fast-forward, at NYAPRS, where I worked, we had a model called "peer bridger," and this was where we not only had peer-support meetings in the community but we had them in the hospital, and then as people were transitioning out of the hospital, we would match up with them and provide skill support, community-adjustment skills, social supports, connect them to resources in the community, and sometimes even have people out in the community while they were in-patient so they would help them transition and prepare for the process, so they would get privileged status, and that became standard practice, that people would, while in-patient,

have a chance to come out into the community, get used to being out again, and get a chance to be supported.
So, that was peer bridger.
Then we had a peer wellness coaching model, where we started focusing on health and wellness on another level and needs to get financial wellness and educational wellness and environmental wellness, spiritual wellness, all kinds of different dynamics in that regard.
Do you mind if I keep going?
>> Well, I was wondering, capturing before you got involved with peer-to-peer and there was no safe space, what did you do?
'Cause I kind of remember when I was 15 to 16, if I wasn't at home or playing sports, I was just hanging with the fellas.
And, you know, there was that point in time, as a juvenile, you get close to doing stuff you shouldn't be doing.
And I was just wondering, where were you before you got to peer-to-peer?
>> Well, I was using drugs.
I was dealing.
I was running away from police.
I was certainly not home.
And when I was home, it was tough on my family.
>> So, the creation of that safe space for you to go to was critical in your change or transition?
>> Oh, absolutely, because I wasn't succeeding in school.
I was really struggling in school.
We had to switch out of school 'cause of the fights I was getting into, and a lot of times I was just protecting myself,

'cause I was being bullied, or
self-defending in that regard,
but the reality was I wasn't
feeling safe anywhere, including
in my own home.
I thought my parents were trying
to kill me.
I thought they were poisoning my
food.
I started judging and
mistrusting people as soon as I
met them.
I would see things and hear
things that weren't there.
I would wake up screaming 'cause
of a dream that I had or visions
that I was having at night.
So, the peer support wasn't just
an alternative.
It was the only thing I would
do.
It wasn't like there weren't
treatment options offered to me
or even special -- I was
separated from classroom, the
mainstream, very soon.
Probably by the time I was 6
years old, I was in a separate
program for students that were
struggling like me, but that
wasn't engaging me, either.
So, this was one of the first
places where someone like me,
who wasn't engaged by anything
else, was finally going to on
his own and wanting to, and so
from there, I learned about
treatment options that maybe my
friends were more willing to go
to or my family was more open
to.
That's what made the transition
happen.
>> Okay. In the process, you
were talking about some of the
-- Under the umbrella of
peer-to-peer services, you were
talking about peer advocacy,
peer bridging.
How 'bout wellness coaching?

>> So, wellness coaching was developed by a woman named Peggy Swarbrick, also a peer leader in our community but also a researcher, so she went on to become a researcher and developed a framework called the 8 Dimensions of Wellness.
And within those dimensions of wellness, which now SAMHSA has adopted, these areas were areas that we found ourselves being able to coach each other in improving our health.
So, one area for many of us -- So, for example, there's some research that says those of us with diagnoses or psychiatric histories die 25 years earlier than everyone else, or the general population, and so we wanted to make a dent in that and change that, and part of the way we changed that was having people connect around, you know, for example, issues like awareness of diabetes.
In my community, in my culture, Kerala, where I'm from, has the highest prevalence of diabetes in the world, and so it's just assumed we're gonna get it and not necessarily know how to prevent it, so learning how to eat differently, how to test blood sugar, how to do yoga or see the benefits of meditation or exercise.
There were changes -- quitting smoking, smoking cessation.
There are peer models for that.
There are a lot of outcomes that could occur, including I stopped using drugs.
I found a community that helped me do that.
I was able to connect with myself and my own spirituality and be able to move in that direction a little bit more.

So, anyway, that's what wellness coaching does on a one-to-one and on a group basis, and we have core competencies that we train people in in that regard.
>> And is that part of --
You say SAMHSA now pushes that --
>> Those 8 Dimensions of Wellness very much are part of SAMHSA's framework.
Yeah.
>> Okay. Okay.
And with regard to training, what goes along with those type of services?
>> So, whether it's peer specialist as a more broad, general term or peer bridging or wellness coaching, which are specialized approaches, or even peer-run crisis respite or peer warmlines, there's a number of different modalities of peer work.
There are core competencies that we worked on to develop through SAMHSA's support, and we rolled those out, and those have to do with a common set of values, principles, a common set of actual skills and practices.
When we talk about competencies, we're talking about the things that you do, you can see or hear me doing, differently, and those are core to peer work and have everything to do from the engagement, our ability to engage people and support people in discovering who they are and what's important to them, the ability to have good, strong interpersonal skills.
There are ethics associated with peer specialist work in peer capacities.
We have conversations and training about that.
And so there's a number of

areas, domains, that we would call them.
>> And that training's provided by whom?
>> Right now, depending on the state, each state has their own framework for that, or territory, so in New York, for example, we have an Academy for Peer Services, and it's an online training academy model where the core curriculum is offered via website, through a series of online courses.
There's also in-person models of support for that, so, for example, in New York City, there's something called the Howie the Harp Advocacy Center, and Howie was a person that was a peer that did a lot of peer advocacy, and so they named it after Howie, and that approach was to walk people through a classroom level of training, offering internships as well as job opportunities.
So there's a whole gamut of approaches to it.
It really depends on your particular model that you want to have in your area, so it gets to be specific to your needs.
>> And so that would come from the grassroots determination.
Say, Virgin Islanders --
>> And systems, yeah.
I think grassroots and your system.
I mean, I think the territory government ought to be involved in that, and just like the Academy for Peer Services, that's not run just by the peer community.
We are advisors to it, of course, as well.
>> Okay.
>> But we even run that through Rutgers University for the

development of the curriculum.
It's paid for by the state government.
So, these are investments that are made by the government, recognizing the need for those workforce competencies as a value added but also as a cost-saving to the system, 'cause we're getting better and we're not going in and out of hospitals anymore.
>> Well, you've been in the Virgin Islands before 2017, before the hurricanes, and then, after, you've come and visited us again.
Have you seen any changes with regard to the delivery or the approach to delivery of services since you're coming back and forth to the Virgin Islands?
>> Well, I wouldn't be able to make a comment on the delivery, necessarily, but based on what people are saying up to this point is that what we have are a greater commitment to mental health as an overall strategy.
That commitment didn't seem to be as strong when I was first here.
It was certainly there with a consent decree.
It was there with a strategic plan.
It was there with a group of advocates, whether it was NAMI or peer groups or advocates that met with me through your convening.
There was a number of places where there were promising advocacy efforts.
Now what I'm seeing as a result, including as a result of the hurricane, is that everyone can relate to the trauma and the resulting mental-health impacts of that trauma in a way that

hasn't occurred before.
So, there's not one person I've talked to that can't relate to what it means to struggle to get moving throughout the day, and the only thing they can point to is the hurricane or children who have been struggling with making it to school or feeling hopeful or have been reverting, as was in our recent NPR interview -- you know, reverting to wearing diapers when they didn't before.
So, these are dramatic changes in people's experience and connection to mental health that I think now is creating, as the governor even kind of referred to, we're not crying in the dark anymore.
We want to cry together and really hear each other more.
So, I would say it's the commitment that I'm seeing change.
>> Okay. And with that commitment, we had talked about, or you had talked about earlier --
Would you describe what's called a collaborative care system in regard to delivery of and promotion of mental-health services?
>> Sure. So, one of the things that people here spoke about as well as across the country is the fragmentation of the system, so one of the observations in the New Freedom Commission report that was done way back in 2003 was that the system was so fragmented and siloed that even if somebody did get help, they oftentimes were dropped or fell through the cracks or the wide chasms of our system.
And so collaborative care and a model that actually coordinates care takes accountability and

responsibility for every person that is coming through the system so that now -- so, just to use care coordination as an example, a care coordinator, not a case manager -- and it used to -- we have case management that still can operate within silos, but a care coordinator makes sure that whoever's being involved in that person's care is now aligned with that person's goals, hopes, dreams, and priorities.
So the person is at the center of care, and everybody else is working collaboratively towards their goals, so that's the psychiatrist, that's the nurse, that's the peer specialist, that's the vocational, the human, the housing, employment. All of these things are now tied in together.
>> And can you give an example of where you may have seen those kind of systems in place?
>> Sure.
>> Yeah.
>> Well, just even in New York, we've created a model for care coordination.
There's something called the health home model that was both nationally -- you know, federally -- implemented, and it was an opportunity -- and I don't want to get into the weeds of the financing, but, essentially, it allows for states to share in this network of services that could get funded, and it really changes and forces providers to get into a collaborative model of care around one person or family.
And so that health home model resulted in a new kind of service called home and community-based services that

support people to go back to school, go back to work, get their families back, or get more engaged in peer services, and these are all using a mix of Medicaid and state funds.
>> And with that, say, collaborative-care systems, is there a leader or driver of that approach?
>> Ultimately, the driver is the person receiving services.
>> Right.
>> And from there, there's an accountable organization, and that's called the health home that coordinates all of those cares, and the care manager is the person that individually helps manage that care.
So, that's everything from primary care to all of the other specialty needs.
Now, that's just one model. There's other ways in which collaboration can occur across systems even without introducing a new system like that.
>> Okay. Well, let's take a break before we get back, or deeper into that subject, and we're gonna take some time for our sponsors, and we'll be right back at you.
Virgin Islands, this is Disability Rights' "Ability Radio -- You and Your Life."
>> ...quarrels and try to live as brothers.
And try to find peace within without stepping on one another.
And do respect the women of the world.
Remember you all have mothers.

>> Now's the time for all good men to get together with one another.
>> We're back here on "Ability

Radio -- You and Your Life."
I'm here with Chacku Mathai, who's a consultant, and we're talking about different types of delivery of services in mental healthcare.
And I want to read to you just a short synopsis of what has been identified for the Virgin Islands that was part of Act 8152.
It says there are approximately 700 persons registered within the Virgin Islands Department of Health to receive behavioral-health outpatient services -- 300 on St. Thomas, 300 in Christiansted, 90 in Frederiksted, and 26 on St. John, as well as we have listed 25 persons who probably are off island for mental-health services under the criminal-justice system.
The intent of identifying is taking those numbers within what you've seen as far as our system's in place, would a collaborative-care system be appropriate or something that can be developed here in the Virgin Islands, from your perspective?
>> Oh, certainly.
I think it starts with a policy-level commitment to coordinating across all the islands alone.
So, you mentioned numbers, whether it's St. John, St. Thomas, or St. Croix, having a practice and a policy model that everyone is committing to together, so the providers that are engaged, the people across the territories who are representing the territory are engaged, and a shared commitment, first of all, towards these outcomes.

We would start with philosophies and practices like a recovery-oriented system.
What does that mean, to have a system for every person in St. John, St. Croix, and St. Thomas in the U.S. Virgin Islands that would say, "We want to make sure that every person has not only access to care but gets the opportunity to live, learn, work, and play, have health, home, community, and purpose, as SAMHSA would put it.
Those are ways in which we would ensure people are not only just getting care but are also now coming back into our community, becoming part of the fabric of our community, contributing in a way that only they could, not just having people mainstream into a very narrow understanding of what community life is but really widening the stream enough to really bring their gifts to our community and see how we grow.
But the culture of the islands is beautiful.
There are so many strengths within the culture of U.S. Virgin Islands that can be drawn upon that people are now able to engage.
That's the vision, and the practice of collaboration actually only reflects that further -- the culture of the community.
The community is collaborative.
We ought to reflect that.
>> And from your discussions with some of the consumers not only recently but from in the past, one of the things that's always brought up is the recidivism -- going in, getting minimal care, some drugs and some talk therapy but never

really breaking out of that cycle.
And would you perceive the peer-to-peer services being a critical aspect of helping those consumers break out of that cycle of repeated commitments?
>> Absolutely.
So, first of all, one of the things that we talked about last time and I want to make sure we talk about now is the engagement.
The engagement is not compliance.
Compliance with a system or with services, especially services that are clinical, is maybe a benefit when somebody's receiving care for a period of time.
However, engagement is about what happens when I'm not in care.
Am I coming back to you?
Am I interested in what I've received?
Am I feeling a sense of connection to the people that are involved in my life?
What is the sound of my voice when I'm engaged versus when I'm just being compliant?
Compliant is an external expectation.
Engagement is pursuing my internal ones.
So, peer-to-peer work as well as non-clinical supports and clinical supports can all be focused on engagement at another level.
Now, once you include peer supports and non-clinical supports like psychosocial rehabilitative supports, these fill in gaps and offer a safety net as well as critical opportunities for people to engage care before they get into

a situation that's much worse.
So, this way you are being much more preventive when somebody is struggling initially but not so much that they find themselves having to go to hospital, but now they can go to a peer-run crisis respite instead or they can call a warmline instead or go to the recovery center instead.
Now that crisis has been averted and there's been no need to even go through the systems that were previously recidivist.
>> You mentioned one thing that I always ask for clarification on.
Everybody hears of hotlines. Could you explain what is a warmline?
>> Sure. So, a hotline is what you're calling when there's a crisis.
A warmline is anything prior to that.
So, if I've come out of hospital, for example, now I'm scared about walking into my community or going to the library or even turning on the stove, I have a person I can call, a line that will actually have a live person available to talk to.
Maybe I'm just feeling lonely and I'm feeling like I want to connect with somebody.
Now, that warmline can not only be somebody on the phone but bridges me, even through the phone, to other supports that are available in the community.
So, sometimes the first time I call, I may not be as open to that, but because of the connection we develop, all of this starts from relationship.
Now through that relationship, I've been more open to your

ideas, and when you say, "You know what?
Going to the library and checking out some opportunities for work isn't a bad idea," the first time I talked to you, I thought it was a terrible idea.
[Both laugh]
Nobody wanted me out there.
So, this can change through those, so, yeah, that's what a warmline is.
>> And how they are initiated, 'cause someone had asked me about it.
I said, "Well, maybe we can get some sponsors who would come forward and offer a telephone line that people can serve on the warmline," 'cause you brought up the idea.
Two or three people talked to me about it, and I said, "Well, let's get, you know -- let's form a group and see if somebody will, out there, sponsor a warmline for the Virgin Islands."
>> That's a great idea.
I think having some private investment into these opportunities allows you --
You can still get the training, you can still pursue the model and what's needed for it, but there's a community commitment to it now that wasn't there in the same way.
So, I think it's a fantastic idea.
And it's not hard to start these up, and it doesn't have to be 24 hours.
They can be open for -- have people be aware of them being open for -- a few days or a period of time each day to just get it started.
Maybe you do it at the most critical times, when services

aren't available, such as evenings and weekends, things like that.
>> Well, I remember when we tried to do some drop-ins for homeless in Cincinnati.
In Cincinnati, Ohio, we asked their churches to sponsor a day of the week where they would have the services or open it up or one church would offer the space and then individuals would offer their time.
So maybe that's something here that the Interfaith Church Council can think about, developing a warmline, because, again, the critical aspect that was on the National Public Radio was our children are in crisis, and the need for intervention is now and the need for services is now.
And, essentially, this is a cry for help, and it's been sponsored, or, I mean, put out there in the public.
Let's see if we get some response out of that.
>> That would be fantastic. Great idea.
>> And following up on one of the things we, in our last couple days, talked about are some goals and measures, and you also mentioned SMART.
When we develop goals and objectives for developing these systems, could you explain what the SMART system is and how we should --
>> Oh, sure.
So, whether it's building advocacy goals, which is what we were talking about, or any goal, for that matter, SMART is an acronym that's been used widely.
"SMART" is spelled S-M-A-R-T, so "S" is really about those goals and objectives being specific.

So, instead of having vague goals that may sound really good and make me feel good about when I say it, if I'm not being specific about it, then it makes it harder to achieve.
It makes it harder to reach.
"M" means "measurable."
Can I see or hear it being done, and can I come up with a way to measure it, whether that needle has moved or not in terms of the change?
That's really important for advocacy, if you can imagine, right?
So, if we're advocating for change, we want to see whether that change has actually occurred.
"A" is "achievable," "R" is "realistic," and "T" is "timebound," so, in other words, putting a timeline on it is helpful, as well, so when do we want to see that change occur that we're pursuing?
Is that helpful?
>> Yeah. That's very helpful.
And, again, as we develop these goals in the Virgin Islands, because some people are saying, "Oh, some of these things are too lofty, we'll never get there," you got a little phrase about achieving goals and, you know, I guess it's "Impossible till the possible is seen."
That was a quote that you had.
>> Oh, okay. Yeah. Yeah.
A lot of times an old mentor of mine and colleague who's now passed, Ed Knight -- his delusions were his goals, right?
And so at times, people would tell him, "Oh, you're just being grandiose or delusional," and, eventually, someone finally told him, "You know what?
Those delusions of yours --

those are your goals.
Believe in them."
And so then, in order to make them real, we had to really get into the specifics about how to make them happen, and, yeah, I agree.
These are things we want to see happen, and we need to commit to them, create some commitment.
>> And believe that they can be achieved...
>> That's right.
>> ...in this community as well as for the sake of the youth coming up through the system, 'cause that's why I wanted to show through your life example that there can be some turnaround, that they can achieve goals beyond their parents' or their teachers', 'cause a lot of times, especially when we deal with certain issues, they don't understand that the child may have an illness.
They just figure, "Oh, he's a bad kid."
>> Right.
>> So, one of the things we always talk about -- why are there so many boys not graduating from school?
And nobody looks to see if they have an issue with learning disability, reading, dyslexia, or something, than just more or less banning them from the school system.
>> That's right.
>> And I'm wondering, is that some of the things you see in the States, especially in New York, where they're more or less tossed aside, out of the system, and basically -- well, we always talk about the school-to-prison pipeline.
>> Yeah. That's right.

So, when we're talking about young people or people who are adults with disabilities, the inability to see us as capable or the ability to achieve our roles and our goals really holds back any effort around those areas, so when we make commitments like you were mentioning, as educational facilities or really including the full array of systems as opposed to having to be fragmented when we had a system, and we were talking about them as trauma-informed communities, whether it's education or criminal justice or mental health or substance use.
These are systems that need to work more collaboratively and have a shared vision of someone's ability to not only change but to be a contributing member of our community, and so especially for young people, if we're suspending or expelling and forgetting and not encouraging a way for people to be restored back into the community process, that will become a school-to-prison pipeline, as well.
Exactly.
>> And one of the final aspects of it that we've been talking about as far as training is crisis intervention, be it through the police or other persons who are, I guess, delivering or assisting people to get to involuntary commitment or out of the home.
What are some of the available avenues and some of the approaches with crisis intervention?
>> Well, one of the first ones is helping people to see each other, especially when we're in

crisis, as not something to be scared of but as another member of our community that's going through some tough times and to believe that we're not somebody that just needs to be sent away or picked up and taken out of community but somebody who's going through a hard time and that I, even as a neighbor or as a member, walking by, of community have a role in connecting with people.
Not everybody has to see it through the whole way, but we can all be part of that process.
When we start to see each other as dangerous or afraid of that connection or that opportunity, we start to separate ourselves from the experience and want somebody else to handle it.
And so even police and others have been now part of a training process called "crisis intervention training," CIT, "model" that was actually started by a police unit in Memphis, Tennessee, decades ago now that started from a shooting, unfortunately, where there was a person with mental illness that was shot, and this was continuing to happen, and it still does, and so police departments have now since learned methods of engagement, just as I was talking about earlier, de-escalation, and ways to engage and communicate without the use of force or the need to negotiate with force.
The idea is to really have opportunities for connection in that, even by a police officer, but also even by programs that we're building on relationship and connecting people to supports.
So, that was not just a training

model for the individual police officer or unit.
It was also a systems transformation approach.
The unit and the whole community had to change around how we were seeing people in order to have that work.
>> Before I interrupt you, I was gonna let you say some more on that, but we're gonna have to take a break for a commercial, and then we'll get back to you on this issue of crisis intervention.
>> We got to iron out our problems and iron out our quarrels...

>> ...men to get together with one another.
We got to iron out...
>> Welcome back, Virgin Islands, and we're here with Mr. Chacku Mathai, and we're talking about peer-to-peer services, alternative services for mental healthcare, self-directed services, as well, and one of the issues that we were just talking about is crisis intervention, and it does not -- just for clarification -- does not only entail the use of police but, I would think, EMT, Department of Health.
Give us some of those partners and players in this process.
>> Yeah. So, whoever the first responders are in a community -- so, sometimes it's police, sometimes it's fire departments, sometimes it's EMTs or the ambulance, sometimes it's community members or neighbors -- there are approaches that really help people see those experiences, especially when they're emotional,

high-intensity experiences as
things that we can actually
support each other through.
So, when I mentioned the
peer-run crisis respites, that's
a place where people can go when
we're in more difficult times,
as opposed to having to go to
hospital.
Well, there's been more
collaboration with police in
some communities and with EMTs
in others.
Instead of going to hospital,
they're being able to get
referred and supported to get to
a respite or to a peer community
or to a provider of some kind.
There are ways in which, from an
intervention perspective, that
people now connect to a model
that's called ECPR.
Emotional CPR is the idea there.
And that's a model that's been
trained by the National
Empowerment Center, which is a
national peer-run organization
which helps, and that's actually
been trained here and Puerto
Rico, as well.
So, we're -- the honoring of
what somebody is going through,
and it's not just about being an
alternative.
It's about being complementary
to what's happening in the
system, as well.
So, it's something that can work
hand in hand with what's already
being offered.
>> One of the aspects of that
kind of intervention is that the
government of the Virgin
Islands, through the
legislature, actually,
appropriated some money for a
mobile wellness van for the
district of St. Thomas and St.
Croix, under the Division of
Mental Health, to provide

screening, outpatient treatment, substance abuse, including opioid education and primary services and referral services to outpatient intensive treatment services and other healthcare.
And one of those, I think, under that umbrella should cover crisis intervention prevention.
And how would that work in a community that you've observed?
>> Well, mobile support, especially mobile crisis support, has been valuable to a lot of communities, and the more it's been available to respond quickly but also not be intrusive, so when it follows some of the philosophies that we talked about earlier --
Are they recovery-oriented?
Is it engaging and voluntary?
Is it person-centered?
Is it relationship-focused?
And most of all, is it trauma-informed?
So, when a community recognizes that trauma has a huge role in how people are being experienced as well as experiencing you --
so, in other words, if the way I'm coming across is now being viewed from the lens of trauma, it may not be pathologized as quickly or judged as quickly.
It may also be understood that, "Hey, this person's actually afraid right now and just needs to be understood a little more, given a chance to talk."
There's a lot of different things that change in that.
Now, at the same time, you could implement mobile support in the exact opposite way.
You can be very system-centered and not see somebody as able to recover and cause some disengagement and have that be

very intrusive to them.
So I would encourage any implementation of a mobile process which really has the opportunity to engage people where they are, when they are, and when they need it the most to follow those philosophies of a recovery-oriented, person-centered, culturally congruent, and trauma-informed system.
>> Well, Chacku, thank you for all your input, and, hopefully, we'll engage in a lot training and a lot more support in bringing what I would say home and community-based services to the Virgin Islands.
Do you have any last words for the Virgin Islands in our quest for total mental healthcare facilities and collaborative-care systems?
>> Well, I think the final point would be that there are so many strengths in the community, including in the people that are struggling the most.
Oftentimes, when people are in pain, that's the best time to listen to them, and the solutions are in those struggles, and even the crisis that we thought we were trying to run away from was actually an opportunity to re-engage ourselves and our community and learn from what I'm going through.
So, those times were my moments of opportunity and growth and healing, and, at a community level, I feel like that's true, too.
The self-efficacy is also our community's efficacy, and I see a lot of that here.
I'm excited.
I can't wait to see what happens

next year.
>> Right. Out of chaos comes opportunity.
>> There it is. There it is.
>> Thank you, Chacku.
Thank you, the Virgin Islands, and have a great weekend.
>> Now's the time for all good men to get together with one another.
We got to iron out our problems...