INNOVATION PLAN
COUNTY OF FRESNO

COMMUNITY PLANNING PROCESS: FINAL REPORT

Department of
Behavioral Health

Introduction

In June of 2019, the Mental Health Services Oversight and Accountability Commission (MHSOAC) through delegated authority approved Fresno County's Innovation plan focused on Community Program Planning Process. The plan would focus on ways to identify challenges, needs, ideas, and insights from its stakeholders which could inform possible Mental Health Services Act (MHSA) services and Innovation funded plans, pilots or demonstration projects.

Background

As community planning for Innovation projects had been more challenging than other components for many counties, Fresno County proposed a plan that would allow it (Fresno County) to use approximately 5% of its Innovation annual revenue to generate more community input and insights so to support program plans, opportunities and strategies. Counties were permitted to use up to 5% of their overall MHSA funds for community planning, and in this case, the plan would allocate 5% of INN funds to support Innovation Planning related activities (mirroring overall MHSA community planning by dedicating a budget with specific focus and deliverables).

Fresno County began to use the funds for the approved Innovation plan in August of 2019 approximately two months after the plan had been approved by the MHSOAC.

The Innovation plan allocated **$750,000** over five (5) years to foster community stakeholder input to inform Fresno County's efforts for developing possible pilots, research, demonstration projects or plans.

Goal

The goal of the plan was to use projects and community engagement to garner insights, identify gaps, needs and opportunities for an inclusive process to have diverse community involvement in broad based planning and development of research, pilots, projects and plans to support local community wellness needs.

These efforts were facilitated through some third-party agreements and some direct efforts by Fresno County. During the five years of the plan the county was able to foster 20 different efforts to engage stakeholders, hear from underserved groups, and obtain data and insights to inform its use of MHSA and Innovation planning.

Fresno County used the Innovation Community Program Planning and Process as a means to improve behavioral health equity but focusing on underserved and historically marginalized communities.

FIGURE 1 - YOUTH WELLNESS SUMMIT- SAN JOAQUIN

Of the 20 projects under the Community Program Planning Process there were four population targeted community needs assessments (several others where planned but other factors prevented them from coming to fruition). Several market research efforts were conducted with a professional marketing agency that focused on specific populations to help understand and improve engagement, communication, etc. Townhalls and youth summits were conducted with goals to direct engagement with underserved and underrepresented populations in Fresno County. Several direct research efforts were also a part of the Innovation CPPP Plan, contributing valuable insights and guiding its development.

Projects Under the Community Program Planning Process

The tables below briefly identify the projects from each of the five years. Some are robust projects; some are small supports that gained access to data or unique information.

In the appendix, all previous Annual Updates to this Innovation plan are provided, which include details of both planned efforts and actual projects. Additionally, the appendix contains many reports, outcomes, and other related information from these various community needs assessments, research, and events.

Year One Projects (2019-2020)

- **Market Research Focus Group (Spring)**
  Nine Populations:
  1. Unhoused Populations
  2. Substance Use Disorders
  3. Rural Youth
  4. Transitional Ages Youth
  5. LGBTQ Youth
  6. LGBTQ adults/older adults
  7. African American Community
  8. Persons impacted by Human Trafficking
  9. Domestic Violence

  Highlight-Valuable understanding of needs and ways to effectively engage various targeted communities and populations.

- **Sponsor Third Annual Asian Pacific Islander Mental Health Empowerment Conference** (Fresno, CA. 2019).
  Opportunity to engage Asian Pacific Islander community on mental health.
  Highlight - Received community input through survey responses from 108 individuals in English, Hmong, Punjabi and Vietnamese.

- **BeHealth Fresno**
  Youth lead project development using human centered design.
  Highlight – Identified need for more information and access for youth and those with commercial coverage.

Year One Expenditures $148,491

Year Two Projects (2020-2021)

- **Black Indigenous Persons of Color (BIPOC) LGBTQ+ Fresno-centric Analysis, Training & Engagement Consultation**
  Highlight- Developed a training tailored to Fresno County based on data and input from the local BIPOC LGBTQ stakeholders.

- **Mental Wealth Services/Engagement**
  Sponsored six session community mental health education sessions focused on African Americans.

Highlight - Insights for local community project opportunities and understanding what forums were more effective for services and engagement.

- **Subscription/Sponsorship - Fresno County Health Improvement's Trauma and Resilience Workgroup**
  Funded Subscription via sponsorship to the ACEs Connection
  Highlight- FCHIP's Trauma and Resilience Workgroup provided access to valuable data and work around ACEs and trauma.

Year Two Expenditure $40,542

Year Three Projects (2021-2022)

- **Market Research Focus Group**
  Seven Target Populations:
  1. LGBTQ+
  2. TAY 16-18
  3. TAY 18-24
  4. Parents/Guardians with Children under the age of 17
  5. Latinos
  6. Individuals Familiar with Mental Health Services
  7. Individuals Familiar with substance use services

  Highlight - increased awareness of possible barriers for local community-based organizations joining network and formal considerations by the purchasing department.

- **Collective Wellness and Restoration Event**
  Sponsorship of Event.
  Highlight - Staff and others attending based on breakout formats were able to hear about local needs, ideas, and insights.

Year Three Expenditures $23,169

Year Four Projects (2022-2023)

- **African American Community Participatory Action Research Project (two-year project)**
  Community Participation Action Research focused on local African American Community
  Highlight - Increased mental health literacy and creation of a local community driven council focused on needs and opportunities for African American wellness.

- **Huron Wellness Town Hall**
  Community townhall in the rural city of Huron (entirely in Spanish)
  Highlight - 35 monolingual adults from a town of 6300 attended.

- **Human Centered Community Needs Assessment for Spanish Speaking Parents/Guardians**
  A community needs assessment focused on Spanish speaking parents/guardians.
  Highlight - Affirmed access challenges based on language and reduction in stigma around mental health for Spanish speaking Latinos caretakers.

- **Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM)**
  A MHSOAC Sponsored Year Long learning collaborative and technical assistance.

  Highlight - Opportunity to improve engagement strategies with underserved communities.

- **2023 Juneteenth Community Event**
  Participated in one of the two-day weekend event.
  Highlight - Surveyed 23 African American transitioned aged youth and increased presence within the community.

Year Four Expenditures $ 101,179

Year Five Projects (2023-2024)

- **Community Event Sponsorship - BreakBox Thought Collective**
  Sponsored local community-based organization working with African American Youth
  Highlight - Participated in event, learned of youth-centric wellness activities, etc.

- **Behavioral Health Board Supports**
  Sponsorship for California Association of Local Behavioral health Boards and Commissions
  Highlight - Including needs and opportunities for local behavioral health board to access other supports.

- **San Joaquin Youth Wellness Summit**
  Youth Wellness Summit focused on youth/teens in rural community.
  Highlight - Engagement with 35+ and input from Latino youth in a rural isolated community.

- **Community Needs Assessment of Perceptions of Mental Health of the Fresno Residents Council: The Children's Movement**
  Residents' council focused their meeting and surveyed on mental health.
  Highlight - specific insights from underserved communities who seek and want/need wellness supports.

- **Parlier Youth Wellness Summit**
  Youth Wellness Summit focused on youth in the rural community of Parlier.
  Highlight - Local Latino youth from a rural community expressed interest in supporting marketing, education, and messaging.

- **Huron Youth Wellness Summit**
  Youth Wellness Summit focused on high school age youth in rural community of Huron.
  Highlight - Over 70 students participated in the half day event with over half enrolling in the Soluna App.

- **Community Needs Assessment of Punjabi Speakers: Jakara Movement**
  In partnership with Jakara Movement, the community needs assessment focused on the Punjabi speaking community in Fresno County.
  Highlight – Vital insights to a community who is an emerging language group in our community and specific needs and considerations.

- **Community Needs Assessment of Mental Health Challenges Among LGBTQ Youth In Fresno: Fresno EOC's LGBTQ Center**

Working with the Fresno Economic Opportunities Commission's (EOC) LGBTQ Center to identify mental health needs of the local LGBTQ community.
Highlight - Need for affirming care, training, and cultural proficiency.

- **Concept Paper Development Use of Doulas in Behavioral Health**
  Creation of a plan/proposal for curriculum for certification of Doulas in mental health.
  Highlight - Formal white paper for Doula mental health training leading to certification.

- **Supporting Staff Success at Times of Increased Stress**
  Customized training to support diverse staff in how to be seeking and support psychological safety in the behavioral health workplace, with goal of workforce wellness and retention.
  Highlight - Developing 30 staff "champions" who will work to promote inclusive and psychological safety in the workspace for behavioral health professionals and support strategies for workforce wellness.

Year Five Expenditures $293,755

Through numerous stakeholder focused efforts and projects, Fresno County expended $ $607,266.76 of the total $750,000.

Challenges

Under the CPPP Innovation Plan, Fresno County was able to do a number of needs assessments through trusted third-party community organizations. There were other community needs assessments planned (see past Annual Updates) however, implementation was not possible for this due to several reasons. This plan was also impacted in the early years by the global pandemic which curtailed opportunities for community engagement and meaningful discussions.

FIGURE 2 - BIPOC LGBTQ+ TRAINING.

In the latter part of the plan more community, in-person efforts were developed to ensure meaningful input, ideals and insights could be gained from stakeholders but with a focus on unserved, underserved or often inappropriately served communities.

The initial goal of the Innovation CPPP was to foster new ideas from community input (either in focus groups, market research, needs assessment, research projects and other engagement opportunities). The intention of Fresno County was to then use these ideas, data, and input for possible innovation plan considerations, projects to address service gaps, address needs, or reduce health disparities in either the form of future innovation projects, but also to inform or integrate those insights into strategies and designs of MHSA funded programs and services.

The passage of Proposition 1 will reshape the public behavioral health landscape and shift the focus from upstream efforts that included prevention, stigma reduction and education to traditional behavioral health services and more prescriptive approach to providing behavioral health services. The change in funding requirements of services as MHSA moved to Behavioral Health Services Act (BHSA) will limit current opportunities to develop or pilot new programs and plans, but the insights, input and lessons are able to still inform strategies in engagement, communication, identifying and addressing disparities, and gaps in our current system. So, the work from the Innovation CPPP may not provide in the near future specific Innovation projects, but it will inform how services are designed, where gaps and needs are, and how to best improve the care of our community.

Budget Narrative

The plan projected an even breakdown of the funds over the five years, but ultimately the project was flexible in allocating approved funds to projects which could support the plan's goal. Some plans/ideas came to fruition and others were not able to be completed. The projects ranged from large multi-year efforts which were at high end of $205,000, to numerous needs assessments completed for $25,000, to smaller youth summits and event sponsorships that were around $1,000 each. Majority of the work under the Innovation CPP plan were conducted through trusted local community partners and leaderships through contracts.

The plan also included administrative costs, such as supplies, staff time in developing agreements, assessing the reports, to travel and mileage for events, event incentives, etc., however these were intentionally kept minimal so to maximize the opportunity for community involvement and input through various approaches.

There was $142,733 remaining in the plan's allocated budget that were not expended. Those funds will revert based on the Department of Healthcare's Service's reversion timeline for the funds (July 1, 2024). Delays in the several efforts to conduct needs assessments did impact some of the expenditures. At the same time while the goal was to use these funds to conduct community planning, solicit insights and ideas from the community for possible MHSA and INN

plans, there is a fiduciary responsibility to care for these public funds and if there was not a viable plan or effort to fund, they were not funded.

Lessons Learned

The Innovation CPPP Plan was a critical opportunity for Fresno County to better engage with its diverse communities, received critical input and identify the challenges that the community faces with regards to behavioral health needs. Many of those efforts have also yielding recommendations and considerations which are being applied and/or are now part of the way services are approached, planned and designed. Thus, the outcomes of the plan are not seen in new innovation plans but will be woven into the future care delivery.

FIGURE 3 - COMMUNITY EVENT SPONSORSHIP

The community planning allowed for the Department of Behavioral Health to engage with new community partners, access input from underserved communities, and learned new and effective ways to engage in planning. As a result of projects under this plan, the Department of Behavioral Health afforded new relationships with more communities and organizations who serve and/or are of those communities. These practices and relationships will continue to be used in future community planning, strategies, and inclusion.

The appendix of this final report provides tremendous insights and data. The past Annual Updates have broad overviews of the efforts under this plan, but the appendix also includes specific information from the various needs assessments, projects, evaluations, etc.

List of Appendices

A. Market Research Group Report Spring 2020
B. Third Annual Asian Pacific Islanders Mental Health Empowerment Conference
C. BeHealth Report
D. BIPOC LGBTQ Summary Memo and Training PowerPoint
E. Mental Wellness of any public Memo or Survey completed
F. Market Research Group April 2022
G. African American Participatory Action Research
H. Huron Townhall
I. Human Centered Community Needs Assessment for Spanish Speaking Parents/Guardians'
J. San Joaquin Youth Summit Report
K. Community Needs Assessment of Mental Health Perceptions of Fresno Residents Council
L. Parlier Youth Wellness Summit Report
M. Huron Youth Wellness Summit Report
N. Community Needs Assessment of Punjabi Speakers
O. Community Needs Assessment- Mental Health Challenges Among of LGBTQ Youth In Fresno
P. Mental Health Training for Doulas
Q. Supporting Staff Success At Times of Increased Stress – Consultation and Development of Training

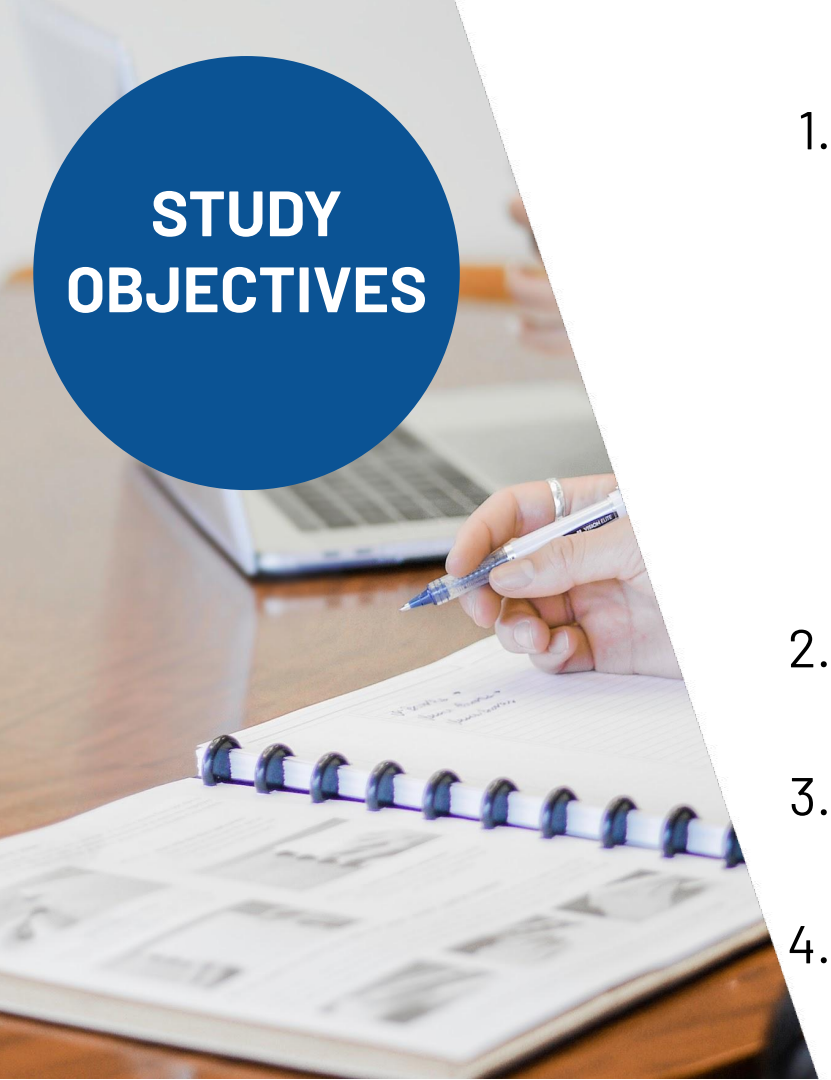
Appendix A – Market Research Group Report Spring 2020

DEPARTMENT of BEHAVIORAL HEALTH

Feedback Sessions Research Executive Report

June 2020

Presented by JP Marketing

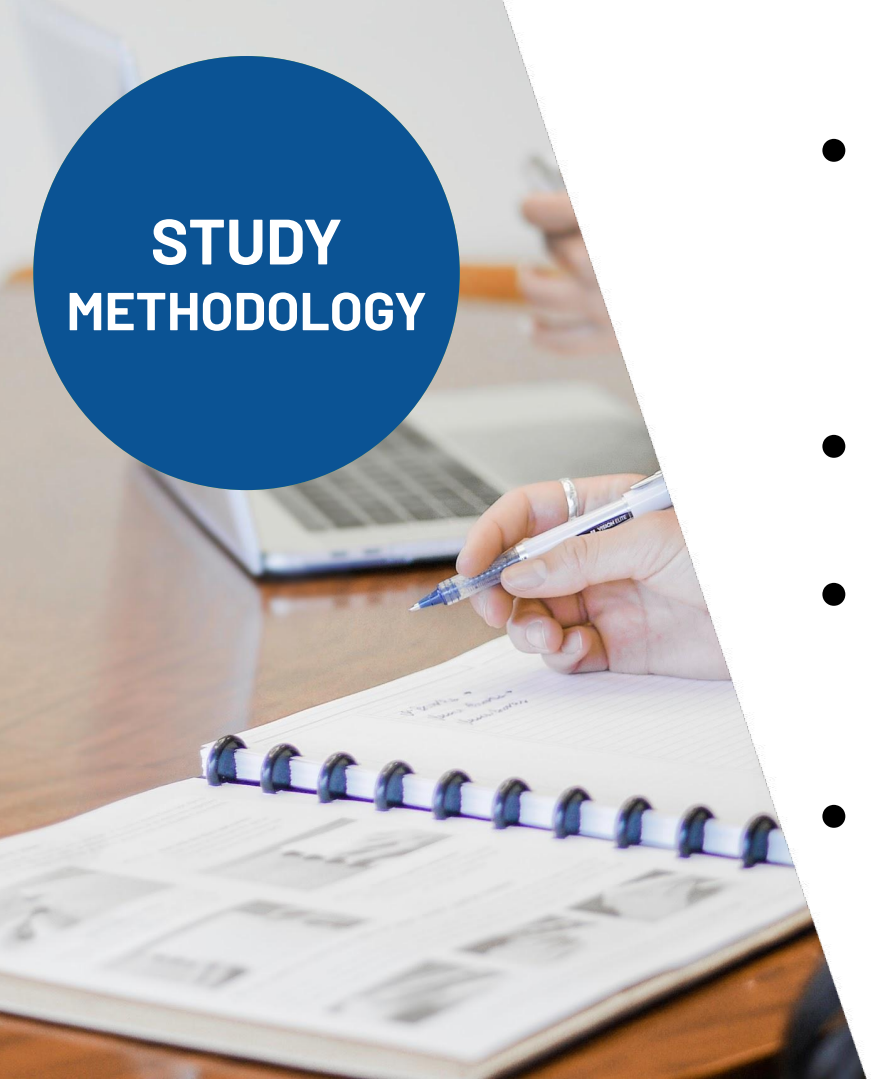


STUDY OBJECTIVES

1. To capitalize on the valuable data and insights captured in Spring 2019. This is a continuation of a research commitment seeking to gain deeper understanding from additional audiences throughout Fresno County that are vulnerable and hard-to-connect (HTC).
2. To gain understanding for how HTC audiences define mental health.
3. To assess HTC audience preferences for message content and delivery.
4. To gauge knowledge of and trust in FCDBH, its programs and services.

STUDY APPROACH

1. To identify priority vulnerable, hard-to-connect audiences that were not studied in Spring 2019 and/or revisit audiences that warrant additional investigation.
2. To implement focus groups for qualitative insights designed to shape messaging and delivery methods that will resonate with vulnerable HTC audiences.
3. To utilize the same discussion guide that will allow for the aggregation of feedback from 2019 and 2020.



STUDY METHODOLOGY

- To utilize community partners and professional firm to recruit and screen six to eight participants per group using approved screener.
- To procure groups homogenous to the HTC audience.
- To provide incentive to participate to compensate for participant's time ($70 Amazon gift card or cash).
- To shift methodology from in-person to online via Zoom platform to comply with shelter orders during the COVID-19 pandemic.

STUDY LOGISTICS

- Participant screening and recruitment was facilitated by community partners, professional recruiters and JP team members.
- All sessions were hosted and moderated by JP Marketing online via Zoom.
- Nine homogeneous groups through 10 feedback sessions were held over the time period of May 13, 2020, through June 4, 2020; an index of the sessions can be found in the Appendix.
- Total of 66 participants.
- Experienced facilitators conducted the sessions, three by Jane Olvera and seven by Kevin Gordy.
- All sessions were recorded and transcribed for reference and documentation.

Overall Facilitator Observations

1. Most groups had an understanding of mental health issues and saw there was need for better awareness to remove the stigma associated with mental health.

2. Use of the emotive images varied, revealing that everyone's experience with mental health is personal and different from everyone else's.

3. Common mental health issues that arose throughout the sessions included anxiety and depression as those have become easier to openly discuss.

4. There is still low overall awareness of FCDBH. Groups were more aware of efforts being done at schools and colleges but not necessarily connecting them to FCDBH.

5. Most groups noted the need to start discussing mental health at a younger age and equipping kids (predominantly middle school and high school) with the tools to recognize when they need help.

6. HTC audiences that were in a recovery group noted that they most likely trust their own network of survivors for information.

Group 1: Substance Use Disorder

- Know
- Think
- Can
- Kind
- Want

Key Insights

- This audience had much more familiarity with the Department of Behavioral Health due to personal interactions they have had. These include recovery programs, required recovery, and searching online.
- The group connected mental health issues overall with addiction, depression and anxiety.
- Having someone who had gone through an experience similar to theirs was valued in terms of trusted resources.
- Many noted that of the assistance they received, coping mechanisms were beneficial and sponsors/mentors helped them but they felt it took awhile to get to that point.
- The group noted that they would like to see more resources allocated for staff, support and follow up.

"Struggling with alcoholism. And I've been admitted to the hospital multiple times for it. So learning to master that support. "

"I feel like when people have problems, they feel like they're a burden to others..."

"[I trust] somebody that actually had like experience with the problem, and then has kind of overcome their problem."

Definitions of Mental Health

- The definition varied among this group between comparing it to an illness and seeking treatment to one's overall well being and coping.
- The group had a mix of both inclusive definitions with positive aspects compared to ones that skewed towards a negative perception connected exclusively to a weakness in the brain.

"I would define mental health as illness just like a cancer or diabetes or whatever, that we have to remember that we're going to be on medication. And it is a disease, but it can be treated, and we can live a normal life."

Mental Health Barriers

- Too many steps: many of the participants of this group noted that they went through many steps to finally get to the service that eventually would be most beneficial to them. This led to patient fatigue.
- Confusion: when going through the Department of Behavioral Health they would usually be met with a list of resources but were confused on which they would qualify for with their insurance.
- Perceived availability: it was noted that many of the departments this group had encountered seemed understaffed and unable to assist them.

"The most help I've gotten from mental health is with a lot of their coping skills... the tools they teach us are phenomenal."

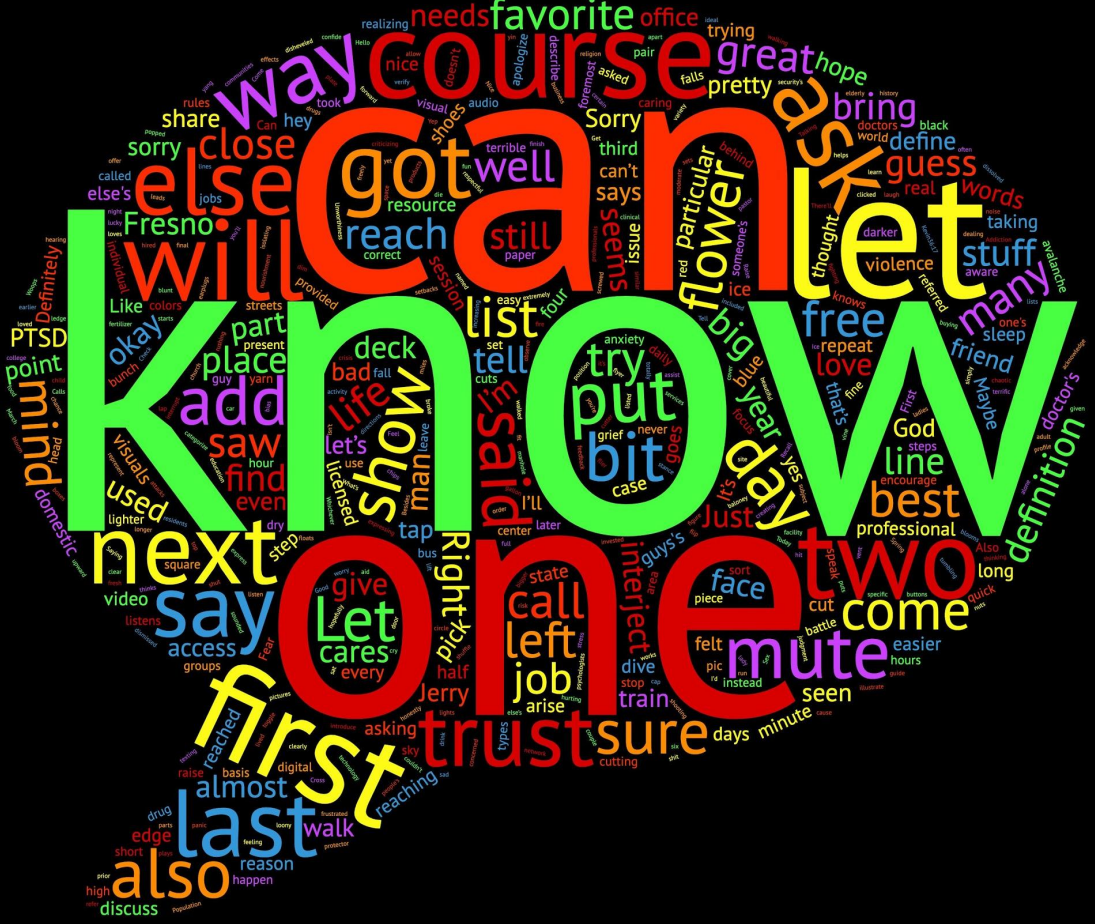
"I think they need more employees that are going to be able to take new patients... I just barely got a therapist through a separate program and I needed one the entire time."

"I've had a really, really good experience through this whole process but I agree that the follow up [is needed]."

"I think maybe having more available services like they have suicide hotlines and things like that, where you can call and talk to a person right then and there. But with the Fresno County Department, it was a little bit difficult. You know, when I had gone in for my, for depression, I mean, I had to walk in and then wait. And then, you know, I had to wait until a representative became available to speak to me. And then when I spoke to them, they just gave me referrals to places. So, I had spent basically an entire day in the behavioral health building and only got a list of services, essentially."

Group 2: Homeless Population

- Know
- See
- Want
- Ahead
- Trust



Key Insights

- This audience has been more directly impacted by COVID-19 by it being mentioned throughout that the resources have been reduced and their ability for basic needs has been stunted.
- Many have heard of the Department of Behavioral Health and had a positive connotation to its resources.
- A lot of the top mental health issues brought up would be connected back to lack of resources and the stress of being homeless and their environment.
- The group wanted to see more direct communication efforts as they felt that a lot of other types of reaching out did not seem genuine or compassionate.

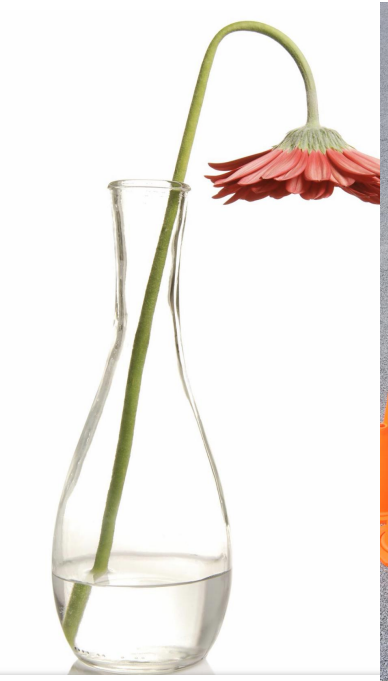
"I think a lot of mental health issues is a lot of people are on the streets. We need to get some more help for them. A lot of them are really struggling and they really need to get some more resources out here. It's pretty bad."

"Some people just need to talk. They don't want any solution when they are talking to another human being but it is not just professional they just need to vent."

Definitions of Mental Health

- This group defined mental health in two ways: one was in relation to stability and comfort emotionally and the the other was the ability to function in society.
- The definition also included examples of how they perceive mental health in connection with physical health as drug and alcohol abuse were mentioned.
- The ability to be part of the majority was connected with their self-worth.

“Mental health is just being able to mentally be able to function out here in society right now.”



Mental Health Barriers

- Access: it was mentioned several times that reaching resources is a challenge and has been multiplied even more so due to COVID-19.
- Direct communication: as a group, it was noted that there are a lot of steps to even reach a human being to talk to, whether it be in person or on the phone, and having that direct communication makes a big difference.
- While appreciative of the current resources, the perception was that more resources are needed to take care of this population including basic needs in addition to their emotional and mental needs.

"Maybe that's because of resources also, if they don't have anything, they don't have any family at all. Nobody to reach out to."

"And people really don't like the idea of counseling, a lot of people automatically think that 'I can't go there'... that is not true. People will accept another person more if they face their setback."

"I think the way to open the conversation... is someone coming up and actually showing that they care."

“If somebody actually came and opened up that line of communication with one, you know with me, out here and actually came up and can show that they cared… I’d feel a lot more comfortable opening up that way rather then having to track things down to two hours of phone calls. You dial a number you get put to another switchboard you get put to another switchboard. You talked to six recordings, and then you know you're just frustrated… You have to go through so much baloney in order to get that. We don't have that resource of being on a phone for that long and going through all these recordings and doing that. And, you know, that's a big problem… to have where we could get somebody to actually show that they really cared. Now, that would be neat so. And I believe that would be coming up and talking to somebody face to face. Instead of a bunch of recordings on the phone.”

Group 3: Domestic Violence

- Think
- Health
- People
- Want
- Feel

Key Insights

- All of this audience had noted that they were not familiar with the service of the Fresno County Department of Behavioral Health.
- They connected services to other entities such as CPS.
- Most mental health issues brought up were in relation to emotional trauma or issues brought up as a result of trauma.
- All were mothers and connected their experiences to motherhood.

"The reason I'm here today I sort of educated myself with looking online and it, it does feel personal to me with what I experienced and that may be different from [names removed for privacy] I'm sure we all have our own little facets of reasons why we're here today."

"When you're in an abusive relationship, I think it's way different with my older daughters. I think I was just in survival mode.... And it gives me a lot of guilt."

Definitions of Mental Health

- Everyone agreed that their definition of mental health was based on their personal experiences.
- Being in a group related to domestic abuse, they connected a lot of mental health to terms such as shame, depression, regret and trauma.

"I think people have a fear of the unknown and what they can't see. And you cannot see mental health the way you can see a physical disability. "

Mental Health Barriers

- Fear: all participants were mothers and believed Child Protective Services were part of the FCDBH. All noted a fear of potentially losing custody of their children as a result of seeing services.
- Personal judgment: participants expressed they knew the situation they were in was bad and felt shame. This led them to delay getting out of the abusive relationships.
- Needs of others first: the needs of their families are ultimately the priority for all the participating mothers. Not until they saw the negative impact the domestic violence was having on their kids would they ultimately seek help.

"They see somebody walking up the street with a broken leg. I instantly know how they're feeling because I've broken bones before. I can empathize with the pain that they're going through. But I haven't experienced schizophrenia. "

"I think that once you're a mom, your mental health is completely neglected. All you're thinking about is caring for your individual that you have no clue how to do it..."

“You feel ashamed. I can’t believe I got myself in this position.
If I got myself in I should be able to get myself out.
The truth is important that people know what you are going
through and that you don’t have to do it alone.
There are people that want to help you…”

Group 4:
Human Trafficking

- **Know**
- **Think**
- **Right**
- **Kind**
- **Now**

Key Insights

- This audience was very forthcoming about their experiences as they were familiar with each other through the programs getting them out of human trafficking.
- The shared experience has created a bond between them. It was noted that they are most comfortable with others who understand them without judgement.
- Much of the discussion around mental health related to the stigma of how people are taught to repress or not discuss mental health issues.
- Group had some familiarity with FCDBH but also addressed critiques of seeing more overmedicating patients.

"When you say the word 'mental health', I automatically think like, a red flag, don't talk about it. It's very stigmatized, and then in recent years, I've noticed that there's been an effort to try and talk about mental health."

"There's a positive side and there's a negative side. Basically, the mental health or the positive is courage, strength. And then there's the negative side that wants to beat you up and tells you don't pay attention to that, you're worthless.."

Definitions of Mental Health

- When defining mental health, the entire group agreed that it was a complex topic to define and very much related to their own personal experiences.
- All noted that there was an initial red flag when they hear “mental health” as there is a lot of stigma to it.
- Most definitions related more to one’s well-being.
- When using the image exercise, the image of projecting a happy face was dominant.

“First word that comes to mind is fear.”

“It’s like your logical and your emotional stability.”

Mental Health Barriers

- The main barrier identified was the stigma related to mental health. Participants related how breast cancer and physical problems are easier to discuss than mental health.
- Starting the conversation earlier was brought up. High school and middle school were both discussed as good introductions to mental health for kids.
- As human trafficking survivors, it was mentioned that they have spoken to kids in schools about their experiences and the kids want this information.
- For seeking information, all noted Google and the network they have created through their survivor group.

"Mental health is such an inward issue that it almost becomes taboo. Because no one wants to talk about those things they can't explain, or that other people can't see. Other people can't see a chemical imbalance... but they can see a broken arm."

"Why is it all they want to do is just throw meds at you?"

“I think what makes things that were once taboo or not taboo *is when the American people start to normalize it. I mean, before the Me Too Movement, no one was talking about girls being raped. And no one was talking about human trafficking before we started screaming at the top of our lungs that girls needed help and suddenly there was this outpouring of support... You just have to be pro-people. In order to really normalize mental health. You have to realize loving people for who they are. And that's hard.”*

Group 5:
LGBTQ Older Demo 50+

- One
- Can
- Right
- Health
- People

Key Insights

- This HTC audience had some familiarity with FCDBH but mostly through work and some personal experiences and then the rest just had heard of them.
- A lot of their mental health experiences revolved around self-awareness and self-acceptance before they could go the next step of seeking help for any issue.
- Mental health was important to this group as each noted it leads to a better life. The main obstacle to them was not the awareness of resources but finding empathetic professionals they could relate to and trust.

"[On how to start the conversation of mental health] I think taking away the stigma that it's something wrong because if you go through the list that you had (of mental health issues) I think everybody has something on that list. So it's not really something abnormal."

"I don't think my issues is that I don't trust the resources that are out there...My trust issues start with whoever I end up talking to."

Definitions of Mental Health

- The term mental health had more of a positive connotation for this group.
- They defined being mentally healthy as a positive and how therapy and self-care are important to being functional and happy.
- Learning how to cope with any dysfunction in one's life was an important part of mental health as well as being comfortable in one's own skin.

"Mental health is about how comfortable you are in your own skin. How happy you are with yourself, how much you accept yourself, and how you deal with others in the way they accept you."

Mental Health Barriers

- Words that came up as to why this group would **not** seek help for their mental health included embarrassment, shame and fear.
- Finding a professional who is both compassionate and empathetic was also a challenge.
- This HTC audience brought up that having someone that would not judge them as LGBTQ is critical as some have had experiences where the professional would linger on that element and automatically the patient would lose their ability to trust that professional.

"It's always coming to terms with yourself, like you facing yourself is the hardest part."

"It's not just LGBTQ I mean, what if you were a person of color... To see some white bread shrink? Who has no clue what it's like to live in your skin."

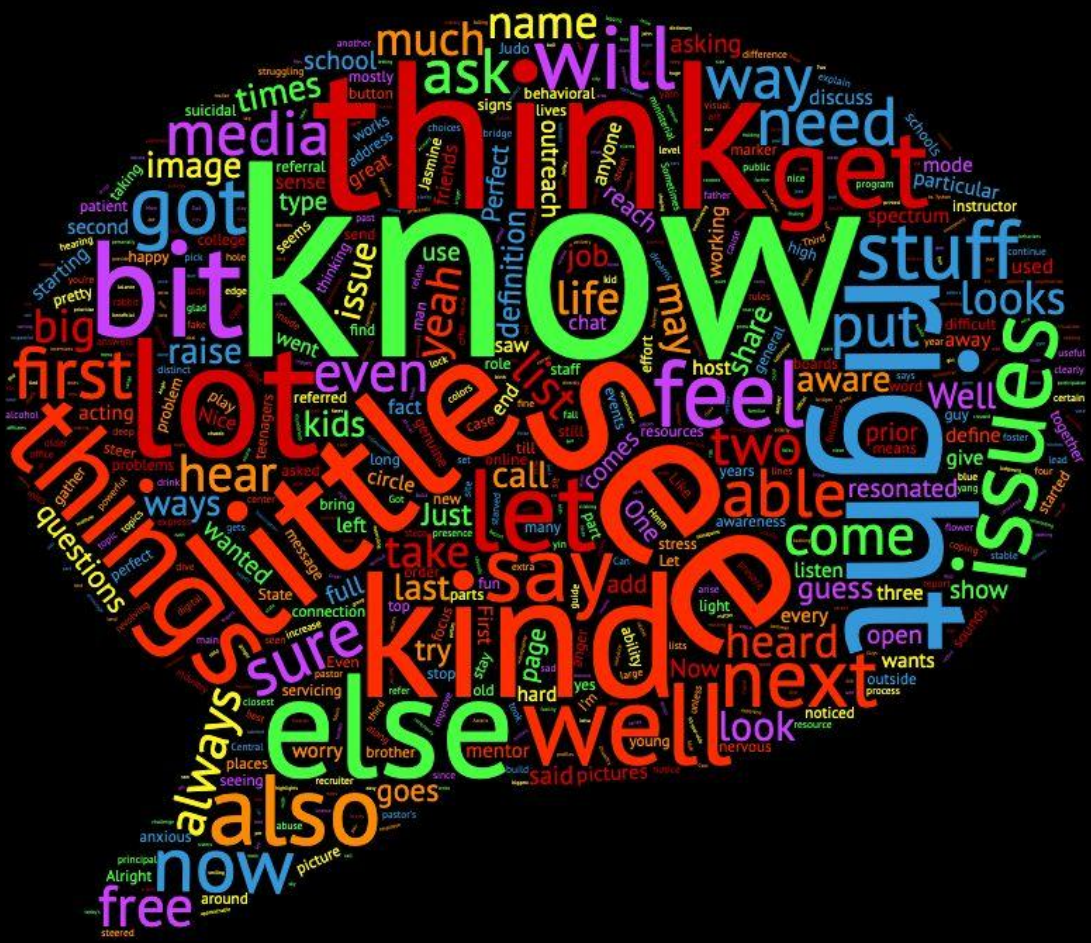
"It's about self-care. It's also about therapy for me, which I'm a huge advocate of in learning coping skills through that therapy."

“In my case, I actually found a resource. And again, this was many years ago and went to see this person... in that conversation, I mentioned in passing that I was gay. And that's the only thing that that person heard, got to the end of the point five minutes, and he just looked at me and said, ‘So you're gay.’ And that was it? That was the one thing I talked about?”

“Lack of experience in I would say different areas like LGBTQ trans things like that. I think that, for me, going to a therapist who wasn't open or knowledgeable or anything like that would stop the conversation almost immediately.”

Group 6: African American

- Know
- Think
- People
- Kind
- Little



Key Insights

- Half of the African American HTC audience had familiarity with FCDBH but most of it was either through work or programs they have seen and not personal experience.
- This group noted that a lot of mental health issues stem from childhood and were the first to organically suggest having programs start at younger age groups and having representatives explaining these services.
- It was noted that mental health is not readily discussed in their households.
- For the efforts they see at colleges, they would like to see more representation and approachable resources as currently those resources don't feel genuine.

"I feel like they (FCDBH) should let it be more like 'we're there' and also that it's okay. They should let people know that it's okay to come get help."

"I think showing up to schools like having representatives actually show up and talk about it... because there are plenty of kids who have parents who aren't maybe getting the help that they need. So not only for the kids but also for their parents as well."

Definitions of Mental Health

- Defined as being able to function normally in society and make moral choices.
- Many definitions related to comfort and personal happiness.
- Being personally happy was related to their ability to have mental stability with the most often cited mental health issue being depression and anger.

"It's the ability to stay stable, confident, comfortable, happy..."

"I look at mental health as being comfortable... not being anxious or nervous."

Mental Health Barriers

- The largest barrier mentioned was communication. The topic of mental health is not discussed at home and many noted they would prefer to see it discussed more openly at school for younger kids.
- Representation: while they do see efforts at the college level, this group did not see the resource tents as engaging and saw them more as advertisements that did not come across as genuine.
- Trust: this group noted they trust doctors, family and church the most with getting this information. They also noted that they would like to see more genuine messaging about normalizing seeking help if advertising online.

"I think as (kids) get older, they tend to isolate themselves and get farther away from help... So, I think we should start young."

"I think that credible information... it's really hard to come by. It's really hard to find because all of the different opinions..."

"The people who are representing (FCDBH)... appear to be relatable... not someone that looks like Mrs. Doubtfire but someone that looks like someone I really want to go and talk to."

“So, if you have someone that you can relate with, that will make them feel more comfortable. But just letting people just know in general, that getting help is okay. If you're suffering through something mentally it's okay to reach out and get help. Because it's not that it’s not really talked about, it's not really comfortable to talk about, especially in a black community. It's not really talked about like that.”

Group 7:
Rural Youth

- Know
- Can
- See
- Think
- Feel

Key Insights

- This HTC audience had the least familiarity with FCDBH overall.
- Parents were not brought up as a trusted source to confide in as most brought up their trusted sources as friends, coaches/mentors, teachers and counselors.
- This group also had more connection to their faith as part of their mental health journey.
- While all trust their friends with info, it was also noted that a negative impact could be friends being dependent on each other emotionally in an unhealthy way.

"To be mentally healthy, it probably means to be free of anxiety and depression."

"Mental health is always looked at as like something negative like if you have it there must be something wrong with you when in reality it's not."

"Mental health being a touchy subject for certain cultures and religions... my parents it's kind of a different topic just because of like different generations."

Definitions of Mental Health

- The definitions of mental health ranged, with common threads coming up related to being able to function and managing stress.
- Common mental health issues that came up were anxiety, depression, stress and even different types of dysmorphia.

“When I think of mental health, I usually think of ‘how do I keep myself calm? How do I take care of myself when things tend to get stressful?’ “

Mental Health Barriers

- Accessibility: all of the participants noted that being in a rural area was a big hindrance in their ability to find credible resources.
- Suggestions for tackling this issue was to reach out via social media as well as tangible messaging through postcards and flyers at schools.
- Many noted that they trusted school and medical locations for trusted information and would like to see that connection if they saw an ad online.
- This HTC audience also liked the idea of starting education on mental health at a younger age but with more diversity in counselors.

"[Male rural youth] When I was a senior, we had two counselors and they were females... I feel like there should be one male counselor... because I didn't feel comfortable sharing how I feel."

"I think anyone can experience some form of mental health (issue). I think it could start as early as middle school."

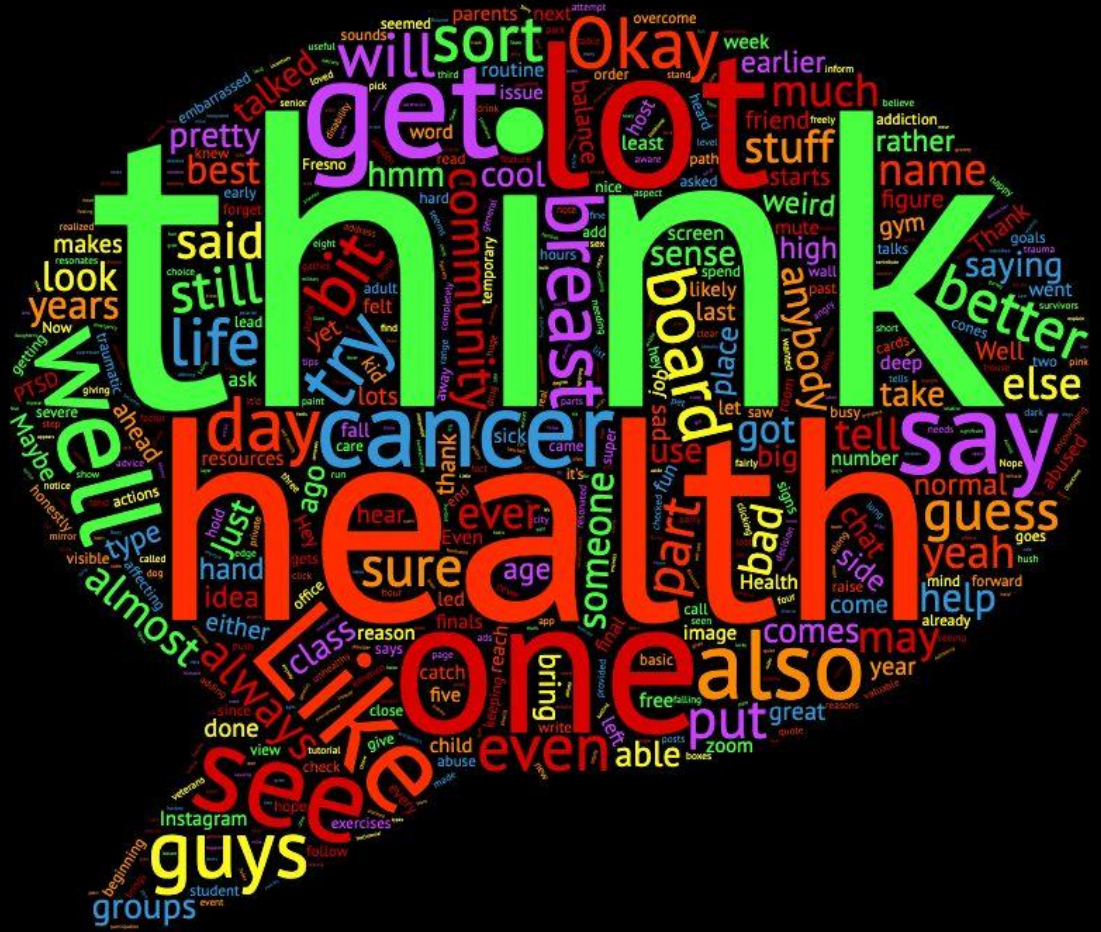
"You don't really hear a lot about all the available resources within the city."

“Even though social media is amazing, I believe too, it’s also caused a lot of mental health issues.”

“I’ve had some really close relationships with people and then it becomes codependency, which I think can be a big problem because then you’re not really thinking about your own problems, and you’re only relaying them to other people.”

Group 8: Transitional Youth

- Think
- Health
- Feel
- Well
- Cancer



Key Insights

- This HTC audience had the most balanced perspective on mental health while organically noting both positive and negative aspects of the subject.
- Group had examples of how they have felt mental health impacts them and had more intimate experience with therapy and self-help.
- Noted that education should start at home as they do see attempts happening at the school level but noted that more could be done.
- Most of the examples brought up were issues they felt could be self-addressed.
- Most common issue brought up was anxiety.

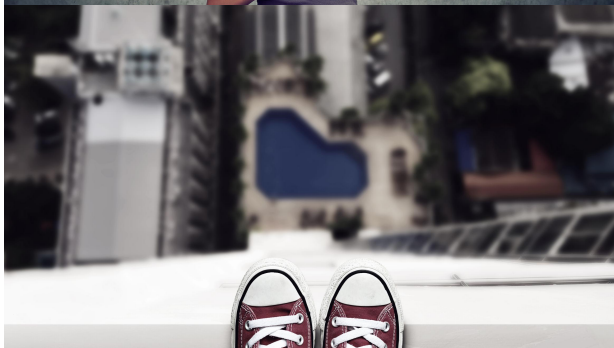
"I would say awareness is the most important thing. So just being aware of your thoughts, your emotions, your feelings, whether those are good or bad, but just having that connectivity with yourself, and just being aware of that inner dialogue."

"I feel like some things have really negative connotations to them. So people don't want to identify themselves, like alcoholism... cancer is something that you don't choose to have. But you did take some actions to lead you to alcoholism."

Definitions of Mental Health

- Definitions were balanced in noting that there are people who are steady and aware of their mental health in addition to people who struggle with it.
- How an individual's mindset affects their mental health was mentioned and not so much the chemical balance.
- Social media's effect (both good and bad) was brought up with this group.

"My definition of mental health is finding a balance between your social, your work, your school, and your goals. Just having balance."



Mental Health Barriers

- How someone should treat or recognize a mental health issue was debated in this group, as the group could recognize that people need help but also found it difficult to decide when someone should seek help.
- Some did not want to seem like a victim and noted the catch-22 of when would be an appropriate time to talk about one's mental health.
- Noted the contradicting messaging seen related to mental health issues (e.g., alcoholism) by how students connect drinking as a stress relief but also see how it becomes a hidden problem.

"I think it's just the idea of some people are victims, and then some people... suffered a bad situation, but then you can empower them to not be a victim."

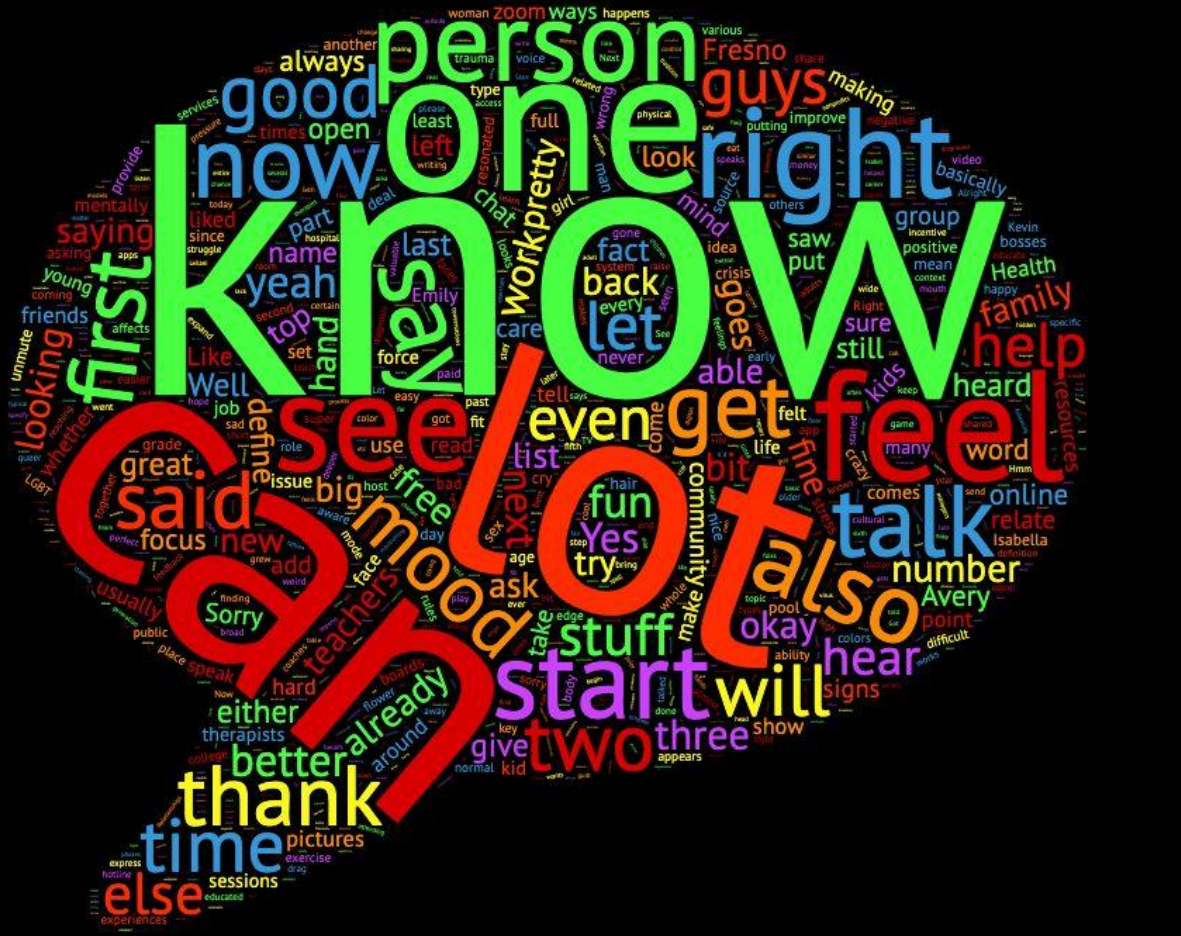
"A lot of us [college students] are battling with anxiety and depression, especially now because a lot of people are isolating and quarantining."

"I feel like a lot of people, including me and my friends, are talking about going to therapy and talking about our anxieties and trying to overcome those fears."

“I think we were originally like, ‘Oh, we shouldn't talk about it,’ because we misunderstood what it was. And then when we started educating, and we started having those conversations, then we realized like, oh, and that's when we were able to empower and have, you know, these good movements. And so, I think that's what happened with breast cancer. I think that's where maybe education could come in because it can eliminate this space for misunderstanding. So, we understand, ‘Oh, what does it mean to have schizophrenia? What does it look like to have anxiety?’ and those things, and that's how we can sort of bridge this gap to create spaces in the home to have those conversations.”

Group 9:
LGBTQ Youth

- **Know**
- **Can**
- **Right**
- **Mood**
- **Feel**



Key Insights

- More than half of this HTC group were familiar with FCDBH through school, work or word-of-mouth.
- This group resonated most with messaging and messengers that seemed to try to connect with the LGBTQ community.
- However, authenticity was priority as this group was very skeptical of “influencers” or paid advertising that did not seem genuine.
- The starting age for mental health awareness was requested to start in elementary school.
- This group encouraged use of genuine people within their community to push them to seek resources.

“We need more apps… there’s a hotline for suicide, so there should be a hotline for depression or anxiety or mental health.”

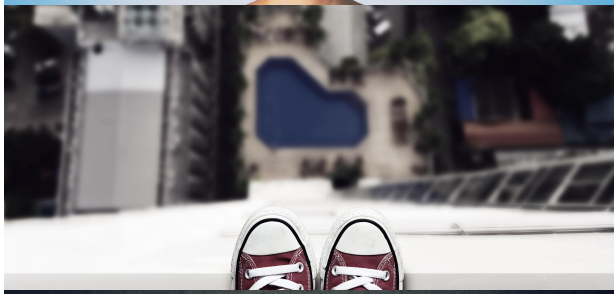
“A lot of people are going to want to connect with someone that they can relate with, especially if it’s somebody who’s either a little bit older or they’re just a little bit more well-known.”

“… making it more accessible for the children to go and get help and reach out to somebody.”

Definitions of Mental Health

- The definition of mental health included a balance along with processing and coping with traumatic experiences.
- A lot of mental health issues that came up related to anxiety, depression, traumas and unacceptance when looking towards the LGBTQ community.
- This group would also have both a negative and positive connection to the visual cues.

"...to be able to function under stress. But not like be in such a stressful situation where basically like, you just feel overpowered or down. And then also to me, venting and being able to talk to people really helps."



Mental Health Barriers

- Access: while it was noted that having the topic of mental health should start at home, it was acknowledged that LGBTQ youth struggle to discuss these items with parents and that the schools may be the easiest route for them to get assistance.
- For when to start exploring these topics, this audience had the youngest starting age, as early as third grade,
- It was recommended that dedicated professionals should be utilized in schools that they could relate to as teachers and counselors may not be equipped for it.
- It was also recommended to start using apps and peer support groups as those are likely to be trusted and be more anonymous for participants.

"I know for a lot of young LGBT folks going to the parents isn't an option. And a lot of the times they go to teachers, but teachers, they don't have that knowledge that LGBT kids really need."

"I think as early as elementary school, I can't recall a memory of someone ever discussing mental health with me when I was under the age of 13. And I think that even young children struggle with it. And their parents don't know."

“But I definitely think there should be designated one person to two people on campus. Whether that's elementary, middle or high school, even college, because if these kids have these kind of feelings, whether it's within the community or even just feeling some kind of anxiety or anything... because teachers they won't understand; parents: some do, some won’t.”

Message Development Feedback

- Most of the groups noted that anxiety and depression are the top mental health issues they are aware of and spoken about most casually. Because they are more normalized they can potentially be easier to use to start the discussion of mental health.
- All groups had a preference to trusting someone who represents what they are going through.
- Groups based on survivor HTCs noted trusting their own support circles the most.

Message Distribution Feedback

- Most groups noted schools as a great point-of-contact for discussing mental health.
- Social media and YouTube were other frequently populated channels but with the added note that there is some mistrust if they don't connect the message to a credible source.
- Younger demographics related to stress more often. They could benefit from access to resources that don't seem like a huge commitment (like hotlines, or quickly getting information).

NEXT STEPS

1. Incorporate findings into customized messaging and distribution tactics to effectively reach these vulnerable, hard-to-connect audiences.
2. Share these findings and insights with partners, community leaders, etc.
3. Continue to invest in audience research in future budget years.

APPENDIX

- Transcripts
  https://jpmarketing.egnyte.com/fl/ZyBuWNejmj
- Video Recordings
  https://jpmarketing.egnyte.com/fl/cp1lTOfYF1
-

CREATING WINS,
cultivating relationships

Appendix B – Third Annual Asian Pacific Islanders Mental Health Empowerment

APIMHE Conference Schedule

November 21, 2019	
8:00 am – 9:00 am	Registration & Continental Breakfast
9:00 am – 10:15 am	**Opening Ceremonies: Dragon Dance & Spiritual Leader** Welcome/Opening: Dawan Utecht MC: Gena Lew Gong **Keynote – Dr. Jei Africa: API Mental Health Empowerment**
10:15 am - 10:30 am	Break & Music
10:30 am – 11:45 am	Workshop Session 1
10:30 am -11:45 am	Youth Vision & Mental Health Workshop
12:00 pm – 1:30 pm	Lunch & Entertainment
1:45 pm – 3:00 pm	Workshop Session 2
3:00 pm to 3:15 pm	Break
3:15 pm – 4:30 pm	Workshop Session 3
4:30 pm – 5:00 pm	Closing Remarks
5:00 pm – 7:00 pm	Reception

November 22, 2019	
8:00 am – 9:00 am	Breakfast & Entertainment
9:10 am – 9:35 am	**Welcome/ Opening:** Susan Holt MC: Gurdeep Hebert **Keynote - Dr. John Tran: Trends in Mental Health Diagnosis and API Community**
9:35 am – 11:15 am	**Panel:** Dr. Ghia Xiong, Dr. Jonathan Logan, Dr. Ya-Shu Liang, Kylene Hashimoto & Senator Melissa Hurtado
11:15 am – 11:30 am	Break
11:30 am - 12:00 pm	**Table Top Activity & Closing Remarks:** Paul Hoang and Maryann Le

APIMHEC 2019

ASIAN & PACIFIC ISLANDER
MENTAL HEALTH EMPOWERMENT CONFERENCE

ACTION FOR WELLNESS: THE POWER OF LEGISLATION

2019 KEYNOTE SPEAKERS

DR. JEI AFRICA
DIRECTOR OF BHRS AT THE COUNTY OF MARIN

DR. JOHN TRAN
CHIEF OF PSYCHIATRY FOR UCSF FRESNO

KYLENE HASHIMOTO
THE WILDFIRE EFFECT

JON LOGAN
CLOVIS UNIFIED SCHOOL DISTRICT

DR. YA-SHU LIANG
THE VALLEY APIMH PROJECT

DR. GHIA XIONG
DIRECTOR OF LIVING WELL CENTER

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APIMHEC 2019 Workshop Schedule			
Thursday, November 21, 2019			
Location (Capacity)	**Breakout 1** **10:30am - 11:45am**	**Breakout 2** **1:45pm - 3:00pm**	**Breakout 3** **3:15pm - 4:30pm**
Independence B (162) / Live Stream	*Cultural Humility & Community Collaboration: Ensuring access and Reducing Stigma for Asian American and Pacific Islanders (Special Services Group)*	*It Takes a Village to Serve a Hmong Youth (Merced County HSA) *Requested Session 2*	Moving Forward with API Crisis Response Model - An Eastern - Western Integrative Approach (MFPI)
Independence A (144)	*Peer Support, System Transformation, & Advocacy (Alameda County BH) *Requested Session 1*	*Game Over & Out of Luck - Problem Gambling with the Asian American Communities (NICOS Chinese Health Coalition)*	*Alameda County's Outreach and Engagement Programs to Unserved and Underserved API Communities (Alameda County BH)*
Veterans A (90)	*Starting Emotional Wellness Conversations in Punjabi Communities (South Asian MH Consortium)*	*Advocating for Mental Health Literacy in API Communities (Alliant University)*	*Promoting Mental Health Care for Asian Pacific American Survivors of Domestic Violence (Justice & Logic)*
Veterans B (90)	*Viet-CARE's Body-Mind Approach to Empower and Combat Mental Illness (Viet-CARE)*	*Engaging Asian Youth in Challenging the Stigma - a Model for a Youth-Led Program (Public Health Institute)*	*Impact of Senior Empowerment Program - From Receivers to Community (Korean Comm. Ctr of the East Bay)*

Appendix C – BeHealth Report

Background

Fresno County Department of Behavioral Health (DBH) entered into an agreement with San Diego State University on February 25, 2020 to facilitate ideas for a youth innovation project, developed by youth, for youth, using human centered design. This youth project was one effort of the Department's Community Planning Process Innovation (INN) Plan, which seeks to use INN funds to foster community engagement and develop innovation project concepts.

The project faced a number of delays and challenges due to COVID-19, including limited in-person interactions and gatherings which were central to the initial planning of the work; zoom fatigue that developed over time, making virtual meetings less appealing; and retention of youth participants over the duration of the project.

The original intention of this project was for Fresno County youth—including youth from our rural communities, and underserved or inappropriately served communities—to be included in the process of identifying and developing several youth-focused and youth-driven innovation project ideas. Due to the challenges described above, the project yielded only one proposal from students at Bullard High School. This memo will address/describe the proposal; its limitations as an Innovation project; and next steps for developing a youth-focused, youth-led Innovation project in Fresno County.

Proposed Project

The consultants, community members, and youth participants overcame many obstacles in their effort to develop a possible youth led, youth focused project. COVID restrictions made it difficult to access and engage project participants. The small number of participants and inability to gather in-person may have affected the dynamics of youth collaboration and the synergy that can come from working together in person. Despite these challenges, the project resulted in a small group of energized youth from within the city of Fresno presenting the final idea.

The proposal was a project to develop a website that would provide youth with information on accessing behavioral health services. The website listings would be provided by youth who would identify and rate providers who render youth-focused services. The project participants developed a prototype website, and suggested that the County create an Innovation project to further populate and promote the website. If the County were to pursue this project, it would implement the first resource database developed by and for youth, with a mechanism for youth to provide feedback on services.

Considerations

Limited participation

Factors behind anyone's control resulted in youth from one geographic area/neighborhood driving the project. While SDSU project staff attempted to recruit youth from across the county, one high school was particularly responsive and able to retain participants throughout the

project. While the presented project may be valuable to the youth in this area, youth in other parts of the city or the County may prioritize different needs over being able to find youth-focused providers in their area.

As large and diverse as the city and county of Fresno are, it would be important to have a youth led and youth identified project be more inclusive than one small group of youth at one school as there are over 30 high-schools in Fresno County.

Existing resources

Currently there are several existing platforms for providing information and local linkages to care. These include, but are not limited to, the following:

- United Way's 2-1-1
- DBH website (DBH provider directory, etc.)
- Unite Us
- The Multi-Agency Access Point (MAP) Program
- Exceptional Parents Unlimited
- Psychology Today and other Managed Care Plan sites
- Department of Social Services has a Directory of Community Resources (available on-line)
- Building Healthy Communities Fresno
- Fresno Metro Ministries (has an on-line resource now)
- Fresno County DBH's 24/7 Access Line

Furthermore, the project/prototype website did not touch on many of the free resources already available to youth, such as access to the 24/7 National Suicide Prevention Lifeline, which is on the back of student ID cards for all California students. It made no mention of school-based services such as the All4Youth. There was no mention of the various free chat, text, and call information to support youth, such as the Teen Line. The omission of these services demonstrates the narrow lens through which students may view behavioral health services, and the need for better communication and promotion of existing resources by the Department and the system of care.

Should this project be completed as suggested, the County would duplicate existing services by creating an additional resource platform. The County's goal of providing a coordinated system of care would be undermined without a deep understanding of how the new project would fill a gap in existing services. It is possible that this project arose from a lack of awareness of behavioral health resources which can be better addressed through targeted marketing and promotion efforts.

DBH Scope of Work

The proposed project and services that were identified on the website were primarily providers outside the public behavioral health system of care. The providers that were the focus of the website were those that are under the Managed Care Plans (MCPs). Many of those are services

or providers who do not serve the same population as Fresno County Department of Behavioral Health.

In order to adequately execute this proposed project, the Department would need to elicit direct input from the MCPs to address the needs of youth attempting to access care under their family's health insurance coverage. The MCPs would be needed to determine what costs are covered by insurance plans, insurance-related procedures (such as authorizations), and how to better identify and advertise services for youth performed by the MCP.

In a recent report conducted by the California Pan-Ethnic Health Network (CPEHN) *Medi-Cal Managed Care Plan Mental Health Services*, identified the need for MCP to improve their websites and the availability of information about behavioral health services. The need for improved websites may be better addressed if the current MCPs in Fresno County worked with youth to design and implement a youth section on each MCP website.

Next Steps

Fresno County's Innovation Vision

Fresno County Department of Behavioral Health has committed to developing community-driven, sustainable Innovation projects under its MHSA plan. In recent years, the Department has embraced a philosophy of using Innovation dollars for learning projects, rather than dedicating funds to narrowly focused service programs. These learning projects center largely on increasing access to services for Fresno County residents who are unserved or inappropriately served by the public behavioral health system. In this case of this project, the opportunities for learning might be limited; rather, the funding would be used to create a project that would need to be sustained.

Furthermore, Mental Health Services Act (MHSA) funding is to be the funding option of last resort. As previously mentioned, there are other resource platforms in existence that are funded by a variety of sources. MHSA funds, including Innovation dollars, should not be used to develop and fund a system which can be developed and funded through other option.

Commitment to producing a youth-designed, youth-led Innovation project

While this memo has noted some challenges with such a project being put forth as an Innovation Plan, the Department sees great value in continuing the work initiated by the youth leaders in the Be Well project.

The Department's intention to put forth a youth-developed, youth-led, and youth-focused Innovation Plan has been memorialized in the 2020-2023 MHSA Three-Year Plan. This intention is further described in each Annual Update, and in the Innovation Community Planning Process Plan (which funded this endeavor). At this time, the Department will focus its efforts on leveraging the knowledge gained from this project into existing strategies to create a coordinated public mental health system. This may include working with currently operated MHSA-funded

programs such as CBANS and MAP to help better educate the community on mental health literacy, how to access care, and what resources are available. The Department may also pursue a project in which youth leaders assist in planning to integrate the variety of resource navigation websites into a cohesive whole. Youth could advise the Department on topics such as creating access to more youth-friendly resources, and how to adopt and implement youth-driven rating systems.

The Department remains committed to sharing this report and presentation with other organizations that may be interested in working with youth to improve access to behavioral health services for youth. In October 2021, Fresno County shared the report and presentation with the California Pan-Ethnic Health Network (CPEHN) for use in its advocacy work, driven by the *Medi-Cal Managed Care Plan Mental Health Services* report.

The Department is using the report in its on-going communication and promotion efforts to inform its efforts to rendering more youth-centric messaging and work to improve the youth focus and appeal of youth specific services.

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For registration questions contact Stephen Faille: sfaille@sdsu.edu.

RESCHEDULED DATE

Register for BeHealth™ | WORK
Saturday April 24, 2021 10am-2pm
https://fresnotay041021.eventbrite.com/

THE COUNTY OF FRESNO 1856

DEPARTMENT of BEHAVIORAL HEALTH

County of Fresno
DEPARTMENT OF BEHAVIORAL HEALTH
SUSAN L. HOLT
INTERIM DIRECTOR

BE Health-Transition Aged Youth Lead Innovation Design

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- Psychology Today and other Managed Care Plan sites
- Department of Social Services has a Directory of Community Resources (available on-line)
- Building Healthy Communities Fresno
- Fresno Metro Ministries (has an on-line resource now)
- Fresno County DBH's 24/7 Access Line

Furthermore, the project/prototype website did not touch on many of the free resources already available to youth, such as access to the 24/7 National Suicide Prevention Lifeline, which is on the back of student ID cards for all California students. It made no mention of school-based services such as the All4Youth program. There was no mention of the various free chat, text, and call information to support youth, such as the Teen Line. The omission of these services demonstrates the narrow lens through which students may view behavioral health services, and the need for better communication and promotion of existing resources by the Department and the system of care.

Should this project be completed as suggested, the County would duplicate existing services by creating an additional resource platform. The County's goal of providing a coordinated system of care would be undermined without a deep understanding of how the new project would fill a gap in existing services. It is possible that this project arose from a lack of awareness of behavioral health resources which can be better addressed through targeted marketing and promotion efforts.

DBH Scope of Work

The proposed project and services that were identified on the website were primarily providers outside the public behavioral health system of care. The providers that were the focus of the website were those that are under the Managed Care Plans (MCPs). Many of those are services or providers who do not serve the same population as Fresno County Department of Behavioral Health.

In order to adequately execute this proposed project, the Department would need to elicit direct input from the MCPs to address the needs of youth attempting to access care under their family's health insurance coverage. The MCPs would be needed to determine what costs are covered by insurance plans, insurance-related procedures (such as authorizations), and how to better identify and advertise services for youth performed by the MCP.

In a recent report conducted by the California Pan-Ethnic Health Network (CPEHN) *Medi-Cal Managed Care Plan Mental Health Services*, identified the need for MCP to improve their websites and the availability of information about behavioral health services. The need for improved websites may be better addressed if the current MCPs in Fresno County worked with youth to design and implement a youth section on each MCP website.

Next Steps

Fresno County's Innovation Vision

Fresno County Department of Behavioral Health has committed to developing community-driven, sustainable Innovation projects under its MHSA plan. In recent years, the Department has embraced a philosophy of using Innovation dollars for learning projects, rather than dedicating funds to narrowly focused service programs. These learning projects center largely on increasing access to services for Fresno County residents who are unserved or inappropriately served by the public behavioral health system. In the case of this project, the opportunities for learning might be limited; rather, the funding would be used to create a project that would need to be sustained.

Furthermore, Mental Health Services Act (MHSA) funding is to be the funding option of last resort. As previously mentioned, there are other resource platforms in existence that are funded by a variety of sources. MHSA funds, including Innovation dollars, should not be used to develop and fund a system which can be developed and funded through other options.

Commitment to producing a youth-designed, youth-led Innovation project

While this memo has noted some challenges with such a project being put forth as an Innovation Plan, the Department sees great value in continuing the work initiated by the youth leaders in the Be Health project.

The Department's intention to put forth a youth-developed, youth-led, and youth-focused Innovation Plan has been memorialized in the 2020-2023 MHSA Three-Year Plan. This intention is further described in each Annual Update, and in the Innovation Community Planning Process Plan (which funded this endeavor). At this time, the Department will focus its efforts on leveraging the knowledge gained from this project into existing strategies to create a

coordinated public mental health system. This may include working with currently operated MHSA-funded programs such as CBANS and MAP to help better educate the community on mental health literacy, how to access care, and what resources are available. The Department may also pursue a project in which youth leaders assist in planning to integrate the variety of resource navigation websites into a cohesive whole. Youth could advise the Department on topics such as creating access to more youth-friendly resources, and how to adopt and implement youth-driven rating systems.

The Department remains committed to sharing this report and presentation with other organizations that may be interested in working with youth to improve access to behavioral health services for youth. In October 2021, Fresno County shared the report and presentation with the California Pan-Ethnic Health Network (CPEHN) for use in its advocacy work, driven by the *Medi-Cal Managed Care Plan Mental Health Services* report.

The Department is using the report in its on-going communication and promotion efforts to inform its efforts to rendering more youth-centric messaging and work to improve the youth focus and appeal of youth specific services.

Based on the challenges with the proposed program, the Department does not deem the current proposed project to be a viable INN plan at this time and will continue to explore for youth, by youth possible INN project.

BEHEALTH.TODAY

County of Fresno Department of Behavioral Health

Final Report
Social Policy Institute
San Diego State University
August 12, 2021

San Diego State University
Social Policy Institute

TAY HELPING TAY

Creating New Ideas to Innovate Behavioral Health

The Fresno County Department of Behavioral Health (DBH), in partnership with its richly diverse community, is dedicated to providing quality, culturally responsive behavioral health services to promote wellness, recovery, and resiliency for children, youth, individuals and families in the community. With Transition Aged Youth (TAY) in mind, DBH invited the San Diego State University Social Policy Institute to bring Human Centered Design to the county.

TAY BACKGROUND

Transition Aged Youth (TAY), 16 – 25 years old, are developmentally moving into young adulthood and facing a range of opportunities and challenges that position them to move beyond dependency to independence in some areas, and interdependence with peers, family, and the community. Positive behavioral health is vital to quality of life and the achievement of age-appropriate developmental milestones.

For some youth, the transition to adulthood presents exciting opportunities, while for others it brings a number of challenges in meeting their basic needs. Youth in transition may not be able to connect well with others, find employment that covers a minimum income and offers health benefits, find safe, affordable housing, etc. For youth leaving foster care or juvenile detention facilities, youth who have run away from home or dropped out of school, or youth with disabilities, the challenges can be even greater. Further, starting in 2020 with the onset of the global coronavirus pandemic, all youth began to face unprecedented challenges in the areas of loneliness and isolation, digital access, body image related to changes in movement patterns, academic challenges in a virtual environment, etc. Many of these issues are exacerbated by behavioral health challenges, and yet positive behavioral health can help buffer risk and create opportunities to thrive.

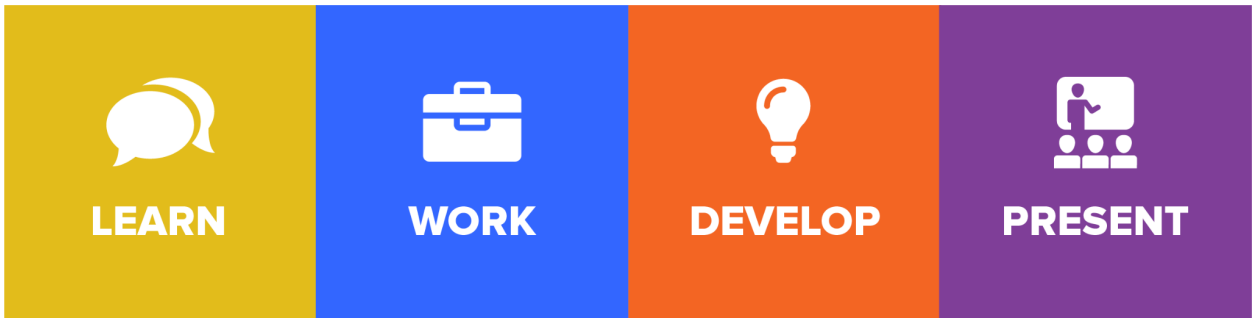
DESIGN FOR BEHAVIORAL HEALTH INNOVATION

BeHealth.Today, based on Human-Centered Design, also known as Design Thinking (HCDT), is a complete process from education to workshops to presenting a proposal that facilitates positive behavioral health for TAY. Design Thinking has become popularized by academic institutions like Stanford's D School, and innovation experts, like IDEO, to generate innovative solutions to improve current situations, including those impacting TAY.

Developed by SDSU Social Policy Institute and The Idea Guy™, BeHealth.Today™ provides the opportunity for participants to generate new approaches in the design and delivery of behavioral health services and supports. The project was to create meaningful community engagement of

Transition Age Youth (TAY) 16 – 25 years old. The approach was a “by TAY for TAY” to develop Innovation projects to improve opportunities for TAY wellbeing in Fresno County.

The BeHealth.Today approach is composed of cohorts of community participants coming together to learn about human-centered design, work through skills necessary to generate a good idea, and develop their proposals on innovating behavioral health. The process is complete when participants present their ideas in a formal presentation to an expert panel and their peers.



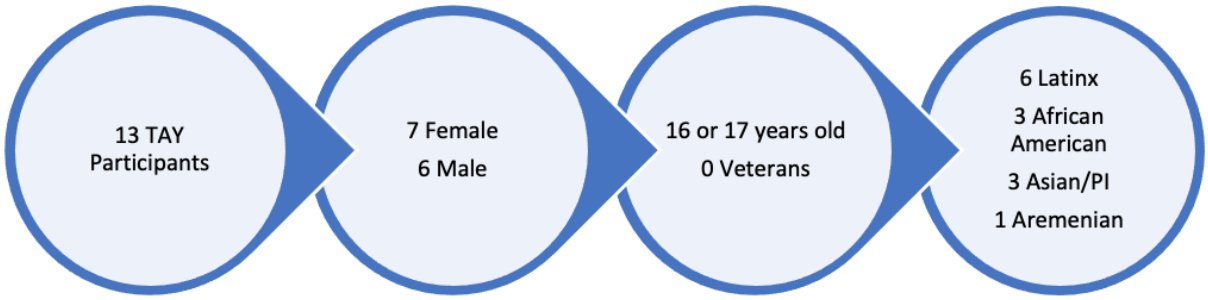
Such community-generated ideas create a bank for potential Innovation projects. Innovation projects are funded through a special component of the Mental Health Services Act (MHSA). Projects are submitted by the County to the MHSA Oversight and Accountability Commission for approval. The MHSA statute requires that Innovation projects have novel approaches to behavioral health issues, be time-limited and designed to answer research questions related to innovating and improving mental health.

OUTREACH AND RECRUITMENT

The Design Team (SPI and The Idea Guy™) began with a list of potential ambassadors/partners identified by the Fresno Department of Behavioral Health (DBH) of key local stakeholders who already had existing relationships with diverse TAY populations. Then the Design Team actively recruited leaders through virtual presentations, flyers, and direct outreach in order to engage and register TAY participants. The Design Team believed this strategy of cultivating champions and engaging influencers would be most effective to inform, involve and inspire individuals to participate in the human centered design thinking process. Please see Appendix A for a listing of TAY allies, champions, and influencers.

In order to achieve diverse participation, the Design Team implemented an integrated marketing and communications platform for outreach, engagement, registration and completion of an initial project proposal. The foundation for communication was the website, which included all the information and functionality. The social media profiles on Facebook, Twitter and Instagram helped interject the program into social conversations. Email marketing reached out to people on lists compiled by the Design Team of potential ambassadors/partners. Links on the website,

social end user email led back to a process for multi-language registration supported by Eventbrite. Please see Appendix B for a snapshot of the marketing and outreach campaign.
The combined targeted recruitment resulted in a diverse representation of High School participants, who were English speaking TAY enrolled at Fresno Unified School District's Bullard and Hoover High Schools. Overall, there were thirteen (13) TAY participants, 7 of whom identified as female and the remainder identified as male. All were aged 16 or 17. Six participants were Latinx, three were African American, three were Asian/Pacific Islander, and one was Armenian. There were no veterans or active-duty military among them. See Appendix A, initials are used for confidentiality of minors.



While this was a robust cohort that in the end produced a remarkable proposal, it was hoped that even when outreach strategies were adapted in response to COVID, there would be additional cohorts participating. Additional analysis of this dynamic is presented in "Lessons Learned."

DESIGN PLANNING AND IMPLEMENTATION BY COLLABORATING PARTNERS

Collaborative Partnership/Learning Community

The Design Team established regular meetings as a working group, and also met (virtually) regularly with DBH to report progress, debrief project stages, and agree on immediate next steps. The Design Team was organized to align and maximize the complementary competencies, resources and networks of the partners with HCDT as well as designing/delivering behavioral health and community based human services. Each team member was committed to the goals and stretched outside the box of their "comfort zones" in developing and implementing the plan. This innovative collaboration helped to demonstrate how diverse participants can use HCDT to achieve a greater good even in the midst of a pandemic.

Adapting HCDT for Fresno TAY in a COVID Environment

The Idea Guy™ contributed a previously developed iteration of Human Centered Design (that remains proprietary) for the project. Its successful experience with diverse, cross-sector,

intergenerational populations heavily influenced the Human Centered Design for this DBH target audience.

Although the initial intention was to conduct activities in real time in Fresno County at venues known by and comfortable for TAY, the HCDT process was able to engage participants in a structured virtual workshop environment. The structured activities and resources in the four-hour workshop allowed participants to deepen, expand and revise initial ideas or issues that they had originally wanted to address. Materials and supplies normally distributed during on-site events were shipped to influencers for distribution to youth in sanitized, individualized packets.

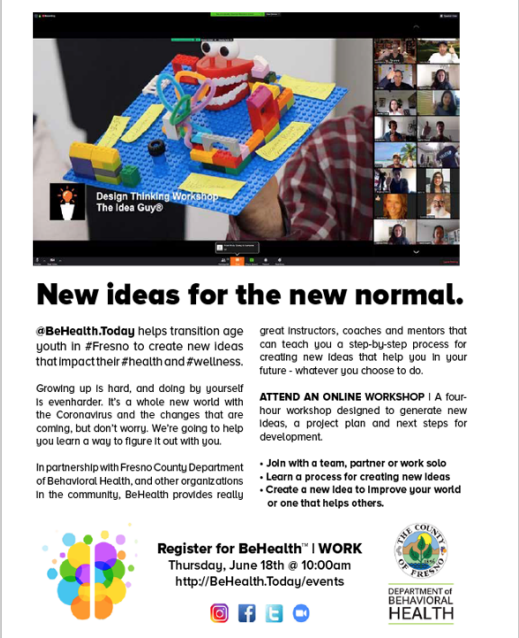
PROJECT LOGISTICS

Platform: The Message and Vehicles for Dissemination

WordPress (a web-based tool), used for initial development of BeHealth. Today, worked well for adapting TAY-specific content that was easy to navigate. All technical requirements for ease of use and updating/managing the site by the Design Team were accomplished. Informal feedback from participants indicated they found the site to be engaging and informative. The social media selected (Facebook, Instagram, Twitter and LinkedIn) were well-suited for TAY target audiences.

In reflection, the Design Team would suggest investing in efforts to engage the intended audiences in advance through targeted social advertising and email marketing so messages would reach the maximum audience and generate interest.

Promotion: Spreading the Word



Key influencers were identified for personal connections with TAY and were open to leveraging their program distribution lists to reach a larger target audience. The key influencers suggested by DBH indicated interest in the needs of the TAY population, the HCD process and strong support for DBH's goals and purpose. Influencers were engaged as prominent and credible messengers for testimonials (see promotional videos by Kylene Hashimoto, Dr. Robert Pimentel and Dr. Tiffany White.

Allies and influencers who assisted with outreach had requested "talking points" and video/visuals to support their verbal outreach and to use as a reference for potential participants to refer back to. BeHealth.Today handouts, brochures, consumer flyers and FAQs were informative, well received and very useful in our approach to outreach and engagement of diverse stakeholders. These materials were also posted on the website to encourage visits for more information and registration for

upcoming events. All printed material was created at 8th grade reading level to ensure comprehension by a wide TAY audience. It is noteworthy that social ads used content from previous events to target stakeholders that meet the key demographics (e.g., TAY, people with lived experience, DBH providers, Community-Based Organizations/Non-profits, advocates, etc.) whenever possible in hopes that TAY sees someone like him/herself which encourages empathy, understanding and raises awareness of behavioral health issues. Please see Appendix C for a full copy of the materials, including fliers, social ads and videos (See "Lessons Learned" for a discussion of the role of incentives for participants and for the potential ambassadors/partners as a social justice issue in promotion, as well as the unique impact of COVID on vulnerable Fresno communities.)

Event Administration/Logistics

Registration was conducted using EventBrite and the process functioned as designed for online registration. While the Design Team had translation services and material available, none were requested for this project.

Originally the first learning event was to be held at the Westside Youth Center but was cancelled due to COVID-related shelter-in-place statewide mandate. For any future events, locations selected should be easy to find and well known in the community, accessible to public transportation, have sufficient parking spaces, at little or no cost whenever possible.

Translation/Accommodations: Despite the diversity in Fresno, there were no requests made for language translation, nor for accommodations due to a disability.

IMPLEMENTATION

BeHealth.Today is a complete process, from education to workshops to a presentation of a proposal for consideration to the Fresno Department of Behavioral Health.

- A **Learning** event to provide an overview of the process and encourage participation.
- A **Workshop** to provide hands-on experience in HCDT and create an initial project proposal for generating new ideas.
- A **Project Development Phase & Coaching** to test the project and implementation plan as well as receive individualized coaching.
- A **Presentation** to an Expert Panel of the Design Team, key stakeholders and peers for feedback and evaluation.

Learning: A one-hour overview of the BeHealth experience.

This is an important event because it is the top of our marketing/engagement funnel – educating/encouraging people on the value of the project and their participation. The more TAY who attend, the greater number of TAY who are informed and potentially will register for the workshop. A Press Release was issued before the program start date to maximize attention and

“buzz” for the events. Livestreaming the learning event on Facebook would expose more people to the HCDT program and DBHS’s goals. The video can also be converted into a social ad on Facebook to inform and engage intended audiences. Livestreaming the learning event on Facebook would expose more people to the HCDT program and DBHS’s goals. The video can also be converted into a social ad on Facebook to inform and engage intended audiences.

Workshop: A four-hour event designed to generate new ideas, a project plan and concrete next steps to develop a successful proposal.

The Workshop was developed with a variety of approaches for understanding and experiencing the HCDT process. The workshop required four hours to fully execute. Initially, participants were surprised at the fast pace of the activities (3 – 4 minutes to complete a task), but by the middle of the workshop they readily moved at a faster pace. They see the value of many ideas and the diverse perspectives from the other participants. See Appendix D for the running order of the Workshop.

Development: Group work on participant’s project plan, further development of ideas and prototypes, and testing to identify potential impact.

The TAY teams were encouraged to meet with a coach to prepare their projects. This provided an opportunity to assist in the project planning and offer feedback on the prototyping and the diversity of the proposed team. Coaches were available to help the team understand whether they have the right people involved to be successful.

For future HCDT projects, all teams must create an approved project management plan that identifies the sequence of activities. This allows the team to understand the path for successfully completing their proposed project. All teams should meet with their coach to review work on the steps of the process in the project plan with a go / no-go decision at key points. This would assist teams to execute the testing stage and any re-prototyping that's indicated within the allotted time.

Presentation: Delivery of participant's project (formatted to proposal guidelines) for consideration by an expert panel and peers.

The Design Team requested that teams submit all their materials in advance of presentation. Of the two teams that continued after the Work session, one demonstrated their readiness to make a presentation, having completed a narrative (script) and presentation (slides) on the templates that had been provided. The second team informed their Bullard faculty advisor it was proceeding with the project tasks and would make a presentation, but despite numerous requests never arranged consultation with the coach and did not make a presentation.

Both the Design Team and audience members not affiliated with the presenting team evaluated the proposed project. The audience members did not have previous experience with judging HCDT projects but were able to do so with a brief introduction to the respective rating elements. The audience ratings differed from the Design Team ratings. This was not unexpected and allowed additional insights into the desirability and community interest in a particular project.

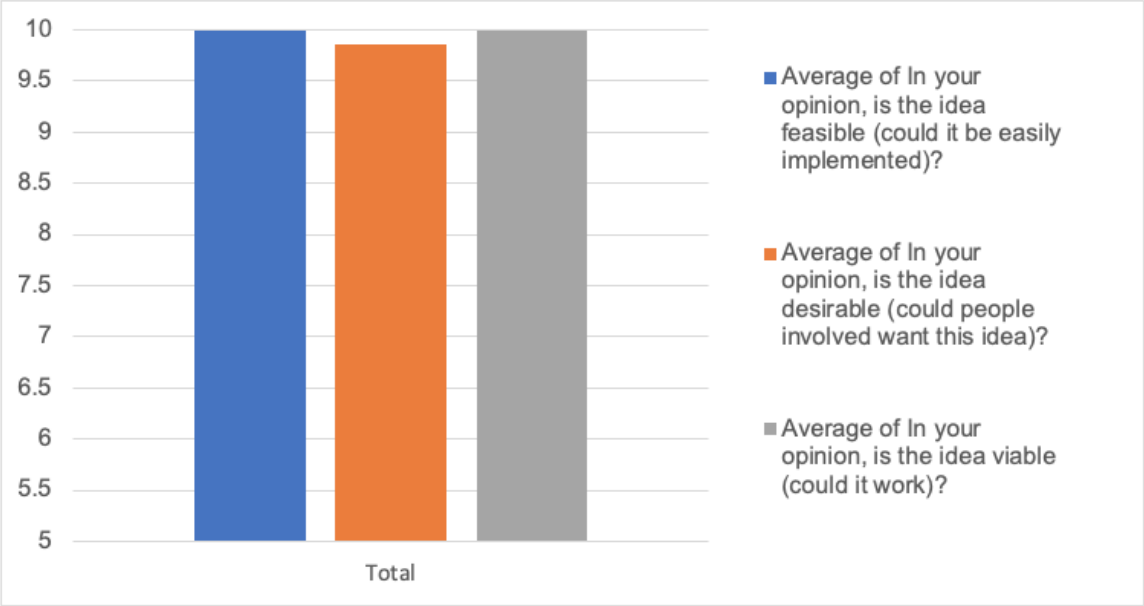
Results

Several promising project ideas emerged, but were presented in the Workshop only:

1. How might we help teenagers and adults understand suicide in order to talk about it and help suicidal people.
2. How might we help children and youth communicate more about the issue and provide sources to help them in order to improve children's mental health.
3. How might we help society identify behavioral disorders/problems in order to help spread awareness and point those in need in the direction of help.
4. How might we help the youth learn to manage adverse experiences to create better experiences with a positive mindset.
5. How might we help teens in high school easily access the correct treatment and recovery needed based on their needs to comfortably face and overcome their problems.

Proposal ideas developed into presentations

One project idea continued through development and presentation. The fifth idea, "How might we help teens in high school easily access the correct treatment and recovery needed based on their needs to comfortably face and overcome their problems" was ranked on metrics the Design Team deemed essential for success. See below for definitions and resulting rankings.



- Desirable - the idea makes sense and is wanted by the consumers it is intended to serve
- Feasible - the idea is doable; it could be implemented
- Viable - the idea is fundable through potentially available resources

The full presentation may be viewed here on YouTube here: https://youtu.be/tku0Rd_-Qy0.

NOTE: The BeHealth.Today team process and website assures that the community will continue to be a collaborative partner for the current, and future ideas, developed to be considered by Fresno DBH, MHS OAC, private funders and/or social entrepreneurs. Updates are regularly posted on the BeHealth.Today website at https://behealth.today.

For more information about MHSA and Innovation projects, visit http://mhsoac.gov.

BIG IDEAS/NEXT STEPS

Suggested Project to go Forward

Team 5 presented the ePoint Resource Locator with a review of the project plan and a live demonstration of the website available at https://epoint.today. Their presentation highlighted the project plan, the tasks completed as well as the expanded focus of the project as they gathered feedback during their outreach and prototyping. The team developed the ePoint Resource Locator website to help the Bullard community identify options for student social emotional support, access community-based resources and treatment programs to impact mental health and wellbeing. The team surveyed key stakeholders of students, parents, teachers and

counselors, developed a 10-item scorecard to rate local programs on location, access, quality, cost and availability for youth behavioral health needs/issues. The team also developed short videos explaining the rating for the programs to better inform their target audience youth and their families. In their conclusion, the team highlighted suggestions to further improve the website's functionality to be even more user friendly.

According to the feedback during the presentation as well as from the community stakeholders surveyed, there is a clear community need for Fresno TAY to have more information and access to meet behavioral health issues. Therefore, the team made a commitment to maintain the website during the summer months before they leave for college and hope it will be continued by other students in the Fall. The team successfully created an innovative behavioral health project by TAY for TAY. Given the quality of the project, the presentation evaluations and the closing comments by Fresno Unified staff and NAMI Fresno Executive Director, the BeHealth team encourages the Fresno DBH to consider funding this innovative TAY project.

Brief Description of Fresno TAY Experience and Recommendations for Next Steps

As part of our outreach and recruitment, BeHealth worked with several key Fresno stakeholders to help mitigate “being the outsider”. Dr Tiffany White and her intern, Graciella Angeles, were initially helpful in connecting us with stakeholders and some possible non-traditional TAY groups that might be included. Kylene Hashimoto provided important background and current information on TAY issues and opportunities in Fresno. Both were enthusiastic supporters of the project and made testimonial videos to get out the word available on this YouTube playlist.
Originally planned to be an in-person process, the first cohort was scheduled to be launched in April 2020 at the Westside Youth Center. The Covid 19 lockdown meant postponing this event. When it became apparent that Covid lockdown was indefinite, the BeHealth team in consultation with the DBH staff and local champions decided to present our human centered design model virtually in a zoom platform. The team was confident the sequence of activities could be delivered remotely as long as the participants had access to a computer and secure internet connection. The team believed that not only were TAY at home and spending their time on the internet, but that the human centered design process might be a “welcome change” from COVID restrictions and typical classes.

Over the summer in dialogue with Fresno Unified staff, the BeHealth team decided to wait until the Fall when school was in session to reduce the conflicts and uncertainty of the summer months. Initially key Fresno Unified staff included Darryl Du’chene and Tara Kaitfors, but once it was decided to engage Bullard and Hoover High School students, the Fresno staff team expanded to include: Troy Odell, Michele Mar, Ralph Vasquez and Celia Lopez. The Fresno Unified staff met at least once a month during the Fall of 2020 and bi-weekly during the 2021 to manage program issues and logistics.

The Idea Guy made weekly outreaches to the five teams via email, though only two teams led by V.S. and A.D., responded despite numerous requests through the end of March 2021. The project lead worked with the respective Fresno faculty to encourage and support all five teams.

Unfortunately, Spring Break and the re-opening of the school campus, in early April, made it difficult for the student teams to set meeting times and follow through on their prototyping and testing efforts. As one of the faculty pointed out, for the first time in almost a year, students are able to participate in all the regular outdoor sports teams and there is just too much demand to be with friends enjoying community activities. Further by the end of April, preparing for finals and the end of year High School prom made it even more difficult. The Presentation event was scheduled and rescheduled three times to try to accommodate these conflicts.

LESSONS LEARNED

1. Proof of concept was achieved that "BeHealth.Today can be implemented in a virtual platform exclusively, if and when social and health conditions warrant."
2. The impact of BeHealth.Today is anticipated to be magnified beyond the current scope of the project. Participating TAY are seeing the opportunity to use design thinking to help them evaluate next steps ahead for them; faculty and staff are using HCDT and bringing it into the classroom; TAY will have a deeper sense of civic engagement and learned leadership skills;
3. Maximize outreach by coordinating with a wide variety of agencies focused on youth and issues of interest to youth. Engage partners in thinking through, "How might we better coordinate and align the messaging?"
4. Consider a "by region" or "by neighborhood (or school district)" approach to maximize local impact and involvement.
5. Think through the age of Transition Age Youth (TAY) who are likely to engage. High school seniors are good candidates because they are looking forward. Tay who are out of school (graduated) are also likely candidates.
6. As a matter of social justice and equity, provide meaningful incentives for participation to youth and partner agencies.
7. Engage post-TAY youth to ask what they wish they would have had (as TAY) to help them be successful.
8. Coaching and accountability to a timeline are essential to the success of the program.
9. Flexibility is required to manage external constraints (i.e. the presentation date was changed three times due to unforeseen circumstances.)

APPENDICES

A. TAY Allies, Champions, Influencers and Participants
B. TAY Marketing and Outreach Campaign
C. TAY Outreach Materials
D. Event Overview / Agenda

Appendix A: TAY Allies and Influencers

Allies, Champions, Influencers

Johnny Garza	jgarza@chusd.org	Director of Student Services- Coalinga-Huron Unified School District
Cresencia Cruz	ccruz@faihp.org	Fresno American Indian Health Program
Coreen Campos	ccampos@uwfm.org	United Way of Fresno and Madera
Ashley Rojas	ashley_rojas@fresnobarriosunidos.org	ED Fresno Barrios Unidos
Kylene Hashimoto	kylene@thewildfireeffect.org	Behavioral Health Board TAY Member, OAC TAY Workgroup Member
Gleyra Castro	gcastro@fresnocountyca.gov	DBH Children's' Services Supervisor
Emily Vargas	evargas@tpocc.org	Program Manager. Turning Point-Rural Mental Health Services
Chris Roup	chris@namifresno.org	ED- NAMI Fresno
Malia Sherman	msherman@mail.fresnostate.edu	Director of Student Mental Health Services-Fresno State
Tiffany White	tiffwhite@fresnocountyca.gov	Adj. Prof. Juvenile Justice Campus-Fresno City College, BHS Diversity Officer
Yolanda Randles	yrandles@wfresnofrc.org	ED West Fresno Family Resource Center
Saul Salinas	SaulSalinas@cusd.com	Student Services Clovis Unified
Jason Williams	jasonwilliams@casafresno.org	Fresno CASA
Joanna Litchenberg	joannaz@focusforward.org	Focus Forward
Jennifer Cruz	Jennifer.Cruz@fresnoeoc.org	Fresno EOC LGBTQ Center
Dino Perez	dperezwsy@gmail.com	Westside Youth Center
Martin Macias	mmacias@gpusd.org	Superintendent Golden Plains Unified School District
Jojo Reyes	jojoreyes@mendotaschools.org	Director of Student Services-Mendota Unified
Dr. Janelle Pitt	jepitt@mail.fresnostate.edu	Professor, Fresno State
Dr. Malia Sherman	msherman@mail.fresnostate.edu	Director, Student Mental Health Services Fresno State
Jen Cruz	Jennifer.Cruz@fresnoeoc.org	Fresno EOC LGBTQ Center
Darryl Du'chene	Darryl.Du'chene@fresnounified.org	Project Manager, Dept of Prevention & Intervention
Dr Robert Pimenthel	robert.pimentel@fresnocitycollege.edu	VP Educational Services
Tara Kaitfors	Tara.Kaitfors@fresnounified.org	Coordinator College and Career Readiness
Troy Odell	Troy.Odell@fresnounified.org	Supervisor
Michelle Mar	Michelle.Mar@fresnounified.org	Supervisor
Celia Lopez	Celia.Lopez1@fresnounified.org	Faculty, Bullard HS
Ralph Vasquez	Ralph.Vasquez@fresnounified.org	Faculty, Bullard HS

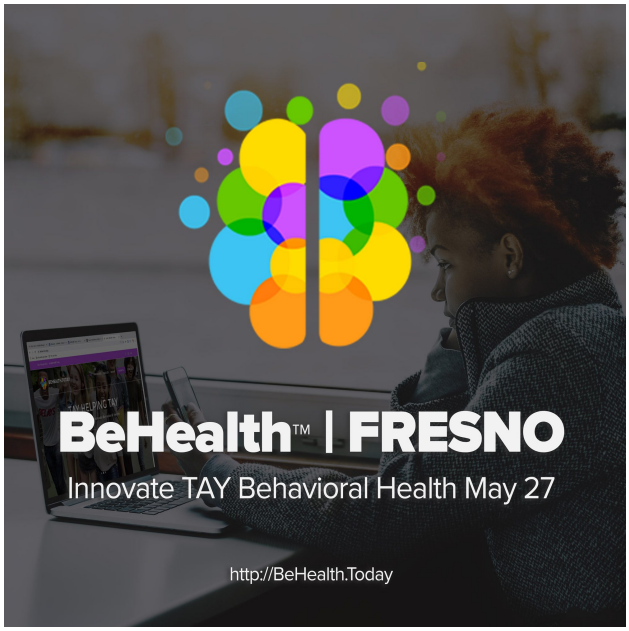
Participants

ID	Name	Gender	Age	Ethnicity/Race
3	C.M.	Female	16	Hispanic/Latino
9	T.P.	Female	17	Native Hawaiian or Other Pacific Islander
5	E.S.	Female	16	Hispanic/Latino
6	N.H.	Female	16	Hispanic/Latino
1	A.G.	Male	17	Hispanic/Latino
4	D.A.	Male	16	African American
10	V.S.	Male	17	Armenian
7	J.N.	Female	17	Asian American
8	R.C.	Male	17	Hispanic/Latino
2	A.D.	Female	17	Hispanic/Latino
11	M.R.	Male	17	African American
12	B.G.	Male	17	African American
13	K.V.	Female	16	Asian Hmong

Appendix B: TAY Marketing and Outreach Campaign

Item	*Date*	*Description*
Website	4/20/2020	BeHealth™ | Fresno Events Posted
Social Media	4/28/2020	BeHealth LEARN Event
Social Media	5/20/2020	BeHealth™ | Fresno Ad Campaign
Video	5/20/2020	BeHealth™ | Hello Fresno
Social Media	5/22/2020	BeHealth™ | Fresno : Tiffany White
Event	5/27/2020	BeHealth LEARN
Social Media	5/28/2020	BeHealth™ | Fresno : Kylene Hashimoto
Video	5/29/2020	BeHealth™ | Fresno : Robert Pimentel
Social Media	5/29/2020	BeHealth™ | Fresno : Robert Pimentel
Video	5/29/2020	BeHealth™ | Fresno : Kylene Hashimoto
Social Media	5/29/2020	BeHealth™ | Fresno : Kylene Hashimoto
Video	5/29/2020	BeHealth™ | Fresno : Tiffany White
Social Media	5/31/2020	BeHealth™ | Fresno : Robert Pimentel
Social Media	6/2/2020	BeHealth™ | Fresno Advertisement
Social Media	6/2/2020	BeHealth™ | Fresno Advertisement
Event	6/4/2020	BeHealth LEARN
Social Media	6/10/2020	BeHealth™ | Fresno Advertisement
Social Media	6/18/2020	BeHealth™ | Fresno Advertisement
Social Media	12/8/2020	BeHealth™ | Fresno : WORK Advertisement
Event	1/23/2021	BeHealth WORK

Social Media	1/26/2021	BeHealth™ | Fresno : WORK Promo
Event	6/6/2021	BeHealth PRESENT
	6/6/2021	ePoint Review: Discovery Mood & Anxiety Program
	6-6-2021	ePoint Review: Alpha Behavioral Counseling Center
Website	6/21/2021	BeHealth™ | Fresno : ePoint added to Big Ideas



Appendix D: Event Overview / Agenda

- BeHealth™ LEARN Agenda
- BeHealth™ WORK Presentation
- BeHealth™ PRESENT Agenda

Appendix D – BIPOC LGBTQ Summary Memo and Training PowerPoint

Innovation-Community Planning Process Plan
Exploration of LGBTQ+ Intersectionality and Responsive Care
Mini-Project Brief

In the past few years Fresno County Department of Behavioral Health has worked to ensure inclusion and culturally appropriate care and services for its vulnerable, underserved, and inappropriately served populations.

This project is one of many through the County' approved Innovation Plan for Community Planning Process to help identify through stakeholder engagement opportunities for learning. In this case DBH will seek to use some of the community planning to examine if there is an opportunity to improve the behavioral health equity for our LGBTQ communities in Fresno County.

While there have been efforts to improve care for our LGBTQ members through training, outreach, and a sub-committee dedicated to promoting equity for the LGBTQ+ community, the efforts have not factored nor examined the intersectionality of some LGBGTQ Populations. Black, Indigenous, and Persons of Color (BIPOC) who identify as LGBTQ often have additional challenges including lack of support, acceptance, and access to appropriate care.

Fresno County has limited services and community organizations with capacity to render culturally responsive clinical care for LGBTQ populations. Community organizations who target BIPOC LGBTQ and specifically African American LGBTQ are non-existent at this time.

Our observation of many trainings and approaches to providing responsive care for LGBTQ populations often ignore or minimize the experiences of African Americans who identify as LGBTQ+. There is a lack of appropriate training to effectively support African American LGBTQ in a clinical setting. Many of the trainings, guidelines, and tips for LGBTQ clinical care do not focus on the intersectionality of LGBTQ+ and often less for African American LGBTQ+. If and when trainings, guidelines and tips do focus on this underserved population they are based on communities where there is a great number of LGBTQ+ resources and resources for those with the intersectionalities. In Fresno, these types of community resources are lacking which make appropriate care challenging.

DBH is seeking to survey existing providers who serve LGBTQ communities to identify how many providers exist who focus on culturally responsive services, as well as what their training and/or experience in providing services to BIPOC LGBTQ+ communities in Fresno County. Secondly, DBH seeks to provide training to assist providers and practitioners in our system of care to better understand the specific needs of BIPOC LGBTQ, and really the intersectionality and need for a specific approach. Applying general care designed for LGBTQ populations does not always correlate to effective care for BIPOC LGBTQ. This is even more of a challenge for BIPOC LGBTQ youth.

The surveying of contracted and non-contracted providers who identify as providers specializing with LGBTQ will allow for assessment of resources and the evaluation of cultural responsiveness will allow for portion of a need's assessment.

The survey and interview will review both provider directory and other listings to review what providers specialize in working with LGBTQ+ populations. Then each of those providers shall be contacted directly to participate in a survey or interview which will seek to identify:

1. Do your practice services include LGBTQ persons, or do they specialize in serving LGBTQ+?

2. Of those whom they serve, who identify as LGBTQ, about how many do identify as BIPOC?
3. What training have they received to provide behavioral health services to LGBTQ populations.
4. How do they serve LGBTQ BIPOC persons? Have they received any specialized training for working with BIPOC LGBTQ, and if so what?
5. What have they seen as barriers to care for BIPOC LGBTQ persons?

This type of review locally can help inform what if any needs may exist, gaps and/or barriers.

For the second phase of this project DBH will work in collaboration with Dr. Ebony Williams to develop and design a specific training for Fresno County that will address the intersectionality of BIPOC LGBTQ+ populations, how to best serve those populations locally, better engage for appropriate care, and be effective supporting an often underserved inappropriately served and vulnerable population. The training seeks to address statistical disparities related to age and accessing health services/various supports, use/abuse of substances, trauma and violence, and suicide for BIPOC LGBTQ populations.

The training will serve up to 25 individuals per session. DBH intends to facilitate two sessions for up to 50 people. It will also record the training (with an additional cost), so it may be used in the future through Relias for training of other providers/practitioners on the specific topic of intersectionalities of BIPOC LGBTQ+ communities. The participants will consist of some DBH direct services staff and contracted providers in our system of care. This training is geared for clinicians, case managers, peers support and other direct services providers in our system of care.

The Training will include strategy implementation and follow up of participants. These will be determined with input and direction from Staff Development.

This effort shall assist Fresno County and its system of care in several ways. Upon better informing workforce members on the intersectionalities of BIPOC LGBTQ+, the Department can then gather information on potential program or services needs and gaps for BIPOC LGBTQ+ populations. This process will help assess if training can best address the challenge of inappropriately served persons or if there is a need for specific programming. In order to explore such needs and topics, the workforce members would need to understand the different needs and how to provide more responsive care for BIPOC LBGTQ+, so to provide input based on training and knowledge rather than conjecture.

- The training will provide much needed insights so the Department may provide culturally appropriate care to an inappropriately and underserved populations.
- In addition to improved quality of care DBH hopes training professionals, providing them with necessary information for BIPOC LGBTQ, can then provide a more informed response to our inquiry on their perspective on service needs, capacity issues, and ability to effectively provide services, etc.

The insights may be obtained through a post training survey of all the participants who completed the two rounds of training. Additionally, if a follow up session is included additional information and experience may be obtained at that time as well. These questions would be included in the training, to ensure completion by participants.

DBH anticipates using survey questions similar to the ones below for subject exploration.

Innovation-Community Planning Process Plan

Exploration of LGBTQ+ Intersectionality and Responsive Care

Mini-Project Brief

1. Prior to receiving information through this training and information obtained from this training did you feel or know there was a need for a different approach for working with BIPOC LGBTQ than non-BIPOC LGBTQ?
2. Based on what you have learned in the training, do you feel there is a need to alter your approach for BIPOC LGBT+ persons served?
3. Based on the training received do you estimate a need for BIPOC-LGBTQ population specific services?
    a. Is there a need for services based on specific intersectionality (own programs)?
    b. Can the BIPOC LGBTQ be served in existing programs with more training?
4. How viable is it to have a BIPOC LGBTQ program at this time? Based on the following factors.
    a. What do you estimate are the number of BIPOC-LGBTQ persons in care?
    b. Are there already providers who have capacity to meet the needs of the community?
    c. Are there sufficiently trained providers to provide population specific clinical services?
    d. What are resources that could fund such services?
5. How can BIPOC LGBTQ be better served in our system of care?

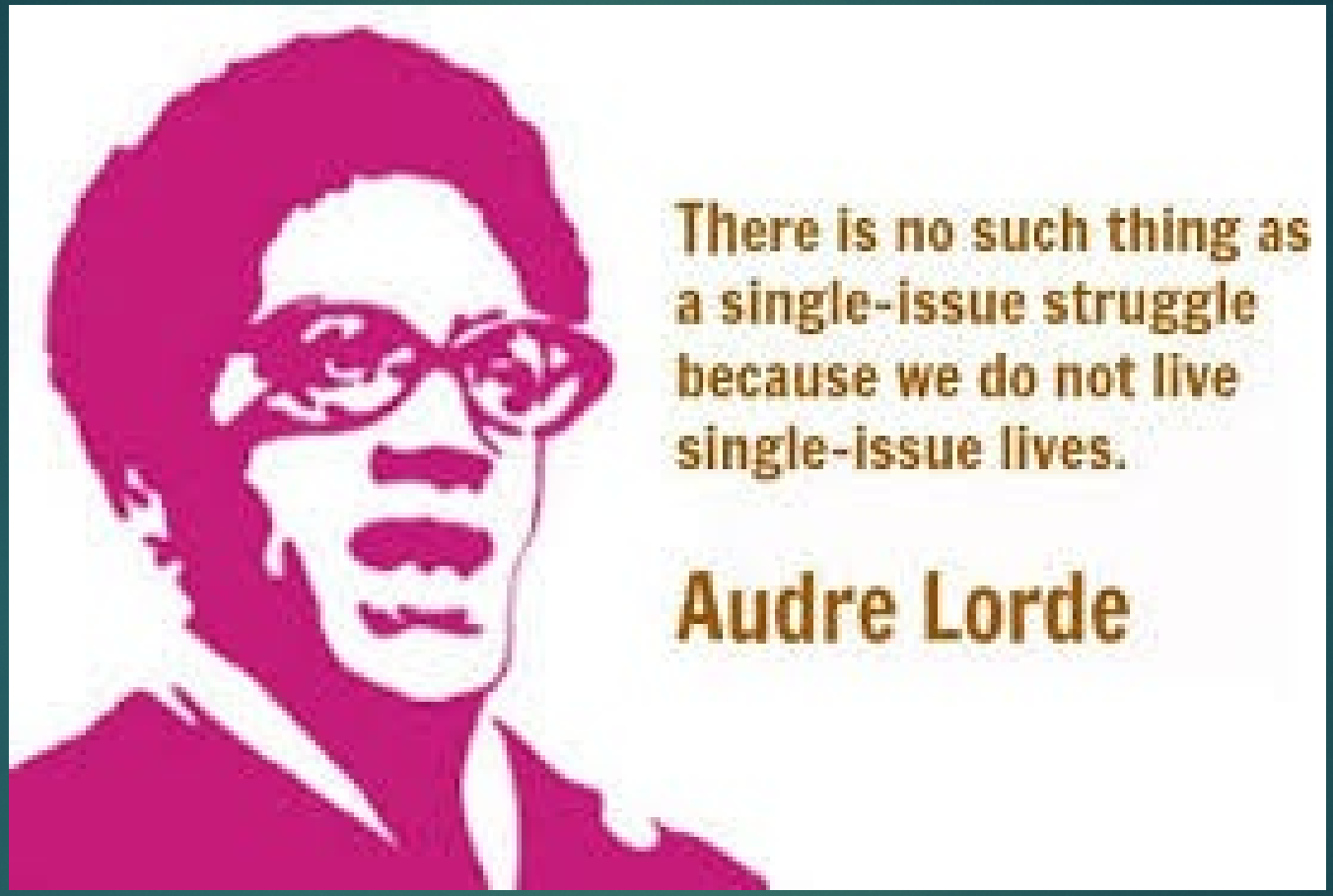
These insights and findings based on a local needs' assessment/or GAP assessment and greater understanding of the subject will then be used by DBH to explore options for possible Innovation funded services, or pilots. The exploration of current services, populations in addition to also seeking input from informed and trained providers in the system of care can provide the input necessary to examine if there is a need for services or training, or access navigation.

This project, both the assessment and training will be part of the larger Innovation Community Planning Process, using funding from DBH's Inn CPP plan. This project will help identify if there are opportunities for improving health disparities and health equity in our system of care.

Best Practices for Serving QTBIPOC Communities

Advanced Integrative Services, Inc.

Ebony M. Williams, Psy.D.
drwilliams1055@gmail.com


There is no such thing as a single-issue struggle because we do not live single-issue lives.
Audre Lorde

Aspects to consider…

- Role of religion
- Experience of prejudice or discrimination
- Circumstances around migration and immigration status
- Acculturation and assimilation
- Past/Current SES
- Family structure and roles
- Gender-Related issues and roles
- Co-existing diagnoses
- Educational attainment
- Language
- Identity development

Intersectionality

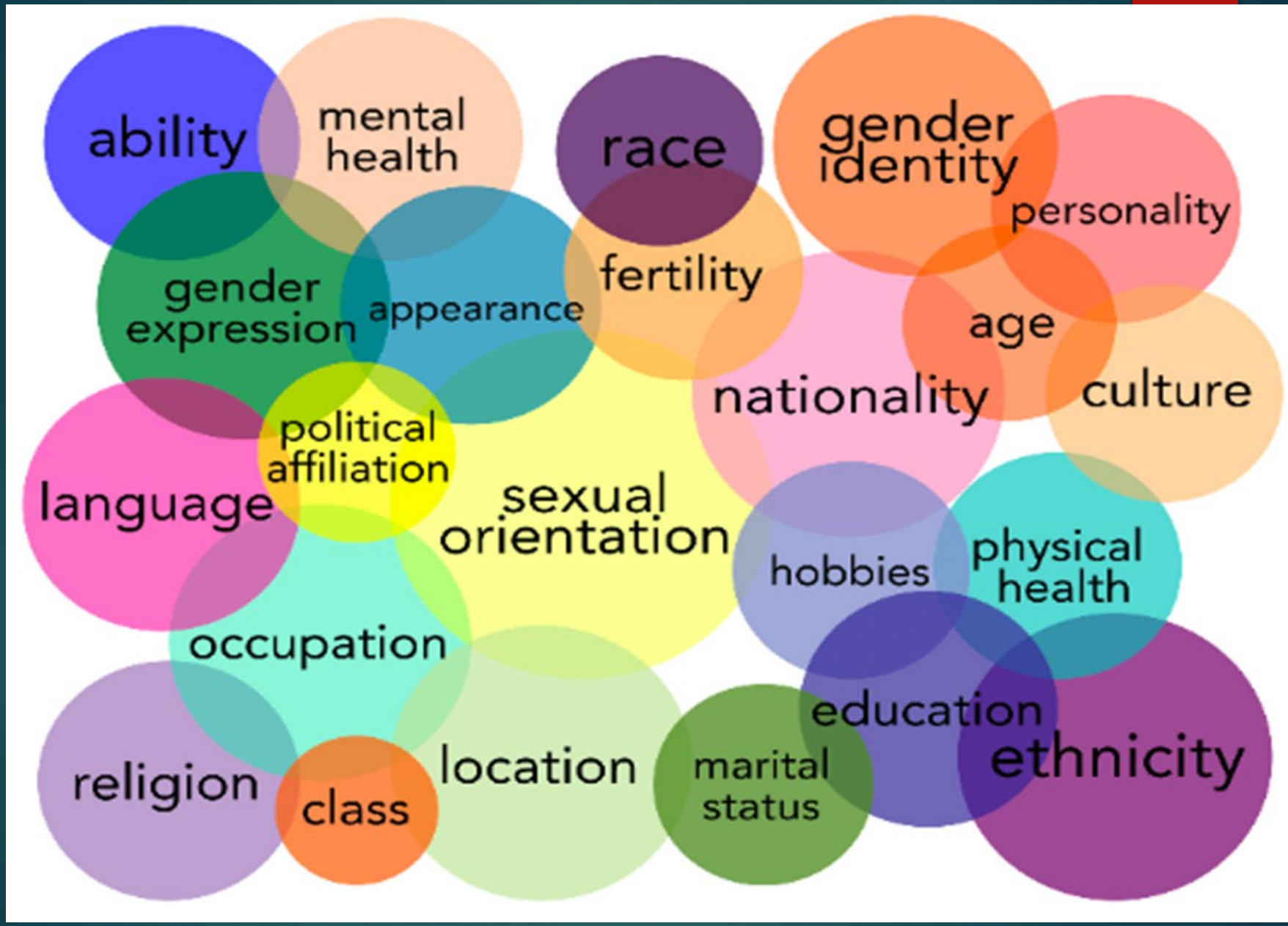
- The interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage

- The complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, heterosexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups

Intersecting Identities

- Because LGBTQ individuals are so diverse, it is important practitioners recognize the influence and impact of multiple identities and multiple oppressions.
- This is particularly true for those working with LGBTQ people of color.
- Focusing on only one identity can cause the therapist to neglect the struggles and challenges of those who have multiple and intersecting identities

(Fukuyama & Ferguson, 2000)


ability
mental health
race
gender identity
personality
gender expression
appearance
fertility
age
nationality
culture
political affiliation
language
sexual orientation
hobbies
physical health
occupation
education
ethnicity
religion
class
location
marital status

The Urgency of Intersectionality

- https://youtu.be/X5H80Nhmn20

Minority Stress Model (Meyer, 2003)

The model describes stress processes, including experiences of prejudice, expectations of rejection, hiding, concealing, internalized homophobia and ameliorative coping processes.

Questions:

- What are your intersections?
- Are there some categories/identifications you identify with more than others?
- How have these categories/identifications been experienced personally and professionally?

Seeking Cultural Proficiency

"Self-awareness of one's internal heterosexism or homophobia is the critical first step toward cultural competence."

(Van Den Bergh and Crisp, 2004)

Seeking Cultural Proficiency

Achieving competency includes:

- Acquiring accurate and scientifically valid knowledge regarding the unique needs, challenges, and issues of LGBTQ communities and individual members (Bieschke, et al., 2000; Hunter & Hickerson, 2003; Reynolds & Hanjorgiris, 2000)
- Professionals must also educate themselves regarding the stigma, discrimination and oppression these populations endure (Kulkin, et al., 2000)
- Novices in the field need to seek supervision or consultation on a regular basis from those professionals who have the necessary knowledge and experience working with LGBTQ clients (Hunter & Hickerson, 2003)

Seeking Cultural Proficiency

- Professionals should also honor the experiences of each individual LGBTQ client, learning that every person also has their own unique story to tell (Hunter & Hickerson, 2003).

- When working with LGBTQ individuals, professionals should not overly attribute a client's issues to their LGBTQ status, nor should their LGBTQ identity be dismissed or ignored (Matthews & Selvidge, 2005; Morrow, 2000; Van Den Bergh & Crisp, 2004).

"Do No Harm"

Harm may be caused through well-meaning, though detrimental actions due to:

- **lack of education**
- **lack of adequate supervision**
- **heterosexist ideology**
- **firmly held religious beliefs or, a combination of any of these**

Crisp, 2006; R.-J.Green, 2000, 2004; Guthrie, 2006; Hunter & Hickerson, 2003; Morrow, 2000; Twist, et al., 2006; Van Den Bergh & Crisp, 2004; Van Voorhis & Wagner, 2002).

LGBTQQIAA Symbols

All symbols researched:

Lambda.org

LGBTQ Basic Terms

Language Continues to Evolve

- The language used to refer to sexuality and gender is constantly changing, and preferred terms vary by age group, ethnicity, geographic region, and other factors.
- Clients appreciate health care professionals' efforts to be inclusive and culturally competent. This includes a willingness to adopt and use appropriate terminology when delivering services to their community.
- If clients use a term you don't know, ask ***them*** what they mean when ***they*** use it.

Terms

- Sex
- Gender
- Sexual Identity
- Gender Identity
- Gender Expression
- Intersex
- Sexual Orientation

Terms and Definitions Specific to Sexual Orientation

- Bisexual
- Gay
- Lesbian
- Heterosexual
- MSM
- WSW
- Queer
- Asexual
- Pansexual
- Omnisexual

Can Sexual Orientation be Changed?

- While there is no scientific evidence that these efforts are effective, ***there is evidence that they are harmful psychologically, socially and spiritually***

Efforts to change someone's sexual orientation in youth or adulthood are opposed by:

- the American Medical Association
- the American Psychiatric Association
- the American Psychological Association
- the National Association of Social Workers
- Many other professional organizations
- LGBT community organizations and leaders

Can Gender Identity be Changed?

Efforts to change gender identity are **no more effective** than efforts to change sexual orientation: instead of helping, they can cause lasting harm.

Terms and Definitions Specific to Gender Expression

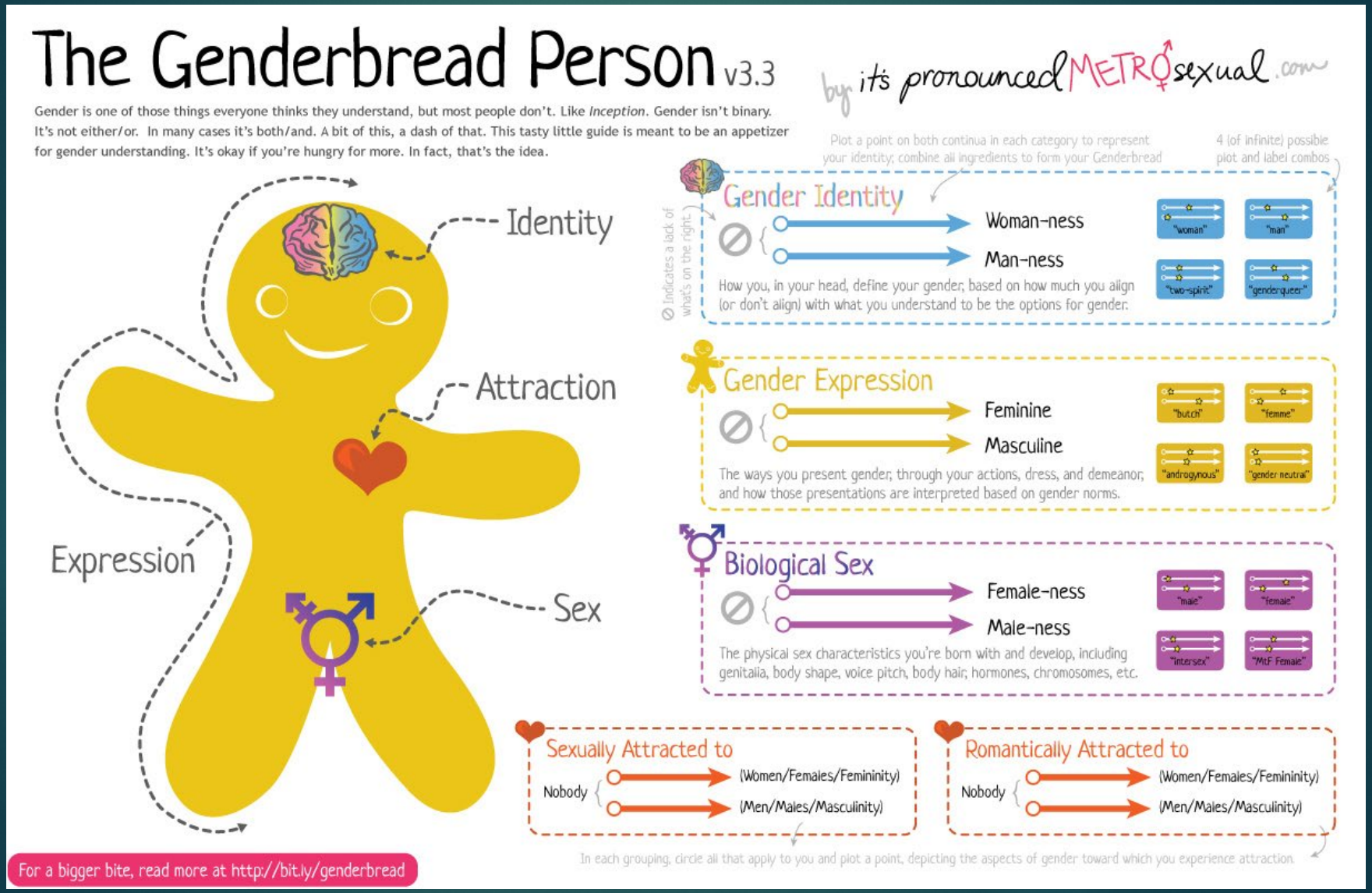
- **Transition** refers to a term used to describe the period during which an individual who identifies as transgender begins to express their gender identity.
  - During transition, a person may change their name, take hormones, have surgery, and/or change legal documents
    - **Not all individuals find it necessary to complete their transition with surgery or a combination of any of the above in order to identify as transgender.**

Gender Expression

- **Gender expression does not predict sexual identity:**
  - masculine women can be straight
  - feminine women can be lesbian or bisexual
  - masculine men can be gay or bisexual
  - feminine men can be straight

- **Gender non-conforming people, regardless of their sexual or gender identity are at risk to experience more**
  - harassment and bullying,
  - anti-gay discrimination, and
  - hate-crime violence including murder

“Genderbread” Person…



LGBTQ Terminology

2010, Gay and Lesbian Alliance Against Defamation, Inc.

Terms to Avoid

- "homosexual"
- "homosexual relationship"
- "sexual preference"
- "gay lifestyle" or "homosexual lifestyle"

Terms Preferred

- "gay, gay man, lesbian, gay person/people"
- "relationship"
- "sexual orientation" or "orientation"
- "gay lives" or "gay and lesbian lives"

Appropriate Terms Used

- **Lesbian, gay, bisexual, and transgender (LGBT)** are terms of the communities' own choosing.
  - **BIPOC LGBTQIA+**
  - **LGBTQQDIPA**
  - **LGBTQQIAA**
  - **"Two Spirit"** (among many Native American individuals)
  - **"Genderqueer"** or **"queer"** (among many youth)
  - **QTBIPOC** (Queer, Trans, Black, Brown, Indigenous People of Color)

Pronouns (Black Emotional Mental Health Collective, 2022)

- Referring to people by the pronouns they determine for themselves is basic to human dignity.
- Being referred to by the wrong pronouns particularly affects transgender and gender nonconforming people.
- As with all languages, the communities that utilize these and other words may have different meanings and reasons for using different terminology within different groups.

Pronouns (Black Emotional Mental Health Collective, 2022)

- **Quick Pronoun Glossary**

- ne/nem
- xe/xem
- they/them
- she/her
- he/him
- e/zir
- ze/hir
- ey/em
- ve/ver

Pronouns

(Black Emotional Mental Health Collective, 2022)

Ways to ask about pronouns:

- "Sorry, I forgot to ask. I use they/them/theirs pronouns, how about you?"
- "Can you remind me which pronouns you use?"

Ways to greet:

- "Hello Friends"
- "Hello constituents"
- "Hello Folx"

Is (Homo)Sexuality A Choice?

Is (Homo)Sexuality A Choice?

Historically, there have been three basic positions in this discussion:

1. the cause is biological
2. the cause is environmental
3. both biological and environmental causes are the source

(Ellis & Symonds, 1897; Gibson, 1997; Kennedy, 1997; Nicolosi & Nicolosi, 2002; Rothblum, 2000; Sullivan, 2003; Wikholm, 1999)

There's also a presumption that heterosexuality is the normative and therefore natural sexual orientation (Long & Lindsey, 2004)

In addition, there is the supposition that heterosexuality and homosexuality are opposites, rather than "variations on a single theme of human romantic attachments, sexual attraction, and the capacity for love" (R.-J.Green, 2004, p.xiv).

"…One of the biggest problems for the trans community is that transgender appears in the DSM as sexual identity disorder. That really causes problems. Every time I've gotten counseling for depression and anxiety, they call it being transgender. For me, anxiety and depression come from not being accepted in society—it's not an issue of mental illness."

Barriers to Care for LGBT People

- Limited Access
- Negative Experiences
- Lack of Knowledge
- Common Health Issues Among LGBT People

Strategies for Health Care Staff

- Expectations
- Practical Thinking
- Communication Basics
- Pronouns and Preferred Names
- Understand Diversity and Fluidity of Expression
- Practicing Making LGBT People Comfortable
- Maintaining a Non-Judgmental Attitude
- Create an Environment of Accountability
- Avoid Asking Unnecessary Questions
  - **"Is my question necessary for the patient's care, or am I asking it for my own curiosity?"** Instead,
  - **"What do I know? What do I need to know? How can I ask for the information I need to know in a sensitive way?"**

Intersectional Conversations: Prepare Yourself (Trevor Project, 2022)

To anchor yourself going into these discussions, consider these questions:

- What is your **motivation** for having the conversation?
- What is your degree of **comfort** with talking about race, police brutality, and white supremacy?
- What research might help you in communicating your viewpoint?
- What are your **assumptions** about the other person's understanding?

Intersectional Conversations: Prepare Yourself (Trevor Project, 2022)

To anchor yourself going into these discussions, consider these questions:

- What **environment** and time do you think will be the safest to ask someone to engage in a conversation with you?
- What are the **ground rules** for the conversation?
- What is your **plan** if the conversation reaches a point where you no longer feel safe?
- Do you need help **organizing your thoughts?**

Ways to Maintain Authentic Allyship (Trevor Project, 2022)

For non-QTBIPOC individuals:

- Do your research.
- Get uncomfortable.
- Hold yourself accountable.
- Listen.
- Take Action.

Gay Affirmative Practice (GAP)

Six major themes of the GAP model are in the following framework:

Attitudes

- 1. Same gender sexual desires and behaviors are viewed as a normal variation in human sexuality.
- 2. The adoption of a GLBT [*sic*] identity is a positive outcome of any process in which an individual is developing a sexual identity.

Knowledge

- 3. Service providers should not automatically assume that a client is heterosexual.
- 4. Important to understand the coming out process and its variations.

Skills

- 5. Practitioners deal with their own heterosexual bias and homophobia.
- 6. When assessing a client, practitioners should not automatically assume that the individual is heterosexual.

"Relying on deviation from the norm as the definer of dysfunction raises questions of how much gender conformity is enough and how much gender nonconformity is too much—and who will be the arbiters of normal versus pathological gender expression."

(Brownlie, 2006)

Questions?

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BEST PRACTICES - TRAINING

for Serving **QTBIPOC Communities** of Fresno County

THURSDAY, JUNE 29TH
8:30 AM - 12:30 PM

IN PERSON TRAINING
Health & Wellness Center
1925 E. Dakota Ave.
Fresno, CA 93726

SUMMARY OF COURSE CONTENT
Helping to equip direct service providers to improve equity and responsiveness of services for the members of the both the LGBTQ+ and BIPOC Communities.

LEARNING OBJECTIVES

- To introduce QTBIPOC statistics and intersectionality within a QTBIPOC lens.
- To explore implicit bias and microaggressions, and health inequities and their impact on QTBIPOC individuals and communities.
- To introduce and process cultural humility and strategies for implementation with a focus on social justice and equity balancing.
- To introduce and review Gay Affirmative Practice (GAP).
- To gain deeper understanding for the need to possess appropriate cultural and cross cultural responsiveness when providing equitable, safe, and effective services.

CEs Pending

Ebony M. Williams, Psy.D

Registration Required - Space is Limited
Register: dhorn@fresnocountyca.gov

Intended Audience - this course was developed specifically to support Fresno County's QTBIPOC communities and behavioral health direct service providers In Fresno county.

Department of Behavioral Health

Appendix E – Mental Wellness of any public Memo or Survey completed

Presents

Mental Wealth Series (6 Sessions)

For African American Parents, Professionals, and Community Providers

Monday, May 24, 2021

Time: 5:30 – 7:00 pm

"**E**xamining Psychological Distress & Mental Illness**," Session #2**

Presenter: Dr. Tonya Armstrong, Founder & CEO, The Armstrong Center For Hope, Durham, NC

Space is limited! Register Now:
https://us02web.zoom.us/meeting/register/tZUvcOysqDotGdKAo0d1TNlB877MGaCeetdG

Register to receive a confirmation email containing information with the link to join the meeting.

Q & A Session and Raffle Prizes Included!

For more information contact Dr. Karen Crozier at drcrozierwfcc@gmail.com or 909-215-8722.

Event partners are Fresno County Department of Behavioral Health and Gaston Middle School

County of Fresno

DEPARTMENT OF BEHAVIORAL HEALTH
Dawan Utecht
Director

Inter-Office Memorandum

DATE: July 8, 2020
TO: Dawan Utecht, Director
FROM: Ahmad Bahrami, Division Manager/Ethnic Services Manager
Tiffany White, Diversity Services Coordinator
CC: Behavioral Health Executive Team
Erinn Reinbolt, MHSA Coordinator

SUBJECT: African American Faith Based Mental Health Promotion Using The Innovation Community Planning Process Plan

Purpose

The book Community Mental Health Engagement with Racially Diverse Populations was explored for similar considerations for Fresno populations. This review of the literature resulted in an idea that can support new program development dialog with underserved and inappropriately served communities, that would bring cross sector partners into a process.

The Department of Behavioral Health (DBH) has an Innovation Plan that allows for funding of activities related to Community Planning Process. On average DBH has $150,000 a year to spend on these efforts. In the past the Plan has been used to conduct feedback and social market research on targeted populations, development of youth projects by youth using human centered design.

Now, we would like to explore the possibility of performing a similar project that uses a Community Based Participatory Research approach with model detailed in the text as a means to initiate dialog with our local African American community around mental health, use that engagement to inform the community about mental health, address underserving African American communities and perceptions toward those systems that have provided mental health services so that then meaningful discussions can then be held to discuss the needs of the local community and have direct input and participation in planning and developing programs or services for the African American Community.

The goal of the Faith-based mental health promotion was strategic partnership development of a Black faith community to address 1.) Underrepresentation of marginalized groups in research studies; 2.) Treatment efficacy for Black, Indigenous and Persons of Color (BIPOC); 3.) and general health disparities. To achieve these goals a Community-Based Participatory Research (CBPR) approach was used. The CBPR approach recognizes the community as an entity with its own strengths and resources, allowing for a multi-tiered approach to address disparities when combined with research efforts. The centrality of faith-based organizations in African American culture made Faith Based Health Promotion (FBHP) in a community-centered approach makes CBPR the most appropriate. Black faith institutions, that are faith-based organizations that are both African American controlled and populated, have been a more appropriate setting to address health inequities than dominant settings. Past research has indicated that FBHP have been a source of mental health support for African Americans. In some instances, clergy have been mental health first responders where other resources have been underutilized by this population. Faith and organizations in the African American Community will be the focus.

As DBH has been exploring some similar possibilities of working through local faith-based organizations for engagement with local Black populations the research and model may prove to be useful in those efforts. The study that was reviewed provides some models for consideration.

Background/Overview

CBPR partnership model in the reviewed project utilized the following stakeholders:

1. Organizational representatives (Several Local Churches)
2. Members of the community (Concerns and considerations)
    i. Primary Investigator (PI)-
3. Academics (research expertise)
    i. Primary Investigator

The overarching goal of the CBPR model was to build a partnership between University partners and a local Black faith church to develop and assess, community-led stigma reduction interventions for members of the community. This can be adapted to still include the academics, but to focus on building partnerships between DBH and Black faith groups.

Methods

- **SpeakOut;** Speak Out was the primary intervention in the research study. SpeakOut Combines both faith-based practices including prayer, scripture readings, psychoeducation, and peer-based support that includes sharing personal experiences with mental illness. Each event included a single behavioral health topic discussion (PTSD, anxiety, addiction, etc.) and included local experts to lead the discussion on each topic.
- **Investigators:** The research included two University members and two community members who were IRB and human subjects trained in addition to 8 hours of mixed methods training to the community partners.

  Qualitative interview guide was developed by community investigators that asked 14-15 questions. Community partner researchers were also tasked with obtaining informed consent from participants. Community partners identified church leaders/members to participate in the interviews. Qualitative interviews were recorded and transcribed. Interviews asked participants to reflect on the SpeakOut intervention.

- **Data Analysis** in the form of thematic analysis of transcripts was conducted by the four trained investigators who met in dyads (each dyad consisted of 1 university member and 1 community member) via conference calls and ultimately the group met to create a master codebook with themes identified from interview transcripts.
- **Results-**The results of the survey indicated that the interventions were overall positive regarding the opportunity learn more about mental health and subsequent resources, participate in SpeakOut and share personal experiences of mental health, build external supports through the University, and stigma reduction. The most relevant theme of the interviews was the theme of the Church being a lighthouse by providing support, and a sense of hope, community, and guidance in times of need. The participatory component was well received by participants, as well as having external supports appearing to be comfortable and participating in the faith-based space.

Action Steps

DBH would need the following steps to conclude this project similarly to the SpeakOut. The following is a initial proposal to assist in the conceptualization, and to demonstrate the local assets and capacity for this project, but are in no way the sole option for consideration.

- Organizational representatives
    - DBH-Public Behavioral Health Division
- Community Leaders
    - Not elected per say, but community organizers, educational leaders, community advocates, etc.
- A local Faith Based Organization and subsequent Primary Investigator (PI)
    - PI – (ex. Elder of the church and retired educator, etc.)
- A local University interested in facilitating the research component
- Members of the community who are also experts on mental health related issues if possible, including LMFT/LSCW/Psychologists/Substance Abuse Counselors/Case Managers etc. Who can speak to various mental health and wellness issues? Some local experts and/or profession with community ties:

The presenters would be contingent based on identified topics and the number of sessions. There may be less a need if we focus on weekly vs bi-weekly gatherings. We can do weekly sessions and possibly combine PH every other week and bring some more general health topics in as well and/or things like social determinants of health?

Some of the Key Recommendations of the study will include:

- In order to establish a safe space and provide a strong sense of trust and connection by deliberately attempting to engage the community in a manner that respects the insight that they provide.
- Development of the partnerships between the faith-based organization, a local University, and DBH (organizational representatives) prior to the intervention process.
- If the relationship between DBH is not already organic with the faith-based organization, the development of the relationship by external investigators attending the faith-based organization services is encouraged.

- Identifying a Principle Investigator from each entity (academic and faith-based) who can meet weekly to communicate and document work that has been done.

We recommend using this project as one of the options for our INN CPP as a way to address institutional stigma in the community which can then lead to more open discussions about mental health and the local needs, which can then foster discussion and development of services that are for the community and developed with the community's input. This project would engage an underserved community and forge genuine relationships which can be used to develop other services and efforts (including more career pathways).

As we have discretion on how we use the INN CPP to explore options for community input, program ideas and opportunities to do this one-time effort modeling the SpeakOut. This effort does not require additional plans, or MHSOAC or BOS approval. SpeakOut would address engagement, underserving African Americans and create genuine input on services/or programs which can benefit the target populations. Its cross sector, so bring behavioral health, academic, and local faith communities together to have meaningful conversations around mental health.
This project may yield a formal advisory council who could be funded to do its own local needs assessments and help in development of culturally responsive population specific services.

Research

DBH staff communicated with the authors of the text and study. A similar effort with the project is being undertaken by the same Black faith communities in California as well as the Association of Black Psychologists. However, DBH is not seeking to conduct this work as a Innovation plan, but rather under an existing plan use this as one approach for community engagement necessary for any planning.

Funding/Financial Impact

Over the next four years, the department has to expend the remaining $600,000 of INN funds allocated to this plan for meaningful efforts for engagement, community input and planning to support considerations for INN and MHSA projects. Allocating $100,000 to this project for the

coming fiscal year would be in alignment with the plan and allow DBH to work to draw down the plans allocation.

Such a project would meet funding usage of those INN funds, can contribute to learning that can support future INN plans, but also other MHSA services and/or WET activities that have primary considerations and/or focus on local African American residents.

Next Steps

Formal approval of the concept, so we may begin initiating discussions for service agreements, procurement inquiring participation and availability from interested parties, plan and coordination of the effort.

The goal will be help increase the understanding of the public behavioral health system so to improve stakeholder input, advocacy and support in developing appropriate services. Developing and activating such a council may in itself be a Innovation project, to see how through local community empowerment can access and use of behavioral health services improve.

Appendix F – Market Research Group April 2022

DEPARTMENT of BEHAVIORAL HEALTH

Focus Group Research

Mental Health & Substance Use Services Feedback

Executive Report

April 27, 2022

Presented by JP Marketing

The Value of Focus Group Research

- Focus groups are a form of qualitative research that is commonly used in marketing and sociology research as they provide a broader range of information and deeper insights.
- A focus group is a carefully planned discussion of 6-12 people led by a moderator, designed to engage individuals and gather opinions on a defined topic.
- They allow for the collection of detailed information about personal and group feelings, perceptions and opinions, while saving time and money compared to individual interviews.
- Data collected from focus groups is typically in the form of transcripts, word clouds, narratives, and audio/video recordings.
- Focus group research ensures messaging that is created that is appealing and sensitive to target populations while avoiding assumptions.

STUDY OBJECTIVES

1. Garner insights and feedback from Fresno County on the services provided by the Fresno County Department of Behavioral Health
2. Gain understanding for what services Fresno County residents have the most awareness about from FCDBH
3. Get feedback on recently used ads and outreach
4. Specific suggestions and feedback on Mental Health and Substance Use Disorder services

STUDY APPROACH

1. Utilize 2022 budget dollars for research that will inform FCDBH
2. Identify recent outreach methods to test with audience for feedback
3. Generate a discussion guide to steer focus group conversations without curbing valuable tangents
4. Determine groups that represent Fresno County as well as groups that have not been targeted in previous focus group sessions

STUDY METHODOLOGY

- Utilize professional firm to recruit and screen 6-8 participants per group using approved screener
- Seating 5-7 participants per session
- Groups to be homogenous based on predetermined demographics to target including:
  - LGBT population
  - Young Adults 18-24
  - Parents with children 17 and under
  - Hispanic
  - Mental Health service familiarity
  - Substance Abuse Disorder service familiarity
- Provide incentive to participate to compensate for time ($80 gift card)
- Sessions conducted online via Zoom

STUDY LOGISTICS

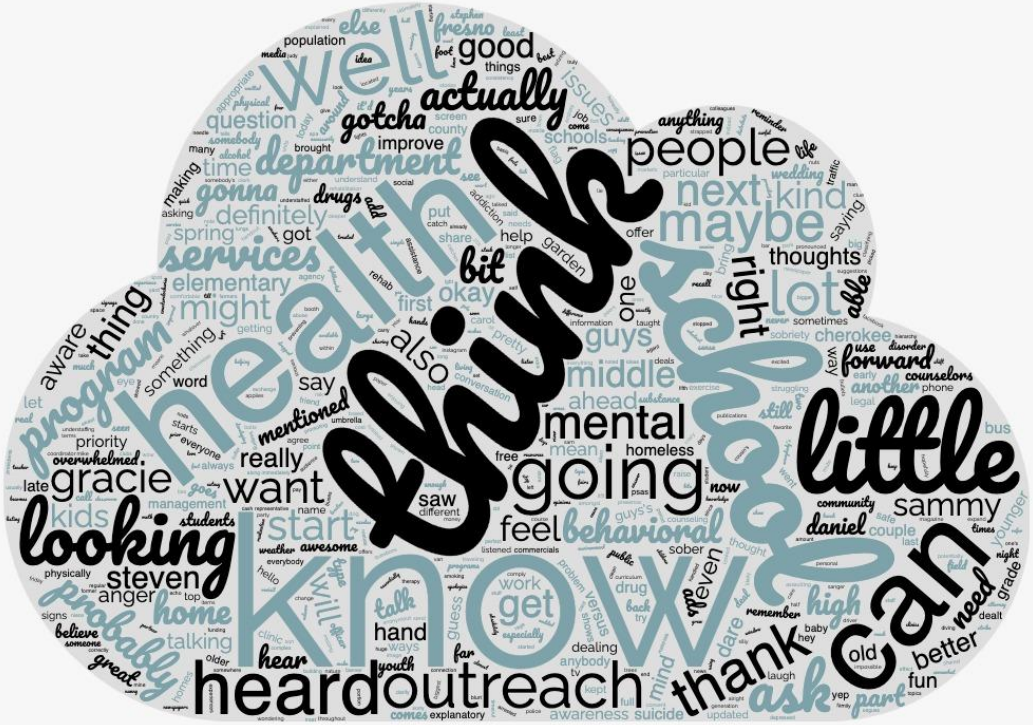
- Participant screening, recruitment and incentives handled by SIMI Marketing
- 2 groups screened and recruited with assistance of FCDBH for groups targeting those that have familiarity with their services
- 6 homogeneous focus groups were held between March 7, 2022 and April 22, 2022 with a total of 38 participants in attendance
- Experienced facilitators conducted the sessions: 4 by Kevin Gordy & 2 by Elida Avina
- All sessions were recorded and transcribed for reference and documentation

Overall Facilitator Observations

- There was a general consensus that more education was needed in the community about the specific programs DBH offers
- Education could begin as early as elementary school to get kids to discuss mental health and to also provide education that is shared with the household to further remove the stigma related to mental health
- Education related to substance abuse could begin also with youth but not as young as what was expected for mental health
- Substance abuse messaging is not as easy to understand when presented in medical jargon and should be adjusted to be more understandable and flesh out the negative effects substances can have on individuals

- Need to also provide more outreach to those in social proximity of individuals seeking services; both for the continued support of the individual and for their own support
- All groups agreed that the services provided are important and need to outreach to people that are not the stereotypical image people perceive when they think of those affected by substance abuse disorders
- For outreach, social media was a common theme to connect with the public but it was also recommended to provide physical outreach with clinics and schools
- More in-person community education events would also be recommended for further awareness

Group 1: LGBTQ Population



Key Insights

- Most people had not heard about the Department of Behavioral Health but some had through programs like “Exodus” or after discussing the services being offered
- For Mental Health services they felt the offices were overwhelmed and not able to help everyone to the degree they could
    - Suggested improvement: have more physical presence to promote services, e.g. schools or mobile units
- This group also addressed having a presence in areas that the LGBTQ community is located, e.g. nightlight access
- More free access to reduce harm
- Starting as young as elementary but also educating parents with tools to talk to kids

“I truly believe they're (DBH) overwhelmed is one of the biggest issues that are going on. Just not enough staffing, not enough resources, not enough to really meet the needs, I think it's really shown in the homeless population. ”

”Having a presence at clubs, I'll say that there are many people dealing with substance abuse, cocaine, addiction, Meth, heroin, opioids, and also party drugs”

Group 2: Young Adults 18-24

Key Insights

- This group had organic awareness is related to therapy and mental health services
- Agreed the DBH could reach out to students and parents earlier for educating them on services offered
- Need more awareness of programs in general via social media, tv news spotlights, commercials, etc.
- Re: substance abuse, noted that more education on the effects substances have on the body is needed
- Need more ongoing support even past their original seeking of help and resources targeting those closest to the individual needing help

"Learning more about the substances themselves and how they affect the human body and stuff and how they affect them; what effects they're having on us currently."

"Working with the wellness centers they have in colleges, I know a lot of them have Instagrams probably collaborating with them. Give, a flyer if you're seeking health or substance abuse."

Group 3: Parents/ Guardians with Children 17 and under

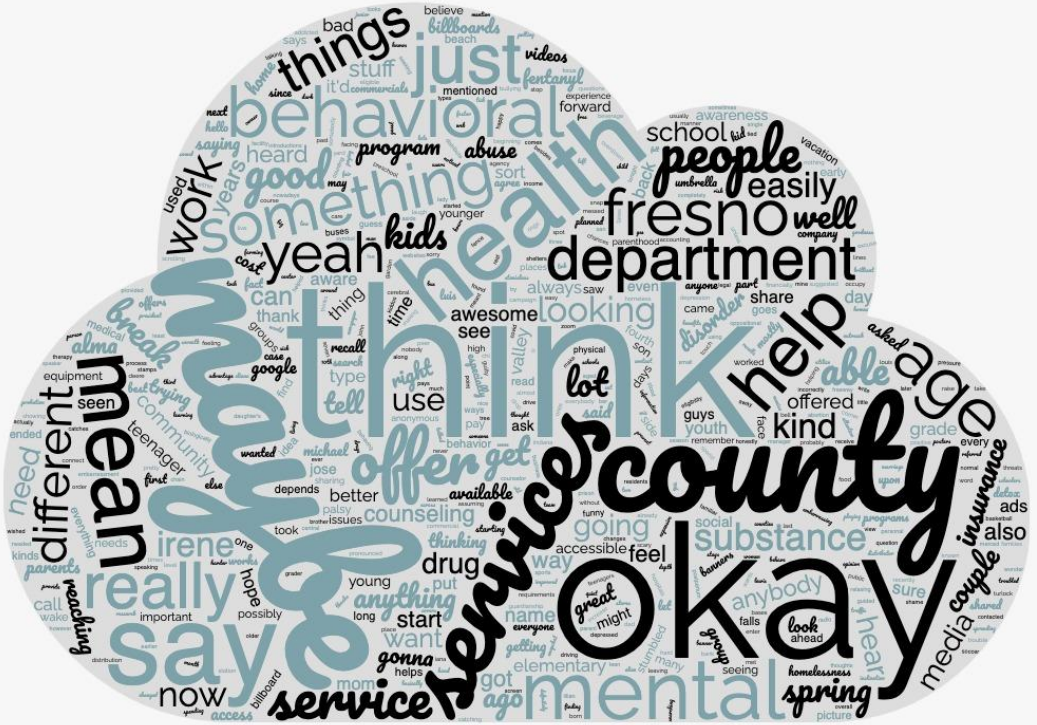
Key Insights

- This group had a lot more intimate familiarity with the services offered by DBH and especially related to suicide prevention services
- Parents had more awareness of youth programs e.g. runaway youth, suicide prevention, high school groups
- For mental health, noted that more support is needed overall; whether it be more employees, more normalization within schools, and outreach to kids at the same level D.A.R.E. was done in the past
- For substance abuse, want to see more support to help people use services as opposed to being charged with a crime and more support for people that work in these services since they note a lot of burn out from employees

"We have a lot of people that need this (but) everytime I hear about people needing counseling or something, there's always a wait list, like a long waitlist "

"If you look at Fresno County as a whole... children are not taught mental health skills, children are not taught coping skills, because, you know, either their parents don't know or their parents are not able to"

Group 4: Hispanic Population



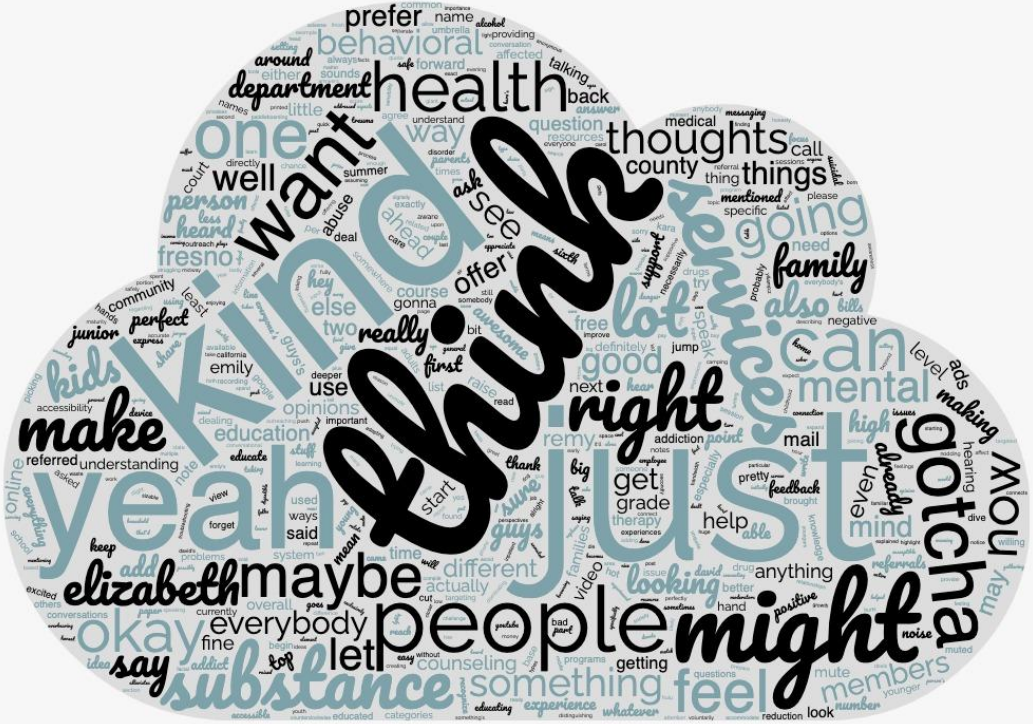
Key Insights

- This groups organic association with DBH was with counseling, support for kids, and mental health support
- Areas recommended to educate people on the services offered include: schools, school banners, social media, radio
- Agreed that younger kids need to be educated on ways to address their mental health
- For substance abuse, the conversation steered towards support for the homeless population and for providing more awareness to detox programs
    - Secondary audience was targeting kids in high school
- For awareness of substance abuse, noted that providing outreach in places that are available to teens like Planned Parenthood or school

"I'd say the younger, the better. Because as they get older, maybe they feel that, you know, since they never shared anything that maybe it's not good to share"

"I just think it's really needed (substance abuse services). With our high schoolers, especially you hear about the overdoses and the fentanyl and things like that. Again, awareness is something that's really important.."

Group 5: Individuals Familiar w/ Mental Health Services



Key Insights

- This groups familiarity knew about the services either through personal experience, family looking for services, and through Instagram
- This group had the most variety of services they believed the DBH provided to the public
- For both mental health and substance abuse, need to provide more physical resources at the time of recommendation and not just expecting people to look up information on their own
    - At doctors offices and schools
    - Everyone agreed to bring it up as young as elementary
    - Schools are an better place to reach people who may not be able to access these services physically
- Recommendation of providing service information alongside other public services, e.g. WIC

"It would help people to start somewhere if they were given a phone number or a handout (at hospitals)"

"Some of us come from a culture where are not allowed to feel sad and need to brush it off..."

"I live in the rural area and the access to these services is an issue"

Group 6: Individuals Familiar w/ Substance Abuse Services

Key Insights

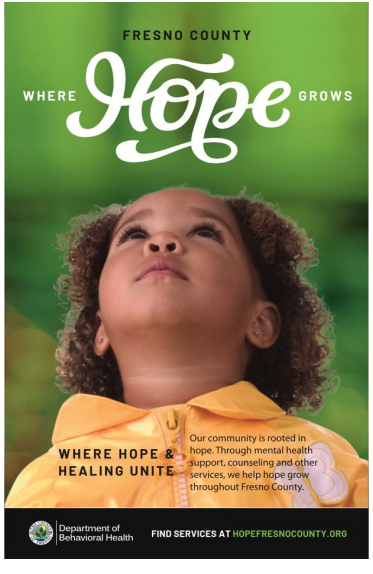
- This group had familiarity with the services used through experiences of family and themselves and were aware of many of the services offered by DBH
- Agreement on the subject of more education and outreach to younger audiences to talk about their mental health and tools for being mentally healthy that can extend to the household
- Need to address that outreach for substance abuse needs to be communicated in more understandable language
- Need more services for the families of people affected by substance abuse since they are also being impacted (especially kids)
- Noted that the success of programs is based on getting people to a point where they want to find treatments as opposed to forcing them to get treatment
    - Recommend providing more resources to people adjacent to those that need help to encourage them to seek it on their own

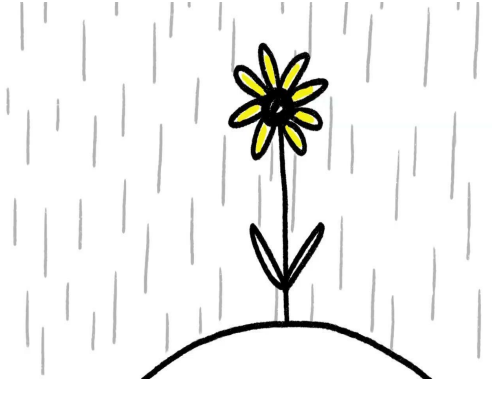
"I definitely agree with me making education more accessible. And, you know, getting kids educated about mental health as early as junior high..."

"I don't see any reason why first graders can't be learning about their mental health. Of course, it'll be different for each grade level. But I think young people, especially in Fresno County, have experienced a lot of what we call adverse childhood experiences..., learning about mental health can be really valuable."

"(Re: Substance Abuse) But I've heard a lot of like, big medical terms ... I'm not familiar with like the names or the side effects."

Tested Outreach





Organic Message Recall

- Some groups recalled message outreach related to the harms of vaping and the fentanyl advertisements
- The green “Hope” campaign had some familiarity with the color
- Most recall came in the form of commercials or a vague familiarity of the message, not the specifics
- Overall, groups had minimal recall of outreach messages but once they saw some of the messages they would recall vaguely that they had seen them somewhere

Message Feedback

- The overall favorite outreach message was the flower video noting that it was sympathetic but also informative
- The ad with the message “For every person, every family, every community” was also well received because it was very informative
- The billboard and “hope” poster were not as well received noting that it was difficult to find the website url or contact information and those should be made more prominent
- The consensus with all the printed ads was to make sure the message is straight to the point and that the contact information is easy to find

Conclusions

1. All groups agree that education can begin younger and be more consistent throughout kids as young as elementary school to be educated on Mental Health services
2. Substance Abuse Disorder services can also be shared with kids as young as middle school
3. Encourage communication at home and overall awareness of the specific services offered by the County

APPENDIX

- Transcripts
- Video Recordings

Appendix G – African American Participatory Action Research

Jewel of JUSTICE
WOMEN'S PERSONAL & PROFESSIONAL DEVELOPMENT

Black Life, Health, and Wellness

REGISTER TODAY

KAREN@JEWELOFJUSTICE.COM OR 559-931-1953

This initiative is being funded by the Fresno County Department of Behavioral Health

PURPOSE

"For Black people, of all ages, to explore needs and create change around health and wellness"

Tuesday, June 13 2023

5:00 p.m. - 8:00 p.m

In-Person (Legacy Commons)
2255 S. Plumas Street, Fresno, CA 93706

FOOD & RAFFLE PRIZE | FAMILIES ARE WELCOME | BRING SOMEONE

FOR MORE INFORMATION, CONTACT US AT KAREN@JEWELOFJUSTICE.COM OR 559-931-1953

County of Fresno
DEPARTMENT OF BEHAVIORAL HEALTH
SUSAN L. HOLT, LMFT
DIRECTOR/PUBLIC GUARDIAN

Inter-Office Memorandum
DATE: August 17, 2023
TO: Susan Holt, Director

FROM: Ahmad Bahrami, Division Manager
Dennis Horn, Diversity Services Coordinator
CC: DBH Leadership
Erinn Chan-Golston, MHSA Coordinator
Lisa Crossley, Staff Analyst-Innovations

SUBJECT: Update of African American Community Participatory Action Research

Purpose
To provide an update on the African American Community Participatory Action Research project, findings from the initial year, and what may be actional items to improve engagement, care, responsivity of services and to reduce health disparities.

Background/overview
The African American Community Participatory Action Research (AfrAm CPAR) is funded through our Innovation Community Planning Process Plan. This project seeks to improve community engagement with an underserved and ineffectively served community, specifically Fresno County's African American community. The CPAR creates a partnership with community organization to spearhead project. In this case, the partner is Jewel of Justice. Phase one (first year) of the project was to focus on community information, increasing mental health literacy so to inform work in phase two. Phase two entails the work of a taskforce created from participants in the first phase and other community members to identify, develop, or recommend opportunities to address specific behavioral health needs of Fresno County's African American communities, which may come from new programs, strategies, or initiatives that have been driven by the community, that will allow our system of care to address health disparities.
In phase two, the taskforce will have a budget to use to support its work, such as working with consultants for technical assistance, bringing on trainers, presenters, researchers, etc. who can support their efforts in identifying services or strategies by the African American community for the African American community while having learned about the system of care, public behavioral health, existing resources, etc. The goal is to determine if this taskforce and this CPAR can result in the development of a proposal for program, services, training, strategy that can be funded with Innovation funding.

Current Issue

No issue, update on the work so far and some things to be aware of so that they may be addressed in the future as part of DEI work and service improvement.
This project has a total of 11 months remaining. These efforts were initiated long before the legislative proposals for changes to the current Mental Health Services Act.

Research
The research and learning from this project is ongoing. This project also includes a independent evaluation component, which is being facilitated by Fresno State. Please see the attached evaluation. The evaluation is an opportunity for graduate students to experience and learn how to provide formal evaluation of public projects and initiatives such as this so to increase the number future workforce members who understand and can better perform evaluation.

Funding/Financial Impact
Project moved into its second and final year or phase two. This project will coincide with the end of funding for the INN CPP plan. As such there is no additional extension of options under this current funding/project.

Recommendations
Reviewing the document is important to help identify insights and impact of the AfrAm CPAR thus far. The report focuses on the key areas that note access and perceptions. As the program continues to move into its second phase, it is critical for us to identify opportunities for improvement, respond to the feedback, and develop efforts to address those gaps and/or barriers to wellness.

- *"Many of the participants in the intervention phase were aware of behavioral. health practices and utilized them. In addition, they expressed excitement about the work we were doing because it was needed although we struggled with how to access the number of people who were in need and to resource them for access to trustworthy providers and systems of support and care."*

- *African Americans would probably have an increased utilization of public behavioral health system if:*
  - *More providers were Black and African American*
  - *More of a relational and trust building focus during the intake process rather than a current high-volume paperwork and bureaucracy*
  - *Going into the home and community as and option for services*
  - *Resourcing and supporting known and trusted individuals and provider who are access to the people as a bridge.*
  - *Lack of capacity for small and emerging providers to be able to provide Medi-Cal services and thus are not able to become providers.*
- *Building on community learning to increase community mental health literacy.*
- *Perceptions and challenges of having care that is responsive to or design for them.*
- *Greater demand for providers who understand the community and their needs.*

A previous evaluation, which focused on current request for proposal process also raised some similar issues and concerns. Those included lack of providers, challenges to become a Medi-Cal provider and providers who are culturally responsive.

Action Needed
While allowing the AfrAm CPAR project to continue to move forward, the Department should consider examining opportunities to address some of the issues which were raised thus far. These include the following:

- Explore interventions and approaches that are more culturally responsive.
- Work on pathways that can develop diverse AfrAm staff in the system of care.
- Examine ways that CalAIM can be used to better support smaller and new CBOS, with a focus on equity in our system of care/provider network.

Next Steps
Roll these efforts and possible responses into existing DEI efforts, staff development, HR, hiring, managed care, etc**.**

Intervention Report and CPAR Design Meeting

May 30, 2023

I. Report for Intervention, Year 1 -
   a. This project focused on the behavioral health needs of African Americans and Black people in Fresno County in the areas of literacy, awareness, and utilization of public, private, and personal services. We focused on promoting the project to the specific sub-groups of African American and Black people in Fresno County although all were welcome to attend and participate. They were:
      Black Faith Communities and Leaders
      Black Students Grades 7-20 (School Sites and Group Homes) (7-12 no survey just sign-in information)
      Black Athletic Coaches, Mentors, Teams, and Families
      Black Professionals – (Hair Stylists, Barbers, Educators, Clinicians)
   b. The intent in year 1 was to build trusting relationships both internally and externally through the evaluation of a behavioral health intervention process. The intervention consisted of conversational and educational sessions on topics that were primarily chosen by Black community participants at the African Americans & Behavioral Health Launch Event. Additional topics were chosen by DBH. The topics engaged were: Bearing the Burden (Collaborative Agreed On and Led-Topic), Cultural Identity & Awareness (Black Professionals/Community-Led Topic), Mental Health 101 (DBH-led topic), The Public Behavioral Health System (DBH-led topic), Suicide Prevention and Intervention (DBH-led topic), Generational Trauma (Black Professionals/Community-Led Topic), Grief & Loss (Black Professionals/Community-Led Topic), Healing with the Arts (Black Professionals/Community-Led Topic with Black Woman-Led Art Non-Profit), Parenting While Black: 1 & 2 (Black Professionals/Community-Led Topic), Speaking Up & Out (Black Professionals/Community-Led Topic), Black College Students & Behavioral Health (Black Professionals/Community-Led Topic). We conducted both in-person and on-line 2-hour sessions in an attempt to increase participation and visibility of the project. The Department of Behavioral Health provided Black behavioral health professionals to lead sessions to help build relationships between the agency and Black and African American participants. We designed and implemented conversations and educational learning sessions as the two-way Intervention for both the Black and African American individual participants and the Department of Behavioral Health. In most instances, Black participants were both part of the community and the partnering agencies.

   c. Baseline Data: We gathered data from the participants through a survey that was designed and administered by the collaborative and elicited responses from participants who attended on their current or desired behavioral health practice.

There were two iterations of the survey instrument. We evaluated/assessed of the intervention sessions regarding the impact on the Black community's behavioral health awareness, literacy, and service utilization/facilitation of the intervention sessions. (Please see surveys.) We also requested data from the Department of Behavioral Health to identify and address (make recommendations) the barriers to utilization of behavioral health services, programs, and funds by African Americans. There is an overutilization of Black people in the SUD court referred services and an underutilization in the other services. Does this suggest that Black people can only get public behavioral health care when they are in custody of the court?

d. Anecdotal Observations, Outcomes and Experiences

The Stigma – In general, Black people and African Americans continue to experience medical and behavioral health institutions and practitioners as untrustworthy and lacking providers who represent them. Many of the participants in the intervention phase were aware of behavioral health practices and utilized them. In addition, they expressed excitement about the work we were doing because it was needed although we struggled with how to access the number of people who were in need and to resource them to get access to trustworthy providers and systems of support and care. Then, there seemed to be limited to no usage of the public behavioral health system by the intervention participants. For the few that did report usage, it was not a positive experience. From several intervention sessions, it was identified that Black people and African Americans would probably have an increased utilization of public behavioral health system if the following conditions were met: 1) more providers who were Black and African American, 2) more of a relational and trust building focus during the intake process rather than the current high volume of paper work and bureaucracy, 3) going into the homes and communities as an option of service, and 4) resourcing and supporting known and trusted individuals and providers who have access to the people to be a bridge. Even if these conditions were met, it still would be a struggle because we heard from a Black faith-based provider that they were informed not to work with the Department of Behavioral Health, and from a Black clinical provider that they will not work with the Department of Behavioral Health because the function of the agency is to recoup medi-cal dollars and not empower and support small, burgeoning providers who do not yet have the infrastructure to be a partner to have dollars returned for not servicing accordingly as designed by medi-cal. In closing, while the traditional stigma of being afraid to talk about behavioral health challenges is waning, the lingering effects are still there and county agencies must become more trustworthy.

Messaging (Research focus vs. community's immediate behavioral health needs/concerns/challenges -

Centering Moment –

Providing and Protecting a Black Space -

e. Survey Outcomes
f. What was learned
g. Next Steps
h. Anything else not mentioned?
i. How can we make reports to agencies beyond DBH such as Fresno State's Executive Leadership and Mental Health Task Force and CSU's Black Student Success Strategic Taskforce; other agencies could be First 5, EPU Assessment Center for Children, FHA, Department of Public Health,

Community Participatory Action Research (CPAR) Design Updates

I. Updated Proposed Area(s) of Inquiry
   A. Parenting/ed While Black: Exploring Family Dynamics in Behavioral Health Literacy, Awareness, Utilization, and Needs of African Americans
   B. Exploring Sickness and Weariness and Health and Wellness
   C. Exploring Barbers & Hair Stylists as Healers and Connectors
   D. Additional Areas of Inquiry of Interest
II. Design
   A. Self-Recordings with four to five selected questions to answer
   B. Selected 1:1 Interviews
   C. Ongoing Interventions & Surveys or Focus Groups (I do not think we have the capacity to do both)

Next Meeting – June 6, TBD

Evaluation of the Fresno County "**African American & Behavioral Health Community-Based Participatory Action Research (CBPAR)"** Project

Jewel of Justice: Dr. Karen Crozier, Garbralle Conroe, Kalisha Goodwin & Candace Mayo
California State University, Fresno: Dr. Travis W. Cronin, Dr. De Anna Reese, Dr. Reva. E. Sias, Dr. Cheryl A. Whittle, & Dr. Jenelle Pitt-Parker.

REPORT: Year 1

African American & Behavioral Health Community-Based Participatory Action Research (CBPAR)

Executive Summary

ABSTRACT

Prior to the approval of this project, the intervention representatives from Jewel of Justice (JOJ-a community advocate), the representatives from Fresno County Division of Behavioral Health: Equity Division (DBH-the funding source), and the cross-disciplinary evaluation representatives from California State University, Fresno (i. e., Fresno State's Departments of Africana Studies/History, Education, English, and Social Work) came together to collaborate. We met monthly to establish the scope of work (March through August of 2022). Once DBH had executed the contract with JOJ (June 2022), we began to discuss the kick-off event (September 24, 2022), and established a core team with representatives from each of the partners: JOJ, DBH, and the Fresno State Evaluation Representatives, (FSER). For the purpose of this report, the African American & Behavioral Health Community-Based Participatory Action Research (CBPAR) data was analyzed and completed by the FSER, in collaboration with JOJ.

THE PURPOSE

The aim of this African American & Behavioral Health Community-Based Participatory Action Research (CBPAR) project is to gain insight from Fresno County's African American/Black community regarding their experiences with matters related to behavioral health, and to utilize this insight as a foundation to increase behavioral and mental health literacy. The data from this project will be used by DBH, to understand the specific behavioral health needs of African American/Blacks in Fresno County, and to leverage this data towards the design and implementation of culturally appropriate behavioral health services.

SCOPE OF WORK

The scope of work document indicated a start date of August 2022, for the FSER. Yet, the agreement was not in place until October 18, 2022. Nevertheless, the African American & Behavioral Health CBPAR kickoff event was held as planned on September 24, 2022. Intervention sessions were facilitated by JOJ throughout Year 1. Some of the sessions took place in person, and others took place online. The FSER worked with the JOJ representatives and DBH to establish the CBPAR methodology for Year 1. We decided that our primary mechanism for

data collection would be a survey. The survey evolved over time to include additional areas of interest. Thus, some items within the data were only available once the revised survey was distributed to participants (February 2023). Additional forms of data collection in Year 1 included observations from the intervention/evaluation representatives, data collection during the kickoff event, and information gathered from the sign-in sheets.

Overall, the data indicated that participation in community learning sessions (Intervention Sessions) increased mental health awareness and literacy among most participants. However, the matter of how mental health services are utilized and impacted by the community learning sessions/interventions was less clear.

Background/Introduction

This project focuses on the behavioral health needs of African and Black Americans in Fresno County, California, in the areas of literacy, awareness, and utilization of public, private, and personal services. We use the terms 'African American' and 'Black' to denote all people of African descent in the United States, which includes those in Fresno County who may trace their African/African American heritage from voluntary immigration to the United States (i.e., Caribbean, West Indian, Jamaican, Canadian, South African, etc.), as well as those who may trace their African/African American ancestry prior to the twentieth-century, through the global involuntary trans-Atlantic slave trade. For Year 1, we focused on promoting the project to specific sub-groups of African American and Black people in Fresno County, although all Black people were welcome to attend and participate. They were (1) Faith Communities and Leaders, (2) Students Grades 7-12 (School Sites and Group Homes) (7-12 no survey just sign-in information), (3) Undergraduate and Graduate Students, (4) Athletic Coaches, (5) Mentors, (6) Teams, and (7) Other Professionals – (Hair Stylists, Barbers, Educators, and Clinicians).

The intent in Year 1 was to build trusting relationships both internally and externally, through the evaluation of a behavioral health intervention process. The intervention consisted of conversational and educational sessions on topics that were primarily chosen by Black community participants at the African American and Behavioral Health Launch Event. Additional topics were chosen by DBH.

The topics engaged were: Bearing the Burden (Collaborative Agreed On and Led-Topic), Cultural Identity and Awareness (Black Professionals/Community-Led Topic), Mental Health 101 (DBH-led topic), The Public Behavioral Health System (DBH-led topic), Suicide Prevention and Intervention (DBH-led topic), Generational Trauma (Black Professionals/Community-Led Topic), Grief & Loss (Black Professionals/Community-Led Topic), Healing with the Arts (Black Professionals/Community-Led Topic with Black Woman-Led Art non-profit), Parenting While Black (Black Professionals/Community-Led Topic), Speaking Up & Out (Black Professionals/Community-Led Topic), and Black College Students & Behavioral Health (Black Professionals/Community-Led Topic).

We conducted both in-person and online 2-hour sessions in an attempt to increase participation and visibility of the project. The DBH provided Black behavioral health professionals to lead sessions to help build relationships between the agency and Black/African American participants. We designed and implemented conversations and educational learning sessions as the two-way Intervention for both the Black/African American participants and the DBH. In most instances, Black participants were both part of the community and the partnering agencies.

We gathered data from the participants through a survey that was designed and administered by the collaborative and elicited responses from participants who attended on their current or desired behavioral health practices.

There were two iterations of the survey instrument.[1, 2] We evaluated/assessed the intervention sessions regarding the impact on the Black community's behavioral health awareness, literacy, and service utilization/facilitation of the intervention sessions. We also requested data from the DBH to identify and address (e.g. make recommendations) the barriers to utilization of behavioral health services, programs, and funds by African American/Blacks.

During the initial exploration of this project, the DBH representatives asked us to utilize a community-based participatory research (CBPR) approach, and to center African and Black American community member experiences.

Toward the beginning of year one, a DBH representative was asked by JOJ and FSER for data about DBH service utilization by African and Black Americans. Several sets of data were provided. However, the data available from DBH was not sufficient to discern the utilization of DBH services by African and Black Americans. The data sets made available to JOJ and FSER did not provide any workable understanding of utilization or experience of African and Black Americans with regard to DBH programs and services.

Literature Review

Even as contemporary scholarship and clinical research titles suggest modifications of the research term (i.e., Community-Based Participatory Research (CBPR), Community-Based Participatory Action Research (CBPAR), and/or Community Participatory Action Research (CPAR)), there is no denying the strategic, collaborative, and social importance of community-based action research, which brings together the voices and expertise of academic researchers, community advocates, behavioral and mental health stakeholders, and the public/community at large, to identify and address the needs, goals, outcomes, and resources for targeted and diverse groups, people, and communities. For the purpose of this literature review, as found in the published scholarship, the respective research terms (i.e., Community-Based Participatory Research (CBPR), Community-Based Participatory Action

[1] Appendix A is the first iteration of the survey.
[2] Appendix B is the second iteration of the survey.

Research (CBPAR) and Community Participatory Action Research (CPAR)) are interchangeable, as well as signify that CBPR, CBPAR, and CPAR may have similar research designs, aims, and outcomes. To understand the collaborative trajectory of CBPAR, this review of contemporary scholarship illuminates relevant intersections, such as (1) Community Action Research Paradigm; (2) Mental Health Literacy & Stigma; and (3) African Americans and Mental Health Disparities.

COMMUNITY ACTION RESEARCH PARADIGM

We acknowledge that the African American & Behavior Health CBPAR was inspired by Alfiee M. Breland-Noble's *Community Mental Health Engagement with Racially Diverse Populations* (2020).[3] The seminal text theorizes and focuses on identified behavioral and mental health disparities that may impact marginalized populations, in general, as well as may impact racially diverse groups and people of color, more specifically. In the chapter, "Faith-Based Mental Health Promotion: Strategic Partnership Development of a Black Faith Community-Academic Pilot Project," Breland-Noble, et al. reflect on the importance of community-based research initiatives. They explain:

> Over the past 15-20 years, alternate methods to traditional research have been proposed to improve the participation of people of color in clinical research, to improve treatment efficacy, and as a means of addressing health disparities. Of these approaches, community-based participatory research (CBPR) has emerged as a potential solution given its adaptability and cultural relevance for diverse populations. CBPR is a partnership approach to research in which members of the community, organizational representatives, and academics contribute expertise and share decision making. This process integrates the academic expertise of professional researchers with the concerns and considerations of community members, making it highly adaptable and culturally relevant for diverse populations (113-114).

While community-based action research projects do not have to have a faith-based component or research perspective, scholars agree that CBPR, CBPAR, and CPAR empower community engagement (Burns, 2009; Breland-Noble, et al., 2020; Maiter, 2008). Still, the collaborative nature of community-based action research is valuable, and its ethical, social, and culturally relevant attributes should not be underestimated. For example, as our current study demonstrates, and as Lawrence W. Green and Shawna L. Mercer conclude, "Public health agencies can provide a bridge between university-based researchers and community-based projects, using participatory research at the agency level to adapt best practices and at the community level to ensure relevance of the research to the community's needs and actions" ("Community-Based Participatory Research," 1928). It is through the bridging of ideas, expertise, and resources that CPAR projects open a space beyond the traditional one-to-one research design and analysis models, such as researcher-to-public/community, researcher-to-community agency, and/or community agency-to-mental health stakeholder.

[3] County of Fresno Department of Behavioral Health Inter-Office Memorandum, dated July 8, 2020.

Thus, we look to guidance of DBH as the "bridge" for the African American & Behavior Health CBPAR collaboration.

Moreover, scholars maintain that action research is distinctive from traditional research methods because the "[a]ction involves taking calculated steps toward solving a community, social, or organizational problem" (Vivona and Wolfgram, 514). On the other hand, scholars like Michelle Fine (2008) and Ernest T. Stringer (2014) argue that action research is not a research methodology as used with other data collection and analysis models, but it is a research paradigm for investigation and social change. Stringer states, "The primary purpose of action research is to provide the means for people to engage in systemic inquiry to design a way of accomplishing a desired goal, and to evaluate its effectiveness" (*Action Research* 6). As proposed, community-based action research is a vehicle for community engagement, organizational awareness of a problem, critical investigation, and evaluation of goals and outcomes, which are true markers of collaborative research and knowledge development.

<u>MENTAL HEALTH LITERACY & STIGMA</u>

To foreground our critical community-based action investigation in the African American community, it was important to understand and have a general scope of behavioral and mental health literacies. In the groundbreaking article "Mental Health Literacy," Anthony F. Jorm, et al. offer the first definition for mental health literacy. In 1997, Jorm, et al. explain:

> "Health literacy" has been defined as the ability to gain access to, understand, and use information in ways which promote and maintain good health. By extension, we have coined the term "mental health literacy" to refer to knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognize specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking (182).

Scholars and clinicians agree on the definition of mental health literacy, as the Jorm, et al. study is referenced widely in publications across many disciplines, such as Public Policy and Marketing, Nursing, Women's Health, Social Work, College Student Development, and Medicine (just to name a few). While there are socioeconomic and environmental factors that may cause a delay in treatment or seeking help (i.e., poverty, lack of providers, lack of financial resources, etc.), research shows that individual and shared communal beliefs may also impact a lack of care. "For example, those living with a mental health condition are sometimes challenged by the stereotypes and prejudices that result from misconceptions about mental illness" (Kemp, Davis, and Porter, III, 262). Silence and silencing within and outside of the African American community may prevent mental health help-seeking. As Sullivan, et al. explain, "Additional barriers for African Americans may include having different, non-medical views of the etiology of mental health problems, stigma related to mental disorders, and mistrust of providers or of certain types of treatment such as medication" (540-541). Likewise, as sampled about *stigma* and *mental health literacy,* Sullivan, et al. report:

> *Stigma.* Participants in both focus groups and forums described widespread stigma associated with having mental illness or with seeing a mental health professional. They felt stigma was a key barrier to help seeking, and some even suggested that individuals would refrain from telling friends, their primary care providers, or pastor about mental illness either in their family or about their own symptoms. Older people sometimes viewed symptoms as a weakness; younger people were very concerned about what their peers would think (557).
> […]
> *Mental health literacy.* Participants in both forums and focus groups were concerned that most people did not know how to recognize mental illness and would, therefore, not understand when treatment was needed. […] Poor mental health literacy was also directly demonstrated by some of the participant's comments. There was a great deal of concern expressed about the need to educate children early about mental health (557).

Even as history and scholarship show that African American/Blacks are less likely to seek behavioral and mental health services than other ethnic groups, it is our belief that our current community-based participatory action research project may illuminate and facilitate mental health literacy in Black communities.

AFRICAN AMERICANS & MENTAL HEALTH DISPARITIES

Racially diverse and marginalized people of color are underrepresented in behavioral and mental health studies. Scholarship also shows that current knowledge of and best practices in mental health literacy have had a smaller impact and reach in African American communities. "In general, African Americans suffer from common mental disorders (such as depression and anxiety) at rates similar to Whites, but they are significantly less likely than Whites to receive treatment" (Sullivan, et al., 540). In light of racial and ethnic disparities in the United States, the U.S. Surgeon General has determined that historical and sociocultural factors, such as slavery, racial bias, racism, poverty, homelessness, incarceration, etc., in combination and individually, are uniquely linked to the mental health accessibility and treatment of Black people (*Mental Health,* 1999; *Mental Health: Culture, Race, and Ethnicity,* 2001). "The legacy of slavery and discrimination continues to influence their social and economic standing. The mental health of African Americans can be appreciated only with this wider historical context" (2001, 53). Yet, race-based assessments, when considering mental health care, are undervalued and/or omitted in many studies and in clinical practices.

According to McGuire and Miranda, a clear definition of racial/ethnic disparities in mental health is complicated. They explain:

> A consensus about what constitutes a "disparity" has not been reached despite a voluminous literature on the topic. The term disparity clearly connotes an unfair difference, but measurement of this difference is far from uniform. Here, we rely on the definition employed by the Institute of Medicine (IOM) in its *Unequal Treatment* report: a disparity is a difference in health care quality not due to differences in health care needs or preferences of the patient. As such, disparities can be rooted in inequalities in access to good providers, differences

> in insurance coverage, as well as stemming from discrimination by professionals in the clinical encounter (393).

Even with a lack of consensus, scholars also cite environmental and political factors (i.e., police brutality, violence/danger, political protests, etc.) as disparities that have a direct impact on mental health and well-being (Avent Harris, et al., 2020; Brown, 2008; Hirshbein, 2021). The level of trust or mistrust in authority figures, such as healthcare professionals, clergy, etc., may consciously and unconsciously hinder help-seeking and treatment. In addition, historical adversities must not be overlooked. According to the U.S. Surgeon General's Supplemental Report on Culture, Race, and Ethnicity:

> Historical adversity, which include slavery, sharecropping, race-based exclusion from health, educational, social, and economic resources, translate into socioeconomic disparities experienced by African Americans today. Socioeconomic status, in turn, is linked to mental health: Poor mental health is more common among those who are impoverished than those who are more affluent (57).

But even as it is recognized that people of African descent in America "suffer a disproportionate burden of mental illness," Newhill and Harris note that the Surgeon General's "report concluded that there is a large gap between the need for services and the services actually provided" (2007, 108). Likewise, with respect to our current CBPAR project, we also recognize the important distinction, and are hopeful that the community-based action research data may be used as an assessment tool for analysis of any racial/ethnic disparities and gap(s) "between the need for services and the services actually provided."

Methods

RESEARCH QUESTIONS

Q1) Does participation in community learning sessions impact community mental health awareness?

Q2) Does participation in community learning sessions impact community mental health literacy?

Q3) Does participation in community learning sessions impact community mental health service utilization/facilitation?

SUMMARY OF METHODOLOGIES UTILIZED IN YEAR 1

The representatives from Jewel of Justice (JOJ), Fresno State (FSER), and the Fresno County Department of Behavioral Health (DBH) met often during Year 1 to discuss the project overall, and the methodologies we wanted to utilize. Several meetings were open to the entire team, but early into Year 1 a core leadership approach was used where a single representative from Fresno State (Dr. Pitt-Parker or Dr. Travis Cronin), and DBH (Mr. Dennis Horn) joined the JOJ

representatives. Meetings were held 1-2 per month to plan for the events (community learning sessions/interventions) and to process observations and data collected during the events. These meetings informed the data collection process, served as an initial space to discuss the data as it was collected, and helped the collective project assess what adjustments were needed to maximize our success as we headed into Year 2, where we would utilize a community-based participatory action research (CBPAR) approach. The DBH representatives specifically expressed their interest in a CBPAR design for both the intervention and evaluation.

We decided to create a simple survey to understand at a basic level if the community learning sessions/interventions were helpful to raising behavioral/mental health awareness and literacy. The initial survey had four quantitative items and an open-ended item. The initial survey was used for the first seven learning sessions (September - December 2022). The representatives decided to keep four of the initial items, add five substantive items (related to awareness, literacy, and utilization), and add three demographic items.

EVENTS AND ATTENDANCE

Jewel of Justice hosted 18 events (e.g. launch, intervention sessions, CBPAR presentation, and Leadership Council Development Dinner), with 171 participants across the 18 events. The events ranged from two to 30 participants, with a median of 7 participants. Three events had more than 20 participants.

Event	**Date**	**Number Registered**	**Number Attended**
Project Launch – Jewel of Justice, Fresno State, and DBH	9/24/22	5	13
Bearing the Burden – African American Community Co-Facilitator w/ Jewel of Justice	10/14/22	0	2
Mental Health 101 – DBH Black Staff Co-Facilitator w/ Jewel of Justice	11/7/22	2	5
Mental Health 101 (online) DBH Black Staff Co-Facilitator w/ Jewel of Justice	11/17/22	2	2

The Public Behavioral Health System – DBH Black Staff Co-Facilitator w/ Jewel of Justice	12/5/22	1	3
Generational Trauma African American Community Co-Facilitator w/ Jewel of Justice	12/9/22	1	2
The Public Behavioral Health System (online) DBH Black Staff Co-Facilitator w/ Jewel of Justice	12/15/22	8	8
Grief & Loss – African American Community Co-Facilitator w/ Jewel of Justice	1/13/23	0	2
Cultural Identity and Awareness – African American Community Co-Facilitator w/Jewel of Justice	2/10/23	8	12
Healing with the Arts Jewel of Justice Collaborated with B Awesum	2/17/23	12	30
Suicide Prevention & Intervention – DBH Black Co-Facilitator w/ Jewel of Justice	3/6/23	1	4
Suicide Prevention & Intervention (on-line) – DBH Black Facilitator w/ Jewel of Justice	3/22/23	7	7

Parenting While Black, Pt. 1 – African American Community Co-Facilitator w/ Jewel of Justice	3/29/23	7	8
Parenting While Black, Pt. 2 – African American Co-Facilitator w/ Jewel of Justice	4/12/23	10	6
Speaking Up & Out – African American Community Co-Facilitator w/ Jewel of Justice	4/19/23	8	8
Black College Students Behavioral Health Conversation – Jewel of Justice and Fresno State	4/27/23	0	28
CPAR Inquiry and Design Presentation	6/13/23	20	23
Design of Leadership Council Dinner Gathering	6/29/23	14	11

Table 1 (Year 1; Submitted By: Karen Crozier)

Findings & Results (Key Learnings & Analysis)

Q 1) What do we know regarding question 1 (awareness), and how do we know it?

RQ 2) What do we know regarding question 2 (literacy), and how do we know it?

RQ 3) What do we know regarding question 3 (utilization/facilitation), and how do we know it?

PARTICIPANTS

We had multiple strategies to learn about the identities of the participants including the data on sign-in sheets. Demographic identifiers were not included on the first iteration of the survey due to historical and contemporary misgivings about the research process among many African

American/Blacks. We purposely kept a lower profile with regard to demographic questions in hopes of building a sense of trust with participants. The second iteration of the survey (n = 31) included items regarding ethnic/racial identity, gender, and age.

Participants could select multiple racial and ethnic categories. The most common ethnic and racial identities were African American (n = 18, 58%), and Black (n = 12, 39%). Other responses with at least one response, yet less than four responses : Black African, Afro Latina/o/x, Afro Caribbean, multi-racial, and biracial.

Most of the participants (n = 25, 81%) identified as female. The remaining (n = 6, 19%) identified as male.

The age variable was collected in categories to protect anonymity within a small sample. The age categories included: 18-25 (n = 3), 26-35 (n = 11), 36-45 (n = 7), 46-55 (n = 0), and 56 or older (n = 7). Three participants did not select an age answer.

SURVEYS

We received 21 responses to the initial survey. There were 35 participants when the initial survey was administered, therefore the 21 survey responses represented a 60% response rate. All 21 participants (100%) answered “yes” to the prompts: This event helped me to think about how I take care of my mental health; I want to attend other events similar to this; and I intend to share what I learned from this event with other people. Twenty of the 21 participants (95%) answered “yes” to the prompt: This event helped me to think about how I receive mental health support from other people. The remaining participant (5%) indicated that they were “unsure” about this item. Eighteen of the 20 participants (90%) answered “yes” and two participants answered “unsure” to the prompt, “This event helped me to think of new ways to take care of my mental health.” One participant did not respond to this prompt. Of the 21 participants who submitted a survey, 11 (52%) answered the open-ended prompt: Please share any other information you would like to share with us about your experiences this evening. The most common sentiments included gratitude, and safety. For example, one participant wrote, “Thank you for giving me the space (to) talk about concerns I don't get the chance to talk about.”

We received 31 responses to the second iteration of the survey. There were 136 participants when the second iteration of the survey was administered, therefore the 31 survey responses represented a 22% response rate. All 31 participants (100%) answered “yes” to the prompts: This event helped me to think about new ideas to take care of my mental health; Attending this session helped to build my mental/behavioral health awareness. Thirty participants (96%) selected “yes” to the prompt: I intend to share what I learned from this session with other people. Twenty-nine participants (93%) selected “yes” to the prompt: This session helped me to think about how I take care of my mental health, one participant (3%) selected “unsure,” and the final participant (3%) selected “no” in response to this item. Twenty-eight participants (90%) selected “yes” to the prompt: This session helped me to think about how I receive mental health support from other people. The remaining 3 participants (10%) selected “no” in response to this item. Of the 31 participants who submitted a response to the second iteration of the

survey, 10 (7%) answered the open-ended prompt: Please share any other information you would like to share with us about your experiences this evening. The most common sentiments included gratitude, and safety. For example, one participant wrote, “I think this session was very healing and freeing. It was nice to have a safe space to express myself and hear from other women who are like me. It was nice to find community and to experience this space with this amazing group of women.”

The second iteration of the survey included additional items in an attempt to understand behavioral health utilization issues. Twenty-nine participants (93%) selected “yes” to the prompt: I plan to use what I learned in this session. The remaining two participants (7%) selected “unsure” in response to this item. Two items were added to understand which behavioral health resources and medicines had been utilized in the past year. Participants could select all of the choices provided including the category of “other”. The resources utilized included: prayer (n = 24), deep breathing/meditation/mindfulness (n= 24), therapy/counseling (n = 20), talking to a friend, kin, elder, mentor, coach, teacher (n = 15), exercise/yoga (n = 14), telehealth (n = 11), talk to your medical/healthcare provider in person (n = 9), faith community (n = 6), talk to your faith leadership (n = 4) and, Department of Behavioral Health program or services (n = 4). Medicinal strategies used in the last year included: tea (n= 23), plant-based/herbs (n = 11), prescriptions (n = 10), none (n = 4), homeopathic (n= 2), over the counter (n = 2), and walking (n = 1).

Overall, the data from the two iterations of the survey (*N* = 52) indicated that the interventions were helpful to most participants with regard to mental and behavioral health awareness (RQ 1), and mental and behavioral health literacy (RQ 2).

The second iteration of the survey helped us to understand behavioral health utilization (RQ 3). A strong proportion of the participants who completed the survey are praying (n = 24, 77%), practicing mindfulness/deep breathing (n = 24, 77%), and accessing counseling/therapy in the community (n = 20, 64%). Despite the fact that these participants report utilizing multiple strategies to manage their mental and behavioral health challenges, few reported utilizing DBH programs and services (n = 4, 13%).

OBSERVATIONS

The Stigma. In general, Black people and African Americans continue to experience medical and behavioral health institutions and practitioners as untrustworthy and lacking providers who represent them. Many of the participants in the intervention phase were aware of behavioral health practices and utilized them. In addition, they expressed excitement about the work we were doing because it was needed although we struggled with how to access the number of people who were in need and to resource them for access to trustworthy providers and systems of support and care. There also seemed to be limited to no usage of the public behavioral health system by the intervention participants. For the few that did report usage, it was not a positive experience.

Barriers to Treatment. From several intervention sessions, it was identified that Black people and African Americans would probably have an increased utilization of public behavioral health system if the following conditions were met: 1) more providers who were Black and African American, 2) more of a relational and trust building focus during the intake process rather than the current high volume of paperwork and bureaucracy, 3) going into the homes and communities as an option of service, and 4) resourcing and supporting known and trusted individuals and providers who have access to the people as a bridge.

Medi-Cal. Even if these conditions were met, it still would be a struggle because we heard from a Black faith-based provider that they were informed not to work with the Department of Behavioral Health (DBH), and from a Black clinical provider that they will not work with the Department of Behavioral Health because the function of the agency is to recoup Medi-Cal dollars and not empower and support small, burgeoning providers who do not yet have the infrastructure to be a partner to have dollars returned for not servicing accordingly as designed by Medi-Cal. In closing, while the traditional stigma of being afraid to talk about behavioral health challenges is waning, the lingering effects are still there and county agencies must become more trustworthy.

Messaging (Research focus vs. community's immediate behavioral health needs/ concerns/ challenges). Throughout Year 1, the representatives regularly discussed the challenges associated with the call from community members for immediate relief by way of direct services. As Jewel of Justice conducted community learning sessions/interventions and met with members of the community, there was an ongoing challenge related to the way we share the message about this project. Toward the end of Year 1, we (JOJ, FSER, & DBH) had a meeting to discuss the last large scale event of the fiscal year. During that meeting we collectively decided that we needed to adjust our messaging towards African American/Blacks health and well-being rather than use the language of mental and behavioral mental health. This dynamic will likely play a central role as we shift our attention to Year 2 and its reliance upon community participatory action research methodologies.

Discussion (Suggestions on Project Viability)

The data from the first year was promising with regard to the first two research questions. Participants indicated an appreciation for the interventions, and indicated the sessions enhanced their community mental health awareness and literacy. These findings were borne of the survey results and observations.

It was much harder to discern if the interventions impacted community mental health service utilization and facilitation. In fact, the findings pointed to a number of structural factors that hindered community mental health service utilization. Therefore, the data from Year 1 suggested that it is unlikely that participation in community learning sessions/interventions will be sufficient to increase African American participation in community mental health programs.

As we transition into the second year of this project we suggest continued efforts to offer community learning sessions/interventions. The survey results and observations[4] clearly indicated African Americans and Black people in Fresno County reported increased awareness and literacy as a result of participating in community learning sessions/interventions. Consideration should be given to finding ways to scale up the community learning sessions/interventions. Some of the sessions were quite small (n = 2-3), yet other events were much larger (23-30). Certain events may call for smaller groups, but we suggest aiming for a middle ground for events in the second year (10-15). If the smaller events can draw additional participants, it stands to reason that the reach of this project will grow. The data from the larger events yielded important observations as well, so we suggest that larger events remain a part of the strategy as we move into the second year.

As reported in the observational findings, the participants perceived substantial structural problems with regard to the systems designed to provide behavioral and mental health support in the community. Participants urgently wanted direct, meaningful, and effective treatments that were designed for them. The community learning sessions/interventions in some ways appeared to partially fill this gap. As noted in the literature review, historical adversities such as enslavement should inform the design of services for African Americans. The findings from Year 1 suggest this all be woven into the design of the services, not simply stacked on top. The findings and literature together, suggest providing programming and services that align with the historical and contemporary challenges faced by Black and African American residents within Fresno County.

The participants called for providers that could understand and meet their needs. One way this was articulated was through the call for providers who "look like me." Practices that account for hiring and retaining Black and African American practitioners are challenging in a landscape where affirmative action programs have been eliminated. Nevertheless, if this finding remains neglected, the systems designed to care for the behavioral and mental health needs of African Americans may continue to go unmet.

Conclusion

During the first year of this CBPAR project, JOJ built important relationships throughout the community. This foundation was underscored by the call for "more" action similar to the community learning session provided during Year 1. At every turn in the data the findings suggested that funding this project was an important first-step towards enhanced behavioral

[4] Appendix C: Observations from community events submitted by Dr. Reese

and mental health awareness and literacy among Black and African Americans living in Fresno County. There is a great deal of work ahead, and Year 2 will provide the opportunity for the second step towards building a bridge between the community and DBH. Historical and contemporary abuses of people of African descent are the foundation of this bridge. The findings from Year 1 suggest that telling the truth about these abuses may be the only way to build a bridge worthy enough to walk across. The journey in Year 2 should focus on gathering data about Black and African American experiences that may help to inform behavioral and mental health services designed specifically to enhance their well-being.

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APPENDIX A

Survey (First Iteration)

Your participation in this survey is voluntary. You may skip any question you do not want to answer. Your answers will be used to evaluate this session and to assist us as we plan future programming. Any information you provide will be anonymous and will not be used to identify you or the answers you provided. Thank you for attending this event!

This survey should take approximately 10 minutes to complete. Do you wish to participate in this survey?

No
Yes

This event helped me to think about how I take care of my mental health.

Yes
No
Unsure

This event helped me think of new ideas to take care of my mental health.

Yes
No
Unsure

I want to attend other events similar to this.

Yes
No
Unsure

I intend to share what I learned from this event with other people.

Yes
No
Unsure

Please share any other information you want us to know about your experience this evening. (text box provided for typing)

APPENDIX B

Survey (Second Iteration): New content in bold

Your participation in this survey is voluntary. You may skip any question you do not want to answer. Your answers will be used to evaluate this session and to assist us as we plan future programming. Any information you provide will be anonymous and will not be used to identify you or the answers you provided. Thank you for attending this event!

This survey should take approximately 10 minutes to complete. Do you wish to participate in this survey?

No
Yes

This event helped me to think about how I take care of my mental health.

Yes
No
Unsure

This event helped me think of new ideas to take care of my mental health.

Yes
No
Unsure

This session helped me to think about how I receive mental health support from other people.

Yes
No
Unsure

Attending this session helped to build my mental/behavioral health awareness.

Yes
No
Unsure

I plan to use what I learned in this session.

Yes
No
Unsure

I intend to share what I learned from this event with other people.

Yes
No
Unsure

Please share any other information you want us to know about your experience this evening. (text box provided for typing)

What behavioral health resources have you used in the past year? (Mark all that apply)

telehealth
prayer
therapy/counseling
deep breathing/mindfulness/meditation
talk to your medical/healthcare professional in person
talk to your faith leadership
talk to your friend, kin, mentor, elder, coach, or teacher
Department of Behavioral Health services or programs
faith community

exercise/yoga
Other (text box provided)

In the last year, what medicinal remedies have you used to treat your behavioral health?

plant-based/herbs
prescription
over-the-counter
homeopathic
tea
none
not mentioned, please specify (text box provided)

If you have used a service within the past year with the Fresno County Department of Behavioral Health, please briefly describe or name the service below. (text box provided)

What is your age?

18-25
26-35
36-45
46-55
56 or older

How do you racially or ethnically identify? (Mark all that apply)

African American
Afro Caribbean
Afro Latina/o/x
Biracial
Black
Black African

Multiracial
Not Mentioned (text box provided)

What is your sex or gender identity? (mark all that apply)

Female
Non-binary
Male
Trans
Non-conforming
Expansive
Prefer to describe (text box provided)

APPENDIX C

The following observations were made by Dr. Reese during two of the community events.

Fresno State Black Behavioral Health Forum April 27, 2023
On April 27, Fresno State representatives and Jewel of Justice led a Black Behavioral Health Forum with guest speaker and a licensed Marriage & Family therapist Dennice McAlister from the Fresno State Counseling Center.

The goal was to center Black student voices, experiences, and truth in order to create a robust, extensive awareness on behavioral literacy and the utilization of services at Fresno State.

Dr. Karen Crozier acknowledged that generational trauma, and cultural identity affect and inform the creative ways Black people take care of their behavioral health.

Dennice Mc Alister said that at least 83 out of 763 Black students at Fresno State used services at the Counseling Center (approximately 5%). The leading areas influencing student visits on campus are: social anxiety, isolation, and learning how to navigate after the COVID-19 pandemic, microaggressions, a higher level of anxiety or depression, and suicide which is highest for those ages 15-24.

The myths that keep Black students from seeking therapy are:

- the idea that 'therapy is for White people' without recognizing that everyone has 'trauma'.
- A lack of trust and awareness about what therapy can do; he/she won't understand
- A lack of people of color in therapy
- Misunderstanding that therapists tell you what to do rather than guide you in your decision making
- A lack of family support

During the session, students spoke on how racism, not feeling seen or heard (isolation), and the lack of an infrastructure at Fresno state to cater to African American students
have all interfered with their mental health and wellness.

McAlister thinks it's important to change the idea of always having to be strong to "being courageous"– in which one is allowed to be both authentic and vulnerable.

Questions arose on the difference between “behavioral v. mental health” to which there was some discussion around the latter which is often discussed in relation to drug and alcohol abuse. McAlister said that there will be a new team at Fresno State to address substance abuse.

Black Life, Health, and Wellness Event June 13, 2023

On June 13th, 2023, Jewel of Justice and the Fresno State Community Participatory Action Research (CPAR) representatives sponsored an in-person event “Black Life, Health, and Wellness” at the Legacy Commons. The purpose of the event was for Black residents of all ages “to explore needs and create change around health and wellness.”

Among the goals for the event was to enter into conversation on how to hold others accountable in relation to our children by sharing with the community our research, design methods and plan, and gain feedback and recommendations. Dr. Crozier shared that the first year of the CPAR project aimed at building trust and transparency,organizing interventions, designing and engaging the project, and informing and learning from the community.

The research representatives announced and explained our big question “Parenting/ed While Black” which was chosen because Black communities are disproportionately impacted by structural and interpersonal racism that leads to burdens on their physical and mental health. This is coupled by the stress and trauma associated with the post-pandemic. While Black families are strong and resilient, they are more likely to experience intergenerational trauma (defined as a traumatic event that gets passed down from one who directly experiences an incident to subsequent generations) which also affects parenting styles as survivors face challenges (e.g. shame, low self-esteem, depression, substance abuse, etc.) when they are parents, including difficulty bonding to and creating healthy emotional attachments with their children. The question addresses the support that Black parents need, their lack of access to care, and how they cope.

After sharing our design plan which includes self-recordings with selected questions generated by the research representatives, focus groups]with one specifically for barbers, hair stylists, and nail technicians, surveys (when deemed appropriate) after each training intervention session, and intervention training (one or two for half or full-day sessions) for the Leadership Council and broader community, these were some of the ideas, questions, recommendations, and feedback heard from the community during the event.

- Making the idea of “trauma” explicit in our research topic
- Creating listening sessions via Zoom to create broader access for those with different schedules and perspectives at least once a week or more

- Research participants be added as “authors”
- Sharing report results with community before submission
- Including those who are not parents
- Including foster children and exploring how parenting (in “survivor mode”) done when basic needs go unmet
- Addressing the lack of Black therapists in Fresno County
- How do we market and build messaging in the Black community around the use of services given stigma around where these services are located and who benefits from them?
- Adding to the research design a pre/post evaluation of DBH’s utilization rates before and after the project
- Does the design plan address those who are the most vulnerable in the community and are linked “with the highest levels of pathology” to make sure they are not ‘slipping through the cracks’?
- Adding DBH consumers or ”persons served” who could offer first hand information
- Adding more qualitative information driven by stories and experiences

Evaluation of the Fresno County "**African American & Behavioral Health Community-Based Participatory Action Research (CBPAR)"** Project
California State University, Fresno: Dr. Travis W. Cronin, Dr. De Anna J. Reese, Dr. Reva. E. Sias, Dr. Cheryl A. Whittle, Rudo Kamutepfa, & Dessalines Yamoussou
REPORT: Year 2 Final Report (Year 1 inclusive)

African American & Behavioral Health Community-Based Participatory Action Research (CBPAR)

Executive Summary

AUTHOR'S NOTE

Material reported in gray was from the Year 1 report. New content for the final (Year 2) report is in black. The term Community-Based Participatory Action Research (CBPAR) was used throughout this report instead of Community Participatory Action Research (CPAR) because the review of the available literature used the term CBPAR more frequently, and there was no clear distinction made between the two terms.

Dr. Jenelle Pitt-Parker led, organized, and coordinated the assembly of the Fresno State Evaluation Team (FSET). She left California State University, Fresno for a position at another university as Dean at the end of Year 1. Dr. Pitt-Parker did not receive any funds allocated to this project due to university rules prohibiting administrators (she was the Associate Dean of the Kremen School of Education at the time). Dr. Pitt-Parker played a dynamic and essential role in the development of the entire CBPAR project, and was a major contributor to its success in Year 1.

After the submission of the Year 1 report, it became clear to the partnering agencies that a substantial misunderstanding occurred. The Jewel of Justice (JOJ) believed that the FSET would conduct the CBPAR. Simultaneously, FSET believed the JOJ would conduct the CBPAR. In the end, the focus of Year 2 was the formation and business of the Leadership Council (LC) by the JOJ. FSET played a supportive role by attending the LC as non-voting members, attending LC sponsored community events, and conducting interviews with LC members (N = 5).

Both "African American" and "African/Black Americans" will be used throughout the report to acknowledge a broader identification among people of African descent.

ABSTRACT

Prior to the approval of this project, the intervention team from Jewel of Justice (JOJ-a community advocate), the team from Fresno County Division of Behavioral Health: Equity Division (DBH-the funding source), and the cross-disciplinary evaluation team from California State University, Fresno (i.e., Departments of Africana Studies/History, Education, English, and Social Work) met monthly to establish the scope of work (March through August of 2022). Once DBH had executed the contract with JOJ (June 2022), we began to discuss the kick-off event

(September 24, 2022), and established a core team with representatives from each of the partners: JOJ, DBH, and the Fresno State Evaluation Team, (FSET). For the purpose of this report, the African American & Behavioral Health Community-Based Participatory Action Research (CBPAR) data was analyzed and completed by the FSET, in collaboration with JOJ.

This Year 2 evaluation was completed by the FSET. The report builds upon the foundation set by the Year 1 Report. The FSET collaborated with Dr. Crozier from the Jewel of Justice to hire two graduate student assistants: Rudo Kamutepfa (Social Work), and Dessalines Yamoussou (History). The primary methodologies used for evaluation in Year 2 were observations of the Leadership Council (LC) by the FSET, and semi-structured interviews of members of the LC (*N* = 5). The goal of completing a CBPAR project proved too ambitious. Nevertheless, the findings suggest the formation and maintenance of the Leadership Council (LC) of African/Black Americans in Fresno County appears to be a promising practice. This report will outline the merits of the LC, how the JOJ and the FSET addressed the Scope Of Work (SOW), and highlight some of the challenges related to this endeavor.

THE PURPOSE

The aim of this African American & Behavioral Health Community-Based Participatory Action Research (CBPAR) project is to gain insight from Fresno County's African American/Black community regarding their experiences with matters related to behavioral health, and to utilize this insight as a foundation to increase behavioral and mental health literacy. The data from this project will be used by DBH, to understand the specific behavioral health needs of African/Black Americans in Fresno County, and to leverage this data towards the design and implementation of culturally appropriate behavioral health services.

The formation and maintenance of the LC by the Jewel of Justice (during Year 2) was the crowning accomplishment of this project. Members of the Fresno County African American/Black community were brought together to form the LC, to discuss the behavioral health challenges in their lives, and to work towards solutions that may provide some relief from these challenges. Given the historical and contemporary challenges African/Black Americans in Fresno County experience, this was a monumental undertaking.

SCOPE OF WORK

The scope of work document indicated a start date of August 2022, for the FSET. Yet, the agreement was not in place until October 18, 2022. Nevertheless, the African American & Behavioral Health CBPAR kickoff event was held as planned on September 24, 2022. Intervention sessions were facilitated by JOJ throughout Year 1. Some of the sessions took place in person, and others took place online. The FSET worked with the JOJ team and DBH to establish the methodology for Year 1. We decided that our primary mechanism for data collection would be a survey. The survey evolved over time to include additional areas of interest. Thus, some items within the data were only available once the revised survey was distributed to participants (February 2023). Additional forms of data collection in Year 1 included observations from the intervention/evaluation teams, data collection during the kickoff event, and information gathered from the sign-in sheets.

Overall, the data indicated that participation in community learning sessions (Intervention Sessions) increased mental health awareness and literacy among most participants. However, the matter of how mental health services are utilized and impacted by the community learning sessions was less clear.

The Scope of Work remained the same for the FSET in Year 2.

Background/Introduction

This project focuses on the behavioral health needs of African Americans and Black people in Fresno County, California, in the areas of literacy, awareness, and utilization of public, private, and personal services. We use the terms 'African American' and 'Black' to denote all people of African descent in the United States, which includes those in Fresno County who may trace their African/African American heritage from voluntary immigration to the United States (i.e., Caribbean, West Indian, Jamaican, Canadian, South African, etc.), as well as those who may trace their African/African American ancestry prior to the twentieth-century, through the global involuntary trans-Atlantic slave trade. For Year 1, we focused on promoting the project to specific sub-groups of African American and Black people in Fresno County, although all Black people were welcome to attend and participate. They were (1) Faith Communities and Leaders, (2) Students Grades 7-12 (School Sites and Group Homes) (7-12 no survey just sign-in information), (3) Undergraduate and Graduate Students, (4) Athletic Coaches, (5) Mentors, (6) Teams, and (7) Other Professionals – (Hair Stylists, Barbers, Educators, and Clinicians).

The intent in Year 1 was to build trusting relationships both internally and externally, through the evaluation of a behavioral health intervention process. The intervention consisted of conversational and educational sessions on topics that were primarily chosen by Black community participants at the African American and Behavioral Health Launch Event. Additional topics were chosen by DBH.

The topics engaged were: Bearing the Burden (Collaborative Agreed On and Led-Topic), Cultural Identity and Awareness (Black Professionals/Community-Led Topic), Mental Health 101 (DBH-led topic), The Public Behavioral Health System (DBH-led topic), Suicide Prevention and Intervention (DBH-led topic), Generational Trauma (Black Professionals/Community-Led Topic), Grief & Loss (Black Professionals/Community-Led Topic), Healing with the Arts (Black Professionals/Community-Led Topic with Black Woman-Led Art non-profit), Parenting While Black (Black Professionals/Community-Led Topic), Speaking Up & Out (Black Professionals/Community-Led Topic), and Black College Students & Behavioral Health (Black Professionals/Community-Led Topic).

We conducted both in-person and online 2-hour sessions in an attempt to increase participation and visibility of the project. The DBH provided Black behavioral health professionals to lead sessions to help build relationships between the agency and Black/African American participants. We designed and implemented conversations and educational learning sessions as

the two-way Intervention for both the Black/African American participants and the DBH. In most instances, Black participants were both part of the community and the partnering agencies.

We gathered data from the participants through a survey that was designed and administered by the collaborative and elicited responses from participants who attended on their current or desired behavioral health practices.

There were two iterations of the survey instrument.[1, 2] We evaluated/assessed the intervention sessions regarding the impact on the Black community's behavioral health awareness, literacy, and service utilization/facilitation of the intervention sessions. We also requested data from the DBH to identify and address (e.g. make recommendations) the barriers to utilization of behavioral health services, programs, and funds by African/Black Americans.

In Year 2, the focus shifted to the formation and maintenance of a Leadership Council (LC) comprised of African/Black Americans residing in Fresno County who participated in at least one of the Year 1 activities. The Jewel of Justice (JOJ) facilitated a community meeting at Richard's Prime Rib and Seafood to discuss Black Life, Health, and Wellness on June 29, 2023. This community event served as the kick off and recruitment for the LC. The event was attended by behavioral health professionals, behavioral health consumers, clergy, and community members with a variety of personal and professional experiences.

It became clear early in Year 2 that there was a misunderstanding between the Fresno State Evaluation Team (FSET) and the JOJ regarding the roles and responsibilities for carrying out the CBPAR portion of the overall project. After reviewing the respective Scope Of Work documents, it became clear that conducting the CBPAR could not be conducted as outlined. Therefore, the work of JOJ to form and maintain the LC became the central component to the work of the CBPAR project in Year 2. The role and responsibilities of the FSET remained to evaluate the overall project through participation and observation. The FSET expanded in Year 2 to include two graduate research assistants (RA) Rudo Kamutepfa and Dessalines Yamoussou. These RAs attended several of the events, met regularly with the FSET Principal Investigator, met with JOJ, conducted interviews with members of the LC, and transcribed the interviews. Their contributions were integral and important to the completion of this evaluation by FSET.

In August of 2023, the FSET met to discuss how to proceed with our evaluation of the CBPAR project. Our aim was to measure the success and impact of the project and provide a formal report of our activities and outcomes. The following comments are part of this report. We were not entirely clear until this time that the Scope Of Work (SOW) under the research phase of the CBPAR project would be solely led and implemented by the Jewel of Justice (JOJ).

[1] Appendix A is the first iteration of the survey.
[2] Appendix B is the second iteration of the survey.

The FSET had originally planned to use the following as part of our methodology for the CBPAR project: a survey, focus groups, and personal narratives via audio recordings. In late summer 2023, we met and created four questions to be used for personal narrative interviews with the Leadership Council in an attempt to assess the Scope Of Work and target the information requested by DBH (to utilize the findings from the CBPAR project to develop a foundation for understanding behavioral health and increasing behavioral health literacy in Fresno County's Black community). The FSET also drafted and prepared to submit an IRB proposal in September 2023. FSET did not submit the proposal once Jewel of Justice (JOJ) acknowledged it was responsible to lead and coordinate the CBPAR project by administering and collecting surveys and relevant demographic data for the project participants. As of December 2023, the Leadership Council became the center of the project since JOJ did not have the capacity to focus on both the LC and the community at large (a sampling of those who participated in the training sessions). Among the questions to be answered: What can be learned from the experience of LC members in relation to mental health?

Literature Review

Even as contemporary scholarship and clinical research titles suggest modifications of the research term (i.e., Community-Based Participatory Research (CBPR), Community-Based Participatory Action Research (CBPAR), and/or Community Participatory Action Research (CPAR)), there is no denying the strategic, collaborative, and social importance of community-based action research, which brings together the voices and expertise of academic researchers, community advocates, behavioral and mental health stakeholders, and the public/community at large, to identify and address the needs, goals, outcomes, and resources for targeted and diverse groups, people, and communities. For the purpose of this literature review, as found in the published scholarship, the respective research terms (i.e., Community-Based Participatory Research (CBPR), Community-Based Participatory Action Research (CBPAR) and Community Participatory Action Research (CPAR)) are interchangeable, as well as signify that CBPR, CBPAR, and CPAR may have similar research designs, aims, and outcomes. To understand the collaborative trajectory of CBPAR, this review of contemporary scholarship illuminates relevant intersections, such as (1) Community Action Research Paradigm; (2) Mental Health Literacy & Stigma; and (3) African Americans and Mental Health Disparities.

COMMUNITY ACTION RESEARCH PARADIGM

We acknowledge that the [African American & Behavior Health CBPAR] was inspired by Alfiee M. Breland-Noble's *Community Mental Health Engagement with Racially Diverse Populations* (2020).[3] The seminal text theorizes and focuses on identified behavioral and mental health disparities that may impact marginalized populations, in general, as well as may impact racially diverse groups and people of color, more specifically. In the chapter, "Faith-Based Mental Health Promotion: Strategic Partnership Development of a Black Faith Community-Academic Pilot

[3] County of Fresno Department of Behavioral Health Inter-Office Memorandum, dated July 8, 2020.

Project," Breland-Noble, et al. reflect on the importance of community-based research initiatives. They explain:

> Over the past 15-20 years, alternate methods to traditional research have been proposed to improve the participation of people of color in clinical research, to improve treatment efficacy, and as a means of addressing health disparities. Of these approaches, community-based participatory research (CBPR) has emerged as a potential solution given its adaptability and cultural relevance for diverse populations. CBPR is a partnership approach to research in which members of the community, organizational representatives, and academics contribute expertise and share decision making. This process integrates the academic expertise of professional researchers with the concerns and considerations of community members, making it highly adaptable and culturally relevant for diverse populations (113-114).

While community-based action research projects do not have to have a faith-based component or research perspective, scholars agree that CBPR, CBPAR, and CPAR empowers community engagement (Burns, 2009; Breland-Noble, et al., 2020; Maiter, 2008). Still, the collaborative nature of community-based action research is valuable, and its ethical, social, and culturally relevant attributes should not be underestimated. For example, as our current study demonstrates, and as Lawrence W. Green and Shawna L. Mercer conclude, "Public health agencies can provide a bridge between university-based researchers and community-based projects, using participatory research at the agency level to adapt best practices and at the community level to ensure relevance of the research to the community's needs and actions" ("Community-Based Participatory Research," 1928). It is through the bridging of ideas, expertise, and resources that CPAR projects open a space beyond the traditional one-to-one research design and analysis models, such as researcher-to-public/community, researcher-to-community agency, and/or community agency-to-mental health stakeholder.

Moreover, scholars maintain that action research is distinctive from traditional research methods because the "[a]ction involves taking calculated steps toward solving a community, social, or organizational problem" (Vivona and Wolfgram, 514). On the other hand, scholars like Michelle Fine (2008) and Ernest T. Stringer (2014) argue that action research is not a research methodology as used with other data collection and analysis models, but it is a research paradigm for investigation and social change. Stringer states, "The primary purpose of action research is to provide the means for people to engage in systemic inquiry to design a way of accomplishing a desired goal, and to evaluate its effectiveness" (*Action Research* 6). As proposed, community-based action research is a vehicle for community engagement, organizational awareness of a problem, critical investigation, and evaluation of goals and outcomes, which are true markers of collaborative research and knowledge development.

MENTAL HEALTH LITERACY & STIGMA

To foreground our critical community-based action investigation in the African American community, it was important to understand and have a general scope of behavioral and mental health literacies. In the groundbreaking article "Mental Health Literacy," Anthony F. Jorm, et al. offer the first definition for mental health literacy. In 1997, Jorm, et al. explain:

> "Health literacy" has been defined as the ability to gain access to, understand, and use information in ways which promote and maintain good health. By extension, we have coined the term "mental health literacy" to refer to knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognize specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking (182).

Scholars and clinicians agree on the definition of mental health literacy, as the Jorm, et al. study is referenced widely in publications across many disciplines, such as Public Policy and Marketing, Nursing, Women's Health, Social Work, College Student Development, and Medicine (just to name a few). While there are socioeconomic and environmental factors that may cause a delay in treatment or seeking help (i.e., poverty, lack of providers, lack of financial resources, etc.), research shows that individual and shared communal beliefs may also impact a lack of care. "For example, those living with a mental health condition are sometimes challenged by the stereotypes and prejudices that result from misconceptions about mental illness" (Kemp, Davis, and Porter, III, 262). Silence and silencing within and outside of the African American community may prevent mental health help-seeking. As Sullivan, et al. explain, "Additional barriers for African Americans may include having different, non-medical views of the etiology of mental health problems, stigma related to mental disorders, and mistrust of providers or of certain types of treatment such as medication" (540-541). Likewise, as sampled about *stigma* and *mental health literacy,* Sullivan, et al. report:

> *Stigma.* Participants in both focus groups and forums described widespread stigma associated with having mental illness or with seeing a mental health professional. They felt stigma was a key barrier to help seeking, and some even suggested that individuals would refrain from telling friends, their primary care providers, or pastor about mental illness either in their family or about their own symptoms. Older people sometimes viewed symptoms as a weakness; younger people were very concerned about what their peers would think (557).
> […]
> *Mental health literacy.* Participants in both forums and focus groups were concerned that most people did not know how to recognize mental illness and would, therefore, not understand when treatment was needed. […] Poor mental health literacy was also directly demonstrated by some of the participant's comments. There was a great deal of concern expressed about the need to educate children early about mental health (557).

Even as history and scholarship show that African/Black Americans are less likely to seek behavioral and mental health services than other ethnic groups, it is our belief that our current community-based participatory action research project may illuminate and facilitate mental health literacy in Black communities.

African/Black Americans have a diverse array of cultural norms, beliefs, and practices that shape attitudes towards mental health, help-seeking behaviors, and perceptions of mental illness

(Griffith, et al., 2018). By acknowledging the diversity within the Black community and the importance of culturally competent care, scholars recognize the need for mental health services that are sensitive to the cultural contexts of Black patients. Black people face unique challenges when it comes to seeking mental health support and these include stigma, mistrust of the healthcare system, and cultural barriers.

AFRICAN AMERICANS & MENTAL HEALTH DISPARITIES

Racially diverse and marginalized people of color are underrepresented in behavioral and mental health studies. Scholarship also shows that current knowledge of and best practices in mental health literacy have had a smaller impact and reach in African American communities. "In general, African Americans suffer from common mental disorders (such as depression and anxiety) at rates similar to Whites, but they are significantly less likely than Whites to receive treatment" (Sullivan, et al., 540). In light of racial and ethnic disparities in the United States, the U.S. Surgeon General has determined that historical and sociocultural factors, such as slavery, racial bias, racism, poverty, homelessness, incarceration, etc., in combination and individually, are uniquely linked to the mental health accessibility and treatment of Black people (*Mental Health,* 1999; *Mental Health: Culture, Race, and Ethnicity,* 2001). "The legacy of slavery and discrimination continues to influence their social and economic standing. The mental health of African Americans can be appreciated only with this wider historical context" (2001, 53). Yet, race-based assessments, when considering mental health care, are undervalued and/or omitted in many studies and in clinical practices.

According to McGuire and Miranda, a clear definition of racial/ethnic disparities in mental health is complicated. They explain:

> A consensus about what constitutes a "disparity" has not been reached despite a voluminous literature on the topic. The term disparity clearly connotes an unfair difference, but measurement of this difference is far from uniform. Here, we rely on the definition employed by the Institute of Medicine (IOM) in its *Unequal Treatment* report: a disparity is a difference in health care quality not due to differences in health care needs or preferences of the patient. As such, disparities can be rooted in inequalities in access to good providers, differences in insurance coverage, as well as stemming from discrimination by professionals in the clinical encounter (393).

Even with a lack of consensus, scholars also cite environmental and political factors (i.e., police brutality, violence/danger, political protests, etc.) as disparities that have a direct impact on mental health and well-being (Avent Harris, et al., 2020; Brown, 2008; Hirshbein, 2021). The level of trust or mistrust in authority figures, such as healthcare professionals, clergy, etc., may consciously and unconsciously hinder help-seeking and treatment. In addition, historical adversities must not be overlooked. According to the U.S. Surgeon General's Supplemental Report on Culture, Race, and Ethnicity:

> Historical adversity, which include slavery, sharecropping, race-based exclusion from health, educational, social, and economic resources, translate into socioeconomic disparities experienced by African Americans today. Socioeconomic status, in turn, is linked to mental health: Poor mental health is

> more common among those who are impoverished than those who are more affluent (57).

But even as it is recognized that people of African descent in America "suffer a disproportionate burden of mental illness," Newhill and Harris note that the Surgeon General's "report concluded that there is a large gap between the need for services and the services actually provided" (2007, 108). Likewise, with respect to our current CBPAR project, we also recognize the important distinction, and are hopeful that the community-based action research data may be used as an assessment tool for analysis of any racial/ethnic disparities and gap(s) "between the need for services and the services actually provided."

Although there is a growing literature on behavioral health risks among African American sexual minority men, fewer studies have focused on African American sexual minority women (Pérez, 2020). African Americans are described as experiencing 'triple jeopardy' as a result of multiple areas of marginalization and oppression that include but are not limited to their race, gender, and sexual orientation. African Americans may also experience discrimination within the Black community when it comes to mental health. These multiple forms of oppression place them at increased risk for negative mental health outcomes.

AFRICAN AMERICANS & CULTURALLY COMPETENT BEHAVIORAL HEALTH SERVICES

A major barrier hindering African Americans from accessing behavioral health care is a shortage of culturally competent providers which emphasizes the importance of exploring community-based interventions aimed at promoting mental well-being (Lemelle, et al., 2011). To address these barriers, it is important to emphasize the significance of culturally competent care, advocating for approaches that respect and integrate the unique cultural beliefs and experiences of African Americans. Be that as it may, it is important to celebrate the resilience and strength of African Americans as individuals and communities in navigating mental health challenges despite systemic obstacles. The intersectionality of identities should also be acknowledged as it takes note of experiences that influence African American mental health, highlighting factors like gender, socio-economic status, and disability.

A strengths-based parent intervention program was designed to support African American families in the context of parenting (Huguley, et al., 2023). The intervention program was conducted in spring of 2021 via Zoom due to COVID-19 prevention efforts. The program emphasized a strengths-based approach, which focused on identifying and building upon the existing strengths and resources within African American families. This approach contrasted with deficit-based models that overlook the resilience and capabilities of Black families. It is important to acknowledge the unique challenges faced by Black parents, including navigating systemic racism, socioeconomic disparities, and cultural expectations. These challenges can and do impact parenting practices and family dynamics.

The intervention program includes structured activities and workshops aimed at enhancing parenting skills, improving parent-child communication, promoting positive discipline strategies, and fostering supportive parent-child relationships (Huguley, et al., 2023). It also incorporates

cultural sensitivity by acknowledging and respecting the cultural values and practices of African American families. As a result of this parent intervention program, participants reported improvements in their parenting practices, increased confidence in their parenting abilities, and enhanced family functioning. These improvements contributed to better child outcomes, including increased emotional well-being and academic success. This highlights the importance of culturally tailored interventions that recognize and leverage the strengths of African American families. Such programs not only support parents in overcoming challenges, but also empower them to create nurturing environments that promote positive child development. Therefore, strengthening parenting skills and family relationships can have ripple effects on community resilience and social cohesion.

COPING RESPONSES TO RACIAL DISCRIMINATION

Coping responses to racial discrimination can be categorized along a multiaxial plane, including active and passive strategies (Jones, et al,.2019). Active coping refers to cognitive or behavioral strategies to address the root causes of stressors, whereas passive coping refers to cognitive and/or behavioral attempts to avoid stressors or reduce the resultant emotions that arise from such stress. It is possible for individuals to engage in active coping efforts (e.g., activism) to combat the stress that emerges from discrimination. At the same time, given the pervasiveness of racial discrimination, it is also possible for passive coping to be used, given that these strategies are often used when it is assumed that one's circumstances will not change. Both active, and passive coping strategies can be adaptive (i. e., leading to prosocial relief from the impact of racial/ethnic discrimination). Professional behavioral health services may help guide African/Black Americans to assess the degree to which their active and passive coping strategies are adaptive, or maladaptive.

THE IMPACT OF STRESS ON BLACK PREGNANT WOMEN & THEIR FAMILIES

This area of the literature review was added because of the emphasis early on in Year 2 with regard to the selection of the theme ‘Parenting While Black’. The focus on Black women and the impact on their pregnancy has implications for the stress it can create across an entire family system. Additional literature could be added in this section on the impact to Black men and children, yet the focus on women was informed by the interests expressed by participants in Year 1.

Discrimination has been defined as the “social practice that organizes prejudicial attitudes into the formal or informal segregation of social groups or classes stigmatized by the collective prejudice” (Dove-Medows, et al. 2020). African/Black American women may face systemic racial discrimination, which can lead to chronic stress and negative health outcomes. Discrimination in healthcare settings, employment, housing, and daily interactions can contribute to psychological distress which leads to them experiencing preterm births.

Moreover, African American women are more likely to experience psychological distress compared with White women (Dove-Medows, et al. 2020). Chronic exposure to racial

discrimination and adverse neighborhood environments can result in psychological distress among African/Black American women. This distress often manifests as anxiety, depression, or chronic stress, which are known to impact pregnancy outcomes. Psychological distress and stressors associated with neighborhood environment and racial discrimination are linked to increased rates of preterm birth among African/Black American women. Preterm birth, defined as birth before 37 weeks of gestation, is associated with various health risks for both the infant and the mother.

"The Talk," is a crucial conversation that many Black parents have with their children about racial discrimination, systemic racism, and how to navigate encounters with law enforcement or authority figures. This conversation is necessary to prepare children for potential racial biases and to instill strategies for survival and resilience. (Anderson et al. 2022) discusses various strategies that Black parents employ to protect and empower their children in a racially unjust society. This includes teaching children about their cultural heritage, fostering racial pride and resilience, and advocating for their rights in educational and social settings. Black parents engage in acts of resistance against racial injustices while fostering resilience within their families. This resistance can take the form of community activism, advocacy for policy change, and challenging racial stereotypes that affect their children's development and opportunities. Black parents navigate and create safe spaces for their children, both physically and emotionally, within their communities and educational institutions. These safe spaces are essential for nurturing a positive racial identity and protecting children from the psychological impact of racism. Therefore, it is important to emphasize the intergenerational transmission of knowledge and experiences related to racial discrimination and resilience, shaping the ways Black parents approach parenting.

Methods

RESEARCH QUESTIONS

Q1) Does participation in community learning sessions impact community mental health awareness?

Q2) Does participation in community learning sessions impact community mental health literacy?

Q3) Does participation in community learning sessions impact community mental health service utilization/facilitation?

As the emphasis shifted from the CBPAR to the development and maintenance of the LC, the focus of the evaluation shifted to understanding how the LC and community members perceived the project’s capacity to answer the research questions.

SUMMARY OF METHODOLOGIES UTILIZED IN YEAR 1

The teams from Jewel of Justice (JOJ), Fresno State (FSET), and the Fresno County Department of Behavioral Health (DBH) met often during Year 1 to discuss the project overall, and the methodologies we wanted to utilize. Several meetings were open to the entire team, but early into Year 1 a core leadership approach was used where a single representative from Fresno State (Dr. Pitt-Parker or Dr. Travis Cronin), and DBH (Mr. Dennis Horn) joined the Jewel of Justice Team. Meetings were held 1-2 per month to plan for the events (community learning sessions) and to process observations and data collected during the events. These meetings informed the data collection process, served as an initial space to discuss the data as it was collected, and helped the collective project assess what adjustments were needed to maximize our success as we headed into Year 2 where we would utilize a community participatory action approach.

We decided to create a simple survey to understand at a basic level if the community learning sessions were helpful to raising behavioral/mental health awareness and literacy. The initial survey had four quantitative items and an open-ended item. The initial survey was used for the first seven learning sessions (September - December 2022). The team decided to keep four of the initial items, add five substantive items (related to awareness, literacy, and utilization), and add three demographic items.

SUMMARY OF METHODOLOGIES UTILIZED IN YEAR 2

The survey from Year 1 underwent multiple iterations in an attempt to gather additional data, and to better understand the experiences of the participants. In the end the survey had 14 items. Eleven items pertained to the participant's experience in the Year 2 sessions/events. Three items were demographic (age, gender/sex, and parental status including ages of their children).

The FSET continued to attend and observe the LC and a majority of the events/sessions planned and carried out by the LC.

The FSET conducted semi-structured interviews with members of the LC to understand their experience as members of the LC, and to understand their perception of the project overall. The interviews were transcribed and subsequently analyzed using phenomenological analysis (Moustakas, 1994, Padgett, 2016). Informed consent forms were signed by the participants (Appendix D). Participants were offered a $30 gift card to Chef Paul's, an African American/Black owned business in Fresno County.

EVENTS AND ATTENDANCE

Jewel of Justice hosted 18 events (e.g. launch, intervention sessions, CBPAR presentation, and Leadership Council Development Dinner), with 171 participants across the 18 events. The events ranged from two to 30 participants, with a median of 7 participants. Three events had more than 20 participants.

Event	Date	Number Registered	Number Attended

Project Launch – Jewel of Justice, Fresno State, and DBH	9/24/22	5	13
Bearing the Burden – African American Community Co-Facilitator w/ Jewel of Justice	10/14/22	0	2
Mental Health 101 – DBH Black Staff Co-Facilitator w/ Jewel of Justice	11/7/22	2	5
Mental Health 101 (online) DBH Black Staff Co-Facilitator w/ Jewel of Justice	11/17/22	2	2
The Public Behavioral Health System – DBH Black Staff Co-Facilitator w/ Jewel of Justice	12/5/22	1	3
Generational Trauma African American Community Co-Facilitator w/ Jewel of Justice	12/9/22	1	2
The Public Behavioral Health System (online) DBH Black Staff Co-Facilitator w/ Jewel of Justice	12/15/22	8	8
Grief & Loss – African American Community Co-Facilitator w/ Jewel of Justice	1/13/23	0	2
Cultural Identity and Awareness –	2/10/23	8	12

African American Community Co-Facilitator w/Jewel of Justice			
Healing with the Arts Jewel of Justice Collaborated with B Awesum	2/17/23	12	30
Suicide Prevention & Intervention – DBH Black Co-Facilitator w/ Jewel of Justice	3/6/23	1	4
Suicide Prevention & Intervention (on-line) – DBH Black Facilitator w/ Jewel of Justice	3/22/23	7	7
Parenting While Black, Pt. 1 – African American Community Co-Facilitator w/ Jewel of Justice	3/29/23	7	8
Parenting While Black, Pt. 2 – African American Co-Facilitator w/ Jewel of Justice	4/12/23	10	6
Speaking Up & Out – African American Community Co-Facilitator w/ Jewel of Justice	4/19/23	8	8
Black College Students Behavioral Health Conversation – Jewel of Justice and Fresno State	4/27/23	0	28
CPAR Inquiry and Design Presentation	6/13/23	20	23

Design of Leadership Council Dinner Gathering	6/29/23	14	11

Table 1 (Year 1; Submitted By: Karen Crozier)

The participation in Year 2 intervention sessions and training ranged from 2 - 80 participants.

The events of Year 2 included:

Narrative Medicine Workshop Training for Jewel of Justice and two LC members at Columbia University Medical School in New York, 10/13-15/23

Trauma Informed Care for Leadership 11/5/23

Black Self-Care and Wellness Series: Grief & Loss 3/14/24, Healing H.E.R 3/21/24, Parenting Again 3/28/24, Single Parent Millennials 4/11/24, Conflict Resolution 4/18/24, and Owning Your-Self-Care 4/25/24

Trauma Informed Care for Black Clergy and Congregational Leaders, 4/20/24 (2 clergy attended)

Trauma Informed Black Self Care for the Community, 5/4/24 (80 community members attended)

African Americans Integrating Cognitive Psychology for Everyday Success, 6/1/24

Navigating Therapy While Being Black, 6/13/24

In addition, the LC met on the following dates: August 29, 2023; November 14, 2023; December 12, 2023; January 30, 2024; February 29, 2024; May 30, 2024

Findings & Results (Key Learnings & Analysis)

RQ 1) What do we know regarding question 1 (awareness), and how do we know it?

RQ 2) What do we know regarding question 2 (literacy), and how do we know it?

RQ 3) What do we know regarding question 3 (utilization/facilitation), and how do we know it?

This evaluation attempts to answer the same research questions as posited in Year 1.

PARTICIPANTS

We had multiple strategies to learn about the identities of the participants including the data on sign-in sheets. Demographic identifiers were not included on the first iteration of the survey due to historical and contemporary misgivings about the research process among many African/Black Americans. We purposely kept a lower profile with regard to demographic

questions in hopes of building a sense of trust with participants. The second iteration of the survey (*N = 31*) included items regarding ethnic/racial identity, gender, and age.

Participants could select multiple racial and ethnic categories. The most common ethnic and racial identities were African American (*n* = 18, 58%), and Black (*n* = 12, 39%). Other responses with at least one response, yet less than four responses: Black African, Afro Latina/o/x, Afro Caribbean, multi-racial, and biracial.

Most of the participants (*n* = 25, 81%) identified as female. The remaining (*n* = 6, 19%) identified as male.

The age variable was collected in categories to protect anonymity within a small sample. The age categories included: 18-25 (*n* = 3), 26-35 (*n* = 11), 36-45 (*n* = 7), 46-55 (*n* = 0), and 56 or older (*n* = 7). Three participants did not select an age answer.

In Year 2 an additional 122 surveys were collected (*N = 122*). **It is important to note that some of the surveys may have been submitted by the same participant because the same survey was distributed at each event or training. Thus, the FSET cannot determine the amount of duplication from participants who may have submitted multiple surveys. This note also applies to the data collected in Year 1.**

The racial and ethnic identity question did not help the FSET other than to confirm that those who answered this item were similar to those in Year 1. Specifically, the data available to FSET on this item was (*n* = 20) substantially less than the data on other items. Roughly speaking, the breakdown of participants' racial and ethnic responses were reversed from Year 1 with more selecting "Black" compared to "African American" (i.e., 60% Black; 35% African American, 5% Other).

A notable portion of participants opted not to respond to the remaining demographic survey items (15-17%, n = 18-21).

As in Year 1, the sample in Year 2 was predominantly female (67%, *n* = 82), with the remaining responding participants identifying as male (18%, *n* = 22).

With regard to age in Year 2, the highest number of respondents selected the category over 56 (35%, *n* = 43), the second most selected category was 26-35 (23%, *n* = 28), with the remaining responding participants (*n* = 30, 25%) reporting another age cohort (i.e., 18-25; 36-45; 46-55).

During Year 2 an item was added regarding parental status including the ages of the participants' children. Of the 90 participants who responded to this item, 64 (71%) reported being a parent, and the remaining respondents (29%) selected another category (i.e., not a parent; not a biological parent though a parental figure, "parenting again").

SURVEYS

We received 21 responses to the initial survey. There were 35 participants when the initial survey was administered, therefore the 21 survey responses represented a 60% response rate. All 21 participants (100%) answered “yes” to the prompts: This event helped me to think about how I take care of my mental health; I want to attend other events similar to this; and I intend to share what I learned from this event with other people. Twenty of the 21 participants (95%) answered “yes” to the prompt: This event helped me to think about how I receive mental health support from other people. The remaining participant (5%) indicated that they were “unsure” about this item. Eighteen of the 20 participants (90%) answered “yes” and two participants answered “unsure” to the prompt, “This event helped me to think of new ways to take care of my mental health.” One participant did not respond to this prompt. Of the 21 participants who submitted a survey, 11 (52%) answered the open-ended prompt: Please share any other information you would like to share with us about your experiences this evening. The most common sentiments included gratitude, and safety. For example, one participant wrote, “Thank you for giving me the space (to) talk about concerns I don't get the chance to talk about.”

We received 31 responses to the second iteration of the survey. There were 136 participants when the second iteration of the survey was administered, therefore the 31 survey responses represented a 22% response rate. All 31 participants (100%) answered “yes” to the prompts: This event helped me to think about new ideas to take care of my mental health; Attending this session helped to build my mental/behavioral health awareness. Thirty participants (96%) selected “yes” to the prompt: I intend to share what I learned from this session with other people. Twenty-nine participants (93%) selected “yes” to the prompt: This session helped me to think about how I take care of my mental health, one participant (3%) selected “unsure,” and the final participant (3%) selected “no” in response to this item. Twenty-eight participants (90%) selected “yes” to the prompt: This session helped me to think about how I receive mental health support from other people. The remaining 3 participants (10%) selected “no” in response to this item. Of the 31 participants who submitted a response to the second iteration of the survey, 10 (7%) answered the open-ended prompt: Please share any other information you would like to share with us about your experiences this evening. The most common sentiments included gratitude, and safety. For example, one participant wrote, “I think this session was very healing and freeing. It was nice to have a safe space to express myself and hear from other women who are like me. It was nice to find community and to experience this space with this amazing group of women.”

The second iteration of the survey included additional items in an attempt to understand behavioral health utilization issues. Twenty-nine participants (93%) selected “yes” to the prompt: I plan to use what I learned in this session. The remaining two participants (7%) selected “unsure” in response to this item. Two items were added to understand which behavioral health resources and medicines had been utilized in the past year. Participants could select all of the choices provided including the category of “other”. The resources utilized included: prayer (n = 24), deep breathing/meditation/mindfulness (n= 24), therapy/counseling (n = 20), talking to a friend, kin, elder, mentor, coach, teacher (n = 15), exercise/yoga (n = 14), telehealth (n = 11), talk to your medical/healthcare provider in person (n = 9), faith community

(n = 6), talk to your faith leadership (n = 4) and, Department of Behavioral Health program or services (n = 4). Medicinal strategies used in the last year included: tea (n= 23), plant-based/herbs (n = 11), prescriptions (n = 10), none (n = 4), homeopathic (n= 2), over the counter (n = 2), and walking (n = 1).

Overall, the data from the two iterations of the survey (*N* = 52) indicated that the community learning sessions were helpful to most participants with regard to mental and behavioral health awareness (RQ 1), and mental and behavioral health literacy (RQ 2).

The second iteration of the survey helped us to understand behavioral health utilization (RQ 3). A strong proportion of the participants who completed the survey are praying (n = 24, 77%), practicing mindfulness/deep breathing (n = 24, 77%), and accessing counseling/therapy in the community (n = 20, 64%). Despite the fact that these participants report utilizing multiple strategies to manage their mental and behavioral health challenges, few reported utilizing DBH programs and services (n = 4, 13%).

Due to incomplete attendance data, a response rate could not be calculated for the Year 2 survey collection. Either the response rate was much stronger in Year 2, or participation was much higher. In either case, substantially more surveys were submitted in Year 2 compared to Year 1. It appears the scope of this project reached a broader portion of African Americans in Year 2 comparative to Year 1. Challenges within the methodology (duplication of participants due to the possibility of multiple surveys per participant) make it hard to assess the breadth of community members reached, but the event with 80 community members alone serves as evidence of growth from Year 1 comparative to Year 2 as this event was more than 3 times larger than the highest attended event in Year 1.

The data from Year 2 followed the data from Year 1 with a resounding approval for the events and their impact on the participants.

It is likely there was a problem with Item 1 as evidenced by a low response rate (*n* = 5). The five participants who responded stated that the session helped them to think about self-care and wellness for Black people.

A grand majority of the sample (*n* = 119, 98%) reported that the session gave them new ideas about self-care and wellness. The same 98% affirmed “this session helped me to think about how I receive self-care and wellness support from other people such as family, friends, clergy, and healthcare providers.” For Item 4, 120 participants responded that the session they attended helped to build their awareness about self-care and wellness. Slightly less (*n* = 116, 95%) reported an intention of sharing what they learned with other people. A full 98% reported their intention to use what they learned in the session.

In response to self-care and wellness resources used in the past year, the participants were given a list and asked to select all that apply. Prayer was the most endorsed item (*n* = 98) followed closely by deep breathing/mindfulness/and meditation (*n* = 94). Slightly more than

half (*n* = 64) of the participants selected therapy/counseling, or talking to your friend, kin, mentor, elder, coach or teacher. The next most common strategy was exercise/yoga (*n* =51), followed closely by talking to your medical/healthcare professional in person (*n* = 49). A full third of participants endorsed talking to their faith leadership (*n* = 40), with slightly less (*n* = 38) endorsing telehealth, or their faith community (*n* = 30). Less than a quarter of the sample reported using a Department of Behavioral Health service or program (*n* = 17).

The top two medicinal remedies used by participants for self-care and wellness were tea (*n* = 66), and plant-based herbs (*n* = 45). A quarter of participants (*n* = 30 reported using medications, homeopathic remedies (*n* = 23), and/or over-the-counter medicines for self-care and wellness. Interestingly, some participants (*n* = 12) reported a strategy that was not mentioned and the same number reported not having used strategies for self-care and wellness in the past year.

Overall, the Year 2 survey data strengthened our assessment that this project increased behavioral health awareness (R1) and literacy (R2). The survey's design and implementation made assessment of utilization (R 3) more challenging to evaluate, yet the participants who filled out surveys in Year 2 appeared to utilize a variety of behavioral health strategies towards self-care and wellness. These results are encouraging, yet further study is warranted to better understand strategies to enhance utilization of behavioral health services and programs within the African/Black community in Fresno County.

OBSERVATIONS

The Stigma. In general, Black people and African Americans continue to experience medical and behavioral health institutions and practitioners as untrustworthy and lacking providers who represent them. Many of the participants in the intervention phase were aware of behavioral health practices and utilized them. In addition, they expressed excitement about the work we were doing because it was needed although we struggled with how to access the number of people who were in need and to resource them for access to trustworthy providers and systems of support and care. There also seemed to be limited to no usage of the public behavioral health system by the intervention participants. For the few that did report usage, it was not a positive experience.

Barriers to Treatment. From several intervention sessions, it was identified that Black people and African Americans would probably have an increased utilization of public behavioral health system if the following conditions were met: 1) more providers who were Black and African American, 2) more of a relational and trust building focus during the intake process rather than the current high volume of paperwork and bureaucracy, 3) going into the homes and communities as an option of service, and 4) resourcing and supporting known and trusted individuals and providers who have access to the people as a bridge.

Medi-Cal. Even if these conditions were met, it still would be a struggle because we heard from a Black faith-based provider that they were informed not to work with the Department of

Behavioral Health (DBH), and from a Black clinical provider that they will not work with the Department of Behavioral Health because the function of the agency is to recoup Medi-Cal dollars and not empower and support small, burgeoning providers who do not yet have the infrastructure to be a partner to have dollars returned for not servicing accordingly as designed by Medi-Cal. In closing, while the traditional stigma of being afraid to talk about behavioral health challenges is waning, the lingering effects are still there and county agencies must become more trustworthy.

Messaging (Research focus vs. community's immediate behavioral health needs/ concerns/ challenges). Throughout Year 1, the teams regularly discussed the challenges associated with the call from community members for immediate relief by way of direct services. As Jewel of Justice conducted community learning sessions and met with members of the community, there was an ongoing challenge related to the way we share the message about this project. Toward the end of Year 1, we (JOJ, FSET, & DBH) had a meeting to discuss the last large-scale event of the fiscal year. During that meeting we collectively decided that we needed to adjust our messaging towards African/Black American health and well-being rather than use the language of mental and behavioral mental health. This dynamic will likely play a central role as we shift our attention to Year 2 and its reliance upon community participatory action research methodologies.

As highlighted in Appendix E, the FSET made a range of observations throughout this project pertaining to its effectiveness. First and foremost, there was overwhelming evidence that several members of the Fresno County African American/Black community found this project to be helpful as evidenced by their comments during respective events including the LC, their written endorsement on an open-ended survey item, and in interviews conducted by the FSET. Further evidence is laid out in the following section.

Secondly, (also highlighted in Appendix E) there were challenges and barriers throughout this project. The most pressing challenges and barriers were a lack of clarity on the roles and responsibilities of each team, an assessment of the capacity of each team (FSET and JOJ), and a clear timeline. Future projects may benefit from mapping out the project from the beginning and assessing if the project has the resources needed to meet the design.

INTERVIEWS

The FSET conducted interviews with five members of the LC. Their responses were organized into five themes: gratitude, service, community, confusion, and doubt.

Gratitude. The participants who were interviewed expressed a strong sense of gratitude. This gratitude was primarily focused on gratitude for the opportunity to be involved in the project, the funding to make the project happen, and the sense of purpose it provided at various points in the process. One participant expressed it this way, "It's beautiful, it's a great thing that Dr. Crozier has going on. It's a wonderful thing. It's a lot she can offer, Fresno State can offer." Another participant said, "We started stuff, just having the money, and things like that." These

participants and others recognized the collaborative nature required to mobilize community members, and they appreciated the various contributions that helped the group to come together. One participant was particularly grateful for the lessons learned from working with Dr. Crozier in particular, “I just really appreciated watching her work . . . it’s really empowered me to ask more questions and to be more thorough with engaging with people.”

Service. Every participant reported that a desire to serve motivated her/him throughout this project. The hopes expressed by participants focused on the intentionality of the project (as community focused), and by their own engagement throughout the process. One participant stated, “Being a part of a Council that has the intent to serve the community. I think that piece is really important.” Another participant explained “the goal was to create change and offer suggestions to DBH.” Still another participant expressed an anticipated change as they remained engaged throughout the project, “What we wanted to do was just to give people tools to be trauma informed in their own self-care, and I think that is what we ended up doing.”

Community. Participants engaged with this project because of their community connections, their lived experiences, and the sense of community they experienced through their involvement with the project. One participant expressed her commitment to participation in the project by explaining, “I participate a lot in the events we have put on . . . When she [Dr. Crozier] called me, I am there no matter what!” Another participant explained why a focus on African Americans was essential to helping people who cannot speak for themselves, “Especially African Americans, because we don’t trust everybody. We from the old school! You know? We keep things to ourselves, and that is something we don’t want to do anymore.” Another participant explained, “Community work is for everybody! You just have to have the heart for it . . . it’s a labor of love.” The group’s diversity, and the connections built through the project were meaningful to several participants, “And it brought together a bunch of different ideas based on where people lived, or where they were in their life. We had different educations, different ages, different stages of life, and I think that is the valuable part.”

Lack of Clarity. A key challenge expressed on the success of this project by some participants was a lack of clarity regarding its scope and aims. One explained, “A lot of the feedback I got, because I had friends who were going to the events, the lack of attendance, and they thought it was due to a lack of marketing . . . I don’t even understand why a social media marketing budget was not in the initial budget.” Another challenge mentioned was the procedure for conducting meetings which was not as clear as it could have been, as evidenced by this participant’s comment, “I would say start with some rules of order. I mean I understand culturally we’re kind of like a more collective “everyone speaks” to this kind of thing. But that made our meetings go off track, and we didn’t always [finish] our agenda completely, so I say a sort of rules of order.”

Doubt. Universally, the participants agreed that the project had merit. However, not all participants were on board with the approach of providing trainings about trauma to the community. For example, one participant questioned, “How is teaching our community about complex trauma going to drive them to DBH?”This participant was particularly disappointed by

the challenge to do something meaningful regarding peer support (peer support had some momentum early in Year 2). The participant explained peer support this way:

> "I'm gonna go into your home. I'm gonna tell you about the services. I'm going to put you in my car, and take you to the services. I'm gonna help you understand the services." "I'm gonna take you back home. We are going to have lunch; then I'm going to talk about the services. Then we are going to make another appointment for more services. Like that makes sense. It's black and white. The community can understand that."

OBSERVATIONS

The FSET made a number of observations throughout the LC meetings, and its events in Year 2. The themes highlighted during the interviews were present throughout the LC meetings and learning sessions. For example, at the end of the February LC, a community member stood up and expressed gratitude, hope, and community pride. This member became emotional and encouraged the group to "keep going."

The FSET also observed a lack of agreement among participants during the LC meetings. For example, during the final LC meeting two LC members proposed additional community events. One LC member attempted to draw upon Robert's Rules of Order to call the proposals for a vote, yet the group was unsuccessful in gaining the momentum to support the proposals. Several members of the LC expressed their desire to support the proposals, yet the proposals were tabled for further details via email after the LC. After the meeting was over, both proposals were withdrawn.

OPEN ENDED SURVEY ITEM

The open-ended survey item underscored the need for projects like this one from the perspective of participants. In particular, participants expressed their gratitude for the learning sessions and events. Participants wrote things like: "amazing", "I hope to see these events often"; "it was a great event", "it needs to be more widespread"; "great information to build my system of freedom"; and "I needed this session."

Discussion (Suggestions on Project Viability)

The data from the first year was promising with regard to the first two research questions. Participants indicated an appreciation for the community learning sessions, and indicated the sessions enhanced their community mental health awareness and literacy. These findings were borne of the survey results and observations.

It was much harder to discern if the community learning sessions impacted community mental health service utilization and facilitation. In fact, the findings pointed to a number of structural factors that hindered community mental health service utilization. Therefore, the data from Year 1 suggested that it is unlikely that participation in community learning sessions will be sufficient to increase African American participation in community mental health programs.

As we transition into the second year of this project we suggest continued efforts to offer community learning sessions. The survey results and observations[4] clearly indicated African Americans and Black people in Fresno County reported increased awareness and literacy as a result of participating in community learning sessions. Consideration should be given to finding ways to scale up the community learning sessions. Some of the sessions were quite small (n = 2-3), yet other events were much larger (23-30). Certain events may call for smaller groups, but we suggest aiming for a middle ground for events in the second year (10-15). If the smaller events can draw additional participants, it stands to reason that the reach of this project will grow. The data from the larger events yielded important observations as well, so we suggest that larger events remain a part of the strategy as we move into the second year.

As reported in the observational findings, the participants perceived substantial structural problems with regard to the systems designed to provide behavioral and mental health support in the community. Participants urgently wanted direct, meaningful, and effective treatments that were designed for them. The community learning sessions in some ways appeared to partially fill this gap. As noted in the literature review, historical adversities such as enslavement should inform the design of services for African Americans. The findings from Year 1 suggest this all be woven into the design of the services, not simply stacked on top. The findings and literature together, suggest providing programming and services that align with the historical and contemporary challenges faced by Black and African American residents within Fresno County.

The participants called for providers that could understand and meet their needs. One way this was articulated was through the call for providers who “look like me.” Practices that account for hiring and retaining Black and African American practitioners are challenging in a landscape where affirmative action programs have been eliminated. Nevertheless, if this finding remains neglected, the systems designed to care for the behavioral and mental health needs of African Americans may continue to go unmet.

As noted in the literature review, African/Black Americans face a variety of mental health disparities, and challenges related to stigma about receiving formalized behavioral health services. It is essential to recognize that these disparities and stigmas arise from a socio-political context of services that were not designed for African Americans/Black communities. Contemporary discrimination towards African/Black Americans before, during, and after treatment further exacerbates these disparities.

The participants in Year 2 clearly demonstrated a thirst for knowledge about ways to engage in self-care and wellness. They clearly expressed their gratitude for the efforts made to bring them information specific to their lived experiences. These efforts should be replicated through community-based organizations with the connections necessary to facilitate participation. While there was some concern about attendance, it is important to recognize that any new project will

[4] Appendix C: Observations from community events submitted by Dr. Reese

have its 'growing pains'. Establishing a way to continue outreach to African/Black Americans in Fresno County is strongly recommended.

The participants interviewed were service oriented. Nevertheless, to sustain and engage African/Black Americans in formal behavioral health services will require a salary and benefits for full-time employees that are culturally embedded in the practices of both DBH and the African American/Black community in Fresno County.

Perhaps the most robust support for this project comes from the relationships that were built and maintained by the assistance provided throughout this project. The JOJ in particular demonstrated a robust capacity to bring the Black community together in meaningful ways (i.e. sense of community and belonging) and future partnerships with the JOJ should take this strength into consideration.

Bringing people together to work on a complex problem with an extremely long history is likely to be a daunting task. Lack of clarity, and frustration are predictable parts of the process. Nevertheless, the data from the LC interviews provide some supportive guardrails for future efforts. Namely, a clear set of expectations should be outlined by all parties regarding communication, frequency of meetings, budgets, roles, responsibilities, and decision making. Efforts were made in each of these areas; yet, all were in need of some improvement for this project.

When gathering a group to address a problem, it is important to assess if you have the resources you need to develop the needed traction for change. As indicated under the "Doubt" theme (pg. 21), a key strategy (i. e. peer support) was left behind toward the end of the project. The FSET recommends future projects develop a process to assess when this should be done. The resources allocated for this project suggest there may not have been sufficient support for both strategies (trauma-informed care training and peer support training). Therefore, establishing a clear assessment of the task at hand and the resources needed to complete it may be helpful for future efforts.

Conclusion

During the first year of this CBPAR project, JOJ built important relationships throughout the community. This foundation was underscored by the call for "more" action similar to the community learning session provided during Year 1. At every turn in the data the findings suggested that funding this project was an important first-step towards enhanced behavioral and mental health awareness and literacy among Black and African Americans living in Fresno County. There is a great deal of work ahead, and Year 2 will provide the opportunity for the second step towards building a bridge between the community and DBH. Historical and contemporary abuses of people of African descent are the foundation of this bridge. The findings from Year 1 suggest that telling the truth about these abuses may be the only way to build a bridge worthy enough to walk across. The journey in Year 2 should focus on gathering

data about Black and African American experiences that may help to inform behavioral and mental health services designed specifically to enhance their well-being.

At the conclusion of this multi-year effort, we thank all of the participants and Leadership Council members who gave of their time and energy to bring about the success of this project. We also thank the Fresno County Department of Behavioral Health for funding this innovative project, and for believing in its community partners. Specifically, the Jewel of Justice organization did an impressive job of gathering and supporting members of the African American/Black community in Fresno County. The task of completing a CBPAR project proved to be too ambitious given the lack of clarity about the roles and responsibilities for the JOJ and the FSET. Any future projects aiming to complete a CBPAR may need more than the two-year timeframe, and a clear plan for recruitment and data collection. Project partners did a reasonable job to create a research design and a plan for analysis. A future CBPAR may require the funds to assure the adequate faculty and/or staff are available to complete this challenging yet important work. Finally, the FSET sincerely thank Dr. Jenelle Pitt-Parker for bringing us together to participate in such a meaningful project.

It is our intent that the contents of this report prove helpful to African/Black Americans in Fresno County who need more behavioral health support than they currently have at this time. We urge the Fresno County Department of Behavioral Health to use this report to continue its leadership and funding of projects that serve and honor the needs of the Black community with cultural humility. We wish the JOJ and the LC the very best as they set new goals to continue this work beyond the conclusion of this specific project.

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APPENDIX A

Survey (First Iteration)

Your participation in this survey is voluntary. You may skip any question you do not want to answer. Your answers will be used to evaluate this session and to assist us as we plan future programming. Any information you provide will be anonymous and will not be used to identify you or the answers you provided. Thank you for attending this event!

This survey should take approximately 10 minutes to complete. Do you wish to participate in this survey?

No
Yes

This event helped me to think about how I take care of my mental health.

Yes
No
Unsure

This event helped me think of new ideas to take care of my mental health.

Yes
No
Unsure

I want to attend other events similar to this.

Yes
No
Unsure

I intend to share what I learned from this event with other people.

Yes
No
Unsure

Please share any other information you want us to know about your experience this evening. (text box provided for typing)

APPENDIX B

Survey (Second Iteration): New content in bold

Your participation in this survey is voluntary. You may skip any question you do not want to answer. Your answers will be used to evaluate this session and to assist us as we plan future programming. Any information you provide will be anonymous and will not be used to identify you or the answers you provided. Thank you for attending this event!

This survey should take approximately 10 minutes to complete. Do you wish to participate in this survey?

No
Yes

This event helped me to think about how I take care of my mental health.

Yes
No
Unsure

This event helped me think of new ideas to take care of my mental health.

Yes
No
Unsure

This session helped me to think about how I receive mental health support from other people.

Yes
No
Unsure

Attending this session helped to build my mental/behavioral health awareness.

Yes
No

Unsure

I plan to use what I learned in this session.

Yes
No
Unsure

I intend to share what I learned from this event with other people.

Yes
No
Unsure

Please share any other information you want us to know about your experience this evening. (text box provided for typing)

What behavioral health resources have you used in the past year? (Mark all that apply)

telehealth
prayer
therapy/counseling
deep breathing/mindfulness/meditation
talk to your medical/healthcare professional in person
talk to your faith leadership
talk to your friend, kin, mentor, elder, coach, or teacher
Department of Behavioral Health services or programs
faith community
exercise/yoga
Other (text box provided)

In the last year, what medicinal remedies have you used to treat your behavioral health?

plant-based/herbs
prescription
over-the-counter
homeopathic

tea
none
not mentioned, please specify (text box provided)

If you have used a service within the past year with the Fresno County Department of Behavioral Health, please briefly describe or name the service below. (text box provided)

What is your age?

18-25
26-35
36-45
46-55
56 or older

How do you racially or ethnically identify? (Mark all that apply)

African American
Afro Caribbean
Afro Latina/o/x
Biracial
Black
Black African
Multiracial
Not Mentioned (text box provided)

What is your sex or gender identity? (mark all that apply)

Female
Non-binary
Male
Trans
Non-conforming
Expansive
Prefer to describe (text box provided)

APPENDIX C

The following observations were made by Dr. Reese during two of the community events.

Fresno State Black Behavioral Health Forum April 27, 2023
On April 27, Fresno State team and Jewel of Justice led a Black Behavioral Health Forum with guest speaker and a licensed Marriage & Family therapist Dennice McAlister from the Fresno State Counseling Center.

The goal was to center Black student voices, experiences, and truth in order to create a robust, extensive awareness on behavioral literacy and the utilization of services at Fresno State.

Dr. Karen Crozier acknowledged that generational trauma, and cultural identity affect and inform the creative ways Black people take care of their behavioral health.

Dennice Mc Alister said that at least 83 out of 763 Black students at Fresno State used services at the Counseling Center (approximately 5%). The leading areas influencing student visits on campus are: social anxiety, isolation, and learning how to navigate after the COVID-19 pandemic, microaggressions, a higher level of anxiety or depression, and suicide which is highest for those ages 15-24.

The myths that keep Black students from seeking therapy are:

- the idea that ‘therapy is for White people’ without recognizing that everyone has ‘trauma’.
- A lack of trust and awareness about what therapy can do; he/she won’t understand
- A lack of people of color in therapy
- Misunderstanding that therapists tell you what to do rather than guide you in your decision making
- A lack of family support

During the session, students spoke on how racism, not feeling seen or heard (isolation), and the lack of an infrastructure at Fresno state to cater to African American students
have all interfered with their mental health and wellness.

McAlister thinks it's important to change the idea of always having to be strong to “being courageous”– in which one is allowed to be both authentic and vulnerable.

Questions arose on the difference between “behavioral v. mental health” to which there was some discussion around the latter which is often discussed in relation to drug and alcohol abuse. McAlister said that there will be a new team at Fresno State to address substance abuse.

Black Life, Health, and Wellness Event June 13, 2023

On June 13th, 2023, Jewel of Justice and the Fresno State Community Participatory Action Research (CPAR) Team sponsored an in-person event “Black Life, Health, and Wellness” at the Legacy Commons. The purpose of the event was for Black residents of all ages “to explore needs and create change around health and wellness.”

Among the goals for the event was to enter into conversation on how to hold others accountable in relation to our children by sharing with the community our research, design methods and plan, and gain feedback and recommendations. Dr. Crozier shared that the first year of the CPAR project aimed at building trust and transparency,organizing interventions, designing and engaging the project, and informing and learning from the community.

The research team announced and explained our big question “Parenting/ed While Black” which was chosen because Black communities are disproportionately impacted by structural and interpersonal racism that leads to burdens on their physical and mental health. This is coupled by the stress and trauma associated with the post-pandemic. While Black families are strong and resilient, they are more likely to experience intergenerational trauma (defined as a traumatic event that gets passed down from one who directly experiences an incident to subsequent generations) which also affects parenting styles as survivors face challenges (e.g. shame, low self-esteem, depression, substance abuse, etc.) when they are parents, including difficulty bonding to and creating healthy emotional attachments with their children. The question addresses the support that Black parents need, their lack of access to care, and how they cope.

After sharing our design plan which includes self-recordings with selected questions generated by the research team, focus groups]with one specifically for barbers, hair stylists, and nail technicians, surveys (when deemed appropriate) after each training intervention session, and intervention training (one or two for half or full-day sessions) for the Leadership Council and broader community, these were some of the ideas, questions, recommendations, and feedback heard from the community during the event.

- Making the idea of “trauma” explicit in our research topic
- Creating listening sessions via Zoom to create broader access for those with different schedules and perspectives at least once a week or more
- Research participants be added as “authors”
- Sharing report results with community before submission
- Including those who are not parents
- Including foster children and exploring how parenting (in “survivor mode”) done when basic needs go unmet
- Addressing the lack of Black therapists in Fresno County
- How do we market and build messaging in the Black community around the use of services given stigma around where these services are located and who benefits from them?
- Adding to the research design a pre/post evaluation of DBH’s utilization rates before and after the project

- Does the design plan address those who are the most vulnerable in the community and are linked “with the highest levels of pathology” to make sure they are not ‘slipping through the cracks’?
- Adding DBH consumers or ”persons served” who could offer first hand information
- Adding more qualitative information driven by stories and experiences

APPENDIX D

Informed Consent Document

Purpose: You are invited to participate in the evaluation. We hope to learn more about your experience working as a member of the leadership council. You were selected as a possible participant in this study because we believe that you are a valuable member of the Leadership Council and we hope to use this information to perform our evaluation.

Procedures: If you decide to participate, we will make arrangements that fit with your availability. This interview will be a maximum of 45 minutes and the questions of the interview which are six in total. Please note that answering each question is voluntary and if you are not comfortable answering any of the questions, you are free to let the interviewers know and they will move on to the next question. With your approval, this interview will be recorded for the purpose of transcribing, data collection and analysis. Once the process is done, the recording will be deleted to ensure data safety.

Risks: As with any study involving collection of data, there is a possibility of breach of confidentiality of data. Every precaution will be taken to secure participants; information to ensure confidentiality.

Benefits: This evaluation will provide the research team with the data that they need to draft the Evaluation report. However, participants will not receive any direct benefits from this study.

Confidentiality: Any information obtained in connection with this study that can be identified with you will remain confidential and be disclosed only with your permission or as required by law. We will keep the data of the participants private by ensuring that their name is anonymous. All data will be stored in a password protected computer. Moreover, the research team will not ask questions that will reveal the identity of the participant.

Compensation: All participants will be awarded a $30 dollar gift card from Chef Paul's just before the interview begins. Your decision whether or not to participate will not affect your relationship with California State University, Fresno, the Department of Behavioral Health, or Jewel of Justice.

If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty. If you have any questions, please ask us. If you have any additional questions later, Dr. Cronin, travis@mail.fresnostate.edu (559)-278-0064 will be happy to answer them.

You will be given a copy of this form to keep for your records. You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and decided to participate in this research.

Printed Name: _____Date: _____

Signature: _____

APPENDIX E

The following recommendations, observations, and challenges were provided by Dr. Reese of the FSET.

Recommendations (based on discussion from CBPAR meeting with DBH and JOJ on 12/7/23):

- roles of each organization to be clearly defined
- transitions from phase to phase clearly specified with clarity on how to proceed
- a clearly designated timeline

Leadership Council Meeting May 30, 2024:

I. Reflections and observations organized and led by Dr. Thomas

A. Trauma informed intervention among care leaders in the church

i) religious leaders would like more feedback from those in mental health ministry

ii) need for the training of pastors and staff

B. Trauma Informed Black Self Care Event organized and led by Dr. Thomas

i) sharing of 'wounds' and hopes

ii) over sixty people and children in attendance

iii) Dr. Whittle initiated a request for a list of those from the Leadership Council (LC) who were interested in being interviewed by Fresno State students

iv) stipend for executive members around the five steps of self-care

v) 90 minute sessions on the following topics: grief & loss, parenting, conflict resolution, millennials and single parenting

During the meeting Dr. Crozier asked the LC:

Q1: What is one thing you learned about self-care and wellness?

the LC agreed that this was a hot topic and there needs to be more engagement about mental health and this work

LC members commented:

—"We don't always know what self-care is v. self-maintenance"

—"We have a lot of professionals, and (in this space) we can express ourselves and operate like family; need to learn what self-care is and implement it"

—"Self-care is a privilege that most of us don't do"

—The LC is "a safe haven without the backlash and negativity (with most stating) they have received love, and kindness in this space; developed a sense of community

—"Did not know how to find this group; self-care is about me"

—"It's okay for me to be me" and "to say no" after having emptied myself into my profession

—"ready to learn more on this topic and dispel myths around the internal work and peace that comes from doing self-care"

Q2: What have you learned from serving on the Leadership Council?

– "what is good for me"

— "it's okay to ask for help"

— "opening up to one another: learning about each other"

— "here by divine intervention"

— "support (from LC) for professional goals as a therapist allowed one to keep pushing for mental health advocacy work"

Overwhelming confirmation from members that the sessions helped inform them about Black self-care and wellness

The last part of the meeting discussed the "Leadership Council for Black Self-Care & Wellness Budget Report" and statistics from some of the survey responses.

A. Responses revealed that faith community is less likely to be part of self-care and wellness resources

One recommendation was to tap into faith based system with additional health resources

B. Response to where one goes when asking for help included:

- peer support
- therapy
- someone in the community

C. the healing work for clinicians and clergy has to be done to take care of others

Question to LC members— why do people leave the church?

--don't want to deal with old fashioned ideas

--unwilling or unable to understand types of depression, anxiety, stress; discourage group therapy, medication, or other forms of support and healing

– the church not looking at your life or historical condition, but your money

Pastor Dominic recommended:

— the need for more training

—made a comparison between Black churches and HBCUs (which cannot command the same funding as Black churches do)

—Black churches follow White/Anglo models of support

— asked the question of how do we engage men in the Black community?

Recommendations from the LC:

—Black clergy need deeper engagement; the LC would like to take some next steps against these systems of oppression

— clinicians need to become a part of the church

Challenges faced by the FSET evaluators during Year 2 were:

- missing final copy of the JOJ Scope of Work (JOJ reported having only a draft) for the lead organization
- FS evaluators took on a role (developing the research methodology/measures) that was beyond our original SOW
- not allowing student researchers to complete the work they were hired to do
- underutilizing the expertise of assigned evaluators after changes in project's direction by lead organization (lack of survey data to evaluate)

Appendix H – Huron Townhall

¡ÚNETE A NOSOTROS!

UN ENCUENTRO COMUNITARIO POR EL **BIENESTAR**

Department of Behavioral Health

JUEVES 11 DE MAYO DE 2023
5:00pm – 8:00pm

John Palacios Community Center
16846 4th St. Huron, CA 93234

Presentado por:

Department of Behavioral Health

THE LEAP INSTITUTE

Este evento comunitario gratuito contará con presentaciones y paneles de discusión con muchos profesionales que hablaran sobre los desafíos, las soluciones y los recursos específicos de la salud conductual para Hurón.

El evento se entregará principalmente en Español. Se proporcionarán intérpretes.

- **Se proporcionará comida**
- **Sorteo de premios**
- **El evento se transmitirá en vivo a través de Facebook y YouTube**

Presentaciones especiales de:

Dr. Sergio Aguilar-Gaxiola, MD, PhD
UC Davis

Dr. Trinidad Solis MD, MPH
Fresno County Department of Public Health

Dr. Felipe Mercado, EdD, MSW
CSU Fresno

Panel de discusión + preguntas y respuestas con:

Dr. Juan Garcia, PhD, LMFT
Integral Community Solutions Institute

Fausto Novelo, APCC
Beloved Survivors

Dr. Iran Barrera, PhD, LCSW
CSU Fresno

Michael Prichard, MS
Fresno County Department of Behavioral Health

Ana Robleto
Fresno Community Health Improvement Partnership

Dr. Lesby Castro, PsyD, LMFT
Fresno County Department of Behavioral Health

Jennifer De La Cruz, MA, LMFT
Turning Point – Rural Mental Health

Dr. Jeannemarie Carus-McManus, PhD, MBA
Westside Family Preservation Services Network

Aurora Ramirez
Westside Family Preservation Services Network

Póngase en contacto con dhorn@fresnocountyca.gov para obtener más información

HEALTHY FRESNO COUNTY
Better Together

Programa de Salud Móvil Rural

Dra. Trinidad Solis

Oficial Adjunta de Salud Pública, Departamento de Salud Pública del Condado de Fresno

11 de mayo de 2023

Department of Public Health
www.fcdph.org

Los determinantes sociales de la salud

Los determinantes sociales de la salud son las condiciones en las que las personas nacen, crecen, viven, trabajan y envejecen.*

- Los determinantes sociales se agrupan en cinco grupos:

1. Salud y atención médica
2. Estabilidad económica
3. Educación
4. Vida social y comunitaria
5. Vecindario

*Healthy People 2030, Social Determinants of Health - Healthy People 2030 | health.gov

Los determinantes sociales de la salud

- Los determinantes sociales de la salud afectan al bienestar y a la calidad de vida de las personas.
- Estas condiciones sociales contribuyen a inequidades de salud, por ejemplo, cuando las personas no tienen acceso a supermercados con alimentos saludables tienen menos probabilidades de tener una buena nutrición. Eso aumenta el riesgo de problemas de salud como diabetes y obesidad.

¿Cómo mejoramos las inequidades en salud?

- Identificar los determinantes sociales de salud
- Desarrollar soluciones de salud comunitaria

Programa de Salud Móvil Rural

- El Programa de Salud Móvil Rural tiene como objetivo hacer que el acceso a la atención médica sea más justo para las personas que viven en las áreas rurales del condado de Fresno.

Programa de Salud Móvil Rural

OBJETIVOS

- Aumentar el acceso a la atención médica para las personas que viven en las áreas rurales del condado de Fresno
- Incluir a los promotores de salud en los eventos de salud móvil rural para brindar educación sobre la salud y recursos comunitarios
- Reducir el uso de la sala de emergencias por conectar a las personas con un médico de atención primaria

Programa de Salud Móvil Rural

- Grupos médicos: UCSF-Fresno y la Universidad Estatal de Fresno en colaboración con Saint Agnes
- Las personas pueden recibir una variedad de servicios de salud gratuitos de las unidades móviles. Los servicios incluyen:
- Vacunas
- Revisiones de presión arterial
- Pruebas de glucosa
- Pruebas de COVID-19 y tratamientos
- Visitas para enfermedades menores
- Educación de salud

Contáctenos

- Si tiene alguna pregunta o desea un evento de Salud Móvil Rural en su comunidad, comuníquese con el Departamento de Salud Pública del Condado de Fresno:
- **DPHMobileHealth@FresnoCountyCA.gov** o llame al **(559) 600-4063**.

Thank you!

Appendix I – Human Centered Community Needs Assessment for Spanish Speaking Parents/Guardians'

Human Centered Community Needs Assessment

PREPARED FOR
THE FRESNO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

BY EVERY NEIGHBORHOOD PARTNERSHIP

JUNE 30, 2023

Table of Contents

Overview & Methodology

Every Neighborhood Partnership (ENP) surveyed 284 Spanish-speaking (bi- and mono-lingual) individuals living within the County of Fresno. The survey was administered in Spanish and contained 9 demographic questions, 15 multiple choice questions, 1 short answer question, and 1 multiple selection question. To make the survey accessible to individuals with a variety of educational backgrounds, ENP staff verbally surveyed and recorded the answers for respondents when needed. Other respondents completed a written survey, which was then input into a Google Form created by ENP. All survey responses, including demographics, are self-identified by survey respondents.

The purpose of this survey was to gather information from Fresno County's Spanish-speaking community to identify challenges, barriers, and effective approaches to behavioral health care facing that community.

Summary of Demographics

Of the 284 individuals surveyed, 202 (71%) were women, 73 were men (26%), and 9 (3%) declined to answer. Almost all (98.6%) respondents were 15 years of age or older, with only 4 respondents in the 0-14 range. In addition to Spanish, the languages spoken by bilingual respondents are English, Mixtec, and Tagalog.

Around 75% (214) of respondents live in the Fresno/Clovis metro area, while the remaining 25% (70) live in smaller towns or rural areas throughout the County. Respondents represent 48 unique zip codes in Fresno County. We have labeled zip codes according to the nearest city or town that they represent, though respondents may not live within the limits of the city or town.

Zip Code	Nearest city/town	# of respondents
93210	Coalinga	4
93234	Huron	6
93606	Biola	1
93607	Burrell	1
93608	Cantua Creek	1
93609	Caruthers	5
93611	Clovis	8
93612	Clovis	7
93613	Clovis	1
93616	Clovis	2
93619	Clovis	7
93622	Firebaugh	1
93625	Fowler	7
93626	Friant	1
93630	Kerman	4
93637	Berenda	2
93640	Mendota	5
93648	Parlier	3
93650	Pinedale (Fresno)	1
93652	Raisin City	1
93654	Reedley	11
93656	Riverdale	1
93657	Sanger	6
93662	Selma	8
93701	Fresno	5
93702	Fresno	38
93703	Fresno	10
93704	Fresno	8
93705	Fresno	6

93706	Fresno	16
93709	Fresno	2
93710	Fresno	10
93711	Fresno	5
93712	Fresno	1
93720	Fresno	12
93721	Fresno	3
93722	Fresno	7
93723	Fresno	2

93724	Fresno	3
93725	Fresno	18
93726	Fresno	4
93727	Fresno	24
93728	Fresno	9
93729	Fresno	1
93740	Fresno	1
N/A		5
Total		**284**

Summary of Responses

The survey contained 9 multiple choice questions with the following response choices:

- Totalmente de acuerdo (Totally agree)
- De acuerdo (Agree)
- Ni de acuerdo ni en desacuerdo (Neither agree nor disagree)
- En desacuerdo (Disagree)
- Totalmente en desacuerdo (Totally disagree)
- N/A

Respondents expressed overwhelmingly their belief in the importance of mental health services and support groups. 97.1% of respondents chose “Agree” or “Totally agree” in response to the statement “Mental Health Services are important to me.” A similar percentage of respondents, 94.4%, chose “Agree” or “Totally Agree” in response to the statement “Support groups/peer groups are important to me.”

To the question, “Do I find the Mental Health resources (Pamphlets, Flyers, posters, information, etc.) in Spanish or are they available to me in Spanish?”, 29% of respondents disagreed or totally disagreed. (See slide deck #6) 47.7% of respondents reported that they “Disagree” or “Totally Disagree” that “Finding therapists is easy for me.” (See slide deck #5)

Though 66.3% of respondents reported “Agree” or “Totally Agree” that “The mental health of my children (children, adolescents, young people) worries me,” only 23.8% reported that “Finding mental health services for my son/daughter is easy and fast.” (See slide decks #8 and #9)

The survey also contained 6 multiple choice questions with the following response choices:

- No es una barrera (not a barrier)
- Algunes veces es una barrera (sometimes a barrier)
- Con frequencia una barrera (often a barrier)
- N/A

Of all the multiple-choice questions, respondents were most united in their response to "Long waiting list. (The appointments are very long and/or there are no appointments.)" 75.8% responded that this was "often a barrier." (See slide deck #11) 60.1% of respondents also testified that "Lack of Transportation/I don't have transportation to get to appointments" was "often a barrier" or "sometimes a barrier." (See slide deck #13)

Analysis and Themes

In response to the short-answer question, "What challenges have you had or continue to have in seeking mental health care?", respondents provided diverse and insightful feedback. Following is a summary ENP created of the common themes expressed in the responses. We have organized the types of barriers expressed into four types: accessibility, financial, language/cultural, and quality of care.

Accessibility Barriers

- Distance (services are too far away from respondent's homes)
- Lack of available appointments (long waiting lists)
- Lack of adolescent counselors
- Lack of childcare (for parents while they attend appointments)
- Lack of in-person appointments (i.e., appointments are by telehealth only)
- Difficulty accessing information about mental health services

Financial Barriers

- Lack of insurance
- Insurance does not cover the cost of mental health care
- Inability to pay for childcare

Language and Cultural Barriers

- Clinicians and/or administrative staff do not speak Spanish
- Respondents do not speak English or do not feel comfortable communicating in English
- Lack of cultural understanding from clinicians and/or administrative staff
- Lack of support for/resistance to seeking treatment from family and community

Quality of Care

- Lack of natural medicine care options
- Medications prescribed do not improve symptoms
- Not feeling respected/feeling judged by clinicians and administrative staff
- Not feeling listened to/understood by clinicians (lack of cultural empathy)

As reflected in the short-answer responses, long waiting lists and lack of appointments are a primary barrier to care for respondents. Over 75% of respondents reported that "Long waiting list" is "Often" a barrier to obtaining mental health services. This response is reflected in the short-answer response, where lack of available appointments and long waiting lists are one of the most-cited barriers to receiving care.

Lack of Spanish-speaking clinicians and administrative staff is also a primary barrier to care for respondents, as reported in the response to the short-answer question. Our analysis of the responses indicates that not having a Spanish-speaking and/or culturally Latino/a clinician increases feelings of distrust in respondents towards their clinician.

The survey also shows that a lack of Spanish-speaking administrative staff is a barrier to receiving mental health services. 87.9% of respondents said that "Some clinics or mental health services is a machine (recorder) that answers and cannot answer or clarify my doubts or make a query," is "Often a barrier" or "Sometimes a barrier." Only 11.1% of respondents reported that it was "not a barrier" to receiving mental health services. (See slide deck #12)

Another common theme in the short-answer responses was a desire for access to more "natural medicine" treatments for mental health. Respondents expressed sentiments similar to the following quotes: "The system must change in favor of improving us and not just giving us drugs or medicines;" and "We want natural treatments and less drugs." Specifically, a few respondents cited the negative side effects of the drugs they had been prescribed as a barrier to healing. ("the medicines they give make me very sleepy.")

Recommendations

To gain input on desired services, we provided respondents with a list of mental health services accompanied by the prompt, "Please indicate what type of classes or services you would like to receive to help with your mental well-being." The following table shows the choices ranked from most responses to least responses.

Resource	Percent of respondents	Number of respondents
Parent Groups or Support Groups	49.9%	140
Dance classes with physical activity	39.1%	110
Personal Motivation Resources	38.1%	107
Strength training classes	29.2%	82
Yoga and meditation	26.4%	74
Spiritual and prayer resources	24.6%	69
Nutrition classes, health	15.3%	43
All previous	47.3%	133

Respondents indicated that a solution would be to have more resourcing to clinicians who are Spanish-speaking and culturally Latino. Though mental health care resourcing exists, respondents experience a lack of awareness about clinicians who are especially suited to serve their community. More mental health clinicians who specialize in working with children and adolescents is also an expressed solution.

Following is a sampling of services/activities that respondents have identified in their short-answer responses as potential solutions to improving the mental health of their community. ENP chose to include quotes here that represent the responses and concerns of many respondents.

- “There is a need for more programs and community groups that make these issues more common to help encourage change in mental health stigma and help the community find more help if they need it.” –Woman, 35-44
- “More doctors who not only speak Spanish, but who understand it.” -Woman, 55-64
- “[Providing] mental health/trauma education that is also culturally focused.” -Man, 15-24
- “From experience, my son has been helped by groups of domino games and virtual games focused on healing emotions. Also exercises like Tai Chi are very helpful.” -Man, 55-64
- “Workshops where the causes and effects of the lack of mental health are made known, especially to parents.” -Woman 65+
- “…more programs and community groups that make these issues more common to help encourage change in mental health stigma and help the community find more help if they need it.” -Woman, 35-44
- “Walking groups.” -Woman, 35-44
- “It is important that even if it is teletherapy, the doctors who help know the culture of their patient and put their prejudices and their own morals aside and do not keep it in mind when they have a patient.” -Woman, 45-54
- “More information…about mental health and places and addresses where you can have this service with details about the insurance they receive, as well as if they have low-income programs where they pay little for a visit to a mental health therapist and more information in Spanish on TV, schools and information tables in the communities.” –Woman, 45-54
- “We need support groups for migrants.” -Woman, 35-44
- “Socialization groups." -Man, 65+
- “Support groups for migrants.” -Woman, 45-54
- “Social activities, art groups, groups with gardening activities, planting flowers." -Woman, 45-54
- “Workshops to know how to detect depression and other mental illnesses as a preventive measure.” -Woman, 45-54
- “Group exercises such as jewelry classes, knitting group classes, crafts groups classes, Tai-Chi classes.” -Woman, 45-54

Appendix J – San Joaquin Youth Summit Report

Your Time, Your Voice Youth Wellness Summit

San Joaquin

November 21, 2023

AGENDA

7:30am- DBH team to arrive to set up

8:30am- Doors Open/Morning Snack.

Event emcee, Dennis Horn, -Fresno County Department of Behavioral Health

9am-Welcome *Julie Hernandez-Mayor of the City of San Joaquin*

9:10am- DBH Introduction to the day- *Dennis Horn*

9:15am- What we mean when we say behavioral health? *Ahmad Bahrami, Fresno County Department of Behavioral Health*

9:30am- Social Determinants of Health -*Alvishia Johnson, Allegra Chaco, Fresno County Department of Behavioral Health*

10am- Recognizing Risk Factors and Building Resiliency-*Dr. Gustavo Loera*

10:40am- Break

10:45-Professional Round Robin.

- *Jenny Gonzalez-WestCare*
- *Jessica Franco-988/CVSPH*
- *Jessica Saldivar-ENP*
- *Nelly Garcia-Perez- DBH*
- *Louis Angel- DBH*
- *Christina Anejo Holistic Wellness Center*
- *Jose Leon-DPH*

11:20am- Finding your voice through advocacy- *Espi Sandoval*

12pm- Lunch (Taco truck)

12:35pm- Youth breakout sessions. (*Facilitated by Dr. Loera*)

1:15pm- Youth Policy Statements for Change

1:50pm- Raffle/survey (DBH)

2pm-End

YOUR TIME YOUR VOICE
YOUTH WELLNESS SUMMIT

NOVEMBER 21, 2023

Department of
Behavioral Health

1.1 Summary

On November 21, 2023, 37 youth advocates (grades 8 through 12) from San Joaquin Elementary/ Middle School and Tranquility High School gathered in San Joaquin's Veterans Memorial Hall, California, to discuss youth mental wellness and the unique role that young people play in shaping the future health care. It is important to mention that 100% of the youth in attendance were Latinx/ Latino. This is a representation of the youth/student population at San Joaquin and Tranquility schools with 98% being Latinx/Latino. The summit started with an overview of behavioral health and what it means. Then youth were provided with definitions and examples of social determinants of health (SDoH) followed by a case study illustrating the impact of SDoH and protective factors. A round robin activity gave youth access to caring adults/professionals and an opportunity to careers in behavioral health. Finding the youth voice through advocacy anchored the event emphasizing advocacy as an essential tool to support and serve vulnerable communities. The overarching theme of discussion was youth having a presence and calling as advocates and creating hope for youth who feel marginalized and excluded from community life. Finally, youth were divided into four groups and asked to address three overarching questions: (1) Why should youth care about mental health and advocating for youth mental wellness? (2) In what ways can youth play a larger role in their school and communities to stop stigma (and shame) associated with mental health? And (3) What changes can youth make in schools to ensure that their voices and menta wellbeing become a priority?

1.2 Behavioral health literacy in schools

When stigma and shame associated with behavioral health is high, the likelihood that youth-teacher conversations about mental health will occur is less likely. Researchers have found that stigma (and shame) is a significant barrier to people seeking and receiving help in a way that is appropriate,[1] and learning strategies to help manage their health and mental wellbeing.[2] Overcoming the stigma (and shame) barrier can lead to more conversations about stigma inside school classrooms and increase behavioral health literacy among youths. Youths are already engaging in much of their own decision-making about their health and well-being.[3] Early intervention to increase behavioral health literacy while students are in school may foster the development of strategies and coping skills necessary to overcome social determinants of health.[4] This is consistent with the Fresno County's Department of Behavioral Health division's definition of behavioral health as "the promotion of mental health, embracing resilience and wellbeing including the treatment of mental health and substance use disorders." Part of this definition is to also promote the recovery of people, families from historically underserved communities.

[1] Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. Healthcare Management Forum, 30(2), 111-116.
[2] Smith, R. A., & Applegate, A. (2018). Mental health stigma and communication and their intersections with education. Communication Education, 67(3), 382-393.
[3] Cusack, L., Desha, L. N., Del Mar, C. B., & Hoffmann, T. C. (2017). A qualitative study exploring high school students' understanding of, and attitudes towards, health information and claims. Health Expectations. 20, 1163-1171.
[4] Manganello, J. A., (2008). Health literacy and adolescents: A framework and agenda for future research. Health Education Research, 23, 840-847.

1.3 Youth- and school-driven themes: Creating culturally appropriate policies

Theme 1: Youth leadership development

- Ensure youth leadership and community engagement opportunities (e.g., peer-to-peer) that increase youth advocacy and voice to serve others.
- Foster peer-to-peer support networks to promote acceptance and inclusion so that no youth feel alone in their struggle.
- Encourage and empower young people to participate in organized school- and community-focused activities to advocate for more funding to support school-based mental wellness programs.
- Allow participation of youth in school board meetings and other school district activities that give youth a meaningful role and sense of purpose to express concerns and promote positive youth development.
- Build and/or strengthen college and career pathways in high schools and community colleges with a focus on mental health certification for youth advocates to pursue and fill-in workforce shortages in the City of San Joaquin and Fresno County.

Theme 2: Addressing social determinants of health (SDoH)

- Develop whole-school approaches and strategies to detect early onset of stress, toxic stressors, and anxiety that could impact youth's wellbeing and school life.
- Adopt whole-school approaches that highlight the negative impact of stigma and shame associated with mental health, and ALL behaviors that reinforce stigma and shame.
- Combat aspects of social media that promote fear, bullying, and trauma among secondary (elementary, middle, and high school) youth that already feel marginalized.
- Educate teachers and school staff on SDoH associated with youths' mental wellbeing and stimulate classroom discussions among youth and teachers.
- Support social inclusion in secondary schools (i.e., elementary, middle, and high schools) by openly recognizing youths' social, cultural, physical, demographic, sexual orientation, and gender identity characteristics.

Theme 3: Strength-based and school-based strategies

- Encourage school administrators to go to where youth congregate—in the classroom, quad/lunch areas, school clubs—and initiate conversations (e.g., "how are you doing?" "what can we do to better support you and your peers?" "help us better understand what matters most to your peers about mental health?").
- Encourage conversations during in and out of school activities among parents and families that have similar life experiences to dispel some of the negative attitudes (and behaviors) toward mental wellness.
- Promote cultural assets and storytelling (e.g., sharing lived/life experience) as positive or protective factors for youth to overcome determinants of health.
- Promote communication and connections among youth with similar life experiences, creating a sense of community and belonging that leads to positive physical and mental wellbeing and development.

- Ensure that youth have a trustworthy and caring adult to go to when dealing with stress, anxiety, trauma, or just need someone to talk to.

Theme 4: Safe spaces on a school campus

- Dedicate time before, during, and after school to raise awareness and promote positive youth mental wellbeing.
- Engage in districtwide and deliberate training for teachers to create spaces for youth to feel comfortable to talk about their life experiences and make meaningful connections.
- Create and promote welcoming and spaces where young people can practice wellness activities (e.g., mindfulness).
- Create a school environment that treats youth as a person and not as an illness; change the language that school educators use when describing mental health.

Theme 5: Youth resilience and engagement

- Ensure that youth play a significant role in decision-making that help guide school-driven initiatives.
- Create opportunities for young people to participate in school administrator's meeting discussions and decision-making on what matters most to them.
- Empower youth with the knowledge and skills that will help them seek new and challenging opportunities to advance their college and career preparation for the future.
- Promote youth autonomy (self-determination) and healthy decision-making that encourages youth to step out of their comfort zones and explore new experiences.

Next the conclusion, contact information and appendices.

1.4 Conclusion

Overall, youth mentioned key words that emphasized community and school engagement to better understand and change people's perspectives on mental and behavioral wellbeing. For example, one youth said this about exercising their voice during school district board meetings, "We need to be more intentional when addressing our school board and stand firm in our message and not give in until they listen and real change happens in our schools and communities." Other youths recommended rallies or gatherings to raise awareness about youth mental health and ensure that youth get the support that they need. The above five major themes and 22 statements from youth represent policy implications and recommendations for county supervisors, school administrators and educators, and other policy makers, as their call for action to improve school- and community-based mental and behavioral health programs in their schools and communities.

1.5 Contact information

For more information, please contact:
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abahrami@fresnocountyca.gov

APPENDICES

Appendix A: Post-Summit Survey Results

The Fresno County Department of Behavioral Health (DBH) conduced a post-summit survey to collect demographic information and key findings about the event in general, and activities specifically. The survey was used to help inform the DBH and partners on the benefit of the summit in advancing the youth voice and engaging them in decision-making as key stakeholders in the behavioral health field.

A total of 37 youth respondents received a $10 gift card incentive for completing the survey at the end of the summit. Exhibit 1 shows the respondent's age. The majority of the respondents were between 15 and 17 years of age. Another important demographic area was the respondent's preferred languages. A total of 65% of the respondents reported preferring both English and Spanish, and 27% English. Only 8% preferred Spanish (see exhibit 2).

Exhibit 1. Respondent's age

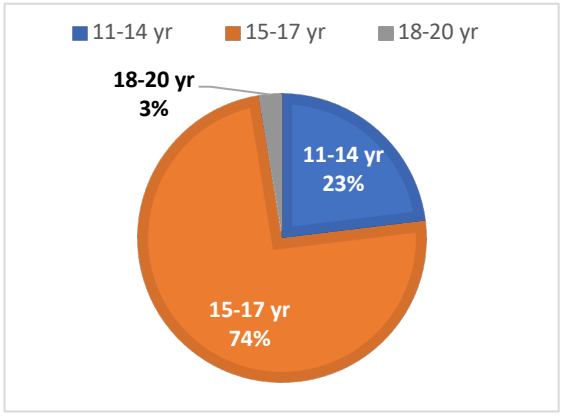
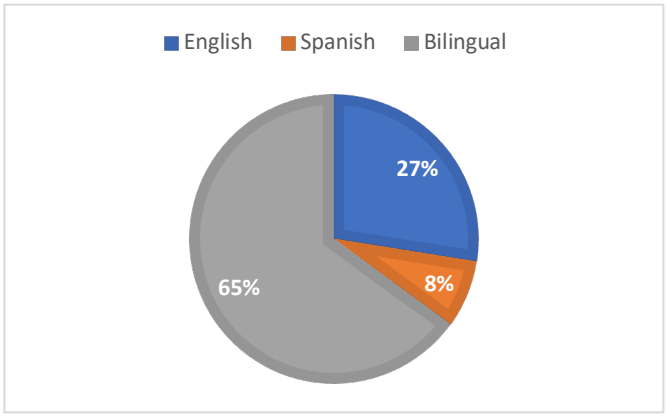


Exhibit 2. Respondent's preferred language



Race and ethnicity were also reported by the youth respondents. A total of 95% self-identified as Latino or Latinx, and 5% as biracial (see exhibit 3). Of the youth who reported Latino/Latinx as their race, 92% indicated being Mexican or Mexican American, 2% Honduran, and 6% other or preferred not to answer. Exhibit 4 shows the respondent's gender breakdown. A total of 60% reported male and 40% female.

Exhibit 3. Respondent's race

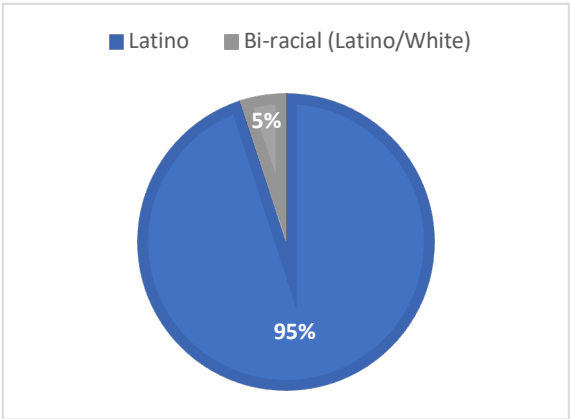
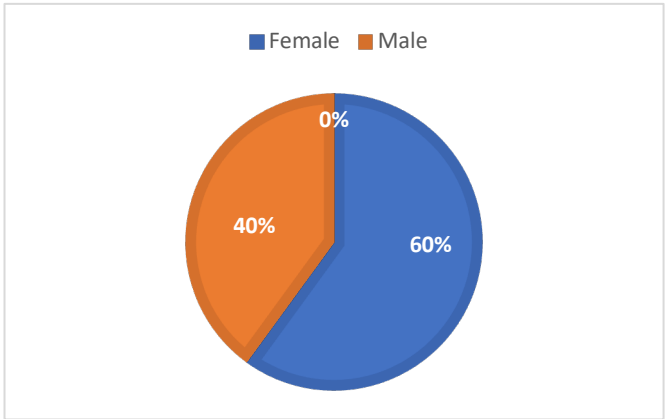


Exhibit 4. Respondent's gender



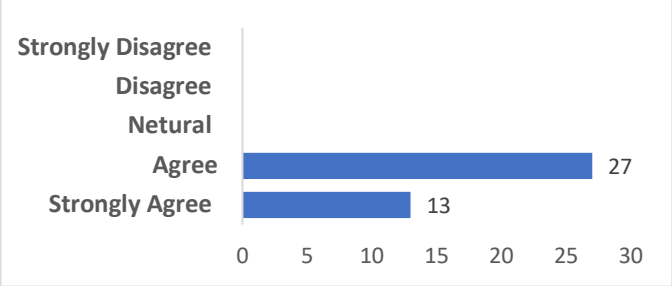
Key Findings

The youth summit participants were also administered a five-question survey to assess the effectiveness of the summit toward increasing their knowledge about behavioral health and understanding of wellness topics. Additionally, to examine their sense of empowerment and motivation to advocate for the behavioral health needs of youth and families from their communities. Below we highlight the results from the five questions. This data reporting has several important limitations that should be noted. Obviously, the small sample size, youth were out of school, and this may have affected how youth responded to the survey. Finally, the survey was not tested for validity and reliability.

Question 1: Did this summit help you to better understand the topic of mental wellness?

As shown in Exhibit 5, 100% (27 or 68% "agreed" and 13 or 32% "strongly agreed") reported having a better understanding about mental wellness as a result of attending the summit. It is possible that the vast majority of youth may have some knowledge of the topic because of their own lived/life experience, or they may have known family or friends who have experienced mental/behavioral health issues. This is worth exploring further.

Exhibit 5. Youth's reported knowledge about mental wellness after attending summit

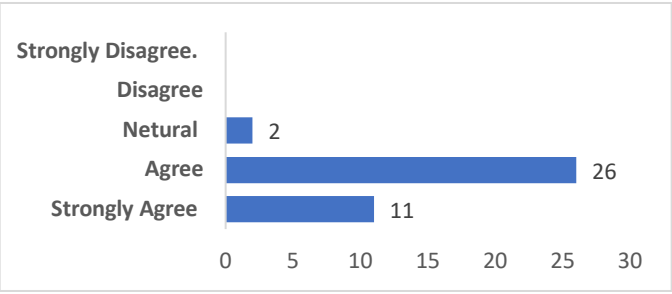


Recommendation: Emphasize youth leadership and civic engagement to raise awareness about behavioral health.

Question 2: Did this summit help you learn how to express your needs and voice?

The goal of this summer was to encourage youth to find and use their voices and increase awareness of mental wellness in their schools so that school educators and students could engage in more early detection, prevention, and intervention activities. As shown in Exhibit 6, of the 39 youth respondents, 37 or 95% reported that they "agreed" to "strongly agreed" acquired strategies to be more intentional about expressing and voicing their needs. For example, advocating and supporting other students and creating hope for those whose needs aren't met.

Exhibit 6. Youth's reported increased skills on voicing concerns and needs

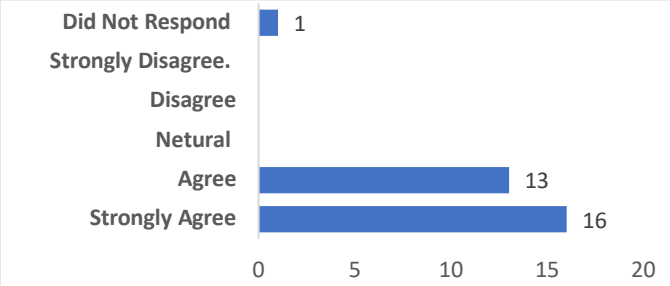


Recommendation: Increase youth capacity to advocate for themselves and others, and encourage them to become ambassadors of wellness.

Question 3: Did the Fresno Department of Behavioral Health (DBH) show interest in listening to youth and your issues?

The vast majority of youth respondents reported favorable toward the DBH showing interest in organizing the summit and its activities in such a way that would engage youth in meaningful learning and conversations about behavioral health and wellbeing. Between 43% and 53% of the youth agreed and felt that DBH were in creating a learning environment for them to openly discuss issues impacting them and brainstorm strategies and solutions for schools and policymakers (see Exhibit 7).

Exhibit 7. Youth's reported satisfaction with the DBH's efforts to listen and learn from youth

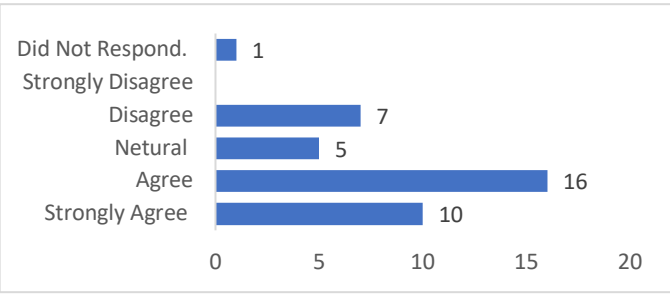


Recommendation: Expand county-wide efforts to increase awareness and education about mental, behavioral, emotional, social, and environmental wellness.

Question 4: Did the professional round robin increase your interest in pursuing a career in behavioral health?

The youth reported a strong approval of the personalized brief question and answer mentoring sessions (see Exhibit 8). For example, 26 or 67% of the youth "agreed" to "strongly agreed" that speaking with professionals from diverse capacities within the behavioral health field gave them a good sense of each profession. This activity covered a range of careers including social work, therapy, research, education, community-based organizations, and community health workers. For future professional round robin sessions, it would be helpful to give youth enough time with each professional to engage in meaningful knowledge-sharing experiences.

Exhibit 8. Youth's reported effectiveness of connecting with professionals and learning about careers

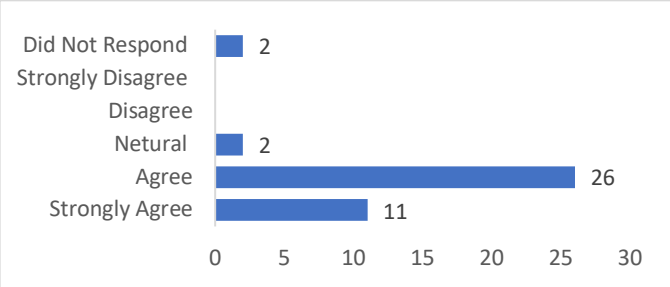


Recommendation: Create opportunities for youth to volunteer at community-based settings, and participate in conversations with local government and businesses about solutions.

Question 5: Did attending this summit or community forum help you feel more confident in advocating for the behavioral health needs for yourself, your family, your peers, and/or your community?

Overall, the youth reported a high confidence in their advocacy abilities. For example, 90% of youth respondents "agreed (26 or 63%)" or "strongly agreed (11 or 27%)" that they can be a voice for themselves and others (see Exhibit 9). Terms such as "empowerment," "resilient," and "confident" were expressed by youth during the summit. Youth demonstrating confidence in their ability to accomplish school and life goals is essential to their preparation, their leadership development, and their career aspirations.

Exhibit 9. Youth's reported self-confidence to advocate and promote wellness



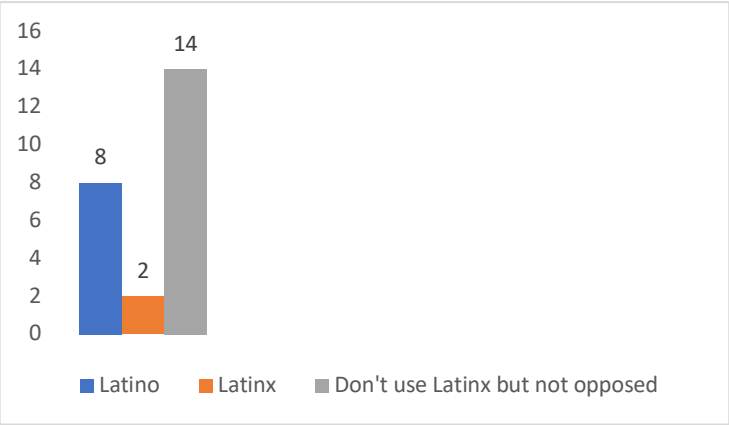
Recommendation: Empower youth to take on leadership roles and become role models and convey the message that asking for help is a sign of strength, self-love, and care for others.

LATINO/LATINX Survey Results

Finally, the summit Latino/Latinx youth participants were asked to identify which term they preferred, "Latino" or "Latinx". Similar to preferred language above, the goal for these questions are to ensure appropriateness and inclusiveness in all communication. That is, being appropriate and inclusive in our communication when engaging communities from diverse backgrounds, increase community engagement, enhances trust, builds positive relationships, and increases access and utilization of county services. Given our large Spanish-speaking populations, having a better understanding of which term is preferred, is a critical step toward meaningful connections.

A total of 24 youth respondents, 33% reported preferring "Latino" compared to 8% choosing "Latinx". However, 58% indicated that while they do not use "Latinx" when self-identifying, they are not opposed to it (see Exhibit 10).

Exhibit 10. Youth's reported preferred self-identified ethnic term



Recommendation: Promote culturally and linguistically appropriate mental health services by focusing on the preferred language and ethnicity of a population. Language and ethnicity are important factors associated with the use of behavioral health services and effective treatment.

Appendix B: Local Media Coverage

- https://abc30.com/fresno-county-youth-wellness-summit-mental-health-services/14076737/ **November 17, 2023**

- https://abc30.com/fresno-county-mental-health-youth-wellness-san-joaquin-summit/14088982/ **November 21, 2023**

Figure 1. Presenters kicking off the youth breakout session.

Figure 2. Professional round robin session(s) where youth connected with professionals. Here are youth interacting with counselors of the 988 Lifeline.

Appendix C: Acknowledgements

The Department of Behavioral Health would like to thank the following individuals and agencies for their assistance with this project.

- Dr. Gustavo Loera
- City of San Joaquin
- Golden Plains Unified School District
- Espy Sandoval
- Fresno County Department of Behavioral Health
- Kings View's Central Valley Suicide Prevention Lifeline
- WestCare, California. Inc
- Every Neighborhood Partnership
- The Fresno Center's Holistic Wellness Center
- Fresno County Department of Public Health

TU TIEMPO TU VOZ

CUMBRE DE BIENESTAR JUVENIL

21 DE NOVIEMBRE DE 2023

9:00 AM A 2:00 PM

SE BUSCA GENTE JOVEN

ESTUDIANTES DEL GRADO 8 AL 12

Venga a conocer los fundamentos del bienestar y ayúdenos a dar forma a una asistencia futura que responda mejor a las necesidades de su generación y de la comunidad.

RIFA GRATUITA!!

San Joaquin Veterans Hall
22001 W. Manning Ave.
San Joaquin, CA 93660

DESAYUNO Y ALMUERZO GRATIS!

City of San Joaquin Founded 1920 CA USA Centennial

The County of Fresno 1856

Department of Behavioral Health

Appendix K – Community Needs Assessment of Mental Health Perceptions of Fresno Residents Council

THE CHILDREN'S MOVEMENT FRESNO

A Qualitative Report on Perceptions of Mental Health of the Fresno Residents Council

Presented to the Fresno County Department of Behavioral Health

December 29, 2023

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The Children's Movement Residents Council

The Fresno County Department of Behavioral Health (DBH) approached The Children's Movement (TCM) to conduct a qualitative study on perceptions of mental health access by its members. The 76-member council is comprised of BIPOC individuals that are both rural and urban, 26% youth ages 15-24, Latino/Hispanic, Hmong, Black, Syrian, with five different languages spoken. With such diversity, the goal is to learn how those of different cultures perceive mental health access, barriers to use of needed services in Fresno County, and ideas for more culturally sensitive delivery of services.

Members of the two-year-old Fresno Residents Council (FRC) are actively engaged in their five identified community issues for organizing and advocacy. First is affordable housing and second is mental health. Not only will this report assist DBH, but it may also provide insight for its members as they determine a direction to pursue within the area of mental health.

Methodology

A consultant designed a short quantitative survey familiar with mental health issues for both Fresno County adults and youth and was reviewed by DBH. Demographic questions were designed as required by the State of California. Respondents had opportunities for qualitative responses within the survey. Of the 76 FRC members, 67 responded to the quantitative survey (88%) conducted November through December 15, 2023. All 20 youth responded and 47 of 56 adults.

In addition, five focus groups through "house parties" brought together by FRC members from their own networks discussed five questions by ethnicities/groups of Latino/Hispanic (in Spanish), Hmong (in Hmong), Black/African American race, Arabic-speaking Syrian refugees, and youth/young adults ages 15-24 with a mix of Black, Hispanic, and Hmong participants. The focus groups conducted in November and December 2023 ranged in size from seven to eleven individuals. TCM provided focus group participants with $20 gift cards.

Survey Demographics

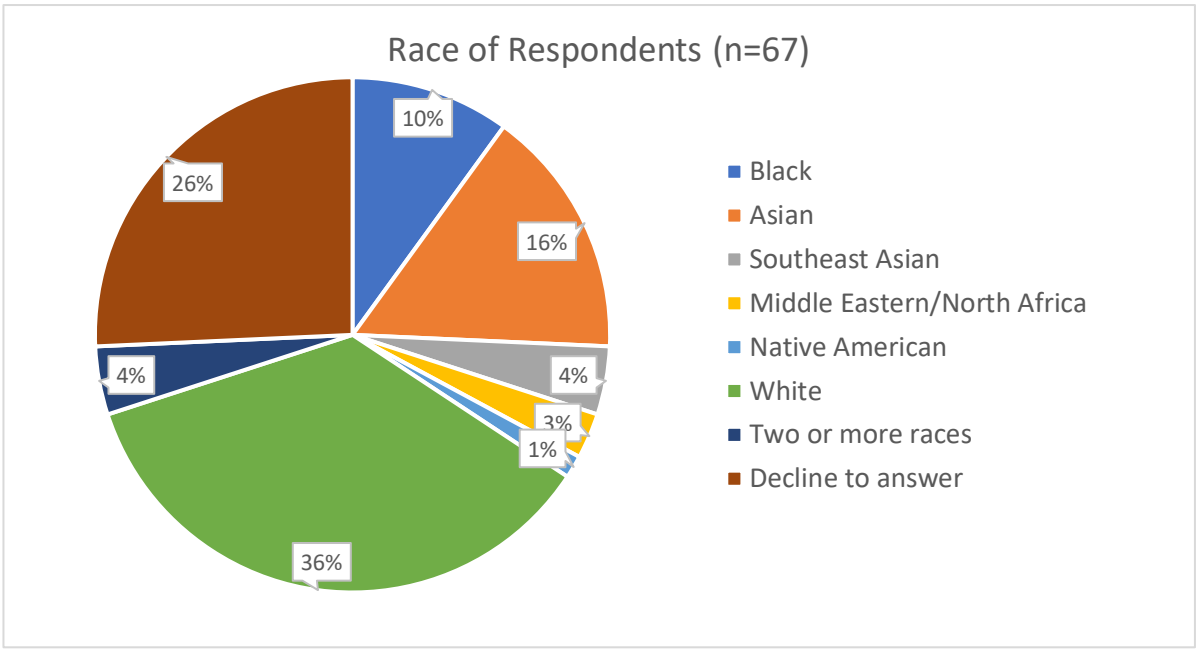
16% **82%**

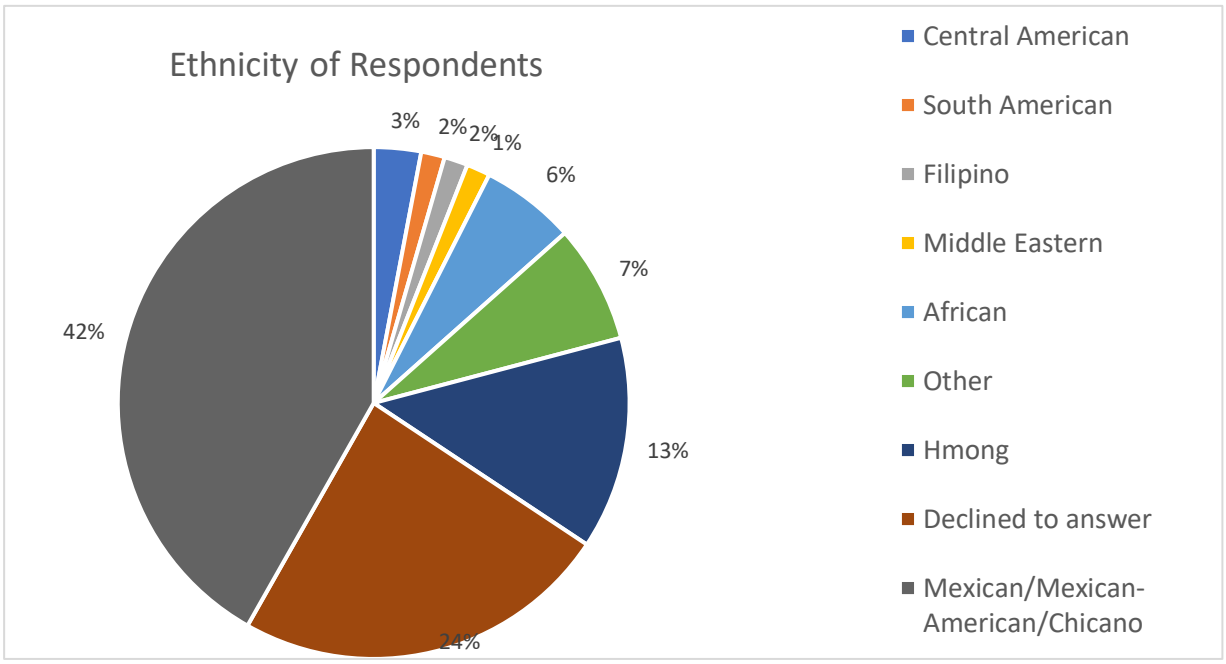
2% Did Not Identify

General Location (Zip code list in Appendix)	Respondent Percent	Number
City of Fresno or Clovis	66%	43
Rural West Fresno County	11%	7
Rural East Fresno County	18%	12
Outside of City Limits but Not Rural	8%	5

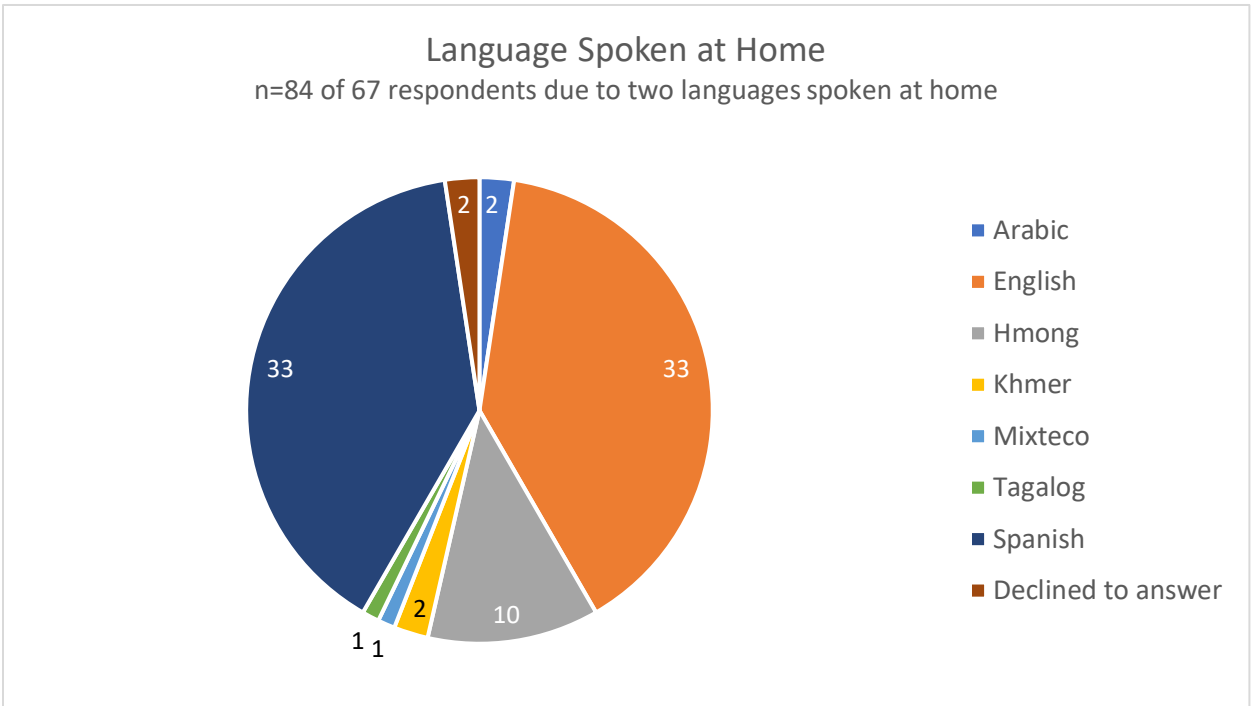
The location of residents in FRC mirrors the county 30% rural, 70% urban demographics overall and is predominantly female.

Although 26% declined to answer race and 24% declined to answer ethnicity, it is a diverse group.





In keeping with that diversity, they speak seven different languages at home with 21% speaking both English and their first language.



Nine respondents identified having a disability (14%), 85% did not, and 1% declined to answer. There were no veterans in the group. Four individuals (7%) identified as

bisexual, 10% did not wish to identify a sexual preference, and the vast majority identified as straight.

Survey Findings

Almost half of respondents (48%) had direct experience with accessing mental health in some way for themselves, children, or family members. A larger 55% knew friends or family members who had tried to access mental health services. Hearing others talk about their experiences accessing mental health services occurred for 48%. Only 22% had no direct experience.

Concerns about Mental Health Access

Respondents selected as many concerns as applied to them from a list of ten, with the option to add more. The top five concerns selected by all 67 respondents:

- **85%** said people don't know where to go or who to call.
- **60%** said people don't have insurance to pay for it.
- **49%** said appointment wait times are too long.
- **33%** said children go to All 4 Youth at schools but then get sent elsewhere because they don't qualify.
- **28%** said they don't like using telehealth.

See the Appendix for full survey results.

There were variations according to different sub-groups in rank order or including a different concern. With one exception, the top three ranked remain in that order for adult, Fresno/Clovis, and age 14-24 sub-group respondents. The exception is for rural respondents the top two ranked remain the same, but the third ranked is "children go to All 4 Youth and then get sent elsewhere."

When viewing results by race or ethnicity, only the first concern remains constant. Rank order by race/ethnicity:

Black Rank Order (n=9)

1. People don't know where to go or who to call. (71%)
2. People don't have insurance to pay for it.
3. Children go to All 4 Youth and then are sent elsewhere.
4. Triple Tie - Appointment wait time is too long, transportation to get to an appointment takes too long, and people don't like using telehealth.

Hmong Rank Order (n=9)

1. People don't know where to go or who to call (100%)

2. Tie - The clinician doesn't speak my language; people don't have insurance to pay for it.
3. People in my area can access only via telehealth but we have no internet connection, or the speed is too low to handle it.
4. Tie – The wait time for an appointment is too long; children go to All 4 Youth and then are sent elsewhere.

Latino/Hispanic Rank Order (n=31)

1. People don't know where to go or who to call (90%)
2. The wait time for an appointment is too long.
3. People don't have insurance to pay for it.
4. People don't like using telehealth.
5. Tie – The nearby clinic doesn't have mental health services; children go to All 4 Youth and then are sent elsewhere.

"When you have insurance, you cannot afford copays for mental health." Age 14-24 female

Race/ethnicities with one or two individuals or who did not specify are not included above.

Best Method to Learn About Mental Health Services

"I feel we have a lot of resources and ways to get information, but the advertisement for it is not there. Unless you are asking for the information, I feel it is not advertised as it should be." Rural resident

Learning about mental health access is desired from multiple sources by a very wide margin from using just one source. The top method across all groups is learning about it from a trusted CBO, with the minor exception of Hmong, which ranked it a close second to learning about it from their doctor. The most pronounced differences were among racial/ethnic groups, rather than location or age. Ties in number of responses are indicated by repeating the rank order number.

Best Way to Learn about Mental Health Wellness and How to Access

All (n=65)	Black (n=6)	Hispanic (n=30)	Hmong (n=9)
1. Trusted CBO 2. My doctor 3. Church, temple, etc 4. Workshops 5. Health plan or insurance	1. Trusted CBO 2. Workshops 3. My doctor 3. Church, temple, etc. 3. Health plan or insurance 3. Website	1. Trusted CBO 2. Church 3. My doctor 4. Workshops 5. Health plan or insurance	1. My doctor 2. Trusted CBO 3. Church, temple, etc. 3. Call center or 2-1-1 4. Schools

	3. Social media		

Those identifying Black ranked learning from workshops second, Latinos ranked it fourth, and Hmong had only one response for workshops because mental health is considered a private matter in the culture. Social media ranked in the top five for the Black respondents only because of a five-way tie for #3 ranked. Surprisingly, youth ranked social media and websites near the bottom. Learning from health plans was ranked fifth across the board except for Hmong, which did not select it at all.

Best Way to Learn about Mental Health Wellness and How to Access

Adult (n=46)	Age 14-16 (n=19)	Rural (n=19)	City & outside limits (n=47)
1. Trusted CBO 2. My doctor 3. Church, temple, etc 4. Workshops 5. Health plan or insurance	1. Trusted CBO 2. My doctor 2. Church, temple, etc. 3. Health plan or insurance 3. Call center or 2-1-1 4. Workshops	1. Trusted CBO 2. My doctor 3. Church, temple, etc. 3. Workshops 4. Health plan or insurance 5. Call center or 2-1-1 5. Social media	1. Trusted CBO 2. My doctor 3. Church, temple, etc. 4. Workshops 5. Health plan or insurance

Understanding of Specialty and Non specialty Mental Health Services

The following description was provided in the survey to determine people's level of knowledge and how different severity levels changed where to go for services. The scale was 0 to 100, with 100 being very knowledgeable.

> **There are two levels of mental health services - Specialty and Non specialty.** Specialty is to help people with severe illness that affects their ability to function, such as psychosis, major depression that recurs, or severe anxiety making it hard for them to work or go to school. Non specialty mental health is for mild to moderate levels of need, perhaps the result of the loss of a loved one or anxiety that affects school attendance.
>
> Specialty mental health needs are provided through the Fresno County Department of Behavioral Health or All 4 Youth at school sites. Non specialty mental health needs are provided by a person's health insurance such as CalVIVA or Anthem Blue Cross or employer insurance.

Survey respondents were asked how knowledgeable they were about the differences prior to reading the description. The average number on the scale for all respondents is 46, which means that most indicated they

> *"I am 44 years of age and barely finding out and seeking help."*
> Native American Male, City

"sort of knew but weren't clear." The range moved from three people at 0 to a high of three people at 100. The median was 50.

Survey participants were then asked how knowledgeable they were about where to find a mental health provider prior to reading the description. The average number was 48 or that they "they sort of knew but weren't sure." The range on the scale again had three people at 0, six people at the highest 100, with the median again at 50.

Cultural Views of Addressing Mental Health Wellness

"They have two extremes: they are either extremely biased toward mental health and stigmatize it [or] they are extremely open about it and free to discussion about resources." Latina female, age 15-24.

The above quotation from a respondent demonstrates the overall bifurcation in response to the open-ended question about how their cultural group addresses mental health wellness. The 62 responses indicate that stigma exists and that it is slowly improving. From adults and all race/ethnicities, concern about children was common.

> *"En mi cultura es como un tabú no se atreven a asentar que hay un problema por miedo a ser juzgados como locos."* *(In my culture it is like a taboo, they do not dare to state that there is a problem for fear of being judged as crazy.)* Adult Latina, City

The Latino/Hispanic responses repeatedly mentioned that people don't seek help because they don't want to be labeled "crazy" and that there is a lot of misinformation. Hmong consider it a very private matter, do not feel comfortable discussing it in public and that it should stay within their own cultural group. Younger adults may be more comfortable seeking help, especially if there is a clinician speaking their own language. A Black response acknowledged that in the past their culture did not feel therapy was necessary, another had no idea what others thought, and others indicated it was important and an ongoing concern. Youth mentioned the concern about therapy being viewed as "feminine," feel the stigma is

> *"The Hmong people believe in our own culture and only doctor when it comes to health problems."* Adult Hmong Female, City

> *"Willingness to access services is improving. Getting services without the run-around is rare and has deterred many to give up their search for services."* Adult Latina, City

lessening, and that there is still a lot of work to be done around stigma.

> *"My culture seems to have little to no awareness of mental health. This is almost like a culture shock when you speak of mental health terms. I am also noticing that it is the same for my community. A large group of people that I mentor are embarrassed to admit that they might need mental health services."* Rural Adult Female

Most Comfortable Way for Cultural Groups to Address Mental Health Wellness

"*Talk to someone they trust and feel comfortable with. Talk to someone who understands their culture and background. Talk to someone who speaks the same language."* Hmong Female Adult

Building awareness in non-threatening ways and spaces with opportunities to interact appears to be the common theme. There were many ideas that mirrored the quantitative selections and added more depth. Many concentrated on more informal, community methods.

- Focus groups/house party where they could learn more.
- A coffee time in the community where they could learn.
- School workshops, community workshops, or informational meetings
- Peer support groups where the same language was spoken.
- One suggested bringing in an expert to help educate on mental health and the effects of not addressing it.
- Another suggested testimonials by those with lived experience be part of education because "if you send them directly to a psychologist, they feel sad and don't want to go."
- Another said to continue with social networks, radio, and television as they are beneficial.
- Provide mental health screenings in homes or schools, with the possibility of primary care doctors screening children prior to entering kindergarten.

Most Important Area to Begin to Improve Communication or Knowledge About Mental Health

The great majority of respondents had the greatest number of responses for Non-specialty Children/Youth services (27) followed by Specialty Children Services (25). Adult services dropped significantly in importance in number to 7 for Specialty and 4 for Non-specialty. Non-specialty children/youth services listed as "somewhat important" were 20 in number. Due to reported confusion with the question design when using cell phones to complete the survey, choices for important or somewhat important may be slightly inaccurate. This renders the weighted average less useful as shown in the chart in the Appendix. However, when combining both "important" and "somewhat important" numbers, the total number shows non-specialty children/youth services clearly the priority.

> *"Addressing the language barrier is important from the initial contact in information about mental health provider(s), costs. Insurance options/coverage, scheduling, to the service itself so families understand."* Adult Female, City

There were few differences between races/ethnicities, age, or location. Only those ages 14-24 indicated specialty youth services should be addressed before non-specialty youth services by a margin of 2 to 1 (13 responses to 6). It is not clear if the phone input issue affected their answers.

Focus Group Findings

There were five focus groups: Black/African Americans (11 participants), Hispanic/Latino (11), Hmong (7), Syrian Arabic speaking refugees (8), and Youth Ages 14-24 (9). Most, if not all, of the focus groups were learning sessions for some participants as well as providing their perspectives.

The Hispanic/Latino group had the fewest identifying they had family members, themselves, or friends who had concerns about mental health. The Hmong and Black groups had all participants identifying personal experience or concerns of themselves or others. All groups identified children and adults who they knew needed help. The Youth group mostly knew of other friends or family members. The Arabic speaking refugees all had issues but first need to learn how to identify their feelings as mental health has not been a part of their culture.

Overall, concerns centered around the themes of 1) Economic and environmental stress impacting mental health 2) Non specialty services; 3) Barriers to Access; 4)

Cost/Health Insurance; 5) Resources – mental health and social services; and 5) Options to Help. Each group had distinctive concerns of importance.

Black/African American Group

The focus group was held at a church in southwest Fresno, with most participants living in the area and comprised of three men and eight women, most working individuals. All of them had personal experience with mental health issues, whether grieving from losses, children-related or children they worked with or mentored, and personal or family members with traumatic backgrounds. They described using levity or normalizing words like "crazy" to avoid looking at the issue in depth or the lack of discernment when a person is joking vs. the need to address real mental health issues.

> *"You can't be African American and not have mental health issues. Trauma, violence, racism, parents on drugs…[but] problems stay hidden. We have trouble talking about it."*

Many in the group had positive experience with therapeutic mental health support but told stories of having to confront the perception of friends and family that therapy "is for white people." They described good doctors leaving, revolving therapists, and mostly the difficulty in finding the few Black therapists and, when found, them being booked solid, even when having excellent employer insurance. "Blacks have the biggest percentage of mental health issues. We need mental health professionals." Other barriers include cost, socio-economic level, and no therapists or support in their part of town.

Participants also took some of their own people to task, citing a lack of accountability of parents when someone tells them their child's classroom behavior is ADHD and a psychiatrist writes a medication prescription, which allows the parent to receive more money for the child from foster care or other government sources. Further discussion spearheaded by two knowledgeable members talked through options that many people do not realize could first occur to address an issue like ADHD before jumping immediately to medication.

One participant working with parents in early education would refer preschool children to child-serving mental health organizations and most parents would take them. "I only heard this from African American parents: 'I don't want my child labeled.' There is a lot of fear associated for parents that the child will be labeled for the rest of their school life."

"I don't want my child labeled," is what a child educator would hear from African American parents when attempting a referral.

The pastor of the church raised the issue of "church trauma," described as a split from other churches and their governing bodies bring long-lasting feelings into the new church. There are also the issues of power dynamics or physical and sexual abuse within the church that can damage attempts to experience faith. "The church has always been an important part of African American culture" and this type of trauma is hurtful and painful. He noted local African American churches are in the beginning stages of introducing mental health to their congregations.

Ideas to address barriers:

- Have workshops in churches, community, and/or schools to educate people on "the different stages of mental health." The workshops should have resources in person available at the end so that people could talk to them about services if they identify a need as a result of the workshop.
- Before a prescription for medication is written for a child, there should be a protocol to make sure that a parent knows and the child has had a full evaluation and discussion of options, such as an ACE screening, mental health screening, a therapist talking with the school psychologist and teacher for background, talk therapy, etc.
- We need to see more targeted advertisements for their culture at schools, bulletin boards, billboards, or church with lists of things that could be helped and where to get help. The brochures may be at a school, but some things should be mailed home instead of just putting into a child's backpack that a parent may never see.
- Develop peer to peer outreach for youth with a professional to train them.
- Kids love to perform, so develop ways for them to share the message, even if just at their school.
- Advocacy for legislation so that more money gets to those who are Black instead of administration and so that Medi-Cal payment doesn't take three years for therapists or organizations.

Hispanic/Latino Group

This group of eleven focused their attention on the need for children in schools to have therapy with just about every person mentioning it. Schools were their focus on where to receive services in the languages of English and Spanish. One

"Que den mas informacion der tema er la escuela." (Give more Information about the topic at school.)

"Hay muchas ideas que nos pueden ayudar pero las personas tienen que tiener conficancon a los que quinen ayudor." (There are many ideas that can help us, but we have to trust those who help.)

expressed the need to give information for therapists outside of school with a phone number provided. They wanted more education about mental health. They spent time talking about the need for school safety as it causes anxiety for students and parents. More bilingual staff was desired, more information on food resources, more police to take care of the schools, healthy food for school lunches, and they wanted to be heard and taken seriously by school officials. It appears that when a teacher holds a student accountable in a tone or way that is perceived as abusive, it circulates widely. While some of what was discussed does not seem to be related to mental health wellness, the anxiety caused reinforces past experience and affects mental health. As one individual said, "There are many ideas that can help us, but we have to trust those who help."

Ideas provided were:

- "Que alla uniforme erlas escuela para que no hagan bullying por su nopu er la escuela." (Uniforms so that they [students] don't get bullied, because [when that happens] they don't go to school.)
- Workshops on mental health at schools were suggested.
- Family therapy.
- Two wanted to know the symptoms of depression.
- One parent appears to be struggling with student isolation at home, "Se ensern en el cuarto e no salon par platcar" (They go to their room and don't come out to talk.)
- People who may not accept help because they are afraid they will be judged.
- They want language availability, as one person noted she speaks Mixtec and knows very little Spanish.
- They want "apoyo moral" or moral support.

Although their early identification of those they know with mental health concerns were primarily adults, their conversation afterwards centered on children, demonstrating a path forward.

Hmong Group

This group of six women and one man also took a holistic approach to mental health regarding resources needed. While the culture in general was said to lack education about mental health, especially older adults, each person in this group identified someone they knew needed help which indicates greater awareness than many. One was a grandchild, another a mother-in-law isolated at home, themselves, and family members. Multiple questions about where to go to learn about depression, how to help children struggling in school, patient rights, disability rights, and how lack of language access at hospitals, Department of Social Services (DSS), Social Security Administration (SSA), and clinics impacts them negatively.

> *"Mental health is sometimes very taboo in our community. It's sometimes hush hush and hidden away. I believe educating people would help."* Hmong Female

This group had more mention of financial concerns and inflation than the Hispanic group, but like them, needed knowledge on where to go for food, health, adequate transportation, housing resources, translators, and not understanding or knowing about or where to find available resources. Written comments by participants primarily were in English, although their comment sheet questions were in Hmong. Taking care of the elders or adults with limited English and their need for Hmong language was commented upon frequently. The lack of feeling safe and not enough sidewalks and public parks were mentioned. Calls to a mental health provider are changed from person to person; 9-1-1 puts them on hold, both of which result in stress. When they feel comfortable talking with someone at school (a teacher or an office receptionist) or doctor's office staff, they want that person to refer them to someone or at least tell them the place to go to find out. One person noted "People who provide services are not educated/trained to help people when they ask for it." These people are trained for their own work but are not

> *"People who provide services [at schools or doctor offices] are not educated or trained to help people when they ask for it."* Hmong City participant

knowledgeable about where to send someone outside of their own sphere, which is their expectation.

Ideas to address barriers:

- Training - for elders on mental health, for staff about mental health and where to obtain help, for people with limited English to know their right to access health care and other public resources, and how to access social services and mental health programs.
- Funding for CBOs, which are "more used [by] community members due to they are the trusted messengers."
- Create internship programs for youth.
- Language support is easily available and accessible at hospitals, DSS, SSA, and clinics.
- Community events to share our culture.
- More funding to support the elders with limited income.
- More financial help.

Arabic Syrian Refugee Group

This group is one of just a small, but growing, number of refugees from different countries arriving in the county. Since the community-based organization (CBO) Fresno Interdenominational Refugee Ministries (FIRM) became a formal resettlement agency for the Central Valley about a year ago, 122 individuals in 30 families have resettled here knowing no English when they arrive. For 90 days, FIRM helps them with housing, resources, school, Medi-Cal, signing up with adult school to learn English (although there is no Arabic interpreter), teach them how to use public transportation, find jobs, and more. They have arrived from Afghanistan, Syria, Armenia, Venezuela, Honduras, Guatemala, Burma (Myanmar), Democratic Republic of Congo, Belarus, and Somalia speaking ten different languages. FIRM has been approved by the federal government to receive 175 people in FY 2024, an increase from 101 people welcomed in FY 2023. The children in these families are attending schools in Clovis Unified, Fresno Unified, and Central Unified in Fresno County, with several more attending in other counties.

The focus group leader for the Arabic speaking group is herself a refugee from Syria eight years ago. She is one of the very, very few Arabic interpreters in Fresno County. FIRM's Executive Director, in a background conversation for context around the focus group, believes that an Arabic speaking clinician is greatly needed

to handle the traumatic experiences and culture shock of refugees in their own language. She noted that there is an Arabic speaking psychiatric resident at UCSF-Fresno and that is the only one to her knowledge.

> *"An Arabic speaking therapist is needed in Fresno County."*
> Christine Barker, Executive Director, FIRM

This focus group was comprised of two men, six women, and three youth ages 16-24 who arrived in April/May of 2023. All of them have concerns about mental health, especially due to the challenges, lack of English, and culture shock of a new country and the concern for children being bullied in school. All the children of participants attend Clovis Unified schools where they receive an hour of English a day, which "is not enough," according to focus group participants.

Participants want to know more about or need:

- Interpretation services to learn English.
- A better understanding of mental health systems and what it looks like in the United States.
    - In their home country, there is no understanding of mental health – it is just that life is hard - and if they talk about it, authorities could view it negatively. It would be viewed as complaining and they could be questioned by authorities in their home country. To avoid that perception, they say "I'm fine." There is a fear of judgement if they share their feelings with anyone.
    - They don't know the difference between being "mentally sick" and "mentally tired." Adults don't know how to recognize their feelings. Guidance counselors at schools help students work through this, especially when they are being picked on or bullied.

> *"They don't know the difference between being "mentally sick" and "mentally tired". Adults don't know how to recognize their feelings."*
> Arabic Focus Group Lead

    - Unsurprisingly, stress is a large factor for adults and children.
    - Although they are on Medi-Cal, there are issues with cost, whether it be co-pays, transportation, or childcare.
- Lack of knowledge in navigating the education system.
- Lack of teachers or the district educating themselves or other students on the culture so that Syrian or Arabic speaking students are not bullied. Examples include the wearing of a hijab (head covering) and fasting during

holidays such as Ramadan which means they don't eat during the day at school.

Families relieve their stress now through smoking, prayer, cooking, and family discussions. The systemic barrier solutions proposed are:

- Increasing the number of competent interpreters.
- Small groups together learn about feelings and how to express themselves in safe spaces.
- Improving teaching practices to learn English; "sink or swim" practices such as one hour a day are not often effective for those older.
- Professionals and specialists learning how to establish trust for those in this culture.

Youth Ages 14-24

The nine youth in this group included Black, Hispanic/Latino, and Hmong. They indicated others – family members or friends – who could benefit from mental health services but not themselves. This group expressed the same racial and ethnic issues described earlier according to their culture. Being nervous and not knowing what to expect if you want therapeutic help was expressed. This group was interested in knowing about alternative methods to therapy and medications. They want to know "what type of therapy would work best for them," so somehow, they know that there are different therapeutic types. They are interested in coping methods. One didn't like the "push for a digital appointment" and another didn't know about online therapy via Zoom. Inaccessibility of therapists, especially to find someone in person after business hours, the time it takes to find a therapist with the "right fit", and the lack of continuity with therapists were mentioned. This group expressed the most concern about therapy being perceived as "feminine," i.e. being vulnerable, especially for boys and men, and especially those who were Latino. This included feeling judged if they reached out to family members. Not having insurance or cost were cited, along with not knowing where to look. One said Medi-Cal does not cover.

> *"Comedic relief is always used to repress mental health issues. Abrupt behavior is something commonly used as a way to mask mental health issues."* Age 14-24

The youth and young adults had some concrete suggestions for improvement.

- Mental health rallies at school campuses (especially during finals) was mentioned frequently.
- Include information on mental health in school emergency packets at registration.
- Identify mental health issues at an earlier age. Teach social-emotional skills and coping skills earlier.
- Have parent workshops on how to help children. Have joint parent and student workshops that can help with working on solving mental health issues at home.
- Have a CBO mental health resource fair. Learn which CBOs have resources where they can reach out.
- Utilize social media AND also have a way to stay anonymous if responding to a post.
- More signs at school with information about how to access therapy services on campus.
- Hold support groups for students to receive support/vent/talk after school.
- Mental health education in elementary and middle school and develop emotional regulation skills. Talk about it more than once. Implement it into our curriculum.
- Health clubs at school.
- Take a mental break and talk to someone.

Conclusion

Mental health is seen as an issue for both survey and focus group participants. In most cases, the level would be described as mild to moderate level initially, rather than severe. Stigma impacts all races and ethnicities, although it has lessened to a degree, likely due to the pandemic. However, the stigma manifests differently in cultures. It was clear that race/ethnic culture had more impact on mental health issues being addressed than location. Accessibility for in person sessions is more difficult for rural residents and they have more internet related issues for telehealth.

For help with non specialty mental health needs, trusted CBOs were at the top of almost every group. It was also acknowledged that they need more funding and training. Suggestions were often made to work more with schools for youth with

less severe needs and to help educate parents. Incorporating mental health and coping skill development into all grades of K-16 was suggested, and there is an opportunity to "normalize" addressing mental health by holding mental health rallies for students, "venting" groups after school or peer outreach, and offering parent workshops.

The first focus is asked to be children and youth non specialty services access.

It is evident in all cultures that mental health is not being talked about, with improvement occurring now in varying degrees of awareness and willingness. The most difficult of the groups involved were the Arabic refugees, who first need help identifying feelings, preferably with an Arabic speaking and culturally knowledgeable therapist. Each identified group has different needs and methods that will work better for that culture. That level of specificity isn't easy in a county where therapists accepting Medi-Cal are difficult to maintain, and where commercial insurance, Medi-Cal health plans, and DBH do not have enough therapists speaking the needed languages so that those seeking help can comfortably express themselves.

No one group, department, or system can be responsible for improvement. Working collaboratively across sectors and agencies is likely needed.

Multiple methods to educate people were provided and the first focus is asked to be for children and youth non specialty services access. Given the holistic needs identified, no one group, department, or system can be responsible for improvement. Working collaboratively across sectors and agencies is likely needed to improve mental health and wellbeing.

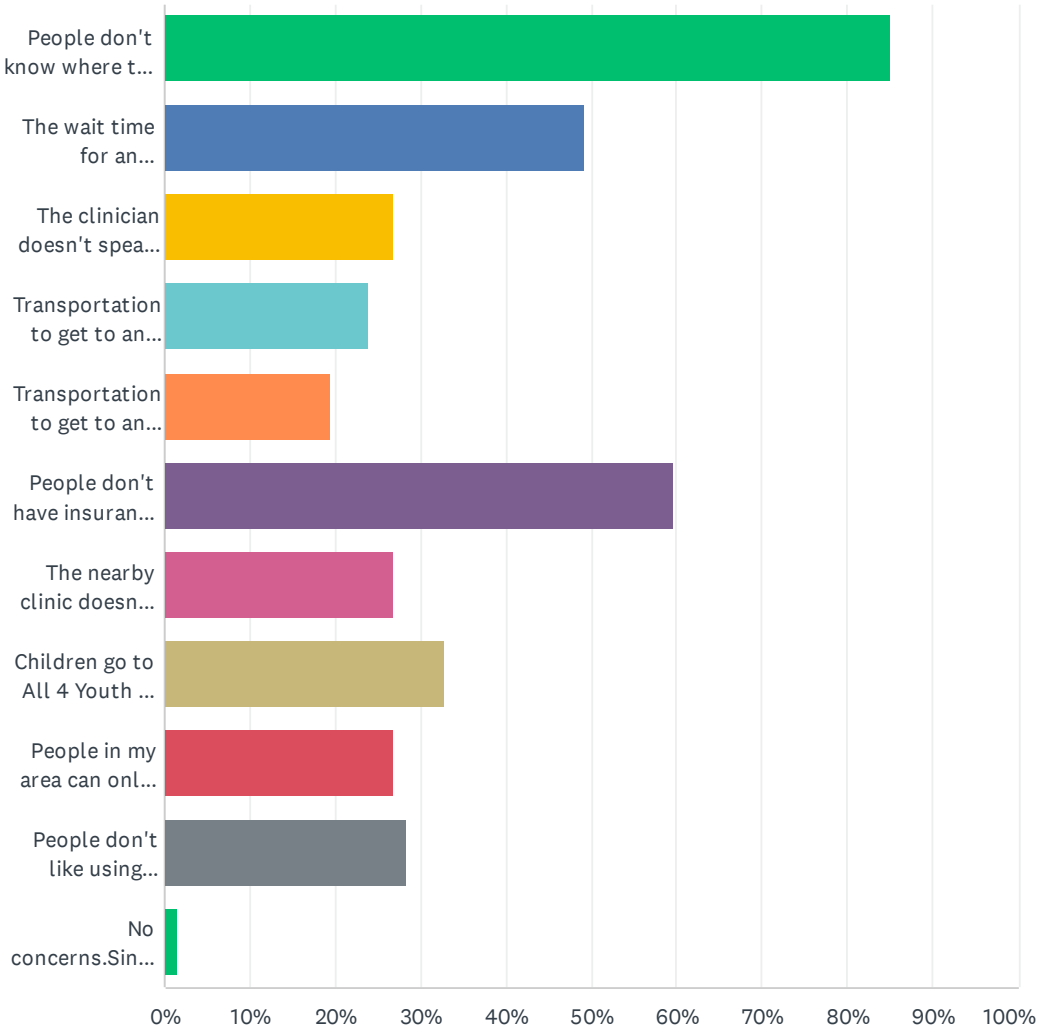
Appendix

The following survey results represent an aggregate of 67 respondents. For specific data cuts by race, ethnicity, rural, city, adult, or youth ages 14-24, please contact The Children's Movement. They are available, but the length to include was considered. All comments to individual questions are included.

Surveys were provided in an English/Spanish format and a Hmong format. Three surveys utilized the Hmong format and their answers were input into the 64 English/Spanish responses for a total of 67 responses shown.

Q1 What concerns you about mental health access? (Check as many as apply.)¿Qué le preocupa sobre el acceso a la salud mental? (Marque todos los que correspondan).

Answered: 67 Skipped: 0

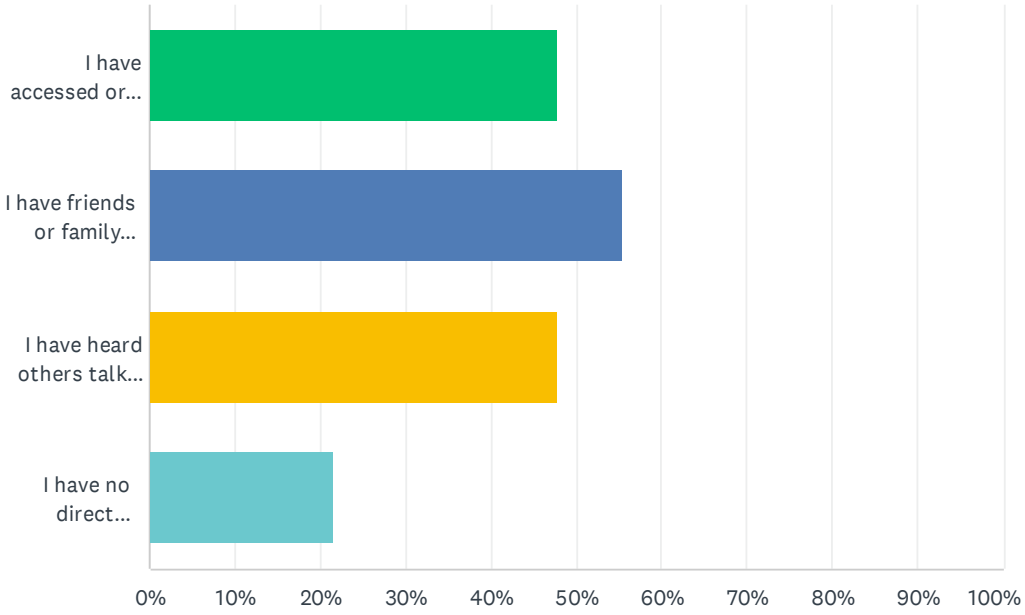


ANSWER CHOICES	RESPONSES	
People don't know where to go or who to call for services.La gente no sabe adónde ir ni a quién llamar para solicitar servicios.	85.07%	57
The wait time for an appointment is too long. El tiempo de espera para una cita es demasiado largo.	49.25%	33
The clinician doesn't speak my language. El médico no habla mi idioma.	26.87%	18
Transportation to get to an appointment takes too long.El transporte para llegar a una cita tarda demasiado.	23.88%	16
Transportation to get to an appointment is too hard to find. Es muy difícil encontrar transporte para llegar a una cita.	19.40%	13
People don't have insurance to pay for it.La gente no tiene seguro para pagarlo.	59.70%	40
The nearby clinic doesn't have mental health services there. La clínica de salud cercana no cuenta con servicios de salud mental.	26.87%	18
Children go to All 4 Youth at schools but then get sent somewhere else because they don't qualify.Los niños van a las escuelas All 4 Youth pero luego los envían a otro lugar porque no califican.	32.84%	22
People in my area can only access via telehealth but we have no internet connection or it is too slow to handle the appointment.Las personas en mi área solo pueden acceder a los servicios a través de telesalud (computadora o teléfono) pero no tenemos conexión a Internet o es demasiado lento para manejar la cita.	26.87%	18
People don't like using telehealth.A la gente no le gusta usar la telesalud.	28.36%	19
No concerns.Sin preocupaciones.	1.49%	1
Total Respondents: 67		

#	OTHER (PLEASE SPECIFY) / OTROS (ESPECIFICAR)	DATE
1	When you have insurance you can not afford copays for mental health services. 2.) most of the mental health services provided my state insurances (such as medical) do not offer a lot of help for people experiencing severe mental illness	12/6/2023 6:41 PM
2	Lack of cultural awareness when providing therapy.	12/6/2023 6:25 PM
3	Our community feels shame requesting mental health services.	11/21/2023 10:22 PM
4	All 4 Youth screening is complicated and I feel it excludes someone that may not fall into a severe case.	11/21/2023 1:00 PM
5	People have a hard time finding the right therapist fit for themselves	11/21/2023 10:40 AM

Q2 What is your experience in accessing mental health services? (Check as many as apply.)¿Cuál es su experiencia al acceder a servicios de salud mental? (Marque todos los que correspondan).

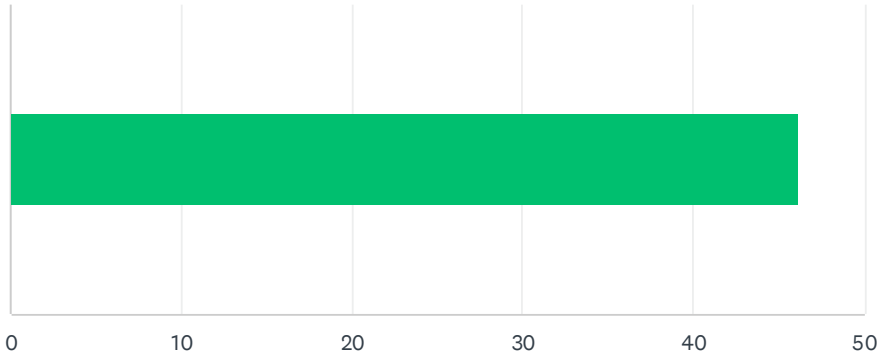
Answered: 65 Skipped: 2



ANSWER CHOICES	RESPONSES	
I have accessed or tried to access services for my child, a family member, or myself. He accedido o intentado acceder a servicios para mi hijo, un miembro de mi familia o para mí.	47.69%	31
I have friends or family members that have accessed or tried to access services.Tengo amigos o familiares que han accedido o intentado acceder a servicios.	55.38%	36
I have heard others talk about services.He escuchado a otros hablar sobre servicios.	47.69%	31
I have no direct experience.No tengo experiencia directa.	21.54%	14
Total Respondents: 65		

Q3 Before you read the description of levels of mental health services, how knowledgeable were you about the difference?Antes de leer la descripción de los niveles de servicios de salud mental, ¿qué conocimiento tenía sobre la diferencia?

Answered: 66 Skipped: 1



ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
	46	3,048	66
Total Respondents: 66			

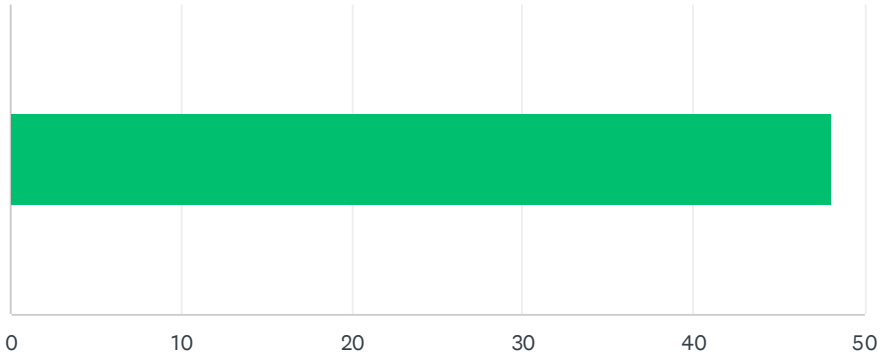
#		DATE
1	52	12/13/2023 7:08 AM
2	51	12/13/2023 6:53 AM
3	50	12/13/2023 6:48 AM
4	95	12/8/2023 11:53 AM
5	47	12/7/2023 9:48 PM
6	61	12/7/2023 9:32 PM
7	60	12/7/2023 8:09 PM
8	41	12/7/2023 5:07 PM
9	97	12/7/2023 3:53 PM
10	45	12/7/2023 1:54 PM
11	52	12/7/2023 12:25 PM
12	64	12/7/2023 8:45 AM
13	48	12/7/2023 7:29 AM
14	100	12/6/2023 6:41 PM
15	27	12/6/2023 6:25 PM
16	70	12/6/2023 4:43 PM
17	45	12/6/2023 4:31 PM

18	45	12/6/2023 4:23 PM
19	50	12/6/2023 4:18 PM
20	63	12/6/2023 4:10 PM
21	60	12/6/2023 4:04 PM
22	2	12/6/2023 3:19 PM
23	47	12/6/2023 2:12 PM
24	9	12/6/2023 12:40 PM
25	53	12/6/2023 12:31 PM
26	47	12/6/2023 11:50 AM
27	72	12/6/2023 10:51 AM
28	39	12/6/2023 12:19 AM
29	50	12/5/2023 8:47 PM
30	55	12/5/2023 7:25 PM
31	59	12/5/2023 6:28 PM
32	7	12/5/2023 6:16 PM
33	100	12/4/2023 2:25 PM
34	51	12/2/2023 9:09 PM
35	14	12/2/2023 5:55 PM
36	45	12/2/2023 5:49 PM
37	0	12/2/2023 5:41 PM
38	3	12/2/2023 5:27 PM
39	47	12/2/2023 5:23 PM
40	0	12/2/2023 5:22 PM
41	0	12/2/2023 5:15 PM
42	58	12/2/2023 5:02 PM
43	56	12/1/2023 7:06 PM
44	55	12/1/2023 6:50 PM
45	49	12/1/2023 2:08 PM
46	99	11/30/2023 12:07 PM
47	53	11/29/2023 12:57 PM
48	43	11/25/2023 8:51 PM
49	100	11/24/2023 1:56 PM
50	75	11/21/2023 10:22 PM
51	48	11/21/2023 9:08 PM
52	1	11/21/2023 8:27 PM
53	64	11/21/2023 7:36 PM
54	50	11/21/2023 7:21 PM
55	12	11/21/2023 2:59 PM

56	12	11/21/2023 1:00 PM
57	2	11/21/2023 12:53 PM
58	9	11/21/2023 12:06 PM
59	46	11/21/2023 11:44 AM
60	25	11/21/2023 11:27 AM
61	54	11/21/2023 11:19 AM
62	75	11/21/2023 11:13 AM
63	67	11/21/2023 11:10 AM
64	14	11/21/2023 10:42 AM
65	3	11/21/2023 10:40 AM
66	55	11/21/2023 10:36 AM

Q4 Before you read the description of mental health services, how knowledgeable were about where to go to find a provider to help?Antes de leer la descripción de los niveles de servicios de salud mental, ¿qué conocimiento tenía sobre dónde encontrar un proveedor que le ayude?

Answered: 66 Skipped: 1



ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
	48	3,173	66
Total Respondents: 66			

#		DATE
1	59	12/13/2023 7:08 AM
2	51	12/13/2023 6:53 AM
3	50	12/13/2023 6:48 AM
4	88	12/8/2023 11:53 AM
5	33	12/7/2023 9:48 PM
6	100	12/7/2023 9:32 PM
7	100	12/7/2023 8:09 PM
8	45	12/7/2023 5:07 PM
9	53	12/7/2023 3:53 PM
10	40	12/7/2023 1:54 PM
11	6	12/7/2023 12:25 PM
12	64	12/7/2023 8:45 AM
13	25	12/7/2023 7:29 AM
14	88	12/6/2023 6:41 PM
15	69	12/6/2023 6:25 PM
16	66	12/6/2023 4:43 PM
17	66	12/6/2023 4:31 PM

18	45	12/6/2023 4:23 PM
19	50	12/6/2023 4:18 PM
20	39	12/6/2023 4:10 PM
21	44	12/6/2023 4:04 PM
22	3	12/6/2023 3:19 PM
23	49	12/6/2023 2:12 PM
24	48	12/6/2023 12:40 PM
25	14	12/6/2023 12:31 PM
26	17	12/6/2023 11:50 AM
27	8	12/6/2023 10:51 AM
28	29	12/6/2023 12:19 AM
29	80	12/5/2023 8:47 PM
30	55	12/5/2023 7:25 PM
31	61	12/5/2023 6:28 PM
32	9	12/5/2023 6:16 PM
33	100	12/4/2023 2:25 PM
34	32	12/2/2023 9:09 PM
35	51	12/2/2023 5:55 PM
36	41	12/2/2023 5:49 PM
37	0	12/2/2023 5:41 PM
38	0	12/2/2023 5:27 PM
39	86	12/2/2023 5:23 PM
40	0	12/2/2023 5:22 PM
41	100	12/2/2023 5:15 PM
42	61	12/2/2023 5:02 PM
43	54	12/1/2023 7:06 PM
44	54	12/1/2023 6:50 PM
45	43	12/1/2023 2:08 PM
46	100	11/30/2023 12:07 PM
47	49	11/29/2023 12:57 PM
48	37	11/25/2023 8:51 PM
49	50	11/24/2023 1:56 PM
50	60	11/21/2023 10:22 PM
51	50	11/21/2023 9:08 PM
52	1	11/21/2023 8:27 PM
53	40	11/21/2023 7:36 PM
54	7	11/21/2023 7:21 PM
55	97	11/21/2023 2:59 PM

56	24	11/21/2023 1:00 PM
57	2	11/21/2023 12:53 PM
58	5	11/21/2023 12:06 PM
59	32	11/21/2023 11:44 AM
60	52	11/21/2023 11:27 AM
61	55	11/21/2023 11:19 AM
62	90	11/21/2023 11:13 AM
63	100	11/21/2023 11:10 AM
64	62	11/21/2023 10:42 AM
65	31	11/21/2023 10:40 AM
66	53	11/21/2023 10:36 AM

Q5 Please tell us how your community or cultural group views addressing mental health wellness.Díganos cómo ve su comunidad o grupo cultural abordar el bienestar de la salud mental.

Answered: 62 Skipped: 5

#	RESPONSES	DATE
1	Nws pab tau ntau ya ko peb nxtua tub paub txog teb kev Kaj siab los yog nyob nyab xeeb ntawm kev xav.	12/13/2023 7:08 AM
2	Don't really communicate.	12/13/2023 6:53 AM
3	Something that we are not addressing in public.	12/13/2023 6:48 AM
4	We have created clubs and programs to help teens stay involved to learn self love and mental stability	12/8/2023 11:53 AM
5	Como una situacion dificil que en ocaciones no encuentran la ayuda necesaria en nuestro idioma.	12/7/2023 9:48 PM
6	My community view, addressing mental health wellness as a very important thing.	12/7/2023 9:32 PM
7	My community speaks about it and has places for people to go if they need help.	12/7/2023 8:09 PM
8	I think we would like to help others that those have it hard and it would help them move on, in a stronger and positive way	12/7/2023 5:07 PM
9	I'm comfortable and well versed in mental health. There is just little acess here in fresno.	12/7/2023 3:53 PM
10	They view it as important.	12/7/2023 1:54 PM
11	Muy poco!!	12/7/2023 12:25 PM
12	At one point in time our cultural view was we do not need to go to therapy	12/7/2023 8:45 AM
13	It helps by u talking about it actually relieve a lot of pain and stress	12/7/2023 7:29 AM
14	This is a difficult question to answer. I came from a low income background where mental health was not addressed. As an adult, I have gained a BA in psychology and am going to graduate school to become a mental health therapist, where mental health is glorified. There are many communities that I belong to each with a different perspective.	12/6/2023 6:41 PM
15	Mental health is treated like it isn’t a real thing in the Latine community. There’s no need to go see a therapist or psychiatrist. It’s better not to take medication.	12/6/2023 6:25 PM
16	For the Hmong people i feel as they don't really view mental health important those who are older may be Bias towards mental health and might mistake their illnesses as superstition in which they don't seel out care for the mentally challenged people in their family.	12/6/2023 4:31 PM
17	My community shows that we aren’t alone especially in mental health, especially at schools we have our teachers, schools talking about mental health.	12/6/2023 4:23 PM
18	Mucha desinformación	12/6/2023 4:18 PM
19	Mental health is taken very seriously. We all have some type of experience or close to individuals that have had or currently receive some type of mental health service. We believe that mental health is just has important and physical health.	12/6/2023 4:10 PM
20	My culture just says ponte Las pilas.	12/6/2023 4:04 PM
21	Ya hay servicio de salud mental pero es tardado p agarrar una cita	12/6/2023 3:19 PM
22	Qué no saben mucho de la salud mental y no saben las consecuencias que esto tiene al no ser tratado como se debería	12/6/2023 2:12 PM

23	La gente es cerrada en este tema y no estamos educados o no tenemos conocimiento sobre salud.	12/6/2023 12:40 PM
24	Les falta mucha información para lis pasos a seguir.	12/6/2023 12:31 PM
25	Mucha gente se pone a la defensiva cuando les mencionas salud mental, y que hay muchos sintomas pero lo miran normal.	12/6/2023 11:50 AM
26	My culture seems to have little to no awareness of mental health. This is almost like a culture shock when you speak of mental health terms. I am also noticing that it is the same for my community. A large group of people that I mentor are embarrassed to admit that they might need mental health services.	12/6/2023 10:51 AM
27	There's a lot of sick kids in my community	12/6/2023 12:19 AM
28	Mental Health is very important and an an ongoing topic of concern.	12/5/2023 8:47 PM
29	Willingness to access services is improving. Getting services without the run-around is rare and has deterred many to give up their search for services	12/5/2023 7:25 PM
30	Pienso que ya hay más comunicación en cuanto a lo que es la salud mental y dónde buscar ayuda.	12/5/2023 6:28 PM
31	No	12/5/2023 6:16 PM
32	No lo consideran fiable y que sea necesario tomar estas terapias de salud mental.	12/4/2023 2:25 PM
33	Más o menos	12/2/2023 9:09 PM
34	En mi cultura es como un tabú no se atreven a asentar que hay un problema por miedo a ser juzgados como locos	12/2/2023 5:55 PM
35	Tienen pena hablar sobre eao	12/2/2023 5:49 PM
36	Mental health is taboo in my culture	12/2/2023 5:27 PM
37	Much more open to services	12/2/2023 5:23 PM
38	Growing up you were taught you didn't need that. Only rich people could afford that.	12/2/2023 5:22 PM
39	There's stigma and many barriers to accessing quality mental health services	12/2/2023 5:15 PM
40	Pues muchos no saben cómo poder encontrar ayuda y las barreras que encuentran al no tener una aseguranza o medical	12/2/2023 5:02 PM
41	In my community they don't addressing mental health wellness very well because they are thinking mental health people are crazy.	12/1/2023 7:06 PM
42	increasing but still below average	12/1/2023 6:50 PM
43	The Hmong people believe in our own culture and only doctor when it comes to health problems.	12/1/2023 2:08 PM
44	Sin mucha información	11/29/2023 12:57 PM
45	En mi cultura casi no nos preocupamos por nuestra salud mental por falta de información y educación.	11/25/2023 8:51 PM
46	Por ignorancia, no saben como lidiar con este problema. Por su estado migratorio temen pedir ayuda. Y mas.	11/24/2023 1:56 PM
47	Talk about in the minimum.	11/21/2023 10:22 PM
48	Muy interesados.	11/21/2023 9:08 PM
49	Mucha gente.no sabe done ir apedir ayuda para la Salud mental.	11/21/2023 8:27 PM
50	INDIFERENTE	11/21/2023 7:21 PM
51	There are not as many stigmas today	11/21/2023 2:59 PM
52	In my cultural group, there is a stigma on mental health, if you seek help or need help you are labeled crazy.	11/21/2023 1:00 PM

53	I’m not sure with most but some of my community friends have a lot concerns about it for their children	11/21/2023 12:53 PM
54	Not server. They thought it was normal but was not. People didn't take mental health seriously.	11/21/2023 12:06 PM
55	I don't really know what their views are on mental health.	11/21/2023 11:44 AM
56	Un buen comienzo para saber sobre la salud mental	11/21/2023 11:27 AM
57	Siempre estamos propensos a que afecte la salud mental, pues al retirarnos de nuestras raíces nos hace vulnerables ante las citaciones de lo desconocido.	11/21/2023 11:19 AM
58	My cultural group views addressing mental health wellness as an important part of dealing with the whole person. However, there is disproportionality in the providers mostly being from my cultural group and not enough bilingual and service providers of color.	11/21/2023 11:13 AM
59	My culture does not believe in mental health services. There is a lot of stigma surrounding mental health and proper treatments.	11/21/2023 11:10 AM
60	My community is fairly empathetic and understanding of mental health. There is still work to be done to reduce stigma and fully understand others with mental illnesses.	11/21/2023 10:42 AM
61	They have two extremes: they are either extremely biased towards mental health and stigmatize it. Otherwise, they are extremely open about it and free to discussion about resources.	11/21/2023 10:40 AM
62	Unfortunately, mental health needs are still a taboo issue in my Hispanic culture….people are not always open-minded to get the necessary help that they need😩	11/21/2023 10:36 AM

Q6 What is the most comfortable way for your cultural group to get mental health wellness addressed? ¿Cuál es la forma más cómoda para que su comunidad o grupo cultural aborde el bienestar de la salud mental?

Answered: 60 Skipped: 7

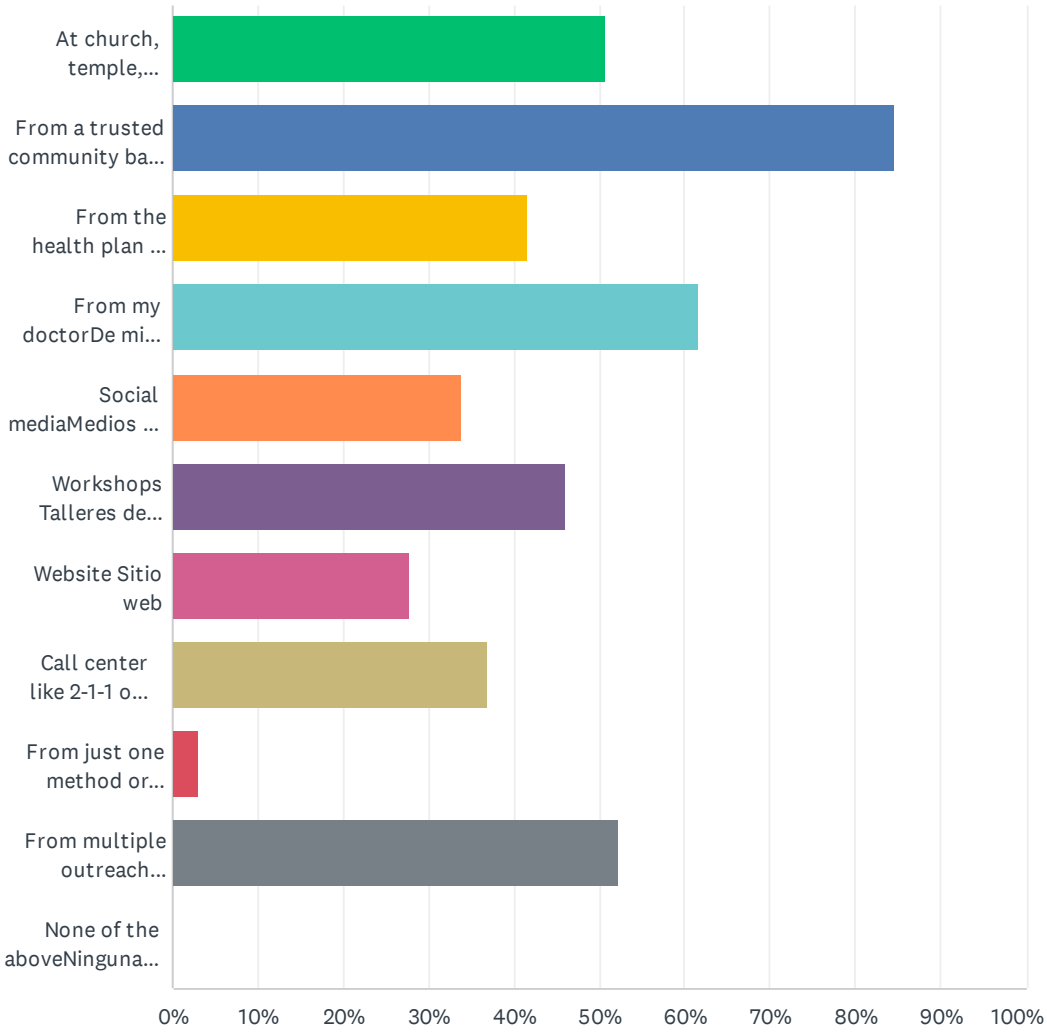
#	RESPONSES	DATE
1	Peb yuav tsum mus peb teb tsev ua pab rau ko nyob nyab xeeb ntawm kev xav thiab nrog teb doctors Tam.	12/13/2023 7:08 AM
2	Privately.	12/13/2023 6:53 AM
3	Talk in privately	12/13/2023 6:48 AM
4	reaching out	12/8/2023 11:53 AM
5	Dejando que nuestra comunidad si le ayudan y si no ellos tratan de hacer lo que pueden.	12/7/2023 9:48 PM
6	The most comfortable way for my cultural group to get mental health wellness address is talking to someone they trust.	12/7/2023 9:32 PM
7	Privately talk to someone they trust.	12/7/2023 8:09 PM
8	I think talking it out with one another is one way to help	12/7/2023 5:07 PM
9	Make it affordable and continue a conversation in the community about mental wellbeing	12/7/2023 3:53 PM
10	Talking to people who know about it.	12/7/2023 1:54 PM
11	Atraves de las Escuelas o clínicas de salud en la comunidad.	12/7/2023 12:25 PM
12	people coming in to address mental health. It is the awareness that helped us.	12/7/2023 8:45 AM
13	I would say ask you one on one first to see if u comfortable	12/7/2023 7:29 AM
14	Hard to say. See question 5.	12/6/2023 6:41 PM
15	I'm not sure because my family is educated by from the looks of other's i am not so sure but, I feel as they do "rituals" to " Cope" with the mental illness	12/6/2023 4:31 PM
16	The most comfortable way for mental health to be addressed is when it’s talked about and not talked about in a bad way, in a good way, talking about it like it isn’t a problem.	12/6/2023 4:23 PM
17	Obteniendo más información	12/6/2023 4:18 PM
18	Most comfortable be by a primary doctor or online resources recommended by said doctor.	12/6/2023 4:10 PM
19	In church.	12/6/2023 4:04 PM
20	Q no de pena buscar la ayuda Porq aveces por eso la gente no busca la ayuda	12/6/2023 3:19 PM
21	Que un especialista del tema les pueda proveer información sobre salud mental y ➡️ y lo grave que es al no ser tratado con tiempo	12/6/2023 2:12 PM
22	Escuchar testimonios de otras personas o experiencia vividas, por que si los mandas directamente a un psociólogo les da pena o no quieren ir.	12/6/2023 12:40 PM
23	Grupo de enfoque y aprendizaje	12/6/2023 12:31 PM
24	en una escula de formacion primaria hay mas posibiliadad de tener a mas padres de familias, pero es bien importante tener el compromiso con la administracion para asegurar que lospadres lleguen.	12/6/2023 11:50 AM
25	I feel that there should be services appointed to each family in public schools or directly to homes in the community. Maybe an assessment with primary doctors with children prior to enrolling into kindergarten.	12/6/2023 10:51 AM

26	Parent classes and meetings as well as 1 on 1's educating families about Mental Health. I believe having open, safe, transparent conversations about what our families and community is struggling with as it pertains to Mental Health. Also having current knowledge and readily available resources!	12/5/2023 8:47 PM
27	School informational meetings.	12/5/2023 7:25 PM
28	Trabajando más con toda la comunidad lo que es la salud mental y que es importante buscar ayuda.	12/5/2023 6:28 PM
29	Language	12/5/2023 6:16 PM
30	Seguir informando en redes sociales, radio y televisión que es mucho el beneficio.	12/4/2023 2:25 PM
31	En las escuelas juntas	12/2/2023 9:09 PM
32	Yo pienso que haciendo grupos de enfoque familiar o de vecinos que estén interesados en involucrarse en el tema	12/2/2023 5:55 PM
33	Clases	12/2/2023 5:49 PM
34	Word of mouth.	12/2/2023 5:41 PM
35	I don't know	12/2/2023 5:27 PM
36	In person is best	12/2/2023 5:23 PM
37	I am 44 Years of age and I'm barely finding out and seeking help.	12/2/2023 5:22 PM
38	Addressing the language barrier is important from the initial contact in information about mental health provider(s), costs. Insurance options/coverage, scheduling, to the service itself so families understand	12/2/2023 5:15 PM
39	Sería muy bien tener un grupo de apoyo donde se hable de salud mental y donde se hable el mismo idioma para que puedan entender mejor	12/2/2023 5:02 PM
40	Usually they talk to someone that they trust with.	12/1/2023 7:06 PM
41	One on one and physically	12/1/2023 6:50 PM
42	Hmong do jingle such as calling back the souls and eat Hmong herbs.	12/1/2023 2:08 PM
43	Como no es aún pero es necesario	11/30/2023 12:07 PM
44	Teniendo reunión personal en centros de la comunidad y haciendo cafecitos	11/29/2023 12:57 PM
45	Dando información de la importancia de la salud mental y lugares donde ir.	11/25/2023 8:51 PM
46	Acercarse a las comunidades para informar, educar y apoyarlas sobree este tema.	11/24/2023 1:56 PM
47	Per support groups	11/21/2023 10:22 PM
48	Virtual.	11/21/2023 9:08 PM
49	Como que alguien los guie.	11/21/2023 8:27 PM
50	PRESENTACIONES Y GRUPOS DE ENFOQUE PARA LA COMUNIDAD Y ESCUELAS	11/21/2023 7:21 PM
51	Through a doctor	11/21/2023 2:59 PM
52	I'm sure they would be fine with a one on one	11/21/2023 12:53 PM
53	Talk to someone they trust and feel comfortable with. Talk to someone who understands their culture and background. Talk to someone who speaks the same language	11/21/2023 12:06 PM
54	I don't know.	11/21/2023 11:44 AM
55	Estar bien informada	11/21/2023 11:27 AM
56	Proporcionando la información	11/21/2023 11:19 AM
57	The most comfortable way to get mental health wellness addressed for my cultural group is to make it known the resources and services available and letting people make the choices of	11/21/2023 11:13 AM

	what they want.	
58	A one-to-one discussion, stressing how significant mental health wellness is.	11/21/2023 11:10 AM
59	I would say the most comfortable way is through presentations or television advertisements/episodes that provide more awareness about it.	11/21/2023 10:40 AM
60	Making workshops that are intended for people that have any type of mental health need….Once people are there, they will realize that they're definitely NOT the only one's going through that…they won't feel like they're the only one's struggling….	11/21/2023 10:36 AM

Q7 What is the best way in your community to learn about mental health wellness and how they can access different types of services? (Check as many as apply.)¿Cuál es la mejor manera en su comunidad de aprender sobre el bienestar de la salud mental y cómo pueden acceder a diferentes tipos de servicios? (Marque todos los que correspondan).

Answered: 65 Skipped: 2

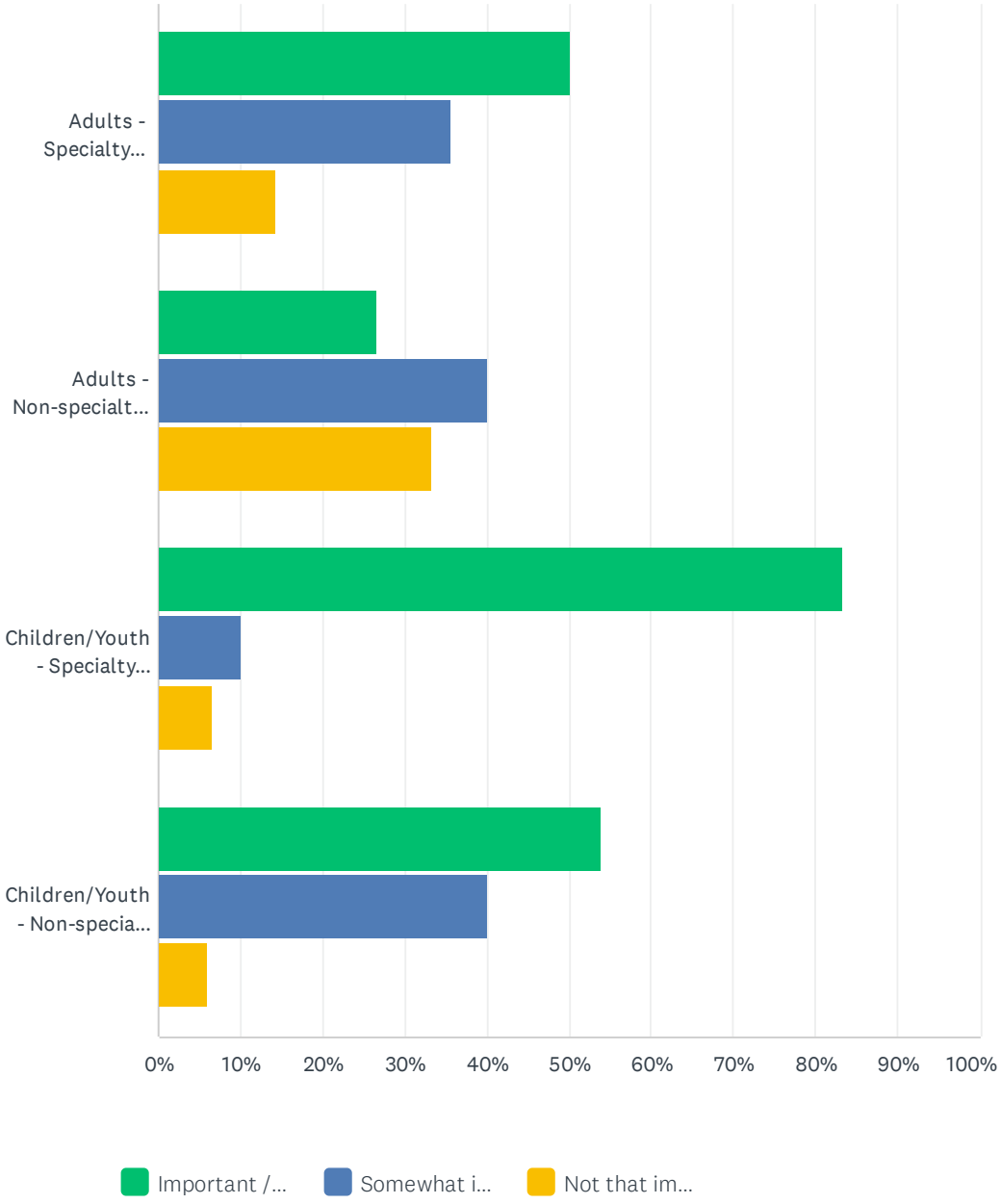


ANSWER CHOICES	RESPONSES	
At church, temple, synagogue, or other faith-based groupsEn la iglesia, templo, sinagoga u otros grupos religiosos	50.77%	33
From a trusted community based organizationDe una organización comunitaria confiable	84.62%	55
From the health plan or insuranceDel plan de salud o seguro	41.54%	27
From my doctorDe mi doctor	61.54%	40
Social mediaMedios de comunicación social	33.85%	22
Workshops Talleres de trabajo	46.15%	30
Website Sitio web	27.69%	18
Call center like 2-1-1 or a Mental Health Help Line Centro de llamadas como 2-1-1 o una línea de ayuda de salud mental	36.92%	24
From just one method or placeDe un solo método o lugar	3.08%	2
From multiple outreach methodsDe múltiples métodos de divulgación	52.31%	34
None of the aboveNinguna de las anteriores	0.00%	0
Total Respondents: 65		

#	OTHER (PLEASE SPECIFY) / OTROS (ESPECIFICAR)	DATE
1	De organizaciones que se identifican con la comunidad.	12/7/2023 9:48 PM
2	School	12/7/2023 9:32 PM
3	School	12/7/2023 8:09 PM
4	Escuelas.	12/7/2023 12:25 PM
5	Escuelas de nuestros hijos	12/6/2023 12:40 PM
6	Neiborhood	12/2/2023 9:09 PM
7	School	12/2/2023 5:15 PM
8	I feel we have a lot of resources and ways to get information but the advertisement for it is not there. Unless you are asking for the information I feel it is not advertised as it should be.	11/21/2023 1:00 PM

Q8 If there are improvements to be made about communication or knowledge of mental health services, what type of services is most important to address first? (Please pick 3, one as important, one as somewhat important, and one as not that important. You may pick only two, but not all.)Si es necesario mejorar la comunicación o el conocimiento de los servicios de salud mental, ¿qué tipo de servicios es más importante abordar primero? (Elija 3, uno como importante, uno como algo importante y el tercero como no tan importante. Puede elegir solo dos, pero no todos).

Answered: 67 Skipped: 0



	IMPORTANT / IMPORTANTE	SOMEWHAT IMPORTANT / ALGO IMPORTANTE	NOT THAT IMPORTANT / NO TAN IMPORTANTE	TOTAL	WEIGHTED AVERAGE
Adults - Specialty (severe mental health needs that affects ability to function)Adultos: especialidad (necesidades graves de salud mental que afectan la capacidad de funcionamiento)	50.00% 7	35.71% 5	14.29% 2	14	1.64
Adults - Non-specialty (mild to moderate)Adultos – No especializados (leve a moderado)	26.67% 4	40.00% 6	33.33% 5	15	2.07
Children/Youth - Specialty (affects ability to function)Niños/Jóvenes – Especialidad (afecta la capacidad de funcionamiento)	83.33% 25	10.00% 3	6.67% 2	30	1.23
Children/Youth - Non-specialty (mild to moderate)Niños/Jóvenes – No especializados (leve a moderado)	54.00% 27	40.00% 20	6.00% 3	50	1.52

#	COMMENTS FOR "ADULTS - SPECIALTY (SEVERE MENTAL HEALTH NEEDS THAT AFFECTS ABILITY TO FUNCTION)ADULTOS: ESPECIALIDAD (NECESIDADES GRAVES DE SALUD MENTAL QUE AFECTAN LA CAPACIDAD DE FUNCIONAMIENTO)"	DATE
1	Very important to help parents and future parents that way we can stop the chain of mental health issues.	11/21/2023 1:00 PM

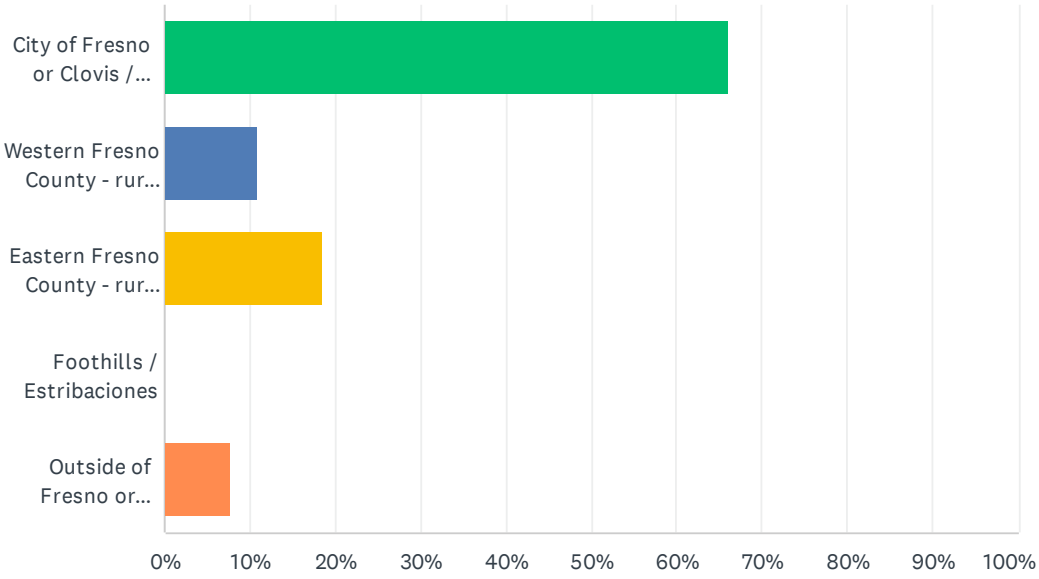
#	COMMENTS FOR "ADULTS - NON-SPECIALTY (MILD TO MODERATE)ADULTOS – NO ESPECIALIZADOS (LEVE A MODERADO)"	DATE
	There are no responses.	

#	COMMENTS FOR "CHILDREN/YOUTH - SPECIALTY (AFFECTS ABILITY TO FUNCTION)NIÑOS/JÓVENES – ESPECIALIDAD (AFECTA LA CAPACIDAD DE FUNCIONAMIENTO)"	DATE
	There are no responses.	

#	COMMENTS FOR "CHILDREN/YOUTH - NON-SPECIALTY (MILD TO MODERATE)NIÑOS/JÓVENES – NO ESPECIALIZADOS (LEVE A MODERADO)"	DATE
1	Problema de salud mental no es solo problema individual sino social	11/24/2023 1:56 PM

Q9 Please let us know the general area where you live.Por favor, háganos saber el área general donde vive.

Answered: 65 Skipped: 2



ANSWER CHOICES	RESPONSES	
City of Fresno or Clovis / Ciudad de Fresno o Clovis	66.15%	43
Western Fresno County - rural / Oeste del condado de Fresno – rural	10.77%	7
Eastern Fresno County - rural / Este del condado de Fresno – rural	18.46%	12
Foothills / Estribaciones	0.00%	0
Outside of Fresno or Clovis city limits but not ruralFuera de los límites de la ciudad de Fresno o Clovis, pero no en zonas rurales	7.69%	5
Total Respondents: 65		

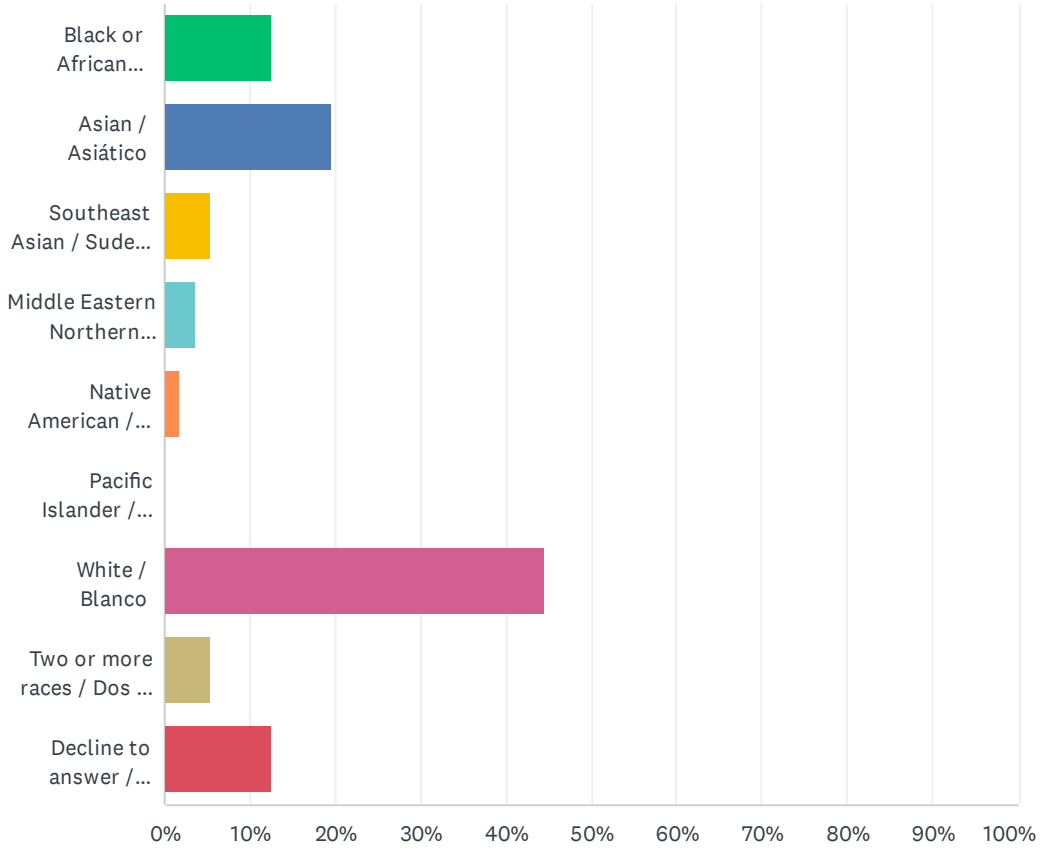
#	WHAT IS YOUR ZIP CODE? / ¿CUÁL ES SU CÓDIGO POSTAL?	DATE
1	93706	12/13/2023 7:08 AM
2	93606	12/13/2023 6:53 AM
3	93725	12/13/2023 6:48 AM
4	93706	12/8/2023 11:53 AM
5	93662	12/7/2023 9:48 PM
6	93725	12/7/2023 9:32 PM
7	93725	12/7/2023 8:09 PM
8	625- 69- 9386	12/7/2023 5:07 PM
9	93703	12/7/2023 3:53 PM

10	93725	12/7/2023 1:54 PM
11	93640	12/7/2023 12:25 PM
12	93706	12/7/2023 8:45 AM
13	93728	12/7/2023 7:29 AM
14	93710	12/6/2023 6:41 PM
15	93727	12/6/2023 4:31 PM
16	93662	12/6/2023 4:23 PM
17	93702	12/6/2023 4:18 PM
18	93728	12/6/2023 4:10 PM
19	93662	12/6/2023 4:04 PM
20	93738	12/6/2023 2:12 PM
21	93706	12/6/2023 12:40 PM
22	93706	12/6/2023 12:31 PM
23	93606	12/6/2023 11:50 AM
24	93706	12/6/2023 12:19 AM
25	93722	12/5/2023 8:47 PM
26	93705	12/5/2023 7:25 PM
27	93640	12/5/2023 6:28 PM
28	93727	12/5/2023 6:16 PM
29	93662	12/4/2023 2:25 PM
30	93654	12/2/2023 9:09 PM
31	93722	12/2/2023 5:55 PM
32	93657	12/2/2023 5:49 PM
33	93657	12/2/2023 5:41 PM
34	93702	12/2/2023 5:22 PM
35	93611	12/2/2023 5:15 PM
36	93727	12/2/2023 5:02 PM
37	93737	12/1/2023 7:06 PM
38	93611	12/1/2023 6:50 PM
39	93727	11/29/2023 12:57 PM
40	93702	11/25/2023 8:51 PM
41	93611	11/24/2023 1:56 PM
42	93611	11/21/2023 10:22 PM
43	93702	11/21/2023 9:08 PM
44	93662	11/21/2023 8:31 PM
45	93701	11/21/2023 8:27 PM
46	93728	11/21/2023 7:36 PM
47	93706	11/21/2023 7:21 PM

48	93725	11/21/2023 2:59 PM
49	93646	11/21/2023 1:00 PM
50	93706	11/21/2023 12:53 PM
51	93640	11/21/2023 11:19 AM
52	93636	11/21/2023 11:13 AM
53	93728	11/21/2023 11:10 AM
54	93722	11/21/2023 10:42 AM
55	93720	11/21/2023 10:40 AM
56	93611	11/21/2023 10:36 AM

Q10 How do you identify your race?¿Cómo identificas tu raza?

Answered: 56 Skipped: 11

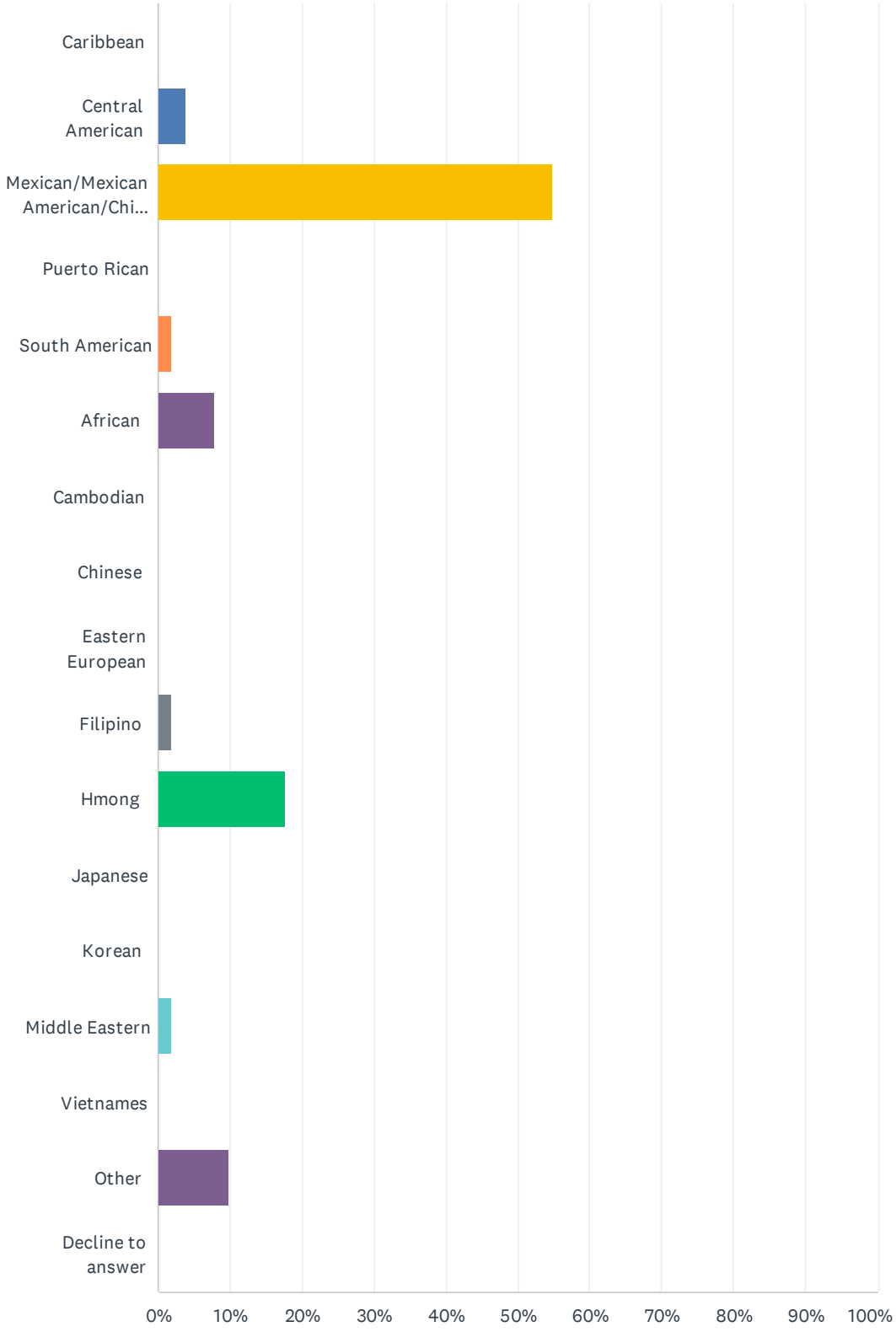


ANSWER CHOICES	RESPONSES	
Black or African American / Negro o afroamericano	12.50%	7
Asian / Asiático	19.64%	11
Southeast Asian / Sudeste Asiatico	5.36%	3
Middle Eastern Northern African (MENA) / Medio Oriente y Norte de África (MENA)	3.57%	2
Native American / Nativo americano	1.79%	1
Pacific Islander / Isleño del Pacífico	0.00%	0
White / Blanco	44.64%	25
Two or more races / Dos o mas carreras	5.36%	3
Decline to answer / Negarse a contestar	12.50%	7
Total Respondents: 56		

#	SELF-IDENTIFIED ETHNICITY / ETNIA AUTOIDENTIFICADA:	DATE
	There are no responses.	

Q11 Ethnicity / Etnicidad

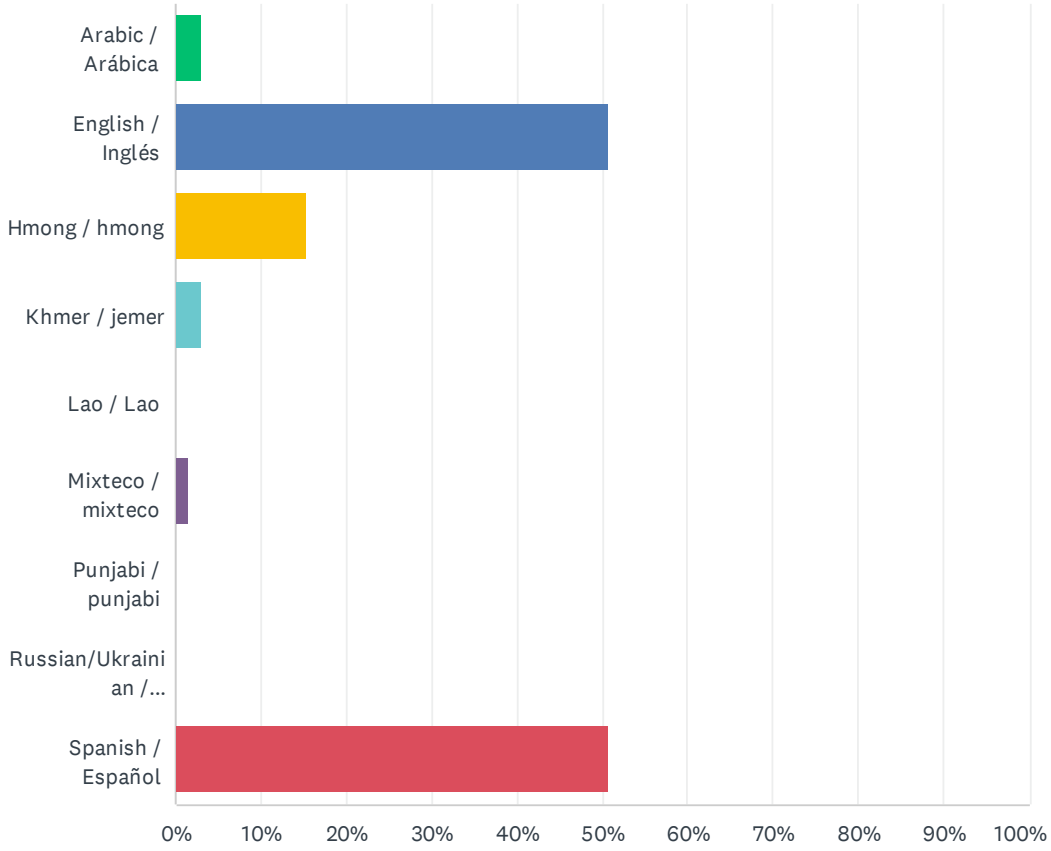
Answered: 51 Skipped: 16



ANSWER CHOICES	RESPONSES	
Caribbean	0.00%	0
Central American	3.92%	2
Mexican/Mexican American/Chicano	54.90%	28
Puerto Rican	0.00%	0
South American	1.96%	1
African	7.84%	4
Cambodian	0.00%	0
Chinese	0.00%	0
Eastern European	0.00%	0
Filipino	1.96%	1
Hmong	17.65%	9
Japanese	0.00%	0
Korean	0.00%	0
Middle Eastern	1.96%	1
Vietnames	0.00%	0
Other	9.80%	5
Decline to answer	0.00%	0
TOTAL		51

Q12 Please share the language used at home

Answered: 65 Skipped: 2



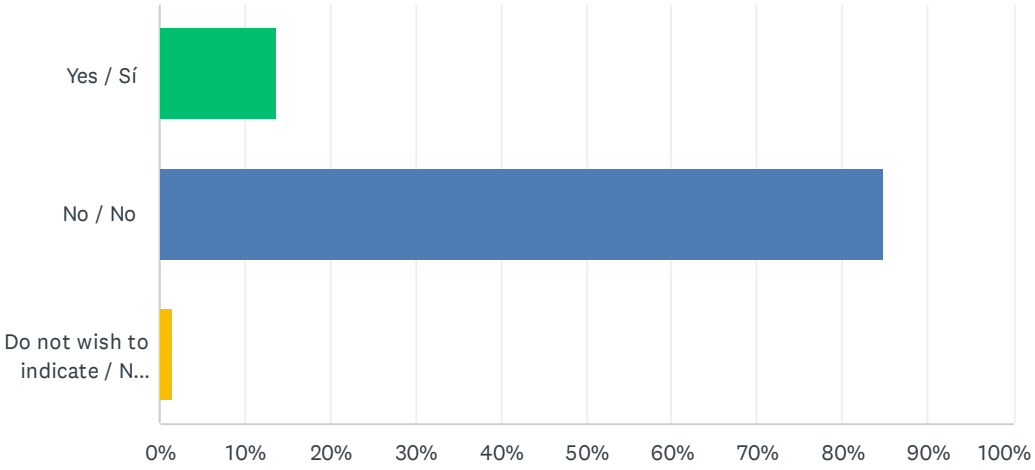
ANSWER CHOICES	RESPONSES	
Arabic / Arábica	3.08%	2
English / Inglés	50.77%	33
Hmong / hmong	15.38%	10
Khmer / jemer	3.08%	2
Lao / Lao	0.00%	0
Mixteco / mixteco	1.54%	1
Punjabi / punjabi	0.00%	0
Russian/Ukrainian / ruso/ucraniano	0.00%	0
Spanish / Español	50.77%	33
Total Respondents: 65		

#	OTHER (PLEASE SPECIFY) / OTRO:	DATE
1	Tagalog	12/5/2023 6:16 PM

2	Some Spanglish	11/21/2023 1:00 PM

Q13 Do you have any sort of disability? / ¿Tiene algún tipo de discapacidad?

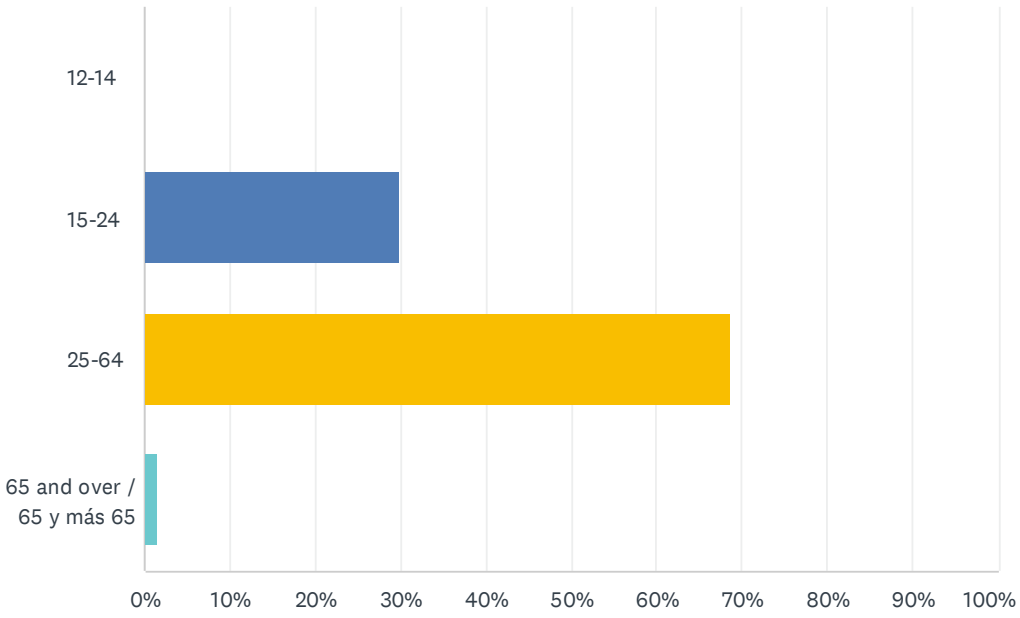
Answered: 66 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes / Sí	13.64%	9
No / No	84.85%	56
Do not wish to indicate / No deseo indicar	1.52%	1
TOTAL		66

Q14 What is your age range? / ¿Cuál es tu distribución de edad?

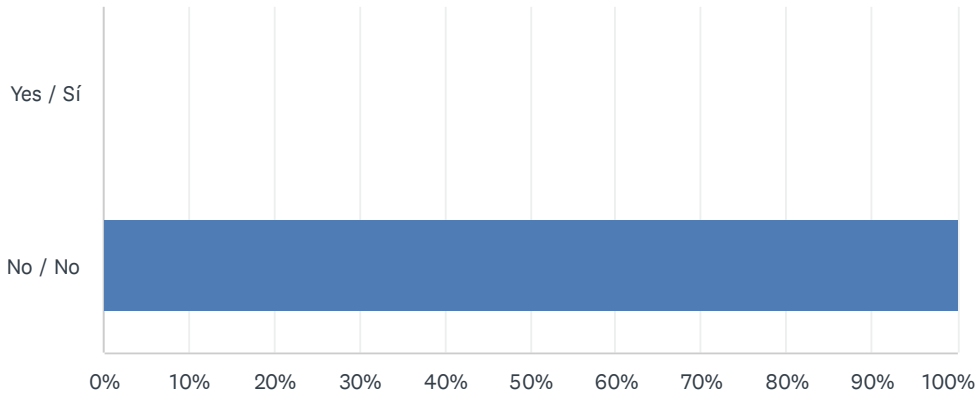
Answered: 67 Skipped: 0



ANSWER CHOICES	RESPONSES	
12-14	0.00%	0
15-24	29.85%	20
25-64	68.66%	46
65 and over / 65 y más 65	1.49%	1
TOTAL		67

Q15 Are you a veteran? / ¿Eres un veterano de las fuerzas armadas?

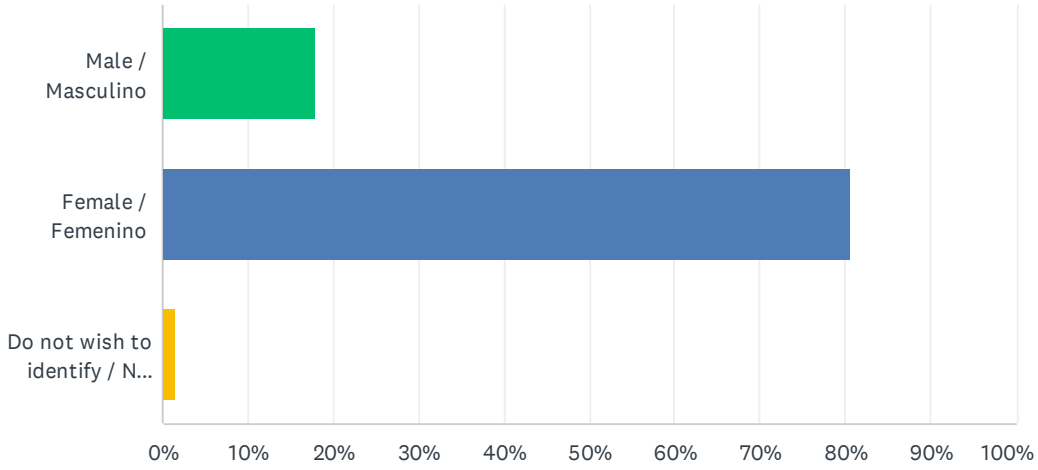
Answered: 67 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes / Sí	0.00%	0
No / No	100.00%	67
TOTAL		67

Q16 What was your gender assigned at birth?¿Cuál fue su género asignado al nacer?

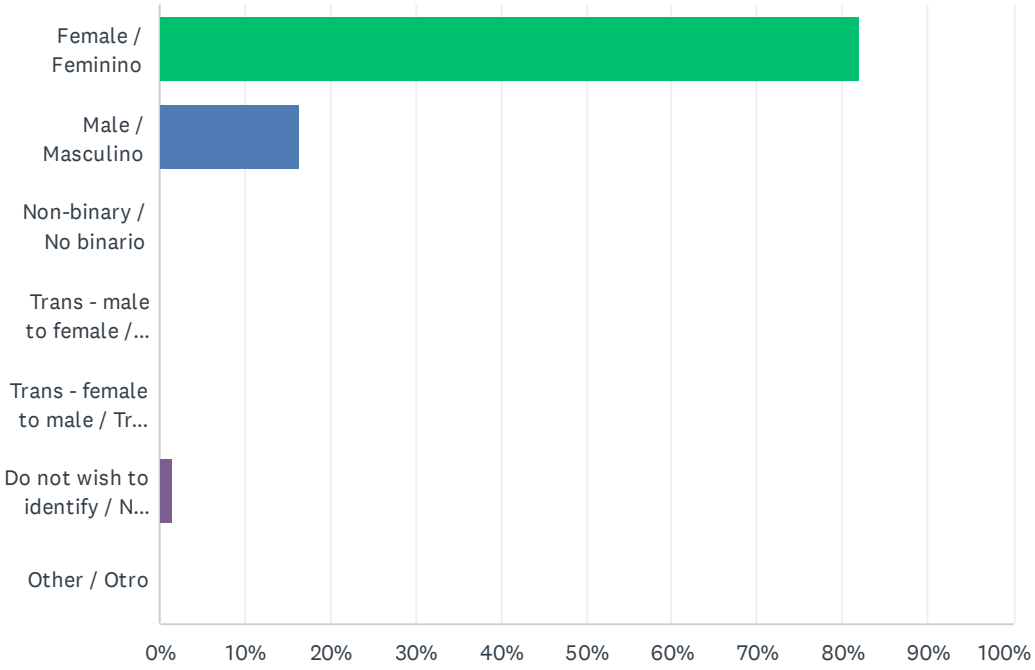
Answered: 67 Skipped: 0



ANSWER CHOICES	RESPONSES	
Male / Masculino	17.91%	12
Female / Femenino	80.60%	54
Do not wish to identify / No deseo identificarme	1.49%	1
TOTAL		67

Q17 How do you currently identify your gender? / ¿Cómo identificas actualmente tu género?

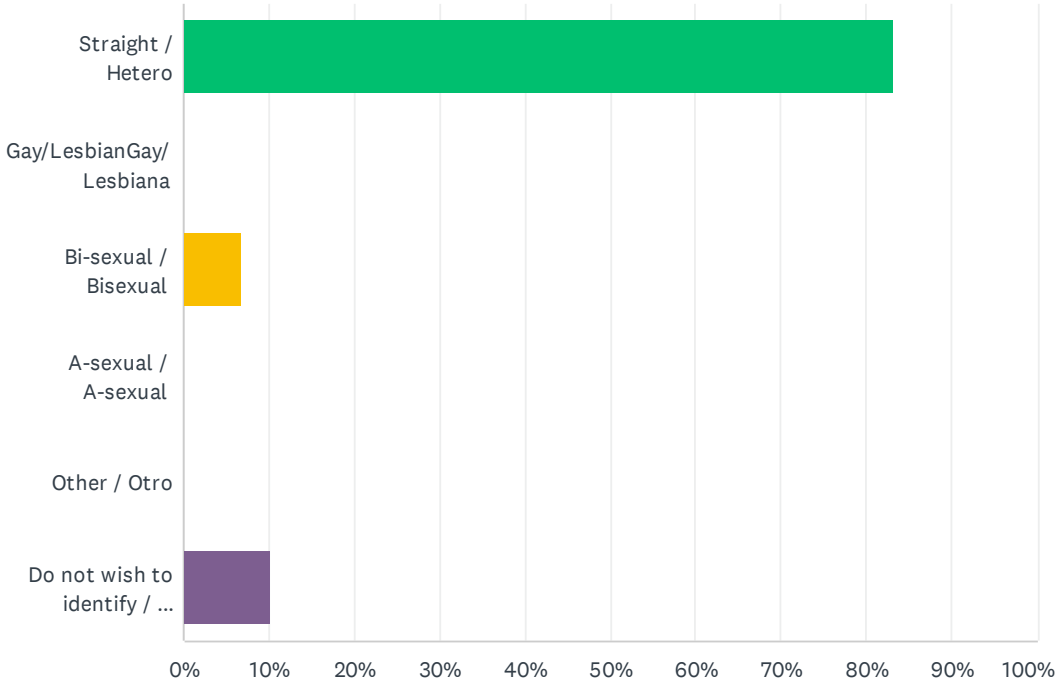
Answered: 67 Skipped: 0



ANSWER CHOICES	RESPONSES	
Female / Feminino	82.09%	55
Male / Masculino	16.42%	11
Non-binary / No binario	0.00%	0
Trans - male to female / Trans – hombre a mujer	0.00%	0
Trans - female to male / Trans – mujer a hombre	0.00%	0
Do not wish to identify / No deseo identificarme	1.49%	1
Other / Otro	0.00%	0
TOTAL		67

Q18 Sexual orientation / Orientación sexual

Answered: 59 Skipped: 8



ANSWER CHOICES	RESPONSES	
Straight / Hetero	83.05%	49
Gay/LesbianGay/Lesbiana	0.00%	0
Bi-sexual / Bisexual	6.78%	4
A-sexual / A-sexual	0.00%	0
Other / Otro	0.00%	0
Do not wish to identify / No deseo identificarme	10.17%	6
TOTAL		59

Q19 Please insert the email address to receive the report below. Introduzca la dirección de correo electrónico para recibir el informe a continuación.

Answered: 51 Skipped: 16

#	RESPONSES	DATE
1	Panhiaseng1@gmail.com	12/13/2023 7:08 AM
2	xiongshengyang35@gmail.com	12/13/2023 6:53 AM
3	phailin890@gmail.com	12/13/2023 6:48 AM
4	traceyy0613@gmail.com	12/8/2023 11:53 AM
5	tapatio1968@yahoo.com	12/7/2023 9:48 PM
6	Chonnikornyang1@gmail.com	12/7/2023 9:32 PM
7	pazoodaraporn@gmail.com	12/7/2023 8:09 PM
8	Ysabelle.rosales@gmail.com	12/7/2023 3:53 PM
9	elmerblanco74@yahoo.com	12/7/2023 12:25 PM
10	ymurrill@live.com	12/7/2023 8:45 AM
11	starrroberts0@gmail.com	12/7/2023 7:29 AM
12	I'm putting a note here instead of my email. I think this survey should have been made by a mental health professional. I also believe there should have been a notes section as well as more identifiers related to education and background.	12/6/2023 6:41 PM
13	chrisvang287@gmail.com	12/6/2023 4:31 PM
14	ashley.xo559@gmail.com	12/6/2023 4:23 PM
15	Sandra1974.Ortiz@gmail.com	12/6/2023 4:18 PM
16	nayely01b@gmail.com	12/6/2023 4:10 PM
17	yahirreyes3211@gmail.com	12/6/2023 4:04 PM
18	roseliamadera@yahoo.com	12/6/2023 3:19 PM
19	Otiliaortigoza86@gmail.com	12/6/2023 2:12 PM
20	Patysalcedo2099@gmail.com	12/6/2023 12:40 PM
21	priscilaalberdin@gmail.com	12/6/2023 12:31 PM
22	diazcecilia497@gmail.com	12/6/2023 11:50 AM
23	nandycruz00@gmail.com	12/6/2023 12:19 AM
24	jstrongallday@gmail.com	12/5/2023 8:47 PM
25	mariana_1721@yahoo.com	12/5/2023 6:28 PM
26	eileen_jane@yahoo.com	12/5/2023 6:16 PM
27	Chepi66@icloud.com	12/2/2023 5:55 PM
28	Bernag975@gmail.com	12/2/2023 5:49 PM
29	Sapphiresyl559@gmail.com	12/2/2023 5:27 PM

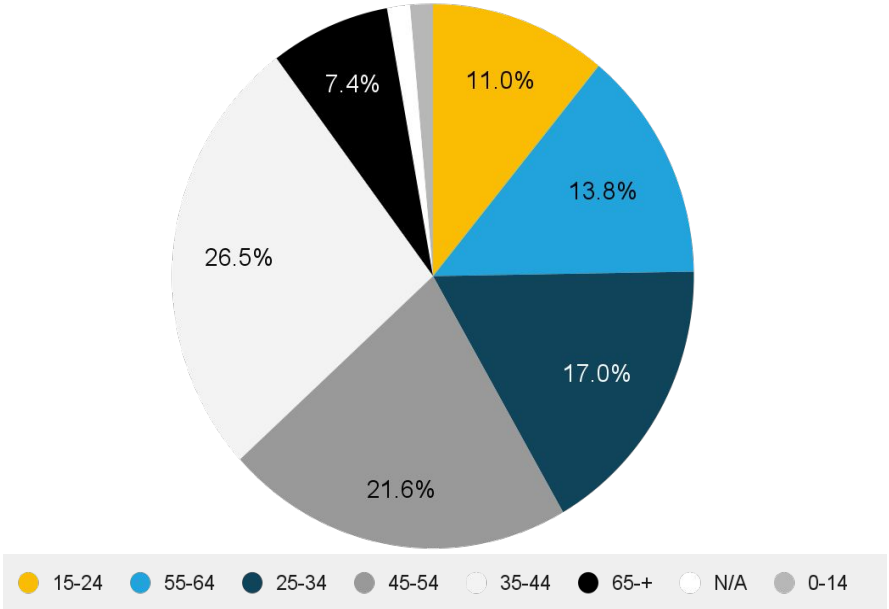
30	annaortiz0707@gmail.com	12/2/2023 5:23 PM
31	Manuel41579@yahoo.com	12/2/2023 5:22 PM
32	bettygmontez@gmail.com	12/2/2023 5:15 PM
33	Fadymax80@gmail.com	12/1/2023 6:50 PM
34	xiongy29@yahoo.com	12/1/2023 2:08 PM
35	Lopezlabrada48@gmail.com	11/30/2023 12:07 PM
36	suarezdearguello@gmail. Com	11/29/2023 12:57 PM
37	hugo_alex_gomez@yahoo.com	11/24/2023 1:56 PM
38	Dalya@firminc.org	11/21/2023 10:22 PM
39	Lilia@familiasenaccionfresno.org	11/21/2023 9:08 PM
40	mojicacesar731@gmail.com	11/21/2023 8:27 PM
41	robertsjanine72@gmail.com	11/21/2023 7:36 PM
42	g.molina199121@gmail.com	11/21/2023 1:00 PM
43	lemoriawoods66@gmail.com	11/21/2023 12:53 PM
44	Nengyang334@gmail.com	11/21/2023 12:06 PM
45	patricianievesarias@gmail.com	11/21/2023 11:27 AM
46	Lorenasalgado2811@gmail.com	11/21/2023 11:19 AM
47	jon.clark@fresno.edu	11/21/2023 11:13 AM
48	dianna.m.alvarez2004@gmail.com	11/21/2023 11:10 AM
49	talia7887@gmail.com	11/21/2023 10:42 AM
50	GabrielleYeager005@gmail.com	11/21/2023 10:40 AM
51	barajasrana@yahoo.com	11/21/2023 10:36 AM

Evaluation of Community Needs

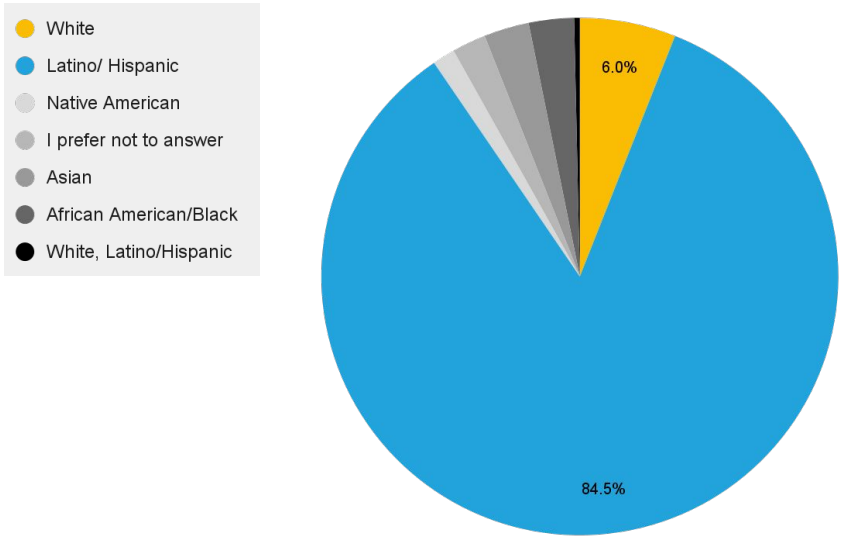
Evaluación de las Necesidades de la Comunidad

Demographics

Age Range

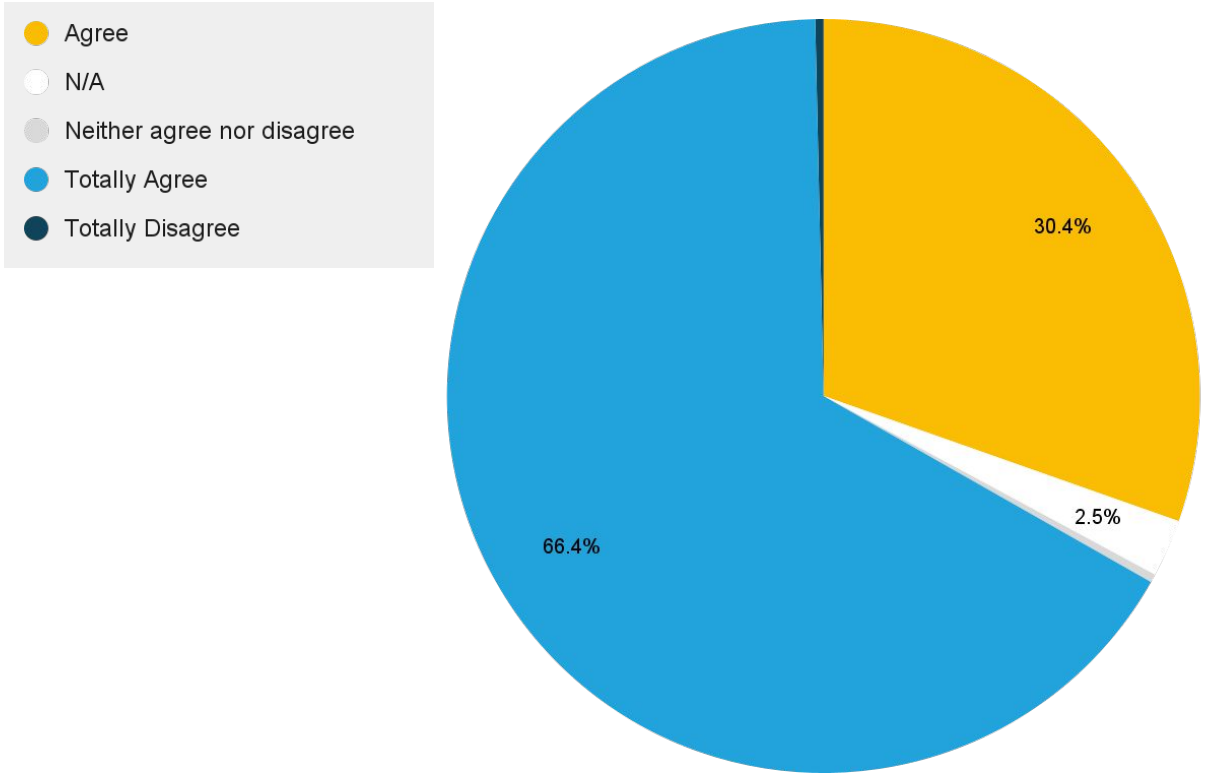


Race



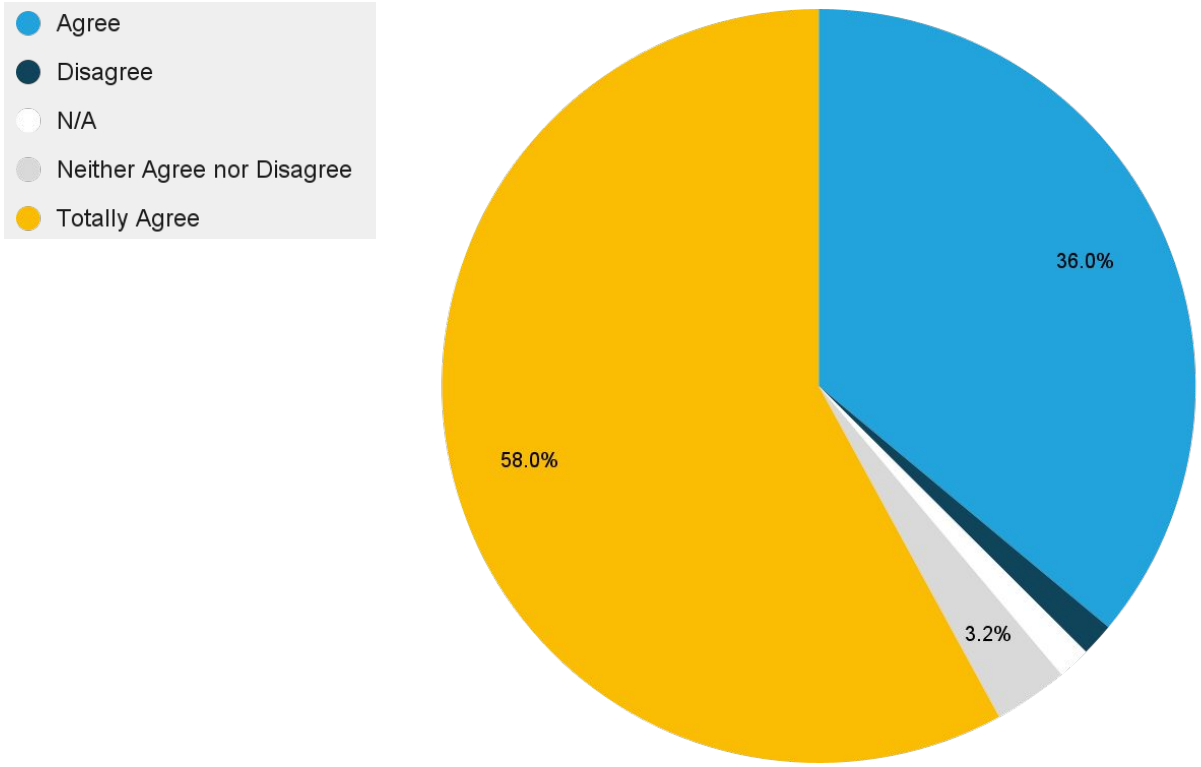
Mental Health Services are important to me?

Los Servicios de Salud Mental son importantes para mí.



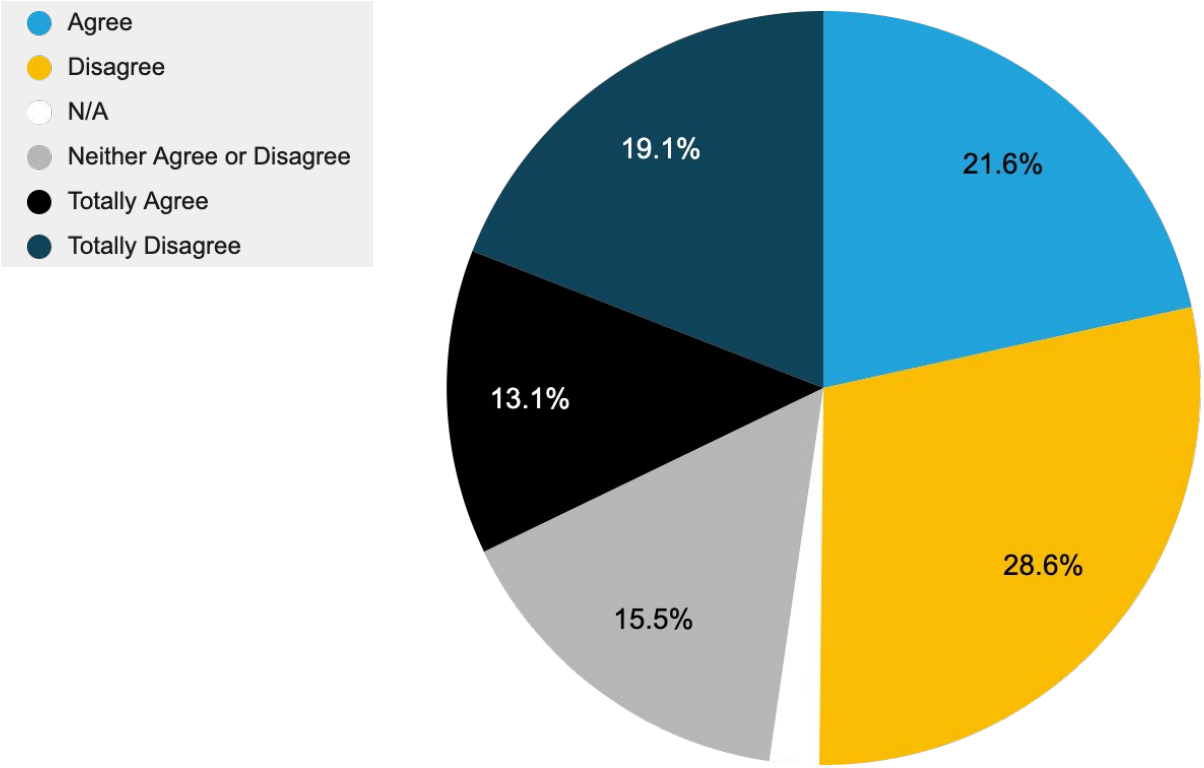
Support groups/peer supports groups are important to me?

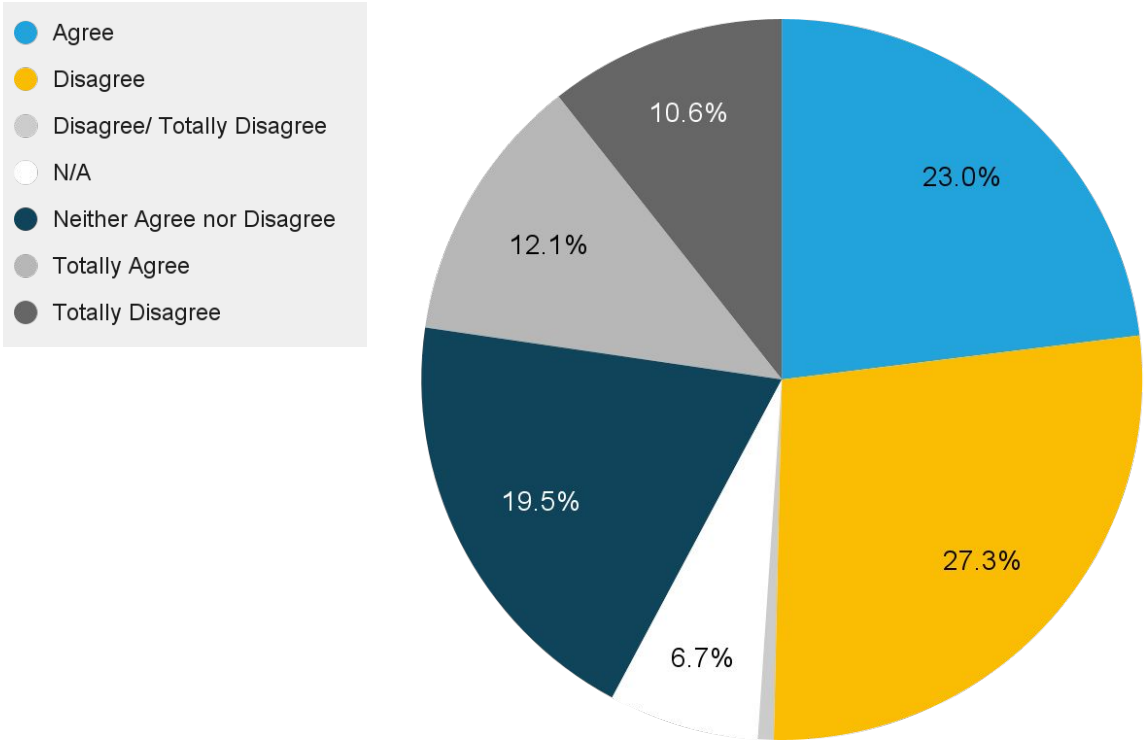
Los grupos de apoyo/grupos de compañeros son importantes para mí.



Finding therapy/therapists is easy for me.

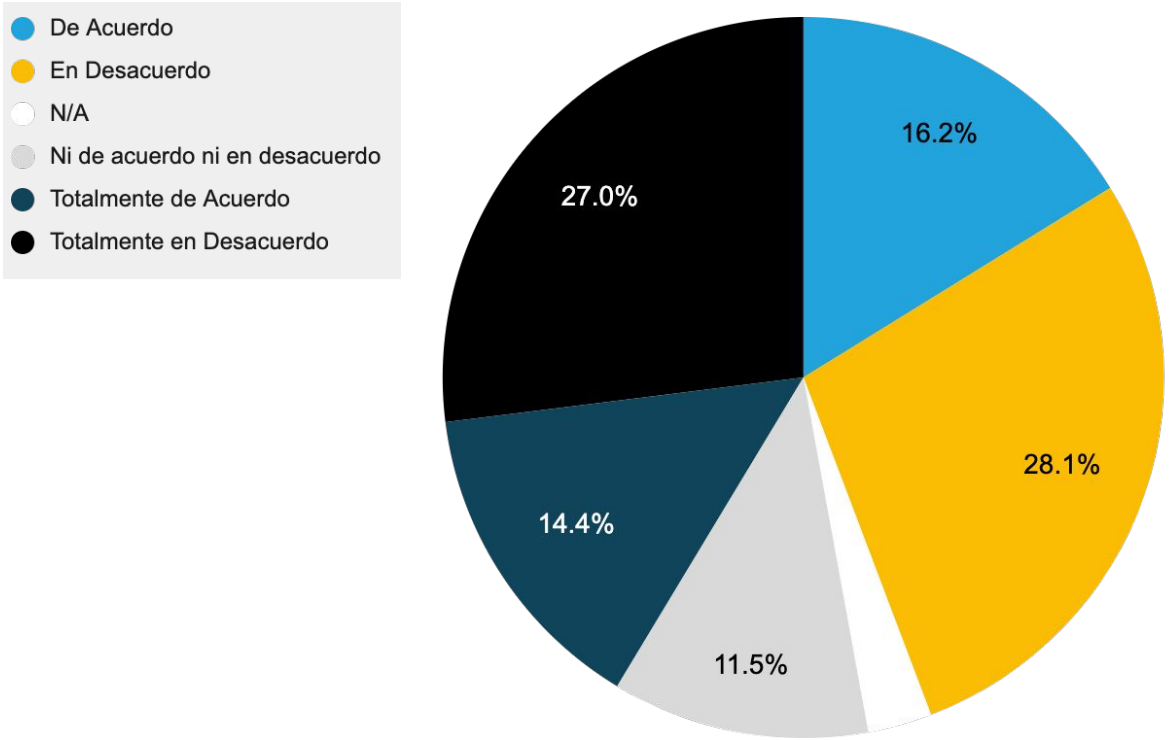
Encontrar terapia/ terapistas es fácil para mí.





Do I find the Mental Health resources (Pamphlets, Flyers, posters, information, etc.) in Spanish or are they available to me in Spanish?

¿Los recursos (Panfletos, Flyers, posters, información etc.) de Salud Mental los encuentro en Español o están disponibles para mi en Español?

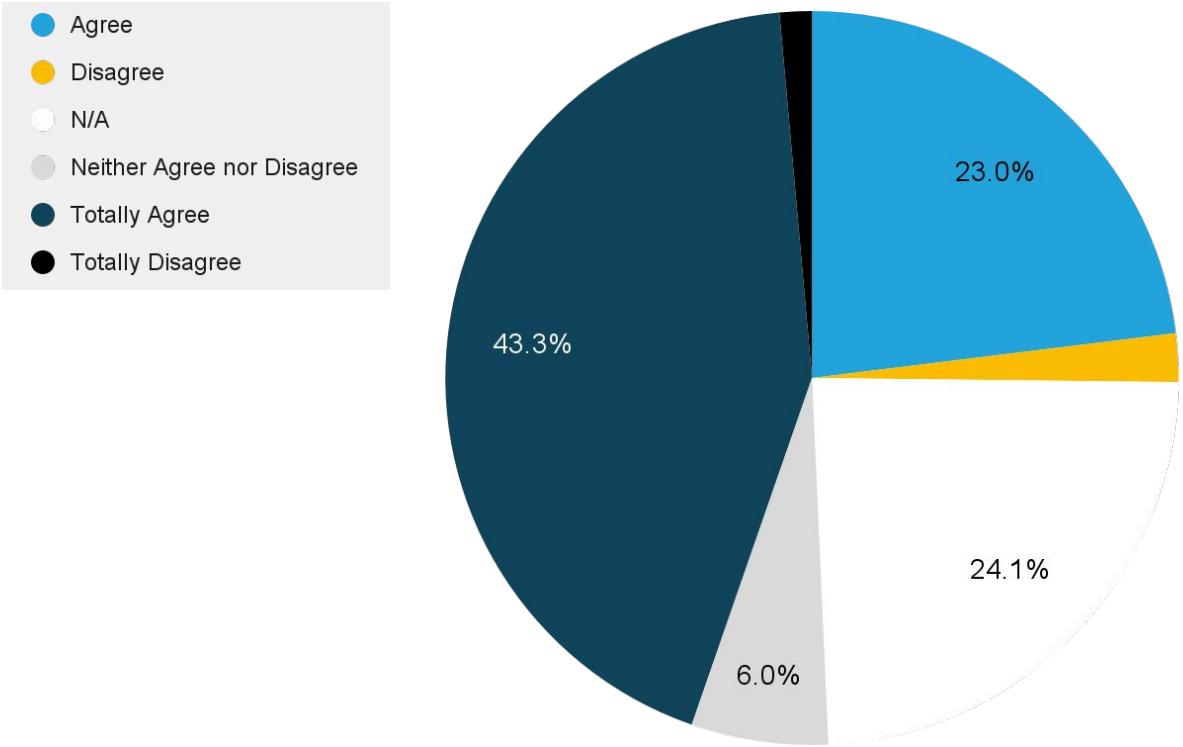


Signs and symptoms of Depression and Anxiety. Are they easy to recognize in the people around me, do I know the different signs and signals?

Los signos y síntomas de la Depresión y la Ansiedad. ¿Son fácil de reconocerlos en las personas que me rodean, se los diferentes signos y señales?

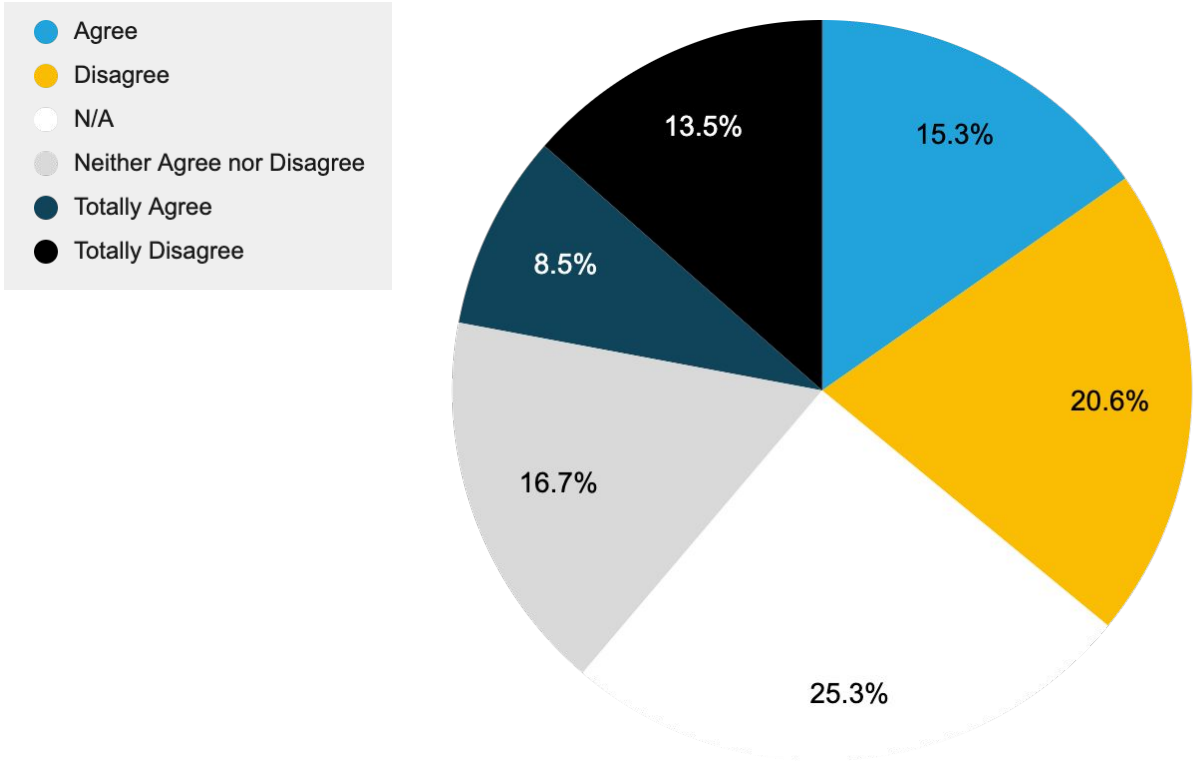
The mental health of my children (children, adolescents, young people) worries me.

La salud mental de mis hijos (niños, adolescentes, Jovenes) me preocupa, me inquieta.



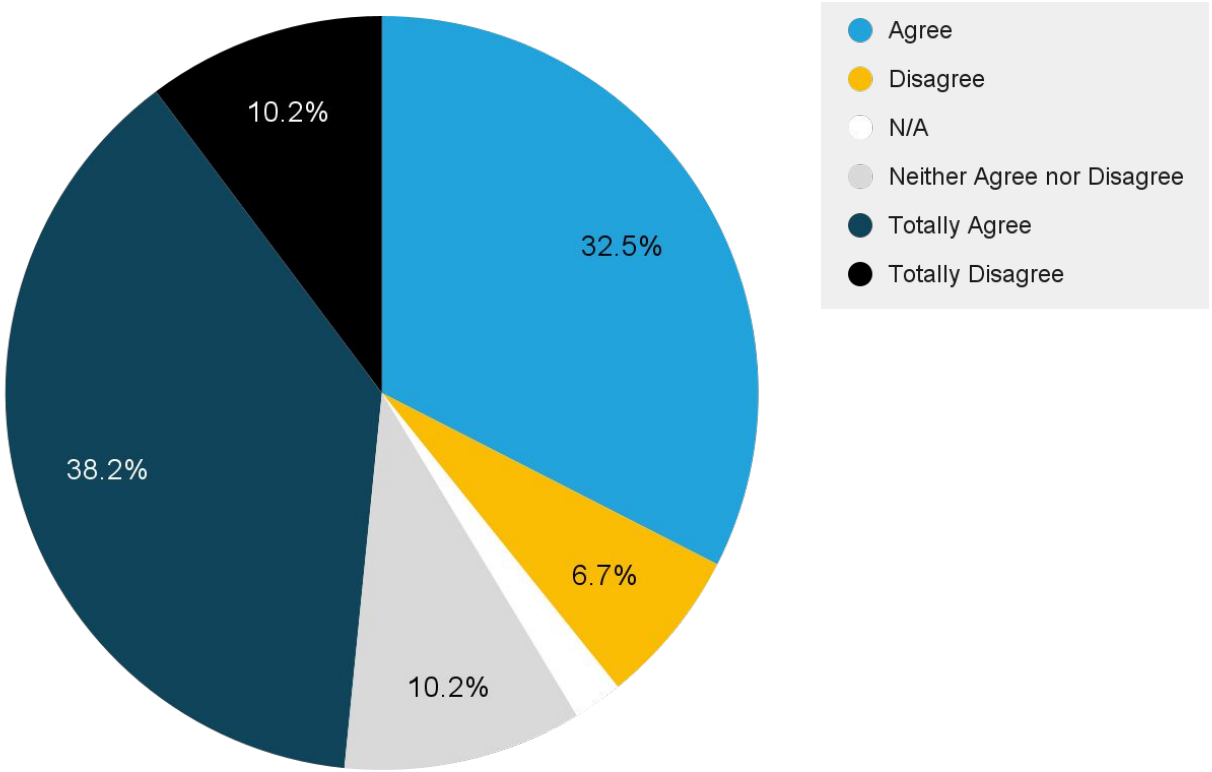
Finding mental health services for my son/daughter easy and fast?

Encontrar servicios de salud mental para mi hijo/hija es fácil y rápido?



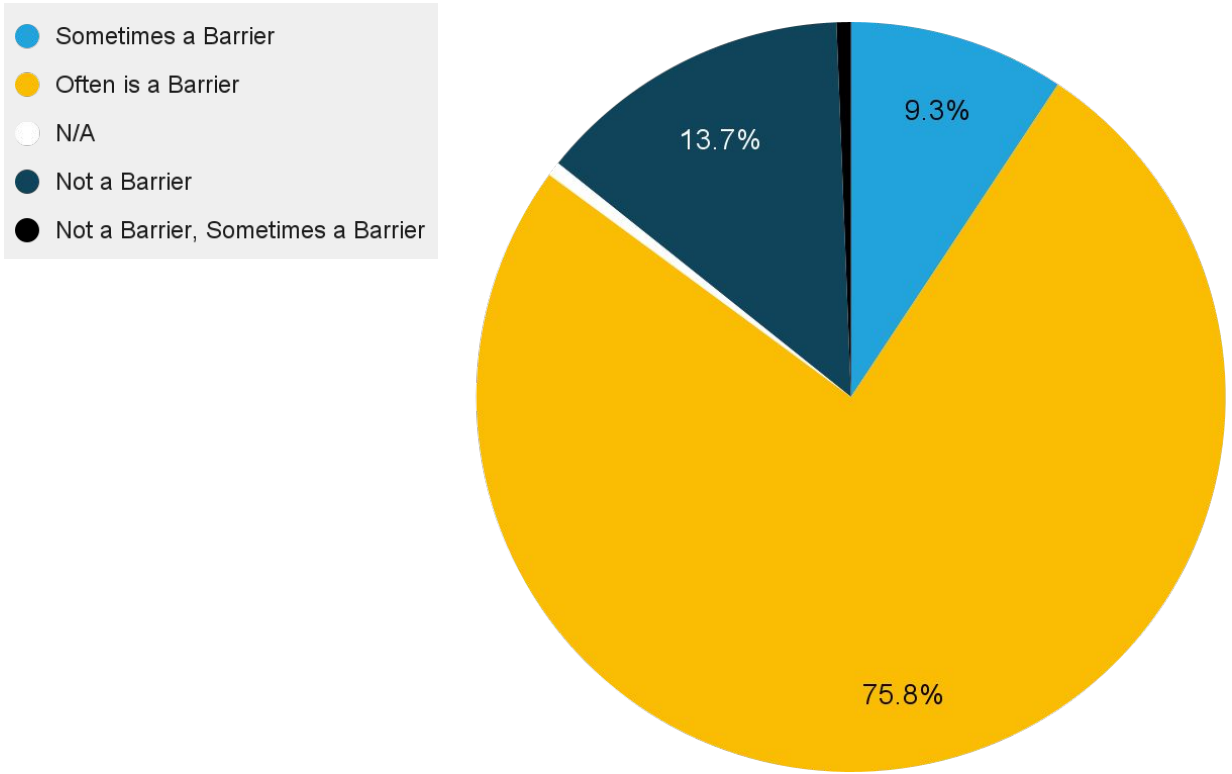
"People who seek Mental Health services are Weak", "People who seek Mental Health services are not Strong". They are labels that are often used and affect to accept the help of Mental Health and speak freely about the subject.

"Las personas que buscan servicios de Salud Mental, son Débiles", "Las personas que buscan servicios de Salud Mental no son Fuertes". Son etiquetas que se suelen usar y afectan para aceptar la ayuda de Salud Mental y hablar libremente del tema.



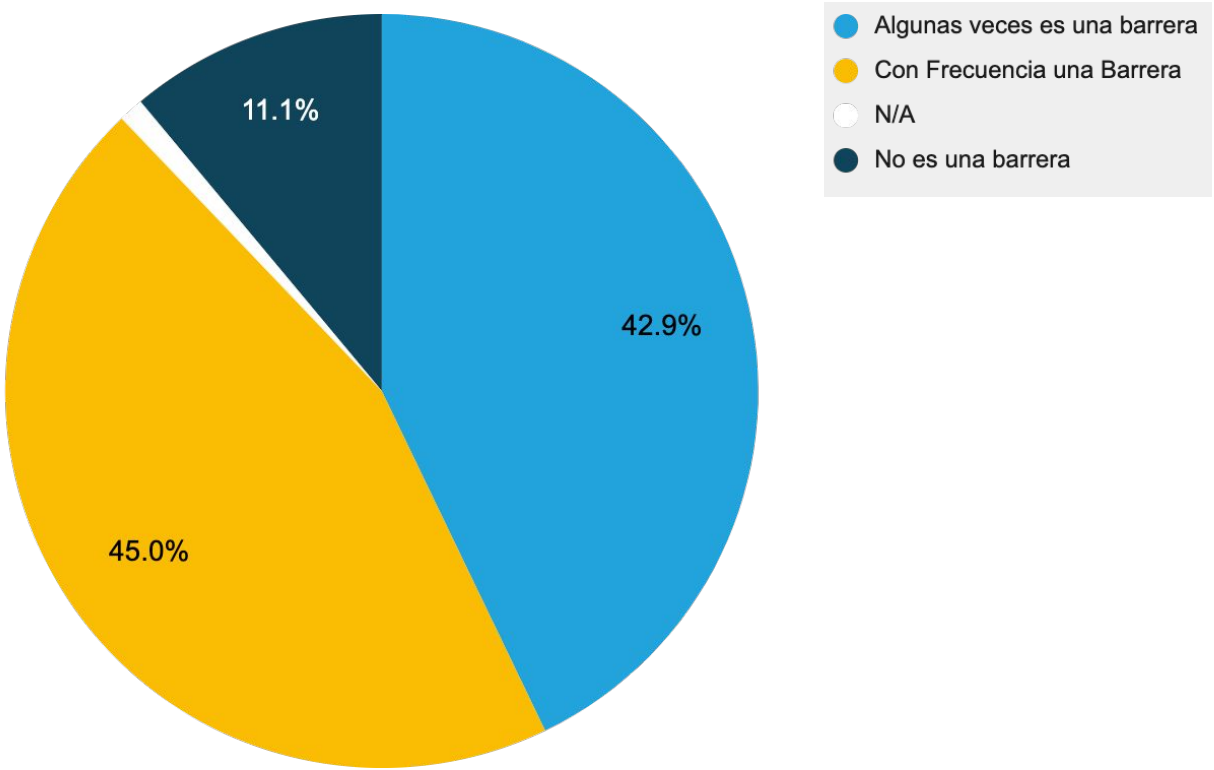
Long waiting list. (The appointments are very long and/or there are no appointments)

Lista larga de espera. (Las citas son muy largas y o no hay citas)



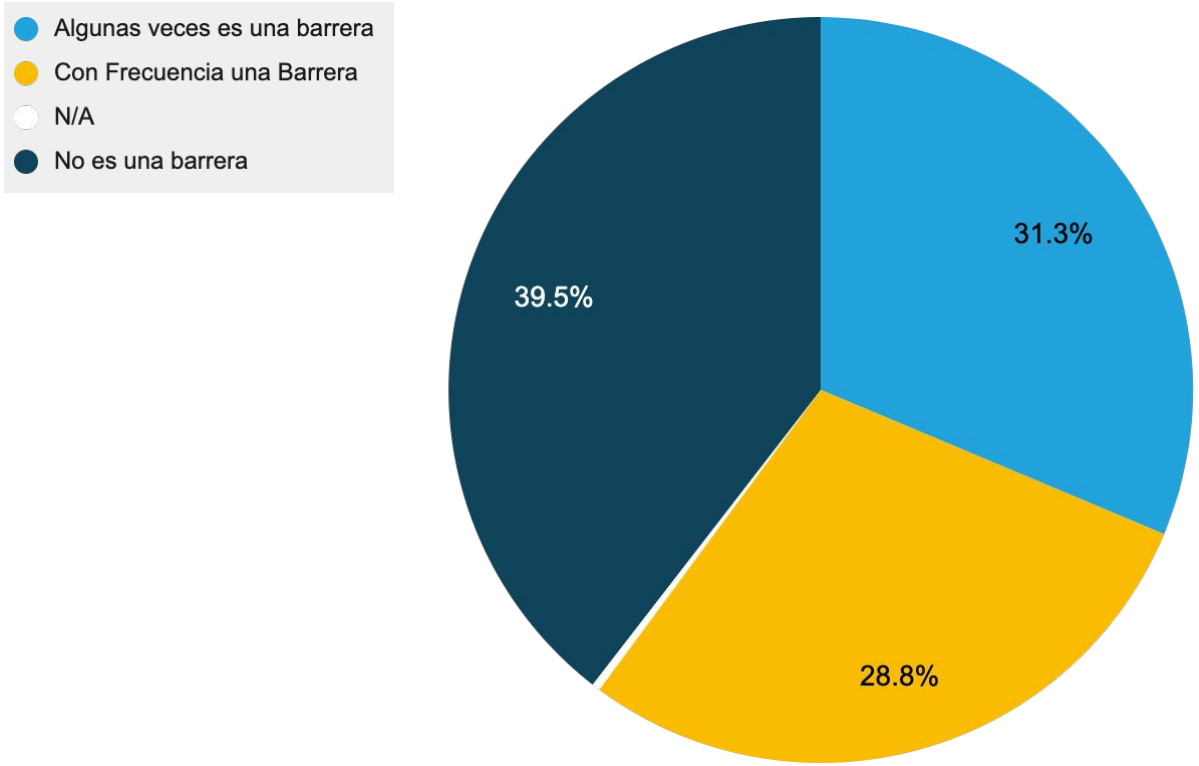
Some clinics or mental health services is a machine (recorder) that answers and cannot answer or clarify my doubts or make a query.

Algunas clínicas o servicios de salud mental es una maquina (grabadora) que contesta y no pueden responder o aclarar mis dudas o realizar una consulta.



Lack of Transportation/I don't have transportation to get to appointments.

Falta de Transportación/No tengo transporte para acudir a las citas.



What challenges have you had or continue to have in seeking mental health care?

¿Qué retos ha tenido o sigue teniendo en la búsqueda de atención de salud mental?

“I have sought psychological care for my daughter, and although she speaks English, I prefer that these therapists understand the language, idioms of speaking and understand the culture, etc.”

“The sessions with the therapists are very expensive, and the insurers do not cover it.”

“Finding a place to get help for me has been very difficult because there are not many low-income places and where I can leave my young children in care to go to counseling.”

“Not enough clinics or offices for low-income patients.”

“They don't speak Spanish and in their advertisements they say they have service in Spanish. They do not understand the culture or traditions. And they currently offer therapy via Zoom or video conference and 3 different families live in my house, so how can I speak freely, and also I don't have anything to help me and the internet is not strong either.”

Please indicate what type of classes or services you would like to receive to help with your mental well-being.
Indique qué tipo de clases o servicios le gustaría recibir para ayudarlo con su bienestar mental.

- **Mental health/trauma education.**
- **Yoga and meditation.**
- **Parent groups or Support groups.**
- **Spiritual and prayer resources.**
- **Dance classes with physical activity.**
- **Personal Motivation Resources.**
- **Strength training classes.**
- **Nutrition classes, health.**

County of Fresno

DEPARTMENT OF BEHAVIORAL HEALTH
SUSAN L. HOLT, LMFT
DIRECTOR/PUBLIC GUARDIAN

Inter-Office Memorandum
DATE: January 10, 2024
TO: Susan Holt, Director
FROM: Ahmad Bahrami, Division Manager
CC: DBH Leadership Team
Erinn Chan-Golston, MHSA Program Manager
Dennis Horn, Diversity Services Coordinator
Lisa Crossley, Staff Analyst III

SUBJECT: Needs Assessment-A Qualitive Report on Perceptions of Mental Health of the Fresno Residents Council

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Purpose:
The Department of Behavioral Health (DBH) recently received a final report from a community needs assessment facilitated by The Children's Movement of Fresno. The Qualitive Report on Perceptions of Mental Health of Fresno Residents Council is attached for review. This memo is to provide basic information on the report.

Background/overview:
The needs assessment was funded through the Department's Mental Health Services Act (MHSA) Innovation Community Planning Process (CPP) plan and is one of several community needs assessments being conducted to help identify gaps, needs, opportunities, input, and feedback that may support future programming, strategies, and efforts for a more equitable behavioral health system of care.
Through a Request for Application process The Children's Movement was selected to support a community needs assessment working with local resident council, parents' group, taskforce, etc. that was exploring behavioral health needs.
The Children's Movement has a Residents Council which has been working over the past few years to address the needs of Fresno's diverse community, including mental health needs. The Residents Council represented rural and metro residents, youth, and adults, as well as many different linguistic and cultural groups.

Research: The report provided by The Children's Movement provides the data and context from the needs assessment, the manner in which the data was collected, and the raw data. This third party needs assessment provides additional insights and considerations to support MHSA, Innovation and other DBH strategies, planning, and quality improvement opportunities.

Funding/Financial Impact
This was a one-time project. The Children's Movement of Fresno was funded up to $25,000 to complete the needs assessment. These were funds from the County's current Innovation CPP plan. The plan's annual updates have identified opportunities for community needs assessments to inform needs and possible opportunities.

Key Findings
The report provides consistent information across several needs assessments which address the issue and needs with timely access and responsive care for mild to moderate levels of care. The feedback of the participants supports previous findings of the need to address language access as a barrier to care and retention.

Residents identified a need for more providers with increased language capacity beyond just the threshold languages, as the language challenges pose access to care.

The respondents also identified challenges with mental health literacy and the role of stigma in some communities. Language barriers and mental health literacy also have an impact on individual efforts to navigating the system of care.
The report also noted a need for cultural considerations and processes to address specific cultural and community needs of some populations. How both language and cultural factors, and lack of mental health literacy is a barrier for some specific populations.

Recommendations
Based on the results of the report, the Public Behavioral Health (PBH) Division recommends this report be shared with DBH leadership, the Quality Improvement Committee (QIC), and the Diversity Equity and Inclusion (DEI) Committee. This along with other needs assessments may help formulate some efforts to improve language access.
The report will be shared on the DBH webpage for public access.
The report will be reviewed and evaluated by the PBH team who currently lead work around stigma reduction, and efforts to improve and increase mental health literacy. The team will continue to focus on the translation of information, marketing in additional languages and to examine how some current or future MHSA programs or services may better support these residents.

The report raises the need for providers who can better address local language needs and the need for providers who speak more specific languages to address local needs. It also addressed opportunities to be more targeted in representative responses and engagement.

It would be helpful for the system of care to identify ways to help link those who need mild to moderate levels of care. This can help mitigate some of the language challenges, stigma, and navigation barriers.

The report may also be shared with Managed Care Plans (MCPs) to understand, and support needs for better language access, timeliness, and cultural considerations.

Action Needed
While the Department has policy and procedures related to language access, translation, and other linguistic supports, it can review those PPGs and work to help increase best practices with language access and provide some processes to ensure that language access is not a barrier to care. These may be efforts of the DEI Committee or QIC in the coming year.

A recommendation would be to have part of the outreach, education, and mental health literacy to include clarification on levels of care, how to access care, and the role and limits of the public system of care.

For as long as funding is available under the MHSA, Prevention and Early Intervention can continue to address mental health stigma, with targeting of some specific communities and languages. A focus needs to be on local communities and using representative images, messaging, and influencers.
The Department may examine the viability of developing a formal plan/process to ensure responsive and representative outreach. This includes continuing to facilitate community learning opportunities and efforts such as the community townhall delivered in Spanish in Huron in May of 2023, the Youth Wellness Summit in San Joaquin in November 2023, and other community educational efforts.

Next Steps
In addition to sharing the report with DBH staff, committees, and partners, DBH's PBH division seeks to meet with the Resident's Council in the coming weeks to address concerns identified in the needs assessment, share the Department's planned use of the data, and explore opportunities to address identified needs.

TCM Fresno Resident's Council Meeting

Tuesday, May 21st, 2024

5:30-7:00 pm

Zoom Meeting https://us06web.zoom.us/j/88516658291

Meeting Results:

- Receive Updates from our TCM Teams
- Reflect on the Residents Summit
- Highlight the progress we made this year!
- Closing and important updates

Time	Agenda Item	Artifacts / Links
5:30pm (10 min)	**Welcome & Icebreaker** ● Interpretation from Linguistica ● Icebreaker: What was your biggest takeaway from the Residents Summit? ● Review agenda	- **Ernie Martinez**
5:40pm (15 min)	**Updates from the Teams** ● Housing Action Team- ○ Recent Meeting with Mayor Dyer ○ Planning meetings for ONE Fresno Housing Strategy Workshops ● Fresno Youth Council- ○ 5/22 YRC Meeting ○ Youth Spotlight! ● FRC Core Team ○ Recent Meeting Highlights ○ Progress on Participatory Grant Making	**- Juana Iris** (5 min) **- Phailee** (5 min) **- Core Team Member** (5 min) **(EM)**
5:55pm (15 min)	**Guest Speaker: Fresno Department of Behavioral Health - Ahmad Bahrami** ● Data from 2023 Mental Health Surveys & Focus Groups	**EM**
6:15pm (30 min)	● **Reflecting on the Residents Summit**	**- Carmen Zamora, Diana Tang**

6:45pm
(10 min)
	• **Highlights From This Year**
	  ○ Looking at our accomplishments
	  ○ What's in store for next year?
		EM

6:55pm (5 min)	**Closing out the Year!** • Questions from Members • Thank you from Staff • How to stay connected over the summer! • Next FYC Meeting 05/22	**EM**

Reunión del Concilio de Residentes de TCM Fresno

Martes, 21 de mayo de 2024

5:30-7:00 p.m.

Reunión de zoom https://us06web.zoom.us/j/88516658291

Resultados de la reunión:

- Reciba actualizaciones de nuestros equipos de TCM
- Reflexionar sobre la Cumbre de Residentes
- ¡Destaque el progreso que logramos este año!
- Cierre y actualizaciones importantes.

Tiempo	Ítem de agenda	Artefactos / Enlaces
5:30 pm (10 min)	**Bienvenida y rompehielos** ● Interpretación desde Lingüística ● Rompehielos: ¿Cuál fue tu mayor conclusión de la Cumbre de Residentes? ● Revisar la agenda	- **Ernie Martínez**
5:40 pm (15 min)	**Actualizaciones de los equipos** ● Equipo de Acción de Vivienda- ○ Reunión reciente con el alcalde Dyer ○ Reuniones de planificación para los talleres de estrategia de vivienda de ONE Fresno ● Concilio de Juveniles de Fresno- ○ Reunión del YRC del 22 de mayo ○ ¡Enfoque juvenil! ● Equipo central de FRC ○ Aspectos destacados de las reuniones recientes ○ Progresos en la concesión participativa de subvenciones	**- Juana Iris** (5 minutos) **-Phailee**(5 minutos) **- Miembro del equipo central**(5 minutos) **(EM)**
5:55 p.m. (15 min)	**Orador invitado: Departamento de Salud Conductual de Fresno - Ahmad Bahrami** ● Datos de encuestas y grupos focales de salud mental de 2023	**EM**

6:15 pm (30 min)	• **Reflexionando sobre la Cumbre de Residentes**	**- Carmen Zamora, Diana Tang**

6:45 p.m.
(10 min)
	• **Lo más destacado de este año**
	  ○ Mirando nuestros logros
	  ○ Qué en la tienda para el próximo año?
		EM

6:55 p.m. (5 min)	**¡Cerrando el Año!** • Preguntas de los miembros • Gracias del personal • ¡Cómo mantenerse conectado durante el verano! • Próxima Reunión FYC 05/22	**EM**

Appendix L – Parlier Youth Wellness Summit Report

YOUR TIME YOUR VOICE
YOUTH WELLNESS SUMMIT

Parlier, CA

May 22, 2024

Department of
Behavioral Health

1.1 About the Community

Parlier Unified School District is located in Parlier, CA. This is a small city of 14,625 persons (as of 2022) with a poverty rate of 27.4% (Data USA, 2024). The city is in rural eastern Fresno County, approximately 20 miles outside of the county seat of Fresno. Based on self-survey results from event all participating youth self-identify as Latino or Latinx. This number is reflective of the community with close to 96% of the community having identified as Hispanic or Latino (Census Reporter).

Figure 1 Parlier High School

1.2 Summary

Building on the success of a youth wellness summit in the late fall, the Department sought to gain additional insights from youth in rural, predominantly Latino communities with additional youth wellness summits. On May 24, 2024, the Department of Behavioral Health, in collaboration with the Parlier Unified School District, facilitated a youth summit for 31 students grade 9th to 12th from both Parlier and San Joaquin Valley High Schools.

The Parlier Youth Wellness Summit was intentionally designed to be like a previous youth wellness summit for continuity of the recommendations from the students. The event was held after school from 1:30pm to 5:30pm, with all the students volunteering their time and having to register for the event. A brief introduction was provided as to the purpose of the wellness summit. A presentation on the social determinants of health (SDOH) was facilitated by the Fresno HOPE HUB with interactive examples of what SDOH are and there impacts on society. Presenters from the California Health Collaborative provided a presentation on advocacy and the role the students can play in advocating for their own and their community's wellness needs.

Figure 2- Activity on Youth Advocacy

Staff from the district lead the youth on a 30-minute art/painting activity that prompted them to paint what a *"world where wellness is a priority"* looks like to them.

At the end of the activity, youth were asked to share how they interpreted the prompt or what their painting signified. The youth were introduced to a California Department of Health Care Services wellness app called Soluna, and were able

to participate in an interactive activity using their smartphones with the app's representative. The Soluna session explained the app and its features, how it can be used to support their wellness, and an exercise in breathwork as an example of skills and tools that can support their own wellness. At the end of the event the Soluna representative noted that 8 youth (about 25%) downloaded/registered for the app during the session.

After a break, youth were allowed to gather in small groups of four to six to discuss the following questions and develop some group responses:

1. *Why should you care about mental health and advocating for youth mental wellness?*
2. *In what ways can youth play a larger role in their school and communities to stop stigma (and shame) associated with mental health?*
3. *What changes can youth make in schools to ensure that their voices and mental wellbeing become a priority?*
4. *As young leaders, what do we (as a group) think ought to be the Department of Behavioral Health's priorities in improving student's mental health?*

The event wrapped up with an overall survey, a survey on Latino/x usage and a raffle of youth centric items (Beats headphones, Dick's Sporting Goods gift card, Game Stop gift card, etc.). Raffle tickets were given to the youth throughout the event to both increase chances for winning items at the end of the day and to entice participation from the group.

Students then were able to obtain dinner from a taco truck on their way out or could congregate for a while at the venue to eat dinner, visit the resources tables, etc.

1.3 Promoting Connections

Prior to the pandemic, numerous studies were focused on examining the importance of social connections for youth, but *"the pandemic disrupted connections to family, school, and community, which are essential supports for youth mental health."* (Delaney et.al. 2024). Therefore, after the pandemic, some efforts are focused on understanding what may be long-term impacts of the pandemic on community connections. The students who participated in the wellness summit included students whose transition years from elementary to middle school and/or middle school to high school were impacted by the social and physical isolation of the pandemic.

The students who participated in the Parlier Wellness Summit, reported a heavy interest in improving their physical environment to support their wellness. This environment is not limited to their school setting, it includes the community of Parlier as a whole. The students expressed an interconnection of a "cleaner" community leading to a safer community, which would then lead to more personal connections. The youth felt that more personal connections would support their overall wellness. For this group, it was important to uplift the community, creating better connections amongst the youth, but also between the youth and their community.

While the information reported in the youth summit did not specifically identify the pandemic as a factor, these students had their educational and adolescent experiences directly impacted by the global pandemic – remote schooling that caused physical and social isolation. Their desire for a connection with one another and their community may come from a want and need to reestablish the ties and bonds that

were lost during the pandemic. The connections may be a means of assurance of stability and a return to normality and safety that they experienced before the pandemic.

It should also be noted that the youths' focus on a "cleaner" environment may have some considerations of how factors, such as SDOH can have an impact on the mental wellness of individuals. That by addressing those environmental factors, the overall wellness of the youth and community can be improved without having to provide direct or specific mental health services or engagement at the individual level.

Overall, the youth at the Parlier Summit had a more community-oriented focus and approach to wellness than individual needs. They expressed a need for more education about mental health and mental health literacy.

1.4 Key Themes

- **Theme One:** *Community and Environmental Factors*
    - SDOH- Youth seem interested in having more of a community wellness focus that could start with more tangible efforts such as community clean up, community activities and community gatherings.
    - Youth did not seem to want "someone" to address local environmental issues, rather interested in community opportunities where they can be involved and support efforts to improve their community and city. A desire to be more of active participants in community efforts and working across their community.
- **Theme Two:** *Connections*
    - Peer Connection - there are models and opportunities for enhancing and strengthening youth connections through peer activities. These can range from general peer connections through campus clubs, to more formal peer to peer support models and programs where youth can learn to support other youth.
    - Exploring opportunities for wellness clubs or a NAMI club on campus that may support connections and promote wellness.
    - Community Connection – The Center for Disease Control (CDC) has resources focused on creating social connections. Facilitating opportunities for youth to be involved locally with their community and engage in community activities that can support their wellness, as well as increase civic engagement from youth to improve their community.
    - Environmental impacts on the local youth and their wellness are a high priority area. The interest to address these environmental needs also ties in with their desire to better connect and interact with their community. Focusing on public "clean up" or "beatification projects" can support this need, and simultaneously provides an opportunity for tangible gains through completion of community projects.
- **Theme Three**: *Education*
    - Education and development of educational staff to help identify and support the mental health needs of students. This can range from training and professional development to having personnel be aware of campus and/or district resources which can support student needs.
    - Mental health literacy - The need to better understand what mental health is, who the care and support network are, what and where the mental health resources are, how to

access supports, etc. All of which are of great importance. This is not limited to educational personnel, but for the youth themselves and their community as well.

- **Theme Four**: *Advocacy and Input*
    - Youth are interested in opportunities to be heard - to share their experiences and ideas to support each other. This ranged from peer-to-peer support, to supporting the development of marketing messages around mental health, to participating in forums where they can lift up their needs or ideas, which can benefit the community.
    - On several occasions, the youth identified their desire to be able to contribute to ideas and ways to share information to help their community connect.
- **Theme Five:** *Awareness and Information*
    - The youth believe more targeted advertising about mental health, the relevant resources and supports are important part of behavioral health services. Knowing where to go to get more information are important and access earlier support needs with more mental health literacy. Having mental health information and resources available at the schools was considered beneficial as well.
    - Information on what mental health is, what it is not, what resources youth can access and use, where to seek support and help, etc. were important areas for the youth.
    - The youth expressed "intensive advertising" as an important area. They communicated the desire to have opportunities to help inform and drive some of the messaging - having a local voice to support advertising to help ensure more effective messaging.

1.5 Conclusion

The students who volunteered to participate in this youth wellness summit were engaged and focused on their community. In the art activity, students demonstrated their understanding of social/emotional challenges, wellness challenges, and an openness when discussing those subjects based on the number who shared their paintings and the meanings to them (with many being images of nature, etc.). The themes clearly show their concern and desire to support their community and to build connections with each other and within that community. The youth were open about the subject of mental health and not curtailed by concerns of stigma, but rather confidence in understanding what mental health is and a higher need for additional mental health literacy.

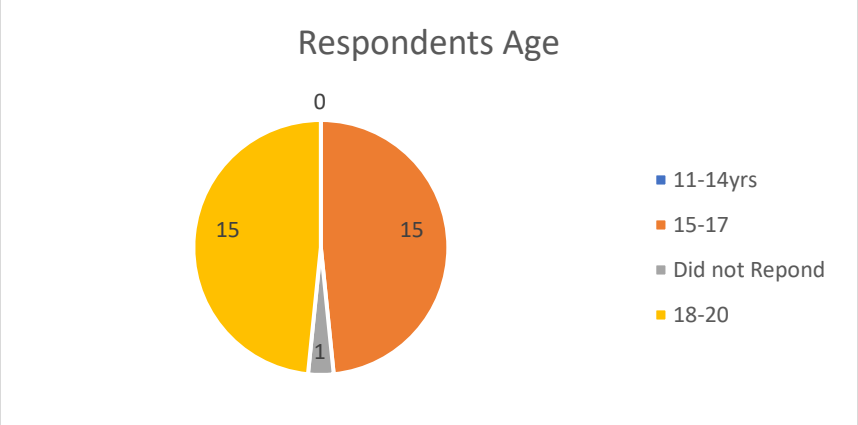
Figure 3-Dialog through art.

Appendix

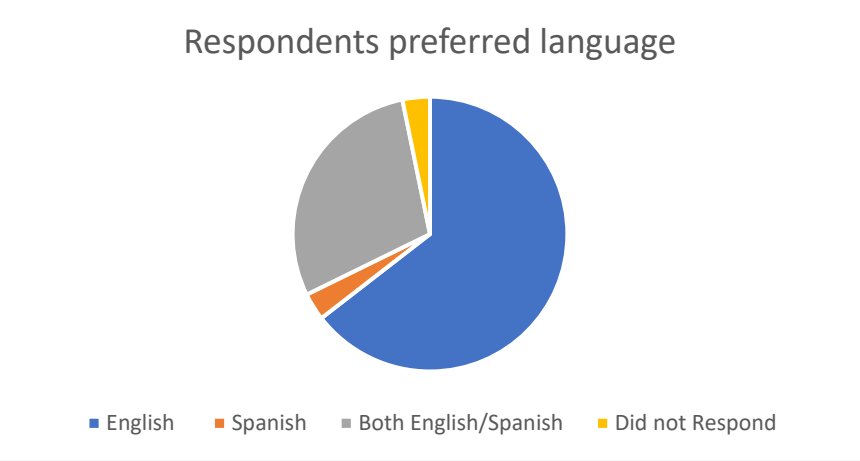
Appendix A- Post Event Survey Results

The Fresno County Department of Behavioral Health (DBH) facilitated a post summit survey for the Parlier event which collected basic demographic information and firsthand feedback about the event and the experiences of the students. The survey was used to help inform DBH and its partners on the impact of the summit's support of the youth in advocating for their own wellness needs, best ways to engage/communicate and support involvement in planning and system improvement.

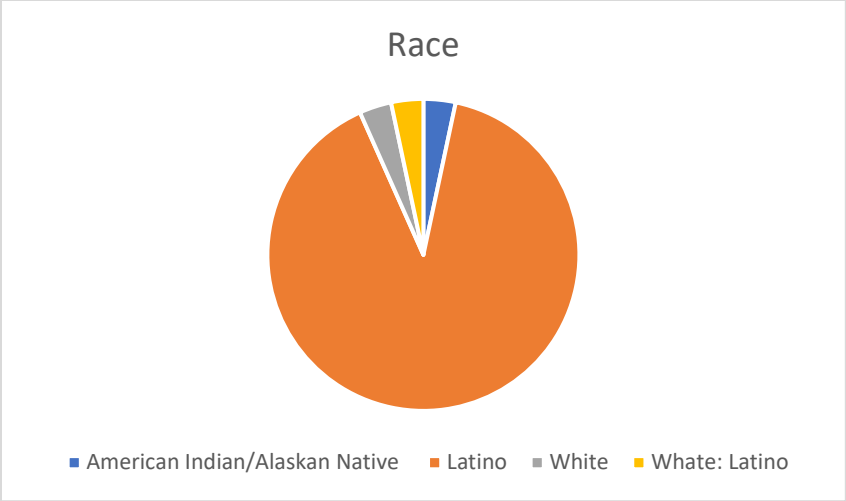
Each of the 31 youth participants received a $10 gift card for completing the event survey at conclusion of the summit. Graph 1 below shows the overwhelming majority of the respondents were between the ages of 15-20 (aligned with age of highschoolers). The school confirmed there were not students in the group 19yrs or older. The students who self-identified as Latinos with Mexican/Mexican American backgrounds were 81% of the participants (according to census data project, Parlier is 96% Latino). 64% of the youth identified English as their preferred language with close to 30% identifying both English and Spanish.



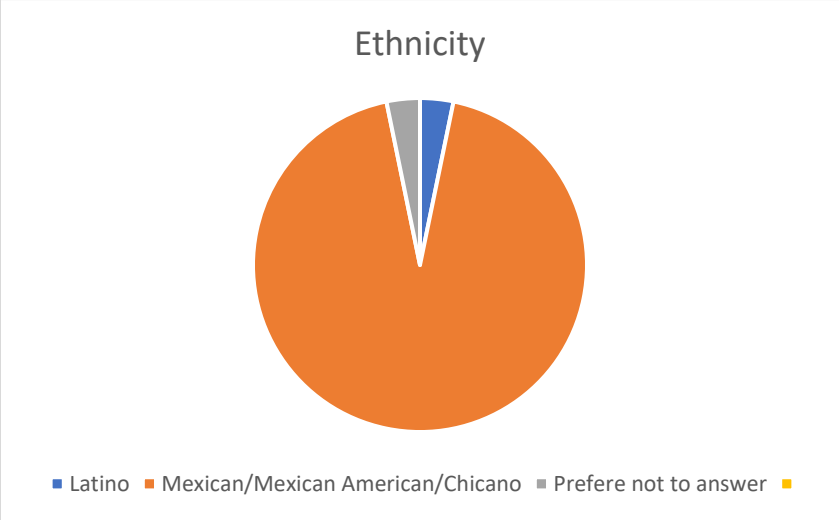
Graph 1



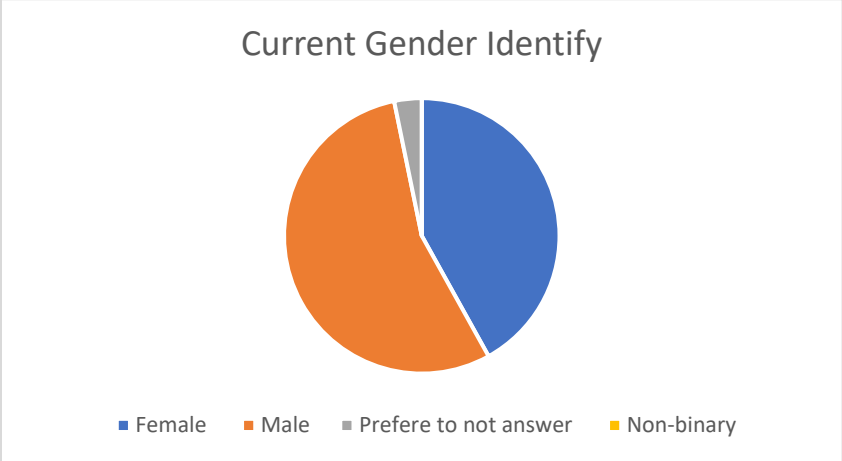
Graph 2



Graph 3



Graph 4



Graph 5

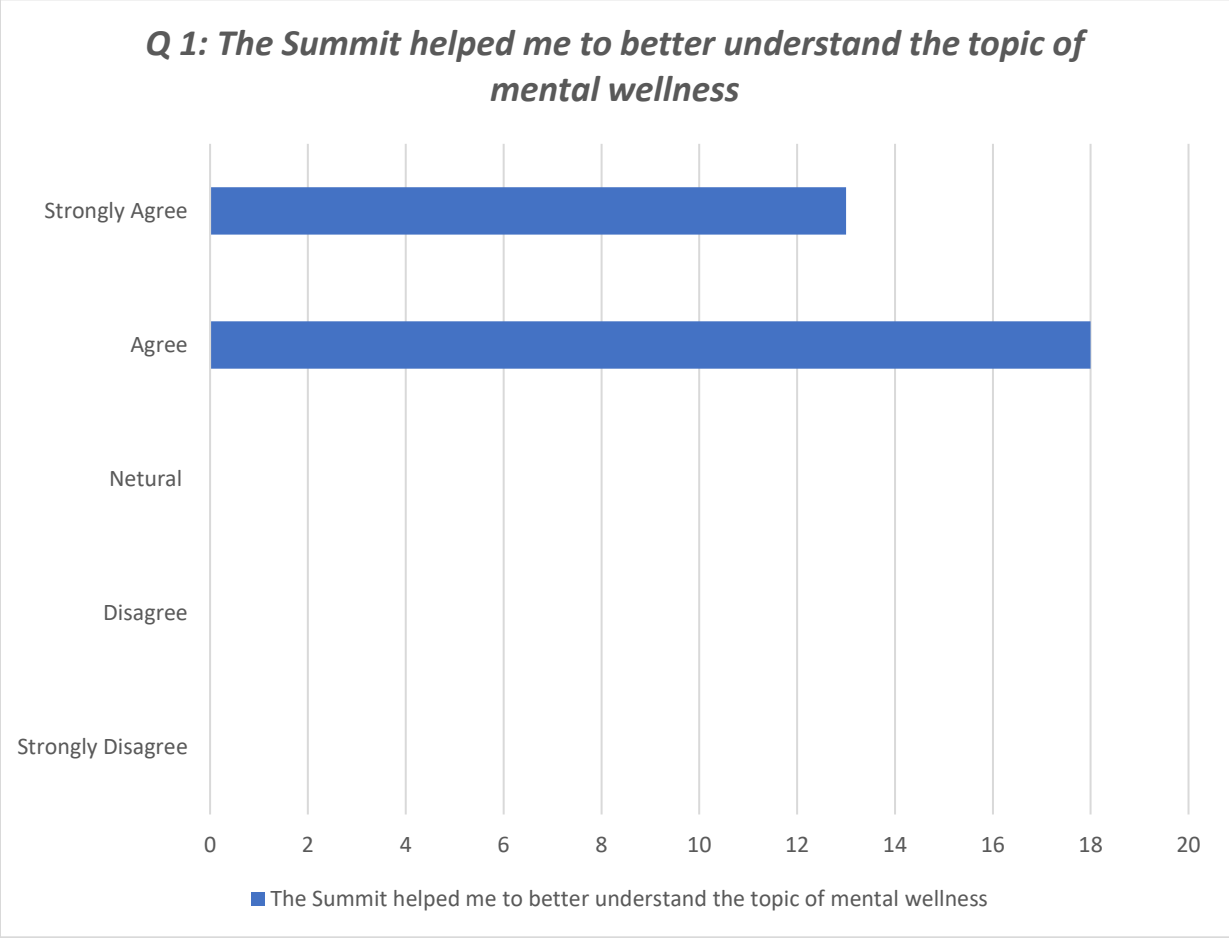
Key Findings and Considerations

At the Parlier event, youth participants were asked to complete a five-question survey to provide data that the facilitators/planners could use to assess the effectiveness of the event and its ability to achieve the goal of information and empowering the youth to be behavioral health advocates.

The survey is applicable to those who participated. The sample size of 31 is not large enough to be indicative of the entire district or the community but it does provide some self-perceptions from the youth.

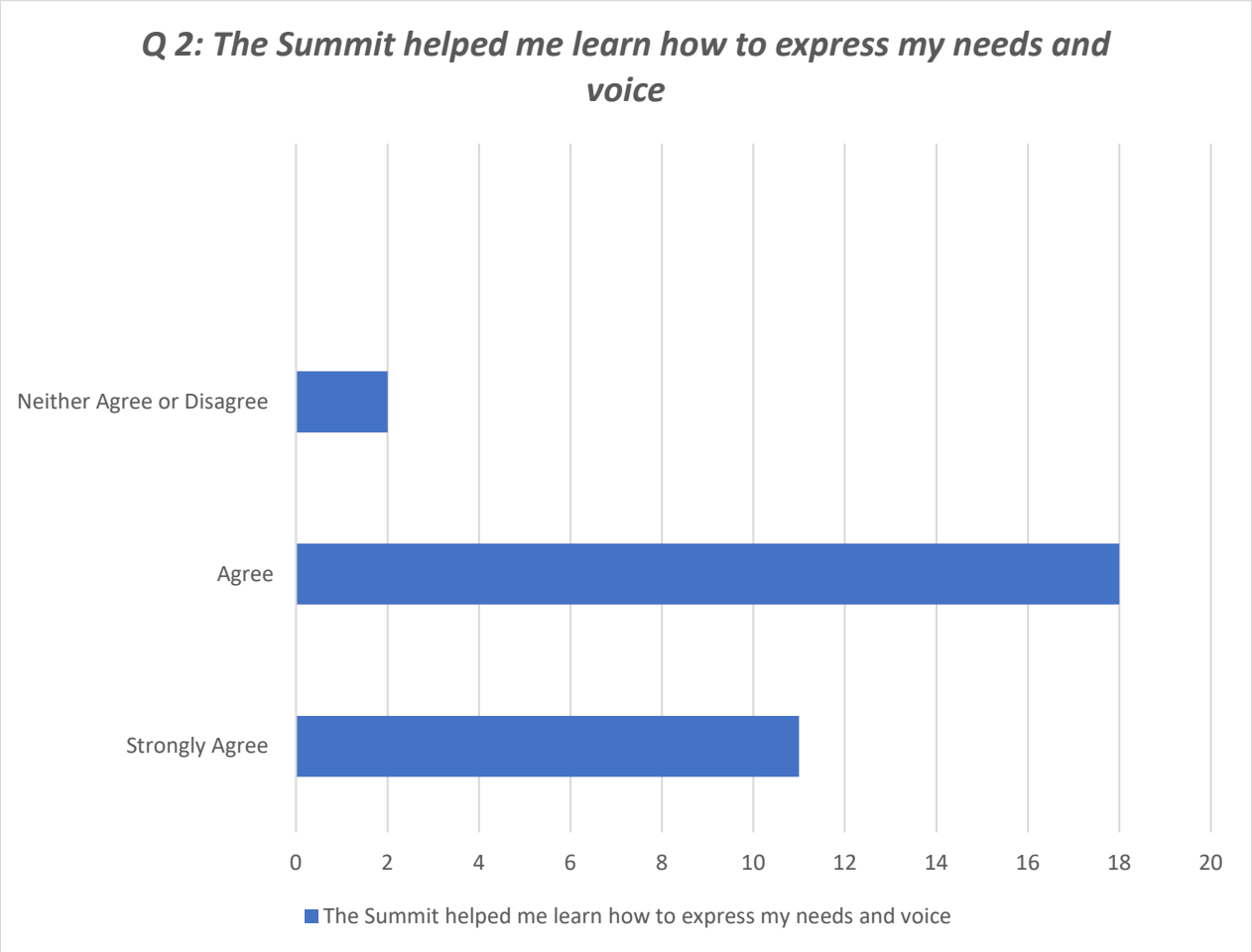
Based on the responses to question one, the youth participants found the summit useful in helping them better understand mental wellness. The survey does not identify which presentations, or activities supported this response.

One of the goals and/or purposes for the summit was to empower youth to inform and advocate for their behavioral health needs, and to become more familiar with the process and ways they can lend their critical voice to systems development, needs assessments, and community planning.

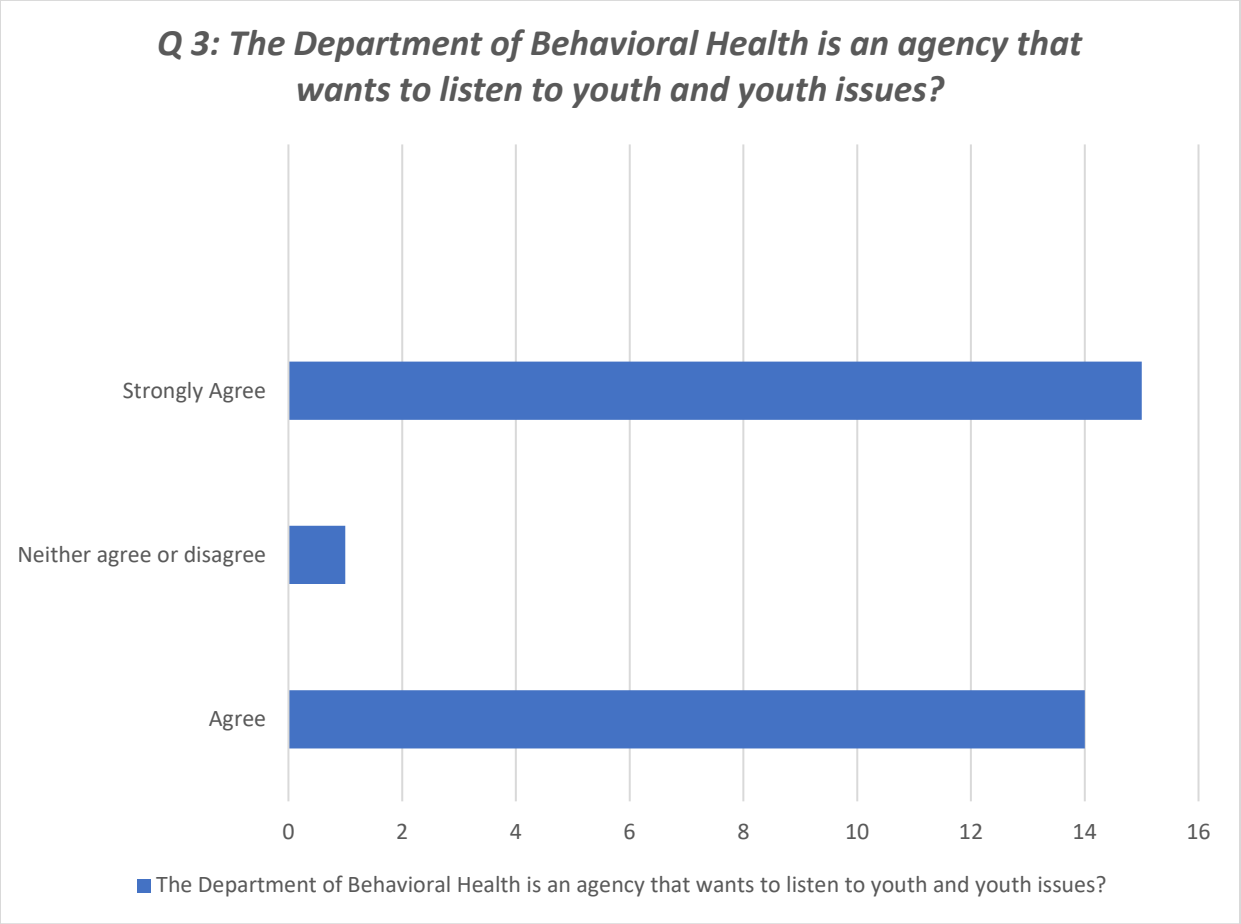


Consideration: The youth are interested in learning more about mental health and wellness and presenting the information in more interactive formats, such as art or technology, to increase interest and understanding.

The responses to questions two and three can affirm the general goal of the summit was met based on youth reports of being able to lend a critical voice to behavioral health discussion and a sense that DBH and the partners were interested in their insights, thus potentially strengthening their future involvement in community planning and stakeholder involvement.

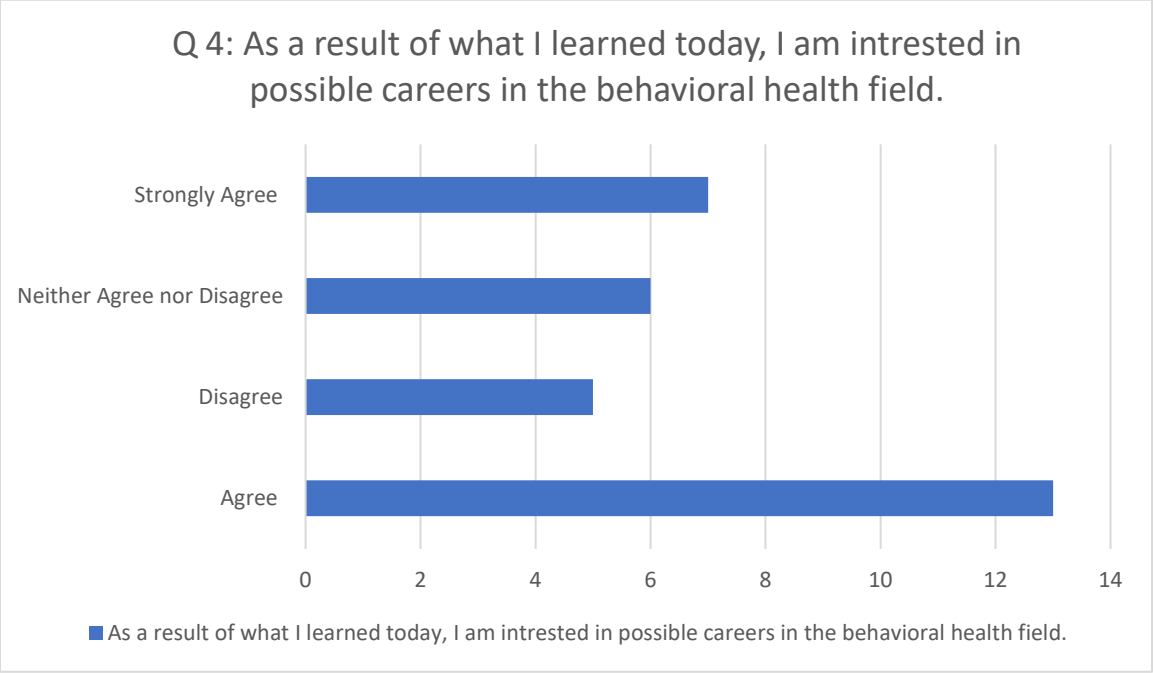


Consideration: Provide ways for youth to increase their involvement in advocacy for each other and community through more youth lead activities. Creation of a "wellness club". Creating a "wellness" officer as part of the student government, explore establishing a NAMI on Campus Club, or developing a youth wellness advisory committee where the youth can engage with peers on needs, feedback, ideas, and be able to formally share with local policy makers.

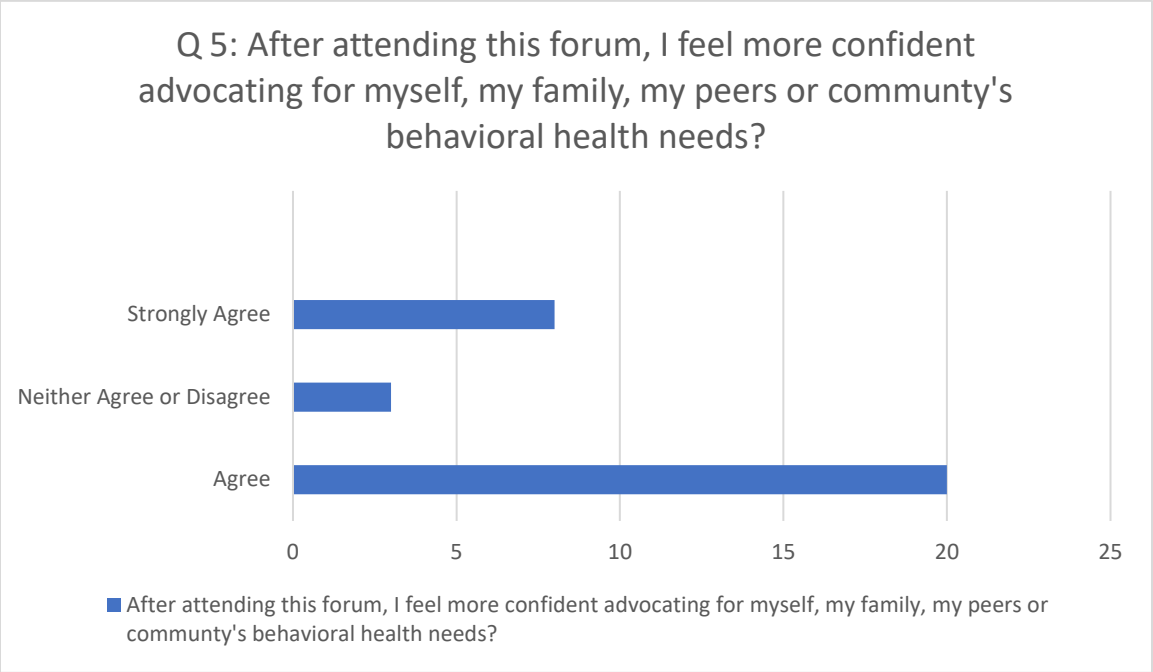


Consideration: Continue to engage with youth from rural communities through partnerships with the district. Explore ways to understand local needs, report/update youth on efforts, and/or include them in development of communication, marketing, and engagement strategies.

This youth summit did not have a presentation/activity that allowed meaningful or focused interactions with behavioral health professionals who could share about work in direct care, but the event did allow them to experience the different concepts and focus areas in the behavioral health field such as advocacy, wellness, social determinants of health, prevention resources, the roles of health/community health workers, policy development, health navigation, wellness coaching, etc. With the limited focused exposure for behavioral health careers, 64% of the summit participants expressed interest in future careers in the behavioral health field.

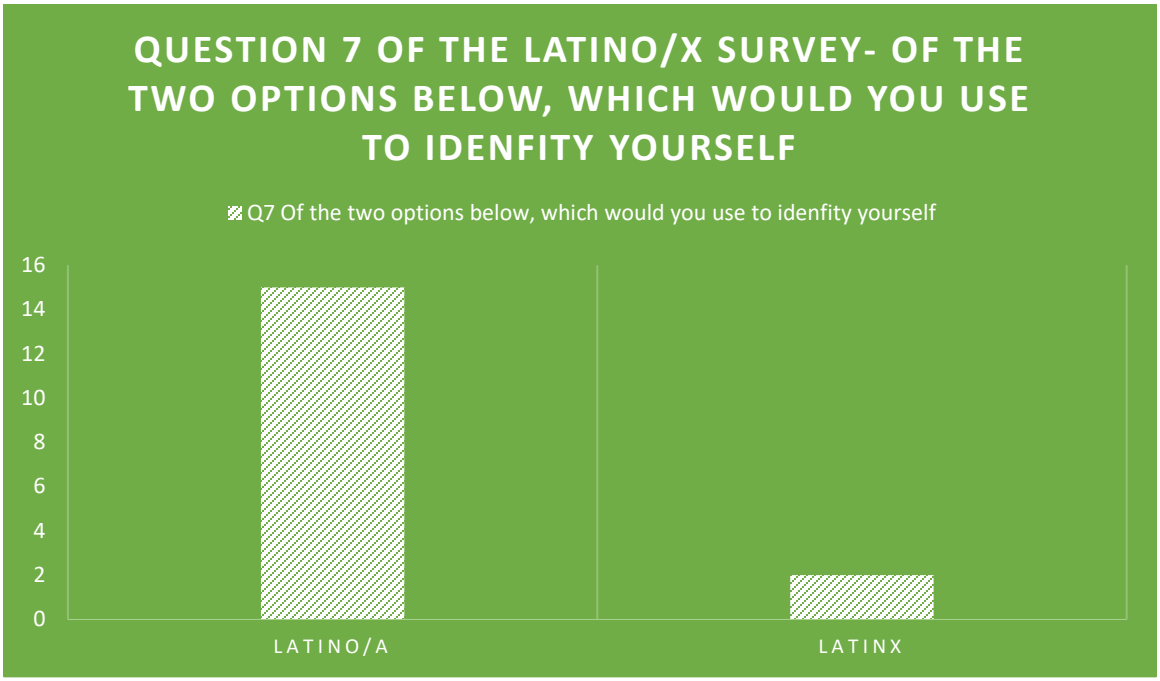


The figure below shows that 90% of the participants now feel more confident about advocating for their local wellness needs. Some may have just needed exposure to the information and opportunity to consider the topics, some may have identified with the topics and areas that interest them, and some may have just developed more confidence in a supportive environment where they were asked for their thoughts, opinions, etc. The "why" is unknown, what is clear is there is an opportunity to include, involve, and develop the youth participants to be informed stakeholders who can support and guide community wellness efforts and planning.

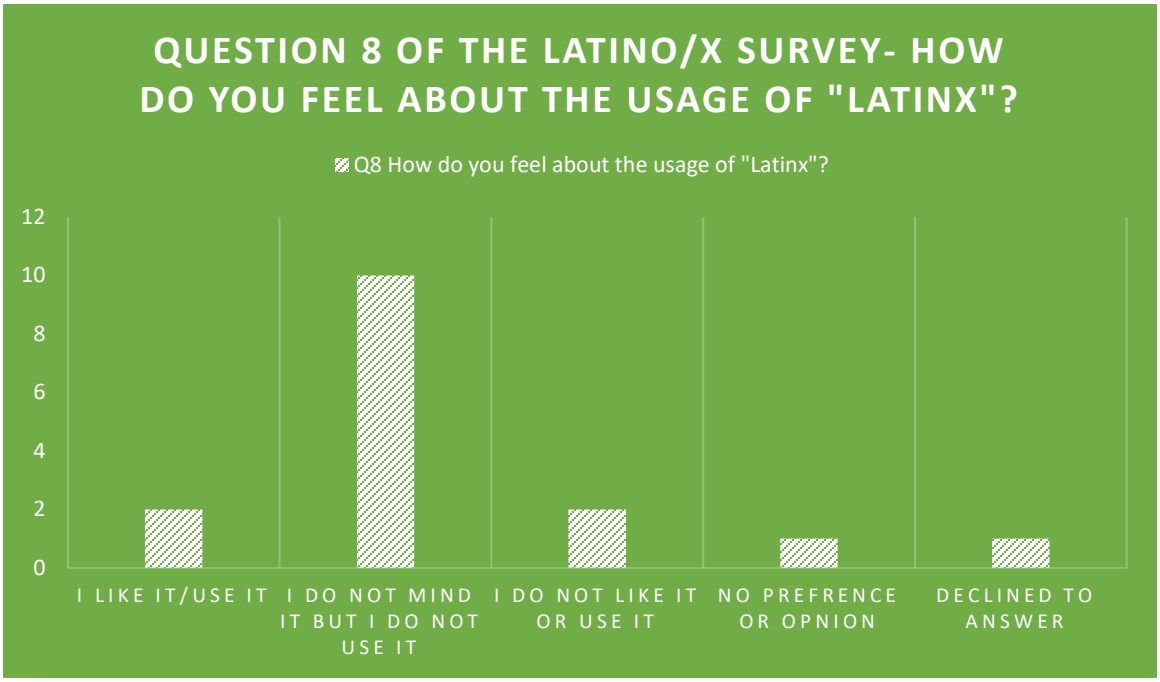


Appendix B- Latino/Latinx Survey Results

Almost half of the summit participants (17 of the 31) completed the Latino/a/x survey. Of those, all 17 confirmed they identify as Latino or Hispanic. 12 (70.59%) of the youth respondents said they are bilingual. Of the same 17 youth, 13 (76%) identified English as their primary language, with 10 (62%) identifying Spanish as their second language. While this is a small sample size, it does show (and if combined with results of this survey in other settings) that many rural Latino youth do not self-identify as Latinx. Of the rural youth (most who are bilingual but consider English their primary language) prefer Latino/a over the term Latinx. This does not mean that use of Latinx should not be used for those who self-identify as Latinx, but it does show that for purposes of communication and more effective engagement with this population they identify as Latino/a. This slight consideration may improve communication and make topics feel more applicable to them if the term Latino/a is used when engaging them. Noting this is a very small sample size.



The figure below shows a greater identification or usage of the terms by Latino/a or Latinx youth.



Appendix C- Event Flyer

Appendix D- Agenda

Your Time, Your Voice Youth Wellness Summit-Parlier

Agenda

1pm DBH team set up.

1:30pm-2:00 pm (Check in, snacks, etc.).

2:00pm-2:15pm Welcome/Intro

2:15pm-2:45pm Social Determinants of Health (SDOH) or Adverse Childhood Experiences (ACES) by *FCHIP Hope Hub*.

2:45pm-3:15pm Advocacy by *California Health Collaborative*

3:15pm -3:50pm Art Activity and Process- *Parlier Unified*

3:45pm-4:20pm Soluna Presentation and Breathing Exercise- *Maria Mayes*

4:20pm-4:50pm- Youth Breakout

5:10pm- Youth Report Out and Recommendation

5:10pm-5:30pm Raffle, survey, warp-up. *FCDBH*

5:30pm-6:00pm Food served/food truck.

6:00pm Complete (start clean up)

Appendix E- Acknowledgements

The Fresno County Department of Behavioral Health would like to acknowledge the support and assistance of the following individuals and organizations in bringing this effort to life.

- Parlier Unified School District
- Lydia Martinez - Parlier Unified School District
- Dr. Rafael Iniguez - Parlier Unified School District
- Dr. Johnny Alvarado- Parlier Unified School District
- Ana Robleto - Fresno HOPE
- Ashlee Hernandez - Fresno HOPE
- Espi Sandoval
- Maria Mayes- Kooth USA (Soluna)
- Miriam Andres - Parlier Unified School District
- California Health Collaborative

Appendix F – References

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Census Profile: Parlier, CA. Census Reporter. (n.d.). https://censusreporter.org/profiles/16000US0655856-parlier-ca/

Data USA: Parlier, CA. (2024). https://datausa.io/profile/geo/parlier-ca

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YOUR TIME YOUR VOICE
YOUTH WELLNESS SUMMIT

Huron, CA

JUNE 4, 2024

Department of
Behavioral Health

1.1 About the Community

Huron is a small city in the southwest part of Fresno County and according to census data is home to 6,377 individuals.

Only 10.5% of the population speaks English only, while Spanish is spoken by 87.5 % of the population (World Population Review, 2024). It is important to note that many of the residents are bilingual (and not mono-lingual Spanish speakers). According to the local organizations, there are communities in Huron who speak indigenous languages that originate in southern Mexico and the Yucatan region including Guatemala, who have limited English or Spanish proficiency.

In 2022, 46.6 % of the city's population were foreign born, and a large percentage (over 50%) of the population are employed in the agricultural sector. 55% of the total population are insured through Medi-Cal/Medicare, with about 24% having private insurance and 18% reporting no coverage (based on Census Bureau ACE 5-Year Estimate).

32% of the population for whom the poverty status is known, live below the poverty line, a number that is double the national average of 12.5%. The current data identifies the largest number of people living in poverty are children below the age of 14. Of those children living in poverty, females ages 6 – 11 are the largest group, followed by females under five years of age, and then males ages 6 – 11. The disproportional impact of poverty is apparent in this community and impacting the most vulnerable.

The city of Fresno, which is the County seat and California's fifth largest city, is approximately seventy miles away. The next closest city to Huron is the city of Coalinga, which is close to twenty miles away, making Huron somewhat geographically isolated from other resources.

The high school age students of Huron are served by Coalinga High School, which is in the neighboring town of Coalinga, 19 miles away (and drive of approximately 24min).

1.2 Summary

In May of 2023, the Fresno County Department of Behavioral Health, with support of the LEAP Institute, and the city of Huron, facilitated a Mental Wellness Townhall event in Spanish. The event included presenters, experts, and panelists who presented information on social determinants of health, trauma from migration and assimilation, substance use, and behavioral health services in the county. The audience of about 30+ Spanish speaking adults attended and participated in the two-hour evening event held in person at the John Palacios Community Center. After the success of that event, the partners suggested conducting something similar but this time with youth from the community.

With the help of the City of Huron, LEAP Institute, and Coalinga-Huron School District, a youth summit was developed that included participation from some local providers as well. The school district supported the effort by allowing high school students who reside in the city of Huron to attend the summit during the last week of school as part of an off-site school activity.

The Huron Youth Wellness Summit followed the format of the previous two youth wellness summits facilitated by the Department of Behavioral Health (in San Joaquin and Parlier). For continuity of the recommendations from the students and for possible comparison the Huron event mirrored the other

two. However, the participation for the Huron event was double of the other previous summits with over 70 youth in attendance. The event was held during the final week of school on June 4, 2024, from 8:00am to 12:30pm.

The Huron Youth Summit hosted 74 high school students who reside in the city of Huron or surrounding areas, who attend Coalinga High School, between 9th and 11th grades.

Most of the youth participating in the summit identified as Latino. The data from Data USA cited the population of Huron, California as 95.7% Latino, with those included a mix of Latino, White and Latino and other multi-racial Latinos. (Data USA, 2024). The summit participation was consistent with the overall population of the community.

Figure 1-One of the presentations.

The Summit adhered to the previous format. A brief introduction was provided with focus on the purpose of the wellness summit. A presentation on the social of determinants of health (SDOH) was facilitated by the Fresno County Department of Public Health to help the youth understand the systems and the local and environmental factors that can impact their wellness. The youth were introduced to the no-cost wellness app called Soluna, from the California Department of Health Care Services, and were able to participate in an interactive activity using their smart phones with the app's representative. The Soluna session explained the app and its features, how it can be used to support their wellness, and an exercise in breathwork as an example of skills and tools that can support their own wellness. At the end of the event the Soluna representative noted 45 youth (about 50%) downloaded/registered for the app during the session.

Youth Leadership Institute (YLI) led an interactive session called Environmental Prevention Activity which focused on problem solving by looking at the difference between individual prevention vs environmental (so to better sustain change). YLI is the Department's contracted substance use prevention provider. Their work helped support the youth in learning how to engage their community and advocate for their needs.

Figure 2-Youth presenting their recommendations to the group.

Participants were then involved in a professional round robin, where youth spent five minutes at a time in small groups interacting with a different professional from the behavioral health field. These professionals ranged from crisis counselors to health educators to school counselors to substance use counselors and grad students to provide an array of work in the field. The

focus was to expose the youth to a variety of behavioral health careers (not just therapy, psychiatry, etc.). and to feature professionals who were representation of the youth (Latino/a and who were from rural communities in the region too). Supporting the concept of representation as a necessity for effective engagement.

After a break, youth were asked to gather in small groups of four to six per group to discuss the following questions and develop some responses. At the end, youth were asked to volunteer to share their responses with the group.

1. *Why should you care about mental health and advocating for youth mental wellness?*
2. *In what ways can youth play a larger role in their school and communities to stop stigma (and shame) associated with mental health?*
3. *What changes can youth make in schools to ensure that their voices and mental wellbeing become a priority.*
4. *As young leaders, what do we (as a group) think ought to be the Department of Behavioral Health's priorities in improving student's mental health?*

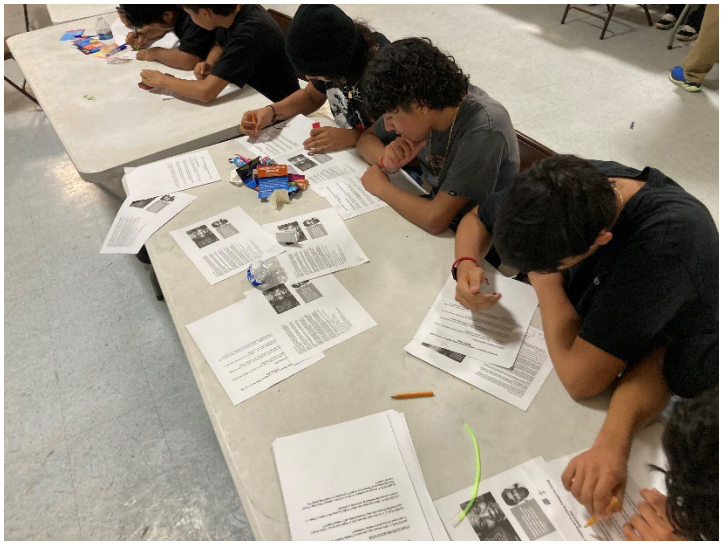


Figure 3-Youth working on responses & surveys.

The event wrapped up with an overall survey, a survey on Latino/x term usage and a raffle of youth centric items (Stanly Cups/tumblers, ear-pods/headphones, backpacks, etc.). Raffle tickets were given to the youth throughout the event to both increase chances for winning items at the end of the day and to entice participation from the group.

Students then were able to obtain lunch from a taco truck on their way out or could congregate for a while at the venue to eat lunch, visit the resources tables, etc.

1.3 Key Themes

- **Theme One:** *Importance of achieving and balancing both physical and mental health*
  - More education and awareness, as well as support, to balance both the physical and mental health of an individual and understanding how both are key to wellness.
  - The participants placed an importance on youth understanding the effects of how mental wellness directly affects them. Desire for information that is centered around their needs and can be applied and achieved by them. Some comments alluded that a more holistic/whole person approach may be more effective than just a mental health focus.
  - The youth expressed wanting to see more wellness centers and wellness focused services available that focuses on their physical and mental wellbeing. The responses did not clarify if those needs included culturally and linguistically responsiveness.
- **Theme Two:** *Outreach within schools with more supports and awareness*

- More Support - A large quantity of students expressed a desire for more mental health and wellness supports. They did not identify these as specific mental health services, but more supports which may include access, wellness centers, and preventative activities.
- Outreach Within Schools - students expressed the need for information via outreach, marketing or education to be conducted in school settings, with the youth being the focus of the content and messaging. More opportunities to learn and understand mental health, how to counter stigma, and to learn about resources and supports available to them. There are models and opportunities for enhancing and strengthening youth connections through peer activities. These can range from general peer connections through campus clubs (NAMI on Campus, Wellness Club, etc.) who can host resource fairs, put on events (May's mental health month, suicide prevention month, etc.) to more formal peer to peer support models and programs where youth can learn to support other youth.
- Awareness - Students included the need for more awareness as well, which could address areas of stigma, help inform them more about the importance of their wellness, what supports there are for them, how they can access support, etc. These are campus events, presentations, more collateral or digital materials targeting youth, etc.
- A noteworthy outcome of the presentation by Kooth on the new state funded wellness app, ***Soluna***, is that although the youth did not seem as engaged during this session, over half the participants (45 of 74) downloaded/registered the smartphone app during the summit. There is an interest from the youth to access more wellness support including through smart-phone apps, etc. An effort may be to have annual presentations by Kooth on campus on the app and to promote the app on campus/schools to students.

- **Theme Three:** *More supports and events that are tailored to mental wellness.*
  - The engagement in Huron started a year before with a mental wellness townhall event that was in Spanish and primarily targeting adults. That evolved into the need to do something similar for youth. Annual youth events around mental health can be done in September to coincide with Suicide Prevention Month and National Recovery Month (substance use), or student led events in May as part of Mental Health Awareness Month.
  - Wellness events, wellness-days, or activities can also be done that include presentations, mindfulness activities, speakers, highlight how some school-based services work and other educational work which has minimal financial impact and can be facilitated locally.
  - Again, the state resource/smartphone app, Soluna, is a no-cost easy to use support tool that can be accessed, promoted, etc. There may be an opportunity for some students to even lead a promotional/educational campaign in the community or campus.
- **Theme Four**: *More Advocacy from The Community.*
  - Students did not specify if the supports or advocacy was thought of as grassroots supports from other youth, families, or local organizations, or if they had a specific idea of where that work would originate from.
  - Increasing mental health literacy can lead to more advocacy. As more community members understand mental health, the need for more local, culturally and linguistically responsive resources, and how mental health services can improve quality of life, then more can engage in development of those care services, access those services and increase the demand. So more access to info, videos, materials that can help increase mental health literacy can support such a goal.

- Localized stigma reduction efforts can normalize mental health and thus lead to greater community supports for care, more advocacy, and more local engagement in those services. Some of the work itself may be stigma reduction which can then support more mental health literacy.
- Possible options are to have youth led efforts around wellness and wellness education and outreach at local events in the community, but also leveraging local organizations to help promote anti-stigma messages and efforts. There may be opportunities to seek effective advocacy and education through use of community health workers, promotoras, or cultural brokers that can effectively engage at the local level within the community on stigma reduction discussions, increasing mental health literacy, and with increasing engagement in wellness activities.
- Possible options for either a district or local/city may be a creation of youth advisory group where interested youth may help identify issues, ideas for how to engage the community, or do some community education and engagement with a youth focus and perspective.

1.4 Conclusion

The Coalinga-Huron School District afforded the students an opportunity to participate in the youth summit event during the last days of school, resulting in a robust cohort of students attending. The youth who participated in the half day event ranged from 9th graders to 11th graders. Personnel from the district were on site for support, assistance with activities, and to ensure students remained at the summit for the duration of the event.

There were two main themes that emerged from the youth voices:

- A desire for more supported advocacy opportunities (locally in Huron)
- A desire to increase their feeling of safety in their community. The students did not identify specifically what they meant by safety (i.e. physical, psychological, or social emotional, but an overall safety that could be attributed to a sense of wellbeing).

Entities such as the district, local providers, or LEAP Institute may seek to foster youth's desire for advocacy through continued youth-centric activities where youth voices are sought and applied to an array of services and needs. Continuation of youth focused listening sessions, youth advisory groups, peer groups, wellness clubs or NAMI on Campus clubs can support some of those needs for advocacy.

Having additional focus groups, or discussions with youth to help define "improving safety" would be beneficial, and to then include youth in plans to address those concerns, which can include things such a peer support groups on campus or in the community, more social emotional programming, and youth focused activities that can support their wellness and increase self-confidence and community connectedness.

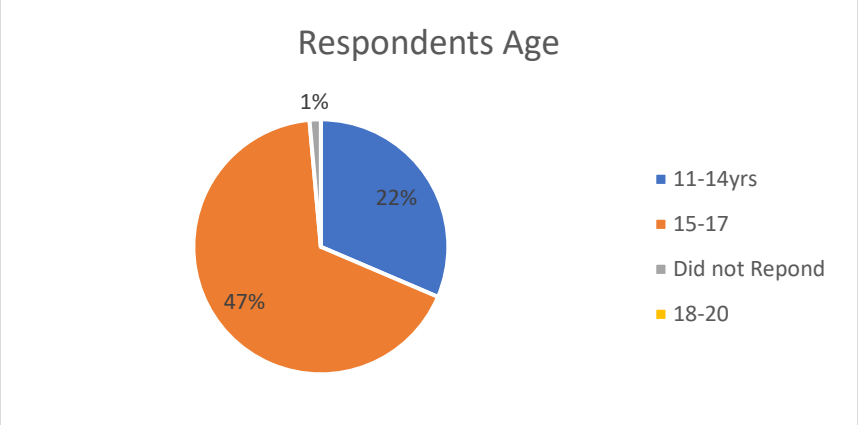
Figure 4-Resouces booths were included throughout the event.

Appendix

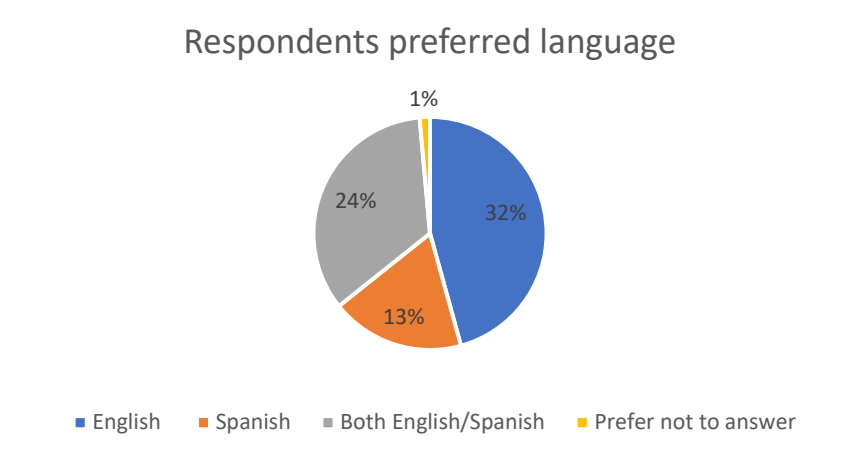
Appendix A- Post Event Survey Results

The Fresno County Department of Behavioral Health (DBH) facilitated a post summit survey from the Huron event which collected basic demographic information and firsthand feedback about the event and the experiences of the students. The survey was used to help inform DBH and its partners on the impact of the summits in supporting the youth in advocating for their wellness needs and the best ways to engage/communicate and support involvement in planning and system improvement.

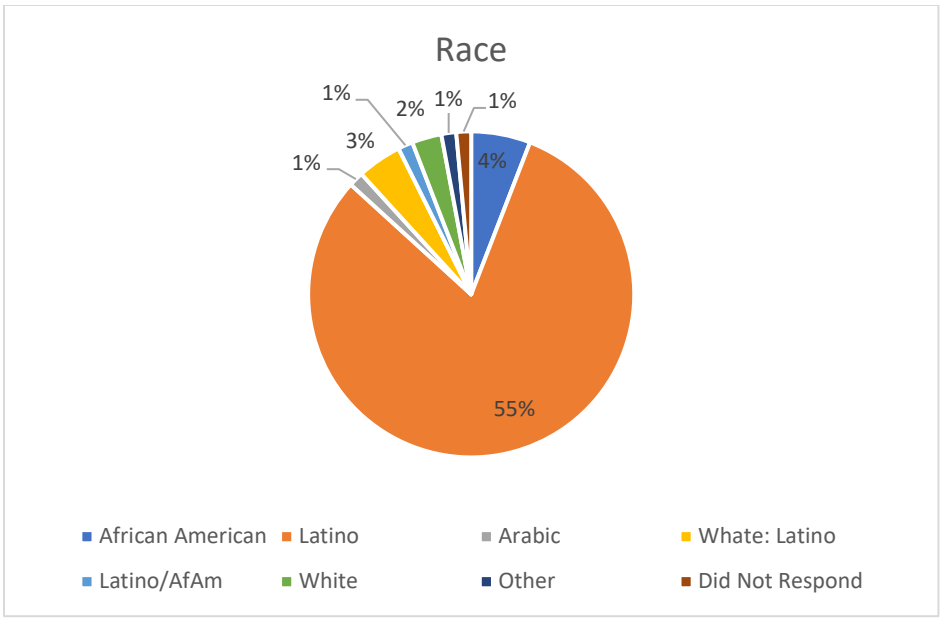
Each of the 74 youth participants received a $10 gift card for completing the event survey at conclusion of the summit. Graph 1 below shows that the majority of the respondents were between 14-19 (aligned with age of highschoolers). 87% of the students self-identified as Latinos with Mexican/Mexican American backgrounds. 64% of the youth identified English as their preferred language with close to 30% identifying both English and Spanish.



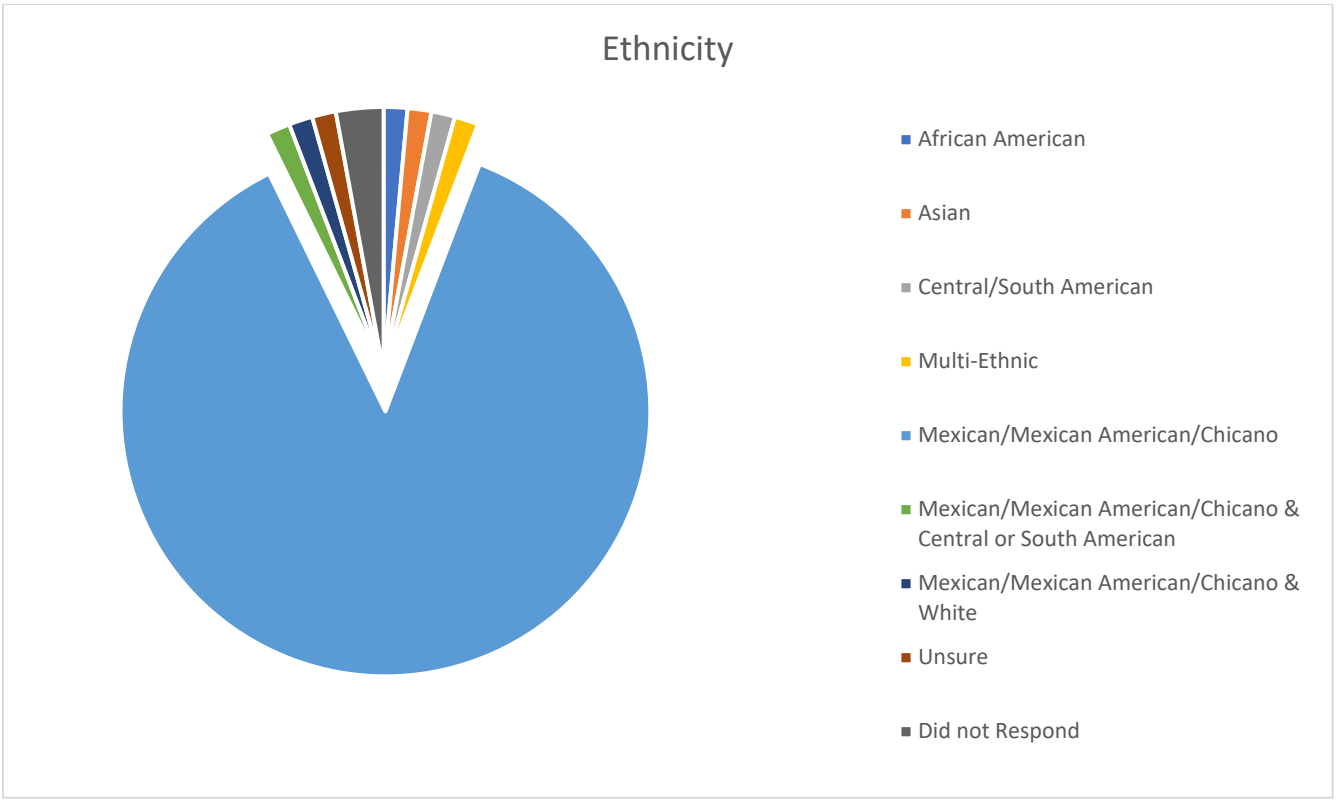
Graph 1



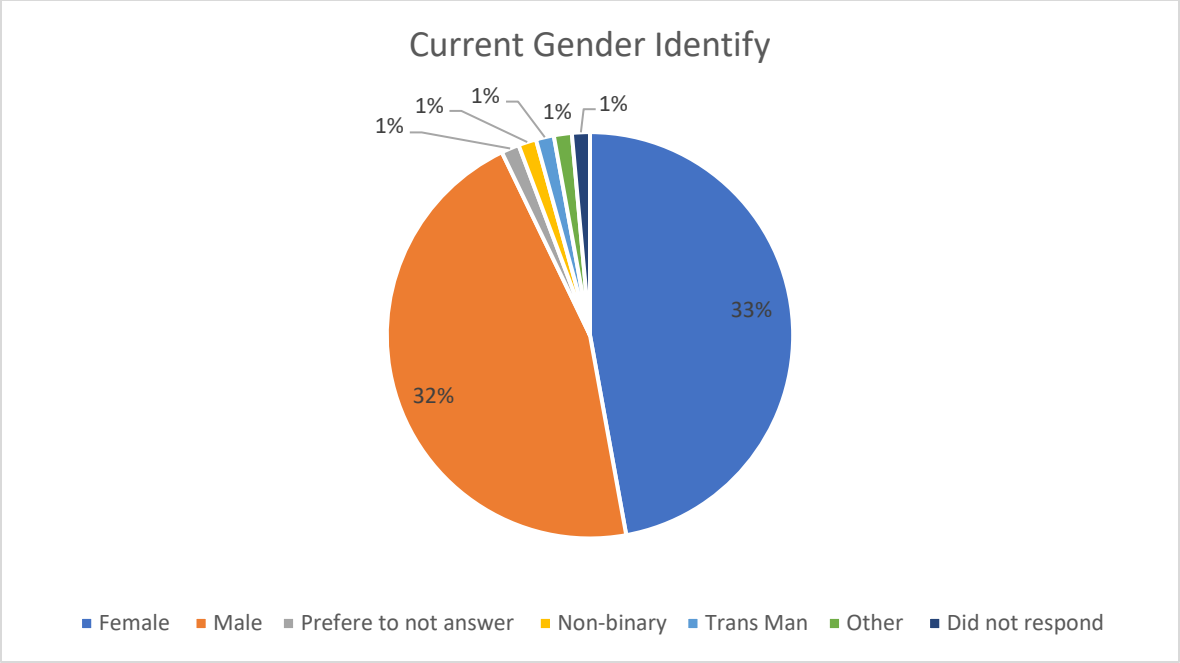
Graph 2



Graph 3



Graph 4



Graph 5

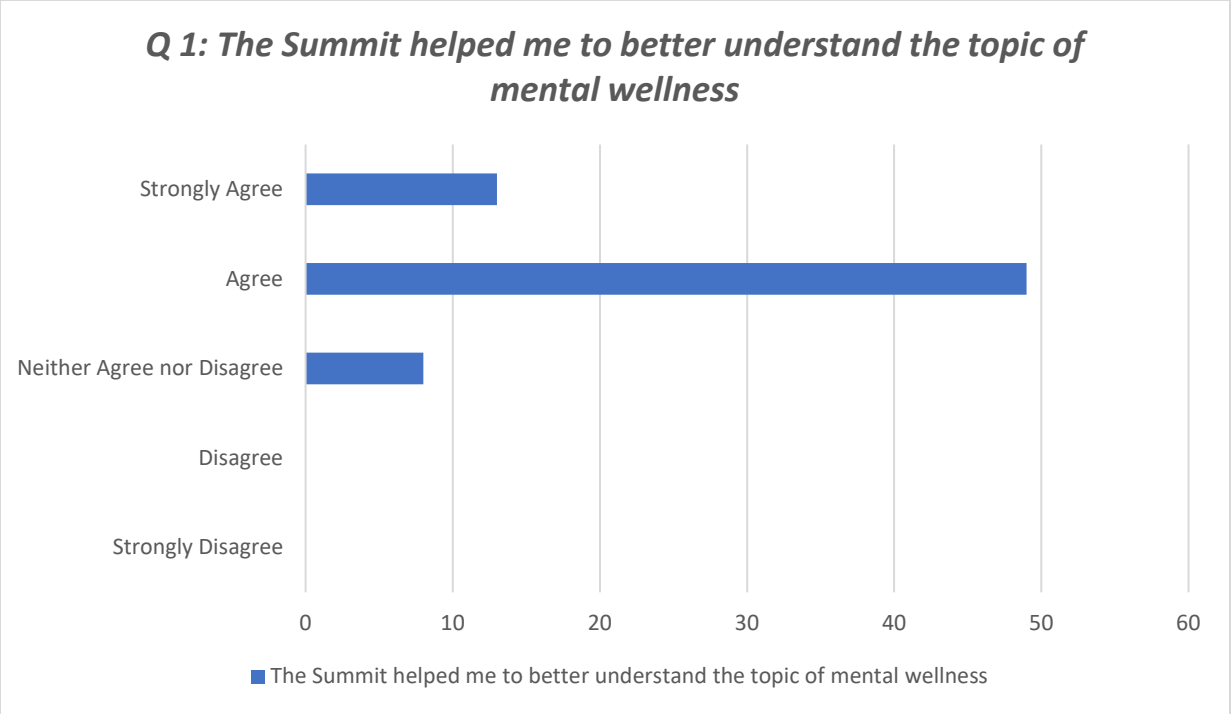
Key Findings and Considerations

At the Huron event youth participants were asked to complete a five-question survey to provide data that the facilitators/planners could use to assess the effectiveness of the event and its ability to achieve the goal of information and empowering the youth to be behavioral health advocates.

The survey is applicable to those who participated. The sample size of 74 is not large enough to be indicative of the entire district or the community but does provide some self-perceptions of the youth.

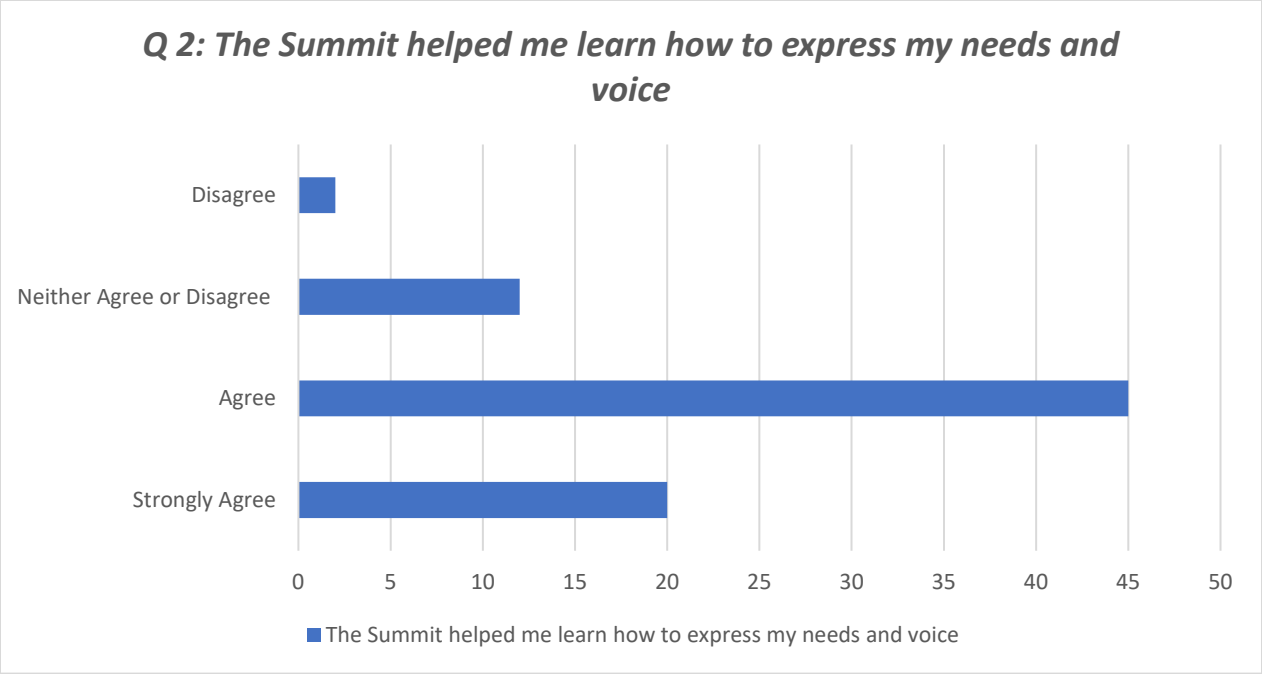
Based on the responses to question one, the youth participants found the summit useful in helping them better understand mental wellness. The survey does not identify which presentations, or activities supported this response.

One of the goals and/or purposes for the summit was to empower youth to inform and advocate for their behavioral health needs, and to become more familiar with the process and ways they can lend their critical voice to systems development, needs assessments, and community planning.

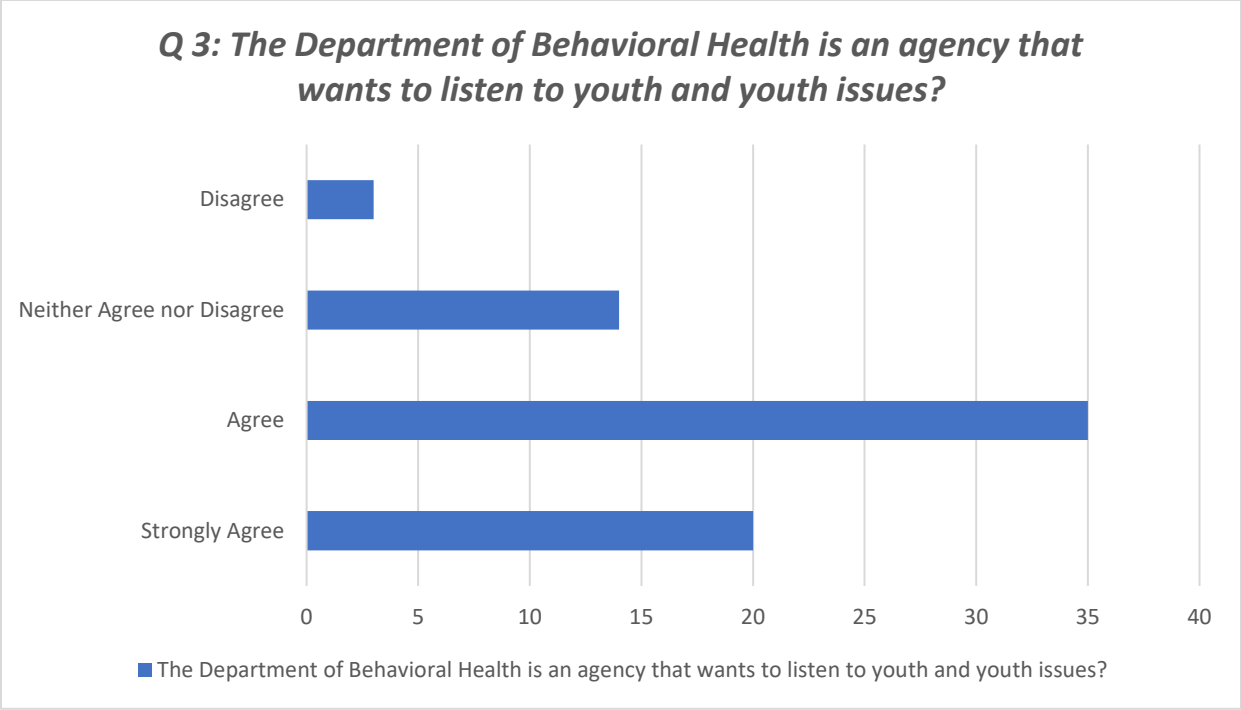


Consideration: The youth are interested in learning more about mental health and wellness and presenting the information in more interactive formats, such as art or technology, to increase interest and understanding.

The responses to questions two and three can affirm the general goal of the summit was met based on youth reports of being able to lend a critical voice to behavioral health discussion and a sense that DBH and the partners were interested in their insights, thus potentially strengthening their future involvement in community planning and stakeholder involvement.

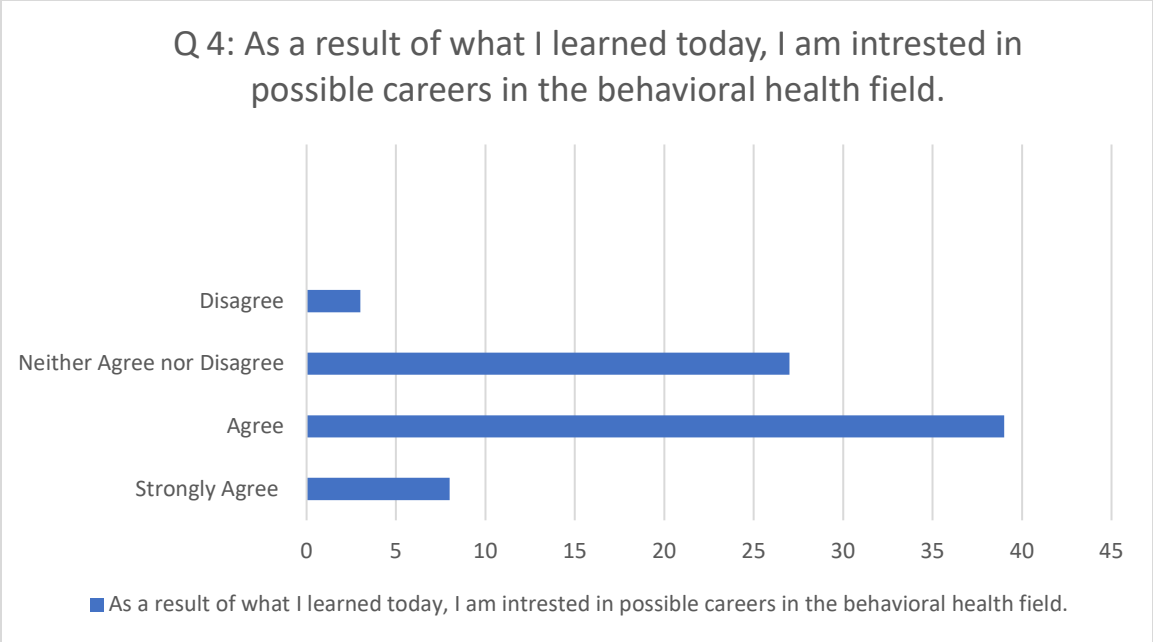


Consideration: Provide ways for youth to increase their involvement in advocacy for each other and community through more youth lead activities. Facilitating community planning or focus groups in Huron. Creating a "wellness" officer as part of the student government, explore establishing a NAMI on Campus Club, or developing a youth wellness advisory committee where the youth can engage with peers on needs, provide feedback, gather youth ideas, and be able to formally share local policy makers. Possible creation of an area youth taskforce led by youth to better define youth needs and possible options.



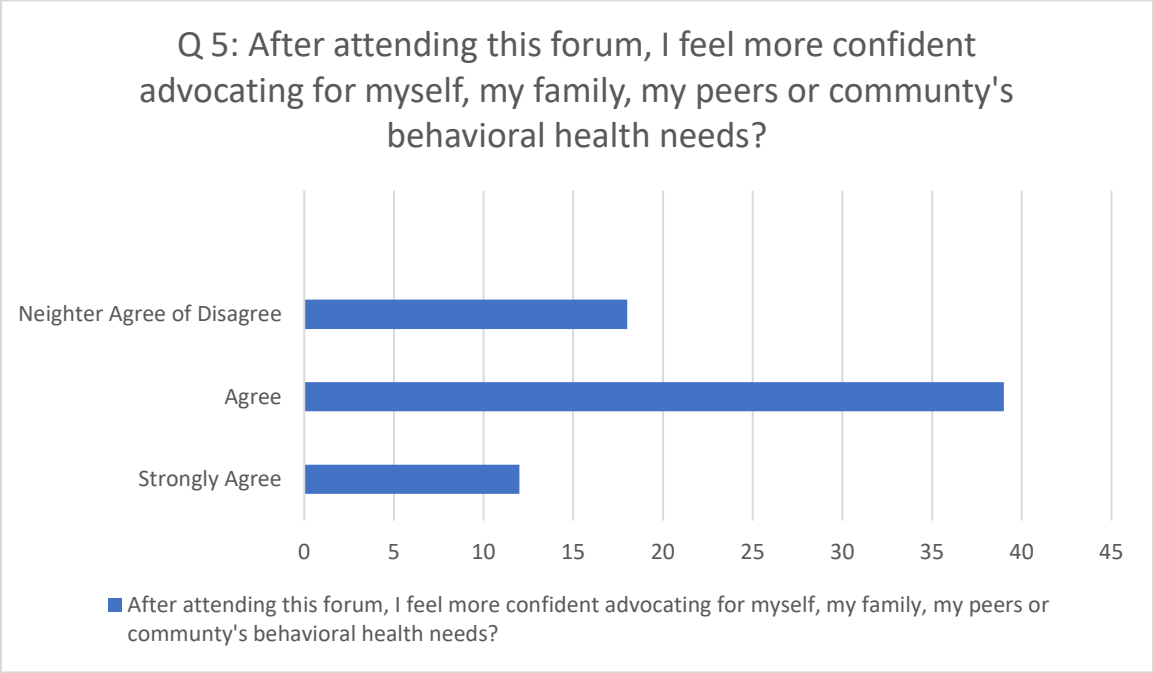
Consideration: Continue to engage with youth from rural communities through partnerships with the school district, city, and local organizations. Explore ways to identify local needs from a youth perspective, report/update youth on the efforts (or validating their time and inputs), and/or include them in the development or design of programs or services that can better address their overall wellness and feelings of safety.

The Huron summit provided youth an opportunity to engage with professionals from an array of behavioral health or wellness field to learn about the work, career tracks, etc. The students interacted with counselors, health educators, substance use professionals, school psychologists, crisis workers, etc. Additionally, an effort was made to factor representation, with an effort to have the professionals be Latino, and/or hail from rural communities or similar backgrounds as the youth in the summit.



Consideration: Continue to engage with youth from rural communities through partnerships, local service providers, and West Hills College for development of career pathways. There may be opportunities to support career pathways with creation of CalHOSA clubs focused on behavioral health careers, peer support programs, or NAMI on Campus Clubs. Possible career fairs that invite behavioral health providers who are also representative of the youth to provide additional opportunities to learn about the work and career tracks.

The figure below shows that more than half of the Huron Summit participants now feel more confident about advocating for their local wellness needs. Based on the data, a large number of respondents did not feel an increased confidence in advocacy. The reasons why they did not feel as confident is unknown, and the survey results were collected at the end of the summit, thus not allowing an opportunity to explore further. Some may be attributed to not knowing where to start, or what specifically they would want to advocate for? Of those who did agree, nearly half may have a better grasp of the options. Additional or future events may delve into those questions and/or afford more opportunities to develop the experience and confidence.



Consideration: Creating participation opportunities for youth be involved in behavioral health advocacy. These may range from wellness clubs, wellness officers, wellness activities on campus, to youth listening sessions and focus groups. There may be opportunities in the future for youth to represent their areas in a youth advisory capacity for behavioral health, or local civic opportunities to provide a youth perspective.

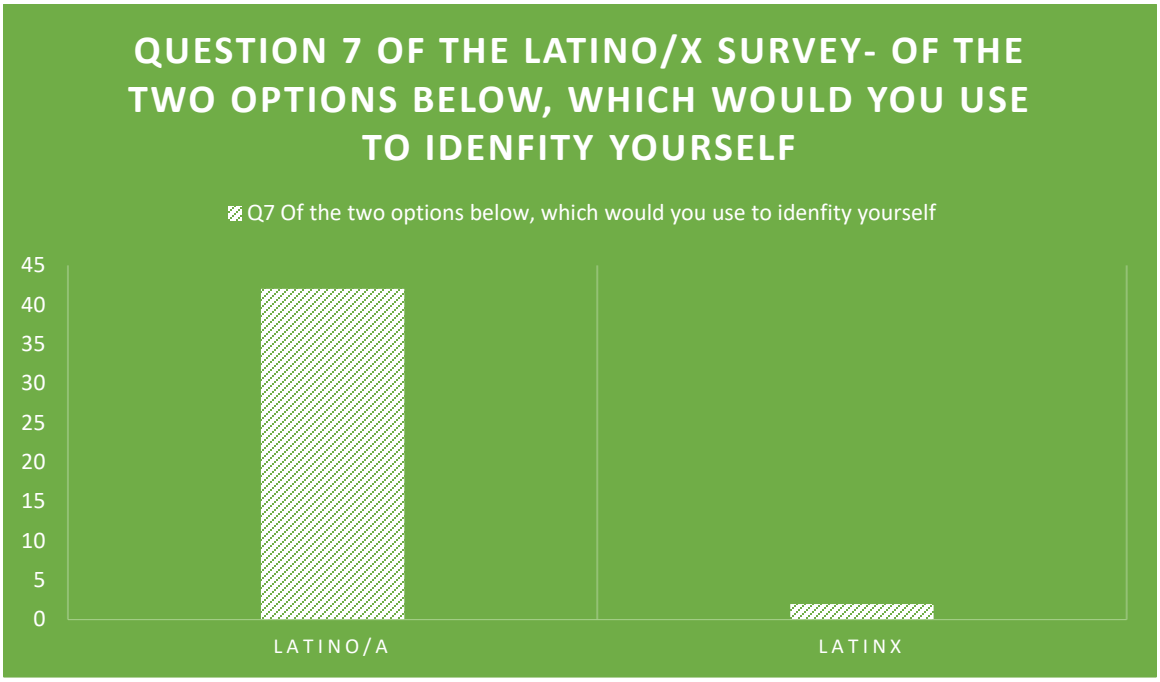
Appendix B- Latino/Latinx Survey Results

60% of the summit participants (45 of 74) attendees completed the Latino/a/x survey. Of those, 43 of the 45 confirmed they identify as Latino or Hispanic.
40 (88%) of the youth respondents identified as bilingual. Of the same 45 youth, 26 (58%) identified English as their primary language, with 18 (40%) identifying Spanish as their primary language. While this is a small sample size, it does show most the rural Latino youth do not self-identify as Latinx.

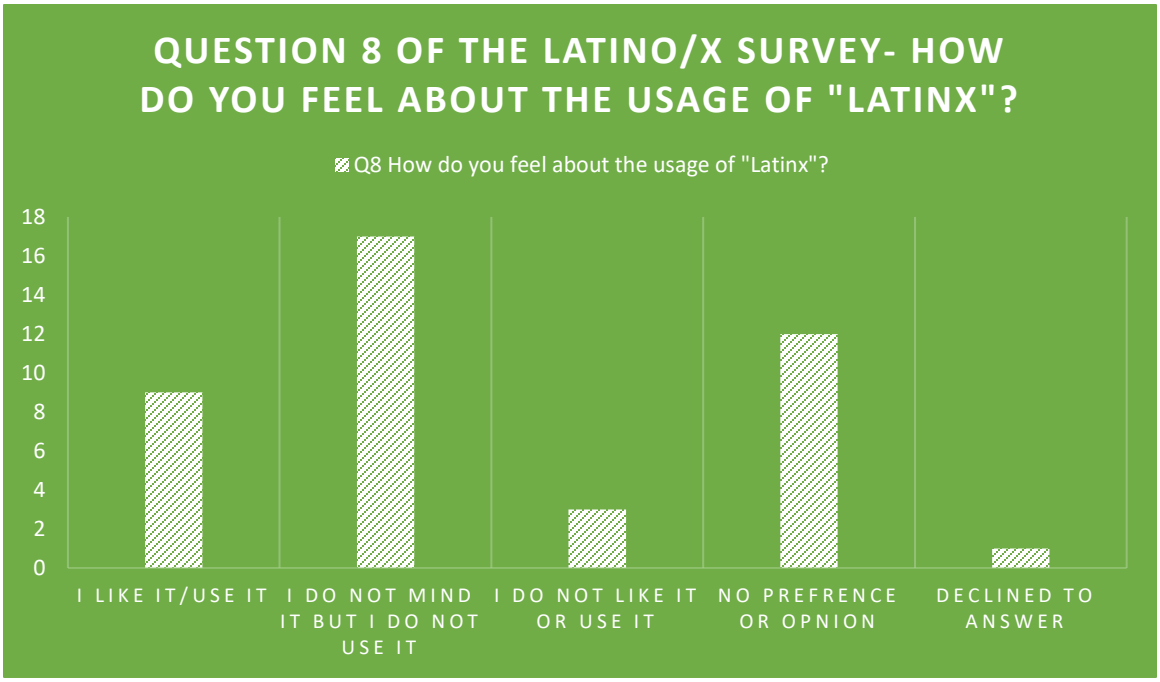
95% (42 of the 45) youth who responded to the survey do not identify themselves as Latinx. Only 4.5% of the respondent's self-identified as Latinx in the survey.

Interestingly, 38% of the youth did not "mind it, but do not use it" in reference to the term "Latinx". There were 27% who had no preference. Only 20% liked it, about 6% did not like the term, and 6% did not respond to that question.

Of the rural youth (most who are bilingual but consider English their primary language) identify as Latino/a. As far as usage goes, most do not have a strong position one way or the other. This does not mean that use of Latinx should not be used for those who self-identify as Latinx, but it does show that for purposes of communication and more effective engagement with this population they identify as Latino/a. This slight consideration may improve communication and make topics feel more applicable to them if the term Latino/a is used with engaging them. Noting this is a very small sample size.



The figure below shows a greater identification or usage of the terms by Latino/a or Latinx youth.



Appendix M – Huron Youth Wellness Summit Report

YOUR TIME YOUR VOICE
YOUTH WELLNESS SUMMIT

JUNE
4TH, 2024
8:00 AM TO 12:30 PM

YOUNG PEOPLE WANTED

Come **learn the foundations to wellness** and help us **shape the future care** that better responds to your generation and cultural needs.

FREE!

RAFFLE

FREE!
LUNCH/FOOD
PROVIDED!!!

- John Palacios Community Center
16846 4th St
Huron, CA 93234

THE LEAP INSTITUTE

City of Huron California
Incorporated May 3, 1951
The Heart of The Valley

Coalinga Huron Unified School District
School Based Mental Health & Wellness
Asking for help is a sign of strength

CH

The County of Fresno 1856
Department of Behavioral Health

Appendix D- Agenda

Your Time Your Voice Youth Wellness Summit- HURON

Agenda

7:30am- DBH team to arrive to set up.

8:00am- open doors, donuts and juice set out, students can come in.
Complete a sign-in to verify student attendance.

8:30am 8: 40am-Welcome Mayor from the City of Huron and Department of Behavioral Health

8:40m-8:50am-Level Setting Discussion **(**Fresno County Dept of Behavioral Health)

8:50am-9:30am Social Determents of Health (Department of Public Health)

9:30am to 10:10am- Soluna Presentation and Breath Work (Maria Mayes with Kooth)

10:10-10:15am Break/Raffle

10:15am- 10:35am-Enviromental Prevention Activity (Youth Leadership Institute)

10:35am-11:15am- Professional Development Round Robin

11:15-11:25am Break/Raffle

11:25am to 12:05pm Small group discussions to develop recommendations.

12:05-12:20 pm Report out their top two or three recommendations or policy ideas.

12:30pm- Final Raffael, start of lunch and conclusion.

1:15pm Begin clean-up/breakdown.

We will provide lunch for an hour (12:30pm to 1:30pm students can eat there, hang out, take their food to go, etc. We will have them sign out to get final incentive and food ticket (to be able to track those who where there the full program).

We will have tables in the back that will be out throughout the day with info and resources. During breaks or afterward students can visit to get more information. We are planning for the following:

- ***Department of Behavioral Health and Public Health***
- ***City of Huron***
- ***All4Youth***
- ***Central Valley Suicide Prevention Lifeline (988)***
- ***Soluna***
- ***Youth Leadership Institute***
- ***The LEAP Institute***, etc.

Appendix E- Acknowledgements

The Fresno County Department of Behavioral Health would like to acknowledge the support and assistance of the following individuals and organizations in bringing this effort to life.

- The LEAP Institute
- City of Huron
- The Coalinga-Huron School District
- Westside Family Preservation Services
- Central Valley Suicide Prevention Hotline/KingsView
- Fresno County Department of Public Health
- Youth Leadership Institute
- Fresno County Superintendent of Schools
- Espi Sandoval
- Maria Mayes- Kooth USA (Soluna)

References

Data USA: Huron, CA. (2024). https://datausa.io/profile/geo/huron-ca

World Population Review (Ed.). (2024). Huron, California Population 2024. https://worldpopulationreview.com/us-cities/california/huron

Appendix N – Community Needs Assessment of Punjabi Speakers

Jakara Movement &

Fresno County Department of Behavioral Health

Community Needs Assessment Results

Jakara MOVEMENT

THE COUNTY OF FRESNO

DEPARTMENT of BEHAVIORAL HEALTH

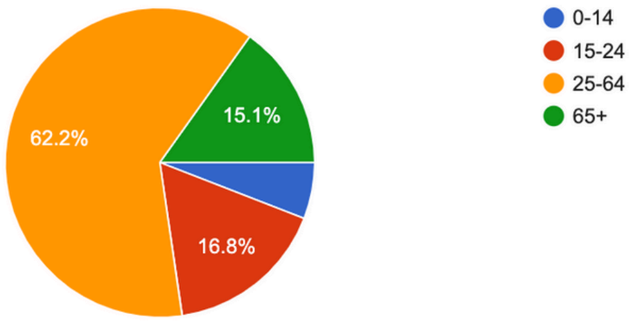
General Information

- 239 participants
- 6 weeks
- 6 in-person events
- Canvassing in low-income neighborhoods
- Text banking

Who We Connected With

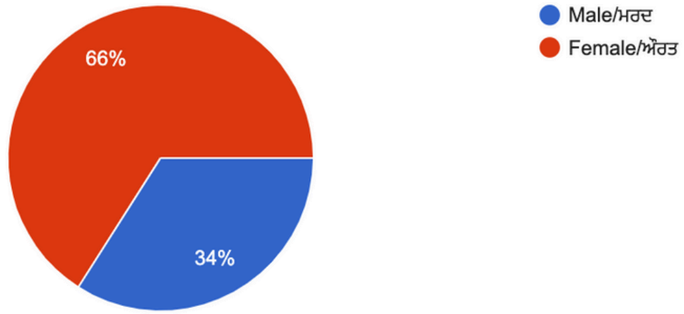
What is your age range/ਤੁਹਾਡੀ ਉਮਰ ਦੀ ਰੇਂਜ ਕੀ ਹੈ?

238 responses



Gender/ਲਿੰਗ

238 responses



Highest level of education/ਤੁਸੀਂ ਕਿੱਥੇ ਤੱਕ ਪੜ੍ਹੇ ਹੋ?

238 responses

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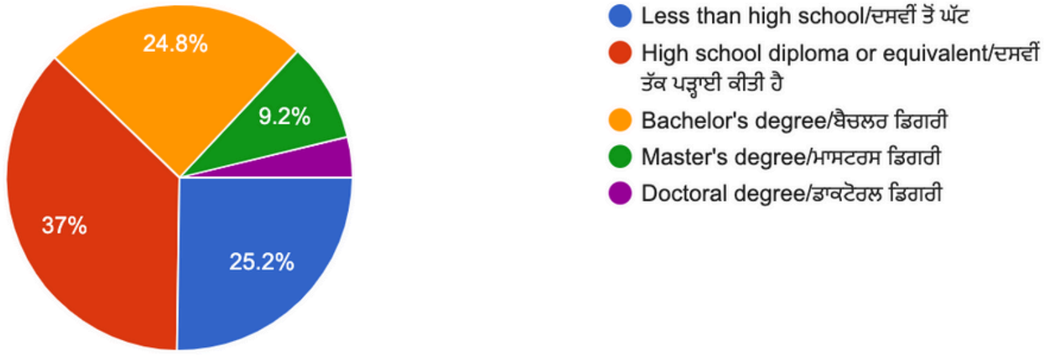


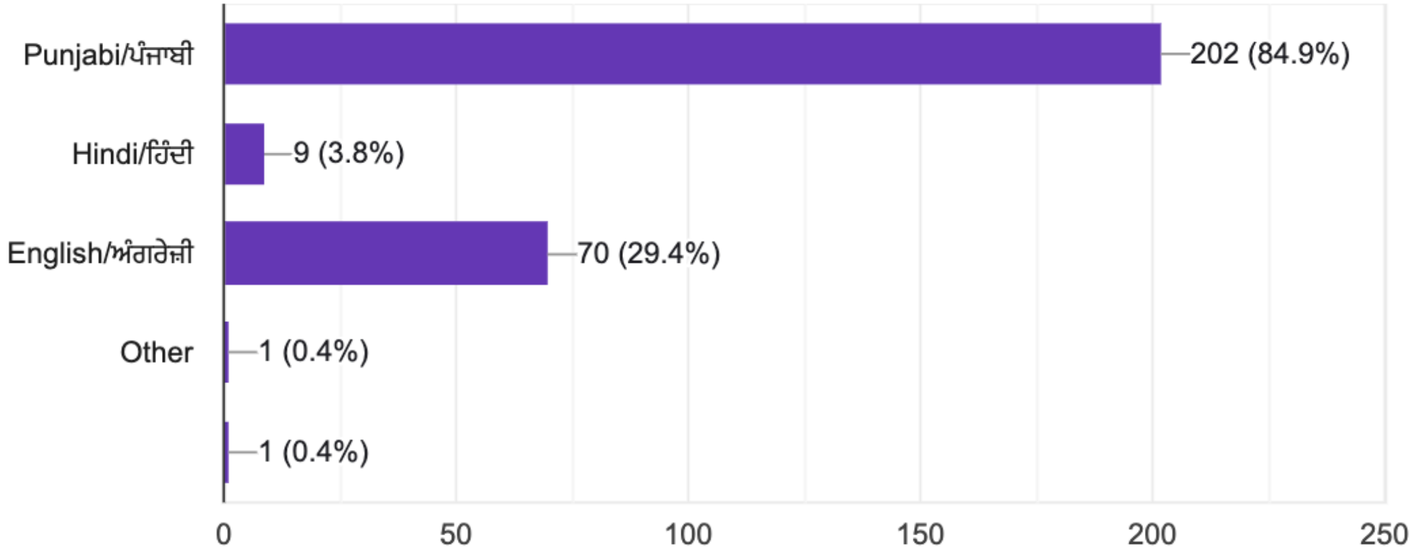
Where We Connected With Them

- Selma Gurdwara
- Pacific Coast Khalsa Diwan Society, Kerman
- Sikh Institute of Fresno
- Gurdwara Nanaksar, Fresno
- Gurdwara Nanaksar Sahib, Fresno
- Farmers Market at Jaswant Singh Khalra Park
- Door to door surveying in 93722 apartments

How We Connected

Preferred Language/ਮਾਂ ਬੋਲੀ

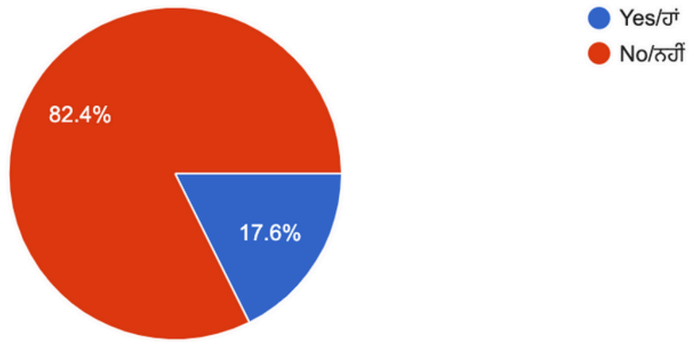
238 responses



What They Shared

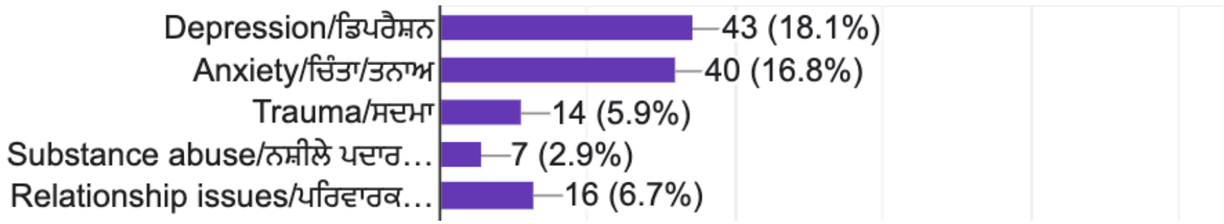
Have you/family ever accessed Behavioral Health resources or treatments?/ਕੀ ਤੁਸੀਂ ਜਾਂ ਤੁਹਾਡੇ ਪਰਿਵਾਰ ਨੇ ਕਦੇ ਵਿਵਹਾਰ ਸੰਬੰਧੀ ਸਿਹਤ ਸਰੋਤਾਂ ਜਾਂ ਇਲਾਜਾਂ ਤੱਕ ਪਹੁੰਚ ਕੀਤੀ ਹੈ?

238 responses



If yes, what were the primary reasons for seeking professional help? ' ਦੇ ਮੁੱਖ ਕਾਰਨ ਕੀ ਸਨ?

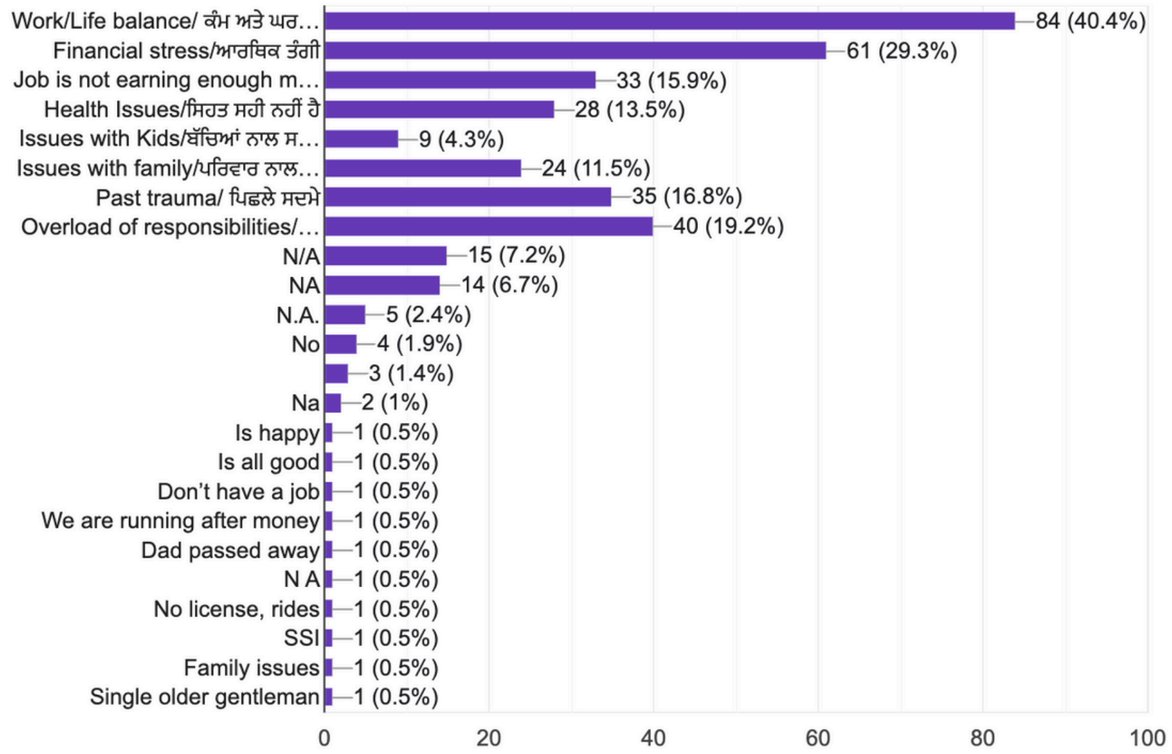
238 responses



What They Shared

What are your largest stresses in your life?/ਤੁਹਾਡੇ ਜੀਵਨ ਵਿੱਚ ਤੁਹਾਡੇ ਸਭ ਤੋਂ ਵੱਡੇ ਤਣਾਅ/ਸਟਰੈਸ ਕੀ ਹਨ?

208 responses



Barriers to access Behavioral Health resources and treatments/ਵਿਵਹਾਰ ਸੰਬੰਧੀ ਸਿਹਤ ਸਰੋਤਾਂ ਅਤੇ ਇਲਾਜਾਂ ਤੱਕ ਪਹੁੰਚ ਵਿੱਚ ਰੁਕਾਵਟਾਂ

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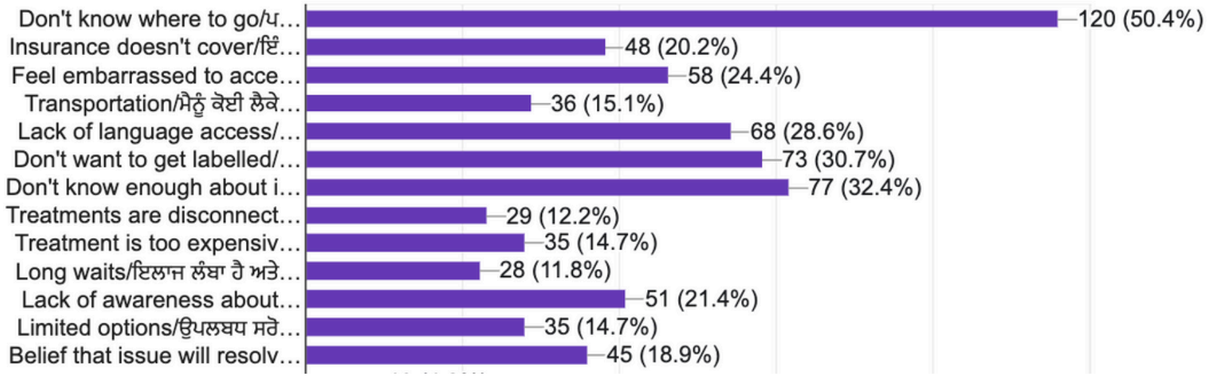
238 responses



What They Shared

How can we help to improve your access your/your family behavioral health?/ਅਸੀਂ ਤੁਹਾਡੀ ਪਰਿਵਾਰਕ ਵਿਵਹਾਰ ਸੰਬੰਧੀ ਸਿਹਤ ਤੱਕ ਪਹੁੰਚ ਨੂੰ ਬਿਹਤਰ ਬਣਾਉਣ ਵਿੱਚ ਕਿਵੇਂ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ?

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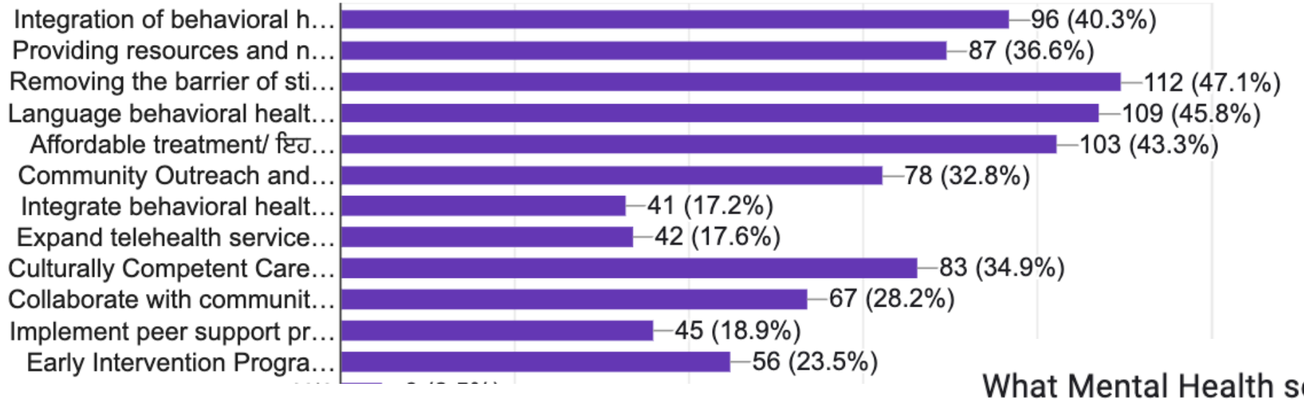
238 responses



What Mental Health services would you like to see to prevent suicide and other harms?/ਖੁਦਕੁਸ਼ੀ ਅਤੇ ਹੋਰ ਨੁਕਸਾਨਾਂ ਨੂੰ ਰੋਕਣ ਲਈ ਤੁਸੀਂ ਕਿਹੜੀਆਂ ਮਾਨਸਿਕ ਸਿਹਤ ਸੇਵਾਵਾਂ ਦੇਖਣਾ ਚਾਹੋਗੇ?

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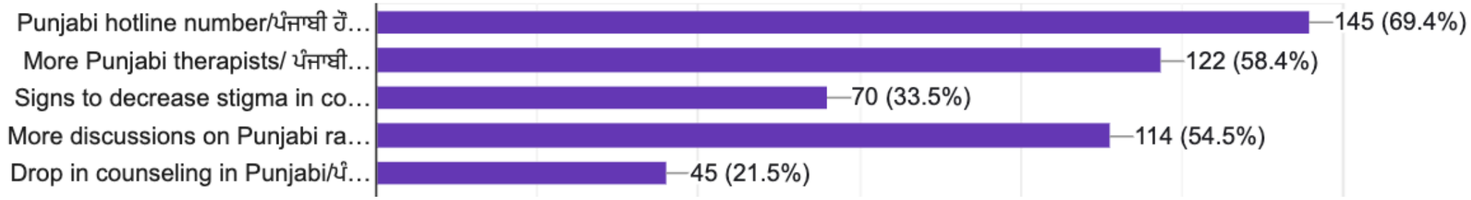
209 responses



Next Steps

- Do deeper data analysis looking for key connections with age, education, etc.
- Share data with community and community partners
- Develop some rudimentary interventions and follow up on suggestions and those that shared personal information
- Continue conversation with County partners to develop new interventions and programs

THANK YOU

JAKARA MOVEMENT

FINAL REPORT

Introduction:

This final report presents the findings of the first mental health survey conducted within the Sikh community in Fresno. Recognizing the importance of mental well-being, this study aimed to explore the unique challenges, experiences, and needs related to mental health in this vibrant and culturally rich community.

Fresno's Sikh population has made significant contributions to the local landscape, yet it faces specific mental health concerns that are often overlooked. Cultural stigma, acculturation challenges, and limited access to mental health resources can create barriers to seeking help and support. Through this survey, we sought to illuminate these issues, providing a platform for community members to voice their experiences and needs.

The data collected highlights key trends and insights, revealing both strengths and areas for improvement within the mental health landscape for the Sikh community. By understanding these dynamics, we aim to inform community leaders, mental health professionals, and policymakers, fostering a more supportive environment for mental well-being.

This report not only presents the findings but also emphasizes the importance of ongoing dialogue and action to address the mental health needs of the Sikh community in Fresno. Together, we can work towards building a healthier, more inclusive future.

Objectives:

The main objective of mental health survey is to assess prevalence and determinants of mental health disorders and substance use within the Punjabi Sikh population in Fresno County. This survey also focuses on identifying trends and assessing disparities in access to care, prevalence rates, and outcomes related to behavioral health issues in the target population. This survey also assessed effective communication and community engagement strategies that are crucial for promoting prevention, education, outreach, and care services as well as effective approaches to improving access to culturally and linguistically care.

Rationale:

Mental health issues significantly impact individual well-being and public health. By conducting this survey, we aim to fill gaps in current knowledge, provide actionable insights for stakeholders, and contribute to the development of informed policies and practices aimed at addressing behavioral health challenges within our community.

Methodology:

This behavioral health survey was conducted over a period of 6 weeks, targeting the Punjabi Sikh population of Fresno county. Participants were categorized into distinct age groups: 0-14, 15-24, 25-64 and 64+ to capture a comprehensive representation of age demographics.

The age group 25-64 constituted the largest segment of survey participants, comprising 62.2% of total responses. 16.8% constituted the age range of 15-24 showing the second in number of the notable presence of the young individuals and their related responses to behavioral health. 15.1% of the population constituted 65+.

Based on the survey data, it was observed that more than 95% of the responses recorded were from individuals identifying as Punjabi Sikh. Conversely, only 5% of the responses were from individuals identifying as part of the mixed population.

84.9% of the population reported Punjabi as their preferred language while 29.4% of the population reported English as their preferred language. 36.7% of the respondents were from the zip code 93722 followed by 19.4% responses were from zip code 93723 and 10.5% were from 93727.

Participants fill out written or electronic questionnaires independently, either online, through email, or in person.

The Jakara Movement employed a multifaceted approach to data collection, encompassing both in-person surveys at key community locations and outreach via phone banking.

In-Person Surveys:

- **Locations Visited:**
    i. Selma Gurdwara
    ii. Pacific Coast Khalsa Diwan Society, Kerman
    iii. Sikh Institute of Fresno
    iv. Gurdwara Nanaksar, Fresno
    v. Gurdwara Nanaksar Sahib, Fresno
    vi. Farmers Market at Jaswant Singh Khalra Park
    vii. Door to door surveying in 93722 apartments

Phone Banking:

- **Approach:**
  b. Jakara Movement staff and volunteers conducted phone banking activities.
  c. Reached out to community members via phone calls to gather survey responses and feedback remotely.
  d. Used this method to expand outreach beyond physical locations and engage individuals who may not have been able to participate in-person.

Findings and Discussion:

A total of 239 responses were recorded from the Punjabi Sikh community. 95.2% people reported of not getting any suicidal thoughts and thought about hurting themselves. Specifically, the largest stressor identified was related to maintaining a balance between work and personal life, affecting 40.4% of participants. Following closely, financial stress emerged as a substantial concern for 29.3% of respondents, highlighting its impact on psychological health. Additionally, 19.2% of participants cited an overload of responsibilities as a significant stressor contributing to their behavioral health challenges.

Of those surveyed, 67.2% indicated that they did not seek professional help. Among those who sought professional assistance, 18.1% did so primarily for depression, while 16.8% sought help specifically due to symptoms related to depression.

The survey revealed significant barriers to accessing behavioral health resources within the Punjabi Sikh community. About half (50.4%) of respondents reported not knowing where to seek help, indicating a lack of awareness. Additionally, 32.4% felt they didn't understand behavioral health well enough, highlighting gaps in knowledge. Another concern was stigma, with 30.7% fearing being labeled if they sought help. These findings emphasize the need for targeted education and culturally sensitive approaches to improve access to mental health support in the community.

A significant majority of respondents, specifically 69.4%, indicated that the establishment of a Punjabi hotline number could effectively contribute to preventing suicide and addressing other mental health-related harms within the community. This highlights the perceived importance of having culturally specific resources that are accessible and supportive.

Furthermore, 58.4% of respondents expressed a need for more Punjabi-speaking therapists. This highlights the demand for mental health professionals who can provide services in Punjabi, ensuring linguistic and cultural competence in therapeutic settings.

Moreover, 54.4% of respondents identified a need for more open discussions about mental health on Punjabi radio platforms. This reflects a desire for broader community engagement and awareness-building initiatives through accessible media channels that cater specifically to the Punjabi-speaking audience.

Addressing the question of how we can facilitate better access to behavioral health services for you and your family. The following responses were reported:

1. Reducing Stigma: 47.1% of respondents emphasized the need to remove the stigma associated with behavioral health issues. This suggests that cultural attitudes and perceptions play a significant role in accessing mental health services.
2. Availability of Behavioral Health Resources: 45.8% reported that having sufficient behavioral health resources is crucial. This likely includes having enough professionals, facilities, and programs tailored to meet the specific needs of the Punjabi Sikh community.
3. Affordability of Treatment: 43.3% identified affordability as a barrier that needs addressing. This underscores the financial challenges that individuals face in accessing mental health care.
4. Integration with Primary Care: The survey also mentioned the importance of integrating behavioral health services with primary care. This approach can make mental health services more accessible and normalized within the community.
5. Community Outreach and Education: Another highlighted point was the necessity of community outreach and education. This involves raising awareness about mental health issues, available resources, and destigmatizing seeking help.
6. Culturally Competent Care: Lastly, respondents emphasized the need for culturally competent care. This means that mental health services should be provided in a way that respects and incorporates Punjabi Sikh cultural beliefs, practices, and language preferences.

In response to open-ended questions about barriers and improving access to care, the Punjabi community highlighted specific needs. They emphasized the importance of providing services in Punjabi to address language barriers and called for culturally sensitive care at Gurdwaras. Workshops and open discussions were suggested as effective ways to raise awareness and reduce stigma.

Additionally, the community sees radio as a valuable tool for reaching people at the grassroots level. They believe community-based organizations can play a pivotal role in using radio platforms to discuss mental health openly and engage the community effectively.

In summary, the feedback stresses the need for culturally appropriate services, using radio for community outreach, and leveraging community organizations to tackle stigma and enhance mental health care accessibility among Punjabi speakers.

Conclusions:

Based on the data from the Punjabi Sikh community on behavioral health, several key findings have been noted. While a majority do not report suicidal thoughts or self-harm, many of them reported of significant stressors like work-life balance, financial strain, and overwhelming responsibilities. Despite these challenges, a considerable number do not seek professional help due to barriers such as lack of awareness, limited understanding of mental health, and fear of stigma.

The survey also highlights a strong preference for culturally tailored resources, including a Punjabi hotline and more Punjabi-speaking therapists. There is also a clear demand for increased discussions on mental health through accessible platforms like Punjabi radio and within the Punjabi community itself, indicating a need for broader community engagement and awareness.

The identified barriers—stigma, affordability issues, and the need for culturally competent care—highlight the urgency of targeted interventions. Efforts to reduce stigma, improve resource availability, integrate mental health services with primary care, and enhance community outreach and education are essential steps forward. These initiatives aim not only to improve access to mental health support but also to create a supportive environment that respects and addresses the unique cultural and linguistic needs of the Punjabi Sikh community.

In conclusion, addressing these findings requires collaborative action among healthcare providers, community leaders, and policymakers. By implementing culturally sensitive strategies, we can effectively support mental health and promote resilience within the Punjabi Sikh community, ultimately fostering a healthier and more supportive environment for all.

Appendix O - Community Needs Assessment- Mental Health Challenges Among of LGBTQ Youth In Fresno

Mental Health Challenges among LGBTQ Youth in Fresno, California

Introduction: Fresno, California, like many other regions across the state, grapples with significant mental health challenges among its youth population. Particularly concerning are the struggles faced by LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning) individuals aged 12-24. This report addresses the specific barriers encountered by this demographic in accessing mental health services and the broader landscape of mental health support in Fresno.

Demographics: In Fresno, the youth population aged 12-24 stands at approximately 200,000 individuals. Among those, LGBTQ youth aged 12-24, experience mental health issues at a rate 50-65% higher than their heterosexual counterparts did. This stark disparity underscores the urgent need for tailored and accessible mental health services for LGBTQ youth in the region. 60% of LGBTQ youth trying to access Behavioral Health Care in Fresno County rated the task as difficult to impossible.

Barriers to Access: The top three barriers identified by LGBTQ youth in Fresno when attempting to access mental health services are as follows:

1. **Timely Appointments:** A significant challenge faced by LGBTQ youth is the difficulty in securing timely appointments with mental health professionals. On average, individuals from this community wait six months for their first appointment, exacerbating their mental health concerns and prolonging their distress.
2. **Transportation:** Transportation barriers further impede LGBTQ youth's access to mental health services in Fresno. Limited access to reliable transportation options prevents many individuals from attending appointments, exacerbating feelings of isolation, and hindering progress toward improved mental health. Approximately 50% of all respondents who were able to make appointments for mental health services stated that transportation was difficult or impossible. This factor can harm client treatment outcomes and increase the likelihood of clients discontinuing services.
3. **Affirming Counselors and Therapists:** A crucial aspect of effective mental health support for LGBTQ youth is access to affirming counselors and therapists. However, more than 50% of LGBTQ youth report rating their service providers as a 1 out of 5 in terms of being affirming about their LGBTQ status. 85% of Transgender and Gender-expansive people rate service providers 1 out of 5 in terms of affirming mental health.

4. **Insurance/Finances:** 80% of respondents reported that finding a provider who accepted their insurance was difficult to impossible. Additionally, more than 50% of respondents who accessed services had some level of financial strain on their households because of attempting to improve their mental health.

Fresno EOC's LGBTQ+ Resource Center works with Mental Health partners that provide culturally and linguistically affirming services in the center. Program staff assisted in training these partners in how to provide affirming Mental Health Care and these partners are diligent about annual and ongoing training to continue providing culturally competent care. Program staff work to engage the LGBTQ+ community in prevention, education, outreach, and support services including Behavioral Health care services using a multi-prong approach for equitable engagement for all of Fresno County in its diversity. The program disseminates information in various ways (i.e. social media, flyer distribution) to communities about new services and resources. The LGBTQ+ Resource Center also provides training to community organizations and local businesses (including behavioral health, mental health, and substance use disorder treatment facilities) to improve their ability to provide affirming services to LGBTQ individuals, -including youth.

Training for the Fresno County Department of Behavioral Health was held on March 13, 2023, and included managers and supervisors of the department. The California Health and Human Services representatives recommended, at that time, that the training be available for all staff who engage with clients. This training would aim to increase the availability of affirming Mental Health care across Fresno County providers. Program staff hope to work together with all organizational structures in Fresno County in the future to improve access to equitable and affirming behavioral health care.

There was a total of 46 surveys and included the following data.

Age

11	Ages 0 – 14
35	Ages 15 – 24

Race

4	Caucasian/White
1	Middle Eastern North African (MENA)
5	African American/Black
4	Asian
2	Southeast Asian
2	Native American
0	Pacific Islander
19	Latino
9	Declined to State

Sex (assigned at birth)

18	Male
25	Female
3	Declined to State

Gender Identity

15	Male
20	Female
2	Trans Male to Female
2	Trans Female to Male
6	Gender Non-Binary
0	Other
1	Declined to State

Disability

8	Yes
32	No
6	Declined to State

Sexual Orientation

0	Straight
40	Gay/Lesbian
4	Bi-Sexual
2	A-Sexual
0	Other
0	Declined to State

Preferred Language (as identified by participant)

46	English
0	Spanish
0	Hmong
0	Punjabi
0	Other
0	Declined to State

Veteran Status

0	Yes
45	No
1	Declined to State

Fresno County Zip Code of Participant

32	93721
2	93722
2	93612
1	93619
2	93701
1	93704
2	93705
4	93706

Appendix P - Mental Training Training for Doulas.

CHAPTER 8

STRONGER FAMILIES: MENTAL HEALTH WELLNESS

IN THIS CHAPTER

Module 1- MATERNAL MENTAL HEALTH & WELLNESS
Module 2- ACEs
Module 3- FAMILY PLANNING AND BODILY AUTONOMY
Module 4- SAFER INFANT SLEEP

KNOWLEDGE OUTCOMES

☐Know and recognize symptoms of postpartum mood disorder
☐Demonstrate knowledge of PHQ-9 questionnaire and Edinburgh Postnatal Depression Scale
☐Provide support for bonding between new parents and baby
☐Apply knowledge to recognize signs of emotional distress, mental health challenges
☐Define trauma types through examples, including intimate partner violence
☐Explain the purpose and level of ACEs
☐Explain key considerations of appropriate environment for trauma sensitive care
☐Use language that is consistent with trauma-sensitive care
☐Build knowledge of support services, local resources specific to trauma care and intimate partner violence
☐Define SIDS and SUID and recall research data
☐Explain risk factors and unsafe practices contributing to SIDS and SUID
☐Demonstrate steps to help parents keep their babies safe while sleeping or in the sleeping area
☐Apply active listening techniques – Listen to Black women
☐Build your doula & client portfolio

ESSENTIAL QUESTIONS

- How can knowledge about mental health screening tools (ACEs, PHQ-9, EDPS, etc.) inform your doula work?
- How does mental health screening improve health outcomes?
- As a doula, how does your work contribute to safer infant sleeping environments?
- How is family planning related to health outcomes?

KNOWLEDGE CHECK

- For additional mandatory tasks, please go to Thinkific

KEY TERMS

ALLOSTATIC LOAD: Allostatic load refers to the cumulative burden of chronic stress and life events.

INTERCONCEPTION: The time period between pregnancies

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LARC: Long-Acting Reversible Contraception

PERINATAL MENTAL HEALTH: The birthing person's mental health state during and one year after pregnancy

SIDS and SUID: Sudden Infant Death Syndrome Sudden Unexpected Infant Death. Sudden Unexpected Infant Death (SUID) is the unexplained death of a baby younger than 1 year old. It occurs suddenly and unexpectedly. Sudden Infant Death Syndrome or SIDS is one type of Sudden Unexpected Infant Death (SUID)

MANDATORY PREPARATION

Abbreviations: Before class – BC

RESOURCE	DUE BY
MIHA Data Fresno County Snapshot 2013 -2015 https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/CDPH%20Document%20Library/2013-2015/SnapshotCo_Fresno_2013-2015_MaternalCharacteristics.pdf	BC

Related external training – certification to be provided before mid-point exam:

RESOURCE	RECOMMENDED DUE DATE	COST
Caltica - 2 Historical The Influence of Community Violence and Culture https://caltica-cirinc.talentlms.com/index	Within 2 weeks	0
ACEs AWARE https://training.ACEsaware.org/aa/pathway	Within 2 weeks	0
BWPC Safer Infant Sleep Training https://bwpc-edu.thinkific.com/courses/take/community-safer-sleep/texts/39538707-black-wellness-prosperity-center-our-babies-sleep-safer	Within 2 weeks	0
ACOG training: Addressing Perinatal Mental Health Conditions in Obstetric Settings https://www.acog.org/education-and-events/emodules/addressing-perinatal-mental-health-conditions-in-obstetric-settings (only part 1)	Within 2 weeks	0

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INTRODUCTION

Regardless of the outcomes of pregnancy and delivery, previously pregnant persons need support to recover, heal (physically and emotionally), and have a healthy and happy post-pregnancy life.

Monitoring emotional aspects and providing support for self-care is very important while serving Black birthing persons.

Depression during or after pregnancy is one of several perinatal mood disorders. It is a serious illness that does not simply go away. Detection and treatment are generally low, and they also show racial and ethnic differences. MIHA data tells us that Black women experience one of the highest percentages of depressive symptoms of all racial/ethnic groups during both the prenatal and postpartum periods. They are also least likely to receive the support they need.

Other factors, such as adverse childhood experiences (ACEs) can have a tremendous impact on life outcomes, including health. ACEs are common and preventable but disproportionately impact Black children. Data also shows that higher ACES scores can also contribute to negative birth outcomes.

Black infant mortality is 2-3 times higher than White infant mortality. Helping parents and caregivers understand what factors make the sleeping environment and sleeping positions safer will also reduce infant mortality rates and help Black families stay stronger and safer.

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MODULE 1 – MATERNAL MENTAL HEALTH & WELLNESS

A major part of holistic health includes mental health and wellbeing. Pregnancy and childbirth take a physical toll on the body. Even low-risk pregnancies come with a certain amount of negative stress. It is imperative for doulas to understand all aspects that influence a new mother, baby, and the family's wellbeing as well as their mental and physical health. Doulas must also have the tools and resources needed to help their clients thrive.

I. Allostatic load

As we covered in the first chapter, Black and racialized women experience "weathering". Weathering is the physiological and biological toll of experiencing systemic racism and other negative stressors. The impact can range from accelerated aging to immune system responses, leaving the body more vulnerable over time. Weathering and Black women's health deterioration in early adulthood as a physical consequence of cumulative socioeconomic disadvantage was hypothesized in 1990's by Arlene Geronimus[1], a researcher at the University of Michigan.

Allostatic load refers to the cumulative burden imposed by chronic stress and life events on the body. Allostatic stress is indicated by substances the body releases in response to stress and the effects that result from the release of these substances. Examples are elevated systolic and diastolic blood pressures, cholesterol levels, and glycated hemoglobin levels.

II. Mental health

Mental health is an important aspect of overall health. It includes emotional, psychological, and social wellbeing. It affects our health, social life, work performance, and every area of life. Every person at every state of life deserves mental health support and self-care. Mental health and wellness can change over time.

Black women, especially during the postpartum period, share that they feel guilty for not being able to take care of the home as much as they did before. The societal pressure to care for others and to always be "strong" can also negatively impact how mental health and self-care is understood.

Doula tip: As a doula, you are working on normalizing discussions around mental wellness. Mental health and wellness are on a spectrum. This simply means that everyone can improve their own mental health and experience adverse times. Community members, Black women, and men often share that mental wellness and caring for themselves is oftentimes stigmatized, understood as being pampered, and is confused with mental illness.

Video – View: Black women talk mental health and healing in powerful roundtable discussion https://www.youtube.com/watch?v=hOQsiSjlih4 [2] (7:44 minutes)

Video – View: BFL S1 E7: Mental Health - How to deal with stress & stigma of mental health in the black community? https://www.youtube.com/watch?v=6W1mNmqU4xY [3] (39:32 minutes)

Perinatal Anxiety

Perinatal anxiety is an excessive worry around pregnancy, childbirth, the baby, or postpartum. It is different than anxiety in a non-pregnant and non-postpartum state. Perinatal anxiety can appear from conception up to 1 year postpartum.

Perinatal anxiety might look different for each person experiencing it. Some might show only emotional, physical, or psychological symptoms, but some people might show a combination of all. Prolonged feelings of anxiety during

pregnancy or after can impact both the mother's and the baby's health outcomes. Mothers can develop high blood pressure. After birth, anxiety can impact the breastfeeding mothers' milk supply. Anxiety during pregnancy is a major risk factor of postpartum depression.

Dysthymia

It is a form of depression, also called persistent depressive disorder. People commonly refer to it as "high-functioning depression" because the person seemingly looks fine, they go to work, and the signs of mental distress are less obvious to an external eye. People who struggle with this form of depression might not be aware of it. Some experts warn against using this expression because it undermines the seriousness of the person's experience. Others look at it as a way of highlighting the variety of symptoms and the multiple ways depression can appear in an individual's life.

Stress

Black women are often the problem-solvers, educators, nurturers, and primary sources of income in their families–they are the key pillars of support for extended families. Toxic stress is more frequently experienced among Black women.

Experts, including ACEs experts, talk about categorizing stress types in the following groups:

- **Positive Stress:** Brief elevations in stress hormones, heart rate, and blood pressure in response to a routine stressor (e.g., a test, game).
- **Tolerable Stress:** Time-limited activation of the stress response that if buffered by relationships with adults who help the child adapt, the brain and other organs recover (e.g., natural disaster).
- **Toxic Stress:** High doses of adversity experienced during critical and sensitive periods of early development, without adequate buffering protections, can become "biologically imbedded" leading to the toxic stress response.

Toxic stress is a condition caused by prolonged exposure to severe stressors. It is a form of chronic stress that can have long-term negative effects on physical, mental, and emotional health. Toxic stress can be caused by a variety of factors, including poverty, abuse, neglect, or violence. It can also be caused by a lack of access to resources such as health care, education, and social support.

Toxic stress can have a variety of physical and psychological effects. These can include depression, anxiety, sleep disturbances, and changes in behavior. It can also lead to physical health problems, such as high blood pressure, heart disease, and diabetes.

The impact of toxic stress can be passed on to the baby in the womb and can increase the risk for the baby to experience adverse health outcomes. These can be developmental delays, sleep disruption, and failure to thrive. Toxic stress also has a negative impact on pregnant persons, increasing their risk of experiencing depression, high blood pressure, stroke, and heart disease.

Doula tip: The idea of "positive stress" might not be obvious for everyone. It is very individual how we each perceive tolerable levels of stress. A doctor's appointment can be stressful even if the care is excellent. The start of labor is exciting but also stressful. It is important to acknowledge what triggers a stress response in a person. As a doula, you can help your client by exploring with them self-care practices that can be easily accessible and work for them.

During pregnancy, new triggers can make women/birthing persons feel more worried. These things can include:

- Pregnancy discomforts
- Fear from bias interactions in healthcare settings
- Hormonal changes that can lead to sudden changes in mood and feelings
- Finances and other responsibilities
- Birth outcomes of birthing persons and babies and past traumatic events

Doula tip: Not all causes of negative stress can completely go away. Focusing on what is possible to be controlled is a good start to managing stress during pregnancy.

- Help your client anticipate sources of stress in the next 6 months
- Learn about your client's life and behavior before pregnancy
- Get to know your client to be able to provide individualized affirmations
- Start building a self-care plan
- Encourage your client to build their support community – forms of support can include help with groceries, running errands, or childcare. Circle of trust: talk to family and friends about worries. Join support groups.
- Encourage your clients to rest as much as possible – try to help them come up with a sleeping and rest routine.
- Exercises that are enjoyable (individual preferences) and are safe to do during pregnancy. If the situation allows, build a short walk into your appointment. For example, during the walk, you can also debrief the previous appointment, get a sense of how emotionally and physically your client is doing, and share an activity.
- Help them to take care of themselves: help them find simple activities in their routine that make them happy: read, weave, or get a massage/beauty appointment, etc.
- Encourage birthing persons to never minimize their health concerns
- Refer clients to perinatal health providers

III. Maternal and Infant Health Assessment (MIHA)

MIHA is an annual, statewide-representative survey. The survey started in 1999. The survey participants are women with a recent live birth in California. Participants are asked to self-report about their maternal and infant experiences and about maternal attitudes and behaviors before and after pregnancy.

The anonymous aggregated information is used to monitor the health of California's birthing population, and to inform the development of health policies and programs.

Tool – View: MIHA 2022 Survey
https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/CDPH%20Document%20Library/MIHA-2022-SAQ.pdf [4]

Tool – View: MIHA Data Snapshot, County of Fresno by Maternal Characteristics, 2013-2015
https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/CDPH%20Document%20Library/2013-2015/SnapshotCo_Fresno_2013-2015_MaternalCharacteristics.pdf [5]

Among others, MIHA shows racial differences in:

- Depressive symptoms and care: Black, Hispanic, or low incomes women or Medi-Cal for beneficiaries are more likely to experience prenatal and postpartum symptoms of depression but they are also less likely to receive appropriate care
- Workplace breastfeeding support: Black women are less likely to have workplace breastfeeding support than White women

- Intimate Partner Violence: Black women experience intimate partner violence during and after pregnancy at higher rates

IV. Baby Blues

This is a type of state of mental health that is normal after birth. It is characterized by feelings of sadness, irritability, and fatigue. Baby blues appear because of hormonal changes in the postpartum body. It usually starts a few days after giving birth and can last up to two weeks. It is important to note that the "baby blues" are a normal part of the postpartum period and do not usually require medical treatment.

Video – View: "Baby Blues" -- or Postpartum Depression? https://www.youtube.com/watch?v=6kaCdrvNGZw [6] (4.35 minutes)

V. Postpartum Depression

Signs and Symptoms

Postpartum depression, also known as perinatal depression, is a type of depression and mood disorder that affects individuals during pregnancy or after birth. Postpartum depression causes negative impacts to the mother's mental, emotional, and physical health, as well as causes challenges with bonding between mother and baby.[7] Symptoms of postpartum depression can look very different, but commonly includes feelings of guilt, anger, isolation, emotional withdrawal from the baby and fear of harming the baby. Physical symptoms can also manifest through increased blood pressure or unexplained pain or nausea from constant stress after delivery, trouble sleeping, problems with breastfeeding. Postpartum depression can lead to developmental and verbal complications in babies. [8]

Racial Disparities

Postpartum depression impacts approximately 1 in 8 new mothers, but like other adverse health outcomes, Black pregnant women and new mothers are at a higher risk of developing postpartum depression compared to other ethnic/racial groups. A variety of factors contribute to Black women experiencing higher rates of postpartum depression, including lack of access to quality healthcare services, high stress living environments, and exposure to trauma from racism and discrimination.[9] While barriers, shame, and stigma surrounding postpartum depression can exist across race and ethnicities, Black women face the most barriers to care for postpartum depression. These include past inaccurate diagnoses, distrust, and lack of representation in the healthcare system, perceptions of mental illnesses in the Black community, and racial discrimination in healthcare settings.[10]

A study from 2011[11] analyzed data of a subset of New Jersey's Medicaid beneficiaries who gave birth between 2004 and 2007. The study focused on postpartum mental health treatment initiation, follow-up, and receipt of continued care. The analysis found that, on the one hand, a disproportionate number of Black and Latina women who suffer from postpartum depression do not receive needed services. On the other hand, it also shows that even those Black and Latina women who started treatment had lower chances of receiving follow-up or continued care than their White counterparts. Finally, the study also shows further racial differences in care: Black women had higher odds of initiating care in an outpatient mental health setting, but Black and Latina women who initiated antidepressant use had much lower chances of refilling a prescription.

In the community conversations that BWPC has led, postpartum depression is a topic that often comes up as a significant challenge of motherhood. Community members often share their difficulties in recognizing signs and symptoms, seeking treatment, and experiences about communicating needs.

"- When I was pregnant, I had in the back of my mind that I'm going to take care of my baby this way, I'll do this or that. I just wanted to try everything with my baby. So, I realized I started drifting away from things I wanted to try. I just don't want to touch the baby. (…) I let the baby cry. So, I felt this is not normal. That is how I came to know that I don't think this is normal. (…) I guess he got what I really wanted to say, he understood me very well. He was never judgmental about me."

Video – View: Black Maternal Mental Health: Black Doula Consortium Webinar on August 31, 2021 https://www.youtube.com/watch?v=eO0ITx0d4Cc[12] (1:11:43 minutes)

Video – View: Listening to Mothers in California: Opening Up About Maternal Mental Health https://www.youtube.com/watch?v=1tjH68WRcXk&t=14s [13] (3:29 minutes)

VI. Screening

Screening for mental health and wellbeing throughout pregnancy and during the postpartum period is a critical component of early identification and support.

ACOG in its Number 757 Committee Opinion on Screening for Perinatal Depression[14] released in 2018 recommended that OBGYNS and other obstetric care providers screen patients at least once during pregnancy for depression and anxiety symptoms using a standardized, validated screening tool. If this screening happened, additional screening should then follow as a part of the comprehensive postpartum visit. There are many tools that clinicians use. ACOG does not endorse specific screening instruments. These include:

PHQ-9

PHQ-9 is a self-assessment tool that asks patients about their mental wellbeing over the past 2 weeks. Scores above 5 might indicate mild to severe depression. The tool requires clinician follow up to make sure that questions and answers were well understood, how the answers were given, and that any additional relevant information was also explored. PHQ-9 has 9 questions, and each question has a 4-point-scale answer.

The PHQ-9 tool is annexed to this chapter.

Edinburgh Postnatal Depression Scale (EPDS)

EPDS was developed to learn more about pregnant or postpartum women's mental health in the past 7 days. In particular, EPDS helps detect mothers suffering from postpartum depression. The survey has 10 questions in the form of statements. It is a self-administered tool given and followed up by clinicians. Score of 10+ or 12+ might require medical attention and a treatment plan.

The EPDS tool is annexed to this chapter.

Doula tip: While you are not a clinician, incorporating questions from these tools into your appointments can be beneficial. Each appointment should include assessing the client's well-being, recognizing signs of possible depression, and connecting the client with appropriate help.

Both screening tools include questions about having thoughts of self-harm. While not all self-harm thoughts indicate suicide attempts, certain types of these thoughts might be more indicative of that.

Video – View: Interview with Sayida Peprah - Understanding Maternal Suicide and Supporting Individuals at Risk https://www.youtube.com/watch?v=4ntWRViE3BU [15] (18:16 minutes)

MODULE 2 – ACEs

I. Adverse Childhood Experiences

In the previous chapters we touched upon the impact of adverse childhood experiences. The more we understand about ACEs and toxic stress, the clearer it becomes that toxic stress is treatable. Early detection and intervention seem to be effective parts of the solution.

Being ACEs aware and building it into prenatal care during pregnancy is one way that doulas can use to help coordinate a care plan and if needed, refer pregnant persons to the appropriate care resources. Most importantly, screening and referral to the appropriate level of care can help reduce the intergenerational transfer of poor outcomes and toxicity.

Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur when we are young. These include experiencing violence, neglect, and insecurity. ACEs and the associated toxic stress they create are the root causes of some of the most common health issues, including 9 of the 10 leading causes of death such as cardiovascular disease.

While ACEs are common, they are not to be taken lightly. The life expectancy of individuals with six or higher ACEs is 19 years shorter than that of individuals with none.

Resource – View: CDC: Adverse Childhood Experiences Resources
https://www.cdc.gov/violenceprevention/ACEs/resources.html [16]

II. Birth Outcomes and ACEs

It is known that ACEs can alter life trajectories as they impact mental health and the development in childhood. Research also shows that ACEs impact birth outcomes. A Wisconsin-based study[17] examined the birth outcomes of 1848 low-income women who gave birth between 2015 and 2018 and received services from home visiting programs. The researchers find that high-level of ACEs score undermine reproductive health as it increases the likelihood of pregnancy loss, preterm birth, and low birthweight.

Another recent research from 2021[18] examined the relation between ACEs, pregnancy, and birth outcomes, with a focus of pregnancy complications. Participants of this study composed of 1274 women enrolled in a perinatal collaborative mental health care program between 2017 and 2021. Participants were asked to complete the ACEs questionnaire and their health records were analyzed. The data revealed an association between the mother's high ACE score and hypertensive disorders of pregnancy and preterm birth.

Video – View: Understanding ACEs with Dr. Nadine Burke Harris
https://www.youtube.com/watch?v=Hh1idR1XkC4 [19] (7:18 minutes)

III. Screening Tools

ACEs

The ACEs screening tools have both de-identified and identified formats. In the former one, the respondents count the number of ACE categories on the screening tool and indicate only the total score. They do not need to put a checkmark next to the categories. In the identified screening format, respondents count the number of ACE

categories on the screening tool and by adding a checkmark, they indicate which ACE(s) they or their child have experienced.

Tool – View: Screening tools: https://www.ACEsaware.org/learn-about-screening/screening-tools [20]

Doula tip: Be mindful that your client might be experiencing these adverse experiences as you work with her. She may be under the age of 18 or may be older. These experiences might be emotionally and physically triggering her. For the ACEs to be discussed and meaningfully support clients, trust building and emphasizing confidentiality are essential.

PEARLS

Because of the impact of ACEs, it is also recommended to screen children for exposure to ACEs and other potential risk factors for toxic stress. The PEARLS has two sections, and it is completed by the caregiver.

Tool – View: Pediatric ACEs and Related Life Events Screener (PEARLS) https://www.ACEsaware.org/wp-content/uploads/2019/12/PEARLS-Tool-Child-Parent-Caregiver-Report-De-Identified-English.pdf [21]

IV. Trauma-Informed Care

In Chapter 3, we discussed trauma-informed approaches. The birthing population we serve is affected by various types of trauma, starting with the long-lasting impact of historical trauma and extending to Adverse Childhood Experiences (ACEs). Even those who have not extensively experienced trauma may take time to build trust. Some clients might need more time to understand the exact scope of a doula's work, as they may not know what to expect from each session and your support.

The list below provides a couple of practical considerations that can help build safe relationship with clients and are also trauma-informed. Considerations for discussing ACEs, trauma, and mental health:

- Emphasize confidentiality
- Relevance: Explain why you are interested in these questions and how traumas and mental health challenges can impact health outcomes and motherhood
- Emphasize that the client has the ultimate control over what she shares – you ask questions to help her, but it is up to her what and how much she shares. This can include refusing questions, taking breaks, coming back to questions later.
- In certain situations, clients are not ready to share. While asking about experiences, do not press for details. Short answers can be equally helpful in the process of opening up about traumas
- Praise and highlight her strengths that she is able to talk about her experiences. Highlight any details that demonstrates her strengths in surviving and living with the trauma
- Express that you are here to listen and help if you can. Her feelings and experiences are valid, you do not question those
- Help the client explore her feelings and support
- Watch out for any signs of distress and acknowledge when they come up. Try to explore your clients' self-soothing and reassuring strategies and provide space for building those into the conversations
- Check in on how she is feeling during and at the end of the conversation and if you can be of any support after the prenatal appointment

Video – View: Trauma Informed Care Champions: From Treaters to Healers: https://www.youtube.com/watch?v=KkeLz-fI0Mo [22] (11:49 minutes)

MODULE 3 – FAMILY PLANNING AND BODILY AUTONOMY

I. Interconception Health and Autonomy

Postpartum Check-up: The postpartum visit provides an opportunity for the provider to assess how the body is healing and discuss concerns. This is also a great time for patients to finalize their family planning (birth control/choice) options and work with their provider to develop an interconception care plan.

Interconception health is the period between pregnancies. During this period, the goal is to get to optimal health and address existing health conditions and health goals before getting pregnant again.

For example, if the birthing person has an untreated mental health condition or could benefit from improving nutrition, exercising, smoking cessation, or could benefit from achieving a healthier weight, this is the time-period to address the health conditions and get stabilized---*before* getting pregnant again.

Data tells us that about half of pregnancies are unintended. In 2011, a total of 6.1 million pregnancies occurred in U.S., and about 45% of these were unintended. Among groups such as teens, this number is much higher. Unintended pregnancies and births are also higher among Black women. Black and Hispanic women also give birth resulting from unintended pregnancies more often than White women.[23]

Another study[24] from 2010 analyzed data from the Early Childhood Longitudinal Study to examine childbearing intentions. The sample included 9,100 mothers of a cohort of children born in 2001. The research examined the link between relationship type racial and ethnic differences in childbearing intentions and the link between race and ethnicity and childbearing intentions (unwanted, intended, or mistimed) by relationship type. The results suggest for most relationship types (married, cohabiting or neither), Black mothers had higher relative risks than White mothers of having had an unwanted birth, rather than an intended or a mistimed one.

The reasons behind having an unplanned, unwanted, or mistimed pregnancy are complex. Factors include access to evidence-based and inclusive sexual health education, healthcare, narratives around healthy relationships, support for expectant and parenting youth, and a wide range of social determinants of health.

<u>Birth Spacing</u>

It is best to wait at least 18 months after giving birth before getting pregnant again. Having babies close together increases the risk of pregnancy complications and delivering preterm (birth before 37 weeks). Preterm birth is the leading cause of infant death in the U.S. before the baby's first birthday. Birth spacing allows mothers to recover from childbirth, address any chronic health conditions, and provides time for family planning.

An unplanned pregnancy can be stressful and difficult on the body. It can also add to the level of chronic stress experiences.

<u>LARC (Long-acting Reversible Birth Control)</u>

Long-acting reversible birth control (LARC) is a type of contraception that provides long-term protection against unintended pregnancy. It is a safe and highly effective form of contraception that can be used by women of all ages. LARC methods include intrauterine devices (IUDs) and contraceptive implants.

IUDs are small, T-shaped devices that are inserted into the uterus by a healthcare provider. They can be made from plastic, copper, or a combination of both. IUDs work by releasing small amounts of hormones or copper ions to prevent pregnancy. They are very effective at preventing pregnancy, with a failure rate of less than 1%. IUDs can last for up to five years, depending on the type.

Contraceptive implants are small, flexible rods that are inserted under the skin of the upper arm by a healthcare provider. They release hormones to prevent pregnancy and can last up to three years.

Doula tip: Each person will make a family planning decision based on their values. As a doula, your role is to support your clients with evidence-based education so that birthing persons can make an informed decision that is right for them. You may not agree with the decision—always remember to support bodily autonomy and support clients with evidence-based information in a respectful manner.

The family planning and reproductive health brief is annexed to this chapter.

II. Roe v. Wade and California

For almost 50 years the 1973 Supreme Court decision Roe v. Wade, recognized provided protection for the right to decide whether to continue a pregnancy. In 2022, a Supreme Court decision, Dobbs v. Jackson Women's Health Organization, overturned Roe v. Wade, ruling there is no constitutional right to abortion. In November 2022, Californians voted to approve Prop 1, which adds abortion and contraception rights to the state constitution.

Doula tip: There are many factors that impact one's pregnancy and contraception intentions. BLACK Wellness & Prosperity Center believes that women/birthing persons have a fundamental right to be the sole decision-making authority over their bodies and their healthcare. In our view, the right to access reproductive healthcare is non-negotiable.

We strongly believe that women/birthing persons are the experts on their body. Women know what they need. Every woman should receive ALL information and education to make an informed decision that is best for themselves and their families. All women deserve access to safe family planning options. Unintended and unwanted pregnancies can have implications on the health outcomes of the mother and baby. For these reasons, we are building evidence-based family planning in the doula education portfolio.

MODULE 4– SAFER INFANT SLEEP

BWPC's Safer Sleep Training for Parents & Caregivers is a mandatory training for BDN Doulas. Knowing what makes a sleeping environment safe is as much as important as knowing how to share this information.

Endnotes

[1] Warren-Findlow. 2006. "Weathering: Stress and Heart Disease in African American Women Living in Chicago." Qualitative Health Research 16 (2): 221–37. https://doi.org/10.1177/1049732305278651.
[2] "Black Women Talk Mental Health and Healing in Powerful Roundtable Discussion | Nightline." 2022. Www.youtube.com. Accessed October 3, 2022. https://www.youtube.com/watch?v=hOQsiSjlih4.
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EXTERNAL REVIEW OF
CHAPTER 8
STRONGER FAMILIES: MENTAL HEALTH AND WELLNESS

This document consists of four parts: 1) instructions for reviewers; 2) a general overview of the BLACK Doula Network (BDN); and 3) a review form to be returned to BWPC.

INSTRUCTIONS FOR REVIEWERS:

Thank you for reviewing the BWPC doula training curriculum. External reviews are an important part of ensuring the accuracy, neutrality, and quality of our work. Please review the following instructions/steps.

1) To learn about the project, please read the **GENERAL OVERVIEW OF THE BDN.**
2) All reviewers should complete and then return the **REVIEWER RESPONSE FORM**, the last few pages of this document.
    a. While reading the draft, add comments as they occur to you to **Table 1: Section and Page Specific Comments.**
    b. After reading of the draft, complete **Table 2: Analysis Evaluation**, to clarify whether the report meets its target.
    c. After reading for the draft, add broad comments and questions to **Table 3: Summary and General Comments**
    d. Return **REVIEWER RESPONSE FORM** to BWPC staff: Kata Nemeth: BDN@Black-Enterprises.com

GENERAL OVERVIEW OF BDN

The purpose of the external review is to help assure the accuracy, appropriateness of approach, completeness, and clarity of BWPC curriculum.

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Increasing mental health, wellness and resilience in the Black community is a horizontal objective of BWPC. Behavioral health is integrated into all our programming. Our BLACK Resource Center, a pregnancy and newborn care-focused resource library includes self-care, stress-relief, and postpartum depression resources. We provide pregnancy and wellness bags and offer free weekly community yoga as a stress-reduction resource.

As part of BWPCs strategic growth, we aim to 1). Increase the number of mental health access points and 2). Increase the knowledge, screening, and referral skills of our Black public health workforce, with a targeted focus on Doulas.

To achieve this, BWPC invested in two privacy pods, to increase the available space for mental health screenings, case coordination, and for use to community members for telehealth appointments.

Second, BWPC incorporated mental health education and screening tools into our doula training curriculum. Doulas are non-clinical professionals that support women before, during, and after pregnancy. Our doula training program is a rigorous first-of-its-kind training program that is approximately 125 hours and has been endorsed by the California Midwifery Association. Doulas are regarded as trusted partners during the perinatal and postpartum period and are well-placed to support behavioral health improvements through screening, identifying risk factors, and referrals to appropriate levels of care before, during, and after pregnancy.

Based on available data, priority curriculum and training topics include stress, postpartum depression, birth trauma, anxiety, and trauma. Soft-skills development includes motivational interviewing, mindfulness, conflict resolution, and cultural humility.

Our commitment to providing the highest quality of care to our community, demands a critical review of our training curriculum by a licensed behavioral health professional and assistance with development of a referral algorithm.

Your review is based upon your current knowledge of the field; reviewers are not expected to conduct their own literature reviews or background research.

NOTE: An identified deficit of this curriculum is the lack of focus on Black fathers and their experiences during pregnancy. BWPC co-developed and launched the Black Fatherhood Legacy program in 2021 (currently being reviewed) with Black men, which regularly provided a space for Black men to discuss topics relevant to mental health, pregnancy, and fatherhood. Some topics included Black manhood and fatherhood, loss and grief, and racism. BWPC plans to use the results of that program to enhance the curriculum in the next round of curriculum updates.

Effectiveness of Clinical Approach	a) The extent to the approach described in the curriculum, required external trainings, and BWPC education enhancements may be generally recognized (as demonstrated by a review of scientific and peer reviewed literature) by the behavioral health community as being effective in the training of lay persons to screen and refer for mental health conditions and trauma.
Public Health Impacts	a) The curriculum's potential impact on the health of the community, including the desirable health outcomes related to prevention (such as those provided by reduction of multigenerational effects).

EXTERNAL REVIEWER RESPONSE FORM

Date: 6/24/24

Reviewer Name: Dr. Alfonzo W. Tucker (Professional Psychologist).

Institution (if applicable): Noesis-3

Using the 3 tables that follow, please comment on the article.
Please note: Comments on specific wording, spelling, grammar, and format are not necessary.

Table 1: Section and Page Specific Comments. As you read the draft, please add comments, adding rows, as necessary.

Reviewer Initials	Section and Page Number of the draft	Comment (Example: Unclear sentences, leaps in logic, questions about approach, repetition, additional context, etc.)
AB	*Methodology, page 1*	*Here the reviewer adds a comment.*
AWT	Section 1, Maternal Mental Health and Wellness.	Although the opening information discusses *Weathering, for further assistance of the client it is believed that the curriculum would benefit from offering observational notes of the client and her then visual and perceived emotional appearance. For example, a MSE (Mental Status Exam) for which the evaluator would write a brief explanation describing the clients Appearance, General Behavior, questions related to insomnia and appetite, etc., and asking the client to self-describe their current feelings and note if the evaluator agrees.* https://psychscenehub.com/psychinsights/ten-point-guide-to-mental-state-examination-mse-in-psychiatry/#:~:text=Ask%20the%20patient%20to%20describe,have%20you%20been%20feeling%20recently%3F
AWT	Section II, Mental Health. (Positive Stress)	In this section the term Positive Stress is presented. It is believed by this evaluator that use of the term – Eustress is appropriate. For example, Eustress is the positive response which involves optimal levels of stimulation: a type of stress that results from challenging but attainable, enjoyable or worthwhile task. Use of this term formally i.e., Eustress may assist with clarity as to clinical meaning of positive stress so to prevent discombobulation. https://dictionary.apa.org/psychological-Eustress https://www.verywellmind.com/what-you-need-to-know-about-eustress-3145109

Reviewer Initials	Section and Page Number of the draft	Comment (Example: Unclear sentences, leaps in logic, questions about approach, repetition, additional context, etc.)
AWT	Section II, Mental Health (Toxic Stress)	In this section the term "toxic stress" is describes the possibility of physical and psychological effects, which is accurate. However, the clinical term more commonly used is Distress (A state of emotional suffering characterized by symptoms of depression, and anxiety). https://dictionary.apa.org/psychological-distress
AWT	Section III, Maternal and Infant Health Assessment (MIHA)	Within the opening statement of this section, the survey discussed (MIHA) is described as having taken place in after a recent live birth. As described in the article https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10684283/ there is a greater likelihood of PDS, did not discuss their symptoms accordingly within the first two to six weeks post pregnancy. Thus, offering information as to timeline for non-reporting of symptoms could increase PDS symptoms where prevention of more serious cases of PDS could be prevented with more frequent reporting measures.
AWT	Module 2 – ACEs, Section II. Birth Outcomes and ACEs.	Within the section the trajectories of the child's life are discussed via degrative impact within mental health and the development in childhood. It is the opinion of this evaluator that the theory of why the impact is negative should be presented through the lens of psychologist John Bowlby (I.e., Attachment Theory). https://www.simplypsychology.org/attachment.html#:~:text=Attachment%20theory%20suggests%20that%20there,avoidant%2Ddismissive%2C%20and%20disorganized.
AWT	Module 2 Section IV, Trauma Informed Care.	Within this section, Trauma Informed Care is discussed. It is the opinion of this evaluator that information relating to the theory of psychologist Tedeschi and Calhoun should be offered relating to Post-traumatic-Growth https://www.taylorfrancis.com/chapters/edit/10.4324/9781315805597-3/foundations-posttraumatic-growth-expanded-framework-lawrence-calhoun-richard-tedeschi

Reviewer Initials	Section and Page Number of the draft	Comment (Example: Unclear sentences, leaps in logic, questions about approach, repetition, additional context, etc.)
AWT	Module 3 – Family Planning and Bodily Autonomy	It is the opinion of this evaluator that information pertaining to women, most notably women of color, and how they would benefit for mental health treatment to help prevent postpartum depression could be reiterated in this section. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3733216/

Table 2: Analysis Evaluation. After reading the draft, please evaluate the following:

Criteria	Reviewer Initials	Rating 1 = unsatisfactory 2 = satisfactory 3 = exceptional	Comment (if necessary)
Is the background information accurate and objective? Neutral language should be used to discuss politically sensitive issues. Technical terms should be defined appropriately.	AWT	2	The background information is accurate and objective.

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Criteria	Reviewer Initials	Rating 1 = unsatisfactory 2 = satisfactory 3 = exceptional	Comment (if necessary)
Is the curriculum practical for non-licensed providers? The curriculum should equip non-clinical professionals with the necessary skills understand basic to intermediate mental health concepts and to recognize symptoms, screen, and refer for behavioral health issues	AWT	2	The information within this report is practical for a non-licensed provider.
Is the approach complete? The report should adequately address relevant issues of medical effectiveness for all patient populations especially women of color and possible public health impacts.	AWT	2	It is the opinion of this evaluator that the approach could offer more robust information in the area(s) of MSE (Mental Status Exam), and PTG (Post Traumatic Growth).
Are the supplemental trainings appropriate? External trainings should reflect relevant and timely topics from the highest quality source.	AWT	2	Yes, it is the opinion that the training information is updated, yet the sources could benefit from more peer-reviewed articles associated with the APA (American Psychological Association).

Table 3: Summary and General Comments. After a full reading of the curriculum please answer this table's high-level questions.

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Question	Reviewer Initials	Answer
What are the three high points? Please share three to four high points of the curriculum. This will help us know whether the curriculum is generally on track.	AWT	1. The Curriculum covers information presented in the "Knowledge Outcomes" discussed at the beginning of chapter eight. 2. The Essential questions are answered within the information presented. 3. Online information is offered within the "Resources" section.
Overall advice? Do you have any overall advice about the curriculum? This will help us think about "big picture" issues.	AWT	It is the opinion of this evaluator that information relating MSE (Mental Status Exam) and PTG (Post-Traumatic Growth), and updated language pertaining to Eustress, and Distress would offer a robust understanding within the curriculum.

Please return this form to BWPC staff by _____: Kata Nemeth: BDN@Black-Enterprises.com

FAMILY PLANNING

You and your partner deserve information about family planning or reproductive planning options. Information and planning will help you achieve your pregnancy desires.

PREGANANCY PLANNING

- **Choose a contraceptive that is right for you**
- **Talk to your provider about pausing your contraceptive**

YOU MAY OR MAY NOT CHOOSE TO HAVE CHILDREN. YOU HAVE CHOICES! REMEMBER:

- **Explore your contraceptive options** and choose the one that fits your life plans
- Schedule your reproductive health **appointments annually**
- Do a **breast self-examination at home** once per month
- Talk to your doctor about the right cervical and mammogram **screening routine** is right for you
- **Getting tested** for Sexually Transmitted Infections (STIs) and **discussing birth control options** with your partner is a healthy way to plan your future health and birth outcomes
- Only condoms provide protection **against both STIs and unintended or mistimed pregnancies**
- **This is your body** - you deserve to choose when you become a parent

WHEN CHOOSING A METHOD, CONSIDER FACTORS SUCH AS:

EFFECTIVENESS · STI PROTECTION · REVERSIBILITY · HORMONAL · LENGTH OF PROTECTION · FITS YOUR MEDICAL HISTORY · DESIGNED FOR FEMALE OR MALE ANATOMY · ACCESSIBLITY

LONG-ACTING REVERSIBLE CONTRACEPTIVES (LARC) ARE THE MOST EFFECTIVE AND REVERSIBLE METHODS FOR PREVENTING A PREGNANCY

INTRAUTERINE CONTRACEPTION

Levonorgestrel Intrauterine System (LNG IUD)

- It is a LARC
- Your healthcare professional places a small T-shaped device in the uterus
- Only your provider can insert it
- **Releases progestin hormone**

Top 4 Characteristics

- ✓ **Effectiveness - more than 99.9%**
- ✓ **Long Acting - Works for 3-8 years**
- ✓ **Reversible**
- ! **DOES NOT protect against STIs**

Copper T Intrauterine Device (IUD)

- It is a LARC
- Provider places a small T-shaped copper-wired plastic device in the uterus
- Only your provider can insert it
- **It is non-hormonal**

Top 4 Characteristics

- ✓ **Effectiveness - more than 99%**
- ✓ **Long Acting - Works for up to 10 years**
- ✓ **Reversible**
- ! **DOES NOT protect against STIs**

HORMONAL METHODS

Implant

- It is a LARC
- A thin rod is inserted under the skin of the upper arm
- Only your provider can insert it
- Hormonal methods can cause changes in the period and may take time for the body to adjust

Top 4 Characteristics

- **Effectiveness - more than 99.9%**
- **Long Acting - Works for 3-years**
- **Reversible**
- **DOES NOT protect against STIs**

Injections

- A healthcare professional injects your arm or buttocks every 3-months with a hormonal shot
- Effective for 3-months
- May cause weight gain
- Hormonal methods can cause changes in the period and may take time for the body to adjust

Top 4 Characteristics

- **Effectiveness - 96%**
- **Long Acting - Works for 3-months**
- **Reversible**
- **DOES NOT protect against STIs**

Oral Contraceptives

- Pills must be taken daily at exactly the same time
- May cause breast tenderness
- Most oral contraceptive pills require prescriptions
- Hormonal methods can cause changes in the period and may take time for the body to adjust
- **Opill is the first over-the-counter (does not require a prescription) contraceptive pill** that is available in some stores in the U.S.

Top 4 Characteristics

- **Effectiveness - 93%**
- **Must take daily at the same time**
- **Reversible**
- **DOES NOT protect against STIs**

Patch

- A healthcare professional prescribes the patch
- The patch is placed on the lower abdomen, buttocks, or upper body for 21-days in a row and there is a one-week break
- May cause breast tenderness
- Hormonal methods can cause changes in the period and may take time for the body to adjust

Top 4 Characteristics

- **Effectiveness - 91%**
- **Must wear one for 3-weeks**
- **Reversible**
- **DOES NOT protect against STIs**

Vaginal contraceptive ring

- You place the ring inside your vagina and leave it inserted for the period of time instructed by your provider
- The ring releases the hormones progestin and estrogen
- May cause irregular bleeding

Top 4 Characteristics

- **Effectiveness - 93%**
- **Self-placed**
- **Reversible**
- **DOES NOT protect against STIs**

BARRIER METHODS

External Condoms (penis)

- Condom is placed over the penis
- Single-use only
- Several types are available

Top 4 Characteristics

- **Effectiveness - 87%**
- **Not reusable**
- **PROTECTS against STIs**

PERMANENT METHODS OF BIRTH CONTROL

Tubal litigation (uterus)

- A surgical procedure to cut, block, or seal off the fallopian tubes to prevent the sperm from reaching the egg
- May cause bloating, abdominal cramps, and nausea
- **Non-hormonal method**

Top 4 Characteristics

- **Effectiveness - more than 99%**
- **PERMANENT**
- **NOT REVERSIBLE**
- **DOES NOT protect against STIs**

Vasectomy (penis)

- A healthcare professional cuts and closes the tubes that carry sperm from the testicles
- Does not impact overall health
- **Can be reversed but no guarantee of fertility**

Top 4 Characteristics

- **Effectiveness - more than 99%**
- **Vasectomy reversal may be possible**
- **DOES NOT protect against STIs**

EMERGENCY CONTRACEPTION

- Methods can be: **Copper IUD insertion** or **emergency contraception pills**
- Can be used AFTER unprotected sex or birth control method fails
- Reduces the chance of pregnancy for up to 5-days after having unprotected sex
- May affect period and have some mild side-effects
- There are three different types of pills available in the U.S.
- **Levonorgestrel** tablet 1.5 mg, is a non-prescription product without age restrictions

Top 4 Characteristics

- **Timing and method impacts effectiveness**
- **Single-time use**
- **Used by persons with a uterus**
- **NOT a regular form of birth control**
- **If your weight is over 165 pounds, the effectiveness of the emergency contraceptive pill may decrease**

QUESTIONS TO ASK YOURSELF & YOUR PARTNER:

- What method is the most consistent with your shared family planning goals?
- What additional information is needed about family planning?
- What method is right for your medical history?
- How do you share the costs of safe family planning?
- What makes you feel safe and respected in your relationship?

LEARN MORE:

- womenshealth.gov/a-z-topics/emergency-contraception
- cdc.gov/reproductivehealth/contraception/index.htm
- hopkinsmedicine.org/health/treatment-tests-and-therapies/tubal-ligation
- stanfordhealthcare.org/medical-treatments/v/vasectomy/procedures.html

Updated: 3/29/2024

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USE OF DOULAS IN BEHAVIORAL HEALTH & WELLNESS
FINAL NARRATIVE
PROCUREMENT AGREEMENT NUMBER: P-23-44323-443
ORGANIZATION: BLACK WELLNESS & PROSPERITY CENTER (BWPC), 2201 CALAVERAS STREET, FRESNO, CA, 93721
GRANT PERIOD: AUGUST 30, 2023 - JUNE 30, 2024
DATE: 7/1/2024

DELIVERABLES:

- **Enhance BLACK Doula Training Curriculum's relevant chapter to integrate behavioral health component:**

Expert review and training specific to doulas:
During the fall of 2023, we engaged the expertise of a licensed behavioral health professional, Dr. Alexandra Addo-Boateng, to review the chapter of our doula training curriculum dedicated to perinatal and postpartum mental health. This chapter was assigned as mandatory preparation for all training participants. In collaboration with the professional, we co-facilitated a specialized session tailored for doula trainees. The primary aim of this session was to deepen the participants' understanding of perinatal anxiety and postpartum mental health disorders, equipping them with the skills to effectively recognize signs and symptoms. The session concluded with a practical exercise where participants were guided through the questions and scoring of various screening tools. Additionally, training participants gained insights into potential interventions and treatments commonly employed by mental health professionals. This hands-on approach enhanced their ability to apply their knowledge and support clients experiencing perinatal and postpartum mental health challenges effectively. For example, it provided them with sample questions to explore anxiety and stress level and effective coping strategies. This process not only enriched the training experience but also facilitated the identification of additional areas related to perinatal mental wellness. Following the training, in the past months we made progress on integrating content we identified after the training (obsessive-compulsive disorder (OCD) during and after pregnancy, and ADHD). Furthermore, we established a temporary referral system to streamline the process of connecting clients with appropriate mental health support services as needed. The training benefited 14 participants.

Community Resource Directory: Community linkages:
In collaboration with another partner organization, we have started to develop a Fresno-specific community resource directory. This resource's purpose is to facilitate effective linkages to resources and services for clients. Through desk research and information sharing, our team organized information into a user-friendly and searchable format. This resource is integrated into the doula training, and serves as a valuable tool for doulas, family advocates and other case workers as it points to verified resources. The directory also integrates a Black provider list and behavioral health resources.

- **Training content endorsed by a licensed professional - clinical professional review specific to doulas and CHWs:**

We have contracted another licensed professional, Alfonzo Tucker, to further enhance our ability to support birthing clients and their families. The first set of activities included a written evaluation and recommendations for enhancing the chapter's accuracy, neutrality, and quality of our work. According to the expert opinion, the training is currently practical for non-licensed providers, and the content is accurate and objective. The evaluation provided additional directions to consider, including bonding and attachment theories, communication, Mental Status Exam (MSE), and Post Traumatic Growth (PTG). The second set of activities included a training (see below).

- **Black Maternal Child Health workforce/ Doula professional educational opportunities:**

Trauma-informed care opportunities:

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ACEs: In April, Surgeon General, Dr. Diana Ramos attended the 2024 Black Maternal Health Symposium as a special keynote speaker. Her talk focused on Adverse Childhood Experiences (ACEs). The event was attended by 100 participants, including doula trainees, certified BWPC doulas, and all BWPC staff. The event was recorded, making the talk a valuable training asset for our team to use in future doula and Community Health Worker (CHW) education. Dr. Ramos's talk established the science behind of trauma-informed care in healthcare, which laid the foundations of the upcoming trauma-informed care training with Dr. Alfonzo Tucker.

Trauma, communications, mental health training: In June, we organized another training opportunity facilitated by Tucker. We implemented a trauma-informed care and case management training specifically tailored for allied health professionals, with a focus on doulas, CHWs, and case coordinators. The training built on the doula training curriculum and the online ACEs Aware training, which was a prerequisite. The training benefited 22 participants.

Mental wellness access points – Infrastructure expanded -Privacy pod:
Prior to launching the first privacy pod, BWPC asked staff and community partners to visit various pods during different opportunities (airport sleeping pods, breastfeeding pods, sporting events, mobile units etc.) and then report back their experience of being in a small, confined space. Anecdotally, all the feedback was positive with not concerns voiced about feelings of confinement. This grant, in partnership with an additional grant from the Sierra Health Foundation, allowed BWPC to invest in our infrastructure with the addition of two mental health and social services coordination access points. The first privacy pod was formally introduced to the community during Black Maternal Health Week 2024. Several hundred community members, including CBO partners, had the opportunity to learn about its future use as a mental health access point and appointment space.

Appendix Q - Supporting Staff Success At Times of Increased Stress – Consultation and Development of Training

Supporting Staff in Times of Increasing Stress Survey Results

Prepared by Heliana Ramirez, PhD, LISW

One June 24-26, 2024, Fresno County Behavioral Health staff attended the training event "Supporting Staff Success in Times of Increasing Stress." **The training addresses psychological safety and nervous system regulation as key to employee wellness and team success.**

35 of 40 training registrants completed a survey about their workplace experiences of support and stress for the purpose of tailoring the event to their interests and motivations for attending the event. Some questions were skipped.

Questions by Page

Executive Summary

Ranked interests in training topics:

Workplace stress reduction tips and activities (N=28)
Activities to settle the nervous system (N=25)
Information about workplace psychological safety (N=20)
Information about Racial Battle Fatigue and Racelighting (N=14)
To develop distress tolerance for Accountable Allyship (N=13)

Burnout:

51.43% occasionally feel burnout
17.14% always feel burnout
17.14% often feel burnout
14.29% are not burntout

Resourcing to reduce burnout and stress:

31.43% Occasionally receive resourcing
28.57% Often receive resourcing
20% Not applicable- I do not tell supervisor about my burnout
8.57% I always receive resourcing

77.14% feel **Somewhat (46%) or Mostly (31.4%) Comfortable** being authentic self at work.

Psychological Safety themes include Supervisors/Directors' communication (e.g., acknowledging high workload, thanking employees for their work), inviting staff feedback, and messaging that "if something doesn't work out, it's ok." Collegial relationships based on trust and respect, consistency of teaming, and communication (e.g., safe spaces to share opinions and feelings) also increase psychological safety.

Psychological safety is undermined when workspaces are infused with inescapable politics, pressure to go with the crowd in "safe spaces," indirect and inefficient communication, continuous overwhelm and failed attempts of new processes created by administrators, lack of communication, judgement, willful ignorance and intolerance, lack of supervisor support, losing promotional opportunities, micromanaging, potlucks, and unrealistic expectations.

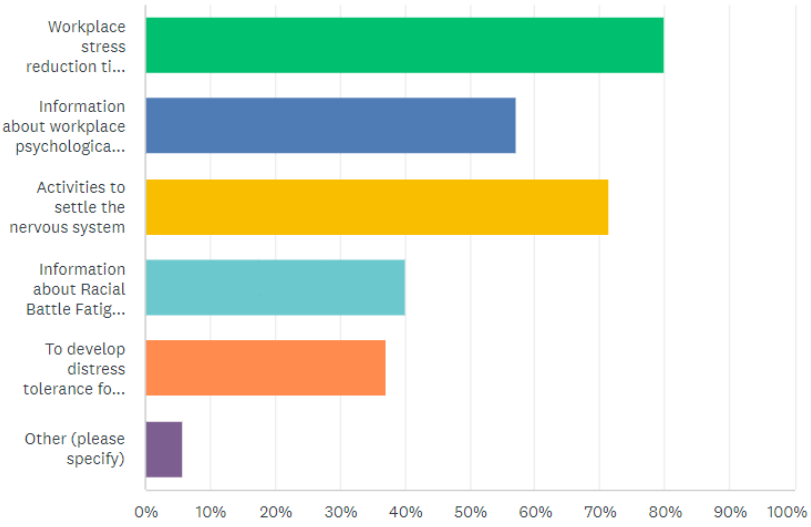
When staff support psychological safety by interrupting bullying or discrimination, a variety of outcomes follow from nothing being done to being rewarded and supported and mixed responses. Some people are unaware of outcomes and others report there is no bullying or discrimination in their area and another person mentioned low morale in their team due to retaliation against people who ask questions and point out issues.

Examples of courageous conversations include discussions about reorganization, inclusivity, and transparency. Several people mentioned being unaware of courageous conversations while others made recommendations for future courageous conversations including "Learn more about Mexican/ Americal Mental Health studies in adversities" and another person suggested that staff who ask for time off for stress be given that time off without asking questions.

Question 1: Training Interests

What are you most interested in receiving from this training? Please select all that apply.

Answered: 35 Skipped: 0



ANSWER CHOICES		RESPONSES	
Workplace stress reduction tips and activities		80.00%	28
Information about workplace psychological safety		57.14%	20
Activities to settle the nervous system		71.43%	25
Information about Racial Battle Fatigue and Racelighting		40.00%	14
To develop distress tolerance for Accountable Allyship		37.14%	13
Other (please specify)	Responses	5.71%	2

Other Comments:

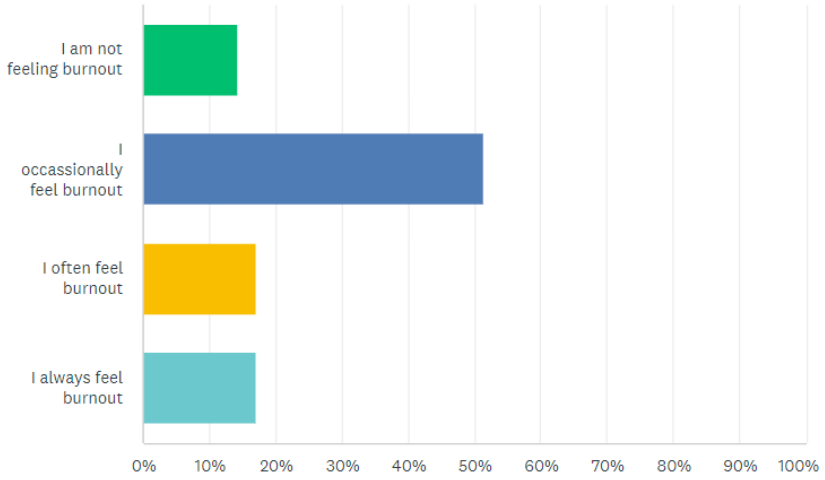
"I'm not sure what to expect or anticipate."

"N/A"

Question2: Burnout

Burnout describes a sense of exhaustion, detachment, cynicism, and/or lack of interest due to chronic stress at work or in one's personal life. To what extent do you feel burnout? Please choose one option.

Answered: 35 Skipped: 0

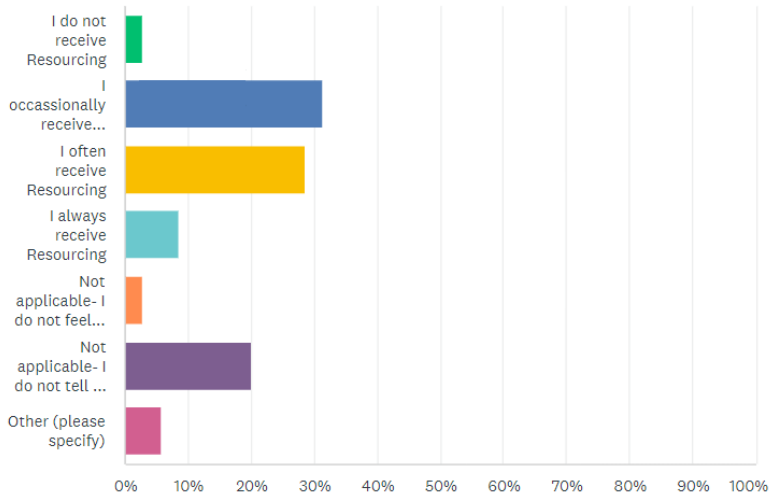


ANSWER CHOICES	RESPONSES	
I am not feeling burnout	14.29%	5
I occassionally feel burnout	51.43%	18
I often feel burnout	17.14%	6
I always feel burnout	17.14%	6
TOTAL		35

Question3: Resourcing that reduces staff stress and/or burnout

Resourcing describes supportive words, actions, and tangible resources that reduce employee stress and/or burnout (e.g., Employee Assistance Programs, Employee Resource Groups, sick and vacation leave, supervisor responsiveness to concerns about workload, bullying, or discrimination). To what extent do you receive Resourcing when you report stress or burnout to your supervisor or Human Resources (HR)?

Answered: 35 Skipped: 0



ANSWER CHOICES		RESPONSES	
I do not receive Resourcing		2.86%	1
I occassionally receive Resourcing		31.43%	11
I often receive Resourcing		28.57%	10
I always receive Resourcing		8.57%	3
Not applicable- I do not feel stress or burnout at work		2.86%	1
Not applicable- I do not tell my supervisor or HR when I feel stress or burnout.		20.00%	7
Other (please specify)	Responses	5.71%	2

RESPONSES (2) WORD CLOUD TAGS (0) Sentiments: OFF

Other Responses:

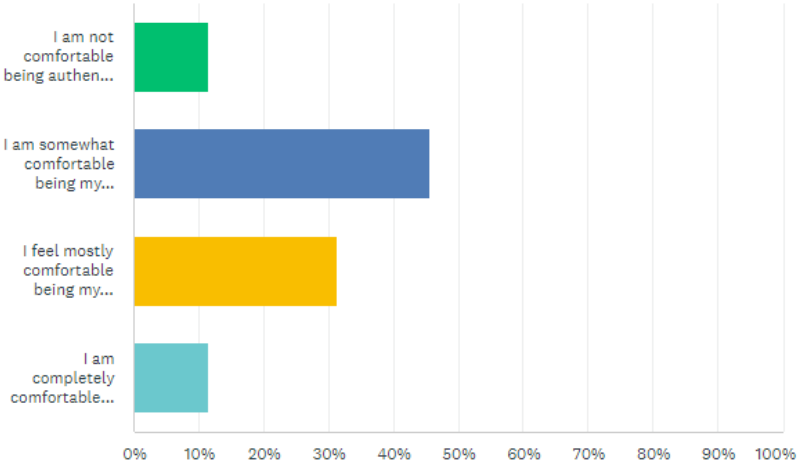
"My supervisor is helpful, but I never reach out past her. #1 there appears to be no need #2 involving HR only complicates the situation and work make more work our of being overwhelmed"

"Staff appreciation is once a year and surveyed to death before it happens, not the most rewarding or stress-free experience. I take my own time off because although my immediate supervisor is understanding and supportive, HR, and documentation will only fuel the fire. As an employer you should know when your staffing levels are down, you should know when your workloads are too heavy, and you should support and maintain the damn before it breaks."

Question 4: Being Authentic Self at Work

To what extent do you feel comfortable being your authentic self at work (e.g., sharing information about your culture, speaking in ways that are natural to you, wearing your preferred hairstyle or cultural clothing styles)?

Answered: 35 Skipped: 0



ANSWER CHOICES	RESPONSES	
I am not comfortable being authentic at work	11.43%	4
I am somewhat comfortable being my authentic self at work.	45.71%	16
I feel mostly comfortable being my authentic self at work.	31.43%	11
I am completely comfortable being my authentic self at work.	11.43%	4
TOTAL		35

Question 5: Psychological safety is the sense that it is ok to share honest opinions and make mistakes without being chastised, humiliated, or retaliated against. What if anything increases your psychological safety at work?

#	RESPONSES
1	Not sure.
2	Not having things mention in a safe environment come back later in another context:environment.
3	The opportunity my supervisor gives us to share our ideas relating to our assignments and the disclaimer she gives that if something doesn't work out, it's ok.
4	Ability to talk with staff
5	Mandatory in person meetings that can be done remotely just to make us come in. People say so they can see our faces but I don't want them to look at my face
6	Rapport with supervisor
7	Repetitive safety. The same division or team or supervisor or work load. Consistency, continued experience of being safe is what will make me feel safe
8	transparency, communication, support from fellow staff
9	I would like to have more knowledge on how to manage stress in my work environment.
10	Able to feel safe and comfortable. Allowing focus to complete work assignments.
11	Mutual trust and respect between my colleagues.
12	Validation. Non judgement
13	Teamwork
14	A supportive supervisor
15	Work drama and work politics.
16	Safe zones to express feelings
17	Open communication
18	Rational/Understanding supervisors & managers
19	When I do not feel supported
20	N/A
21	Knowing and feeling supported by managers/supervisors as it relates to discussing processes, staff issues, etc.
22	The support of my team.
23	Having a supervisor that is understanding.
24	friendships
25	feeling free to express myself. being able to talk about my family, culture, background without judgement.
26	Knowing my supervisor is a Republican, (political topics are always initiated by them). They also listen to a conservative talk radio show with their door open throughout the day (were other staff such as myself can hear).

27	Time with the same team, work, etc. Working with and spending prolonged time with a team without incident or issue makes me feel psychologically safe to be honest.
28	When a Deputy Director or Director is acknowledges we all have a lot on our plates and thanks me for the work I do even if it's a little late in its submission.
29	I have the most supportive wonderful direct supervisor. I so feel very psychologically safe at work.

29 out of 35 survey respondents answered the question "Psychological safety is the sense that it is ok to share honest opinions and make mistakes without being chastised, humiliated, or retaliated against. What if anything increases your psychological safety at work?"

The most common theme (N=10) about factor of psychological safety involves **Supervisors and Directors**. People noted the importance of feeling supported and understood, which includes the ability to openly discuss challenges without fear of punishment. Supervisors who acknowledge high workload, thank employees for their work even when it is late, invite staff feedback, and who message that "if something doesn't work out, it's ok," create a sense of psychological safety. Psychological safety is undermined when workspaces are infused with inescapable politics as described in this quote "Knowing my supervisor is a Republican, (political topics are always initiated by them). They also listen to a conservative talk radio show with their door open throughout the day (were other staff such as myself can hear)."

Communication (N=6) is another common factor in psychological safety. Maintaining confidentiality of information shared is "safe spaces," ability to speak "openly" with staff including the ability to shares one's feelings, and supportive communication like being thanked for one's effort and growth mindset messaging (e.g., that mistakes and failures are a normal part of business) are key to workplace psychological safety.

Another common theme involves relationship **dynamics with colleagues** (N=5). Key factors include teamwork and support, trust, respect, friendly interactions, and avoidance of "work drama and office politics."

Of note, **consistency** of supervisor, team, and workload and being allowed to focus time to complete work assignments are key to some people's sense of safety. Further, prolonged time spent with the same team "without incident or issue" create a sense of psychological safety.

Work practices that undermine psychological safety include "Mandatory in person meetings that can be done remotely just to make us come in. People say so they can see our faces but I don't want them to look at my face."

Question 6: What if anything decreases your psychological safety at work?

#	RESPONSES
1	Not sure.
2	When I'm invited to be vulnerable to provide feedback, but the energy in the room is to go along with the majority because if will be used against me later because my thoughts don't align with the individualistic beliefs. They align will collective good for the group.
3	Nothing
4	The idea that a title means you cannot fraternize with coworkers because of job title
5	Working from home
6	When I can tell people aren't being direct with me
7	Continuing to be overwhelmed. Talking about fixing things but never fixing things. New processes developed by those who don't do the job implemented despite those who do the job pushing back...just to implement and find new process doesn't work or is harder
8	lack of communication, judgement
9	I believe negative responses and limiting growth, only reduces opportunities to nurture psychological safety.
10	Allows more stress and anxiety. Unlikely to complete work assignment.
11	Willful ignorance and intolerance.
12	Judgement. Gossip.
13	Fears others may take offense to what I say.
14	No stability
15	A not so supportive supervisor
16	Judgement and loosing promotional opportunities
17	Potlucks, food
18	Hovering or micromanaging
19	Inefficient communication
20	Unrealistic expectations.
21	N/A
22	Not feeling supported by managers/supervisors
23	Amount of work
24	N/A
25	Workload, lack of training, high caseloads, productivity numbers, and a lack of documented procedures.
26	being judged or ridiculed about my culture, family, etc.
27	Talking to my spouse.
28	Big groups, continuous change, in person meetings.
29	When I have constructive criticism/recommendations regarding a work product created by my

30	Weird decisions that come down from the executive level at DBH.

Question 7: What happens in your team when employees support workplace psychological safety by interrupting bullying, reporting discrimination, or requesting support for interpersonal or project-based challenges? Are employees rewarded, ignored, retaliated against, or something else entirely? Please describe.

#	RESPONSES
1	Usually, those types of actions are reported to HR and dealt with by them.
2	The team I report to leads to shut down. My direct reports experience psychological safety a majority of the time. When they do not, they reach out to me individually.
3	Rewarded
4	Management is uncomfortable with concepts of racial justice. Though does not effect work performance at this point to my knowledge
5	Nobody does that
6	Not much
7	Has not happened
8	Rewarded/supported
9	It can help in racial diversity growth and learning processes.
10	I don't believe anything happens.
11	Employees are supported and encouraged when coming up against workplace inappropriateness.
12	Heard
13	Nothing happens, and if so, we don't hear about it.
14	N/A
15	It is supported. If anything inappropriate or offensive was said someone usually feels comfortable to bring it to your attention
16	Mixed
17	My direct team doesn't have these issues. I have not experienced them around me.
18	Acknowledged as a good example. Cannot speak for department as a whole.
19	No reward. But it is recommended by my boss to report anything to her
20	N/A
21	Unfortunately, in my specific work area there is a very low employee morale as there is a lack of support and actually a feeling of retaliation against staff if they bring up any questions regarding processes or workflows, etc. This has caused a significant level of stress and not feeling safe to provide feedback to bring up questions.
22	Have not experienced
23	Bullying - Ignored, lack of action/ plan Project base challenges - Minimal to no support
24	I think employees are supported by the team. No one is rewarded, ignored, or retaliated against. I have never been made to feel like I couldn't go to my supervisor or team and

	express concerns of any kind.
25	I see team members occasionally supported. I know my supervisor becomes defensive when I or the team asks questions. Often I am reminded that they, "Talked about this in the meeting."
26	I have never experienced an employee bully another employee. I have seen employees complain about processes or workload and we mostly hear that either our concerns were already voiced by our management or that this change is temporary and will be reevaluated, we just have to get through until then.
27	Not sure.
28	My Team is very supportive of each other and our direct Supervisors are also incredibly supportive, helpful and understanding. I'm very lucky as I have not always had this experience working for the County, ESPECIALLY in the Behavioral Health Department.

Question 8: Are there any courageous conversations or successful risk taking in Fresno County programming or employment practices that can be highlighted in our training as increasing workplace psychological safety?

#	RESPONSES
1	No, I have brave conversations with co-workers but nothing on a large scale.
2	Conversations regarding reorganization.
3	I love this training. I have faith in the leadership of Susan Holt and the deputy director
4	No, I feel all these trainings are to cover the county legally so when something happens they can say everyone is trained and the county isn't liable for damages.
5	Dbh is fairly well intended with Inclusivity
6	?
7	Transparency
8	Learn more about Mexican/ Americal Mental Health studies in adversities.
9	N/A
10	NA
11	N/A
12	N/A
13	If someone says they need time off for stress or other emotional support, there should be no stigma about it. If an employee does not want to talk about it with their supervisor, that should be okay too.
14	Please listen to your staff. They are doing the best they can and create a safe place to ask questions for clarification and confirmation. It is not to attack a supervisor, even if they already discussed this question/topic in a previous meeting.
15	No.
16	I'm not aware of any.