



# 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

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## 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

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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.

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.<sup>1,2</sup> 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

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<sup>1</sup> Appendix A is the first iteration of the survey.

<sup>2</sup> 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 Alfree M. Breland-Noble's *Community Mental Health Engagement with Racially Diverse Populations* (2020).<sup>3</sup> 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.

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<sup>3</sup> 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.

#### 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 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.

<b>Event</b>	<b>Date</b>	<b>Number Registered</b>	<b>Number Attended</b>
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<sup>4</sup> 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

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<sup>4</sup> 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