MENTAL HEALTH IN HISTORICALLY BLACK COMMUNITIES: THE ROLE OF LOCAL NON-PROFITS

by

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ABSTRACT

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This study examined the role that local non-profit organizations play in bridging the gap to mental healthcare services in historically Black communities. With a focus on the Oak Cliff neighborhood of Dallas, Texas, semi-structured interviews were gathered from participants working for local non-profit organizations, specifically those that connect the community to mental health services. Utilizing a phenomenological approach to qualitative analysis, the key themes that emerged were those of combatting shame, building trust, and engaging with community stakeholders. Additionally, there were themes of helplessness in the face of systemic barriers as well as empathy towards a participant's cultural community. Though there were significant limitations to this study, the results suggest that current organizations advocating for mental health in Oak Cliff stress the importance of consistent and multi-faceted strategic approaches. It also suggests significant limitations on the impact of such organizations without active support and participation from community stakeholders.

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CHAPTER 1

INTRODUCTION

1.1 Problem Statement

The United States, over the years, has struggled with the reckoning of inequitable mental health opportunities for minoritized populations, particularly the Black community (Porter, 2016). There is a distinct tie between repeated race-related trauma and generational social issues such as poverty, youth violence, youth suicide, incarceration, substance abuse, teen pregnancies, and school failures (Porter, 2016). For instance, frequent experiences with racial discrimination and racially-motivated violence have been shown to lead to higher rates of mental health disorders that – without intervention – lead to poor coping mechanisms, low self-esteem, and a higher risk of being involved in the criminal justice system.

Additionally, though experts agree that addressing these issues requires mental health intervention, ethnic minorities on average receive "half as many counseling sessions as their white counterparts" (Alegría, 2010). This gap is further exacerbated by a history of Black Americans who sought mental health services being faced with being overmedicated, an overuse of in-patient services, and culturally insensitive, unsympathetic mental healthcare providers (Akbar, 2004). Non-Hispanic whites comprise approximately 90% of mental health providers (Ida, 2007), which makes the need for trauma-informed and culturally sensitive interventions more pressing. Though there is a consensus on this need, there is limited research on specific practices or tools that may be used to address this gap between the Black community and mental health services. However, what is clear is that there is promising evidence that community stakeholders may play a significant role in addressing these barriers.

1.2 Purpose of the Study

Though the efficacy of community advocates is unclear, the potential benefits that they may provide the community are what make this study critical. There has been an abundance of scholarly work written about the prevalence of intergenerational trauma in Black communities and its role in facilitating the cycle of social issues and inequities for the community (Porter, 2016; Alegría, 2010; Akbar, 2004). Many scholars in this field have recommended trauma-informed solutions; though closing this mental health gap would be critical to healing scars from systemic inequities (Ida, 2007; Porter, 2016). There has been limited research in specific practices that may be used. Further, though some research has mentioned the use of "community liaisons" (Alegria, 2010), few have studied the role mental health advocates would play. However, in designing healing solutions for historically Black communities, it is imperative that we first understand the current status of accessibility of the community and its current limitations. Thus, the necessity of collecting this data from current local non-profit organizations advocating for access to mental health services in historically Black communities over the course of this study becomes evident.

CHAPTER 2

LITERATURE REVIEW

2.1 Current Knowledge of the Problem

Intergenerational trauma, as a concept, was first recognized in the children of holocaust survivors in 1966 (DeAngelis, 2019). By definition, it is simply the assertion that trauma can be passed down from generation to generation. Brent Bezo, a doctoral psychology student who conducted a qualitative pilot study of survivors of the Holodomor – the mass starvation of millions of Soviet Ukrainians from 1932-1933 – and three generations of their families, described the phenomenon: “Each generation seemed to kind of learn from the previous one, with survivors telling children, ‘Don’t trust others, don’t trust the world.’” (DeAngelis, 2019). Though there is limited research tying current trauma in the black community to slavery, the correlation between generations of racial discrimination and trauma is well known. For example, in the United States, the ongoing epidemic of police brutality and “commissioned extrajudicial killings” (Williams et al., 2018) of African Americans – particularly men – has necessitated parents to have traumatizing (though necessary) precautionary conversations with their children about potentially fatal police encounters (Williams et al., 2018)

Due to these findings, peer-reviewed literature on this subject leans heavily on identifying the need for trauma-informed solutions to social issues (Prewitt, 2019). In recent years, there has been recognition of the correlation between the high rates of suicides, substance abuse, incarceration, and violence in African American communities and the racial trauma they face as a minoritized group (Porter, 2016). Particularly, much of the literature stresses the causal relationship between race-related stressors and the decline of mental health that ultimately places African Americans at a systemic disadvantage (Alegria, 2010; Anderson & Mayes, 2010; Williams, 2018; Liggan & Kay, 1999; Ida, 2007).

Though combatting this systemic oppression requires cross-sector change, there has been research that supports the theory that it is possible to facilitate recovery processes to heal mental and emotional trauma attributed to a "racially stratified society" through psychotherapy (Liggan & Kay, 1999; Ida, 2007). Much of the literature available addresses the dynamic between therapists and African American clients. Given that 90% of mental health providers are non-Hispanic whites (Ida, 2007), they specifically emphasize the need for cultural sensitivity and cultural competency in the therapeutic relationship (Alegria, 2010; Comas-Diaz & Jacobsen, 1991; Ida, 2007; Gonzalez, 2005).

Despite evidence that mental health services may greatly benefit the community, African Americans largely drop out of therapy at high rates, with "the percentage of African Americans receiving mental health treatment about half that for whites" (Ida, 2007). Evidence suggests the role of mental health stigmas in this dilemma is significant due to the history of neglect, mistreatment, and misdiagnosis of African American individuals (Comas-Diaz & Jacobsen, 1991; Gonzalez, 2005). A 2013 study examining the experiences of African Americans participating in mental health research found that many were distrustful of the healthcare system, including mental healthcare, with some worrying that their answers may lead to them being involuntarily hospitalized (Williams, 2013). Though in recent years there have been efforts to incorporate cultural competency in training programs required for mental health providers, there is still hesitancy from the community to return to a system that has earned their distrust (Gonzalez, 2005). Furthermore, because African American communities experience higher levels of poverty, there is the additional economic barrier to accessing mental healthcare (Gonzalez, 2005).

Thus, it is for this reason that organizations like the Robert Wood Johnson Foundation and the Campaign for Trauma-informed Policy and Practices (CTIPP) recommend cross-sector solutions (Porter, 2016). Though peer-reviewed literature of solutions to bridge this gap is limited, the Self-Healing Community Model (SHCM) – a study published by the Robert Wood Johnson Foundation – was one such attempt to create an equitable, innovative solution to address and heal the root causes of intergenerational issues of these communities (Porter, 2016). Its flexible approach tailored each effort to the specific needs of every community. It showed vast improvements through the use of community-based coalitions that foster community leadership to address the unique issues in their community in Cowlitz County, Washington (Porter, 2016). The communities that tested the model reduced youth suicides/ suicide attempts by 98%, teen pregnancies by 62%, youth arrests for violent crime by 43%, and high school dropout rates by 47% (Porter, 2016). Additionally, other literature mention similar exploration of "models of multi-level community interventions that can be developed in partnership with families and practitioners" (Alegria, 2010).

Though these articles iterate that there is still a need for additional research into "the effects of participation and partnerships" from these types of solutions, they mention specific individuals that may assist in this facilitation. First is the mention of "individuals and groups who espouse protective values and upon whose behavior they can model their own" (Alegria, 2010). Second is the mention of "cultural liaisons or community aids that can assist [mental healthcare providers] in recognizing the significant role of culture, language, ethnicity, and local context in how diverse families prioritize, respond to and adhere to mental health treatments" (Alegria, 2010). In testing these approaches, however, they emphasize "the value of tailoring community interventions on the basis of what families want and direct them on the development of local resources as an overarching intervention goal" (Alegria, 2010).

A 2019 study found that the effects of discrimination on health care utilization could be mediated by "self-efficacy to communicate with physicians" (Cavalhieri, Chwalisz, & Greer, 2019). A 2020 study examined the differences in patient perspectives of patient-provider communication between Black women and White women. Black women were "less likely to describe having their needs met" and were "more likely to report experiencing poorer communication with providers", which may be "improved by technology and advocates" (Anderson, Graff, Krukowski, Schwartzberg, Vidal, Waters, Graetz, 2020). Black women also reported a "willingness to discuss sensitive topics," but believed those conversations "made their providers feel uncomfortable", and shared "personal stories of disempowered interactions and noted the importance of patient advocates" (Anderson, Graff, Krukowski, Schwartzberg, Vidal, Waters, Graetz, 2020). A 2013 pilot study adapted a patient advocate intervention to overcome barriers for asthmatic adults from low-income neighborhoods that typically have inferior health outcomes due in part to barriers to accessing care and patient-provider communication. The patient advocate "modeled preparations for a medical visit, attended the visit, confirmed understanding, facilitated scheduling, obtaining insurance coverage, and overcoming barriers to implementing medical advice" (Apter, Wan, Reisine, Bogen, Rand, Bender, Bennett, Gonzalez, Priolo, Sonnad, Bryant-Stephens, Ferguson, Boyd, Ten Have, & Roy, 2013). The intervention demonstrated potential for "improving asthma control and quality of life" (Apter, Wan, Reisine, Bogen, Rand, Bender, Bennett, Gonzalez, Priolo, Sonnad, Bryant-Stephens, Ferguson, Boyd, Ten Have, & Roy, 2013). Another 2021 study highlighted the potential value of "targeting barbers as key stakeholders and social support determinants for African American men's mental health and well-being" by "fostering awareness of mental illness and providing resources to address it to reduce the stigma of depression in African American culture" (Carlton, Woods-Giscombe, Palmer, & Rodgers, 2021, p.137). A similar 2017 study examined the impact the Peer Navigator Program (PNP) would have on homeless African Americans with serious mental illness in utilizing "individuals with similar lived experiences to navigate the healthcare system and improve healthcare utilization" (Corrigan, Pickett, Schmidt, Stellon, Hantke, Kraus, & Dubke, 2017, p.101). The study found significant improvements in healthcare utilization the longer the study continued (Corrigan, Pickett, Schmidt, Stellon, Hantke, Kraus, & Dubke, 2017). A 2010 study found that an important barrier to appointment attendance in African American hypertensive patients was "perceiving racial discrimination" (such as assuming a patient's inability to afford services) in clinical encounters (Greer, 2010). A 2020 study examined the Bridges to Care and Recovery program that gave church members "mental health training and skill building so that they can serve as personal mental health educators and advocates" (Scribner, Poirier, Orson, Jackson-Beavers, Rice, Wilson, & Hong, 2020). The program was found to "reduce the perceived stigma of mental illness" and "strengthened partnerships between behavioral health service providers and the African American community" by partnering with the African American faith community (Scribner, Poirier, Orson, Jackson-Beavers, Rice, Wilson, & Hong, 2020). In a 2021 study, genomic researchers investigated "what constituted effective engagement of individuals from underrepresented groups" (Lewis, Turbitt, Chan, Epps, Biesecker, Erby, Fasaye, & Biesecker, 2021). While mistrust was a big consensus between the focus groups, it was found that participants are most effectively engaged when researchers "identify activities for them to join, develop trusting relationships and ensure mutual understandings of the research aims, and define clear roles for researchers and participants" (Lewis, Turbitt, Chan, Epps, Biesecker, Erby, Fasaye, & Biesecker, 2021).

CHAPTER 3

METHODOLOGY

As previously stated, there is clear evidence of significant barriers to mental healthcare access in Black communities. This research project is intended to shed light on the current state of mental health access in a historically Black community. With the goal of understanding the current strategies, limitations of local non-profit organizations, and responses of individuals working for these nonprofits. The following purpose will be explored throughout this study:

- Understanding how local non-profit organizations advocate for access to mental health services in a historically Black community

This research falls under qualitative methodology because it intends to gather and interpret in-depth data to understand participants' behavior and experiences. Specifically, it will leverage phenomenological theory which seeks to examine the lived experiences of people who experience a particular phenomenon. In this instance, the study will ask participants to recall their experience advocating for mental health accessibility within their organization. From their interviews, the researcher will analyze common themes that emerge from the recounting of their experiences.

3.1 Recruitment

This study utilized criterion sampling to ensure each participant's experience is relevant to the phenomenon being studied. This style of sampling is useful to identify and understand information-rich cases (Cohen, 2006). The criteria of this study required that participants:

- are at least 18 years or older,
- work or volunteer with a Dallas non-profit that serves the Oak Cliff community, and
- work or volunteer with a Dallas non-profit that advocates or connects Black community members to mental health services.

The population of this study included adults that worked for local non-profit organizations with an Oak Cliff area code. The following area codes were used: 75216, 75241, 75203, 75232, 75208, 75224, 75233, 75237. A list of non-profit organizations in these area codes were generated. From that list, the researcher filtered out any organizations that did not offer mental health services or referrals to mental health services. Of the remaining list, the researcher attempted to contact the administrators of those organizations and provide them with a recruitment letter (Appendix A) to disseminate through their email databases. However, of that list, only two organizations responded and sent the email through their email database.

3.2 Conceptualization

For the purposes of this study, the term "historically Black community" is represented by the neighborhood of Oak Cliff in Dallas, Texas. According to Section 81.001 of the Texas Civil Practice and Remedies Code, "mental health services" are defined as "assessment, diagnosis, treatment, or counseling in a professional relationship to assist an individual or group in alleviating mental or emotional illness, symptoms, conditions or disorders, including alcohol or drug addiction; understanding conscious or subconscious motivations; resolving emotional, attitudinal, or relationship conflicts; or modifying feelings, attitudes, or behaviors that interfere with effective emotional, social, or intellectual functioning" (Texas Civil Practice and Remedies Code, 1993).

3.3 Data Collection

The collect data used in this study was semi-structured interviews. Each interview was estimated to last approximately 30 – 45 minutes. Given the nature of the Covid-19 pandemic, the interviews will take place virtually via Zoom Video Communications to allow each participant to choose a private space they feel comfortable in. Each interview will be recorded in order for the researcher to transcribe the audio by hand later on. There will be guided questions prepared beforehand. Some of the questions include:

- What is your positional role in providing or advocating for mental health access and how did you come to do this job?
- What do you think are the most important factors to consider when working with the population and community you serve?
- What would you say are the biggest obstacles to advocating for mental health access for the community you serve?
- What would equitable access to mental health services look like to you?
- Can you describe your organization's relationship with the community and community members?

As is the nature of semi-structured interviews, the researcher may ask follow-up questions to any responses from the participant that need further elaboration. However, all predetermined guided questions will be asked unless a participant declines to answer. There will be two interviews per participant to allow for further exploration of initial responses and to allow participants to have an opportunity to bring up topics they may not have thought of originally.

3.4 Data Analysis

The audio from the interviews was manually transcribed line by line by the researcher. To protect the privacy and identity of the participants, they will be given pseudonyms and referred to only as such throughout the course of this research. The researcher will begin to analyze the transcribed interviews by assigning and building codes over the course of several passes through the transcript. A code, according to Saldaña, "symbolically assigns a summative or evocative attribute for a portion of qualitative data" (Saldaña, 2016). Throughout this process, the researcher will look for patterns, similarities, and relationships to explain why things happen (Saldaña, 2016). The researcher will then look at the collection of codes and assign them into categories. From the categories, the researcher will identify the overarching themes from the data (Saldaña, 2016). These themes will be used to identify the current state of accessibility to mental health services in Oak Cliff.

CHAPTER 4

RESULTS

Two participants from different nonprofit organizations volunteered to participate in this study. One participant completed the second interview, the other did not respond to attempts to schedule the second interview.

Participant 1 works for an organization that offers substance use treatment and mental health services to youth. On top of being a licensed clinical social worker, she is also a native Spanish-speaker and considers herself bicultural and Latina. She grew up thinking that seeking mental health support is only for "crazy people," and it was experiencing that stigma first-hand that motivated her to become involved in the mental health field.

Participant 2 works for an organization that also offers substance use treatment and mental health services. He has a law enforcement background and is a licensed clinical social worker. He was retired at one point but was recruited to work with the organization due to his background and experience running a crisis intervention unit.

4.1 Micro-level Advocacy

"Well I think normalizing is a big factor. So if we can normalize – if we cut ourselves cutting a tomato in the kitchen, we're going to bleed. So if trauma happens, there's going to be an effect in our brain, and there's going to be symptoms and that's normal because the brain is like any other organ in our body. So kind of sending those messages […] it's another important part of our body that we want to take care of." – Participant 1

“Sometimes they will make that first appointment. So it’s very important to have someone for that initial contact who can pick up on those cues of ‘I’m hesitant’, ‘what are you about’ so that they can normalize, they can have a very friendly, nonthreatening language. If you have someone who does not speak the language […] or is rude and cold and it’s like a disappointment to you, and that’s it, sometimes, they close the doors. ‘That’s it. I’m not going to go. It’s just not for me […] not for my kid.” – Participant 1

“We try the best as possible from the time they call to be supportive, to have a nonjudgmental stance with their families. ‘Hey, you know we’re here for you. We understand if you’re hesitant about seeking support, but it’s okay, we are here when you are ready. So from the moment they hear the person who answers the phone to the moment they meet with us, up to even their follow-ups – part of what we do, we do 30, 60, 90, 120 day follow-ups with their families – and we try to stay connected with them.” – Participant 1

“It could be between 3-6 months of treatment, depending, and we still stay with them anther 6 months, so that’s a whole year. So in that year, they have that support, and in turn, when they find or families might need this support, they’re like ‘hey they’re still helping us.’ It’s not just like ‘okay, you’re done and that’s it.’ They can still come back and we’ll continue. We have something called recovery support. So for those who have complete treatment, we’ll stay with them and kind of make sure they’re still getting support they need.” – Participant 1

“A newer program is mental health. We have been traditionally known for prevention services and the treatment of substance use, but we know that substance use and mental health services or mental health issues come together. So there is an intersection between them – both of them. So because of that we decided to extend our services to also cover mental health.” – Participant 1

“Mental health and substance abuse tend to run together. Co-occurring disorders is the way it’s actually looked at in the DSM. So we look at it that way too. We treat the mental health aspect of it. The particular trauma aspect of it and then the coping mechanism which people sometimes tend to use drugs and alcohol to be able to cope with that pain and that trauma. It’s pretty complex when you get down into it, but at the same time it’s fairly simple. That’s what we’re doing: we’re trying to get the muck out of people’s bags.” – Participant 2

“It’s ongoing and it usually happens – there’s a relapse along the way. It doesn’t happen the first time. So those are typical things – two or three times and maybe if that’ll work, message finally gets through to them and they finally start turning up what they need to get out of homelessness or drug addiction or both.” – Participant 2

“Somebody loses their job, you know they don’t go live under a bridge the next day. It’s a process that people become homeless, and it steals the hope out from underneath them. That’s the problem. When we’re treating them, it’s like we have to deal with the hopelessness of their situation. So we have to be pretty steeled ourselves, our treatment providers, to be able to handle that really hopeless situation. You get some hope back into that person so they can be strong enough to deal with their treatment." – Participant 2

"Well I think it's important to actually meet people where they are. If you meet a homeless person, that person is not going to be the same person as another person who is homeless too. They may share similar characteristics, but they have to look at people individually and see and really listen. This is where it is critical for social workers to really understand with really good clinical background, of treating people individually, everybody has worth, I mean we have to go in with that, and then have the respect, self-respect to understand all the problems that this person has gone through. And they may be self-inflicted, bad decisions, other problems that they could have had treated and they didn't treat. So even at that, we want to be non-judgmental. 'Okay I'm still not here to judge this person, I'm here to help this person get treatment and help that they need.' So it's real important to look past that judgmental finger-wagging phase into just realizing 'I'm only here for this reason right here. Not to try to condemn this person but to try to help them be all that they can be.'" – Participant 2

"Yeah. Uhm, let's take a black male if you look demographically. That black male has gone through many many experiences, a lot of them very different than a white male like myself have gone through. I came from a low middle class income area and so I had certain situations that came up that maybe a black male that came from a completely middle class area, we don't see the same thing. So it's going to be very different. Course there's racism and all the problems that go with that and all the history that goes with it.

So demographically, yeah, you have to understand what experiences that person has gone through in their life, and there may have been some very very strong trauma that has been attached to it, childhood trauma in particular is really difficult to dig out." – Participant 2

4.2 Meso-level Advocacy

"Reducing the shame and guilt, there's a lot of shame and guilt. Especially from parents. It's like a reflection of my parenting right? They argue because I did something wrong or I didn't do this or that or whatever. Well, that could happen. Sometimes parents make mistakes, and that can happen. But sometimes that's not just the factor. And especially with minorities, there is that big stigma and sometimes because of shame they might not want to get help because what would that say about our family, that we have a drug addict in our family. No. We can't." – Participant 1

"There might be other providers but they're like no no no, we want to wait for you guys because they have been hearing some other families that they were supported and they got better so that is a good thing, and again double-edged sword because I hate it – it kind of mortifies me all the time that we do have people waiting. When someone needs help, that's when they need help. By the time you call them sometimes, they're like oh no I'm fine, the crisis in their mind is over right? And so they think 'Oh I'm fine, I don't need it.'" – Participant 1

"We have families that finish treatment, and parents and maybe their kid relapses and they're concerned and they call us. And we will support them. So it's not like 'sorry you finished treatment.' Like they can still call us and they can find support." – Participant 1

“I do play a role in just the messaging and making sure that it is trauma informed, making sure it is culturally relevant with the linguistic piece, it’s important as well.” – Participant 1

“We do a lot of mental health presentations. So we, again, go to schools, community centers, all the local nonprofits. We see if there is a mental health fair or fairs that the community has, then we try to be there and have our information for the community.” – Participant 1

“Well it’s a linkage right? It’s that type of what I was talking to you about: by being out there in the community and doing some prevention workshops. Sometimes that’s where you begin, you know. Prevention is about awareness and by being provided that awareness, that’s when people are like, ‘oh alright, maybe I need to talk to someone about what’s going on in my family.’ So the prevention piece and that location piece in kind of helping creating awareness I think it’s all about awareness because sometimes people are not aware of ‘I might need a little extra help,’ or aware of ‘Oh I didn’t know there was some help for me available nearby where I live or that it’s okay to ask for help.’” – Participant 1

“Especially for minority groups, mental health has a big stigma. We try to normalize the fact that all of us need help, that’s part of our message. This is- there is nothing shameful about this. Everyone needs help. We are here to support. We do engage in social media as well. To spread that message. Especially during like mental health awareness month, substance abuse month, just to get the word out.” – Participant 1

“We do have a prevention program as well, so we are in the community, we are in the housing community, we are in schools, we do have partnerships with schools like for Dallas ISD, Children’s Hospital, other local nonprofits, for prevention services as well as treatment. I would say that a lot for our clients come because of word of mouth too. It’s very common.” – Participant 1

“Being in the heart of Oak Cliff now, the population here has diversified. But our census for substance use treatment – about 80% Latinx, Spanish speaking parents. We do have a few Spanish-speaking clients youth only, but I think that’s culturally very appropriate in the community. So like if you got help, it’s like, ‘go there because they can help you, and someone speaks Spanish.’ So we get a lot of referrals in that way as well.” – Participant 1

“Too much pushback from like North Dallas; they don’t want a treatment center coming into their area no matter what because the majority of our population are homeless people. And whatever you think about that, they’re still people, they still have worth. So that’s the two points that really drove us to south of the trinity- is to afford the building and secondly just the NIMBY factor.” – Participant 2

“When we moved into this building several years ago, it had some pushback from the community. It’s directly in this community here in the singing hills area. It’s a fairly nice little area. It is right across from the apartment complex that says in a big sign: ‘Safe and Clean.’ Now if you see an apartment complex that says safe and clean, then that’s probably not where you want to go to rent an apartment. So other than that, the rest of the homeowners were trying to protect the value of their property. And I completely understand so there was some pushback on that from the neighborhood association." – Participant 2

"Fortunately we had a lot of really good support from the politicians, both from the county commissioners and city council members. And they all went to bat for us, including the district attorney. And when you have all these politicians lined up and going in your favor, that pretty much evened things out. That stopped all the NIMBY stuff down here and they realized that anybody can have a problem, substance abuse or mental health problem, most families do have that. They just don't want to talk about it. They just want to push it aside and say, 'well, that family over there has it or that family over there has that problem.' They don't realize of course that they have problems themselves too." – Participant 2

"There's a whole lot of research on NIMBY, It's Not in My Backyard. 'Build it, for sure, but don't build it in my backyard'. In other words, you're a homeowner, do you want a drug treatment center opened up right next to your house? When you look at it that way it brings – it's easy to say 'oh all these people they're all NIMBY people, they don't want it in their backyard,' well then, how about then in your backyard? Do you want a drug treatment center in your backyard? Well, most likely not. So it has to be some give and take here. One of the things that we did in convincing them was what we did, but also letting them know that when the people are finally treated and released, they're not going to be released out into their neighborhood. So even though treatment is happening in this neighborhood, people will not be – the homeless people will not be released into that neighborhood. They'll be in boarding homes, apartments, things like that. So it's important to understand what NIMBY really is than just pointing fingers at them and realize they do have a legitimate point and how can you address that, not just in words, but how can you do it in deeds so that you have a working relationship with that community." – Participant 2

"We're about the only one, drug treatment center that is funded by Medicaid, Medicare, so the funding is there through the state. In other words, you don't have to have insurance to be treated here. And so it consequently plays a really large role in drug treatment of co-occurring disorders. It's the biggest one. Treat the most people and has been that way since 1980 so that's quite a long history." – Participant 2

"Sometimes they come in from outside. They heard that there is a drug treatment center is happening here at low cost or no cost and if you have insurance we'll take the insurance, typically, you can pay it through your insurance or not." – Participant 2

"I like the outreach that's been going on, particularly amazingly enough since the pandemic that started realizing that people needed appointments and they couldn't have appointments because they didn't have internet because a lot of appointments were made on the internet and so the economic divide was really aggravated and became a digital divide so then more resources have been poured into that, getting broadband out to more people, being able to talk to people like we're talking on Zoom right now. This would be a session. So if you couldn't get here or one of us, maybe you were just getting over covid and you were concerned about being out in the community, well okay, so we do a session like this. Not as effective as face to face but close, pretty close." – Participant 2

4.3 Macro-level Advocacy

"There is such a huge demand, I feel like, the stigma, it's getting better, but now everywhere there is such a big demand and not enough clinicians or treatment clinicians so you end up with waitlists everywhere. Everywhere you call, oh yeah, I was put on this waitlist. Because unfortunately, there is just a lot of need, and the resources and finances are tight in most non-profits, and if you do private practice but your clients don't have insurance, then that also limits access as well." – Participant 1

"I wish I would be able to hire 5 more clinicians for our team right now because that's just the demand that we have." – Participant 1

"In mental health, depending on what insurance you have, then you get sessions, right? Or you get a time limit. You get only X amount of units. So if you count individual and group counseling, let's say if you have Medicaid, they give you X amount, and then you have to ask for authorization and they might deny it. So in an ideal world, then we will get rid of it and we will just provide meet-you-where-you-are, individualized treatment plans. You need 5 sessions? Great. You need 100? Great. But we are having to navigate all of the systems and kind of advocate for our clients and push the systems like 'hey, we are not done yet,' but they have maxed out so that is very challenging to have to navigate that." – Participant 1

“A lot of it has to do with justifying needs. But even with that, it is a larger system because we are dealing with the state. Some of it is state funding.” – Participant 1

“I think educating also grantors like community foundations because that is maybe where we can have a little bit more of an impact. Because hopefully, and that’s what we’re working on, hopefully we can rely on the community support and community foundations to subsidize the treatment for those clients that maxed out their insurance benefits because they need more than that, so we can balance things out. So I think we would have more of a leeway by educating our community partners and foundations in the need because we can make a bigger impact there. Because there is too much red tape with the state and the government. I don’t think they are going to change that quick.” – Participant 1

“We have a managed care system, in other words, there’s only so many dollars they’re going to allow you to treat people, and because of the population that we have here, we have a fairly extensive waiting list to get treated here. Now people show up every day in the waiting room, every day. Two days ago there were 30 people when we opened the doors up. Standing in line waiting. Now they didn’t have a chance of being treated that day, but we try to assess them, do an assessment, and get them on a list so that we can treat them versus trying to go into a treatment center, a for-profit center and they ask you, well who is responsible for the payment?’ when you say, ‘I am,’ and they say ‘what’s your insurance?’, ‘well, I don’t have any’, ‘well I’m sorry, we can’t help you.’ So there’s a big difference right there is you can get help. Unfortunately there’s going to be a long line of people in front of you.” – Participant 2

"Oh sure, well I've always been kind of an advocate. The problem we've always had has never, we've either never had politicians supporting us, we've never had the funding, or we never knew exactly how to do it. Now once this homeless thing came up and people started kind of waking up to what's really going on, then the money started coming in. Then the politicians started getting political will, we want to do this thing, and then we figured out how to do it, we had the politicians right where we needed it, we had the funding right where we needed it, and we knew how to do it. So we had all three things right then, I said "that's it, I got to get back in this" and I know how to do some of this and I'm going to do it." – Participant 2

"One of the 3 problems it's been funding, political will, or just didn't quite know how to do it. Now we know how to do it from reaching out across the nation and seeing a couple other role models that are going on right now. Houston has one. We're not unique to Texas. Now we'll be the 2nd one that's operational. So we learned how to do it, what works, what doesn't work, we have the funding, we have the political will, the politicians we have right now, right now, are perfect. I mean they are the perfect politicians for really getting in there and fighting. So it's a tremendous time to get in there and do the work." – Participant 2

"Yeah. Money. That's why. It's funding. There's plenty of treatment centers that are for-profit. Turn on your TV and I think within 15 minutes you'll see a drug treatment center. Now if you want to know how to go spend some time at a lake and you can ride a horse and go for a picnic every day, those are the drug treatment centers you're looking for. But we don’t have the money to do that. We just have the money to actually provide the treatment itself. So funding has, particularly in Texas, funding has terribly constrained the ability to provide the services that the people need.” – Participant 2

“I have colleagues in other states, and they tell me what the culture is like there. I have friends that are not just all liberals thinking like me. I’m only progressive up to a certain point. There is a little conservatism in me. But then there’s some people who are really, really conservative, really, really very political and in those states, they’re not going to have very many services. And this is one, unfortunately, one of those states that just doesn’t see the need for helping people pull themselves up- lift themselves up by their own bootstraps. They’re not going to get much help.” – Participant 2

“Well first of all, you have to not do it from a profit basis. But you can’t get away from that. Managed care in terms of physical health is terrible enough, and mental health is really bad. So I don’t see any managed care being involved in this. A person needs how many let’s say the [inaudible] comes to you and is dealing with something in their life right now. And it’s a single shot problem that they’re dealing with and they just need to talk to a counselor. But in talking to that counselor, that mental health social worker, it’s unraveled that it’s a bigger problem that that’s just a precipitating point of a much larger problem so it’s going to take more sessions to work with this person. To really get a handle on the real depth of that problem so that it won’t continue to effect their behavior and their lives. If you try to put that in terms of managed care, they’re only going to give you like 5 sessions to do that in. So it may take more than 5 sessions. So first of all, you

have to get rid of all the financial burden that goes along with that. And not treat it like okay this can be done in 5 sessions then you'll be well again. That's ridiculous thinking."
– Participant 2

CHAPTER 5

DISCUSSION

The themes of advocacy that emerged from the data highlighted the significance of a multi-pronged, strategic approach to advocacy; specifically, the categories all fell under a 3-tiered structure: micro-level advocacy, meso-level advocacy, and macro-level advocacy.

5.1 Micro-level Advocacy

For the purposes of this study, the micro-level of advocacy refers to the interactions the participants and their organization had with the individuals they served on a personal, one-on-one basis. In these scenarios, the following codes emerged from the results: empathy, patience, non-judgmental, meeting people where they are, recognizing the individual, and continued support. From those, tactics that facilitated building trust and combatting shame were key advocacy categories. However, the data hints at the representation of one's identity in these organizations being a possible influential factor in building trust. While both participants worked for an organization that served a historically Black community, by their own admission, neither were members of the Black community. While further research is needed to understand the significance of this detail, it can be noted that that neither participant identified the area they served to be historically Black. Further, Participant 1 showed a strong sense of empathy when discussing working with Latinx clients. Interestingly, she also identified the population her organization served (according to a census) as 80% Latinx. She attributes this to the level of attention to detail their organization gives to ensuring comfort to anxieties Latinx clients and their families may have. While Participant 2 was empathetic towards both the homeless population and the NIMBY group, he also acknowledged that his experiences were inherently different from a member of the Black community. Future researchers may gather demographic data on the population of both the population those organizations serve as well as the demographics of the organization itself to draw further conclusions on the significance of the demographic make-up of an organization in building trust with a specific demographic in regard to mental health service utilization.

5.2 Meso-level Advocacy

For the purposes of this study, the meso-level of advocacy refers to the interactions the participant and their organization had with the family, community stakeholders, and other key players in the local or small community level. In these scenarios, the following codes emerged from the data: trauma-informed messaging, engage with various community stakeholders, and maintain a community presence. On this level, while engaging with community stakeholders was a key category, the data suggests a need for higher levels of community engagement in order to tackle systemic barriers. Both participants emphasized the importance of their relationship with the community in the utilization rate of their services (indicated by the amount of clients that were referred to them by word of mouth) as well as the effectiveness of their services (due to building trust). This is a prime example of the importance of each of the tiers of advocacy; their relationships with each other are directly correlated with their corresponding effectiveness. Additionally, combatting shame on a community level was also significant. In this context, however, it refers to combatting shame as a concept of generational or societal mental health stigma. Both participants acknowledged a social stigma that needed to be addressed, and both participants seemed to conclude that engaging with the community was an efficient way to address those issues as well as others on a macro-level. Something that was interesting to note was the way that each participant chose to interpret the term "community." When asked to describe their organization's relationship with the community, Participant 1 interpreted the term to describe their outreach efforts with the housing community, schools, other local non-profits, and members of the population her organization serves. In contrast, Participant 2 interpreted the term to describe the issues his organization had with homeowners nearby. While there is not enough data to support any concrete conclusions, it is fair to say that these interpretations were the instinctual associations the participants had for that term.

5.3 Macro-level Advocacy

For the purposes of this study, the macro-level of advocacy refers to the interactions the participant and their organization engaged in on a broader sense to address systemic issues on a large-scale community, state, or national level. These interactions are mostly indirect from the individual themselves, but are equally important and can include developing interventions to causes to systemic issues. On this level, challenging systemic barriers was a key advocacy category. However, the method of challenging those systems varied. Both participants placed heavy emphasis on the issues they faced in a managed care system in regards to healthcare. They each stressed that a detrimental barrier to accessibility was the health care system. If an individual had no insurance, it severely hinders their ability to find any affordable mental healthcare providers. Even if an individual has health insurance, they are largely at the whims of the insurance companies and whether they decide to authorize their use of the insurance for mental health services. In their recounting of this process, the participants seem to describe this process as overwhelming for an individual to navigate on their own. Even with someone who understands how these systems work, it largely gives the impression that those who need help are having to justify their struggles to a system that quantifies their lived experiences and may coldly discredit them by only allowing a set number of sessions to "fix the problem" so to speak. While this coincides with the micro-level category of "continued support" (in which organizations supplement this cutoff by offering services themselves to ensure these individuals don't feel abandoned), this also speaks to the macro-level of advocacy because they are the advocates that stand with the individual and push against the systems with their expertise and knowledge. Further, the participants particularly highlighted that crucial aspect of their organization's ability to function: the community's involvement and investment. As the literature supported, the data collected from these interviews reinforces the crucial role the community and its stakeholders play in bridging the gap to mental healthcare. Though the participants expressed frustrations and feelings of helplessness in changing the healthcare system itself, they seemed more hopeful in their ability to circumvent those issues. However, the participants each had a different approach on this circumvention. Participant 1 detailed that their organization's strategy was aimed at engaging and educating community foundations and other community partners. She explained that they hoped to rely on their support to subsidize the treatments for those that have maxed out their insurance or for those that had no insurance. On the other hand, Participant 2 detailed that their organization's strategy was to engage political actors including the district attorney, county commissioners, and city council members and leverage their support to push against the system. While there were limitations due to the size of the participant pool, the limited data seems to suggest that without active support and participation from the community, the impact of these organizations will be significantly limited.

5.4 Conclusion

The results of this study proved to be troublesome for several different reasons and led to further questions when analyzing the relationship between local nonprofit organizations and access to mental health in historically Black communities. At the end of these interviews, it was clear that there were many underlying issues that needed to be addressed before the question of non-profit work in these communities could be analyzed. The surface layer of these issues includes the limited number of participants willing to voluntarily contribute to this study and their demographic makeup. The interviews with the participants shed light on the actors involved in the community of study and perhaps were the greatest examples of why participation was limited. If these are the individuals most willing to engage with a voluntary survey concerning mental health access in historically Black communities, then it seems clear why there was a lack of Black participants in a study concerning the Black community. This point leads to the underlying issue made clear in this section, and that is contemplating who was not represented in the study, and why. If those most eager to engage in projects concerning the community are not representative and are inherently unable to empathically understand Black experiences and historical trauma in mental health, how can these services be seen as accessible to the Black community? Though Black experiences are the centerfold of this study and are the greatest testament to how well non-profit service is truly doing in the community, there is still a barrier on both sides of the spectrum to accessibility – both for researchers to gain comprehensive knowledge and for patients to find access to representative and trustworthy care in their own community.

APPENDIX A

INFORMED CONSENT AND RECRUITMENT EMAIL

The University of Texas at Arlington (UTA)

Informed Consent for Minimal Risk Studies with Adults

My name is Cindy Ledat and I am asking you to participate in a UT Arlington research study titled, "Mental Health in Historically Black Communities: The Role of Local Non-Profits." This research study is about understanding how local non-profit organizations advocate for access to mental health services in a historically Black community. You can choose to participate in this research study if you:

- ☐ are at least 18 years old,
- ☐ work or volunteer with a Dallas non-profit organization that serves the Oak Cliff community, and
- ☐ work or volunteer with a Dallas non-profit organization that advocates or connects Black community members to mental health services.

Reasons why you might want to participate in this study include to share your experiences working with mental health advocacy in the Black community or to further mental health research, but you might not want to participate if you are uncomfortable sharing your personal experiences or if you are unable to commit to completing two 30-45 minute virtual interviews. Your decision about whether to participate is entirely up to you. If you decide not to be in the study, there won't be any punishment or penalty; whatever your choice, there will be no impact on any benefits or services that you would normally receive. Even if you choose to begin the study, you can also change your mind and quit at any time without any consequences.

If you decide to participate in this research study, the list of activities that I will ask you to complete for the research are 1) complete two virtual interviews lasting approximately 30-45 minutes each, and 2) respond to potential follow-up emails to clarify any questions regarding meaning/intentions of what was said in interview. Although you probably won't experience any personal benefits from participating, the study activities are not expected to pose any additional risks beyond those that you would normally experience in your regular everyday life or during routine medical / psychological visits. However, some of the questions that I will ask may be about sensitive or uncomfortable topics.

You will be entered into a raffle drawing for a $50 gift card for participating in this research study. If your name is drawn, you will be notified after all participant interviews have concluded. There are no alternative options to this research project.

The research team is committed to protecting your rights and privacy as a research subject. We may publish or present the results, but your name will not be used. While absolute confidentiality cannot be guaranteed, the research team will make every effort to protect the confidentiality of your records as described here and to the extent permitted by law. If you have questions about the study, you can contact me at cnl7156@mavs.uta.edu. For questions about your rights or to report complaints, contact the UTA Research Office at 817-272-3723 or regulatoryservices@uta.edu.

You are indicating your voluntary agreement to participate by clicking on the "Accept" button below.

Recruitment Letter

Hello, my name is Cindy Ledat, and I am an undergraduate honors student at the University of Texas at Arlington. I am conducting a qualitative research study for my undergraduate thesis, titled "Mental Health in Historically Black Communities: The Role of Local Non-Profits," and am reaching out to you in the hopes of finding participants for my study. Through both my professional and personal experiences, I have noticed that there is a need to both elevate the voices of underrepresented communities and further the understanding of mental health in those communities. The purpose of my study is to understand how local non-profits advocate for access to mental health services in a historically Black community. The goals of this study are to highlight underrepresented voices, advance the body of mental health research, and help clinicians, policy-makers, and advocates to expand their knowledge to best serve the Black community.

You are eligible for this study if you:

1) are at least 18 years old or older
2) work or volunteer with a Dallas non-profit that serves the Oak Cliff community
3) work or volunteer with a Dallas non-profit that advocates or connects Black community members to mental health services

I hope to include 10-15 participants from non-profit organizations local to the Oak Cliff neighborhood in Dallas, Texas in this research.

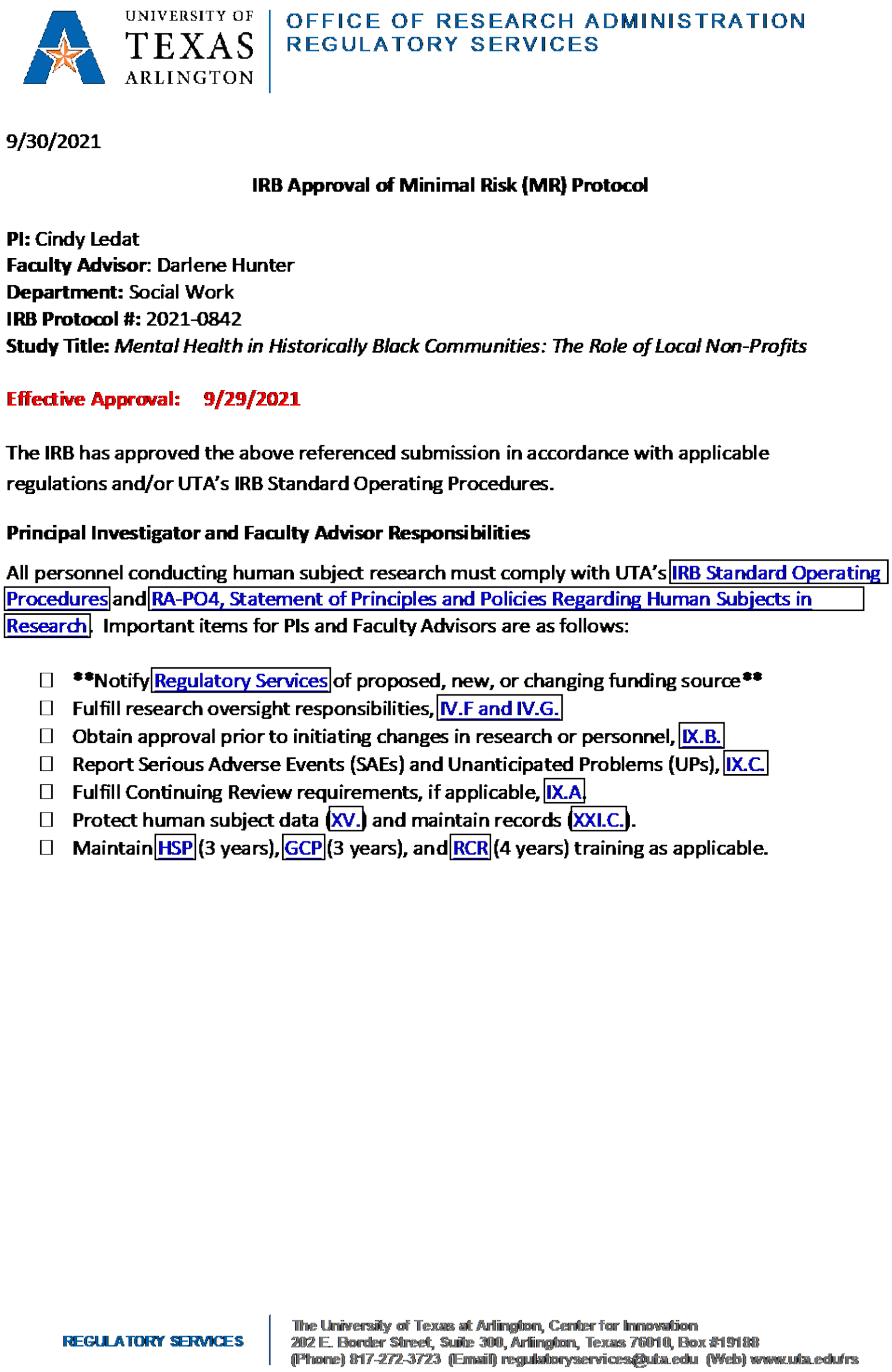
Your participation in this study would involve 2 separate one-on-one face virtual interviews with me lasting approximately 30-45 minutes each, which will include questions regarding your work with the Oak Cliff community. The online interviews will be conducted via a secure Zoom meeting. Any personal information that could identify you will be removed or changed before data is shared with other researchers or results are made public. In gratitude for your time and participation, you will be entered into a raffle drawing for a $50 visa gift card upon completion of the interview. If you are interested in participating in this study, please email me at CNL7156@mavs.uta.edu. If you know of anyone who may be interested, please share this information with them.

Thank you for your consideration!

This project was approved by the University of Texas at Arlington Institutional Review Board (IRB). Dr. Ericka Roland (ericka.roland@uta.edu) and Dr. Darlene Hunter (darlene.hunter@uta.edu) are overseeing this research.

APPENDIX B

IRB APPROVAL



UNIVERSITY OF
TEXAS
ARLINGTON
OFFICE OF RESEARCH ADMINISTRATION
REGULATORY SERVICES

9/30/2021

IRB Approval of Minimal Risk (MR) Protocol

PI: Cindy Ledat
Faculty Advisor: Darlene Hunter
Department: Social Work
IRB Protocol #: 2021-0842
Study Title: *Mental Health in Historically Black Communities: The Role of Local Non-Profits*

Effective Approval: 9/29/2021

The IRB has approved the above referenced submission in accordance with applicable regulations and/or UTA's IRB Standard Operating Procedures.

Principal Investigator and Faculty Advisor Responsibilities

All personnel conducting human subject research must comply with UTA's IRB Standard Operating Procedures and RA-PO4, Statement of Principles and Policies Regarding Human Subjects in Research. Important items for PIs and Faculty Advisors are as follows:

- ☐ **Notify Regulatory Services of proposed, new, or changing funding source**
- ☐ Fulfill research oversight responsibilities, IV.F and IV.G.
- ☐ Obtain approval prior to initiating changes in research or personnel, IX.B.
- ☐ Report Serious Adverse Events (SAEs) and Unanticipated Problems (UPs), IX.C.
- ☐ Fulfill Continuing Review requirements, if applicable, IX.A.
- ☐ Protect human subject data (XV.) and maintain records (XXI.C.).
- ☐ Maintain HSP (3 years), GCP (3 years), and RCR (4 years) training as applicable.

REGULATORY SERVICES
The University of Texas at Arlington, Center for Innovation
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BIOGRAPHICAL INFORMATION

Cindy Ledat is a senior at the University of Texas at Arlington majoring in interdisciplinary studies with minors in political science, diversity studies, social justice & social welfare, and leadership studies. Ledat is passionate about advocating for mental health awareness/accessibility and eliminating the systemic inequities in marginalized communities. On campus, she served as vice president of the Mavericks with Disabilities student organization and received an Undergraduate Research Fellowship to study the role of community advocates in bridging the gap between Black communities and mental healthcare services. In her last semester, Ledat represented The University of Texas at Arlington as a member of the Spring 2022 Archer Fellowship cohort that traveled to Washington, D.C. to study advocacy and public policy and intern at the Consumer Financial Protection Bureau. After completing her honors degree, she plans to attend graduate school to receive a dual master's degree in public policy and social work and pursue a career in social policy analytics.