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Partnering with African American Churches to Create a Community Coalition for Mental Health

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Community partnered participatory research (CPPR) emphasizes community engagement, respect, and empowerment as guiding principles to promote mental health equity. This article describes the "Vision" stage of a CPPR-informed model to implement evidence-based practices for depression in two African American churches in Harlem, New York. Essential parts of the Vision include engagement of stakeholders and collaborative planning. The engagement process increased awareness about the project via a community-focused mental health symposium. The collaborative planning stage resulted in creating a multi-disciplinary Community Coalition for Mental Health, establishing the Coalition's values, agreeing to change the initial chosen study intervention from Interpersonal Counseling to Mental Health First Aid, and developing a website to disseminate the group's work. Key lessons learned from our partnered process are: 1) support from the lead pastor is crucial; 2) balancing community and academic interests can be challenging; 3) icebreaker activities foster relationships and reinforce CPPR principles; 4) multiple communication channels can enhance community participation; and, 5) should organize data in ways that make them easier to interpret. *Ethn Dis.* 2018;28(Suppl 2):467-474; doi:10.18865/ed.28.S2.467

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Introduction

Major depressive disorder (MDD) is among the most prevalent psychiatric disorders in the United States and the leading cause of disability worldwide.[1] African Americans, compared with White Americans, have slightly lower prevalence estimates of lifetime MDD.[2,3] However, African Americans with MDD have a more chronic course of illness and greater disease burden.[4] Treatment rates among African American adults with MDD are between 33% to 50% of treatment rates for White Americans with MDD.[4-6] Sociocultural barriers to care include lack of access,[7] cultural distrust,[8] financial constraints,[9] and stigma.[10] Persistent treatment disparities and the enormous societal costs of untreated MDD underscore the public health significance of increasing engagement

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among depressed African Americans.

Church-based health promotion has received growing interest as a way to reduce disparities in depression case finding.[11] The Black Church is defined as the collection of seven predominantly African American denominations of the Christian faith.[12] Churches may be ideal community partners due to their trusted societal position, ability to reach broad populations, and focus on health equity and social justice.[13] Importantly, African American clergy are trusted gatekeepers for providing brief counseling and referrals to mental health professionals.[14] Hankerson and researchers conducted focus groups with clergy to identify barriers to depression treatment and research in the African American community. Clergy expressed a need for more in-depth training to adequately care for depressed community members and expressed a strong desire to partner with academicians to conduct research.[10]

The purpose of this report is to describe the first stage (ie, Vision) of a CPPR-informed training program for African American clergy.

Jones and Wells created a community engagement model for mental health intervention research called community partnered participatory research (CPPR).[15] The centerpiece of CPPR is an equal, mutually respectful partnership that emphasizes community-academic collaboration at every step of the research process. CPPR approaches proceed through three stages: Vision (engagement of stakeholders and collaborative planning), Valley (implementation of EBPs), and Victory (celebration and communicating results).[16] The core values of community engagement include: respect for diversity, openness, equality, empowerment, and an asset/strength-based approach to the work.[17] A CPPR approach to implement depression quality improvement programs reduced disparities in depression outcomes.[18]

Hankerson received a NIMH-funded Career Development Award (K23) to initiate a CPPR approach to implement a depression management training program for clergy. The overall aim of the study was to reduce racial disparities in mental health treatment. Columbia University Medical Center was the main academic partner. Clergy were recruited from two churches in Central Harlem, New York in the borough of Manhattan. Church #1 is a Baptist church with more than 8,000 members (98% African American) and five clergy. Church #2 is a Catholic parish with approximately 800 members (90% African American) and six clergy. The process of engaging church leaders is described in detail elsewhere (Hankerson, manuscript under review).

The purpose of this report is to describe the first stage (ie, Vision) of a CPPR-informed training program for African American clergy. The goal of this Vision stage was to create a Community Steering Council that would guide all research activities and the development of a specific implementation strategy for clergy.[19] In the CPPR framework, a Council is composed of community members and academicians and leads the planning of health services research. The key research question during this stage was, "Who are the key stakeholders needed to implement this initiative and how are they engaged?"

Method

The project was carried out via a series of interrelated stages – Plan, Do, and Evaluate –that began with the identification and engagement of the central team members who would comprise the Council. As the Council established rapport, it gradually moved into a planning phase that culminated in a major community mental health symposium.

Preliminary Stages: Engaging Key Stakeholders

The Community Steering Council was launched with the goal of creating a diverse, multi-disciplinary group to actively address the multilayered contributors to mental health disparities. We sought representation from faith-based organizations, local government, community-based organizations, non-affiliated community members, and academia. The first Council members were identified when both senior pastors specified which leader from their church they wanted to serve on the Council. Hankerson met individually with each identified church leader to re-

Table 1. Examples of icebreaker activities at meetings of the community coalition for mental health

Meeting Focus (Meeting Number)	Icebreaker Name	Icebreaker Description	Key Outcomes
Building Relationships (Meeting 1)	"Casting The Vision"	Each person throws a piece of yarn to another member of the group and discusses their personal, organizational, and community interest in the study. The yarn forms a net showing how community members support each other.	Outlined responsibilities of Coalition Co-Chair
Brainstorming Service (Meeting 2)	"Swords"	A plastic sword was placed in front of each person. The swords point toward the word 'depression' placed at the center of the table. Each person gives their definition of 'depression.'	Drafted proposal for a community mental health symposium
Organizational Structure (Meeting 3)	"Someone Who"	If you were stranded on a deserted island, describe who you would like with you.	Pastor agreed to host symposium in his church's auditorium

view the study aims, procedures, and gather the names of other community stakeholders for the Council. A similar purposive sampling strategy was employed among community and academic leaders to identify other potential community stakeholders. We distributed a formal invitation for each prospective member (n=12) of the study. This study was approved by the New York State Psychiatric Institute institutional review board (#6975) and all procedures followed were in accordance with the ethical standards of the IRB and the Helsinki Declaration of 1975, as revised in 2000.

Seven people (58% of those invited) attended the first meeting of the Council, which occurred on March 26, 2015. A characteristic meeting process was introduced, which began with dinner (eg, turkey wraps and fruit) and jazz music. Each attendee received a meeting agenda, study description, and timeline for the study's activities. A community member began the meeting by saying a prayer.

After formal introductions, we conducted an icebreaker called "Casting the Vision," which was designed to facilitate connections between community members and the current project. One attendee was given a ball of yarn and asked to discuss their personal, organizational, and communal vision for the project. After discussing these three perspectives, the attendee threw the ball of yarn to another person until everyone was holding a piece of yarn that created a web of yarn in the center of the table. A small stuffed animal lion, described as representing the Harlem community, was then placed in the middle of the web of yarn. Everyone loosened the grip on their piece of yarn, which caused the lion to drop on the table. This activity illustrated that when everyone does not uphold their responsibilities, the community suffers. Meeting #1 concluded with a description of the responsibilities of the Community Co-Chair of the Council.

Attendees agreed to meet bimonthly for the first six months and quarterly thereafter. Subsequent meetings had the same flow: dinner, opening prayer, icebreaker, and then agenda items are addressed. Icebreaker activities, which reinforced a key CPPR principle, allowed everyone in the room to share something new about themselves. Table 1 describes icebreaker activities for the first three in-person meetings of the Community Steering Council.

Planning Council Actions: The Community Mental Health Symposium

At meeting #2, Rev. Dr. Charles Butler was selected by his peers to be Community Co-Chair for the Council. Rev. Butler works for a community-based consortium of more than 90 interfaith congregations in Upper Manhattan. The study's primary investigator (PI) served as the Academic Co-Chair.

The Council's second and third in-person meetings, which occurred in May and June 2015, focused on inviting more community members to participate in the Council. The lead partner from a Catholic parish came up with the idea of a symposium and offered her church's auditorium as the venue. The symposium was called "Community Conversations on Overcoming Stress." The words depression and mental health were intentionally left out of symposium's title due to concerns that such

words were highly stigmatized in the African American community.[20] Attendees proposed to plan the symposium in two months, which seemed like an overly ambitious timeline. One attendee mentioned a phrase that she remembered from her reading: the notion of "building the plane while flying," which implied that we would move forward with initiatives before clarifying all the details. This phrase and commitment to troubleshooting problems as they arise became one of our unofficial mottos.

Do: Implementing the Community Mental Health Symposium

Once plans for the symposium had taken shape, a multi-pronged marketing strategy was used to publicize it. Both lead pastors advertised the symposium from the pulpit. One week prior to the symposium, the PI spoke at Sunday morning services at the Baptist Church to contextualize depression in the Black community and emphasize the importance of the symposium. Fliers were created and distributed in-person to community-based organizations and sent electronically via email. The study's project coordinator also purchased a Facebook advertisement to reach young adults.

More than 400 people attended the symposium, which was held in July 2015. The final program included: 1) a keynote address from the New York City First Lady; 2) remarks from the Executive Deputy Commissioner, New York City Department of Health and Mental Hygiene (DOHMH); 3) a panel discussion involving a pastor, doctor of social work, mental health speaker, and mental health consumer; and, 4) a presentation from the PI about responsibilities of prospective Council members and an invitation for community members to attend the next meeting.

Evaluate: Intervention assessment and Re-design

There were 23 people at the Council meeting after the mental health symposium, representing a 200% increase in attendance from the initial meeting. Full-voting Council members were defined as individuals who attended at least three in-person meetings. Each full-voting member would receive a $75 gift card for attending a Council meeting. We agreed to have an open-door policy with respect to new community members, meaning that anyone was permitted to attend future meetings. The next two in-person meetings involved break-out sessions where community members and academicians worked collaboratively to process and evaluate the symposium proceedings and to brainstorm answers to emergent questions: 1) What does mental health look like to you? 2) What are the most severe mental health concerns in the community? and, 3) How can the church address the emotional/mental health needs of the community? The results of these breakout sessions are shown in Table 2.

One Council attendee suggested a "Steering Council" may be off-putting for some community members and sounded "too much like an academic's word." She thought "coalition" would be a more inclusive description of the community voices we were attempting to reach. Thus, the name of the group was changed to the "Community Coalition for Mental Health."

After changing the group's name, the Coalition re-evaluated using Interpersonal Counseling (IPC) as the study intervention. IPC is a manualized, evidence-based, time-limited (3-6 sessions) model of depression management that was initially selected for several reasons: 1) IPC directly addresses the interpersonal problem areas (eg, grief) that clergy are most likely to encounter in depressed parishioners;[21] 2) IPC can been culturally adapted;[22] and 3) IPC was designed to be delivered by non-mental health professionals, such as clergy.[23]

The diversity of New York City's faith-based community and in-depth interviews with clergy were major considerations in the re-evaluation of the most appropriate intervention for this study. The Coalition understood that there were varying levels of experience and comfort with discussing mental illnesses such as MDD within the Black Church. Most importantly, clergy did not want to increase their counseling caseload as originally proposed with the IPC-focused study design. Instead, they were interested in learning the skills (eg, how to frame depression as a medical disease or give hope to someone) covered by IPC. One pastor stated, "If there's something that I can do that can help me as I talk to folks, I think that that would be wonderful. What I'm *not* interested in is [IPC] increasing my counseling load or doubling it."

During this time, the New York City DOHMH began offering free Mental Health First Aid (MHFA) training as part of a comprehensive initiative to improve

Table 2. Community members' perspectives of mental health and church's potential role in care

What does mental health look like to you?	
Feeling confident and content, to get to a place of peace	The ability to have tolerance with the self and others
The capacity to function in relationships	Being able to do that which makes you feel worth
What are the most severe mental health concerns in our community?	
Depression and suicide	Cumulative trauma and race-based stress
Living in poverty, being able to support oneself	Lack of adequate support and systems
Stigma	Lack of prevention or lack of knowledge and availability
How can churches address the mental health needs of the community?	
Increase promotion towards professional counseling	Equipping pastors and clergy with counseling skills
Church is conscious about mental health to reduce stigma	Improving links between spiritual and professional counseling

population mental health. MHFA is an evidence-based, 8-hour, certified public education program that teaches the skills needed to identify, understand, and respond to signs of mental health and substance use challenges.[24] The trainings' focus on teaching community members to recognize behavioral health challenges enables participants to gain confidence in their ability to help someone experiencing an emotional crisis.

Clergy from both churches enthusiastically supported changing the study intervention from IPC to MHFA. Clergy thought MHFA would be able to reach more people, increase awareness about depression and other mental health problems, and reduce stigma. Changing the study intervention required submission of a new IRB protocol, which significantly delayed the planned training dates for each church.

Results

Partnership Agreement

A total of 14 people (6 men / 8 women) were eligible to be official members of the Community Coalition for Mental Health. They formalized their working relationship by signing a Partnership Agreement in November 2016, roughly 18 months after the March 2015 meeting of prospective Coalition members. This meeting was advertised as a *Signing Ceremony* and represented the Victory phase of our CPPR project. It was a celebratory atmosphere involving a hot, catered meal and each attendee dressed in semi-formal attire. The Dean of the Columbia University Mailman School of Public Health delivered opening remarks and the New York City First Lady shared congratulatory remarks through a pre-recorded message.

Table 3 shows the organizations represented in the CCMH. We have representation from faith-based organizations, community-based organizations, local government, and several schools at Columbia University. The signing ceremony culminated with showcasing our partnership website – http://www.communitycoalitionformentalhealth.com – which describes

Table 3. Organizations Participating in the Community Coalition for Mental Health

Faith-Based Organizations	Academic Organizations
First Corinthian Baptist Church (study site)	College of Physicians & Surgeons, Columbia University
The Parish of St. Charles Borromeo, Resurrection and All Saints (study site)	New York State Psychiatric Institute
Harlem Congregations for Community Improvement	Teacher's College, Columbia University
Mother AME Zion Church	College of Arts and Sciences, Columbia University
	Mailman School of Public Health, Columbia University
	School of Social Work, Columbia University
Community-Based Organizations	Medgar Evers College
Harlem Family Institute	
New York Lawyers for the Public Interest	Local Government
Convent Avenue Family Living Center	New York City Department of Health and Mental Hygiene
Gouverneur Health	

Table 4. Vision, mission, and values of the Community Coalition for Mental Health

Vision	A world where all churches are viewed as transformative spaces for mental health	
Mission	To foster community-academic partnerships to identify ways to increase awareness about depression; reduce stigma; promote social justice; and, encourage help seeking for mental health problems among people in Harlem, with a specific focus on people of African descent in faith-based settings.	
Values	Partnership	Health Equity
	Respect	Openness
	Empowerment	Reciprocity
	Asset / Strength-based approach	

the Coalitions members, research activities, and community events.

The 'Valley' stage of the project will involve implementing MHFA into both church study sites. The Coalition will be involved in helping to recruit participants to MHFA training, publicizing the study to the Harlem community, and deciding what instruments to use to assess the training's impact on stigma and help-seeking behavior.

Values

The vision, mission, and values of the Coalition are listed in Table 4. Our *vision* is "a world where all churches are viewed as transformative spaces for mental health." The centerpiece of our mission is to foster community-academic partnerships to identify ways to increase awareness about depression. Examples of our values are respect and health equity. Other sections of the partnership agreement covered: 1) principles of community partnered research; 2) rights and responsibilities; 3) conflict resolution; 4) project description; and 5) termination conditions.

Subcommittees

The partnership agreement created two separate Coalition subcommittees. The Community Engagement subcommittee was charged with event planning, serving as a liaison between the Coalition and church study sites, and marketing. The Program Evaluation subcommittee was charged with research design, literature reviews, and study outcomes. Subcommittee members scheduled monthly conference calls to assess their progress.

Discussion

We utilized a community partnered participatory approach to create a 14-member, Community Coalition for Mental Health focused on training for evidence-based practices to African American faith leaders in Harlem, New York. Creating the Coalition took roughly 18 months, from March 2015 until November 2016. We share our lessons learned that can inform CPPR initiatives in other communities.

Lessons Learned

Support from the Lead Pastor is Crucial

The pastors from both study sites – a Baptist church and Catholic parish – provided invaluable leadership and support through the entire Vision phase. Tangible examples included providing a signed letter of support on church letterhead for IRB submissions, promoting the study during Sunday sermons, and donating church resources (eg, space and personnel) for the community mental health symposium. Pastoral announcements on Sunday were considered a major factor in the large turnout for the community mental health symposium. Getting buy-in from a high-ranking official, like the senior pastor, has been shown to promote uptake of community-based interventions and increase program sustainability.[25]

Balancing Community and Academic Interests Can Be Challenging

We struggled to fully engage community members between quarterly Coalition meetings. This was most noticeable when a new IRB protocol was submitted to change the study intervention from IPC to MHFA. Other factors that contributed to periods of dis-engagement included the Coalition attempting to address too many issues at once and community members having numerous competing demands for their time.[26]

To address this challenge, one Coalition member suggested that we create concrete, deliverable action items after each meeting. Another

suggestion was to deliver a mental health workshop or art class, which would promote the Coalition's work and promote mental health more generally. Arts programs have been successfully employed in other partnered depression initiatives.[27] Conversely, academicians should do a better job of informing community members of all aspects of the research process. Going forward, we will add more community members to IRB protocols as research personnel to increase their roles in the study.

Icebreaker Activities Foster Relationships and Reinforce CPPR Principles

We meticulously planned each icebreaker to reinforce the overall theme of each CCMH meeting. Coalition members acknowledged that the icebreakers were a highlight of our quarterly meetings, as the activities demonstrated how openness, respect, and empowerment can look in our community. Scheduling conflicts prevented the CCMH Co-Chair from attending meetings, which resulted in academic partners planning nearly all the icebreaker activities. Going forward, we will ensure that community members lead icebreaker activities and plan their own menu items to share with the group.

Multiple Communication Channels Can Enhance Community Participation

Members' diversity in race/ethnicity, sex, age, educational background, and work sector may enhance the Coalition's work. Multiple levels of communication (eg, print ads, sermons, and social media) were utilized to achieve this level of diversity. One CCMH member stated, "We need to follow through with building awareness." She thought a consistent publicity strategy was needed to highlight the Coalition's achievements and attract new members. Creating the Community Engagement subcommittee of the CCMH was one way we attempted to address this concern. Another Coalition member stated, "I believe by having continued discussion with key figures, from within the community, more people will take part in disseminating information." Systematic evaluation of various communication strategies will likely help the CCMH refine future outreach efforts.

Organize Data in Ways that Make Them Easier to Interpret

Presenting research data in lay terms was suggested as a way to more fully engage Coalition and other community members. We created 1-page executive summaries describing results of the initial MHFA trainings. Coalition members thought that qualitative data would resonate more with community members. One member commented, "Stories create a richer picture of a problem than numbers." The Program Evaluation subcommittee of the CCMH will be charged with presenting data in a way that is more relevant for community members.

Conclusion

In summary, the outcomes of our community-partnered Vision stage included creating a Community Coalition, establishing the group's values, forming two subcommittees, and collaboratively deciding to change the study intervention to MHFA. Sustaining community member engagement between in-person meetings will be our main focus as we move to the next stage of the study. Future research is needed to assess how cultural and religious factors impacts faith-based and academic partnerships.

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Conflict of Interest

No conflicts of interest to report.

Author Contributions

Research concept and design: Hankerson, Wells, Adams Sullivan, Johnson, Smith, Crayton, Brooks, Ahmad-Llewellyn, Rhem, Porter, Croskey, Simpson, Butler, Roberts, James, Jones; Acquisition of data: Hankerson, Wells, Adams Sullivan, Crayton, Miller-Sethi, Rule, Ahmad-Llewellyn, Porter, James; Data analysis and interpretation: Hankerson, Wells, Adams Sullivan, Crayton, Brooks, James, Jones; Manuscript draft: Hankerson, Wells, Adams Sullivan, Johnson, Smith, Crayton, Miller-Sethi, Brooks, Rule, Ahmad-Llewellyn, Rhem, Croskey, Simpson, Butler, Roberts, James; Statistical expertise: Hankerson, Wells, Adams Sullivan, Crayton, James; Acquisition of funding: Hankerson, Wells, Adams Sullivan, Porter; Administrative: Hankerson, Wells, Adams Sullivan, Smith, Crayton, Miller-Sethi, Brooks, Rule, Ahmad-Llewellyn, Rhem, Porter, Croskey, Simpson, Butler, Roberts, James; Supervision: Wells,Porter, Jones

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