Case Studies in Community Psychology Practice: A Global Lens

Case Studies in Community Psychology Practice: A Global Lens

"Changing the world one community at a time."

See Contributors Page for list of authors (Edited by Geraldine Palmer, Todd Rogers, Judah Viola, and Maronica Engel)



Case Studies in Community Psychology Practice: A Global Lens Copyright © 2021 by See Contributors Page for list of authors (Edited by Geraldine Palmer, Todd Rogers, Judah Viola, and Maronica Engel) is licensed under a Creative Commons Attribution 4.0 International License, except where otherwise noted.

Contents

Acknowledgements vii

About the Editors ix

Testimonials for the Book xii

What is an Open Textbook? xiii

Contributors xiv

How to Access and Use This Book xxxvi

Preface xxxvii

Introduction 1

PART I. PART ONE: COMMUNITY BUILDING

1. Cultural Development in Underrepresented Communities: Using an Empowerment and Citizen Participation Approach *9*
2. Dare2Dialogue: Promoting Inclusion Through Storytelling and Dialogue *25*
3. Green Space Programs as a Shared Growth and Communal Process: A Somali Gardener's Journey in Minnesota *41*
4. Juvenile Justice Community Activation Project *53*

PART II. PART TWO: GLOBAL PERSPECTIVES

5. Better Together: Creating Alternative Settings to Reduce Conflict Among Youth in Lebanon *69*
6. Promoting Community-Driven Change in Family and Community Systems to Support Girls' Holistic Development in Senegal *82*
7. Proclaiming Our Roots: Centering Afro-Indigenous Voices Through Community Storytelling *108*

PART III. PART THREE: EVALUATION RESEARCH

8. Lessons from Conducting an Equity-Focused, Participatory Needs Assessment *135*
9. Program Evaluation: A Fundamental Component in Effective Community Practice *162*
10. Showing up and Standing with: An Intersectional Approach to a Participatory Evaluation of a Housing First Program *175*

PART IV. PART FOUR: COMMUNITY AND PUBLIC HEALTH

11. A Plan for Prevention: Measuring Equity from the Start *203*

12. Working with Survivors of Gender-Based Violence *221*

13. Journeying Past Hurt: Creating and Sustaining Trauma-Informed Healing Practices With Black Pregnant and Parenting Mothers *234*

PART V. PART FIVE: COMMUNITY PSYCHOLOGY ACROSS DISCIPLINES

14. Community Engaged Learning Opportunity (CELO): A Novel Approach to Community Engagement in Medical Education *251*

15. S.U.P.P.O.R.T. for Unhoused Individuals with Substance Use in Service Planning Area 6 in Los Angeles, California *269*

16. Is Nutrition the Antidote to the Hypertension Epidemic in South Los Angeles? *287*

17. Beyond Birth – Unpacking Postpartum Depression (PPD) in SPA 6 and the Factors Driving Disparity *309*

18. A Biopsychosocial Analysis of the Relationship Between Food Insecurity and Mental Health in South Los Angeles *327*

19. Working Together: A Community Approach to Combat Pediatric Asthma in South Los Angeles *339*

20. Breaking the Cycle: Community-Centered Solutions for Socioeconomic and Environmental Challenges that Drive Childhood Obesity in South Los Angeles *366*

Editors' Notes *375*

Feedback Form: Case Studies in Community Psychology: A Global Lens *376*

Adoption Form *377*

Licensing and Attribution Information *378*

Peer-Review Statement *379*

Accessibility Assessment *383*

Version History *384*

Acknowledgements

We began discussions on this project in late 2019 with no expectations that within six months or less the world would be under siege by the Covid-19 pandemic that spread like wildfire, tearing apart families, communities, cities, and countries. By March of 2020 the world had retreated, those that could, from office spaces, classrooms, theaters, retail stores, banks, and other physical spaces and remote work from teaching to mental health therapy became the norm. Times had indeed changed, yet this change prompted an even more dire need to better understand the dynamics of what it means to be a community practitioner in America and around the world. Black and Brown communities have experienced the brunt of Covid-19, the result of health disparities and other racial policies and practices long in existence, but not uncommon, that continue to be "pushed under the rug". Not only was the world dealing with the pandemic but America was also feeling the effects of civil and racial unrest with the murders of Black/African American individuals by the hands of white police and white supremacists in Louisville, Kentucky, Minneapolis, Minnesota and Macon, Georgia captured on video and viewed by millions. There seemed to be no relief from these tragedies and the insurrection on the nation's Capitol on January 6th, 2021 stood out as a bastion of what a nation had been struggling to confront since 1619. Yet, the power, spirit, and souls of people across the nation and around the world could not be stifled or stilled. This book emerges as a testament to the courage, perseverance, and conviction of people who live in our communities around the world and that's pretty much all of us. We intend for this book to be evidence of when people come together bringing *all* facets of their diversity to the table, in celebration, not toleration, the world is enriched and better for it.

I (Dr. Palmer) speak for all of us editors when I share it has been an honor and privilege to work alongside of the Rebus Pressbooks' team, specifically Apurva Ashok, who diligently showed up each month for a year to help guide us through the technical aspects on our journey of creating something we would be proud of, our magnificent team of authors who patiently revised and revised again their case stories after editor and peer-reviews, our peer-reviewers, and our graphic designer, Jay Hart who never complained as he went back to the drawing table time and time again to create a cover we could all say "yes" to. This book is also very much the product of Rebus Pressbooks, Community Wellness Institute, LLC, Society for Community Research and Action (SCRA) and Textbook Academic and Authors (TAA) Association whose grants allowed us to cover production expenses. Our gratefulness is unparalleled to our contributors: Dr. Jacqueline Samuel, Dr. Amber Kelly, Kathleen McAuliff, Dr. Dessie Clark, Joshua Brown, Dr. Susan Wolfe, Dr. Kyrah Brown, Justin M. Henry, Claudy Jean Pierre, Tamaya Bailey, Jerrise Smith, Dr. Tonya Roberson,

Dr. Deidra Somerville, Ramy Barhouche, Dr. Judi Aubel, Dr. Anna Pruitt, Eva McKinsey, Tien Austin, John P. Barilea, Dr. Patricia O'Connor and Dr. August Hoffman. Equally as important, this book would not exist if not for the individuals, families and everyone else within all of the communities highlighted coming together with community psychologists and allied practitioners striving to create inclusive, equitable spaces in which every single human being gets to live their lives in full dignity and peace. Importantly, I (Geri Palmer) want to take time to acknowledge and publicly thank my co-editors, Dr. Judah Viola, Todd Rogers, and Maronica Engel. I am humbled by your willingness to jump into this project, lean in and give your gifts and talents that make it the great work that it is. I look forward to all the new adventures that await us. I know a community when I see one. Thank you.

We also acknowledge that this work is partially inspired by the team of Lenny Jason, Olya Glantsman, Jack F. O'Brien, and Kaitlyn Ramian (2019) who created their *Introduction to Community Psychology Textbook* in Rebus Pressbooks of which Judah Viola and I (Dr. Palmer) and a couple of our contributors are authors of chapters. We were excited about its dynamic nature, look and feel which in part, prompted our decision to create our work in Rebus Pressbooks.

There is an insurgence around the world as many scholars, practitioners, scholar-activists, activists, abolitionists, and more are fueled by social and racial justice convictions and led and guided by social movements of the past. This book represents a new time, as over 50% of the contributing authors and two of the editors identify as Black/African American or People of Color. We expect this diverse make-up to be the norm and not the exception and is intentional giving us hope that our future within community practice and all other spaces will look different. We hope you see yourself as teacher, student or practitioner, where it won't be uncommon to help heal communities that you may have never stepped foot in before, hold space with groups of people who look or think nothing like you, to work alongside, not *for* , and share your lenses for others to see through. May you be someone who is forever inspired by the *power of community* and you don't think twice about helping others "*change the world, one community at a time.*"



Jay Hart, Graphic Designer

About the Editors



Geraldine (Geri) L. Palmer, Ph.D. (Community Psychology)

Dr. Palmer is the Co-founder/Managing Director of Community Wellness Institute (CWI) in Evanston, IL and an Assistant Professor in the Psychology Department, Clinical Psychology Program at Adler University, Chicago. Dr. Palmer has extensive experience serving in middle and senior executive leadership in the nonprofit/human services sector specifically around the social issues of housing and homelessness. She earned her Ph.D. in Community Psychology from National Louis University where she also teaches a human services management course. Dr. Palmer is an active presenter at academic conferences and workshops, and along with a team of consultants also leads and facilitates the F.A.C. E. of Justice Workshops for CWI. She is a co-author on the chapter, Oppression and Power in Jason, Glantsman, O'Brien and Ramian (Eds) (2019) *Introduction to community psychology: An agent of change* and author of a chapter, Navigating the Road to Higher Education in Viola and Glantsman (2017) *Diverse careers in community psychology.* Her writing has been published in a number of peer-reviewed journals. She is currently the Interim Co-Chair of the Council on Cultural, Ethnics and Racial Affairs (CERA), of the Society for Community Research and Action (SCRA). For more information see https://scholar.google.com/scholar?hl=en&as_sdt=0%2C14&q=Geraldine+Palmer&oq=Ge or https://works.bepress.com/geraldine-palmer/about/



Todd L. Rogers, M.A. (Industrial/Organization Psychology)

Todd is the Co-founder and Operations Director at Community Wellness Institute. He is an Organizational Psychologist with 20 + years in field operations in the pharmaceutical sector. He is currently working in the facilitation, learning and development and performance analytics space in addition to building a private Narrative Coaching practice. Todd served as a research assistant on CWI's first research initiative, *Exploring Historical Trauma Among Black/African Americans* (in progress for publication).



Judah Viola, Ph.D. (Community Psychology)

Judah Viola, PhD is a Community Psychologist and Associate Professor of Psychology at National Louis University in Chicago, Illinois where he co-developed NLU's PhD program in Community Psychology and previously served as Dean of the College of Professional Studies and Advancement. Judah's recent publications include *Community Psychologists: Who We Are.* In L.A. Jason & O. Glantsman, J.F. O'Brien, & K.N. Ramian (Eds.) Introduction to Community Psychology: Becoming an agent of change. Rebus Pressbooks and *Diverse Careers in Community Psychology. Oxford University Press.* Judah currently serves as the Publications Committee chair for the Society for Community Research and Action. He also manages an independent consulting practice specializing in program evaluation, needs assessment, community building, and collaborative community research. Recent clients have included national and international nonprofits, public school systems, museum and art institutions, social service agencies, and community development organizations. His community research and advocacy interests involve neighborhood revitalization, education for students with disabilities,

affordable housing, access to healthcare, access to healthy food, community-police relations, and violence prevention and intervention. For more information see: https://works.bepress.com/judah_viola/



Maronica Engel (Senior Instructional Designer)

Maronica is a senior instructional designer and learning strategist. She has many years of experience in consulting, designing, and developing learning solutions for adult learners in Learning and Development business units in a variety of industries. Maronica assisted with reviewing and editing, and ensuring that the content and layout of the case studies are interesting and engaging, incorporating elements such as photos, links, and visual illustrations. She chose to work on this project because of her strong beliefs in the importance of providing the resources for individuals to be participating and productive agents in their communities; and her passion for education as a life-long learner.

Testimonials for the Book

"This is a great book! The case studies were engaging because I could easily understand terms and theory. When you read the book and just look at the term and explanation at the graduate level, it is really hard to understand what that means. Even though you understood the definition of the theory or the term, it is hard to apply those to a real-world example. However, case studies were beneficial to understand and led me to apply that in the real world!" – Student, Adler University Psy.D. Clinical Psychology Program: Community Psychology class

"As a clinical psychology graduate student, it is tough to think about what we can do as a professional for community mental health well-being. This book makes you think about that." – Student, Adler University Psy.D. Clinical Psychology Program: Community Psychology class

"The case studies were very informative and necessary as they anchored the class discussions and lectures." – Student, Adler University Psy.D. Clinical Psychology Program: Community Psychology class

"It's been wonderful using the open-source online textbook in classrooms. I love the opportunity to use the textbook to expose the discipline of Community Psychology globally." – Dr. Moshood Olanrewaju, Adjunct Faculty, Adler University

What is an Open Textbook?

Student PIRG (2021) offers the following definition for open textbooks: An open textbook is one that falls under an open copyright license, and made available online to be freely used by students, teachers and members of the public. Many open textbooks are distributed in either print, e-book, or audio formats that may be downloaded or purchased at little or no cost. This book has a Creative Commons Attribution license, which allows reuse, revision, and redistribution so long as the original creator is attributed. Please see the licensing information for this book for this book for more information.

University of Minnesota reported that "open textbooks address not only financial issues for students, but pedagogical concerns as well. The open licenses mean that faculty and students can create and edit textbooks that reflect the latest research as well as better speak to their local communities. Content can be updated to reflect recent changes in the law, or breakthroughs in science, and it can be localized and indigenized. By including diverse voices and perspectives as we have done in this textbook, we believe that this has strengthened learning content, and provided context for understanding a variety of issues, particularly the voices of citizens, countries and communities that have historically been silenced.

Open textbooks have also helped tremendously with equity and parity concerns, where voices of BIPOC have been left out of traditional publishing forms (e.g. peer-reviewed journals, textbooks, etc.). Academic publishing is vital to tenure-track professors who must publish as part of their overarching portfolio to move up the track. Also, it is equally important that educational institutions advance the value that the world's knowledge is public good, where knowledge has been an exclusive right of some, and not all. University of Virginia aptly noted that "now we have an extraordinary opportunity to support affordable learning for all by sharing, using, and reusing educational content and tools. This statement aligns with the goals and values of the editors' institutions: Adler University and National Louis University, and corporations we are affiliated with.

This textbook is easily accessible, which will alleviate the stress of purchase for students. For more information on how to access and use this book, please see the next section: How to Access and Use This Book. Laptops that students use are easily transformed into e-book containers and this helps tremendously in keeping students on top of their classwork and reduces the inherent stress of the average college campus.

Contributors

Rutha Adhanom is a second-year medical student at Charles R. Drew College of Medicine in Los Angeles, California. She graduated from the University of Maryland (UMD), College Park, with a Bachelor of Science in Biological Sciences, specializing in Neurobiology and Physiology. She also earned a Global Public Health certificate in the College Park Scholars Program at UMD. Rutha is an aspiring dermatologist who is passionate about autoimmune dermatology, skin of color, and immune dysfunction and its effects on the skin. Specifically, she is interested in dermatological diseases that disproportionately affect vulnerable populations. Rutha is dedicated to addressing health disparities through advocacy, biomedical research, and community service. Her goal is to improve outcomes in skin of color and address the disparities that hinder access to care, such as socioeconomic status and low health literacy. Her current research interests include pediatric dermatology, cutaneous lupus, non-scarring/scarring alopecia, and skin of color.

Sanam Ahadi is an Orange County native who grew up in the city of Anaheim, California with her parents. She graduated from the University of California, Irvine with a Bachelor of Science in Human Biology. Her academic and career goals have primarily focused on addiction medicine and dismantling the stigma surrounding substance abuse. Through early experiences working in rehabilitation facilities and witnessing the impact of drug addiction, Ahadi became inspired to work with this patient population. Working as a medical scribe in the ER during the COVID-19 pandemic only further exposed her to the severity of the opioid epidemic. Her undergraduate research focused heavily on addiction biology at UC Irvine School of Medicine, which deepened her understanding of the biological markers contributing to adolescent drug dependence. As a medical student at Charles R. Drew College of Medicine, Ahadi's passions have fueled her profound fascination with learning medicine at the deepest level while concurrently shedding light on the pervasive health disparities. She is currently the Chair of Community Outreach for the American Muslim Medical Student Association and the lead director for the Student-Run Free Clinic Mental Health division in South Los Angeles.

Ngozi V. Alia is a Prince George's County native who grew up in the Washington Metropolitan area with her parents and brothers. She graduated from Frostburg State University, earning a Bachelor of Science in Health Sciences with a concentration in African American studies. As a health contributor, Ngozi has written articles centered on improving the health outcomes of African Americans and their contributions to the health field. As a medical student at Charles R. Drew University of Medicine and Science—College

of Medicine, Alia is passionate about the intersections between public health, the arts, media, and health edutainment initiatives in underserved communities. She plans to become a health producer, double board-certified internist, and psychiatrist. Alia firmly and actively believes in the World Health Organization's definition of health, "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Ferdinand Anokwuru is a first-generation immigrant, and a first-generation college graduate. He attended a military boarding school in Nigeria for high school before moving to the United States of America. He then attended Baltimore City Community College, where he earned his associate degree. While there, he served in various leadership positions, including; being Appointment by the Governor of Maryland to serve as the student trustee for a year. He eventually transferred to a Morgan State University, where he graduated Summa Cum laude in Biology. After witnessing the health disparities and inaccessibility to good health care for individuals from poor backgrounds, he decided to enter the medical field to become a force for change. He became a Certified Pharmacy Technician and a Medication History Technician to experience outpatient pharmacies (CVS pharmacy and Walmart pharmacy) and Inpatient pharmacies (Johns Hopkins Bayview Medical Center, Northwest Hospital Randallstown, and University of Maryland Baltimore Washington Medical Center) and understand the relationships between hospitals and pharmacies. He also wanted to understand the various roles of medical personnel in inpatient care. He shadowed Physicians, Nurses, Physician Assistants, Pharmacists, and various other medical personnel and was present during rounds where the medical personnel discuss the treatment procedure and current states of patients. Ferdinand understands that Medicine is about people—their feelings, struggles, and concerns. Humans are entitled to compassionate and understanding doctors. People deserve doctors who are constantly questioning and insatiably curious about new medical developments. They deserve someone who enjoys the challenging task of problem-solving and developing unique solutions for them, and he aspires to be that doctor.

Kevin A. Artiga is a South Los Angeles native. He earned his Associate of Arts in General Science at Santa Monica College. He earned his Bachelor of Science in Cognitive Science with an emphasis in Neuroscience from the University of California, San Diego. Artiga completed the Post-Baccalaureate Program in Pre-Medicine at Charles R. Drew University of Medicine and Science. His upbringing in South Los Angeles shaped Artiga's desire to commit his efforts to research education and engagement with underserved communities. Artiga is intensely passionate about community engagement, serving at free health clinics as a patient navigator and conducting clinical research to address health disparities. As a medical student at Charles R. Drew University of Medicine and Science—College of Medicine, Artiga is determined to engage with his fellow South Los Angelenos with a focus on community involvement and research. Previous experiences have driven him to break cultural boundaries and create a Spanish guideline for students interested in learning Spanish medical terminology. Artiga is establishing the inaugural American Association of Neurological Surgeon's Student Chapter at CDU and the Neurological Surgery Student Interest Group, serving as the President for both organizations. Artiga also plans to work with underrepresented community college students interested in medicine and serve as a mentor and resource in navigating the undergraduate pre-medical path.

Esinam Attipoe is a medical student at Charles R. Drew University in Los Angeles, California. Born and

raised in South Mississippi, she earned a Bachelor of Science in Biology from Jackson State University and a Master of Science in Biomedical Sciences from the University of Mississippi Medical Center. Her research background focuses on the genetic basis of hypertensive kidney disease and addressing healthcare disparities in underserved populations. Esinam is an active member of the Student National Medical Association (SNMA) and serves on the Executive Board of the Ghana Physicians and Surgeons Foundation (GPSF), where she works to increase representation in medicine. She has a strong interest in cardiology and anesthesiology but remains open to wherever her medical journey leads her.

Dr. Judi Aubel, Ph.D., is in adult education (MA), health education (MPH) and anthropology & education (PhD). She has worked for many years in community development programs mainly in Africa but also in Latin America, Asia and The Pacific. Her long-standing concern has been the gap between cultural context, roles and values of communities and development programs. She is the Co-founder and Executive Director of Grandmother Project (GMP) – Change through Culture. GMP is a US non-profit organization (501c3) and a Senegalese NGO. She lives between Rome and West Africa where GMP has a small office and team. Judi's work has focused on both research and development of culturally-grounded and community-driven programs on health, education and child protection. Her work is conceptually grounded in community psychology, community development, anthropology and adult education. As a social scientist-practitioner, she has developed programs that: build on community assets; promote intergenerational communication; actively involve elders; and that strengthen community leadership to build social cohesion and social capital. Judi identified grandmothers as an abundant and underutilized resource for programs supporting women and children and she and her team have developed an intergenerational and grandmother-inclusive methodology that contributes to community-driven social change.

Tien Austin, M.A., is a graduate from the University of Hawai'i at Mānoa with a bachelors degree in both Psychology and Studio Art. Her research has examined the continued recovery from homelessness experienced by individuals once housed using Photovoice and content analysis. She has worked in the community as a Homeless Outreach Specialist as well as a Case Manager for people with severe mental illnesses in a transitional living facility.

Abdelkader Awad is a medical student at Charles R. Drew University of Medicine and Science in Los Angeles, CA. He earned a bachelor's degree in Neuroscience from the University of California, Los Angeles and later worked as a Staff Research Associate at the University of California, San Francisco, studying the immune system's role in fetal development and repair. Passionate about immigrant and refugee health, he is currently leading a mixed-methods research project on the medical and psychosocial needs of Palestinian children evacuated from Gaza to the U.S. for treatment. Aspiring to become an Emergency Medicine physician, he is dedicated to disaster medicine, global emergency response, and improving healthcare access for displaced populations. Born and raised in Rammun, Palestine, he hopes to continue serving his community in the future.

Tamaya Bailey, LMSW, is a Behavioral Health Counselor at Prism Health North Texas, the largest local nonprofit HIV/AIDS service organization in north Texas providing HIV care, free STI and HIV testing,

transgender care and more. She works with individuals living with HIV/AIDS and has additional interest in maternal health and postpartum depression. Tamaya earned a Master's in Social Work with a concentration in mental health and substance abuse from the University of Texas at Arlington. Tamaya is also a proud U.S. Air Force veteran.

Ramy Barhouche – After 9 years of focusing my career and studies on international development and community empowerment through Non-Governmental Organizations, (NGO) I decided to shift my focus due to my disappointment in the harmful and colonial structure of the field. I am currently completing my PhD in Community Psychology with a focus on decoloniality and multiple narrative storytelling in the SouthWest Asia and North Africa (SWANA) regions, in the hope to highlight the diverse voices and cultures of the region and dismantle the perceptions of homogeneity, hegemony, and systemic oppression.

Dr. John P. Barile, Ph.D., is the Interim Director of the Social Science Research Institute and a professor of psychology at the University of Hawai'i at Mānoa. Jack earned his doctorate in community psychology from Georgia State University in 2010 and completed a postdoctoral fellowship at the US Centers for Disease Control and Prevention. He currently manages an active research program pursuing questions concerning ecological determinants of health and quality of life. His research aims to improve the lives of historically marginalized communities, including those experiencing homelessness, multiple chronic conditions, and severe mental illness.

Naima Batson is a medical student at Charles R. Drew University of Medicine and Science, College of Medicine. Naima recalls her earliest memory of healthcare being her grandfather's battle with diabetes and glaucoma. As Naima grew older, she learned more about his condition and other diseases that disproportionately affect Black and Brown communities. Naima graduated with a Bachelor of Science and a minor in Chemistry. Naima founded CDU's first Medical Spanish Club, empowering students with the resources to enhance language skills and cultural competency to serve diverse patient populations. Naima's international interests led her to volunteer as a medical assistant helping to provide free vision and healthcare services to patients in Belize. Naima also worked at a Federally Qualified Health Center, where she enrolled uninsured families in Medicaid, Chip, and SNAP, helping her understand the barriers many families face in accessing healthcare. Naima's long-term goal is to have a career in global healthcare by working with the US State Department. She aims to provide nonprofit medical screening clinics, enhance international health and research relations, and learn about effective international healthcare models to improve the affordability and accessibility of global systems. Naima serves her CDU community as Vice-President of the Women in Surgery interest group, and Vice-President of the Plastic Surgery- Sculpt Society. Naima's commitment to international medicine and education emphasizes core values of excellent health and wellness for all in a world without health disparities.

Nicolas Hurtado Bautista, an Afro-Latino from Bogotá, Colombia, was raised in Anaheim, California, by his single mother and grandparents, who instilled in him the value of education. He graduated from UCLA in 2020 with a Biology major and Chicana & Chicano Studies minor, then completed a postbaccalaureate program at Charles R. Drew University to strengthen his medical school preparation. Now a medical student at CDU, he is dedicated to addressing health disparities, promoting cultural

empathy, and increasing Afro-Latino representation in medicine. He aspires to uplift communities and inspire underrepresented students to pursue careers in medicine.

Ann Marie Beals, PhD, is a Two-Spirit Afro-Indigenous L'nu'k scholar, educator, and community organizer from Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq People. They are an Assistant Professor at Wilfrid Laurier University, located on the traditional territories of the Chonnonton, Anishinaabe, and Haudenosaunee Peoples. Ann Marie is the founder of Wele'g Dwennimmen, an academic and community-based institute dedicated to Afro-Indigenous, Black, and Indigenous ways of being and knowing, with an emphasis on health and wellbeing. Their scholarship and community work center Afrikan and Indigenous knowledges, survivance, and relational governance. They emphasize care and protection of and for our Earth Mother, intergenerational responsibility, and the ways Black and Indigenous communities sustain cultural continuity while resisting colonial erasure. Through storytelling, land-based learning, and community collaboration, Ann Marie advances liberatory futures rooted in solidarity, self-determination, and collective wellbeing.

Rania Berkane is a medical student at Charles R. Drew University of Medicine and Science, with a deep-rooted passion for serving underserved communities. Growing up in Algeria, Rania witnessed firsthand the devastating effects of limited healthcare access, including the tragic loss of her father and grandfather. After immigrating to the Unites States, she continued to see the impact of healthcare disparities in Santa Ana, California, where many in her community lacked basic medical resources. These formative experiences, combined with her own journey through motherhood, have deepened her commitment to advocate for vulnerable populations, particularly women of color and immigrants who face systemic barriers in healthcare. With a focus on addressing health disparities and a growing interest in maternal mental health, Rania aims to contribute to research and clinical efforts that support equitable and compassionate care for postpartum women, especially those from marginalized backgrounds.

Nyoko Brown is from Bakersfield, California where she was raised by her mother and grandmother. Brown is a medical student at Charle's R. Drew University of Medicine and Science – College of Medicine committed to furthering CDU's mission of making physicians community leaders of health. For undergraduate, she attended the University of California, Los Angeles. There, she earned a Bachelor of Science in Physiological Science with a minor in Public Health. Before starting medical school, Brown worked as an emergency medical technician and a medical assistant. She used the time with her patients to survey their experiences, and she was inspired by their stories and thus pursued research and community-oriented opportunities to make healthcare more equitable and accessible. With her yoga teacher certification, Brown teaches free classes at her medical college and in her community, eager to share the benefits of the practice with as many people as possible. Currently, Brown is Co-President of the CDU Obstetrics and Gynecology Interest Group and Vice president of the CDU Urology Interest Group, which are both aligned with her passion for reproductive health.

Joshua Brown, LCSW, serves as the Chief Programs Officer for the Fort Bend Women's Center. In this role, he oversees numerous programs serving survivors of intimate partner violence. These programs include mental health services, permanent and rapid rehousing, emergency shelter, children's services, life skills, and

case management. He got his start in the intimate partner violence field developing FBWC's innovative neurofeedback program. Josh has a background in psychology, is a Licensed Clinical Social Worker, and is board certified in neurofeedback.

Dr. Kyrah Brown, Ph.D. is an Assistant Professor of public health at the University of Texas at Arlington. At the intersection of public health and community psychology, her research focuses on addressing social and structural factors that shape racial inequities and disparities in women's/maternal health across the life course. She has expertise in needs assessment and evaluation, community capacity building, and community based participatory research approaches. Dr. Brown was the recipient of the 2021 Reby Cary Faculty Excellence Award from the UT-Arlington African American Faculty and Staff Association and the 2019 SCRA Early Career Award. Dr. Brown is a proud alumna of Spelman College and earned her MA and PhD in Community Psychology from Wichita State University.

Sydney Y. K. Brown, MA, BS, is a distinguished researcher, nonprofit leader, and medical student dedicated to advancing medical innovation and promoting equity in underserved communities. She is currently pursuing her medical degree at Charles R. Drew University College of Medicine, with an anticipated graduation date of 2027. In 2019, Sydney became the youngest scholar and first undergraduate admitted to the prestigious Satcher Health Leadership Institute: Community Voices at Morehouse School of Medicine. She graduated magna cum laude in neuroscience from Agnes Scott College and earned a master's in leadership and public service from Lipscomb University. Sydney has been recognized for her commitment to research excellence, receiving the 2021 Synapse Award in Research Excellence and membership in the Nu Rho Psi Neuroscience Honor Society. A prominent voice in the Black in Neuro community, her research has been featured at leading conferences, including the Xavier University Health Disparities Research Conference, the Annual Biomedical Research Conference for Minority Students, and international forums in Costa Rica, Colombia, South Africa, and Ghana. Notable achievements include her participation in the 2024 Keck School of Medicine of USC and Children's Hospital Los Angeles Summer Oncology Fellowship and the NIH-supported Summer Oncology Research Fellowship.

Jalen Castille is a second-year medical student at Charles R. Drew University with a strong passion for serving underserved communities. Originally from Ontario, California, he earned his B.S. in Biology with a minor in Chemistry from Texas Southern University in 2017, where he was also a student-athlete on the football team. Before medical school, Jalen gained valuable clinical experience as an operating room assistant and medical scribe at UCLA, followed by a post-baccalaureate program in Chicago. His journey has been deeply rooted in addressing healthcare disparities, and he is committed to pursuing a career in orthopedic surgery, with a focus on pediatric orthopedics. Through his work, Jalen aims to bridge the gap in access to specialized care and make a lasting impact on the communities he serves.

Dr. Noé Rubén Chávez is a Community Psychologist, Assistant Professor and Program Director of Psychology in the Department of Social Sciences and Humanities at Charles R. Drew University of Medicine and Science (CDU). Dr. Chávez also co-teaches a Medicine & Society course in the medical school at CDU, and in this role mentors and supports medical students in learning about health justice and the intersection of the social/behavioral sciences in medicine. Additionally, Dr. Chávez serves as a mentor

and co-leads the program evaluation and wellbeing sessions, for the CDU Health Career Opportunities Program (HCOP), that supports the educational and career development of underrepresented pre-Med and pre-PA program students. He is on the editorial boards of *Journal of Latinx Psychology*, *American Journal of Community Psychology*, *Journal of Racial and Ethnic Health Disparities,* and *Journal of Prevention and Intervention in the Community*. His research focuses on community-based participatory action research with Latinx immigrant communities, to address mental health challenges with Latinx families and youth toward developing culturally and community responsive resources to foster wellbeing.

Dr. Dessie Clark, Ph.D., is the Research Collaboration Coordinator for the ADVANCE program at the University of Massachusetts, Amherst. Dr. Clark completed her PhD in Community Sustainability at Michigan State University. Dr. Clark's research interests are broadly related to increasing quality of life for survivors of sexual and domestic violence. More specifically, Dr. Clark is interested in exploring the use of neurofeedback therapy in survivors who have experienced a traumatic brain injury.

Laila Cross is a second-year medical student and member of the inaugural class of Charles R. Drew University's College of Medicine. She is motivated by her commitment to uplifting marginalized communities and addressing healthcare disparities, particularly those affecting pregnancy and early childhood. Cross graduated from Boston University's Sargent College in 2020 with a BS in Human Physiology. While at the University, she helped foster community among underrepresented students by serving as the Public Relations Chair for the Minority Association of Pre-Health Students. Since beginning medical school, Cross has continued to take on leadership roles to promote diversity in medicine, notably as the Head of HBCU Outreach for CDU's Student National Medical Association chapter and Co-Vice President of the Obstetrics & Gynecology Interest Group. Prior to entering medical school, Cross completed several experiences in community health for underserved populations within the metro-Boston area, including an undergraduate practicum experience at Boston's largest day shelter, Saint Francis House, and research on perinatal health outcomes for women with substance use disorders at Massachusetts General Hospital. Additionally, she spent four years as a dedicated research assistant with Children's Health Watch, contributing to a longitudinal study that informs public health policy designed to improve the health of urban pediatric populations. After graduation, she played a pivotal role in managing the Grow Clinic for Children, a program that provides specialized care to children facing growth challenges. More recently, she was selected from a national pool as a Primary Care Leadership Program Scholar for the summer of 2024. During this program, Cross led a team on a research project designed to demystify the Regional Center referral process for the families of developmentally delayed children with limited English proficiency at Clínica Romero, a federally qualified health center dedicated to promoting health in the Hispanic immigrant community. With a passion for primary care and a dedicated focus on reducing disparities in maternal-child health through innovative multidisciplinary interventions, Cross aspires to become a compassionate physician and is excited to make contributions to healthcare equity and enhance primary care practices.

Chidi S. Ezeofor is a Los Angeles native who spent his childhood with his parents and brother in the cities of Carson, California and Long Beach, California. In addition to being a dedicated learner throughout his academic career, what really curated his character was his drive to be fulfilled at whatever he did, be it

sports, games, or skateboarding. He is a graduate of the University of California, Los Angeles, where he earned his Bachelor of Science in Biology. Chidi Ezeofor's exposure to health professionals began when he was in high school. As a student at Millikan High, he had the chance to shadow a health professional for a senior project and he chose a pharmacist. During this opportunity, he was able to interact not only with pharmacists and technicians but also with a few doctors. It was through one of these interactions with a doctor that he was intrigued by the intensive work some doctors do with international communities to address global health inequities, some of which he had witnessed in person. Mr. Ezeofor has engaged in community outreach work including food drives and has volunteered in local community health clinics for underserved communities. As a medical student in the CDU MD Program, Ezeofor wishes to continue the work that inspired him to pursue medicine. With opportunities to engage with underserved populations through interest groups and campus activities, Ezeofor will continue to partake in opportunities to improve health equity during his medical education.

Sigry Ortiz Flores (she/her) was born in Guatemala and immigrated to the United States, where she pursued her passion for healthcare and advocacy. She earned her Bachelor of Science in Biological Sciences with an emphasis in Human Biology from the University of California, Merced, and later completed the Post-Baccalaureate Program at UC Irvine School of Medicine. She is currently a medical student at Charles R. Drew University, where she is committed to addressing healthcare disparities and serving underrepresented communities. Sigry's dedication to global health led her to volunteer in the Philippines, where she collaborated with local healthcare providers and gained firsthand experience in rural, underserved medical settings. Her extensive background in research, mentorship, and community outreach reflects her commitment to improving health equity and medical education.

Josue Fraga is a medical student attending Charles R. Drew University of Medicine and Science in South Los Angeles. Growing up in the Coachella Valley, he saw the dire need for culturally competent medical providers in his community and decided to pursue a medical career. After attending the University of California-Los Angeles for a degree in Psychobiology B.S., he continued his passion to give back to underserved communities by continuing to volunteer at free medical clinics in Tijuana and became a mentor and tutor for students in grade K-12. After obtaining his medical degree, he aspires to become a primary care provider and advocate for Hispanic communities and LGBTQIA+ communities in South LA.

Selom Stacey Gbewonyo, a native of California's San Fernando Valley, is a medical student at Charles R. Drew University of Medicine and Science, committed to addressing healthcare disparities in underserved communities. She earned her Bachelor of Science degree from the University of California, Riverside, where she cultivated her passion for mentorship, leadership, and advocacy through UC Riverside's African Student Programs. Born into a rich Ghanaian heritage, Selom's upbringing instilled in her a deep reverence for her cultural roots and a strong sense of responsibility as the eldest sibling. Her experiences as a Health Scholar provided hands-on clinical exposure, reinforcing her dedication to patient-centered care and strengthening her resolve to pursue medicine. At Charles R. Drew University, Selom serves as President of the CDU Student National Medical Association (SNMA), Parliamentarian of Region One of SNMA, and External Coordinator for the CDU OBGYN Interest Group. She actively creates spaces for aspiring Black physicians and advocates for improvements in medical education and healthcare access. Inspired by the resilience of her

community and the contributions of Black medical professionals, Selom aspires to specialize in Obstetrics and Gynecology (OBGYN), focusing on improving maternal health outcomes for Black women. Through her work, she is dedicated to advancing equitable care, empowering future generations, and ensuring all patients receive the dignity and quality of care they deserve.

Dr. Sheba George is professor in the Department of Preventive & Social Medicine, at Charles R Drew University of Medicine and Science in Los Angeles. She is course director for the pre-clerkship longitudinal course Medicine & Society. She is director of the HRSA funded CDU Health Careers Opportunity program (HCOP) that serves educational and career development of underrepresented pre-Med and pre-PA program students. She is also director of the CDU Community Health Worker Academy that focuses on workforce development for community health workers in clinical settings. She has extensive expertise in using social scientific theories and qualitative/quantitative and community engaged methods in studying health inequities among minority, under-resourced populations. Her research has included the digital divide and its impact on meaningful use of health IT, research participation among vulnerable minority populations and the development of a cultural framework for health. She is also adjunct professor in the Department of Community Health Sciences in the UCLA Fielding School of Public Health.

Harneel Gill is a medical student at CDU. She immigrated to the U.S. at a young age and was raised in an underserved community, where she witnessed the challenges immigrants face in accessing healthcare. These experiences sparked her passion for medicine and healthcare equity. She began her education at Bakersfield Community College before transferring to UCLA, where she earned a B.S. in Environmental Science with a concentration in Environmental Health. At UCLA, she worked as a research assistant in the Parkinson Environmental Gut (PEG) Lab, studying the link between environmental exposures and Parkinson's disease. This experience deepened her interest in research-driven policy change to protect vulnerable populations. She gravitated towards similar projects in medical school and hopes to continue similar work in her future career by serving the most vulnerable populations in our communities.

Eric Gomez is a medical student at Charles R. Drew University of Medicine and Science in Los Angeles, CA. Previously a resident of the Inland Empire, he achieved a Bachelor of Science in Biology at California State University, San Bernardino and a Master of Biomedical Sciences at California University of Science and Medicine. His passion for medicine stems from years of working in the Emergency Department as a medical scribe, where he witnessed both the struggles patient's face when trying to access preventative healthcare and subsequent need to present to the Emergency Department. His goal is to create a system across networks where patients can be directly established with a primary care physician once they leave the Emergency Department. He currently serves as Co-Chair of the Emergency Medicine Interest Group and previously served as the Wellness Chair for the Latino Medical Student Association at CDU.

Jeneane Hamideh is a medical student at Charles R. Drew University of Health and Sciences, currently pursuing her Doctor of Medicine degree (anticipated June 2027) with a deep commitment to advancing healthcare equity and serving underserved communities. She earned a Bachelor of Science in Neuroscience from UC Riverside and completed a postbaccalaureate program at UC Irvine School of Medicine. Her current research roles include investigating pancreatic disease mechanisms at Cedars-Sinai Medical Center's

Pandol Lab, focusing on metabolic pathways and inflammatory responses, and contributing to innovations in minimally invasive urology techniques at the Innovation Center for Urologic Research & Education (iCURE). Jeneane's previous research experiences include studies on social determinants of health and mental illness disparities and chronic kidney disease management at Stanford University. With a clear vision to bridge healthcare access gaps and promote social justice, Jeneane aims to leverage her clinical and research experiences to uplift vulnerable populations and inspire future healthcare leaders.

Justin M. Henry, MPH, MS, is the Grants Manager for Program Compliance in the Ryan White Grants Management Division at Dallas County Health and Human Services. He has worked in strategic planning, management and performance improvement and evaluation since 2015. His experience includes leading, designing, and implementing innovative, performance-driven strategies to scale in addition to improving program evaluation, policy development, and budget formulation for national, federally funded grant programs.

Paola Hernandez is a medical student. Paola attended UCLA and earned her Bachelors of Science, Biology. During her undergraduate studies, she volunteered for five years with Venice Family Clinic, a federally qualified health center (FQHC). Following post-graduation, she became a medical scribe and research coordinator for the FQHC clinic in East Los Angeles.

Dr. August Hoffman, Ph.D., is currently a Professor of Psychology at Metropolitan State University. He earned his B.A. from UC Santa Barbara, M.A. from Radford University in Clinical Psychology, and Ph.D. from UCLA in educational psychology. Dr. Hoffman is an avid Wisconsin Master Gardener and has recently participated in several community development projects (fruit tree orchards, community gardens, and green space programs) in Detroit, MI, Yalpemech, Guatemala, Fond du Lac and Red Lake Tribal Nation, MN. He is a 2020 APA Division 27 Society for Community Research Action (SCRA) Fellow and recipient of the 2020 Metropolitan State University President's Civic Engagement Leadership Award.

Dr. Amber Kelly, Ph.D., is the Executive Director of the Society for Community Research and Action, Division 27 of the American Psychological Association. In addition, she is the founder of Community Engagement Collective (CEC), a community-based nonprofit that fosters human-centered connections through community-engaged events and research. She has worked on various projects focused on community outreach, nonprofit leadership, program evaluation, and community-based participatory research. Dr. Kelly is an Adjunct Faculty member at the University of Cincinnati (UC) and National Louis University (NLU). At UC, she teaches Community Involvement, and at NLU, she teaches Strategies for Community Interventions, Intro to Human Services, Research Methods, and Dissertation Proposal Seminar. She aspires to help students understand the importance of understanding community assets and community voice in promoting inclusion. Dr. Kelly completed her doctoral studies in community psychology at National Louis University. She holds a Master of Public Service Management from DePaul University and a Master of Public Mental Health and Certificate in Health Disparities and Health Inequality from Johns Hopkins Bloomberg School of Public Health. She completed her undergraduate studies at Clark Atlanta University with a Bachelor of Arts in Psychology and Minor in Spanish.

Sherin Lajevardi was born and raised in the San Francisco Bay Area. She is currently a second-year

medical student at Charles R. Drew University of Medicine and Science. She graduated with a B.S. and M.S. degree in Molecular and Cellular Physiology from the University of California, Davis. Sherin has a strong interest in cardiology, specifically how women and minority populations are disproportionately affected by cardiovascular disease. In addition, Sherin is passionate about global and immigrant health, she is committed to addressing healthcare disparities in marginalized communities and aims to bridge these gaps as a future physician.

Ethan Lawrence grew up in Palm Bay, Florida, and graduated from the University of Florida with a Bachelor of Science in Biology and a minor in Sociology. Ethan's academic and career pursuits have displayed a fervent commitment to public health and health advocacy in underserved communities. His volunteer experiences have reinforced the importance of understanding how one's environment, resources, and upbringing can drastically impact an individual's physical, mental, and emotional health. As a medical school student, Ethan serves as Co-President of CDU COM Eye and Ear, Co-Lead of Social Services of CDU COM Student-Run Clinic, and a second-year Medical School Representative of CDU COM Diversity, Equity & Inclusion Committee. He has also been committed to improving patient care through his translational research at Mass Eye and Ear, where he worked on AAV gene therapy for Usher Syndrome. Ethan's passion for serving under-resourced communities and influencing health policy drives him to become a culturally and linguistically competent physician knowledgeable about the social determinants of health. Ethan aspires to use his skills in American Sign Language and experiences in deaf culture to impact deaf and hard-of-hearing individuals in the future.

Rhonda K. Lewis, Ph.D., MPH. is a Professor and serves as the Graduate Coordinator, and the Community Psychology Ph.D. Coordinator in the Psychology department at Wichita State University. She received her Ph.D. in Developmental and Child Psychology from the University of Kansas and her Master of Public Health from the University of Kansas School of Medicine. She is the Director of the Behavioral Community Research and Action Team (BCRAT), where she and her graduate students are engaged in community-based participatory research. She uses social ecological, culturally responsive, and strength-based approaches to build the capacity of community-based organizations. Her research is focused on adolescents and emerging adults, substance abuse prevention, mental health and social justice. Dr. Lewis was the recipient of the Outstanding Contributions for Mentorship in Racial Justice Award from the Society for Community Research and Action (SCRA); she is a SCRA Fellow (Division 27 of APA), serves as an Associate Editor for the American Journal of Community Psychology, and is a member of Delta Sigma Theta Sorority, Inc.

Kevin Lopez is a medical student and passionate advocate for eye health equity, currently in his second year at Charles R. Drew University of Medicine and Science (CDU). With a Bachelor of Science in Biology-Physiology from California State University, Long Beach, and a Master of Science in Biomedical Sciences from CDU. For nearly a decade, he contributed to groundbreaking diabetic retinopathy research at CDU, earning co-authorships in 2013 and 2021. Collaborating with Drs. Omolola Ogunyemi and Lauren P. Daskivich, Kevin helped advance innovative solutions to improve access to diabetic eye care screening for underserved communities across Los Angeles County. Driven by a deep commitment to expanding eye care access, particularly in underserved populations, Kevin envisions a future where CDU houses a

thriving ophthalmology department and residency program. His future goal is to train and empower a new generation of culturally diverse ophthalmologists ready to meet the unique needs of South Los Angeles and beyond.

Briana Lopez is a medical student at Charles R. Drew University of Medicine and Science (CDU). Raised in Fresno, California, she was deeply influenced by her grandparents, Louis and Cecilia, whose support shaped her journey toward becoming a physician and health advocate. She earned a Bachelor of Science in Anthropology from UCLA, followed by a Master of Science in Biomedical Sciences and a Master of Public Health in Urban Health Disparities from CDU. She is honored to continue her medical education as part of CDU's inaugural College of Medicine (COM) class. Her ultimate goal as a physician is to alleviate health disparities in Los Angeles County by fostering community partnerships, cultivating strong patient-centered relationships, and advocating for systemic healthcare reforms. She envisions herself as a physician-leader, working alongside fellow providers and community leaders to create a more equitable healthcare system—one where accessible, high-quality care is a fundamental right, not a privilege.

Stephania Luna is a Los Angeles native, raised in a multi-generational household with her grandmother, parents, and brother. She earned her Bachelor of Science in Biology with a focus on environmental science from Mount Saint Mary's University – Los Angeles in 2019. As a first-generation college student, Stephania dedicated her volunteer work with various programs that focused on providing mentorship to other first-generation college students pursuing a career in healthcare, social justice, health advocacy, and providing services to underserved communities. She is currently a second-year medical student at Charles R. Drew University of Medicine and Science – College of Medicine and is interested in oncology and palliative care to guide patients and their loved ones through vulnerable times, including expanding access to palliative care to underserved patients. Stephania is committed to advocating for health equity for communities of color through policy and health disparities in cancer and palliative care research in the future.

Dr. Katie McAuliff, Ph.D., is a mixed methods community psychologist and health services researcher who completed her Ph.D. at DePaul University in 2017. Her dissertation focused on predictors of health-related quality of life among youth with spinal cord injury. Currently, her research focuses on social determinants of health and health-related quality of life, particularly among populations experiencing disabilities and chronic conditions. She is currently working at Brown University on a project focused on Meals on Wheels. Prior to working at Brown, she worked on a Medicaid redesign initiative in New York State. During graduate school, she worked on several evaluation projects, most of which focused on identifying barriers and improving access to care among underserved populations.

Eva McKinsey , is a PhD student in the Applied Social and Community Psychology program at North Carolina State University. She has done research on various topics, in diverse contexts, and using a multitude of research methods, including: participatory action research on housing and homelessness in Honolulu, Hawai'i ; secondary research on military personnel issues with the Congressional Research Service; and experimental studies within the criminal legal context. She has recently directed her research to better understanding tools, methods, and interventions that have potential in shifting us away from our reliance on retributive justice. Her current work focuses on the transformative potential of trauma-informed and

healing-centered training. She is also a committed learner and advocate of transformative justice, anti-racism, and mutual aid philosophy – in sum, how to be in right relationship with one another. When she's not in researcher-mode, Eva enjoys spending time outside, especially in the water, moving her body, and being in the company of loved ones.

Taylor Mitchell is a medical student at the Charles R. Drew University of Medicine and Science College of Medicine. Raised as an only child in the San Fernando Valley, Mitchell's journey to medicine has been shaped by her dedication to both academics and athletics. She completed her undergraduate studies at Duke University, where she was a student-athlete on the Duke women's soccer team. Mitchell double-majored in psychology and evolutionary anthropology, while also minoring in chemistry. Mitchell is deeply committed to advancing health equity, striving to create a world where it is not only an ideal but an expectation. She seeks to drive this change through both patient care and research. Over the past several years, she has contributed to several research projects focusing on health disparities, doctor-patient communication, shared decision-making, and medical school curricula. She is particularly passionate about advocating for underserved communities, with a focus on supporting Black, Indigenous, and people of color (BIPOC) populations.

Sabrina Montgomery, an Inglewood native, is a medical student at Charles R. Drew University of Medicine and Science, driven by a passion for improving health outcomes for underserved communities and women of color. She graduated from the University of California, Los Angeles (UCLA), earning a Bachelor of Arts in Sociology with double minors in African American Studies and Global Health. During her time at UCLA, Sabrina conducted research examining race/ethnicity and socio-economic status as predictors of postpartum depression and actively volunteered with programs designed to prepare inner-city high school students for higher education, recognizing education as a pathway to improved health outcomes. At Charles R. Drew, Sabrina's commitment to addressing health inequities continues to flourish. She is the founder and Co-President of the OB/GYN Interest Group and actively collaborates on Maternal-Fetal Medicine research with Stanford University's Dunlevie Center of Maternal-Fetal Medicine. Her research explores disparities in stillbirth care, furthering her goal to address the high morbidity and mortality rates faced by Black women in the United States. Sabrina is also a proud member of the Student National Medical Association, where she continues to advocate for diversity and equity in healthcare. Beyond her academic and professional pursuits, Sabrina is deeply connected to her community and heritage. She aspires to serve as an Obstetrician-Gynecologist to prolong the lives of women in underserved communities, grounded in her belief that the health of a society begins with the health of its women.

Alan T. Nguyen is a Los Angeles native who grew up in Canoga Park, California. He is a child of Vietnamese immigrants and the first in his family to pursue medicine. He is a California State University, Fullerton graduate, where he earned a Bachelor of Science in Biological Science with a concentration in cellular and molecular biology and a minor in chemistry. While attending Fullerton, Nguyen was accepted to the Bridges to Stem Cell Research Program funded by the California Institute of Regenerative Medicine to conduct stem cell research at Stanford University. Through the research completed at Stanford, Nguyen co-authored several publications related to pancreatic adenocarcinoma, wound healing, and abdominal adhesions. After his time in research, Nguyen volunteered at a food bank in Canoga Park and began working

at Vida Mobile Clinic. At Vida, he found his work with uninsured patients to be immensely fulfilling. This experience led him to make a life-long commitment to continue working with underserved patients in medicine. As a medical student at the Charles R. Drew University of Medicine and Science—College of Medicine, Nguyen is passionate about providing care to under-resourced communities. He aims to use his research and clinical background expertise to provide high-quality care to patients with complex medical histories. Ultimately, Nguyen plans to pursue a career in surgery for underserved communities.

Dr. Patricia (Pat) O'Connor, Ph.D., is a Professor and the Lorraine Walker Distinguish Chair in Psychology at Russell Sage College in Troy/Albany, NY. She was a director of their graduate psychology programs for almost 25 years and currently is the Chair of the Psychology Department. Graduates of the M.A. in Counseling and Community Psychology program can be licensed as mental health counselors in New York State. As part of Dr. O'Connor's career, she has emphasized building and ensuring quality in master's level education in psychology. In 1989 she helped organize the first national conference on master's standards and was involved in developing accreditation standards in 1995. Further, Dr. O'Connor serves as the Executive Director of the Masters in Psychology and Counseling Accreditation Council (MPCAC) since 2003, which was recently awarded CHEA (Council for Higher Education Accreditation) recognition. Research focuses on conducting program evaluations, working with local, state-based, and national agencies and not-for-profit organizations or groups. Dr. O'Connor encourages the development of an evaluation mentality, a process of incorporating evaluation designs and implementations from the onset of intervention planning to ensure a regular assessment of whether a program or intervention is needed, implemented as planned, produced the expected outcome, and budgeted appropriately.

Matthias Ojo was born and raised in Nigeria before immigrating to the United States. He is currently a second-year medical student at Charles R, Drew University of Medicine and Science. He graduated with a B.S. in biology and an M.S. degree in Healthcare Management with a concentration in Quality Management and Patients Safety. Matthias is committed to eliminating healthcare disparities by advocating for equitable access to quality medical care and increasing health literacy. He is passionate about preventative medicine and seeks to advance research and clinical initiatives that promote early intervention and long-term wellness for chronic illnesses.

Vanessa Peña-Garcia grew up in Highland Park, California, as a first-generation Mexican American and proud daughter of immigrant parents. She earned her Bachelor's degree in Biology from California State University, Northridge. During her undergraduate education, Peña-Garcia researched the effects of inflammatory markers on the maternal gut microbiome, where she received the award for best oral presentation at her institution's honor society research symposium. In 2018, Peña-Garcia joined AltaMed Institute for Health Equity as a Medical Education Specialist, developing the AltaMed Scholars Summer Program for underrepresented medical students. As a medical student at Charles R. Drew University of Medicine and Science, Peña-Garcia was the co-president for her school's Latino Medical Student Association, vice president for CDU's Student Run Health Center, and secretary for the CDU OBGYN Specialty Interest Group. She is involved in various research projects exploring topics such as trauma, medical education, and medical student attrition rates. In 2024, Peña-Garcia was a National Medical Fellowships Primary Care Leadership Program Scholar at Clínica Monseñor Oscar A. Romero in Los

Angeles, conducting quality improvement research on the Los Angeles Maternal Mental Health Access program. She is currently a National Medical Fellowships Health Equity Leadership Program scholar. Peña-Garcia aims to eliminate health disparities by combining her passion for medical education with providing quality care to historically disinvested communities as a future women's health physician.

Claudy Jean Pierre, BSPH, is a professional health planner for the Dallas County Health and Human Services Ryan White Planning Council. He is pursuing his Master's degree in public health at the University of Texas at Arlington and has experience working in women's health and HIV/AIDS prevention. He is also engaged in community-based work related to women's health in Grand-Goave, Haiti.

Dr. Anna Pruitt, Ph.D., is faculty affiliate in the Department of Psychology at the University of Hawai'i at Mānoa and a research associate with the Research Corporation of the University of Hawai'i. Using participatory and intersectional approaches, her research examines the effects of extreme poverty on individuals and communities. Her applied research on homelessness and food insecurity has been used to promote community wellbeing and resilience and to encourage equitable access to resources and voice in decision-making processes for traditionally marginalized communities.

Vishal Rao is a Bay Area native who grew up in the city of San Jose, California with his mother, father, and older sister. He is a graduate of UC Davis, where he earned a Bachelor of Science in Neurobiology, Physiology, and Behavior. From community engagements both locally and overseas, his desire to advocate and serve underserved communities specifically has grown. He has volunteered with such communities in Northern California by conducting blood pressure screening events for people experiencing homelessness, assisting with clinics at local Gurdwaras, and traveling to remote villages in Costa Rica to help provide medical relief. While an undergraduate student, Rao took his interest and passion for strength training to the MyoMatrix Lab at UC Davis, where he conducted research to observe the effects that chronic kidney disease has on muscle fibers. As a medical student at Charles R. Drew University of Medicine and Science – College of Medicine, Rao is curious to build upon his research experiences to learn about the pathophysiology of different diseases and conditions. He currently serves as the Co-President of the Surgery and Radiology Interest Groups at CDU to stimulate interest in other medical students and explore specialties within the fields of surgery and radiology.

Madilynn Reynoso is a second-year medical student at Charles R. Drew University of Medicine and Science. Raised in San Diego, California, she earned her Bachelor of Arts degree from San Diego State University in 2021. Growing up without health insurance and limited access to healthcare, she was inspired to pursue a career as a physician to provide care for individuals facing similar barriers to care. Her passion for humanitarian medicine developed through her experience in free clinics domestically and internationally, including in Mexico and Cambodia. Madilynn was awarded a full-tuition scholarship from the National Health Service Corps for her commitment to providing primary care in underserved communities. Madilynn aspires to complete a dual residency in Family Medicine and Psychiatry. She plans to work as a physician for the Indian Health Service on reservations across the United States and hopes to work internationally with global medicine organizations such as Doctors Without Borders in the future.

Dr. Tonya Roberson, Ph.D. is the Director of Community Engagement, Program Development and Academic Support at Governors State University in the College of Health and Human Services and the CEO/Founder of Helping Communities Help Themselves. Dr. Roberson has vast knowledge in biomedical research, culturally tailoring initiatives, community engagement and practice, survey design, extensive research recruitment, independent consulting, and evaluation. This experience is backed by twenty- five years of clinical nutrition/food service systems management experience which was acquired in large academic medical centers, healthcare organizations and community-based settings. She has a particular expertise in methods to address health inequalities, health promotion theories, and models to assess the holistic health of African Americans in the urban centers. Dr. Roberson is well connected and trusted in the Chicagoland communities and many other large US cities and is committed to giving generously of her time and talents through her community organizing efforts and outreach work to educate, empower and inspire individual be their own advocate for their health.

Martha Romero is a second-year medical student at Charles R. Drew University of Medicine and Science- College of Medicine. Born and raised in Santa Ana, California in a working-class immigrant family, she became the first in her family to graduate from college, earning a Biology B.S. with a minor in Chicano Studies from the University of California, Los Angeles. While at UCLA, Martha established a mentorship linkage between her hometown and UCLA's ALMA Science Academy focusing on reducing educational disparities in underserved communities. Before medical school, Martha continued serving as a leader in the Madison Park Neighborhood Association's educational pipeline programs and working as a bilingual medical assistant and manager at Clinica Medica Guerrero. As a medical student, she serves as president of the Family Medicine Interest Group and secretary of the CDU Latino Medical Student Association chapter. She was selected to participate in the National Medical Fellowship's Primary Care Leadership Program, where she partnered with AltaMed to conduct a community engagement research project. Her work focused on identifying best practices for engaging underserved communities and exploring strategies for community-based organizations to effectively address social determinants of health to reduce healthcare disparities. Martha is dedicated to becoming a compassionate and culturally competent physician, driven by her commitment to improving the health and well-being of her community.

Dr. Jacqueline Samuel, Ph.D., is the Program Director of the Master of Public Administration and Assistant Professor at National Louis University (NLU). Jacqueline is actually returning to NLU as she earned her MA in Public Policy and Ph.D. in Community Psychology. Previously Jacqueline served as the Project Manager for the Housing Authority of Cook County, South Suburban Safe and Thriving Communities Program to address youth violence in 3 suburban townships. She also facilitated and developed quality of life programs for 10 years in the South Chicago Area. She has served on the Health and Healing committee/ Mayor Rahm Emanuel's Commission for a Safer Chicago, The Mayor Rahm Emanuel's Kitchen Cabinet Commercial Development Advisory, Advocate Trinity Hospital Community Health Council, Community Advisory Review Council for the Institute for Translational Medicine (CARC) and the Illinois ACE's Response Collaborative. She was also a Co-Investigator for Community Academic Collaboration to Prevent Violence in Chicago Research for Lurie Children's Hospital Strengthening Chicago's Youth. Recent awards include National Louis University REACH Award, Ann & Robert H. Lurie Children's Hospital

Courage Award, and the Chicago Police Department CAPS Award for the 4th District area. Jackie was born and raised in Chicago. She has a love for the arts and has performed in numerous plays and films based in Chicago.

Jerrise Smith is a senior public health student at the University of Texas at Arlington. She is a proud U.S. Air Force veteran with eight years of exemplary service. Jerrise' s interest and experience span maternal and infant health, food security, posttraumatic stress disorder in low-income communities, and drug and alcohol use among veterans with dishonorable discharge.

Dr. Deidra Somerville, Ph.D., has worked for more than 25 years as an organizer, counselor, advocate, and administrator. Trained as a clinician and macro practitioner, she brings a unique lens and skills set to clients, organizations, and communities. She began her work as a clinician in school settings, youth-focused residential treatment centers and drug treatment settings. Her initial clinical work led to an examination of, and interest in the connections between individual treatment and systems change. She facilitates discussions on this topic, as explored in her workshop titled, "The Master's Tools Will Not Dismantle the Master's House: Organizations As Tools for Community Empowerment", presented in 2013. Her dissertation work, examining the strategies and networks of Black maternal activists in Chicago, has given her insight into the challenges, opportunities, and possibilities for communities to use disruptive practices while working with established systems to improve the quality of life in communities. Her work centers Black mothering, organizing, and the indigenous knowledge that is drawn upon to resist and persist in the face of structural oppression. She is trained in both clinical and liberatory based healing strategies and draws upon these approaches in her work as a community psychologist with clients and communities.

Fatimatou Saka is a second-year medical student at Charles R. Drew University of Medicine and Science. She was born and raised in Togo, West Africa. Her firsthand experience with limited healthcare access, both in her home country and within her community, inspired her to pursue a career in medicine with a focus on serving underserved populations. She earned her undergraduate degree in physiology with a minor in French from the University of Minnesota and later completed post-baccalaureate studies at California State University, East Bay. Fatimatou's commitment to community service is demonstrated through her volunteer work at Los Angeles County General Hospital and West Valley Food Pantry. As a medical student, she continues her outreach efforts and currently serves as the Community Health Screening Coordinator for the Dotun Ogunyemi MD Foundation (DOF). Passionate about health equity, Fatimatou aims to practice medicine in underserved communities and conduct research that advances healthcare outcomes for immigrant populations, minority groups, and low-income individuals.

Austin Hudson is from Carson, California, and currently a medical student at Charles R. Drew University of Medicine & Science (CDU). Prior to beginning medical school, he received a Bachelor of Science in Biology from Xavier University of Louisiana followed by a Master of Science in Biomedical Sciences from CDU. His experiences as an educator, medical scribe, and a volunteer at Martin Luther King Community Hospital laid the foundation for his commitment to addressing health disparities. Austin aspires to become an orthopedic surgeon and ultimately create systemic change that leads to improved health outcomes for underserved communities.

Alexander Afewerki is a medical student at Charles R. Drew University of Medicine and Science. He was born and raised in Eritrea, where his early life experiences inspired his desire to pursue a career in medicine focused on addressing healthcare disparities. He earned his bachelor's degree in human biology and society from the University of California Los Angeles and also earned a master's degree in applied Life sciences from Keck Graduate Institute. As a student, he is involved in community outreach programs working to provide education and mentorship to students from underserved backgrounds. Alexander is committed to returning to similar communities, where he aims to provide compassionate care, address healthcare disparities, and advocate for lasting systemic improvements in health outcomes.

David Heredia is a lifelong resident of the city of Bell Gardens, a small town in Southeast Los Angeles, and lives with his wife and two children. He is a graduate of the University of Southern California where he earned a Bachelor of Science in Human Biology. He has volunteered for over a decade in youth sports teams, city cleanups, and COVID clinics in under resourced neighborhoods, such as his hometown. Over the past six years he has also served as Chairperson of the City of Bell Gardens Traffic and Safety Commission to help promote health through safe outdoor physical activity. As a medical student, at Charles R. Drew University of Medicine and Science College of Medicine, Heredia is considering a career in Pediatric Emergency Medicine. He is passionate about working in underserved neighborhoods with a focus on researching health disparities such as limited healthy food availability and outdoor play, and their effects on youth that lead to cycles of unhealthy habits.

Monika Watat is a medical student at Charles R. Drew University of Medicine and Science. As a first-generation Cameroonian immigrant, she is driven by a desire to care for the communities that raised her. Growing up in Baltimore, she earned a B.S. in Public Health Studies from Johns Hopkins University, where she developed a passion for reproductive health and disparities-based research. She later obtained an MSPH with a focus in maternal, fetal, and perinatal health from the Bloomberg School of Public Health, during which time she worked with local organizations supporting mothers of color with babies in the NICU. As a future physician, Monika aspires to integrate research, advocacy, and clinical care into her practice, and looks forward to deepening her commitment to reproductive health and healthcare equity.

Makeen Yasar, B.S. (he/hm), is a change agent, poet, writer, and medical student attending Charles Drew University of Medicine and Science in Los Angeles, CA as part of their inaugural class. Yasar has roots in Los Angeles by way of his ancestors' migration from Kansas City and St. Louis. Born in Pasadena and raised in Palmdale, CA, Yasar settled down in LA in his late teens and attended Loyola Marymount University (LMU) where he earned his B.S. in Health and Human Sciences with a minor in African American Studies. Yasar aims to become a Family Medicine doctor committed to revolutionary organizing, community-centered healing, and the transformation of health systems.

Amina Latif is a first-generation medical student at Charles R. Drew University of Medicine and Science, driven by a deep commitment to serving vulnerable and underserved populations. Earning her Master of Biomedical Sciences from the same institution further fueled her passion for medicine, solidifying her dedication to bridging healthcare disparities. With a profound curiosity for the complexities of orthopedic surgery, she is determined to advance the field and improve surgical outcomes, ensuring that all

patients—regardless of background—receive the highest quality of care. Through her work, she strives to make a lasting impact on both individual lives and the broader healthcare system.

Daphne Okoro is a medical student at Charles R. Drew University of Medicine and Science in Los Angeles, CA. Originally from Friendswood, Texas, she holds a Bachelor of Arts in Geography, with a minor in Spanish, from The University of Texas at San Antonio. Inspired by her personal experiences growing up with two brothers who have Autism, Daphne's academic interests center on psychiatry, preventive medicine, and the role of nutrition in health and wellness. Her current research explores these themes in vulnerable and underserved populations.

Kaylah Denise Wade B.A, M.S, is a medical student at Charles R. Drew University of Medicine and Science (CDU) and a member of the university's inaugural MD class of 2027. She is from Bellflower, California and considers herself a Los Angeles County native. She earned her Bachelor of Arts in Social Welfare from the University of California, Berkeley, before completing a master's in biomedical sciences at CDU. Her research focuses on mental health disparities, particularly as they impact vulnerable populations.

Lule A. DeShields, a Los Angeles native is a medical student at Charles R. Drew University of Medicine and Science. As the child of an immigrant, Lule A. DeShields was propelled to pursue community medicine after witnessing the barriers communities of color faced when accessing health care. In college, she became involved in a research initiative to combat LA homeless opioid addiction, where she learned about social determinants of health through interviewing social workers, community leaders, and the homeless from Skid Row. This experience influenced DeShields to continue researching different ways to incorporate community resources and implement programming into care for the medically underserved. She earned her Bachelor of Science in Nutritional Science with a concentration in physiology and metabolism from UC Berkeley in 2019, with the intention of having a more holistic understanding of how nutrition plays a role in a patient's overall health. While at UC Berkeley, DeShields served as the regional director of the SCS Noonan Scholars. In this leadership role, she held on-campus events and mentored other undergraduates. She was also a Berkeley Biology Scholar, which allowed her to connect with students who also came from marginalized communities. DeShields is also one of eight recipients of the 2023 LA Care Safety Net Scholarship. Currently, DeShields is conducting research on health disparities in pediatric patients with metabolic dysfunction-associated steatosis liver disease with the Stanford Department of Pediatrics. She is a member of the Student National Medical Association and Internal Medicine Interest Groups. She is also on the executive board of CDU's first student-run free clinic, where she works on Community Outreach. In the future, she aspires to address health disparities in culturally competent care, health literacy, and nutrition through advocacy and community collaboration.

Chrystal Kumar, a medical student at Charles R. Drew University of Medicine and Science—College of Medicine (CDU), is committed to improving healthcare access for underserved communities and nurturing the next generation of physician leaders. Her passion for addressing systemic barriers in healthcare is exemplified by her participation in the National Medical Fellowships Primary Care Leadership Program, where she worked with AltaMed's Government Affairs team to identify strategies for California to increase the number of International Medical Graduates and tackle physician shortages. Additionally, she is a mentor

in the Health Careers Opportunity Program at CDU, directly impacting mentees by guiding them through the medical school application process, as part of her broader vision to diversify and strengthen the medical profession. Ms. Kumar has also founded and serves as the Co-President of both the Women in Medicine and the Pediatrics Interest Groups at CDU. Elected by her peers as Vice President of the CDU College of Medicine Class of 2027, Ms. Kumar's leadership is recognized and valued within her academic community.

Amon Rodgers, MD, MPH, MBA, is a family medicine physician and an assistant professor at Charles R. Drew University (CDU) of Medicine and Science. He serves as the founding co-director for the university's school of medicine's "Medicine and Society" curriculum, a course designed to introduce medical students to topics around health equity, community partnership, and leadership. He also serves as principal investigator and medical director for the university's Mobile Health Outreach Program, which focuses on providing primary care and public health services directly to communities disproportionately affected by health inequities throughout Los Angeles County. Dr. Rodgers received his medical degree from the University of California, Los Angeles and completed his Family Medicine residency at Kaiser Permanente in Fontana. He also completed a fellowship in minority health equity at Harvard School of Public Health where he received his MPH, as well as a fellowship in health equity and leadership at Yale School of Management where he received his MBA. His professional interests include mobile health service delivery, leadership development, optimizing healthcare delivery for underserved communities, understanding the relationship between community development and one's health, and addressing health system strategic decision making through a health equity framework.

Mubarak Sanni was born in Ilesa, Nigeria, and moved to Bridgeport, Connecticut, at the age of four with his family. He completed his undergraduate studies at Wesleyan University in Middletown, CT, majoring in Neuroscience & Behavior and Science in Society. Sanni contributed to community health research, co-authoring a paper on the impact of gentrification in Harlem on aging African Americans. He also co-led a mental health activism group promoting global health awareness. Sanni worked as a healthcare consultant and later joined Weill Cornell Medicine's geriatrics and palliative care unit, conducting clinical research on chronic pain in older adults. As a medical student at Charles Drew University of Medicine and Science, Sanni is passionate about health advocacy for minority populations locally and globally. Growing up in Bridgeport, he has firsthand knowledge of inequities like limited healthcare access, food insecurity, and violence. He aspires to become a culturally competent physician addressing the needs of disadvantaged communities. Sanni is involved with the Student National Medical Association and serves as co-president of the American Muslim Medical Student Association. He is also on the board of CDU's first free clinic, focusing on mental health and addiction services.

Martin Vazquez, a medical student at Charles R. Drew University of Medicine and Science College of Medicine, has a commitment and appreciation for diversity, volunteering, and mentoring. In 2017, Mr. Vazquez graduated from the University of California, Los Angeles where he earned a BA in Chicana and Chicano Studies and BS in Biology. While an undergraduate, he served as the programming director for the Latino Student Health Project, where he helped plan health fair events both in Los Angeles County and across the border in Tecate, Mexico. After graduation, he completed an informal post-baccalaureate program through UCLA and UCSD Extension while working at the Venice Family Clinic, a Federally

Qualified Health Center. He also earned a Master of Science in Medical Sciences at Western University of Health Sciences. His academic and career pursuits have displayed a fervent commitment to health advocacy in underserved communities. As a medical school student, he has volunteered at several clinics for underserved populations and giving back to the unhoused population in downtown Los Angeles. Being part of the inaugural class Vazquez helped establish both the Latino Medical Student Association and the Family Medicine Interest Group. Currently, he serves as the Medical Student Representative on the Board of Physicians for a Healthy California (PHC). In this role, he will be able to advocate and represent the diverse medical student population that encompasses California Vazquez is dedicated to creating a pathway for future medical students. He serves as a mentor for various programs which aim at providing mentorship for underrepresented youth in Southern California who are interested in a career in healthcare.

Darrin S. Ward is a medical student at Charles R. Drew University of Medicine and Science—College of Medicine, currently on the path to realizing his lifelong dream of becoming a physician. Hailing from his hometown of Compton, California, Darrin holds a Bachelor of Science in Psychology from the University of California, Riverside. Post-graduation, he pursued a postbaccalaureate certificate and later earned a Master's in Biomedical Sciences from CDU. Darrin's motivation to pursue a career in medicine was deeply rooted in a personal experience—witnessing his mother go into hypoglycemic shock. The paramedics' timely intervention saved her life, and from that day forward, his mother became his first medical mentor, teaching him how to administer insulin by practicing on oranges in their backyard using a glucose meter. Darrin envisions practicing medicine in his hometown of Compton, where his journey began. His goal is to contribute to the well-being of the community that shaped him and to address healthcare disparities by providing accessible and compassionate medical care to all. Through his dedication, Darrin strives to be a positive force, promoting health equity and empowering individuals to seek medical attention without fear of judgment. At CDU Darrin is an active member of the Student National Medical Association (SNMA) and serves as community Liaison. Darrin is also Vice President of the orthopedic student interest group. Darrin continues to sit as executive board member of the organization "The Coalition of Black Men Physicians"

Denise Willoughby grew up in Los Angeles, California, and graduated from the University of California, Los Angeles with a Bachelor of Science in Psychobiology. Her passion for medicine started at a young age, inspired by watching her father, a dedicated orthopedic surgeon, treat and advocate for his patients in the underserved community. Before entering medical school, Denise gained pivotal insights into surgical care under the mentorship of Dr. Jacqueline Lezine-Hanna as her preceptor. She is also dedicated to providing mentorship to the next generation with the hope of encouraging them to get involved in the medical field by sharing her experiences, opportunities, and resources. While speaking with the members of the Making Choices Mentoring Program, which she used to be a member in when she was younger, she directly saw the impact she could have on empowering young African American females to strive toward success and pursue their career goals. As a second-year medical student at Charles R. Drew University, Denise is determined to use her knowledge and resources to increase the representation of minorities in medicine and decrease health disparities in her community. In the past she has served as the Secretary in the CDU Surgery Interest Group, where they strive to build relationships with residents and physicians in different specialties. She also served as MS1 Liaison in the CDU chapter of Student National Medical Association in hopes of fostering mentorships

with the next MS1 class. She currently serves as Secretary in the CDU Women in Surgery Interest Group, Social Media Chair for the Eye and Ear Interest Group, and Vice President of the Yoga Interest Group.

Ciann L. Wilson, PhD, is a Black woman, scholar, consultant, and mother. Wilson is the 2023 Robbins-Olivier Award Winner for Excellence in Equity Research, as well as a Canada Research Chair in Community-Based Research, Ethics, and Wellbeing. Her interdisciplinary work focuses on the health and well-being of Black, Indigenous, and racialized communities, incorporating intersectional, anti-colonial, and anti-oppressive frameworks on topical issues that range from education to mental, as well as sexual and reproductive health and justice.

Dr. Susan Wolfe, Ph.D. – is a Community Consultant at Susan Wolfe and Associates in Cedar Hill, TX. She conducts evaluations and needs assessments, supports coalition development, builds organizational capacity, and facilitates strategic planning with local community-based, state, and national organizations. She has over 35 years of professional experience. Her work is performed through an equity and decoloniality lens with a focus on systems level change. She regularly presents at national and international conferences and has published numerous peer-reviewed and other journal articles, book chapters, edited volumes, blogs and reports. Dr. Wolfe was the recipient of the US Department of Health and Human Services Inspector General's Award for Excellence in Evaluation and three Exceptional Achievement Awards, the Society for Community Research and Action's (SCRA) Distinguished Contributions to Community Psychology Practice, John Kalafat Practitioner Award, and the Don Klein Publication Award. Dr. Wolfe has a Master of Arts Degree in Ecological Psychology from Michigan State University and a PhD from The University of Texas at Dallas in Human Development and Communication Sciences.

How to Access and Use This Book

It is our intent that this book will be adopted for undergraduate and graduate level courses, and practitioner work in community psychology, and allied disciplines (e.g. community development or community health), as a part of requirement readings. You may use this book as it is, or create adaptations or supplementary materials as needed. An important benefit of *Case Studies in Community Practice: A Global Lens* is that instructors can match the case stories to chapters in other existing textbooks such as *Introduction to Community Psychology: Becoming an Agent of Change* to create customized reading materials for your course(s).

This is our first book in what we hope will be a series of case studies that offer theory, historical context, voices of real people in real situations and offer options for change that demonstrate social and racial justice. Our focus is on providing an inclusionary space where community psychologists and co-creators within communities are centered and highlighted. We hope the book is question-centered, versus answer-centered. We divided the book into four parts which are not inclusive of all community psychology practice, but we hope are broad umbrellas of the case stories we present in this first book. We urge instructors, students, and other facilitators to use the Reflection and Questions section offered after each chapter, and provide us feedback on the feedback form found at the end of the book. Two of the editors are professors and we will be using this book in our classes. We are hoping that it will of great use to practitioners as well.

Make sure to read the licensing information found in this book and take care to attribute the chapters or book properly when reusing, redistributing, or adapting.

This textbook can be read online, and is also downloadable in multiple formats such as PDF from the *home page* of the book. The PDF files can be edited with Adobe Acrobat's Pro, which is the full program that allows you to edit, and is not limited to reading only. Students and instructors may add new sections to an adapted book such as quizzes or new discussion questions. Please see the Rebus Community's Guide to *Making Open Textbooks with Students* for more information and creative ideas.

If you plan to use or adapt our textbook, or chapters, we would be excited to hear about it! Please let us know on the Rebus Community platform or feel free to use our adoption form.

Preface

WHY A BOOK ON CASE STUDIES IN COMMUNITY PSYCHOLOGY PRACTICE?*

The primary impetus behind this book is centered on my (Dr. Palmer's) search for case studies to use in teaching graduate-level classes in community and social psychology. When I found books dedicated to case studies in social psychology, I was happy because I found it easier to move students through an understanding of theory to practice or praxis with good case studies depicting work in the real world. Yet, as a community psychologist my immediate thought when I found a social psychology case study book was, "Don't we need a book like this in community psychology?" My response was, "Of course we do!" My mind flashed back to searching for case studies in textbooks, YouTube videos, articles, PBS videos and more that I could use in my community psychology classes. Most adequate case studies I did find came from sources that were not explicitly using a community psychology lens. There was not one book available within the community psychology discipline that was solely dedicated to offering comprehensive case studies depicting work conducted by academic practitioners, full-time practitioners, or even applied researchers. Yet, having these studies in one volume available online for free can be a critical tool in teaching and practicing our discipline. The current book answers this need and is written to provide students studying community psychology, teachers, and practitioners with a resource that meets their needs. The book can also serve to attract other community-minded individuals to our wonderful field.

WHAT IS THIS BOOK ABOUT?

From a pedagogical lens, researchers concur that teaching and learning styles have changed, moving from lecture-based activities towards more student-centered or active learning techniques. Case studies help bridge the gap between theory and praxis, which is always a plus in teaching an applied discipline. This work

is the quintessence of contextualizing theories in community psychology including settings, empowerment, sense of community, second-order change, and more. Furthermore, case studies portraying community psychology practice promotes active learning, which in turn can enhance learning outcomes by fostering critical thinking skills, an area that has been found to be seriously deficient in many contemporary classrooms (Tsui, 2002).

The discipline of community psychology is ideal for using case study teaching because of the numerous practitioners who work in and with communities and members all over the world.

Moreover, case studies have also been linked with increased student motivation and interest in a subject (Mustoe & Croft, 1999). This book illustrates the benefits and challenges of community psychology-in-action and also shares lessons learned. These lessons can be useful to the reader so they can avoid making similar missteps, but just as importantly, to show the humanity of practitioners and members of the community. We are in a time where this book seeks to play a part in dismantling colonial ideologies, and whenever possible, remove the stigma of dehumanization bestowed upon too many groups. A number of the case studies include field research including participatory action research (PAR) a core technique in community psychology, as part of the initial steps to design and implement an initiative, intervention, or prevention strategy. Also included you will find an emphasis on cultural responsiveness and the importance of continually growing in our awareness and appreciation for how cultures impact settings. We believe that focusing on culturally responsive approaches will support effective partnering with community members to create more equitable spaces. An additional highlight of each chapter is a series of discussion questions that are specifically designed to spur critical thinking on the topic, as opposed to prescribing what readers should think.

ADVANCING EQUITY

This book investigates the practitioners' thoughts and lenses carried with them throughout the projects, with an intentional and unique feature on matters of diversity, equity, inclusion, and racial justice. As community psychology practitioners our work is often focused on dismantling structural systems of inequality and oppression. Historically, a good deal of this important community-engaged work may not have found its way into other textbooks or academic journals. However, this book offers a unique opportunity to highlight the stories of colleagues doing valuable work and learn through reading their narratives and lived experiences. We are "changing the world, one community at a time." Won't you join us?

Geraldine (Geri) Palmer, Todd Rogers, Judah Viola, and Maronica Engel

***This textbook is currently supported on Firefox, Chrome, Safari, and Microsoft Edge internet browsers. Internet Explorer is not currently compatible with our formatting.**

References

Mustoe, L. & Croft, A. (1999). Motivating engineering students by using modern case studies. *International Journal of Engineering, 15*, 496-476.

Tsui, L. (2002) Fostering Critical Thinking through Effective Pedagogy, *The Journal of Higher Education*, 73:6, 740-763, DOI: 10.1080/00221546.2002.11777179

SEE CONTRIBUTORS PAGE FOR LIST OF AUTHORS (EDITED BY GERALDINE PALMER, TODD ROGERS, JUDAH VIOLA, AND MARONICA ENGEL)

Introduction

"…but explanations alone do not bring us to the practice of beloved community…" – bell hooks

Where does the energy come from that all living organisms need to grow and develop? This seems a strange question to ask when this book is all about community psychology and not life science right? Yet we are hoping that the question makes more sense when we recognize that a community is a living organism and needs certain nutrients as all organisms do to convert to energy that of course, is used to develop and grow! It should be noted that a community isn't just geographic space, although it certainly can be. Like the concept of "home" it can be emotional as well, or both geographic and emotional. There are virtual communities, communities of people who similarly identify based on a number of facets and find a safe space to express group affiliation—-a community of professors, community practitioners, and so forth. A second relevant question might be, just what are the nutrients that a community needs to grow and develop? This book offers some answers to this question.



Pixabay.com

Thinking through this, a healthy community needs its citizens to be invested. It also needs kinship partners to invest in the community in concert with other citizens. In a physical community needs range from local small businesses, quality physical and mental health entities, grocery stores, parks and recreational facilities, schools and faith-based institutions,

banks and social services, among so many other resources. What happens to a physical community when its needed resources are scarce or not available? Just like any living organism that does not receive proper nutrients, it does not remain healthy. How do we enjoin with another community, as a community? This book offers one of the answers to this question as well.

The field of community psychology has international origins that vary across continents. In the United States a number of antecedents including the development of preventive perspectives in mental health, reforms in the mental health systems, group dynamics and action research, and movements for social change and liberation are evidenced (Kloos et al., 2012).

Born out of the optimism of society that surfaced after these social change movements of the 1960s took place, and the allied victory of World War II, a group of clinical psychologists were ready for a movement of their own. At a conference for psychologists in 1965, at Swampscott, Massachusetts, a group of clinical psychologists' voices were lifted and heard. The work which they were doing in communities and the implications of deinstitutionalization demanded a new discipline. One that spoke to social change in society and professionals becoming change agents starting within communities. Community psychology was born with the onset of community mental health training programs as well as one of the first clinical-community doctoral programs which began at DePaul University in Chicago in 1966. Another program began in 1966 at the University of Texas at Austin by Ira Iscoe. By 1975, 141 graduate programs existed to formally train community psychologists (Jason et al., 2019, p.). Further community-based research and action took off and in the same year another important component was established, Division 27 of the American Psychological Association (APA) which is now the Society for Community Research and Action. Simultaneously, in response to systems of repression and political exclusion, forms of community psychology were being established in Canada, Australia, New Zealand, Germany, Puerto Rico, Venezuela,



(image is showing Swampscott, Mass where Community Psychology was conceived as a discipline.

Mexico, and Cuba. In Italy, community psychology grew out of efforts to close psychiatric hospitals, and an overarching effort to shift educational, social, and health systems towards an emphasis on prevention, citizen participation and the reduction of victim-blaming (Santinello et al., 2010) and further growth of the field was seen in South Africa in the 1980s as psychologists engaged in the fight against the apartheid regime (Yen, 2007).

Before we dig deeper into this collection of community psychology case stories, let's take a step back and look at the field of community psychology itself and how the role of a community psychology practitioner is different from other social service-based roles. By "social service" based roles we mean roles where the focus is on the health, wellness, and actualization of individuals, families, and communities.

There are many occupations in the social service sector: medical health professionals (e.g., doctors, nurses, medical technicians and supporting medical staff), educational professionals (e.g., teachers, scholar-activists, and child care workers), community infrastructure professionals (e.g. community center managers, policing, community developers and organizers, alderpersons, and community program coordinators) and identity health professionals (e.g., social workers, psychologists, school counselors, therapists). These lists are not exhaustive and there are many opportunities and situations where there is overlap and collaboration between all roles. That said, there is one role that includes all of these types of tasks and that is the role of the community psychologist.

Psychologists of all types are focused on identity construction and how an individual or group develops an identity and uses that identity as a framework for accomplishing goals, life tasks, and achieving their best lives. Many times psychologists work with individuals and groups they are trying to help to develop interventions, ways the system can be shifted and transformed in order for the individual or group to have the best opportunity to live their preferred lives with a sense of agency that demonstrates their understanding of the best version of their ideas about themselves or rather their identity.

For example, a clinical or family and practice psychologist uses talk therapy as well as other techniques like hypnosis or cognitive-based therapies (CBT) to help an individual better see how their understanding of themselves are constructed through their lived experiences within their environments and their family of origin. The psychologist might then help them diminish, dampen and overcome some aspects of those constructions about themselves as they bring forward and strengthen preferred aspects of the person they want to become and are becoming.

A social psychologist studies social norms and conventions and the influence and impact they have on the thinking and behavior of individuals. A social psychologist might devise studies that look at the correlations and consequences or stereotypes, prejudice or discrimination on individuals. Or they might look at how groups make certain types of decisions. The goal is to identify variables that might be leveraged to develop interventions that shift the social system toward more positive outcomes.

An organizational psychologist might look at similar phenomena as a social psychologist but within the context of the workplace. Organizational psychologists may devise studies that look at employee satisfaction and human performance in the workplace and devise interventions that optimize those outcomes.

Now, what about a community psychologist? The central focus of a community psychologist is on identifying, studying, and better understanding the dynamics and patterns of a community that impact individuals, families and our broader society. In addition, through this work community psychologists also seek to better understand a community's impact on individuals, families and our broader society. Community psychologists use social science research methods to understand these dynamics and patterns of influence. With this lens and framework a community psychologist seeks to also eradicate structural systems of oppression and inequity that negatively impacts individuals, families, and communities and seeks ways to eradicate these systems.

A community psychologist might conduct studies, specifically through participatory action research (PAR), phenomenological, ethnographic studies, or photovoice. The results of their studies can be used to inform interventions and promotion strategies that might take the form of a type of Community Action Program (CAP). This work can involve community psychologists applying for grants to conduct research and open the door for community agencies to apply for grants using the studies as data to inform action plans. This work might include a follow-up study that demonstrates that the proposed intervention or prevention strategy worked. In this respect, community psychologists are not just scientists, they are community activists, organizers, abolitionists, and change leaders.

A community psychologist's work has a specific applied focus such as conducting studies and developing interventions and prevention strategies alongside of individuals and families who comprise a community, they imagine new possibilities together to meet community challenges and co-create and promote environments where equitable resources can be realized sustainably. While community psychologists often work in academic settings, others work in research institutions or governmental organizations, or as *community practitioners* in a number of roles including community developers or organizers, program evaluators, or within human services and nonprofit organizations. Community psychologists are often teachers or professors in academia *and* community practitioners! To learn more about the depth and breadth of this exciting and important field see Jason, Glantsman,

O'Brien & Ramian Eds. (2019) Introduction to Community Psychology: Becoming an Agent of Change.

This book is focused on the community psychologist as *practitioner* and is written to provide a glimpse into how practitioners carry out their work in diverse and complex communities and for pure motivation for all of us to get out and change the world!

The structure of Case Studies in Community Psychology: A Global Perspective is organized into four sections: Community Building, Global Perspectives, Evaluation Research, and Community and Public Health. Community Building houses three case stories from Dr. Jacqueline Samuel who authored *Cultural Development in Underrepresented Communities: Using an Empowerment and Citizen Participation Framework* giving the reader a well-spring of information on the positive linkage between the arts and community development. Next is *Dare2Dialogue*, where Dr. Amber Kelly and Kathleen McAuliff share important points on inclusivity among the disability community. Dr. Hoffman's *Green Space Programs as a Shared Growth and Communal Process: A Somali Gardener's Journey in Minnesota* combines the intersection of gardening and community building.

In section three, Program Evaluations and Research the textbook provides case stories that depict what it looks like for community psychologists to work as consultants in program evaluations. Drs. Susan Wolfe and Kyrah Brown, et al. gives first-hand experiences including lessons learned in *Lessons from Conducting an Equity-Focused, Participatory Needs Assessment.* Dr. Patricia O'Connor's case story *Program Evaluation: A Fundamental Component in Effective Community Practice* is next in this section. The case story focus is on the importance of program evaluations in community psychology practice. A third case story in this section is Dr. Anna Pruitt et al., *Showing up and Standing With: An Intersectional Approach to a Participatory Evaluation of a Housing First Program on Oahu*. Pruitt et al., describes a five-year, ongoing participatory evaluation program between a housing program and stakeholders. The last section Community and Public Health is comprised of three case stories: *A Plan for Prevention: Measuring Equity*



London, UK – June 17th 2020: A poster with the message Community is Strength on display near London Bridge station in London, UK.

from the Start by Dr. Tonya Roberson who discusses the importance of using a collective-impact approach and culturally tailored data collection tools to advance health parity. Following Dr. Roberson's work is Dr. Dessie Clark's and Joshua Brown's work, *Working with Survivors of Gender-Based Violence.* The case story does a great job in highlighting how communities can be a tremendous source of support for gender-based violence. Our third case story in this section is Dr. Deidra Somerville's case story *Journeying Past Hurt: Creating and Sustaining Trauma-Informed Healing Practices With Lower SES Black Pregnant and Parenting Mothers* showing the process of development of a curriculum to address trauma among Black children and families. Along with these 11 great case stories, this textbook has some wonderful features that you will learn from and enjoy! The case studies are meant to be a starting point in your journey of learning how to identify and study the different variables that drive the system of communities and how seasoned and new practitioners go about using their research, backstories, practice, and praxis in a practical way to engage all the parts of a community to achieve positive change. We use active links to web pages, articles, podcasts, videos, and more to provide an interactive experience that is sure to be a great learning journey! Go ahead, you're a click away!

References

Jason, L.A., Glantsman, O., O'Brien, J.F., & Ramian, K. N. (2019) *Introduction to community psychology: Becoming an agent of change.* Rebus Pressbooks https://press.rebus.community/introductiontocommunitypsychology/

Julian, D.A. (2006). A community practice model for community psychologists and some examples of the application of community practice skills from the partnerships for success initiative in Ohio. *The American Journal of Community Psychology Practice, 37*(1-2), 77-93.

Kloos, B., Hill, J., Thomas, E., Wandersman, A., Elias, M.J., & Dalton, J.H. (2012). *Community psychology.* Wadsworth, Cengage Learning.

Mustoe, L.R., & Croft, A.C. (1999). Motivating engineering students by using modern case studies. *International Journal of Engineering Education 15*(6), 469-476.

Santinello M., Martini E.R., & Perkins, D. (2010). Community psychology in Italy: Introduction and prospects. *Journal of Prevention and Intervention in the Community, 38,* 1-7, DOI: 10.1080/10852350903393376

Tsui, L. (2002). Fostering critical thinking through effective pedagogy: Evidence from four institutional case studies. *The Journal of Higher Education 73*(6), 740-763.

Yen, J. (2008). Chapter 14: *A history of community psychology in South Africa in Interior: A history of psychology in South Africa,* in Omen C.V. & Painter, D. Eds. Compleat Unissa Press.

PART I

Part One: Community Building

The concept of community building has no universal definition. However, this could be more positive than negative because having no universal definition also keeps the conception of community fluid, which we believe speaks more accurately to its diverse complexities. To have some idea of what we mean by community building we (the editors) start this overview of the first three chapters by first giving you a look at how we conceptualize or think about community. Community can be geographical, virtual, groups of people with similarities such as a community of community practitioners. Importantly, we see community overall as a way of being and doing or navigating life with others. Therefore community building means actively seeking ways and resources to bring forward co-liberation. This might mean we find ourselves building community by holding space for difference. For example, as editors of this textbook, we are community psychologists working in academia and the community, an industrial/organizational psychologist, and an instructional designer. Our commonality is our passion for social and racial justice. We believe that this passion also shows up in the case stories you will find in this section.



IvilinRadkov (2019) (Image is showing a heart drawn on a piece of paper with a red marker with a section torn showing the word "Community")

The first case story, *Cultural Development in Underrepresented Communities: Using an Empowerment and Citizen Participation Framework* is offered by Dr. Jacqueline Samuel. Dr. Samuel's work illustrates community building with those who seek to use art and culture as viable avenues for building community. Students interested in arts and culture, and the health and well-being of communities of all types will find a plethora of information that might guide your journey, as using the arts to inform and reclaim power is not at all a far-reaching idea.

The second case story in this section is Dr. Amber Kelly's and Dr. Kathleen McAuliff's (2021) work alongside members of the disability community, seeking to advance inclusivity in all facets of community life. *Dare2Dialogue: Promoting Inclusion Through Storytelling and Dialogue* brings awareness around negative stigma associated with a disability and ways to address these challenges through dialogue and centering and raising the voices of people with disabilities.

The third case story in this section is the work of Dr. August Hoffman. Dr. Hoffman's passion is visible as he comes alongside of a student using green space to promote communal experiences for the student completing an Individualized Studies program with an emphasis on Gardening Development at Metropolitan State University. *Green Space Programs as a Shared Growth and Communal Process: A Somali Gardner's Journey in Minnesota* moves the reader through the student's experiences with growing healthy foods for the community as part of education, with the ultimate goal of helping children understand the benefits of healthier eating and the actual origins of the foods they consume.

We have added a fourth story to this section! Chapter Four: *Juvenile Justice Community Activation Project* illustrates what we can learn about social determinants of health and its impact on young adults. See what the young adults in South Los Angeles had to say about what they need with respect to their collective health in all facets and collective well-being. There is no better way for empowerment than to hear from those who are the most impacted by prevailing social issues.

1

Cultural Development in Underrepresented Communities: Using an Empowerment and Citizen Participation Approach

JACQUELINE SAMUEL, PH.D.

This case story illustrates the significance of using the arts in community development work which not only speaks to aesthetics but to how we can heal communities and promote well-being.

THE BIG PICTURE



In the late '60s, Chicago Black Theater companies began to grow during a time called the Blacks Arts Movement. There were several Black women, all iconic by today's standards that led the charge. First, there was the mother of Black Theater, *Val Gray Ward*. Val gave us Kuumba Theatre where I became a member in the early '80s. Val was the mother of Black Theater and mentored many. *Abena Joan Brown* former social worker, dancer, founded Ebony Talent Agency later becoming eta Creative Arts Foundation Theater. Then came *Jackie Taylor* founder of the Black Ensemble Theater (BET) Company whose mission was and still is today, to eradicate racism. All of these women participated in the Black Arts Movement including Illinois Poet Laureate *Gwendolyn Brooks*, and *Margaret Taylor–Burroughs* founder of the South Side Community Art Center (home of Black visual arts) and founder of the Du Sable Museum of African American Art. These Black Women were trailblazers and pre-community psychologists in their own right. If you were a performing, visual, or musical artist in Chicago between the 60's-2005, at some point you were touched by their grace and wisdom. The Black Arts Movement gave Black people a sense of community, pride, and voice by creating a space to tell our stories through the arts and cultural experiences. It was a holistic approach, led by several daring Black women with intentionality to use the arts as a tool for liberation.

This experience motivated my work as a performing artist, curator of multidisciplinary arts, in addition to being an art consultant. By 2004, I was working in three different communities: Albany Park (north side of the city), Humboldt Park (northwest side of the city), and South Chicago (the far south side of the city), all very culturally rich and diverse communities

yet struggling in their own way to sustain their arts communities. This is where I learned that I had to know the history of each community. What I found was:



The image is showing separate descriptions of three communities in Chicago: Albany Park, Humboldt Park, and South Chicago.

In 2007, I returned to South Chicago in a new role. I became the intermediary with an arts background and the responsibility to support the implementation of a Quality of Life Plan (QLP) written by the residents and stakeholders of South Chicago. The QLP consisted of projects and program strategies that responded to social conditions that were a concern of the community. South Chicago identified economic development, safety, education, environment, food access, health, housing, youth development, and the arts as their strategic focus.

The challenge was to integrate the arts into community development practices. This meant bringing city government, residents, and other stakeholders to the table with the arts community. This project was complex because arts and cultural exchanges had never been used strategically in this fashion in Chicago. While working and navigating with a small team, a funder, an artist, and a scribe, I knew that we were too small to meet the masses and we would have to rely on a snowball effect in order for this concept to work. In each community, we were met by some form of skepticism. I learned that we had to wait to be invited into the community. When we allowed the time for relationship building we were eventually invited into each community. We engaged in cultural exchanges, tours, educational and reflective conversations as

we broke bread in order to find our commonalities and deepen our relationships. Blending arts/culture and bricks/mortar is not an easy task when both groups do not have experience in working together. They both see their worlds in very different ways. However, the QLP provided the template for action and my past experience gave me the core knowledge I needed to engage both groups. What I did not realize was that I had more to learn.

Cultural Development and Prompting Creative Responses

In the beginning of this work, my colleagues and I spent many hours in meetings discussing issues, reflecting on history, looking at data, mapping where issues occurred, and discussing root causes, but we were not getting anywhere. These discussions were important and useful in understanding the issues but they never seemed to change anything. It felt like we were stuck on information but didn't know what to do with it and how to move forward. Of course, we worked on collective behavioral and policy changes but it seemed more complicated when it came to social conditions deeply rooted in the community's culture, such as violence, mental health and the needs of Black women, who historically have been underrepresented. Of course, there were some wins in deescalating gang violence but domestic violence and its impact on women of color in the community was much more complex. Domestic violence seemed to be a silent ill of society and difficult to detect and prevent from happening without witness support.

Mental health is similar, especially in communities of color where it is rarely addressed because of stigma. However, when we looked at issues impacting the community through the lens of art and culture there always seemed to be a stronger level of engagement from the residents. The answer we were looking for was discovered after attending a conference on the facilitation of community meetings. I was introduced to the Art of Hosting (AoH). AoH is the practice of using different methodologies of discourse with groups of any size based on the context of the gathering. It is supported by principles that help maximize collective intelligence while being inclusive of diversity in addition to minimizing and transforming conflict. When utilizing AoH, the result is collective clarity, wiser actions, and sustainable workable solutions to the most complex problems. The approach ensures that stakeholders buy into the process because their participation in the design of the process is by definition transparent. This led me to change how I hosted the community as a community psychologist (Art of Hosting). To foster solutions, we followed the same processes as before. Together we would educate ourselves about the issue.

So we asked the question, how can we better engage the community to prompt quality responses that promote social change?

I hosted café style conversations where we would break up into small groups and respond to questions related to the social condition. We took the time to reflect and this method helped to give voice to all that participated. We were becoming active listeners. In addition, it increased our collective efficacy. By being in a circle, it erased the hierarchy and reduced conflicts and high expectations. We invited everyone that wanted to have a seat at the table: residents, elected officials, business owners, youth, law enforcement, faith-based leaders, and artists. We were no longer limited by our titles. Using a cultural development lens gave the artists a context of how the social condition impacted the community; everyone became more transparent about their feelings and they let go of their personal agendas. These community conversations changed my trajectory and experience of community psychology. Using AoH allowed me to bring my humility and willingness to experience what communities have to offer. We learned and healed together. It was restorative and engaging and broke barriers and unleashed our truths. Now we were ready for change by using AoH to inform our use of the arts for Healing Centered engagement. The term Healing Centered expands how we think about responses to trauma and offers a more holistic approach to fostering well-being (Ginwright, 2018). By using this approach, participants can use the arts as a tool to collectively address their trauma and restore their well-being.



Image by mcmurryjulie from Pixabay Image is a clipboard with pencil with a circle as a background.

Arts and Healing Centered Engagement Promoting the Well-being Among Black Women

After one of our AoH café sessions, I recall several Black women expressing feelings of a lack of belonging in the community. They talked about feeling like outcasts because the housing complex where they lived was riddled with violence and trouble, and they felt that it reflected poorly on them and their families. I knew at that point I needed to connect them to something that would make them feel valued. The idea was to reduce and ease the impact of historical trauma by creating space through a healing-centered experience that encourages collective voice, the celebration of shared identity, and build a sense of community through belonging.

Historically, Black women have always taken on the weight of the family unit by taking on the challenges of caregivers. Without having any trusted support systems, Black women often forgo self-care. When self-care is ignored, so is your overall health. Lack of self-care increases stress and leads to chronic health diseases that impair Black women's well-being. Therefore, participating in shared cultural engagement can play a significant role in defining good health and supporting

ones' well-being, resilience, and healing. Experiences such as family connections, expressions through spirituality or music, reliance on community networks, and the church can be great sources of strength and support (Nami, 2020). Integrating the arts is a way of achieving these goals to wellness. I thought about putting on a play, but as much as I love theater, I knew that it would take way too long with the planning, auditions, rehearsals, staging, and finding the right play and location. It would take a considerable amount of time and cost to pull it off, but I wanted them to be a part of something. We needed a quick win; something just as powerful but more spontaneous, celebratory, and memorable. I felt it would be better to do another aspect of theater. I was thinking of a "spectacle". Something that would happen one time only and the process would unite us all through the effort of participating in it.

Responding to the Needs of Black Women

Assets

I believe the voices of Black women are powerful assets when used collectively. This assumption is supported by the *MeToo, GirlTrek*, and *Black Lives Matter* movements. Even politicians recognize Black women's power during the most recent election. The challenge is to center their voices universally. Black women today demonstrate that the road to their well-being is traveled by holding space and holistically sharing their hidden stories. These stories define the commonality and range of their lived experiences. When Black women gather in supportive settings, it creates a safe space away from the atrocities of abuse and assaults against their mental and physical health and stability. It occurs in meaningful ways. Some might revert back to ancient and traditional behaviors of their ancestors, such as hosting circles, Bible study, or something of a spiritual nature. They also use their creativity through cooking, art-making, writing, music, and performance. They form groups such as book clubs, sororities, or auxiliaries. They also retain their childhood girlfriends by extending their relationships through social settings such as dinners or travel. The impact of COVID-19 has also increased gatherings through

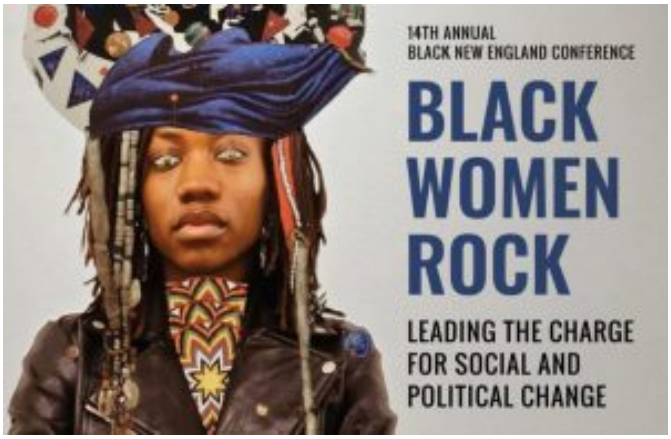


Image shares "Black Women rock" used for dramatic effect.

social media, for example, virtual panel discussions or talks, in addition to live internet events. Whichever way that Black women come together it provides them with a moment to collectively cleanse themselves of their griefs and sorrows, in addition to celebrating their shared identity and experiences.

Needs



(Image is a woman who seems frustrated, holding her head in her hands.)

The core needs for Black women is suggested foster relief from Racial Battle Fatigue (RBF) to improve mental health. Racial Battle Fatigue or RBF comes from the impact of experiencing daily battles of attempts to deflect racism, stereotypes, and discrimination and the necessity to always be on guard or wary of the next attack they may face. Coupled with caregiving, work, and maintaining the household adds layers to this toxic stress. The result can be suppressed immunity and an increase of sickness that causes multiple illnesses from tension headaches to elevated blood pressure, among other factors (Goodwin, 2018). The challenge is that these gateway maladies left untreated over time can eventually lead to chronic illnesses. Although healthcare professionals have recognized how COVID-19 has added another layer to health disparities, particularly within communities of color, it is yet to be seen what actions will be taken to promote health equity. In the meantime, community-based healing-centered engagement can be an accentual component to inspiring collective self-care experiences. So now the stage was set. We hoped to improve the way the community communicates and implemented the QLP strategies. We needed to address the feeling of exclusion from the community for Black women that participated in our gatherings. Now our goal was to find the right event.

When Black Women Gather: Gele' Day

When Black women struggle with acceptance of their body image it is also a result of RBF. Black women are judged by the color of their skin, the size of their lips and hips, and often by the way they wear their hair. The irony is that it is acceptable for others to artificially create these features through tanning lotions, Botox, and fashion statements such as the bustle of the 19th century or the modern-day buttocks injections. However, for Black women, even how they wear their hair can potentially interfere with them keeping their job. The beauty of the Black woman has always been in question. Over the last decade, there has been more of a concerted effort to acknowledge the beauty of Black women in commercials. Actress Pilar Audain was featured in a Dove/Walmart commercial where Pilar walks down the street singing a song adorned in this beautiful head-wrap. Thus, was born Pilar's "Wrap Your beYOUty Movement":



Photo courtesy of Ajani.. Image is showing the head wrapper and one of the women taking part in the head wrapping ceremony.

One day after I was hosting a community meeting about trauma-informed care, Pilar shared with me about the desire to host an event in the parks called Gele' Day. It was a day to celebrate the beauty of Black women. When Pilar explained the event I was immediately sold. I had the resources to produce the project and Pilar knew the perfect location, a lakeside park on the south side of Chicago. Pilar shared how Gele' Day had been done before on a smaller scale. All that was needed was to identify a location for women of color to gather and we would meet in the park and symbolically celebrate womanhood through activities and providing beautiful fabrics to wrap around each other's heads. The adornment was called a Gele'. According to Pilar, Gele' Day is another way of saying that you are "atoning your spirit". However, there's another custom out of Africa which is called the mass dancers. The mass dancers come out to honor a secret society, the mother spirit of the universe. Taking on this idea, Pilar created Gele' Day for Black women in Chicago.

Black women vendors are featured at these events and sell their wares while other Black women provide performances, meditations, testimonials, prayer, and African dance exercises. Men are also welcome but mostly serve in a supportive role. At the end of the day, the women gather and rhythmically walk to the beach led by the elders and continue walking into the lake to cleanse themselves of all of life's challenges. Gele' Day sounded so beautiful I immediately agreed to support the next event. The event was held in Jackson Park on the south side of Chicago, and Pilar used the support of the women of her church to help set everything up for that day. I arrived early as an organizer and participant, to claim my spot and I brought my 91-year-old mother with me. We arrived, found our spot on the grass, registered, and immediately got in line to get our heads wrapped.



Photo courtesy of Ajani. Photo is Dr. Samuel's (author of this chapter) Mom.

The fabrics were beautiful and free of charge. There were women that were wrapping the heads of other women in the most nurturing way. Another special moment was the acknowledgment of our elders. My mom was 1 of 3 in their 90's and it made it a very special day for her. Women would come to my mom and kneel beside her and ask to shake her hand or for a hug. They praised her longevity and asked for her youthful secrets. At one point I think I was getting a bit jealous because I wanted the attention from my mom. It was very humbling. Later a sea of Black and Brown women filled the park while Pilar opened the day in prayer. They explained the meaning of Gele' Day and summoned a group of men to lead us in meditation as they played their Tibetan bowls during the most perfect summer day. There were performances by children, face painters, poets, musicians, and singers. We were also led in a group African dance exercise. We laughed, talked, shared our life experiences.

Near the end of the day, we rhythmically lined up by age as we began to walk to the water. Since my mother was the elder in the group, my mom stood at the front of the line with Pilar. My mom looked at me and said, "Do I get in the water too?" I said, "Yes you do" with a smile wondering if they would actually do it. I didn't think my mom would do it but they marched right in that water. People in the park would stop me and ask who we were and what were we doing as they watched us in awe. I felt like a queen. There was such beauty in the collective cleanse. When my mother and I walked backed to the car I could not help but kneel to clean the sand off her feet. I hope my mom felt as special as I did by being together on Gele' Day.

Pilar is never short of giving back her time, guidance, and healing efforts to those that give and support her. There is an unspoken reciprocity noted between Pilar and her followers which I will call "the Village approach". Some call it, "paying it forward".

Outcomes and Impact



Photo courtesy of Ajani.. After the women completed the head wrapping session, they joined together in Lake Michigan as a symbol of being cleansed, restored, and stress-free.

"Gele' Day" represented healing-centered experiences through spectacle by preserving culture in the way of sharing untold stories, promoting collective pride, acknowledging ones' ancestors, and influencing citizen participation in an open and safe space. The spectacle being both visual and performance-based, also successfully demonstrates that by utilizing the arts as a healing-centered tool, women can feel collectively empowered, cherished, and valued. As much as there is singing and laughter there is also an emotional release that is symbolically enacted by the rhythmic walk to the beachfront and actually manifests based on the reactions that you see and hear. There was inquiry of amazement from onlookers, demonstrations of love, respect and affection among the participants, and the collective response through engagement of the mindfulness activities. The experience was an overall movement, a metaphoric dance, and a holistic healing experience. As intended, it is an experience that one will remember for a lifetime.

A most powerful aspect of the "Wrap Your beYOUty Movement" is Pilar's skills and ability to use citizen participation to reach so many women without standard forms of marketing. Every year there is a noticeable increase in attendance to these events, resulting from a snowball effect–from word-of-mouth. There are no subscriptions, no brochures, no flyers, no posters, and no ads in periodicals. The communication style of the Wrap Your beYOUty Movement can easily be equated to a modern example of the traditional use of the beat of the African Drum to communicate to the Village. Gele' day represents Empowerment and Citizen Participation in its purest form. This can also be compared to the Black Arts Movement where space was also intentionally created to support and sustain the aesthetic voices of the Black Arts Community.

Lessons Learned

Community Engagement and Citizen Participation

It is important to identify the best approach in facilitation that works for you. I prefer the Art of Hosting (AoH) because it not only gives the participant a voice, it also offers different options of facilitation based on the needs of the community. When there are sensitive matters that need addressing such as listening to the victims of violence, we used methods that encouraged storytelling and active listening. When there were community disagreements (and there will be disagreements) there are methods for having courageous conversations that will help get the group back on track. Always keep an open mind to new methods, that

is how I discovered AoH. As much as I feel comfortable working with community groups, I feel my lesson learned through this event is that you have to decide what methods of engagement work best for you in order to achieve the outcomes you desire.

Collaborative Ways of Investing in Underrepresented Communities

There were two positions held in my life that influenced my work as a community psychologist, that of an arts consultant specializing in theater, and that of a community development intermediary for a neighborhood in Chicago. As much as I enjoyed performing, I enjoyed working with people in communities even more. The combination of the two careers built my foundation and prepared me for community psychology. As a community psychologist, the arts provide a platform for collaboration while promoting social change and working at different ecological levels to address social conditions through a creative lens. My work covers many domains but the focus of this work is using arts and culture as tools to support underrepresented voices, specifically Black women to improve social conditions. I have been fortunate to observe best practices through my travels and engaging with creative people that have impacted the world.

It was always a joy exploring a character in a play but it was temporary. However, exploring, connecting, and engaging with diverse populations and cultures in a community setting was more fulfilling.

A Community Psychologist's Role in Disinvested Communities

It cannot be assumed that as a community psychologist one must take the lead, teach, or have power over the community. Although the role of a community psychologist can be subtle, it is imperative to be foremost an active listener and observer as this will guide your actions. Other best practices proposed are:

- Building your knowledge about the community that you are working with.
- Allowing yourself to be invited in and knowing the community's history before you enter.
- Building your networking skills and leveraging resources but never offering anything that you cannot deliver.
- Finding the commonalities to connect and build relationships with the people you plan to engage with.
- Be willing to adapt to the unexpected and watching for any influence that creates barriers for others.
- Reflecting on your work, reflecting with others, while making the effort to center and raise all voices.
- Bringing humility and willingness to experience what the community has to offer you. This helps

to form relationships where lessons are learned, trust is restored, and engagement is sustained; and

- Acting with intentionality to promote social change.

Recommendations

Community Engagement and Citizen Participation

When working with the community, planning is important but I also believe in planning while having smaller events in order to build relationships in the community. Educate the community on the issue that you are addressing so that you are on the same page when you begin to address the issue. Research the multiple ways that you can host a meeting and determine what suits your leadership style. However, make sure your style of facilitation is open to everyone. If they live in the community they have every right to participate if they so choose, prepare to address conflicts, respect the time of others, and make sure meetings are engaging enough where people will want to come back for more.

Working with communities and diverse populations can be stressful, but an equitable representation of the community must be a part of the process. Identify the artists that live in and serve the community. Use their talents. Besides producing their work, I have hired artists to do graphic note-taking in meetings and have found it to be more detailed than writing notes (figures below). There is something about images that stimulates memory. Honor their talents by paying them. Their time is money. Make sure you are working with artists that enjoy working with the community. There are some great artists that prefer to create on their own. This type of artist might be more suitable for showcasing by creating themed pop-up galleries, performances in the park or public art. Artists that enjoy working with the community make great organizers. Engage them in every aspect of community planning and implementation. I have had stakeholders tell me that there are no artists in the area. I always laugh at that because artists are everywhere. If you can offer the use of free or shared space, believe me, they will appear out of nowhere. Just remember to do a contract or memo of understanding so that there are no surprises at the end of the day and everyone is on the same page.

Graphic notes from our community meeting





Photos of both illustrations courtesy of Dr. Jackie Samuel. Illustrator: Kensey. This image is showing the thoughts of the participants on how to use art to build community.

My Work Relative to Community Psychology Practice

Empowerment Theory

Through this case study, we have looked at underserved communities where Black women have felt undervalued and the communities discussed have been underrepresented. We looked at empowerment and citizen participation from a community psychology perspective to better understand how it was achieved in this case study. The *empowerment* theory comes to mind in this case story.

While there are many definitions out there for empowerment, I favor some of the tenets of empowerment

that have been defined by the Cornell Empowerment Group (1989), such as *intentionality, ongoing process*, and *mutual respect*. For instance, intentionality is extremely important because it is the foundation of empowerment that gives the community psychologist their purpose. Intentionality is the reason behind the passion that fuels the action. In the Black Arts Movement, the iconic Black Women that led the charge to make space for Black artists recognized their absence in society, and then determined to create space for them. Their mentorship and coalition building was the driving force for sustainability. Many Black actors have trailblazed alone, but having a vision and recognizing that your needs are in common with others becomes the catalyst to mobilizing others for the cause. So when you are working with a community and you recognize that the group is at a stalemate, you use your influence to expose the group to new ideas and challenge their thinking. In South Chicago, we recognized that the arts were a great tool but it was AoH that unleased their voice and their truths.

The Wrap Your beYOUty Movement recognizes the beauty and value of Black women, so Gele' Day used its influence to help Black women see their beauty. The Wrap Your beYOUty Movement becomes a mirror to show and reflect the power of Black women. It also opens up space for others to see the Beauty of a Black Women. Remember how people inquired about the Black women walking to the lakefront. This means that the Black women's presence was no longer invisible. They were shown respect through acknowledgment. The care and nurturing, the ongoing process of wrapping the beauty of each woman commands mutual respect by being invited into the community of Black Women. When you enter, you enter with humility and a willingness to experience what the community has to offer. This reminds the community psychologist of ones' own vulnerability and we must treat everyone with care and compassion. This Empowerment Framework model is shown below:

Empowerment Framework Table

Empowerment	**Black Women in the Black Arts Movement**	**The Role of Community Psychology Building Communities Through the Arts**	**Wrap Your beYouty Movement for Black Women**
Intentionality	To create opportunities and recognize the talent and contributors of Black Artists	To use the arts as a tool for healing, empowerment, and citizen participation	Holistic healing, atonement, and collective empowerment of Black Women
Ongoing Process	The development of Black institutions dedicated to the uplifting of Black Culture	Program support and the reclamation of art as a community development tool	Annual tradition and celebration of Gele Day and She Through Me to promote collective pride
Mutual Respect	Engagement and mentoring of Black Artists	Inviting into the community and entering with humility and willingness to experience what the community has to offer	The reciprocity of sharing and celebration of each other's talents

Citizen Participation

Citizen participation is another aspect of Empowerment where knowing how to engage others over time requires skill. There is Critical Awareness that informs the purpose of the collective action. It is the social barriers that ignite the need for action. The Black Arts Movement recognizes the need to acknowledge the creative contributions of Black Artist. The Community Psychologist sees the inequities and disinvestment that challenges the quality of life of underrepresent communities. The Wrap Your beYOUty Movement

recognizes the need to bring attention to the value of Black Women. Once the awareness is achieved then we must reflect on how we arrived to this this issue and what did we learn. This is where the skills of Community Psychology are needed. Organizing and the ability to mobilize others to bring awareness requires skills, relationship building, leveraging resources, and trust. Once this is achieved the commitment of others will follow. In South Chicago it was AoH that brought us to the level of commitment. This is where engagement becomes strong. In the Black Arts Movement, 3 Black Women are now the founders of theater companies. Gwendolyn Brooks breaks barriers and become the first Black Women Poet Laureate of the state of Illinois, and Margaret Burroughs opens a museum on city property that showcases Black excellence. South Chicago has a plan with a vision and mission to implement. Wrap Your beYOUty Movement starts with one day and becomes an annual event. Once all of this is steps are achieved then long lasting relational connections are made which leads to sustainability. The Citizen Participation Table is shown below.

Citizen Participation Table

Citizen Participation	**Black Women in the Black Arts Movement**	**The Role of Community Psychology Building Communities Through the Arts**	**Wrap Your beYouty Movement for Black Women**
Critical Awareness	Recognizing the significance of Black talent and cultural	Attention to resources: finding space and disinvestment	Recognizing the significance of Black women in society
Participatory Skills	Mobilizing and building relationships with Black artist and audiences	Mobilizing and building relationships with community artists, residents, and stakeholders	Mobilizing and building relationships with Black women
Participatory Values and Commitment	Respect and honoring Black pride	Collectively respecting the writing and implementation of strategic plans (Arts and Quality of Life Plans)	Respect and honoring pride of Black women
Relational Connections	Mentoring actors and support of the artistic community	Hosting of the community in circle to share wants and needs; Active listening	Sharing of talent and resources to support celebration

Conclusion

I am hoping that by reading through this case story you are inspired to begin to think about ways you can use arts and culture in community psychology work or other work seeking to foster resilience and build community—leaning into advancing social and racial justice. I continue to do this work using my lived experiences and education as a community psychologist and educator. Here is a website with more on Gwendolyn Brooks: https://www.poetryfoundation.org/poets/gwendolyn-brooks

FROM THEORY TO PRACTICE REFLECTIONS AND QUESTIONS

- Share with your classmates or others the ways in which the information in this chapter challenged or

expanded your thinking about how the arts and culture can be used to build community.

- Provide and discuss examples of how gaining an understanding of an underrepresented community will affect your ongoing work.
- What questions does this chapter raise for you related to community psychology, community practice work, or other related fields of study?

References

Art of Hosting (2021). http://www.artofhosting.org/

Cornell Empowerment Group. (1989). Empowerment and family support. *Networking Bulletin*, *1*(1)2.

Ginwright, S. (2018). The future of healing: Shifting from trauma informed care to healing centered engagement. https://ginwright.medium.com/the-future-of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c

Goodwin, M. (2018). Racial battle fatigue: What is it and what are the symptoms? https://medium.com/racial-battle-fatigue/racial-battle-_fatigue-what-is-it-and-what-are-the-symptoms-84f79f49ee1e

NAMI (2020). Black/African American. https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-American

2

Dare2Dialogue: Promoting Inclusion Through Storytelling and Dialogue

AMBER E. KELLY, PH.D.

KATHLEEN E. MCAULIFF, PH.D.

The chapter will share insights on this innovative strategy for promoting inclusion among individuals with a disability using community dialogue and events.



Image above is a "word cloud" or collage of words such as fairness, access, opportunity, ability…

According to the World Health Organization (WHO), more than 1 billion people live with a disability (WHO, 2017). Globally and nationally, disabilities are more commonly found in areas of poverty. Approximately 26% of people in the U.S. have a disability, with the most common disabilities being related to mobility or cognition (Okoro et al., 2018). As people live longer, they are more likely to experience a disability (Bialik, 2020). Although there is a higher prevalence of disability than some might guess, individuals with a disability still experience adverse outcomes when compared to individuals who do not have a disability, including reduced access to healthcare, educational, and employment opportunities (Okoro et al., 2018). While the causes of these adverse outcomes are multi-faceted, one potential avenue for positive social change is increasing visibility and educating the community about the experiences of people with disabilities. While overall perceptions are changing, there are still many myths about disabilities. One of the most common myths is that all disabilities and chronic conditions are visible.

In fact, 96% of people with a chronic condition do not have a condition that is visible, and 73% of people with a severe disability do not use a personal assistive device such as a wheelchair or walker (Disabled World, 2020). Educating people through first-hand experiences can help dispel these myths, and illuminate ways in which the community could change to promote inclusion for people with disabilities. To move our

theoretical framework of awareness and storytelling to practice, we sought funding and begin to put the project together. See highlights below of **statistics regarding disabilities:**

World Health Organization (WHO)

Disability and Health
1 December 2020

Key Facts

- Over 1 billion people live with some form of disability.
- The number of people with disability are dramatically increasing. This is due to demographic trends and increases in chronic health conditions, among other causes.
- Almost everyone is likely to experience some form of disability — temporary or permanent — at some point in life.
- People with disability are disproportionately affected during the COVID-19 pandemic
- If health services for people with disability exist, they are invariably of poor quality or under resourced.
- There is an urgent need to scale up disability services in primary healthcare, particularly in rehabilitation interventions.

Image is a bulleted list showing statistics on the disability and health prepared by the World Health Organization.

The goal of Dare2Dialogue was to bring awareness and engage in storytelling around challenging topics to promote change, specifically focused on individuals with a disability as a means to remove the negative stigma that can be associated with a disability. This goal was initially achieved by having two individuals who live with disabilities share their stories to highlight challenges and encourage dialogue among those who may have the privilege of not living with a disability. Subsequently, three community discussions (including one documentary screening) created an opportunity for 96 Dare2Dialogue attendees to challenge their thinking around inclusion. The chapter will share insights on this innovative strategy for promoting inclusion for individuals with a disability among community events.

Community Needs

Traditionally, local organizations that serve individuals with a physical or cognitive impairment ensure that events prioritize ability. Some examples used in hosting events include using locations that are wheelchair accessible and having sitting space for caregivers. Organizations share a challenge of attracting others to attend that typically do not attend ability-focused events. Attendees are ability advocates, and there is an interest in broadening the audience's diversity when it pertains to interest in ability-related issues. One local initiative emphasizes inclusion through the medium of film (Over The Rhine International Film Festival, 2021). With an open door to help close this gap in initiatives that focus on living with a disability, there were opportunities to create additional events. Further, People's Liberty was a philanthropic lab that awarded

120 visionaries grants to impact their community in an innovative way. The five-year initiative focused on empowering individuals to help improve communities' well-being where they lived and thrived. At the 2.5-year mark of this initiative, People's Liberty hosted a midway celebration, "Intermission", which allowed for twenty grantees to host an innovative event in a storefront space. The first event using this storefront space was the pilot for Dare2Dialogue, and it was the only event during the series that focused on the inclusion of individuals living with a disability. It was one of the most attended events during the celebration, which prompted the development of additional events in ability.

Collaborative Partners

When selecting collaborative partners, they should share the collective vision for promoting the inclusion of individuals living with a disability. Community Engagement Collective (CEC) partnered withStarfire, an organization focusing on empowering leaders to build community and inclusion alongside people with developmental disabilities and People's Liberty using their storefront building as the venue for all Dare2Dialogue events.

Language Matters

Using language that does not demean a population is critical to consider for working within community settings. The disability field has evolved in terms of the preferred language and continues to grow. The American Psychological Association (2019) recommends using language to promote solidarity, respect, and ultimately honor all individuals as human beings. First-person language focuses on the individual, while individual first language emphasizes the disability. Dunn and Andrews (2015) make a case for using both first-person and identity-first language when doing work in the disability field and taking a flexible approach is respectful. Ultimately, using the term preferred by the individuals with the lived experience is the best option (American Psychological Association, 2019).

What Does Inclusion of Individuals with a Disability Really Mean?

Inclusion ensures that people with disabilities have their voices and experiences heard by people who may not see the same barriers or opportunities that exist in a community. If only people without disabilities are making decisions, certain barriers and opportunities may not be identified, thus excluding vital community members. For example, a community may not offer physical public spaces which are ADA (Americans with Disabilities Act) compliant, or a library may not offer spaces for people with sensory processing disorders, such as autism spectrum disorder. As no two people without disabilities are the same, people with disabilities are not a monolith, even if they have the same type of disability. Different disabilities bring different strengths and challenges, so creating an inclusive environment where all voices can be respected and heard is critical. Because most people do not have a disability, openness to learning and listening is imperative to make our communities truly inclusive and create larger community change. Storytelling in diverse settings allows speakers to share their stories and make connections with others that may not have previously had the opportunity.

Storytelling and Inclusion

One method of including individuals with disabilities is through storytelling. Storytelling allows people with disabilities to share their experiences in a structured format where participants actively listen to another person's experiences. One of the 10 principles, that is key to intergroup relations is to provide opportunities for members of different groups to get to know one another as individuals (ASDC for the Community Foundations/Intergroup Relations Program, 1999). Through listening to individual stories from people with disabilities, people without disabilities can put a face to an experience, rather than stereotyping. Additionally, it also provides an opportunity for people to build a sense of community with one another. Storytelling is a unique type of participatory action research method that empowers a participant to shape and share their own narrative, communicating the truth and emotional impact of their experiences (Bailey & Tilley, 2002). Without using prompts or being guided by a researcher's agenda, participants with disabilities can decide which event(s) and experiences they can share.

Community conversations are another method of bringing together people with disabilities and people without disabilities (Carter & Bumble, 2018). Community conversations use an asset-based focus, solution-focused framing, awareness building, and a shared commitment to improving the community for individuals with disabilities. While storytelling and community conversations are similar, storytelling was selected for this event so that the focus could be on the speakers with disabilities sharing their experiences and shaping the narrative to promote awareness, so that the community members could listen, reflect, and, for some, redefine the ways they perceived someone with a disability.

Dare2Dialogue's Linkage to Community Psychology Practice

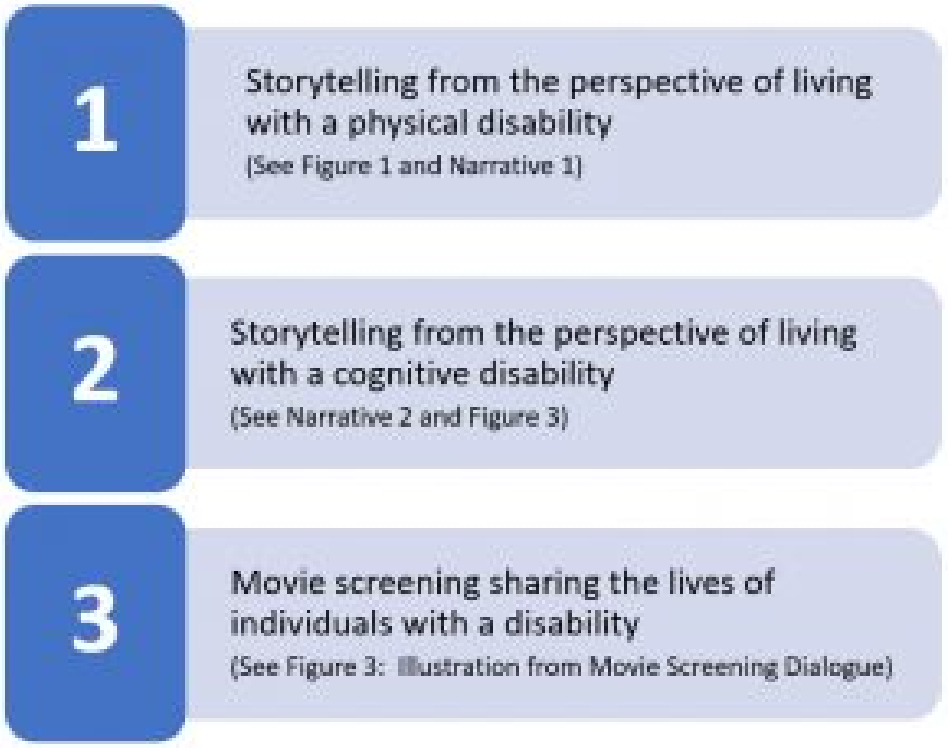
Dare2Dialogue fused together community conversation and storytelling (Dare2Dialogue, 2021) through the use of multiple principles of community psychology. Community psychology explicitly states a sense of community, respect for human diversity, social justice, and empowerment/ citizen participation as some of its core values (Prilleltensky & Nelson, 1997). This particular event is focused on fostering a sense of community through including and listening to the experiences of individuals with disabilities. As inclusivity is often lacking for people with disabilities, creating a sense of community where everyone feels like they belong requires community members to understand the ways in which they (individually, interpersonally, or as a community) may be excluding community members who have disabilities. Furthermore, as disability is a type of diversity, it is also important that people with disabilities are represented and respected in the community. As mentioned earlier in this case story, individuals with disabilities often experience adverse



outcomes because of social injustices, such as reduced access to employment, education, and discriminatory practices.

Description of the Project

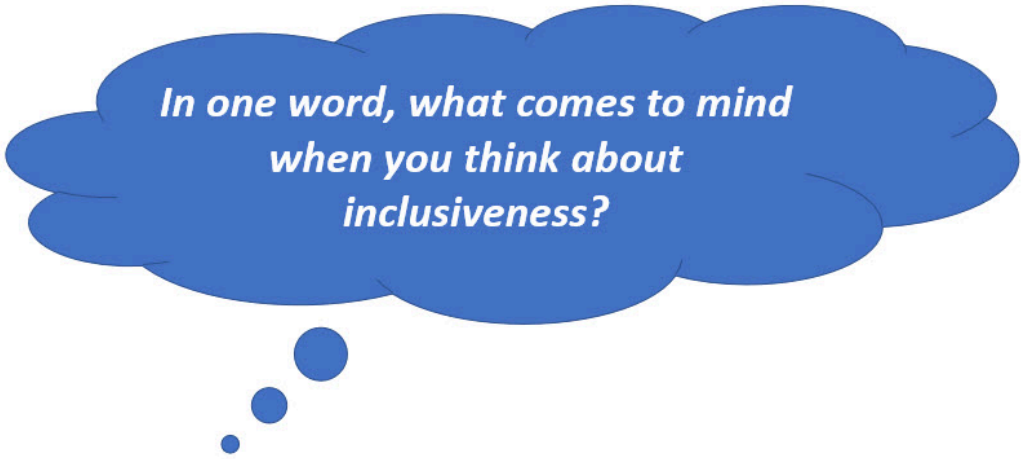
Dare2Dialogue Series on Inclusion consisted of events where an individual (or individuals) with a disability shared their experiences with the larger community, including people without disabilities, in order to educate, enlighten, and promote dialogue about community inclusion for people with disabilities. The series included three distinct events which are: **(1) storytelling from the perspective of someone living with a physical disability**, **(2) storytelling from the perspective of living with a cognitive disability, and (3) movie screening sharing the lives of individuals with a disability.**



The above chart shows the three highlighted points that are written in bold above. The image is a combination of darker blue numbers with lighter blue bars. Font is black.

For recruitment, a snowball sampling strategy was used (Noy, 2008). A snowball sampling strategy is commonly used in qualitative research and involves one participant using their network (i.e., people they know) to recruit additional participants. It is particularly useful in populations that may be difficult to reach or recruit. In some cases, a researcher will ask the participant to provide the contact information for additional potential participants to facilitate recruitment. In other cases, the initial participant(s) will recruit the potential participants, as they already have an established relationship. This event used the latter method for recruiting participants. Each event took place in the same venue, located in downtown Cincinnati, Ohio, close to public transportation, and was accessible. The first event took place during lunchtime, and the

second and third events took place in the evening. When arriving at the first two events, attendees received a card to complete **a word cloud**. For word clouds, the statement should allow for a one-word response only. The same prompt was used. Below is a picture of a cloud with the prompt in it which says, "in one word what comes to mind when you think about inclusiveness?



Attendees had the option of texting their response, completing via website link, or sharing their reactions with a volunteer. A Quick Response (QR) code on the card helped to make the connection to the link easier. The word cloud was shown on a projector for attendees to view. Before the community member spoke, the guests enjoyed free food and drinks since it was close to mealtimes. Attendees took the time to mix and mingle before each event to facilitate community building.

Physical Ability

Word Cloud from 1st Event



Image above is a "word cloud" or collage of words such as fairness, access, opportunity, ability…

Narrative One

Speech from 1st Event

Hello everyone, I would like to start by thanking everyone for showing up for our discussion on inclusion in a midwestern city. So for starters, what is Inclusion? According to Webster, it's the act of or state of being included. That's it, it's just that simple. Now add people to inclusion and it becomes much more convoluted because every one of us is different. Just take a look around the room and you can see the diversity here. Every one of us has multiple qualities that make us unique, be it our physical differences such as our height, color of our skin, body shape, hair, you name it. But we also have different nonphysical qualities which aren't so prevalent, such as our upbringing, education, and financial backgrounds, the way we process information, biases, etc. There is no cookie-cutter form of inclusion that will work for everyone so inclusion will look different in different settings. For example, at my job, I am the only person there who doesn't have to walk anywhere. Steps… pssh I'm not walking up steps. I have my own way of getting around and it doesn't cause me to burn much energy. Just look at this bad boy. 2 all-terrain front wheels, good for climbing obstacles, fog headlights, padded leather back and armrests, and a hydraulic system that'd put most low-riders to shame. It doesn't get any better than this.

"This is an awesome chair but I haven't always been this blessed, over 9 years ago I used to have to walk

like you all until one morning as I was riding my bicycle to my job at the hospital and was hit by a guy making a left turn who didn't see me".

I spent the next 6 months learning how to breathe on my own again, I was determined not to have to be dependent on a ventilator for the rest of my life. So when they tested to see if I could breathe on my own, I'd do it until I couldn't take it anymore. Each time I'd go a little longer. I relearned how to eat without choking because I was on a feeding tube for 3 months. You never know how much you actually miss chewing and tasting food until you can't anymore. Just being able to suck on small pieces of crushed ice was a treat. Eventually, I learned to feed myself, and I was able to strengthen my muscles enough to go home.

All of these tasks were difficult but I would prefer them over not being able to see my daughters for 3 months. You see, my accident happened during "flu season" at the hospitals, and during that time children aren't allowed past a certain point. Thankfully, I had my family who brought me pictures of them. It wasn't the same as seeing them in person but it was better than nothing. My family helped tremendously with my recovery so when I think of inclusion, I think of FAMILY because to be included in a group sometimes can be like gaining a new family.

After my accident, I saw my city differently. I became aware of how inaccessible it really was. I have come across sidewalks that I cannot access so I had to ride in the street with busy traffic, businesses without a ramp or elevator. Transportation for wheelchair users is inconvenient. I began thinking of ways to improve the city in that arena, but I didn't have to think I could change anything alone nor did I have the resources, nor did I know where to start because all of this was still new to me, so my ideas were placed on the back burner. It wasn't 'til I interviewed at my job that I started back thinking about Inclusion. Because when I went for my interview, I needed help getting inside because there weren't any automated doors. My now Supervisor asked if I saw any obstacles for me to work there and the doors were my only issue. Within a few months, plans were in place for an automated door to be put in and now it is truly accessible all because of the pebbles I threw in the pond. So I've learned that little things can cause big ripples and that my city is ready for change.

COGNITIVE ABILITY

Narrative Two

Speech from 2nd Event

I was born 3 months premature. Doctors thought I would not be able to walk (paralyzed). I weighed 1lb. Mom said she could fit me in the palm of her hand). My disability is called cerebral palsy. I have 1 older sister and 2 younger brothers. It is hard being the oldest brother with a disability because I thought I would be the

first one to do everything like drive. I do not like asking people to do stuff for me because I feel like I can do it all on my own. But we all need help sometimes.

Elementary School

My mom asked me did I want to go to a regular school or a school for people with disabilities. My answer was a regular school. I wanted to go to a regular school because I felt like I had to do it. I had a choice. Everyone does not have a choice. Sometimes people make the choice for you. When I came home from school one day, I asked my sister "Why am I different?" She did not have a response to my question. Her mind was puzzled. I asked her because I wanted to know what her response would be. Later, I was bullied in the 1st grade. A student at school picked on me. I stood up for myself. It felt good. Today, I do not like seeing people getting picked on.



Image is a classroom with wooden desks used some time ago.

I played football as a kid. I played football ages 7-12 (except age 9). It was important for my dad to coach me so I could feel like a regular kid. I loved having my dad coach me because he understood me. I loved playing football. When I was 10 years old, my 7-year-old brother played in a game with me. I remember I asked my brother did he want to fill in because we did not have enough players to play that game. He said "Yeah." I said, "These are 10-year-olds, you are 7, are you sure you want to play?" I asked him twice. He said "Yeah." He held his own and he made tackles. I was proud of my little brother. At 7 years old, I would fall to the ground so I wouldn't get tackled. I played basketball too and my dad coached me as well. I was a better basketball player than a football player.

Gym Class Story

This one particular afternoon in school, the gym teacher had asked me to jump rope. My response was no because I did not feel comfortable jumping rope in front of the whole class. I felt embarrassed to be put on the spot like that because she knew of my circumstances. I was upset and that was the hardest thing I went through as a child. It felt great to have my classmates have my back. They asked the teacher why she had me jump rope in front of the whole class when she knew of my circumstance. She did not have a response.

Junior High School

When I first went to Junior High School, I was nervous because it was a new environment. I did not know how I would adapt to the new place. Being accepted in the National Honor Society was an excellent thing. It was great to realize that I was doing good in school. However, in the 7th grade, there was a teacher

who did not want to modify the work for me in my social studies class. To avoid the problem, I just went to a special education social studies class instead. I was disappointed because I wanted to be in a regular social studies class with all of my friends.

High School

I had a wonderful person that scribed for me and helped me with my thoughts. She worked with me since junior high school. The gym teacher was nice. She was very understanding and helpful. My senior year was the most exciting out of my 4 years of high school because I got to participate on the football team. I wanted to motivate people and be an encourager. I did not let anything stop me from doing what I wanted to do. Graduation was emotional. I thought about all the things from elementary school from when teachers did not want to modify my work to graduating high school. I felt like I had completed my goal to graduate from high school.

StarfireU

I wanted to do StarfireU because it was exciting and a 4-year program. I was the youngest in the program. It helped me to learn how to communicate with others. It helped me realize how to be a good friend to people. I learned how to make sure everybody felt like they were included. I remember a few times in the building some people would ask me to pray for them. I would take them to a room and pray for them. This is how I found my calling.

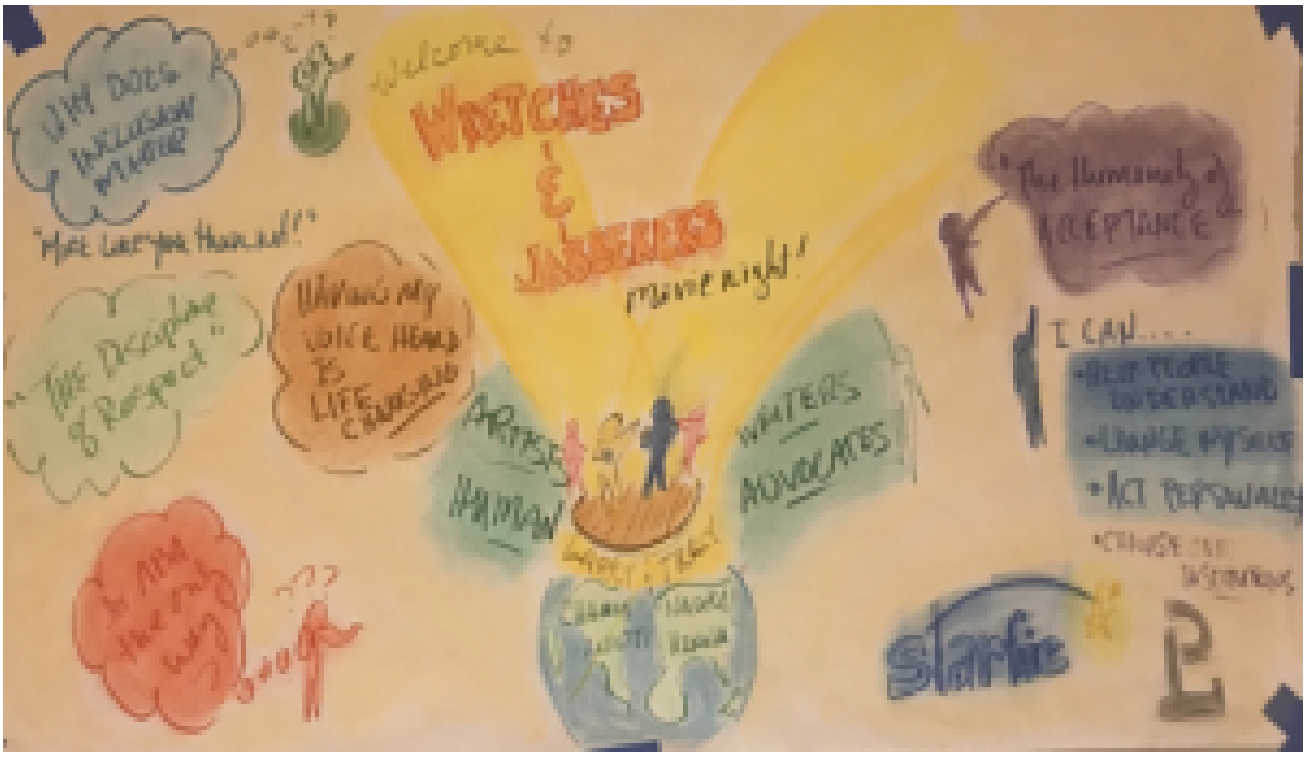
My Calling

My calling is to preach in ministry. It was hard at first to accept the calling because I did not know if people would accept me because of my disability. There were a lot of sleepless nights struggling to accept my calling. Once I accepted my calling, it felt great. The goal of my sermons is to encourage people to be great. I want to let people know they should live life to the fullest and be great at what they do.

Movie Screening

For the final event, a movie screening, which was a collaboration between two local nonprofit organizations Starfire and Community Engagement Collective took place. Partnering organizations shared the event on their social media platforms. Attendees enjoyed fresh popcorn and pizza before the movie. The previous event used in-person storytelling as the foundation; however, this event used movies as a form of art. The movie Wretches and Jabberers follows protagonists Tracy and Larry as they travel the world sharing their advocacy message for individuals with autism. After the movie, attendees discussed their reactions to the film in small groups. Some of the group sharing included statements like “Having my voice heard is life-changing,” “More like you than not,” and ” The humanity of acceptance.” (See Figure 3)

Figure 3 *Illustration from Movie Screening Dialogue*

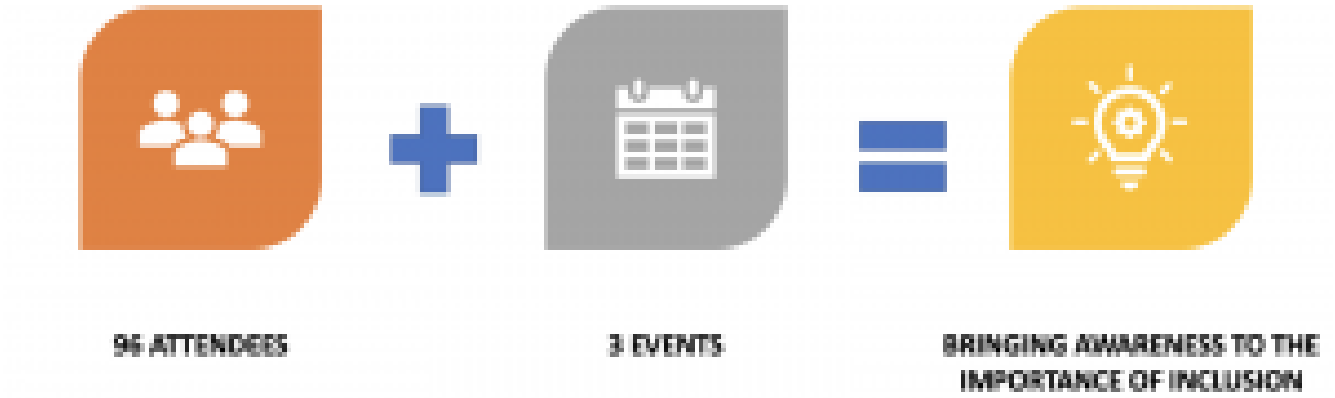


The image shows in graphics the thoughts of the moviegoers.

Outcomes and Impact

The goal of Dare2Dialogue was to bring awareness and engage in dialogue around challenging topics to promote change (See Figure 4). The purpose of the community discussions on inclusion was to bring awareness to the lack of inclusion of individuals with a disability using storytelling, community conversations, and movie screening. After the launch of the Dare2Dialogue inclusion series, the community partners collaborated on various initiatives including training, speaking engagements, and conference planning. The common thread of these initiatives focused on the inclusion of individuals living with a disability. Figure 4 below shows that in the program, there were 96 attendees, 3 events for the purpose of bringing awareness to the importance of inclusion.

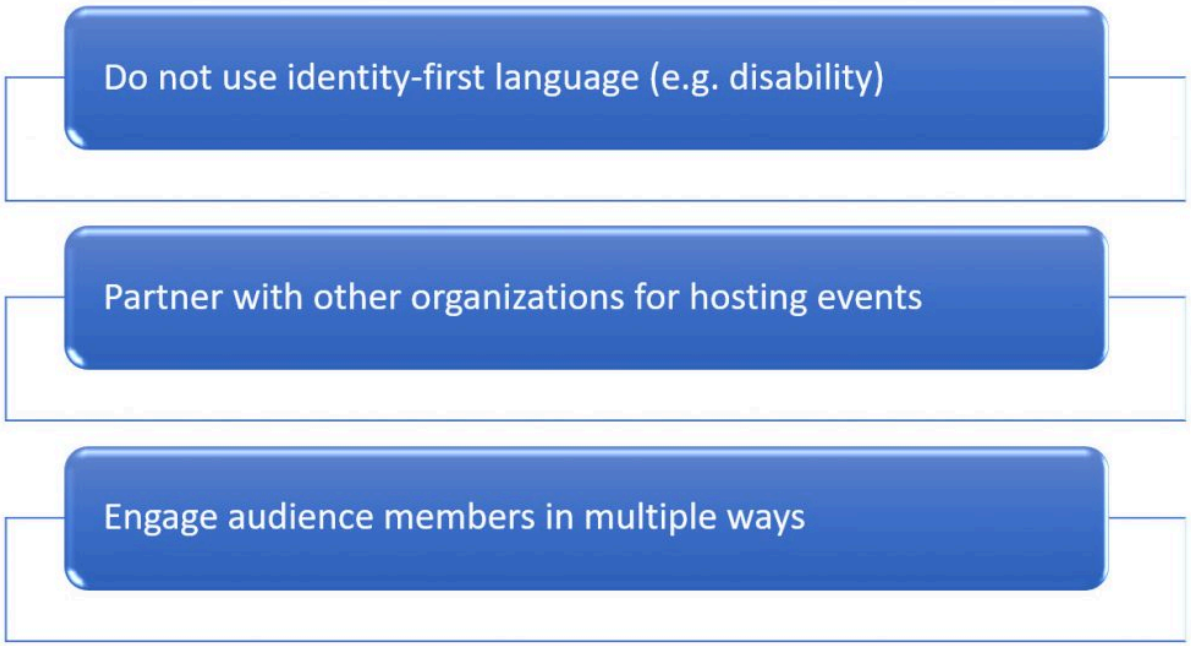
Figure 4: Impact of Dare2Dialogue Inclusion Series



The image above shows in graphics that the 96 attendees in the project plus the three events were successful in bringing awareness to the matter of inclusion among people living with disabilities.

Lessons Learned

We learned through this process three important factors: (1) Do not use identity-first language (e.g., disability), (2) partner with other organizations for hosting events, and (3) engage audience members in multiple ways.

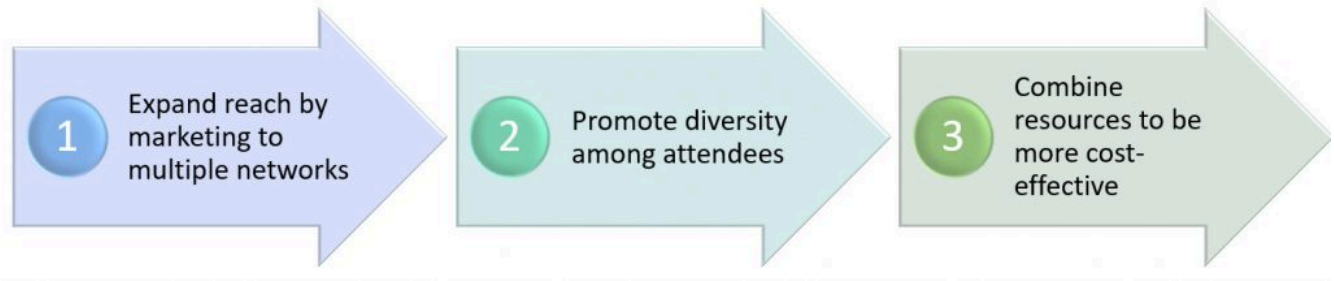


The figure above shows the three lessons learned. They are highlighted in a bar chart with blue background and white font or letters.

Hosting three different events gave insight into how to plan future events that emphasize individuals of diverse abilities. When striving to foster inclusion within events, it is important not to label the event with

disability or ability. This limits the diversity of audience members in attendance. In turn, the conversation's potential impact is limited because the audience members tend to understand the issues within the ability space. People are creatures of habit and tend to participate in events that address a topic of interest versus an unfamiliar issue. For instance, ability advocates are more likely to attend events that focus on ability. To target non-advocates, use terminology that describes the event's activities, not the storytellers and or community members. For example, if a storyteller is living with autism and is sharing gardening, emphasize gardening in marketing materials. In this example, the audience members will build connections due to the collective interest in gardening, not autism. Example words can include diversity, inclusion, conversation, storytelling, dialogue, and community connections in event marketing materials. Intentional marketing helps to reach a broad audience that may have been less likely to connect otherwise.

Partnering with organizations for event planning and implementation can achieve the following: (1) expanded outreach by marketing to multiple networks, (2) diversity promoted among attendees, and (3) combined resources can be more cost-effective.:



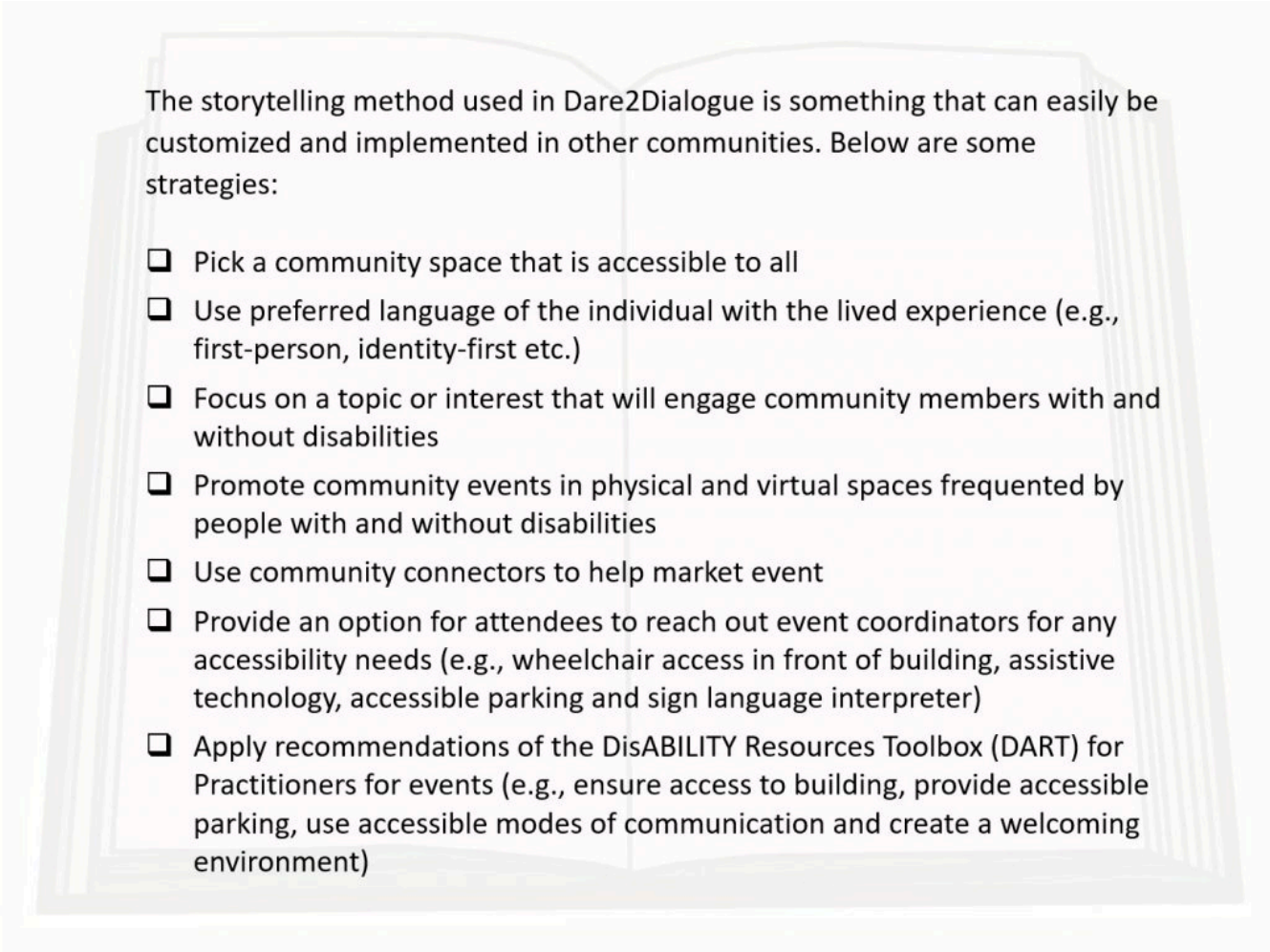
The image shows the progression of achievements through three arrows pointed right (or in a process).

Utilize multiple techniques to engage audience members at events such as word clouds, small group discussions, rotating group conversations, live polls, surveys, and narrative illustrations.

Looking Forward/Recommendations

In order to promote inclusion for people with disabilities, it is imperative that we create spaces and opportunities in the community to make sure their voices are not only heard but are the focus of the conversation. Additionally, storytelling is a relatively straightforward participatory action research (PAR) method of creating knowledge and understanding of a phenomenon. Using PAR allows the participants to shape other peoples' minds with their own experiences, rather than the researcher doing so. As one speaker shared, telling their story was "life-changing." It is important for researchers to consider the power of storytelling from the perspective of the person with a disability. After periods of feeling excluded, being not only included but also respected and heard can help ameliorate previous pain and can foster a sense of community. Furthermore, attending a storytelling event permits attendees to reflect and think about ways in which they or their community can be more inclusive for people with disabilities. Consider the following suggestions as you move forward in your own practice:

Strategies for Replicating in Communities



The image shown above highlights seven strategies that can be used in a similar intervention or project.

Conclusion

We must create and hold space for people living with disabilities whenever we can. We read somewhere that "diversity is inviting people differently in every facet (e.g. ethnically, age, religion or spirituality, physical or mentally diverse, etc.) to the party, but "inclusion" is when they show up, you ask them to dance. We understand that some people living with a disability cannot physically stand up to dance or cognitively grasp what this means, but in this context, we mean "dance" as a metaphor for "engage in "building a relationship or *community*."

DisABILITY Resources Toolbox (DART) for Practitioners

FROM THEORY TO PRACTICE REFLECTIONS AND QUESTIONS

- What does the inclusion of individuals living with a disability mean to you?
- What feelings surface for you when you think about becoming involved in community building alongside people living with any type of disability?
- In order to promote inclusion for people with disabilities, it is imperative that we create spaces and opportunities in the community to make sure their voices are not only heard but are the focus of the conversation. How would you create spaces and opportunities in the community to make sure their voices are not only heard but are the focus of the conversation?

References

Ten facts on disability. (2017). https://www.who.int/features/factfiles/disability/en/

ASDC for the Community Foundations/Intergroup Relations Program (1999). Principles for Intergroup Projects: A First Look.

Bailey, P.H. & Tilley, S. (2002). Storytelling and the interpretation of meaning in qualitative research. *Journal of Advanced Nursing, 38*, 574-583. https://doi.org/10.1046/j.1365-2648.2000.02224.x

Bialik, K. (2020). 7 facts about Americans with disabilities.

Carter, E. W., & Bumble, J. L. (2018). The promise and possibilities of community conversations: Expanding opportunities for people with intellectual and developmental disabilities. *Journal of Disability Policy Studies, 28*, 195–202. https://doi.org/10.1177/1044207317739408

Disabled World. (2020). Invisible Disabilities: List and General Information.

Dunn, D. S., & Andrews, E. E. (2015). Person-first and identity-first language: Developing psychologists' cultural competence using disability language. *American Psychologist, 70*(3), 255–264. https://doi.org/10.1037/a0038636

Noy, C. (2008). Sampling knowledge: The hermeneutics of snowball sampling in qualitative research. *International Journal of Social Research Methodology*, *11*, 327–344. https://doi.org/10.1080/13645570701401305

Okoro, C.A., Hollis, N.D., Cyrus, A.C., & Griffin-Blake, S. (2018). *Prevalence of disabilities and health care access by disability status and type among adults-United States, 2016.* National Library of Medicine. https://pubmed.ncbi.nlm.nih.gov/30114005/

Prilleltensky, I., & Nelson, G. (1997). Community psychology: Reclaiming social justice. In D. Fox & I. Prilleltensky (Eds.), *Critical psychology: An introduction.* (pp. 166– 184). Sage Publications, Inc.

3

Green Space Programs as a Shared Growth and Communal Process: A Somali Gardener's Journey in Minnesota

AUGUST JOHN HOFFMAN, PH.D.

This case study narrative describes the personal growth process, learning experiences, and development of a young Somali-American woman (Amian) through the lens of a community gardening and green space program located in St. Paul, MN.



Photo courtesy of August John Hoffman (Image is of two young women of Somali descent holding vegetables).

Amian[1] is currently completing a graduate program in Individualized Studies with an emphasis in Gardening Development at Metropolitan State University and actively participates in developing healthy foods at several gardens in the Twin Cities region. Her focus is providing members of underrepresented groups with greater access to food plots and enabling them with resources in growing healthier foods. Community growth, collaboration, and communal development of healthy foods is the central thesis of this paper, and how one young woman's efforts to provide access to healthier foods to underserved and marginalized community members gradually became realized through her work at the Inver Hills – Metropolitan State Community Garden during the Summer 2020 growing season. Amian's long-term goals include promoting food justice to marginalized groups residing in the upper Midwest region and developing a more sustainable ecosystem that promotes autonomy and healthy living conditions. This case study identifies important psychosocial factors such as community engagement, collaboration, inclusion, and superordinate goals as vital concepts in not only helping to produce a successful community garden but perhaps more importantly how these intersectional qualities can help us to better understand one another and coexist within a more harmonious society.



Figure 2: Vegetables Grown by Students at Metropolitan State University Photo courtesy of August Hoffman

Community gardening, natural outdoor and green space activities have recently gained empirical support in providing a broad range of health-related benefits, including reduced obesity (Ornelas, et al., 2018), ecological resilience among indigenous populations (Shava, et al., 2010), social capital (Alaimo, et al., 2010) and increased community resilience among immigrant populations (Okvat & Zautra, 2011). While community gardens, green space, and natural environments have long remained popular activities among individuals and family members living in both rural and urban environments, only recently have these environments been examined as providing specific benefits such as psychological well-being (Soga, et al., 2017) and improved quality of life among younger populations such as adolescents and children (McCracken, et al., 2016).

More recently, current research has identified activity and participation within community gardening and green space environments as particularly beneficial to immigrant and refugee populations (Hartwig & Mason, 2016). Community gardening and environmentally sustainable green space activities support fundamental principles shared by community psychologists in that they provide unique opportunities for diverse groups of individuals to work collaboratively and establish a stronger sense of community inclusion, engage in social change, and promote psychosocial health (Fetterman, 2015).

The Inver Hills – Metropolitan State University Community Garden

The Inver Hills – Metropolitan State University Community Garden was established in 2010 for the purpose of providing healthy foods to low-income families of the Dayton's Bluff area located in St. Paul, MN. The garden was established primarily as a cooperative between two higher educational institutions of the Minnesota State System (Metropolitan State University and Inver Hills Community College) and provides an environmentally sustainable learning environment for students from both institutions to work collaboratively in producing a broad

range of healthy foods for community residents. The community garden (approximately one-half acre) is located on the southeast portion of the Inver Hills campus which is located in Inver Grove Heights, MN. The garden is comprised of three separate components or divisions: A cooperative garden area where students work in producing healthy foods for local food banks; a fruit tree orchard (over 60 fruit trees) consisting of over 16 different apple tree cultivars (i.e., Honeycrisp, FrostBite, Haralson, etc.); and the final segment consists of 40 vegetable garden plots (10' X 10') designated for community residents. Since 2010, the Inver Hills – Metropolitan State University Community Garden has produced over 15, 000 lbs. of a variety of fresh vegetables and over 3,000 lbs. of apples which have been donated to local charities and food distribution centers throughout St. Paul and Minneapolis. The purpose of this current case study is to provide a personal and in-depth description of how a young Somali-American woman (Amian) has participated and worked in several community gardens in the upper Midwest region (i.e., Big River Farms located in Marine on St. Croix, MN, The Interfaith Garden located in Minneapolis, MN, and The Inver Hills – Metropolitan State Community Garden).



Figure 3: Aerial View of the Inver Hills – Metropolitan State Community Garden. Circa 2017. Photo courtesy of August Hoffman



Figure 1: Vegetables Grown by Students at Metropolitan State University.
Photo Courtesy of August Hoffman

The current case study will focus primarily on Amian's work in developing her own community garden at the Inver Hills – Metropolitan State Community Garden located in Inver Grove Heights, MN. An interesting component of this case study review is in understanding how one individual uses her personal experiences in witnessing malnutrition and food insecurity as a young child in Somalia as both a transformational and motivational process in growing healthy foods for underserved populations in the Twin Cities region. Amian's primary initiative in green space development and community gardening activities has been her early childhood experiences while growing up in Somalia, where food shortages and other natural resources (i.e., potable water) remain increasingly in short supply. Amian comments: "My goal [at the garden] is to grow food for the community specifically for the elders as well as teach healthy

food options … and encourage health and wellness during these difficult times." Additionally, we hope to provide useful information to other immigrant families who would like to participate in community stewardship programs such as community gardening and forestry programs to improve access to healthier foods.

Community Gardening, Social Integration and Health Promotion among Immigrant Families

Given the rapid increases in the populations of individuals living in impacted and urban environments, the benefits of both green space and community gardens are becoming both necessary and important activities that help in sustaining optimal physical and psychological health. For specific refugee and immigrant populations, often just having access to potable water and minimal amounts of sustainable foods are challenges that are faced on a daily basis. According to recent estimates published by the Food and Agricultural Organization (an international agency devoted to promoting healthy foods to impoverished families throughout the world), over 153 million people or approximately 26% of the population of sub-Saharan Africa will suffer from starvation or food insecurity (Food and Agriculture Organization of the United Nations, 2016). The need to promote community gardening programs and skills in producing healthy foods that are similar to the refugee's native homeland and food environment is critical to the successful transition to the United States (Gichunge & Kidwaro, 2014). In Amian's personal experience as a child growing up in Somalia, she experienced firsthand how food shortages can have serious negative consequences on the health and welfare of community residents, and how immigrants and POCI populations here in the United States often face disproportionate levels of food insecurity. More specifically, as the frequency of refugee and immigrant populations arriving in the United States have increased over time researchers have discovered that access to native foods through horticultural (i.e., community gardening) and green space programs play a critical link in successful adaptation, assimilation, and improved mental health (Hartwig & Mason, 2016; Wilson, et al., 2010).

Communities that educate how native foods are grown and provide tools and resources within those environments that facilitate a successful harvest can help immigrant families adapt to their new communities more successfully and also improve both psychosocial and physiological

measures of optimal health, including a greater "sense of identity with their former selves" (Hartwig & Mason, 2016, p. 1158). Measures of improved physical and psychosocial health included greater access to organic foods (Carney, et al., 2012), reduced cardiovascular disease, depression (Tracey, et al., 2020) and body mass index (BMI) (Soga, et al., 2017). Recent data suggests that community gardening programs have been associated with the development of healthier and more sustainable lifestyles (i.e., connection with nature, social health, and increased physical activity) that are compatible with ethnically diverse families who are currently living in urban environments (Tharrey, et al., 2019). Additionally, recent topics of research within the discipline of community psychology have identified green sustainable programs such as community gardening as a viable approach in promoting wellness and mental health especially among vulnerable populations (Androff, et al., 2017).



Figure 4: Vegetables Grown by Students at Metropolitan State University (July 2020). Photo Courtesy of August Hoffman

Communities that provide residents with opportunities to share knowledge and their own personal experiences in the development of a community garden not only improve food security but have also been identified as providing other numerous benefits to the community, such as increased social capital, resilience and empowerment among those residents who live within those neighborhoods (Alaimo, et al., 2010). Indeed, communities providing residents with an opportunity to participate in green space and community gardens are perceived as desirable



Figure 5: Cucurbita Legenaria Squash (Common name: Winter Squash) from Africa

living environments that contribute to a greater sense of psychological well-being, social cohesiveness and trust (Spano, et al., 2020). Amian immigrated to the United States when she was eight years old and has had a life-long passion to provide healthy foods to the community members where she currently resides in Minneapolis, MN. Growing up in a drought-stricken community in Somalia, food and potable water have never been taken for granted and are considered precious commodities. Amian has seen families struggle in just maintaining enough food to survive and has commented that she would like to see a more "collective effort from the community" in participating and contributing to the development of increased sustainable gardening programs. The culture from which Amian is accustomed to is just that – collectivistically oriented to groups working together in promoting a better way of life for survival. In the United States, Amian has commented that people are more dispersed, competitive, and more concerned about getting ahead at the expense of others rather than working collectively to share benefits with each other. "I came from a communal environment" Amian explains, and "when families experience a crisis, such as a death in the family, the first thing we do is to bring food. Food has a wonderful way of bringing people together especially during times of stress and grief."

Growing Food for a Healthy Community as an Educational Process

An important component of growing healthy foods for the community is education. Part of Amian's goal in developing a healthy foods program is in helping children understand not only the benefits of healthier eating, but also the actual origins of the foods they consume. Amian is convinced that when children play a role in the development and maintenance of a community garden they are improving their knowledge about food but also are more likely to consume the foods that they have helped propagate. This is especially important with vegetables (i.e., leafy greens) that are healthy but are often less preferential and palatable for younger children (i.e., broccoli, spinach, and kale). In more collectivistically-oriented environments, groups of individuals (of all ages) work together and share the benefits of common goals that are vital to the survival and well-being of community members. Perhaps more importantly, younger populations of children who share in the responsibility of growing healthy and sustainable foods such as mulching, cultivating, planting seeds, and harvesting learn the delicate balance of sustainable eco-systems and the human responsibility in respecting the fragile and finite resources of the environment. Amian has indicated that she is "committed to serving the refugee and immigrant community in Minnesota because . . . I have seen first-hand from my

own experiences [in Somalia] coming from an immigrant family. I know that I cannot do this alone, and that is why I have partnered with Big River Farms and The Interfaith Garden."

From Somalia to Minnesota: Foods that Facilitate Resettlement & Assimilation

Community gardening programs, green space, and natural environments are unique in that they provide numerous health benefits to community residents in both urban and rural areas. Adapting to a new environment as an immigrant or refugee can be very stressful, and providing native foods from one's homeland can be an effective stress-coping mechanism that holds numerous benefits to individual health among vulnerable populations (Tracey, et al., 2020). Minnesota is rapidly becoming a common settlement worldwide among refugees and immigrants who are escaping a number of threats to their personal safety and well-being, including malnutrition, oppressive governments (i.e., ethnic genocide), and persecution for religious beliefs. Currently, Minnesota ranks as the 13th leading state within the United States in resettlement for refugees primarily from Sub-Sahara Africa and Southeast Asia (Hartwig & Mason, 2016, p. 1154).



Figure 6: Haralson Apple Tree (Malus Domestica) located at the Inver Hills-Metropolitan State Community Orchard. Originated 1922 MN Horticultural Research Center, Charles Haralson (Zone 3 species) (August 2020) *Photo Courtesy of August Hoffman*

A Greener Vision for the Future

An important scope and general purpose in community gardening and green space programs is the future itself and how to get more community members involved in participating in sustainable and healthy foods production. Several of the student participants in the community gardening program indicated that they enjoyed working with other students and community participants in providing healthier foods for low-income families. One of the student participants (Abdiaziz) commented that he "loved every minute of working outside to help produce healthy foods for the community members. Providing people with these kinds of opportunities gives us an opportunity to get to know each other better and help people who are less fortunate than us." Amian has indicated that she is trying to help community members work with immigrant families in a more collaborative process that will not only teaching participants the nutritious benefits of her native foods from Somalia, but that most food-related problems (i.e., shortages of healthy foods) is actually preventable and human-related. "When I started growing my vegetables in the gardens

I noticed how much food is wasted here in the United States and that hunger is actually a 'man-made' phenomenon." If she is provided with the resources and opportunities, Amian plans to build an even larger sustainable foods program in southeast Minnesota (Kenyon) up to 20 acres. Amian has indicated that some of her most formidable challenges have been in finding community stakeholders who are willing to help provide resources in the continued development of sustainable green space activities and community gardening programs.



Figure 7: Somali students from Metropolitan State University harvesting vegetables. Photo courtesy of August Hoffman

Providing opportunities for immigrants to work in a more collaborative process in the development and proliferation of ethnic foods is an empowering process that can help people from all backgrounds to better understand different cultures. Community psychologists can help facilitate the process of bridging cultural gaps and reducing racial stereotypes by serving as advocates in the development of sustainable green space environments such as community gardens. Amian has found the process of developing sustainable community gardens and providing healthier foods from her native homeland of Somalia personally a very rewarding and intrinsically satisfying experience. Her long-term goals are to provide healthier and organic foods for vulnerable Somali populations and older adults who are currently facing economic hardships. Amian has recognized that "the



Figure 8: Metropolitan State University students cultivating a pepper garden at the Inver Hills – Metropolitan State University Community Garden (circa 2019). Photo courtesy of August Hoffman

voices within the community need to be heard and . . . I would like to see more families eating healthier foods together and growing their own foods." Amian's proposal includes planting native seeds from her native homeland Somalia including leafy green vegetables, beans and even fried bananas for families with low incomes in the United States, including immigrant families from Somalia, Ethiopia, Kenya and Southeast Asia. Amian is also concerned about increasing global environmental pollution (i.e., the proliferation of plastics) which directly impacts the quality of soil and water used for agricultural purposes. Her future plans include working in environmentally sustainable projects in the St. Paul and Minneapolis areas and promoting greater access to healthier foods among Somali and other underrepresented populations in these areas. Additionally, Amian is trying to reduce the impact of global pollution through the education and practice of simple environmentally-responsible behaviors, such as recycling, composting, and developing rainwater irrigation systems for garden sites.

Conclusion

The benefits of community gardening cannot be understated. Results of evaluations and studies offer clear evidence that community gardens provide numerous health benefits, improved access to food, related nutritional needs, and improved mental health. An important aspect that can be overlooked is its promotion of social health and community cohesion, both essential aspects of a healthy community.

Read more at: https://nccommunitygardens.ces.ncsu.edu/resources-3/nccommunitygardens-research/

FROM THEORY TO PRACTICE REFLECTIONS AND QUESTIONS

- Community gardening and environmentally sustainable green space activities support fundamental principles shared by community psychologists in that they provide unique opportunities for diverse groups of individuals to work collaboratively and establish a stronger sense of community inclusion, engage in social change, and promote psychosocial health (Fetterman, 2015). Share with your classmates or others at least one other way, outside of formal education, that can foster a sense of community, engagement in social change, and the promotion of psychosocial health?
- This case story mentions that a challenge in doing social justice work involving food has been

in finding community stakeholders who are willing to help provide resources in the continued development of sustainable green space activities and community gardening programs. Consider and provide examples of how you might address this challenge.

- In addition to physiological well-being, what are some psychological influences of food on one's sense of community?

Note:

[1]The person centered in this chapter summary, Amian (name changed), is aware that this chapter is being published and has provided her consent. Due to cultural restrictions of her native country (Somalia) she has requested to remain anonymous.

References

Africa Regional Overview of Food Security and Nutrition 2016 | FAO | Food and Agriculture Organization of the United Nations

Alaimo, K., Reischl, T. M., & Allen, J. O. (2010). Community gardening, neighborhood meetings, and social capital. *Journal of Community Psychology, 38*(4), 497-514.

Androff, D., Fike, C., & Rorke, J. (2017). Greening social work education: Teaching environmental rights and sustainability in community practice. *Journal of Social Work Education, 53*(3), 399–413.

Carney, P. A., Hamada, J. L., Rdesinski, R., Sprager, L., Nichols, K. R., Liu, B. Y., Pelayo, J., Sanchez, A., & Shannon, J. (2012). Impact of a community gardening project on vegetable intake, food security, and family relationships: A community-based participatory research study. *Journal of Community Health, 37*, 874-881.

Fetterman, D. M. (2015). Empowerment evaluation and community psychology: An alignment of values and principles designed to improve the human condition. In V. C. Scott & S. M. Wolfe (Eds.), *Community psychology: Foundations for practice.* (pp. 329–348). Sage Publications, Inc. https://doi.org/10.4135/9781483398150.n12

Food and Agriculture Organization of the United Nations (2016). Retrieved from:

Gichunge, C., & Kidwaro, F. (2014). Utamu wa Afrika (The sweet taste of Africa): The vegetable garden as part of resettled African refugees' food environment. *Nutrition & Dietetics*, *71*, 270-275.

Hartwig, K. A., & Mason, M. (2016). Community gardens for refugees and immigrant communities as a means of health promotion. *Journal of Community Health*, *41*, 1153-1159.

Jason, L. A., Keys, C. B., Taylor, R. R., & Davis, M. I. (Eds.). (2004). *Participatory community research: Theory and methods in action*. Washington, DC: American Psychological Association.

McCracken, D. S., Allen, D. A., & Gow, A. J. (2016). Associations between urban green space and health-related quality of life in children. *Preventive Medicine Reports*, *3*, 211-221.

Okvat, H. A. & Zautra, A. J. (2011). Community gardening: A parsimonious path to individual, community, and environmental resilience. *American Journal of Community Psychology, 47*, 374-387.

Ornelas, I. J., Osterbauer, K., Woo, L. Bishop, S. K., Deschenie, D, Beresford, S. A., & Lombard, K. (2018). Gardening for health: Patterns of gardening and fruit and vegetable consumption among the Navajo. *Journal of Community Health*, *43*, 1053-1060.

Shava, S., Krasny, M. E., Tidball, K. G., & Zazu, C. (2010). Agricultural knowledge in urban and resettled communities: Applications to social-ecological resilience and environmental education. *Environmental Education Research, 16*(5-6), 575-589.

Soga, M., Cox, D.T.C., Yamaura, U., Gaston, K. J., Kurisu, K., & Hanaki, K. (2017). Health benefits of urban allotment gardening: Improved physical and psychological well-being and social integration. *International Journal of Environmental Research and Public Health, 14*(1), 71. https://doi.org/10.3390/ijerph14010071

Spano, G. D'Este, M., Giannico, V., Carrus, G., Elia, M., Lafortezza, R., Panno, A., & Sanesi, G. (2020). Are community gardening and horticultural interventions beneficial for psychosocial well-being? A meta-analysis. *International Journal of Environmental Research and Public Health, 17*(10), 3584. https://doi.org/10.3390/ijerph17103584

Tharrey, M., Perignon, M., Scheromm, P., Mejean, C., & Darmon, N. (2019). Does participating in community gardens promote sustainable lifestyles in urban settings? Design and protocol of the JArDinS study. BMC Public Health, 19(589). https://doi.org10.1186/s12889-019-6815-0

Tracey, D., Gray, T., Sweeting, J., Kingsley, J., Bailey, A., & Pettitt, P. (2020). A systematic review protocol to identify the key benefits and associated program characteristics of community gardening for vulnerable populations. *International Journal of Environmental Research and Public Health, 17*(6), 1-8.

Wilson, A., Renzaho, A.M.N. McCabe, M., & Swinburn, B. (2010). Towards understanding the new food environment for refugees from the Horn of Africa in Australiam, *Health Place, 16*, 969-976,

4

Juvenile Justice Community Activation Project

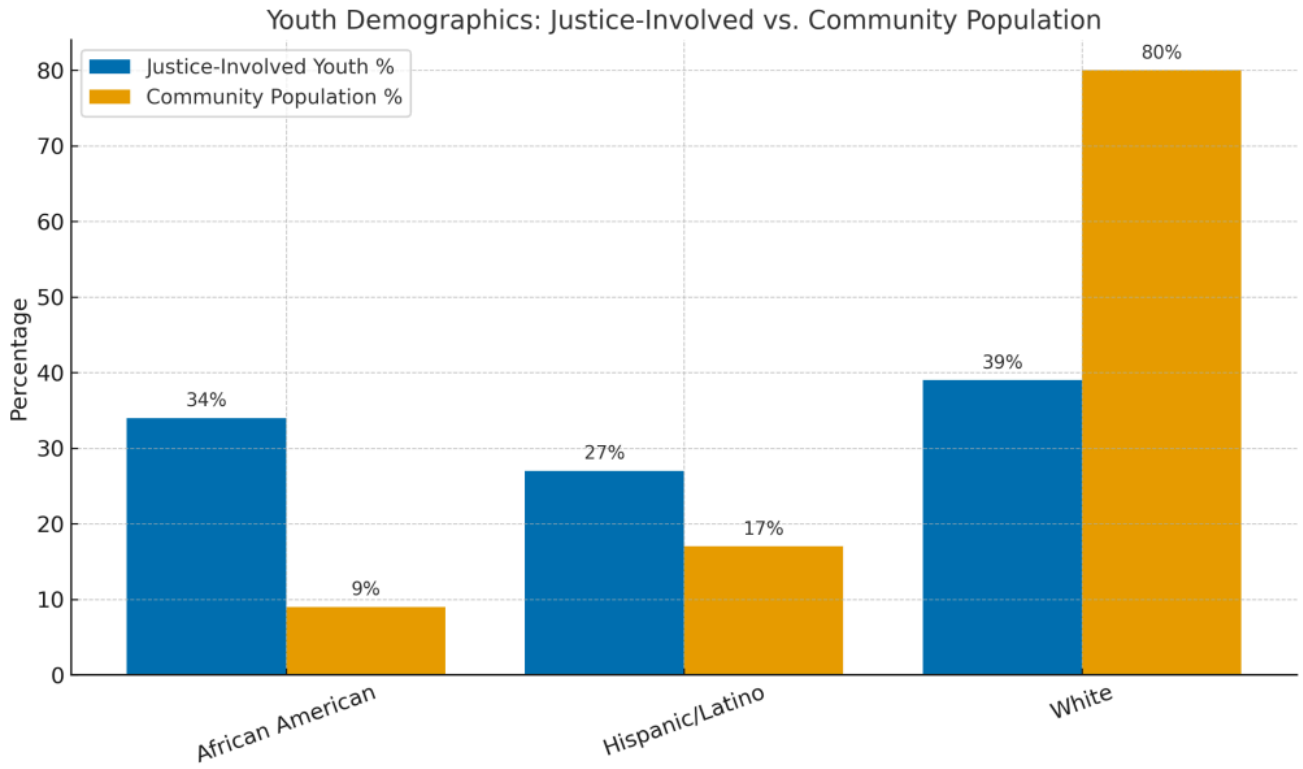
RHONDA K. LEWIS, PH.D., MPH, KEYONDRA BROOKS, PH.D., HANA SHAHIN, PH.D., ROSALIND CANARE, PH.D., STORMY MALONE, PH.D.

BIG PICTURE



Young men in the juvenile justice system

In our community, a disproportionate number of African American and Hispanic youth are in the juvenile justice system compared to the actual population of youth in the community. At the time this study was conducted, 34% of justice-involved youth were African American, 27% were Hispanic/Latino, and 39% were White. In contrast, only 9% of African American youth, 17% of Hispanic/Latino youth, and 80% of White youth make up the population in our mid-sized midwestern community (U.S. Census, 2023).



Youth demographics: juvenile justice system compared to community population in percentages

A partnership was formed between Team Justice, a juvenile justice advisory board consisting of:

- the Sedgwick County's Sheriff
- the Chief of Police
- the District Attorney
- an Administrative judge
- an appointed educational professional
- an appointed probation officer
- appointees from the Board of County Commissioners
- members appointed by the City Council
- the local Department of Corrections
- and a local university research team (the Behavioral Community Research and Action Team – BCRAT)

The goal of this collaboration was to come together to gather input from the community about why there are racial and ethnic disparities in our juvenile justice system. To attain information from the community,

the Behavioral Community Research and Action Team (BCRAT) conducted community needs and assets assessments and listening sessions with diverse groups throughout the community. The primary goal of this project was to use the collected information in the development of a strategic plan at the state level, which would aid in the distribution of funds toward prevention efforts.

Identifying Policy Challenge and Opportunity

This partnership provided a unique opportunity for the community to share their perspective on how resources are allocated that impact juvenile justice. All sectors (schools, law enforcement, faith community, grassroots organizations, and cultural groups – BIPOC and sexual and gender minorities) of the community were brought together to understand why there was a disparity in African American and Hispanic youth being in the juvenile justice system.

The rationale behind this collaboration was to bring awareness to the community about how the Department of Corrections operates and provide information to the Department of Corrections about the community's perceptions of the department. For instance, the community was informed of some of the policies related to juvenile justice, including:

1. Once youth are involved in the system, parents must comply with the orders they are given,
2. There are cultural and language barriers, and parents may not understand what is happening (McCarter & Durant (2022),
3. While their child is system-involved, parents are not given much input,
4. Often, parents and youth cannot pay the fees associated with court costs, and
5. Parents and youth may have transportation issues and cannot actively participate in programs offered by the Department of Corrections.

During the time of the project, the juvenile justice advisory board (Team Justice) was open to gathering input from the community, allowing for justice-involved youth and their families to critique the system and discuss a strategic plan for the state of Kansas to more appropriately distribute funds for youth programming. The voices of youth (Black, youth in foster care, sexual and gender minority, Hispanic/Latino, Asian) and key stakeholders (parents — Black and Hispanic/Latino — counselors, school resource officers) in the community at large were used to challenge current policy to help youth live productive lives and avoid the juvenile justice system.

Implementing the Strategy

To begin the community activation process, BCRAT held work sessions with a team of community advisors. The goals of these work sessions were to identify access points for groups most impacted by the current juvenile justice system and ensure diverse voices were included in the listening sessions. At this point, a community needs and assets assessment was generated using existing surveys from the literature, input from the juvenile justice advisory committee, and youth advocates. The community assessment consisted of 42

questions. BCRAT distributed the community assessment and made the assessment available on paper, at the courthouse, and electronically using a QR code. A total of 281 surveys were gathered from community residents. (See Table 1 for sample questions from the survey.)

Table 1-Sample Questions from Community Needs and Assets Assessment Survey

Community Needs and Assets Assessment Survey
1. What do you think contributes to youth getting in trouble? 2. What does success look like for young people? 3. How might families play a role in youth getting into trouble? 4. What resources does the community have that contribute to the youth's safety and success?

The BCRAT members hosted listening sessions in multiple locations around our midwestern mid-sized community (in-person) and virtually to capture the experiences of youth and adults from various backgrounds. Recruitment flyers were distributed throughout the community, and community partners invited community members to the listening sessions. The BCRAT team developed the listening session protocol and worked with the county representative to conduct the listening sessions.

A total of 18 listening sessions were conducted, with a total of 118 participants. Participants consisted of 77 adults and 41 youth.



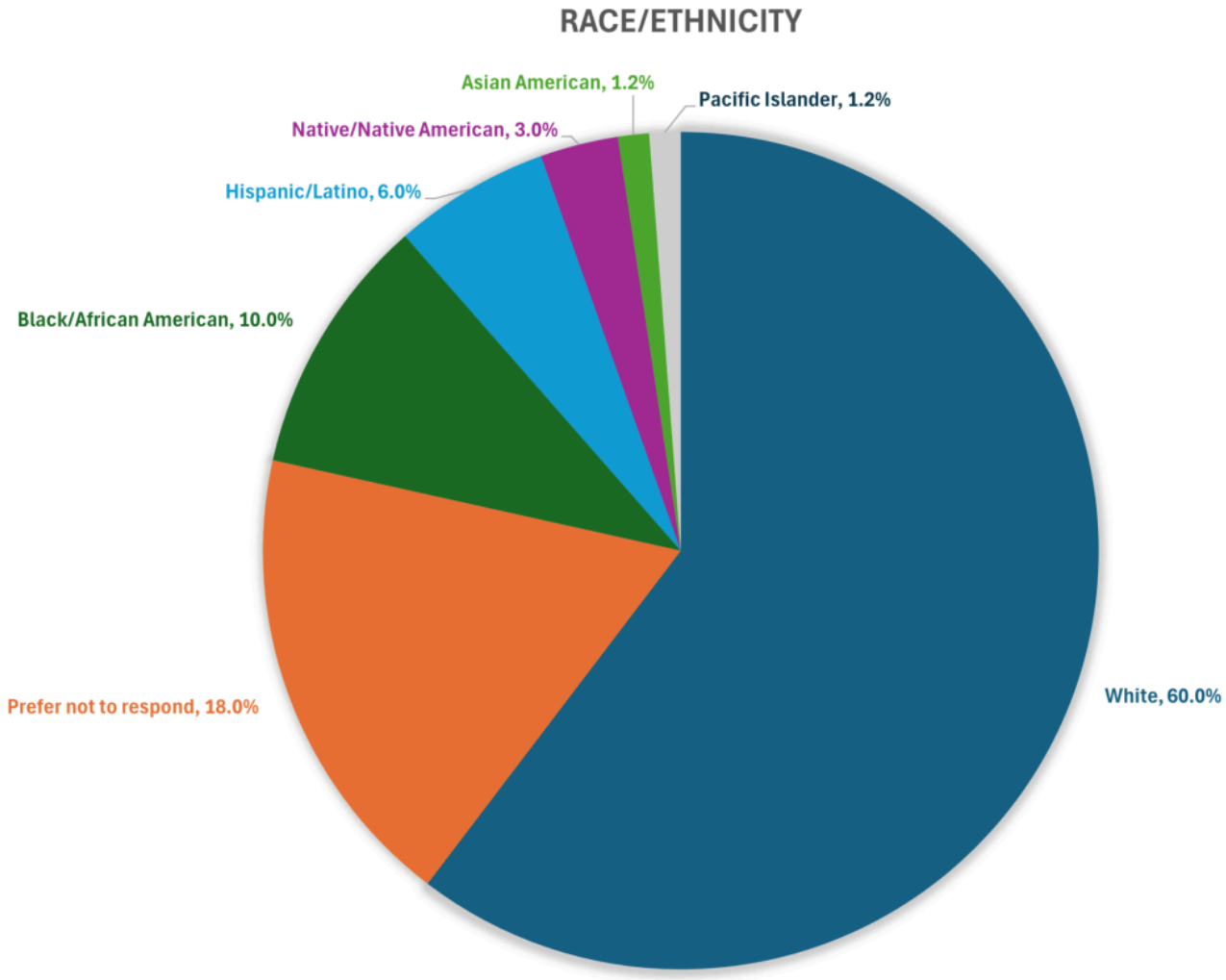
At each session, the protocol included:

1. Providing participants with a general overview of the project,
2. The local county partner describing the purpose,
3. The team sharing local statistics, and
4. Presenting three questions to attendees for individual responses and discussion.

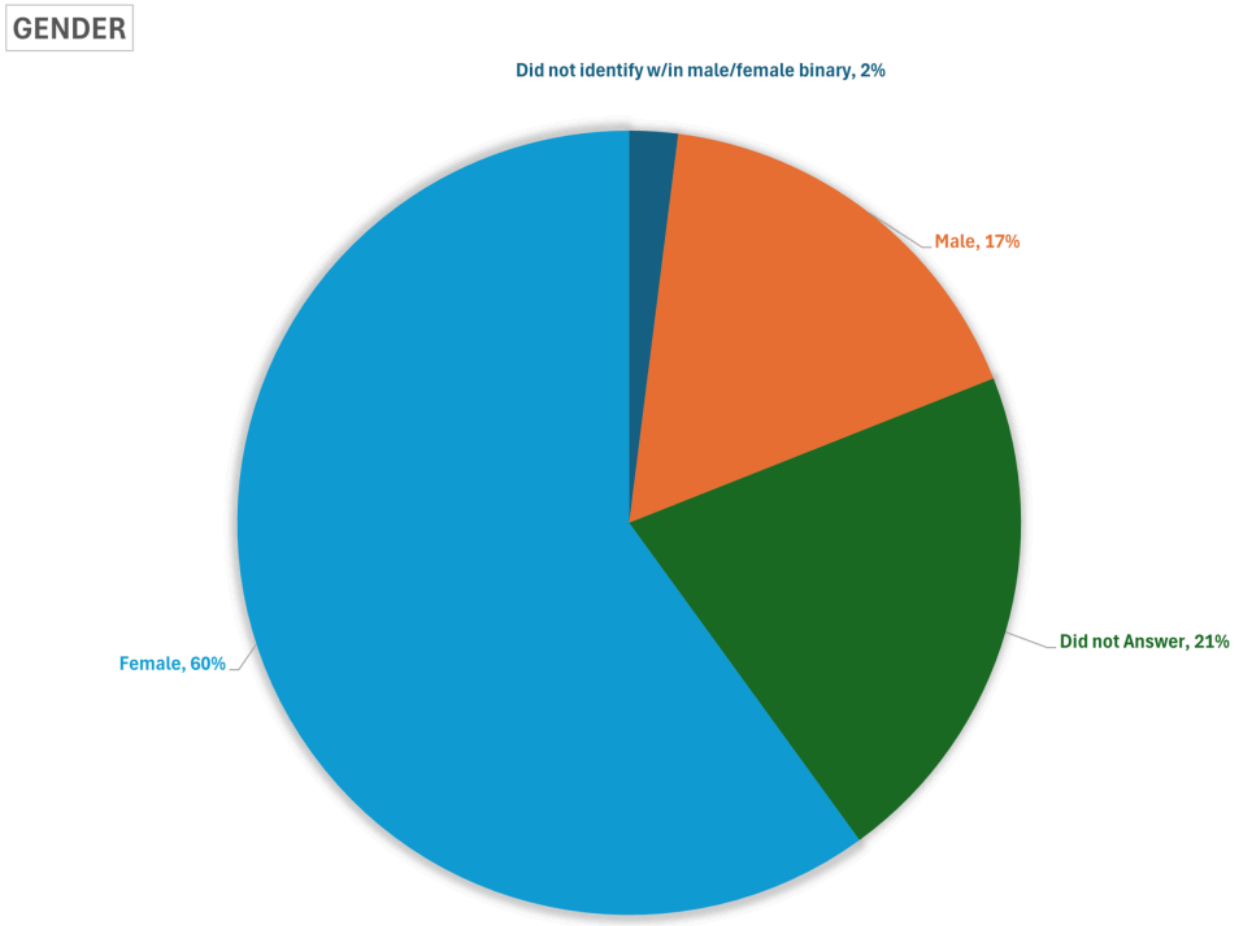
At each session, baseline data were presented to build awareness about how many young people were in the juvenile justice system and to create an understanding of the problem, and to develop critical consciousness about youth in the system. After presenting the purpose and baseline statistics, each session focused on listening to participants' responses to three primary questions. First, participants were asked to respond independently. After participants were given time to write their answer to a question, participants shared their responses, and similar answers were grouped and posted on a flip chart. This process was repeated for each question. Sessions ranged from 30 minutes to 2 hours.

Assessment Results

Demographic data from the community needs assessment showed that 10% of the participants identified as Black/African American, 60% identified as White, 6% identified as Hispanic/Latino, 3% identified as Native/Native American, 1.2% identified as Asian American, 1.2% identified as Pacific Islander, and 18% preferred not to respond. The average participant age was 44, with ages ranging from 16 to 76.



Sixty percent identified as female, 17% identified as male, 21% did not answer, and 2% did not identify within the male/female binary.



Action and Advocacy



Juvenile and Justice Scale

Factors that may impact juvenile justice issues, as identified by the community needs and asset assessment, revealed that mental health, financial needs, healthy foods, and safety needs are the most important. Regarding access to services, GED assistance, substance use help, and healthy food came up most often as factors that may impact juvenile justice issues.

Community Needs and Assets Assessment Results

BCRAT members worked together to develop themes based on responses to the needs and assets assessment. Themes and examples are provided for each question.

What do you think contributes to youth getting into trouble?
Themes included: (1) parenting difficulties (lack of supervision, skills, guidance, and discipline), and (2) poverty and the lack of resources.
A few example quotes include:
"I think the primary contribution to youth getting in trouble begins with the lack of in the home."
"Whether that's having both parents loving, instilling character, principles, morals, value, etc."
"Growing up in families and communities that lack resources. When resources are low, stress is high, dysfunction and instability increases as well. If we took care of the people in our communities, and attention they need to grow up and become healthy and well-adjusted."

Table 2 displays results for question 1: What do you think contributes to youth getting into trouble?

What does success look like for young people?
Themes included: Education and career opportunities, support and mentorship, visible wealth, positive outlook/self-worth and skills.
A few quotes included:
"Finishing school, pursuing more tech school or college then finding a job with benefits. Extremely hard to do while the wealthy oversee our country and 'the economy' is judged (not?) by how the average citizen is affected but how the stock market is doing."
"Learning a skill or skills to be able to do a skill to show them the values of having skills to be a contributor to bettering their communities."
"Exiting the education system with skills and knowledge that will assist them in leading a comfortable and meaningful life."

Table 3 displays results for question 2: What does success look like for young people?

How might families play a role in youth getting into trouble?
Themes included: Parents that exhibit criminal behavior and lack parenting skills/improper parenting.
A few quotes included:
"Many criminal youths came from criminal families. Their families commit crimes, use substances, and are modeling this behavior to their kids. Sometimes it's lack of parenting and consistent structure at home."
"Not being around enough, not being a positive role model, not caring enough to support them and their needs and maybe wanting to be their friend instead of their parent, giving mixed signals to the child and not offering any authoritative parenting skills."

Table 4 displays results for question 3: How might families play a role in youth getting into trouble?

Overall, the community needs and asset assessment provided useful information to the partnership (Department of Corrections, advisory board, and the university research team) by providing input about what community members believed were the contributors to success and failures of the juvenile justice system and why they believed youth were getting into trouble. Overall, community members viewed a lack of mentors and positive role models, and a lack of parenting as a missing support for youth. Youth who see a display of criminal behavior from parents, lack discipline from their parents, and whose parents are not positive role models contribute to youth becoming justice-involved.

Listening Session Results

Eighteen listening sessions (N=118; 77 adults and 41 youth) were conducted with middle school teachers, high school teachers, counselors, pastors, School Resource Officers, youth under supervision of the juvenile justice system, Hispanic/Latino adults, Hispanic/Latino youth, Asian American adults, Asian American youth, Black and African American youth and adults, students in the local school district, LGBTQ+ youth, Foster Care youth, and police officers. Participants who belonged to these groups were recruited through community partnerships, and a listening session was held specifically for each of these demographics. Each listening session focused on three primary questions, as stated below. For each question, responses are shown using a Table and a word cloud.

Table 5: Listening Session Question 1

What do young people need in their lives to grow into healthy and productive citizens?
☺ Mentors
☺ Role Models (People who look like them)
☺ Recreational activities (i.e., sports, hobbies, extracurricular activities)
☺ Capacity building and personal development (e.g., discipline, accountability, love, morals, encouragement, hope, fortitude)
☺ Education (early prevention/intervention, financial literacy/life skills)
☺ Sex education (reduce teen pregnancy, Schools quality teachers, quality education)
☺ Resources (i.e., Mental health, therapy, family therapy, and anger management, tutoring)
☺ Career opportunities and technical (education, and resources about careers; building work ethics, Community connections)

Table 5 – Listening Session Question 1 – What do young people need in their lives to grow into healthy and productive citizens?



Figure 1. Word Cloud for Question 1 – What do young people need in their lives to grow into healthy and productive citizens?

Summary

Overall, several key themes were identified. The community agrees that youth need mentors and role models, resources, career opportunities, parents, and schools. It was noted that schools played a pivotal

role in the lives of children in terms of access to recreational spaces, education about social aspects of life (reproductive health), and career development.

Table 6: Listening Session Question 2

What are the factors that can keep youth out of the juvenile justice system?
☺ Role models (positive)
☺ Parents (more family time, active and involved parenting)
☺ Community Resource/support (Need more help when you have trouble with the policy other than calling the police)
☺ System (reduce sigma of asking for help or receiving mental health help)
☺ Support system (help youth combat gangs)
☺ Education School (More funding for schools; More exposure to college prep)
☺ Teachers (encourage preventing interaction with the juvenile system through training about disparities)
☺ Culturally Relevant Interventions

Table 6 – Listening Session Question 2 – What are the factors that can keep youth out of the juvenile justice system?



Figure 2. Word Cloud Question 2 – What are the factors that can keep youth out of the juvenile justice system?

Summary

Overall, several key themes were noted. Schools also played a key factor in how often students are taken to the juvenile justice system because incidents often occurred at school. Respondents wanted more activities

held at the school and for the school to be a welcoming place. The community participants demonstrated a desire for increased activities and education for the youth, and a need for supportive people to help the family.

Table 7: Listening Session Question 3

What are your recommendations or programs for helping youth to be healthy and productive citizens?
☺ Family and Parents
☺ After-School Programs
☺ Bridge to Workforce programs
☺ Boarding Schools
☺ Volunteering and Community Service
☺ School Environment- Being open to parents.
☺ Classes and Education
☺ Instill hope and a positive outlook!
☺ Maintain Success after Interaction with the Juvenile Justice System
☺ Recreation -Skate Parks
☺ Resources- (i.e., Money, vouchers, Transportation, food)
☺ System changes (Support those aging out of foster care)
☺ Creative and youth appropriate outreach (i.e., LGBTQIA+)

Table 7 – Listening Session Question 3 – What are your recommendations or programs for helping youth to be healthy and productive citizens?



Figure 3. Word Cloud Question 3 – Recommendations

Summary

Taken together, respondents stated they wanted after-school programming available to youth at school. Overall, they expressed that more support is needed through the involvement of more adults who can exert a positive influence on youth, and the development of more resources. Volunteering and community service at school programs are needed once people become system involved. One creative location-specific solution provided by the respondents was to create more skateparks as a positive activity for youth.

LESSONS LEARNED



Youth in the community participation

The primary lesson learned from this project was that the community does know what is best for themselves. Specifically, the youth of the community can provide valuable insight about their own lived experiences and what they need to improve the community. Ensuring that youth had a voice in the data collected was a key element of this project, and as a result, youth now have a voice on the justice system's advisory board. The community assessment and listening sessions provided information to help guide the strategic planning process and helped generate a teen justice advisory board to provide input to Team Justice. The teen justice board is comprised of youth and young adults who are passionate about change within the juvenile justice system.

The community partners also held a juvenile justice summit, which was the culmination of the partnership project. At this community conference, the BCRAT shared the results of the needs/assets assessment and listening sessions with members of the community. Feedback after the summit indicated that the information was well received by both community members in attendance and members of the justice system. Additionally, youth who participated in the project were able to share their experiences of being juvenile justice involved, parents were able to share their experiences of having a youth involved in the juvenile justice system, and how the community could work better together.

Another lesson learned was that this project was only possible with all of the partners working together. The BCRAT was able to access the community and gather varied voices with the help of community

partners. The justice system had an open mind to listen to the feedback provided by the community. The community trusted that their voice would be heard and contribute to meaningful change. Beyond the benefits of collaboration, partnerships throughout the community show youth that collaboration works. Additionally, partnerships may be the solution to fulfilling the missing resources indicated by the youth and their families.

LOOKING FORWARD

As we look forward, several recommendations were made to the local advisory board called Team Justice.

- First, to ensure that youth have a part in the decisions that affect them, there was a recommendation to create the Teen Justice group for youth advocacy (including youth voice (McCarter & Durant, 2022).
- Second, youth in particular stated that there were not enough "hang out" places for youth to be after school that would provide safety, entertainment, and youth capacity building. For example, youth talked about reimagining existing activities available through organizations such as Boys & Girls Clubs and the YMCA, and connecting youth with existing services of which they were unaware.
- Third, folks who have influence need to create more productive outlets for youth, such as Art, recreational activities, and sports activities. These opportunities could serve to keep youth out of trouble, build meaningful relationships, and build career-ready skills. Lastly, the youth and the community suggested that establishing partnerships is key and important for youth to interact with partners in the communities to see that collaboration can work (Mallet, 2018).

REFERENCES

Mallett, C. (2018). Disproportionate minority contact in juvenile justice: today's and yesterday's problems. Criminal Justice Studies. 31, 230-248. https:/doi.org/10.1080/1478601X.2018.1438276.

McCarter, S., & Durant, T. (2022). Disproportionate minority contact (DMC) to racial and ethnic disparities (RED) in juvenile justice: What does it mean and does it matter? Journal of Forensic Social Work, 6, 57-76,

U.S. Census (2023). Retrieved March 13, 2025. https://www.census.gov/quickfacts/fact/table/sedgwickcountykansas/PST045223

ACKNOWLEDGEMENTS

Dr. Delores Craig, Emeritus Faculty member, School of Community Justice, Wichita State University

PART II

Part Two: Global Perspectives



Pixabay.com (Image is part of a world map with passport and camera in the foreground).

When we use the term global we are referring to both physical regions, communities, and spaces around the world, as well as viewing everything from a global lens—which in turn broadens our perspectives and strengthens our foundational truths and helps all to live authentically. Abdul Kalam (n.d.) offers that living globally means, "… to take into consideration the cultures, ethnicity, religions, and living situations of everyone around the world…" (para. 1). From this foundation we bring to the reader three case stories from outside of the United States. We believe you will be enlightened and importantly drawn just a little closer to human lives, that may seem so far away.

The first case story is *Better Together: Better Together: Creating Alternative Settings to Reduce Conflict Among Youth in Lebanon.* Upcoming community psychologist Ramy Barhouche shares a case study of an effort in Lebanon within the Nongovernmental Organization (NGO) sector to collaboratively create alternative and preventive settings to reduce discrimination and prejudice and develop collaborative living and conflict transformation among youth and young adults. Barhouche provides important historical context and rationale for using a process-based relational approach to develop the relationships for collaboration.

The second case story is *Promoting Community-Driven Change in Family and Community Systems to Support Girls' Holistic Development in Senegal.* Dr. Judi Aubel draws you into the country of Senegal, Africa where you get to see the lives of a place often called, "The Gateway to Africa". The case study describes an innovative program designed to address the issue of female genital mutilation (FGM) a seldom-discussed subject, but

here we are going beyond the most popular topics, thus centering and raising the voices of Senegalese girls and women. Read on! You'll never be the same again!

We are excited to expand this section with a third case study: *Proclaiming our Roots: Centering Afro-Indigenous Voices Through Community Storytelling!* *Proclaiming our Roots* is particularly meaningful because it situates contemporary community psychology practice within the historical and cultural foundations that shape community knowledge and resistance. Authored by Drs Anne Marie Beals and Ciann Wilson, faculty at Wilfred Laurier University in Ontario, Canada, offers an innovative community- and arts-based research to amplify the stories of Afro-Indigenous Peoples within the Toronto, Halifax and Winnepeg regions, as well as the territories of the Mississaugas of the Credit First Nation and Six Nations of the Grand River. Take a look, enjoy your reading and hear the stories!

5

Better Together: Creating Alternative Settings to Reduce Conflict Among Youth in Lebanon

RAMY BARHOUCHE

This case story illustrates community psychology in action within the region of Lebanon, where a collaborative partnership worked to create alternative settings for youth to reduce conflict.



Image above is a family in Lebanon with a Lebanese soldier and an internal security guard in the background.

Community psychology in action can be seen through program implementation by Non-Governmental Organizations (NGOs – Nonprofits) and Civil Society in much of the international community. There are two main broad subcategories of NGOs: Humanitarian Aid and International Development. Humanitarian Aid responds to an incident or event (e.g., conflict, natural disaster, poverty, or mass human displacement) and focuses on short-term disaster relief and meeting the immediate needs of the impacted communities. However, these services often take much longer periods than expected due to systemic dysfunctions. International Development programs, on the other hand, respond to long-term systematic problems and focus mainly on economic, social, and political development. It does so through human rights, diplomacy, and advocacy programs; as well as, economic, infrastructure, and capacity development. Both fields, along with others, often are implemented interchangeably and are impacted by and impact local realities.

Lebanon, for example, experienced an influx of Syrian refugees (a quarter of the population) due to the ongoing 2011 Syria conflict. As a result, the country also experienced an influx of International Non-Governmental Organizations (INGO) and Humanitarian Aid funding to support the refugee population. The situation eventually increased tension between host communities and refugees, and between different Lebanese sectarian groups, which can be attributed to the following factors shown below:

Factors Increasing Tensions

- Lebanon is a country of multiple minority groups with a fragile socio-politico-economic system and power-dynamics that can be impacted by minimal demographic changes.
- Lebanon has a history of long-term mass resettlement (e.g., Armenian, Palestinian, and Iraqi).
- Lebanon came out of a gruesome 15-year civil war, which involved local and external forces (Lebanese, Palestinian, Syrian, and Israeli), ending in 1990, with two occupations. After the end of the Israeli (2000) and Syrian (2005) occupations the country was left even more divided, polarized, and with increased corruption, creating the perfect environment for foreign influence (e.g., US-Saudi Arabia vs Iran-Syria).
- Much of the population still has resentment and ongoing fear from the Syrian occupation and influence, which was displaced towards the Syrian refugees.
- The Lebanese economy was impacted by the regional situation and tension, which also led to the increase of unemployment and poverty. Thus, creating more sectarian divide and resentment towards the refugees, which were seen as getting unlimited aid and taking Lebanese jobs.
- The Sectarian system and political elite has been threatened by secular civil society movements, which led to the increase of the sectarian and xenophobic rhetoric; and
- The international community preferred to fund initiatives to support the refugees in Lebanon, Turkey, and Jordan, while restricting their movement to Europe and other neighboring and western countries.

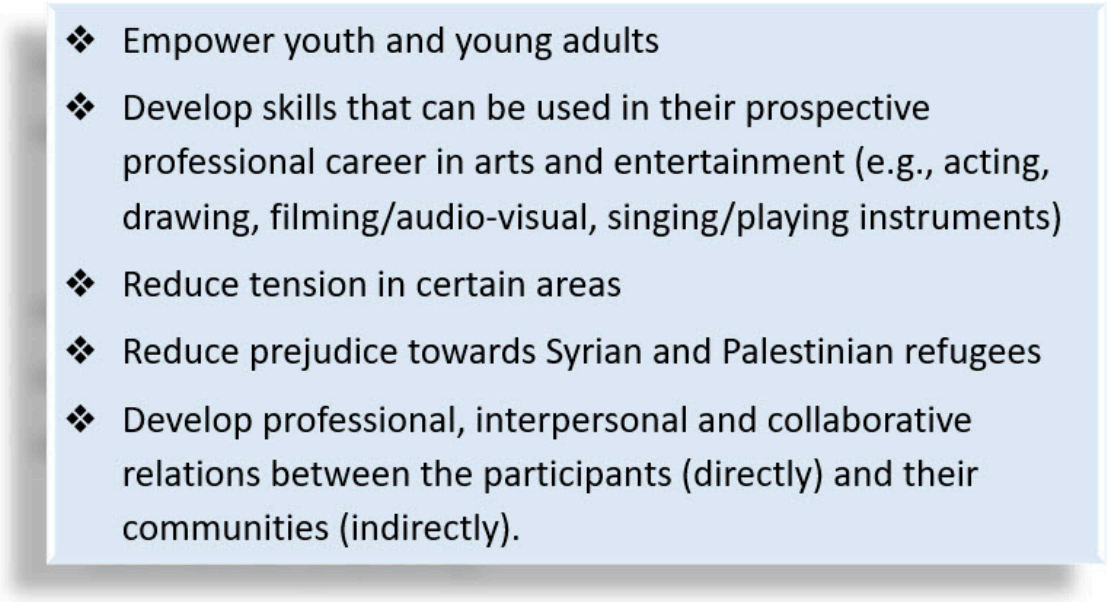
Table above shows a bulleted list of factors and demographics about Lebanon. The background is a lighter blue with black font.

Taking this overview and factors together, this case study will focus on a 2014 project that I (author Ramy Barhouche) worked on, to empower Syrian and Lebanese youth, reduce prejudice and discrimination, and create a culture of dialogue, collaboration, and conflict transformation.

Community Assets/Needs

In the business development process of the project proposal, no formal community assets/needs assessments were conducted. Instead, a brief literature review of past reports, projects, and context were conducted to better understand the situation and needs. In addition, the proposal was developed in consultancy/collaboration with local partners.

We found that youth and young adults in Lebanon have been facing a high level of unemployment. Thus we determined there was a need for capacity development to support prospective job seeking. In addition, we identified a growing market for the arts/entertainment field with little to no opportunities to further develop certain skills. Importantly, there was a rise of tension, prejudice, and discrimination, as mentioned above. As a result, the project team, through local partners, reached out to youth and young adults between the age of 15 to 25, from multiple socio-economic backgrounds (e.g., nationality: Lebanese, Syrian, Palestinian; Religion: Muslim, Christian, Druze; and economic class). With these factors in mind, the project was then designed to: (1) empower youth and adults, (2) develop skills that can be used in future careers, (3) reduce tension in certain areas, (4) reduce prejudice towards Syrian and Palestinian refugees, and (5) develop professional, interpersonal and collaborative relations between participants and their communities.



Some of the participants had previous experience with the designated arts (i.e. acting, drawing, filming/audio-visual, singing/playing instruments), while others had interest but never had the opportunity to be exposed to them. The project hired Lebanese, Syrian, and Palestinian coaches/artists to mentor the participants. The project also asked some of the more experienced participants (active volunteers in local organizations and those with experience in the arts) to act as peer mentors.

Collaborative Partners



SEQ Figure * ARABIC 1: Map of Lebanon – Two red stars pointing to the areas of the project implementation (Bekaa in orange and South in yellow). Source: Maps.com

The project team included a project coordinator, a project associate, and a monitoring and evaluation coordinator from the lead partner, as well as, the coaches and the implementing partners' teams. We worked with two main local partners that were well established in the South and the Bekaa areas. Their relationship with the communities allowed us to better understand the local context and gaps/needs, reach out to Syrian and Lebanese youth and their parents, and recruit interested participants. The partners were part of the strategy team and were also responsible for the local implementation, support, and follow-up with community members, and logistics. The coaches and the coaches-artists came from Lebanese, Syrian, and Palestinian backgrounds and were responsible for teaching and mentoring participants in the four arts/entertainment skills: acting, drawing, filming/audio-visual, singing/playing instruments.

Description of the Project

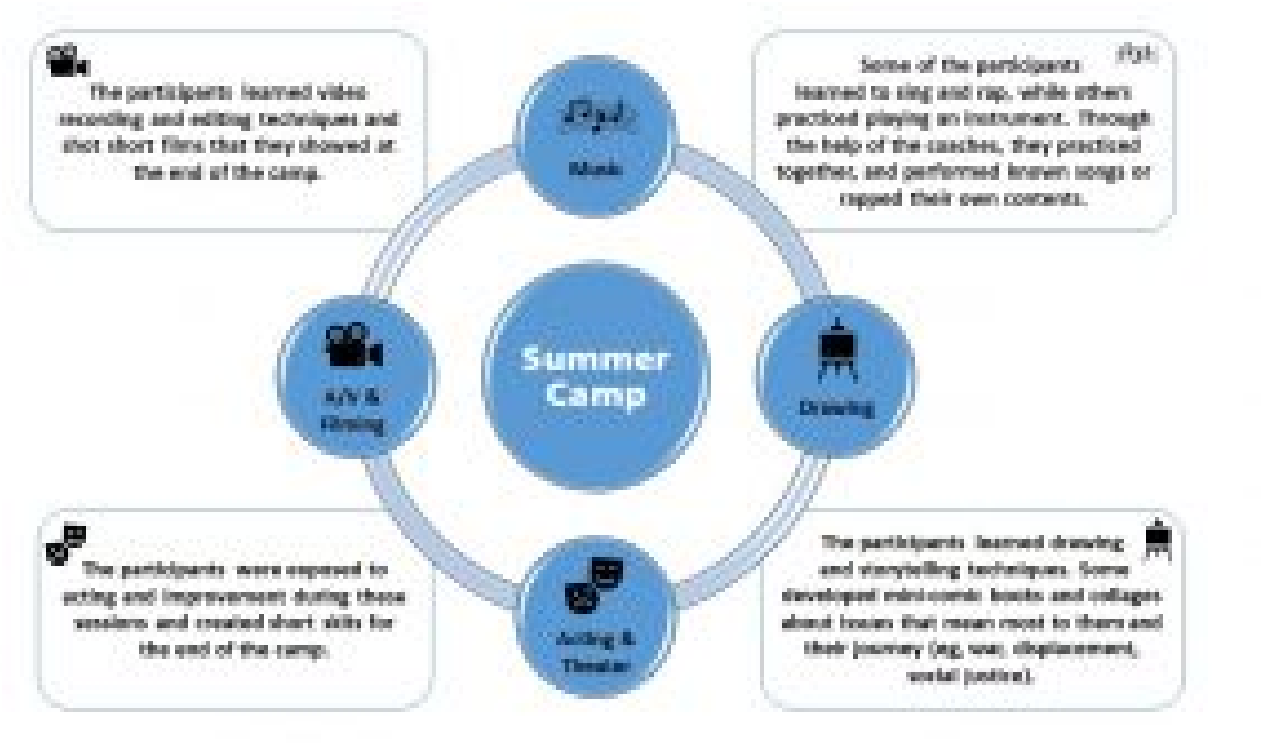
With the foundation in place, the project was set to begin. The following discussion describes the components of the project:

The Summer Camp

Participants were invited to a one-week summer camp in each of the two areas. On the first day, the

participants went through orientation and were matched with youth from different communities, and then were assigned separate tents. The sessions began the next day, and 100% of the participants went to all art sessions to explore and decide which to focus on. The sessions had a theoretical and practical aspect. Figure 1 below shows the model used for the summer camp.

Figure 1: Summer Camp Model



Model of summer camp components shown in a cyclical process leading to the summer camp in the center. Components included: Music, Audio-Visual & Filming, Drawing, and Acting & Theater.

The participants also went through several sessions that focused on social capital and conflict transformation. They were exposed to activities related to the topics, and then had a chance to discuss and reflect on these issues, while linking them to their life experiences, which included narratives on Identity and Perception and Perspective shown below:

Identity - Reflections and discussions included:
The complexity of identity and its multi-layered nature.
The fluidity of identity and the inherited vs acquired aspects of it.
The commonality of identity with those we view as the other vs the indifference that we might experience with those closest to us.

A table above contains the three points on the reflections and content discussed in the summer camp. Table header is dark blue with white font.

Perception and Perspective - Activities to further explore this topic, and build on the reflections from Identity included:	
Leadership	We reflected and discussed what it means to be a leader, in relation to the other, to our communities, and to the self. We also further discussed what are the ideal characteristics of a leader.
Conflict transformation and common ground approach	We reflected and discussed positions vs. interests vs. needs, dignity, empathy, active listening, and practiced conflict transformation.

A table above contains the three points on the perceptions and perspectives of the participants in the summer camp. Table header is dark blue with white font.

The project team also provided individual psycho-social support with a relational needs approach[1]. The participants shared things related to their struggles as refugees, family, relationships, life, as well as to issues that arose because of the camp. We also made sure to address every conflict that arose during the camp and had sessions with the individuals and/or groups that were involved in them. At the end of the day, the team also conducted debrief sessions for the participants and the project team (organizers + coaches) to reflect and assess the day and discuss possible changes.

After the Camp

A similar model was implemented the remainder of the year, where participants met regularly and continued

their sessions while collaborating together to develop their art and content. After the year ended, they presented their work to their communities.

The following year, new participants were recruited, while some of the previous ones were asked to be peer mentors for the incoming ones. Meanwhile, the project included a monitoring and evaluation aspect that recorded all the progress of the participants, activities, and impact.

Outcomes and Impacts

We began seeing signs of possible reduced prejudice by the end of camp. This assumption was determined from the following observation:

- During the first two days of the camp, the participants had avoided hanging or socializing with people outside of their in-groups.
- We began seeing a shift on the third day, where people from different backgrounds (nationality and class) began spending time with each other. By the end of the camp several youth had plans together outside of the project context.

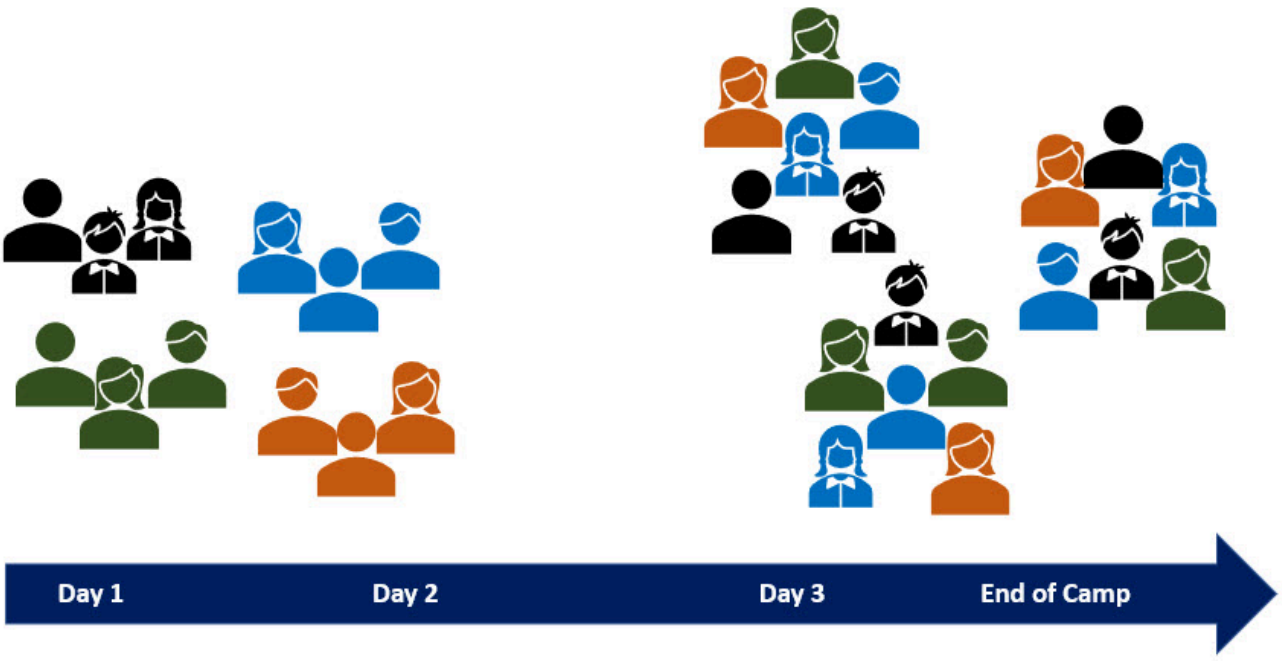


Figure above show outcomes and impact by the use of small images depicting people.

The participants continued building their relationships throughout the year, where they continued meeting regularly for the sessions and collaborating. They also continued meeting outside of the project context, even

after it ended. The information about ongoing relationships is based on their social media accounts, as many followed the project team and stayed in touch. This is significant to us because many youths initially reported not having any friends or romantic relationships outside of their socio-economic background. Some of the participants today still collaborate on art and entertainment projects, while others took an NGO and civil society path. The participants have been actively involved with issues related to social justice, human rights, and anti-racism and gender equality campaigns.

Little impact was noticed within local communities or nationally. During the events held at the end of the project, some of the participants' family members stated that their views changed due to their children's relationships with others. However, no long-term or in-depth follow-up has been made for clearer results. In fact, in the following years, sectarian and xenophobic rhetoric increased, likely due to multiple reasons. At the time of this case story, we do not have the data at hand that sheds light on the reasons. However, as shared in the Lessons Learned and Recommendations section, moving forward, a summative evaluation on long-term changes should, if possible, be included in the program design.

Lessons Learned and Recommendations

The programmatic components of the project had some observed successes with the youth. The process allowed the participants to feel heard and be open to the experiences of others. Meanwhile, they were guided through the process and given tools to explore their realities and emotional well-being. Through the reflection sessions, the youth discussed topics related to their personal, relational, and systematic struggles and possible ways to overcome them and collaborate. This process was extremely important to provide the youth with some tools to further explore their perspectives, build relations with the other, and seek alternative options.

> **It seems that the project did a good job with relational-based changes, however, with little to no evidence of systematically impacting local communities or nationally.**

Importantly, it must be noted the project did not apply a multi-dimensional lens, especially when it came to policy and systematic change, and power dynamics. Rather, the project mainly focused on discrimination prevention and reduction, and cohesive living through interpersonal relationship building (e.g., conflict transformation) skills. This approach comes with the assumption that if the right tools are given to individuals and community members, they do learn to transform conflict and collaborate to achieve common interests. That perspective might work if ideal conditions are in place, however, unfortunately, there are too many factors at play that hinder such ideals. That was seen on several occasions in Lebanon.

The NGO I (Ramy) worked with had several projects running simultaneously, some worked with the community as a whole and municipalities, while others focused on youth, women, police, and/or refugees.

We began seeing more leniency and openness towards Syrian refugees and collaboration with some of the communities we were working with. However, the sectarian and xenophobic rhetoric rose again due to the socio-politico-economic situation in the country and the region. This was especially seen with the rise of unemployment, decreased sense of security, and during political and economic crises. Further, with the recent rise of secular/social justice movements and revolution threatening the sectarian political elite and system, the bigoted and fear-based rhetoric has become more of a norm. Thus, working in the field came with limitations due to realities outside of the project team's control. However, programming and organizational structure and process could be accommodated to better meet the needs of the communities, despite these circumstances.

Creating alternative and preventative settings needs long-term planning and multi-level and multi-dimensional collaborations. However, this is extremely challenging to do with the structure of industrial non-profits/NGOs and the current socio-politico-economic systems in place. Challenges include: (1) limited grants for projects, (2) difficulty in conducting long-term need and asset assessments, and (3) not having the appropriate systems in place.

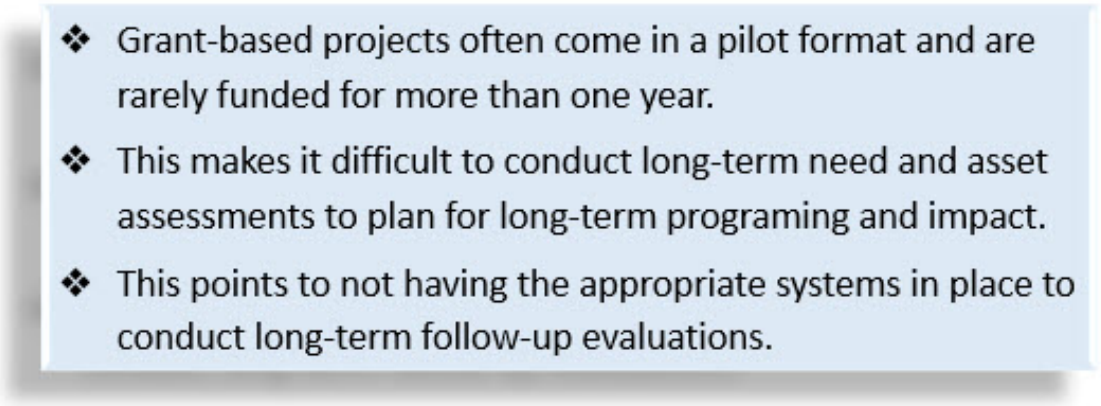


Image highlights the three challenges identified above.

Additionally, it leaves NGOs in a constant cycle of seeking and applying for funding, which takes up much of their focus. At the same time, this forces the organizations in adapting and adjusting their program objectives and proposals to attract grantmakers and increase their likelihood of receiving grants. In addition, the bureaucratic structure of NGOs often forces program teams to focus on administrational tasks and reporting, leaving less time to focus on the programs and communities' needs.

The overall budget and two-year duration of the 'Better Together' project helped some with implementation and allowed for more support. The project team included a project coordinator, a project associate, and a monitoring and evaluation coordinator from the lead partner, as well as, the coaches and the implementing partners' teams. However, their capacity was spread thin, due to most people working on several other projects at the same time. Furthermore, there were challenges with the partnership's distribution of tasks and

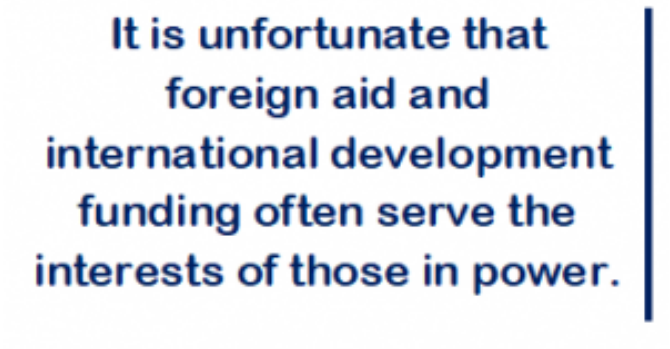
communication, which created several obstacles along the way. Thus, more relationship building, clearer tasks, and conflict resolution processes are needed to be further developed and agreed on prior to the project.

Moreover, grants often come with predetermined objectives, agendas, and/or restrictions that better meet the interests of the international donors (e.g., governmental agencies, INGOs, foundations). The donor determines where and whom to work with or exclude and the structure and limitations of the program. Consequently, this restricts freedom for truly meeting the communities' needs, sincerely taking into consideration local knowledge and lived experience, and is a form of imposing soft-power (neo-colonialism) on the country; which creates a vicious cycle. For example, for much of the duration of the war, European and U.S. donors rarely diplomatically attempted or funded peace initiatives in Syria, due to their opposition to the Assad Syrian regime and the complexity of the conflict. Rather, they focused their funding relief programs in host countries, such as Lebanon, Turkey, and Jordan. This funding later included more social cohesion and international development programs, as the war continued for years.

Looking deeper into the context, the situation in Syria and the region was caused by multiple factors, from foreign interference (geopolitics) to internal injustice, and water drought (climate change). Similarly, regional instability can be traced to the involvement of the U.S. and allies in the middle east long before the current Syria conflict. Their actions facilitated the creation of many extremist groups such as ISIS, which prolonged the Syria conflict. The same regime that the U.S. and allies oppose today, was endorsed to occupy Lebanon in the early 1990s because the regime supported their efforts against Saddam Hussein during the first gulf war. The Syrian Regime, in turn, used intelligence, brutal force, and collaboration with/overseeing Lebanese public agencies/government to control and oppress the people. This dynamic also created more division (Sunni vs Shia)[3] and more corruption in the country. Thus, much of the Lebanese were traumatized by a 15-year sectarian civil war, two occupations, and a corrupt system that did not allow the country to sustainably grow. In turn that trauma and anger were displaced toward the other and those most vulnerable, other sectarian groups and Syrian refugees.

Thus, the donors and countries that are trying to support and fund international development, are the same ones that had a hand in creating the current conditions that led to conflict and division in the region. When we discuss issues surrounding social justice and community psychology we should include geopolitics, coloniality, and global power dynamics. Coloniality in the Middle East takes multiple forms. Sometimes it looks Euro-U.S., while other times it takes the face of regional powers (i.e., Iran, Russia/USSR, Egypt, Israel, Saudi Arabia).

Other times it takes an ideological form (e.g., religion, pan-Arabism, communism, capitalism). This cycle often creates more local divisions and injustices. The reason this narrative regarding historical context is included is that to better support and collaborate with communities, we need to understand their context, history, struggles, and needs. While on the project in this case study, we barely had the chance to do so; and that seems to be indicative of most NGOs.



Although the funding is needed to support those lacking resources and the means to support each other, the funding often acts as a band-aid rather than a transformative solution. Other recommendations include thinking through how to design and implement preventative programming, along with the creation of alternative-based NGO structures that include multidimensional community and participatory-based programming. This programming should include process and relational-based aspects, as well as policy and systemic advocacy and change, in addition to communication and outreach aspects. This would include, human rights and social justice, education, investing in local economies, and long-term local and regional stability initiatives. It is also important to monitor and evaluate these efforts before, during, and after their implementation for learning opportunities.

Looking Forward

I (Ramy) decided to move away from the NGO and nonprofit field for the time being. I am continuing my higher education earning my Ph.D. in Community Psychology. My applied research interests focus on social movements, power dynamics, social transformation, and decoloniality. I will be working in communities in Lebanon and North America, with a multi-disciplinary, decolonial, intersectionality, non-binary, and non-hierarchal approach.

Conclusion

Community psychology practice is integrated into four levels in this case study. The objective of the project was to create alternative and preventive settings that would reduce discrimination and prejudice, and develop collaborative living and conflict transformation. The project used a process-based relational approach, which was important to begin the conversation and develop the relationships for collaboration. Lastly, the program exposed participants to new perspectives, many of whom sought roles and activism opportunities related to social justice, gender equality, LGBTQ+ rights, as well as entertainment and arts.

However, it was important that the project did not include a policy, systemic, and advocacy-based approach. If included, this could have created tension with the local and/or national government, according to the NGO's perspective. In addition, the project raised the team's awareness of local contexts, but not international power dynamics or the structure of the nonprofit field. Therefore, this case study highlights the impact and the need for critical applied research of the impact and structure of NGOs, funders, geopolitics, and systemic change.

FROM THEORY TO PRACTICE REFLECTIONS AND QUESTIONS

- The case study shared that the summer camp participants engaged in training sessions covering the topics of social capital and conflict transformation (Barhouche, 2021). What does social capital mean for you and how would you cultivate it?
- Why does funding that NGOs or nonprofit organizations in the U.S., receive sometimes create a "band-aid" approach versus accomplishing true individual, family or community healing and change?
- Consider what, if anything, you would have done differently when trying to support the reduction of conflict, tension, and highly prejudice bigotry in the context of the Lebanese refugee community? If you would have done something different, what resources would be needed to make that happen?

Endnotes

[1] An approach that is based on the premise that everyone has relational needs (acceptance, approval, affection, appreciation, attention, respect, security, comfort, support, encouragement). Those needs can only be met by having an interdependent community, and with the golden rule of "treating others as they like to be treated". Link: https://www.relationalcare.org/

[2] Pettigrew, T. F. (1998). Intergroup contact theory. *Annual Review of Psychology, 49*, 65–85. https://doi.org/0066-4308/98

[3] Lebanon has a confessional democratic system that represents the sects/religious groups in the country. The situation has often created fluctuating power dynamics and alliances that have been used by geopolitical powers for their benefit. Traditionally the Sunni Muslims have been the main power in the Middle East for centuries, with Shia, Christians, Alawites, Jews, and other minority groups being treated as second class. The situation changed with the creation of Lebanon, moving the leadership to the Christian Maronites, which created tension between them and the Sunni and Druze, which traditionally ruled the Lebanon region, and eventually led to the 1975 civil war. The Ta'if Agreement ended the civil war, by redistributing power which allowed the rise to the Sunni and Shia leadership, and weakening the Maronite leadership and role in the government. The Sunni leadership was supported by Saudi Arabia (Sunni) and the US, while the Shia leadership was supported by Syria's Assad regime (Alawite Muslim) and Iran (Shia). Thus, this situation created more rivalry and division.

6

Promoting Community-Driven Change in Family and Community Systems to Support Girls' Holistic Development in Senegal

DR. JUDI AUBEL, PH.D.

This case study takes a look at an innovative intergenerational approach to promoting girls' rights and development in Senegal.

THE BIG PICTURE



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=169#oembed-1

This is the story of the Girls' Holistic Development Program designed and implemented by the non-profit organization, Grandmother Project – Change through Culture, in Southern Senegal starting in 2010 and evaluated on several occasions by outside researchers. The case study describes this innovative program, the results, and the lessons learned that are relevant to other African contexts, and to other collectivist cultures in the Global South or Global North. This author is the co-founder and Executive Director of the Grandmother Project initiative.

The Grandmother Project's Mission

…is to improve the health and well-being of women, children, and families

in countries in the Global South, by empowering communities to drive their own development

by building on their own experience, resources, and cultural realities.

Senegal Community Context

The American and Senegalese non-profit organization Grandmother Project – Change through Culture (GMP) works mainly in Senegal, on the west coast of Africa. GMP's work is in southern Senegal, a rural area where farming and cattle raising are the main economic activities. This area is severely economically challenged and one of high migration of men to the capital city and in some cases to Europe. The quality of health services and of schools is generally poor. Only very young, inexperienced health workers and teachers tend to work in this area that is a 10-hour drive from the capital, Dakar. Only about 5% of all teachers in the area are women. Very few communities have electricity which makes evening studying very difficult even for very motivated students.



Senegal. Encyclopædia Britannica, Inc. (Map of Senegal and surrounding areas on the continent of Africa.)

More than 95% of Senegalese people are Muslim. People's lives are influenced by Muslim and African values that include respect for elders, solidarity, generosity, and interdependency. While western societies value individual rights and achievement, African cultures are built on collectivist, or relational, values and accord greater importance to interdependency and support of group values and achievement than to autonomy and individual accomplishment.

Like other African countries, in Senegal families and communities are organized hierarchically with men having more power and influence than women and with elders having authority over younger family members. The role of elders is to transmit cultural and religious values to younger generations. An often heard saying in Senegal, and across Africa, says, "What an elder can see sitting on the ground, a young person cannot see even if she/he is on the top of a tree".



Image depicts African proverb: "what an elder can see sitting on the ground, a young person cannot see even if he/she is on the top of the tree"

Intergenerational relationships were traditionally very strong, however, nowadays, in many cases, they are strained by a breakdown in communication between elders, parents, and children. The lives of Senegalese people are very much influenced by non-western, collectivist values, many of which differ markedly from those of western societies. In the Velingara area in Senegal where GMP is working, extended families predominate, and multi-generational decision-making and caregiving of younger family members are prevalent.

Growing up in this context is full of challenges, especially for girls. Some deep-seated social norms greatly limit their opportunities for growth and development. Most families prioritize boys' education over that of girls, and early marriage of girls, sometimes as young as 12, is prevalent, often with families playing a major role in identifying a spouse for their young daughters. For girls who stay in school beyond puberty, teen pregnancy is another very problematic phenomenon.

Female genital mutilation (FGM) is practiced by some ethnic groups in Senegal. A study in 1988 by the Environmental Development Action in the Third World (ENDA) revealed that approximately 20 percent of the female population had undergone an FGM procedure (para. 2). Other estimates suggest the figure is between 5 and 20 percent. Among the Halpularen (Peul and Toucouleur) populations in rural areas of eastern and southern Senegal DHS statistics from 2017 indicate that 50% of women age 15 to 45 underwent the practice. These figures refer to the total population, not the Halpulotas practice.

Background of the Girls' Holistic Development Program in Senegal

At the outset, the international non-profit organization World Vision asked the Grandmother's Project to develop a strategy to specifically address female genital mutilation (FGM) in the Velingara area of Senegal. The World Vision Director told me (Dr. Aubel) that their earlier efforts discourage the practice using traditional health talks had not been effective and they wondered if involving the grandmothers participating in our programs might be a good way to address the issue. I (Dr. Aubel) told them that FGM is a very complex issue and that there are no simple strategies to promote the abandonment of this harmful practice and I proposed an initial Preparatory Phase composed of two activities to understand communities' attitudes toward the practice, and then three additional components: Implementation and Learning Phase, Program Evaluation Phase, and Development of Lessons Learned for a total of four components. This process, was carried out over a 12-year period as an iterative action learning process.



Image shows through an arrow pointed to the right indicating process, the following phases: Preparatory Phase, Implementation and Learning Phase, Program Evaluation Phase, and Development of Lessons Learned.

Preparatory Phase

To develop the Girls' Holistic Development Program, the two initial activities under the proposed Preparatory Phrase were: a *participatory* and *rapid qualitative* assessment and a series of dialogue forums to discuss the results of the assessment with community actors.



Image of a group of grandmothers sitting in front of a hut in Senegal and participating in an exercise of the roles of different family members in FGM.

As it is important to foster an environment where community members are viewed as the experts of the situation in their own communities. The initial assessment sought to first, understand families' priorities and concerns regarding girls' education and upbringing; and second, to understand the attitudes, roles, and experiences of community members and of health and development workers related to FGM. This assessment was conducted by the author (Dr. Aubel) in conjunction with members of the Grandmother Project Team. A participatory approach was used consisting of small in-depth group interviews with traditional community male leaders, religious leaders, grandmothers, men, women, local authorities, health workers, and other Non-Government Organizations' (NGO) staff working in the area.

The rapid qualitative assessment provided critical information on the attitudes of both community and health and development workers toward FGM. However, of greater significance was the information that revealed community members' concerns regarding the education and upbringing of children, and specifically of girls. Three main themes emerged from the interview data related to families' concerns regarding 1) the breakdown in communication between elders, parents, and children; 2) the resulting decrease in transmission of moral, cultural, and religious values and traditions to children, e.g. showing respect for elders and story-telling; and 3) families' concerns regarding children's attitudes and behavior that conflict with priority family and cultural values.

"We should go back to our roots. We need to recognize what is positive within our culture and hold on to it jealously."

Demba, NGO community development worker

"If we lose our cultural values, we will be forced to replace them with other people's values."

Abdoulaye, Teacher

These insights into community members' concerns regarding children's education and development were

critical in subsequently developing an intervention that would respond to their concerns while at the same time catalyze reflection on an issue that we viewed as a problem, but that they did not.

Series of Forum-Dialogues

The second activity in the Preparatory Phase consisted of forum dialogues held in four communities. Each forum involved 25 participants, male and female elders and parents, many of whom were community leaders. The objectives of the forums were: to share the results of the community study; to elicit dialogue on how cultural values and traditions being lost could be revitalized in families and communities to ensure the development and well-being of children, and specifically of girls, and to identify strategies to promote discussion of FGM in communities. Based on participatory adult education principles, the team developed a training design for the forums to encourage open discussion related to these objectives recognizing that FGM had never before been discussed in a public setting.



A group discussion between older and younger adults during a community forum dialogue.

In Africa, community resistance to many social programs is engendered by the fact that they are critical of and aim to change certain ingrained cultural norms and practices. A fundamental principle that shaped the forums and subsequently the entire GHD program, is the idea that programs that promote change in certain harmful traditions, e.g. FGM, should simultaneously promote positive cultural values and traditions.

A key idea that shaped the discussions during these initial forums was a profound statement by Amadou Hampâté Ba, a Malian philosopher (1901-2002), a member of the same Halpular ethnic group as forum participants.

He studied for many years in France and upon his return home, in a letter to African youth he urged them to "Become rooted in yourselves. Preserve positive traditional values and let the abusive customs disappear". This important quote by a respected Malian intellectual was used in the forums to catalyze community reflection on the relevance of different cultural values and traditions for today's children.

"Become rooted in yourselves. Preserve positive traditional values and let the abusive customs disappear."

The forum dialogues consisted of two days of discussions, often based on small group exercises. The first day dealt with communities' expectations and concerns regarding girls' education and development and the second day focused on FGM and community ideas on how to catalyze discussion of this issue within

the wider community. On both days, community members formulated recommendations for actions to be taken by families, community leaders, teachers, and NGO partners.

Feedback from forum participants in all four sites was similar and very positive. Many participants expressed appreciation for the respectful way in which culture was addressed and for the non-directive approach used which, they said, contrasts with the directive techniques often used by other NGOs.

> *"The approach is very good because the discussion took place in the cultural context and was based on the idea of promoting what is good and discouraging what is negative. In the past, development workers would come only to criticize our traditions and propose strange ideas. You have begun by appreciating what exists in our tradition and not criticizing it directly."*
>
> **Bassirou, Community Health Volunteer**

> *"Even though we didn't go to school, we understood everything, we shared our knowledge and everyone appreciated our ideas."*
>
> **Fatamata, Grandmother Leader**

Traditionally in community meetings, there was no open communication between men and women. The inclusive nature of the forums, with men and women of different ages and statuses within the community, was appreciated by almost all community members. However, a few of the elders said that they felt uncomfortable being in the same meeting with people much younger than themselves.

> *"There is often a constraint in community discussions because different categories of community members do not openly speak up. It is good to bring together men and women of different social classes and ages so that everyone can learn from each other."*
>
> **Mballo, Former National Parliamentarian**

> *"In other workshops, we grandmothers were criticized for our traditional ideas. That's why, before coming, we were afraid. But we are happy that we could contribute to the discussion without being criticized."*
>
> **Oumou, Grandmother Leader**

During the forums, there was much discussion on the central role of grandmothers in families and specifically in the lives of girls. Participants stated that any efforts to promote the well-being of girls and to discourage FGM should involve grandmothers first because they are responsible for preserving cultural norms and second because they have a close relationship with the cutters and hence, they have the greatest possibility of discouraging them from continuing this practice.

The combined results of the initial community assessment and forum dialogues provided substantive insight into communities' priorities and concerns regarding the development and upbringing of children, especially of girls, and specific information on community views on FGM. Based on these results, as well as key principles from community development, adult education, anthropology, and community psychology, the GMP team identified a set of concepts and priorities that informed the design of the GHD intervention. These objectives included:



Image of grandmothers, and girls standing in front of a hut. They are wearing Senegal typical clothing.

- to promote multiple facets of girls' development related to positive cultural values and traditions, not only FGM, in order to increase both program relevance to communities and their involvement;
- to address both community and NGO concerns related to GHD;
- to promote positive cultural values and traditions while discouraging harmful ones;
- to relate program goals and activities to religious values and to include religious leaders;
- to build on existing community resources, or assets, in terms of experience, knowledge, and influential roles of community actors;
- to actively involve elders, including traditional and religious leaders on an ongoing basis;
- to strengthen communication between the generations e.g. elders, parents, and adolescents, and between men and women;
- to acknowledge and strengthen the role of grandmothers in families and communities as key transmitters of cultural values and as allies of young girls;

- to strengthen relationships between girls, mothers, and grandmothers;
- to strengthen the skills and commitment of community leaders, both male and female, and of three generations, to work collectively to promote positive change for girls in their communities;
- to use participatory adult learning approaches that catalyze reflection and community consensus-building for change.

Another critical factor related to the interface between the GHD program and communities was the development of respectful and ongoing relationships between GHD staff and community leaders and groups. Understanding of and sensitivity to local cultural values and traditions, and humility, were key parameters for the selection of DHF staff. In African societies, positive relationships are the basis for all interaction and collaboration.

Conceptually the GHD program draws on several disciplines namely, community psychology (especially the work of Foster-Fishman et al., 2007; Trickett et al., 2011; Hawe et al., 2009; Schensul & Trickett, 2009; O'Donnell & Tharp, 2011; Zimmerman et al., 2011); community development (especially Lasker & Weiss, 2003; Chaskin et al., 2001; Hughes et al., 2005); anthropology (Airhihenbuwa, 1995); adult education (Freire, 1972; Brookfield, 1984; White, 1999) and social work (Hartman & Laird, 1983).

Partnership with the Ministry of Education (MOE)

The GHD program is implemented in close collaboration with the District Education Office in Velingara. All of GMP's objectives are related to priority concerns of the MOE related to children's education and development, and specifically, that of girls, concerning girls' education, child marriage, and teen pregnancy. GMP's long-term objective is for the MOE to integrate the GHD intergenerational and grandmother-inclusive approach into their programs with communities.

Implementation of the Girls' Holistic Development Program

A Holistic Approach for Systemic Change

GHD Model

The first funding for GHD came from World Vision and their initial concern was only FGM. However, based on the insights obtained during the Preparatory Phase regarding community concerns and priorities we proposed an approach to address girls' needs holistically. The GHD circle, which has been widely used with communities, teachers and partner organizations, presents the key facets of girls' development that are important to local communities, namely: moral, cultural, intellectual, spiritual, emotional, health, physical, and civic responsibility. Unfortunately, many national and international programs in support of girls ignore some other aspects of girls' development that communities value related to their moral, spiritual and cultural development.

Program Goal and Objectives

The goal of the GHD program is to strengthen community capacity to promote girls' health and well-being, with two general objectives:

1. To strengthen communication and social cohesion within communities and families in order to promote systemic change in harmful social norms related to girls education, child marriage, FGM, teen pregnancy and FGM; and to
2. To promote positive cultural roles, values, and practices that contribute to girls' development and upbringing.

Implementation of the GHD program began in 2008 in the Velingara area in southern Senegal and has evolved over the past 12 years through iterative action research and learning process. It has involved testing, evaluation, revision, and expansion of the program in response to strong support and input from communities and local elected officials.

Holistic Focus on Girls' Rights and Needs

Many international programs to improve the lives of girls address the four priority GHD issues (see objective no. 1 above), all widespread problems across Africa. The predominant pattern in such programs is to target girls, either primarily or solely, in a linear fashion based on the assumption that if they are empowered they will be able to catalyze change in families and communities. From the perspective of both anthropology and community psychology, in African societies, girls are embedded in family, community, and cultural systems, as visualized in the Onion Model (Aubel & Rychtarik, 2015). And those systems impose expectations on girls while at the same time providing them with critical support as they grow up and are faced with life's challenges.

The Onion Model (Figure II) presents key facets of the context in which Senegalese girls are embedded and have several implications for the design of programs to support them: adolescent girls are not isolated and rarely make decisions on their own; various family members are involved in decisions affecting their wellbeing and options in life; grandmothers play a central role in the socialization of young girls, and grandmothers typically have more influence on men's decision-making within the family than do mothers of young girls.

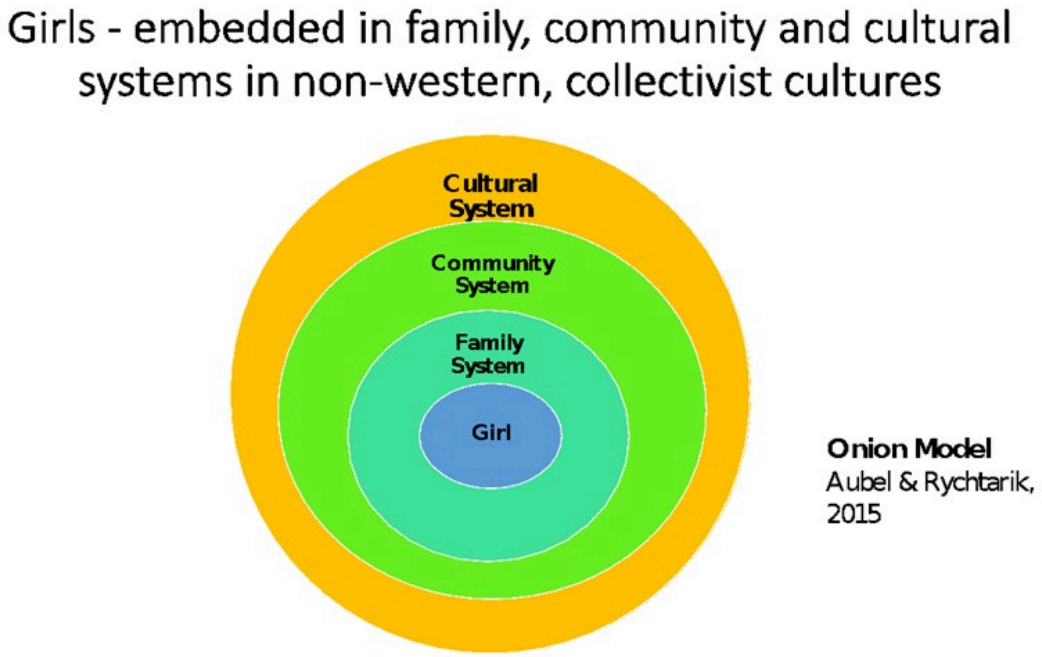


Figure 2: The ecological onion model above show the three systems impacting girls in Senegal. The model clearly suggests that in order to promote change for girls, key family and community actors must be involved.

GHD aims to create an *enabling environment* around girls so that they can flourish. This is achieved by directly supporting girls while at the same time encouraging community-wide consensus building for the adoption of social norms and attitudes that are more supportive of girls. This two-pronged strategy is presented in the simplified *Theory of Change* in Diagram I below.

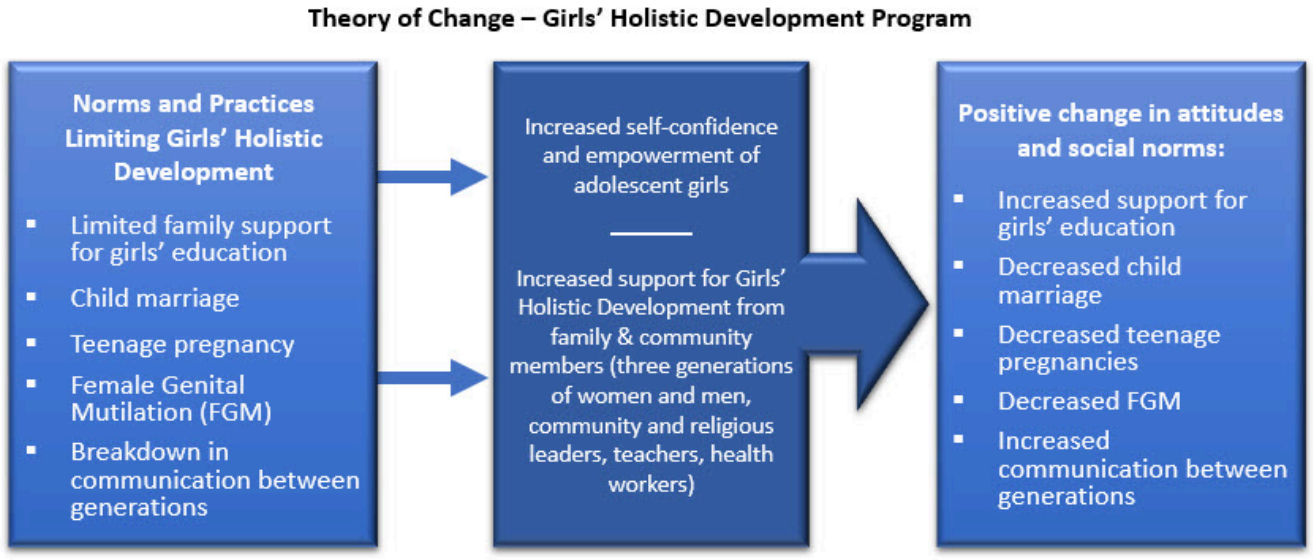


Diagram I above shows a flow process and the progression of the Girls' Holistic Development Program based on the "theory of change".

Building Communication Relationships

To promote community-wide change, key community actors must be involved. Also, strong communication relationships between them are the foundation for open dialogue and reflection on existing social norms and on alternative concepts and practices. In the initial assessment and forum dialogues, community members discussed the serious breakdown in communication between generations that exists in virtually all communities.

The following quote from a community elder illustrates the importance of communication relationships and the situation that existed in many communities at the outset.

"Communication is the foundation of life for any group. Without communication and understanding, there will never be any development. Many interventions failed in our communities because there was not enough dialogue and understanding between people. As long as there is a conflict or the absence of communication, the community will not progress."

Diallo, Community Headman

Involvement of Community Leaders

A prerequisite for the success of any effort to improve community life is the existence of committed leadership, strong relationships between leaders and other community members, and a sense of solidarity often referred to as social cohesion. In light of the role and influence of both formal and informal community leaders, the GHD activities primarily target leaders of three generations (elders, adults, and adolescents), male and female, as well as recognized traditional leaders.

Building on Cultural and Religious Roles and Values



Oustav Balde, a key resource for the GHD program.

In all communities, there are leaders whose roles are determined by cultural and religious values and structures, and they have moral authority and influence on the attitudes of other community members. In the Velingara area, more than 98% of the population is Muslim. Traditional leaders and local Imams share responsibility for ensuring the well-being of their communities. In each community where the GHD program was launched, the GMP team first identified and established rapport with local formal and informal leaders.

A very erudite and respected imam, Oustaz Balde (in the photo on left), has been a key resource for the GHD program. He has participated in many key activities and he is able to articulate the need to create a bridge between "traditional" cultural and religious values and more "modern" ideas related to various aspects of GHD including girls' education and FGM.

"Through a participatory approach that encouraged communication between people, the GHD program has reinforced the sense of celebration among community members and acceptance of those with different opinions. Before, there was a real breakdown in communication between neighbors, within families, and between generations. GHD has encouraged introspection and self-critique. It seems that GHD has brought about an incredible reconciliation between the generations who now accept each other, understand each other, and are more tolerant of each other."

Oustaz Balde, Imam, Velingara

Program Components

Change through Culture Process of Change

For designing any community change strategy there are two fundamental concepts, iterated in both community psychology and community development regarding the importance of *building social cohesion within communities* and specifically between community leaders and groups; and adopting an *asset-based approach* in which existing social resources, e.g. elders, leaders of all ages, are identified and strengthened. In Diagram II below, key elements in the *Change through Culture* process of change are laid out with both of those concepts (in the first column) along with the initial weaknesses in the cultural and community context (second column) identified during the Preparatory Phase.

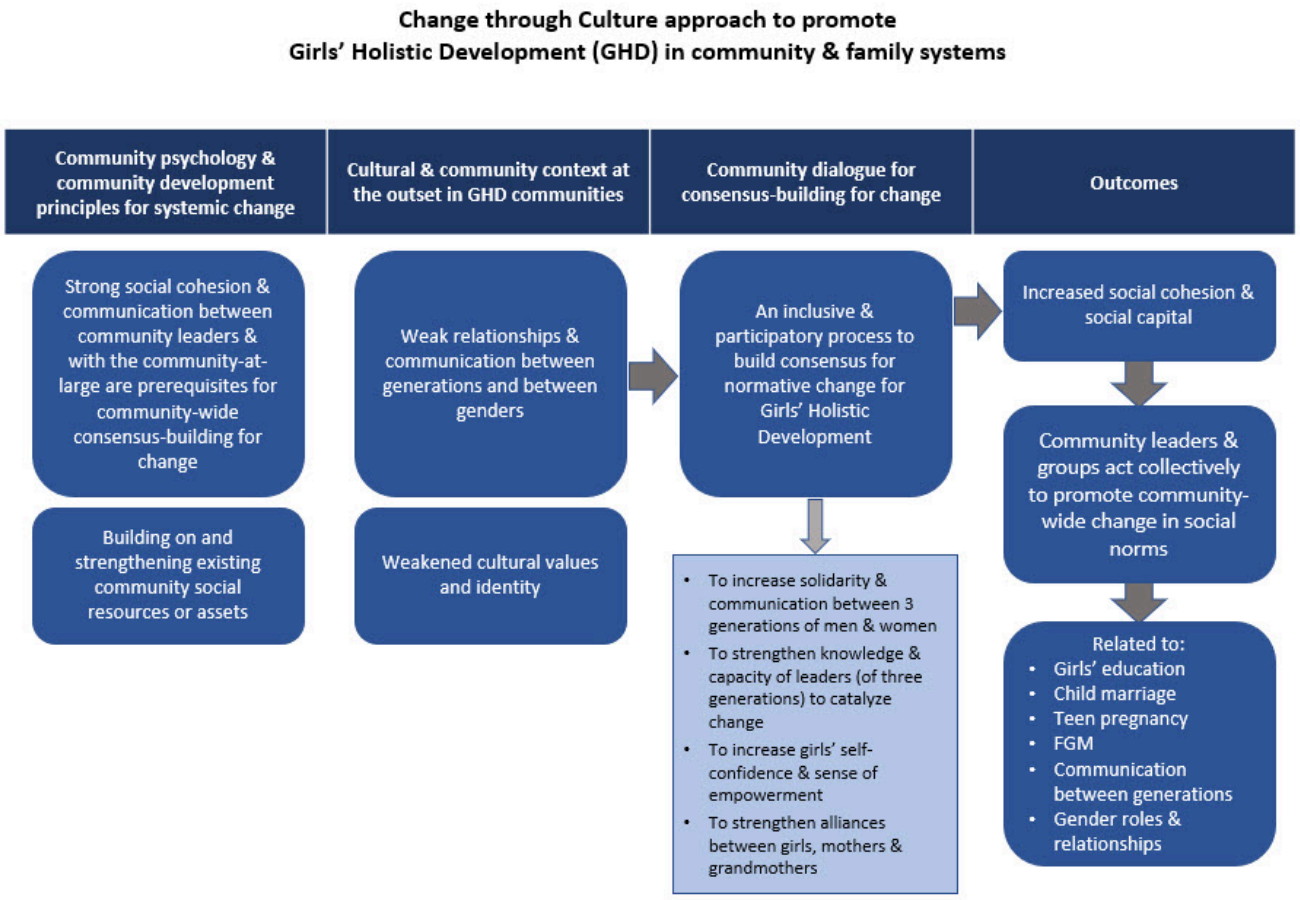


Diagram 2: Illustrates the flow of the *change through culture* approach including key elements related to both of the concepts principles for systemic change (in the first column) and the initial weaknesses in the cultural and community context (second column) identified during the Preparatory Phase.

Community Dialogue for Consensus-Building for Change

In order to promote community-wide change, a Community Dialogue for Consensus-Building approach was developed to involve various community actors in a series of participatory activities to elicit discussion on different facets of GHD. The objective of these activities was to catalyze dialogue and reflection, primarily between formal and informal leaders of both sexes and of three generations, first, to develop a consensus regarding the need for change, for example, to abandon child marriage, and second, to collectively decide on actions to be taken to promote change in existing norms and practices.

In light of the initially weak communication relationships in all communities where GHD has been introduced, an initial and ongoing priority in the GHD program is to strengthen those relationships in two ways: first, to strengthen existing relationships within communities, for example, between girls and grandmothers, and second, to encourage the creation of new communication relationships for example, between fathers and adolescent daughters. The objective is to create a synergistic effect through discussions of the same GHD issues by different community groups that can lead to a community-wide consensus on actions to be taken to promote GHD.

The core elements of the GHD program are a series of dialogical activities that involve different categories and combinations of community actors, of three generations, of both sexes, traditional and religious leaders, teachers, and local health workers. In all of these activities, grandmothers are key actors. Along with other community members, they participate in dialogue and debate, and their involvement strengthens their capacity and commitment to lead positive change.

These key activities are briefly described below in terms of its purpose and participants.

1) Intergenerational Forums

This is the foundational activity in GHD. Participants include leaders of both sexes and of 3 generations, traditional and religious leaders, teachers, and local health workers. The two-day forums build solidarity between participants through a series of carefully designed small and large group exercises, all involving dialogue, problem-solving, and consensus-building. Key topics addressed include the 4 priority GHD issues, intergenerational communication, cultural values, and identity.

"The intergenerational forums are very important as they help to re-establish dialogue between elders, parents, and youth. In the recent past, elders and adults didn't listen to young people's ideas and underestimated them. Thanks to the forums there is now more communication between older and younger community members."

Grandmother Leader

"The forums have increased women's confidence in themselves. Before, they didn't dare express themselves in front of men. During community meetings, only men were allowed to speak. But now men know that women also have good ideas and encourage them to speak up."

Young mother

"Before there was not enough discussion between men and women in families. It was a problem that separated them and was the root of frequent misunderstandings and arguments. The intergenerational forums have helped to solve this problem."

Young adolescent boy

"We never before had the opportunity to sit all together and discuss like this although it is the best way to promote the development of our community elder leaders"

2) Days of Praise of Grandmothers

The purpose of these events is to celebrate grandmothers' role and commitment to promoting the wellbeing of children, especially girls. Participants in these one-day gatherings include grandmother leaders from 8 surrounding communities, traditional and religious leaders, local musicians, local elected officials, and teachers.

Songs of Praise of Grandmothers are used during these events and provide relaxed interludes of singing and dancing.

These special days of recognition of grandmothers reflect the ideas of psychologist, Carl Rogers, on

Unconditional Positive Regard (1980). The concept is that when GMs are recognized and their self-confidence is reinforced, they will be more open to revisiting their existing attitudes and practices. The following quotes reflect community attitudes toward these events.

"This is a very important day because we are here to honor the grandmothers who are the teachers of young couples and of children. Before this project, the grandmothers were practically dead in the village and now they have been revived. It is since the grandmothers have resumed their role that teen pregnancies have greatly decreased."

Mamadou, Village Elder

3) GM Leadership Training

GMP realized that in all communities there are natural grandmother leaders who are recognized by other community members for their dynamism and selfless commitment to promoting community well-being. Through discussions with grandmother groups, five natural grandmother leaders were identified in each community to participate in the under-the-tree GM Leadership Training. The objectives of the training were to: increase GMs' knowledge of adolescence, improve their communication with girls, and to empower them to act collectively to promote and protect girls, building on their status and authority at family and community levels. The training lasted for 8 days, divided into 4 two-day modules conducted over a period of 6 months.

Four months after the leadership training was completed, individual in-depth interviews were conducted with 40 grandmother leaders to assess the outcomes of the training Analysis of interview responses revealed three key results:

1. Strengthened relationships between grandmothers,
2. Strengthened relationships between girls, mothers, and grandmothers, thereby constituting a source of power and influence to protect and promote girls' rights and well-being in a culturally consonant way, and
3. Strengthened relationships between grandmothers and other influential community actors.



Image of grandmother leaders participating in a learning game dealing with girls' education and development. They are sitting on a mat and wearing typical Sengalese clothing.

"Since we participated in the grandmother leadership training, the relationship between us grandmothers has changed. Now there is a permanent dialogue between us. Whenever one person has an idea of what we should do regarding our girls, we get together to discuss. Since the training, the relationships and communication between us have been strengthened".

Grandmother Leader

"Thanks to these training sessions, I have become more confident. I no longer hesitate when there is something that needs to be said or done. I no longer bow my head when speaking before a group of men.

Grandmother Leader

"Before we used to scold our granddaughters all the time and they were rather afraid of us. Through the training, we realized that that is not a good way to communicate with them. Now we talk softly to the young girls and they listen to our advice with regards to sexuality and other things."

Village headman's wife

4) Teacher workshops on "Integrating Positive Cultural Values into Schools" (IPCVS)

Many families do not have a strong motivation to send their children to school nor to let them stay in school for many years. A major reason for families' reticence is that schools do not teach cultural values that are important to communities. In 2019 one of the priorities defined in the Ministry of Education's five-year plan was to expand the teaching of cultural values in schools. In partnership with the District Education Office in Velingara GMP developed the Integrating Positive Cultural Values (IPCV) into Schools strategy. The initial activity in launching this strategy in schools consists of teacher workshops to increase teachers' commitment to developing children's knowledge of cultural values and traditions, in addition to the "modern" knowledge inscribed in the official curriculum, and to strengthen their relationships with communities. Local education officials are very supportive of this strategy as suggested in the following quote.

"These workshops support national priorities to increase children's understanding and adoption of positive cultural values and to strengthen teacher-community relationships and communication".

Amadou Lamine Wade, District Education Office Director

5) Grandmother-Teacher Workshops

Both teachers and grandmothers have frequent contact with and influence on children, and specifically on

girls related to their education, child marriage, and teen pregnancy. However, in most communities, direct contact between teachers and grandmothers is very limited, and teachers often have a sense of superiority over illiterate grandmothers while these guardians of tradition suffer from a sense of inferiority toward well-educated teachers. The objective of these workshops is to strengthen relationships between teachers and grandmothers in order to increase their collaboration to promote both the teaching of positive cultural values in schools and in the community and to promote GHD. These innovative workshops are strongly supported by education officials, teachers, and grandmothers.

"Teachers alone do not have all of the knowledge that children need to learn. They also need to learn about positive cultural values and behavior. I don't know of anyone else in the community who is more knowledgeable regarding the values that children should acquire. That is what justifies the presence of the grandmothers here today. And increased communication between teachers and grandmothers is very beneficial to children, especially to girls."

Mr. Ba, Supervisor, District Education Office

"We are honored to have been invited to participate in this workshop along with teachers and school directors. We are going to work together with the teachers to encourage all children, those in school and not, to learn the values that are important in our culture."

Maimouna, Grandmother

An important component of the IPCVS strategy is the participation of grandmothers in classrooms to facilitate value education sessions with children. This further contributes to strengthening relationships between schools and communities.

6) Under-the-Tree Sessions with Grandmothers, Mothers, and Girls



Image of a grandmother, sitting with a group of girls to discuss girls lives and challenges.

Building on grandmothers' traditional advisory role with adolescent girls, it is primarily grandmothers and girls who are involved in these sessions, but also mothers. A major activity in GHD is frequent participatory dialogue and learning sessions to strengthen communication between the generations and discussion of topics related to girls' education and development. A variety of activities using stories, songs, games, and discussion pictures are used to elicit dialogue and increase understanding between the generations.

7) All Women Forums

An activity that was initiated in 2019, these two-day forums: strengthen communication between girls, mothers, GMs, and female teachers; promote collective empowerment of girls; and catalyze dialogue on concerns to both girls and their mothers and GMs. During these forums, a variety of participatory exercises encourage girls to express their feelings, concerns, and ambitions related to school and life beyond and encourage mothers and grandmothers to listen to, empathize with and encourage girls. This activity aims to strengthen the collective sense of responsibility that mothers and grandmothers have not only for their own daughters but for all girls in their communities.



Photograph of the grandmothers, mothers and girls at the end of a two-day all women's forum.

Below are several comments by adolescent girls who participated in under-the-tree sessions with grandmothers and who also attended the All Women Forums.

"There is a change in our relationships with our grandmothers. Before, we preferred to go to dancing parties or to watch television instead of being with them. Now, we spend more time with the grandmothers, listening to their stories that teach us about important values".

Adolescent girl

"We are closer to our grandmothers now. If we have questions related to sexuality we can discuss them with our grandmothers, more easily than with our mothers. Now we are comfortable talking to the grandmothers".

Adolescent girl

8) Days of Dialogue and Solidarity

In all communities where GHD is implemented, elders play an important role in families and communities and they have a big influence on the social norms that define acceptable attitudes related to many aspects of life. Many facets of GHD, e.g. girls' education and FGM, are influenced by the attitudes of the elders, specifically the elder men in each family, traditional community male leaders, Imams, and grandmothers. These are the community actors who are involved in the Days of Dialogue and Solidarity. The purpose of this activity is to elicit reflection by the elders from several adjacent communities on the role that they can play to promote GHD. As with other GHD activities, the idea is to strengthen the knowledge and the role played by existing community actors. In other terms, the elders constitute a community resource, or asset, that can be strengthened to promote the programs' objectives. In each of these events, participants articulate their plans for actions they can take in their respective communities.

"This meeting has been very useful because it has allowed us to discuss important issues with others from our same village and with people from other villages. In our community we plan to organize meetings with all generations, to discuss what we can do together to prevent child marriage and FGM."

Moussa, Village Headman

"These meetings are very beneficial because they encourage communication and understanding between us. During this meeting, I realized that FGM is not recommended by Islam. Many Imams were present and none of them support the practice".

Cissé, Grandmother Leader

Referring back to Figure 3, I think that you can see how the various dialogical activities organized by the GHD Program created a synergy between the different community actors by promoting community-wide discussion of various issues related to GHD.

GHD Theory of Change and Program Results

At the outset of the GHD Program in 2008, a Theory of Change (TOC) was developed with the GMP team in Senegal. However, during the ten years of development of GHD, there was a conscious effort to encourage a process of continuous learning. To support this learning process, a series of evaluations and studies were conducted by external researchers, in collaboration with GMP staff for two purposes: 1) to understand communities' attitudes and response to the GHD Program, and 2) to identify changes that may have come about as a result of the GHD program. Several external evaluations looked broadly at program results. The additional studies focused on: family decision-making related to child marriage; the process of abandonment of FGM/C in some communities; communication between the generations; changes in gender roles and the status of women; the effects of the grandmother leadership training; and the relationship between the culturally-grounded program and community engagement in it. And in 2019, the Institute of Reproductive Health (IRH) at Georgetown University, in collaboration with the University of Dakar, conducted extensive quantitative and qualitative research to evaluate the results of the GHD program.

Based on the conclusions of the various evaluations and studies, and the GMP team's lived experience with communities carrying out the program, we revised the Theory of Change to reflect what has happened as a result of implementing the program.

Diagram IV (below) synthesizes the relationship between the GHD program and its intermediary and long-term results. We can also refer to this sequence of events as the *pathway to change*.

As the diagram indicates, the implementation of the GHD Program was initiated through the development of respectful relationships between GMP facilitators and community actors. Those relationships were the foundation for a series of dialogical activities addressing GHD. Intermediary results of the GHD Program are observed first, in terms of increased communication and social cohesion between generations and between the sexes. Strengthening those communication relationships supported the subsequent changes at the community level and with schools in support of girls, and of children more broadly. The combination

of those changes has supported change within families, related to family roles and communication which ultimately has had a positive impact on girls. These multi-level results are contributing to long-term changes which are taking place related to increased community capacity to collectively promote GHD in an ongoing fashion and changes in social norms to support girls related to their education, marriage, teen pregnancy and FGM/C.

Georgetown University Evaluation of the GHD Program

The most extensive research on the GHD Program was carried out by the Institute of Reproductive Health (IRH) in the context of the USAID-funded PASSAGES project. Between 2017 and 2019, IRH provided support for several smaller studies (mentioned above) and for the larger Realist Evaluation conducted in collaboration with the University of Cheikh Anta Diop in Senegal. Key conclusions of the two-part IRH research are presented below. They are (1) The GHD program created safe spaces for dialogue and consensus building (2) it provided a space for community discussions, (3) decision making in families and communities became more inclusive and gender equitable, (4) the program reestablished grandmothers as traditional family counselors and advocates for girls in Senegal, (5) relationships between grandmothers and girls was strengthened and girls improved their confidence levels, (6) grandmothers demonstrated more openness and support for girls' education, (7) social changes were visible, and (8) programs should equally focus on family members and communities.

Key conclusions of the Georgetown University of GMP's Girls Holistic Development Program



- The GHD Program has created safe spaces for dialogue and consensus building between the three generations, e.g., elders, adults and adolescents, as well as between men and women. The inclusive strategy has contributed to increased communication between the sexes and between age groups.
- The dialogue-based approach has provided a platform for the community to discuss norms and practices that are harmful to girls and to identify their own solutions through consensus-building.
- Decision-making in families and communities has become more inclusive, more participatory and more gender equitable.
- GHD reestablishes grandmothers as traditional family counselors and advocates for girls. The approach has increased grandmothers' role and power in family decision-making related to all issues concerning girls.
- In GHD-supported communities, relationships between grandmothers and girls have been greatly strengthened and girls have greater self-confidence to discuss and seek grandmothers' advice and support on a variety of issues including sexuality.
- Grandmothers who participated in leadership training demonstrate more open, progressive attitudes and support for girls' education, delayed marriage and pregnancy and abandonment of FGM/C.
- GHD promotes change in culturally embedded social norms and practices related to girls' education, child marriage, extra marital teen pregnancy and female genital mutilation by both empowering girls and creating an enabling environment where family and community actors support change for girls.
- Most programs promoting GHD primarily target girls. Based on the experience of the GHD Programs, interventions that focus more on involving community and family members than adolescent girls can have greater impact on changing norms and behaviors that affect girls.

Lessons Learned from the Girls' Holistic Development Program

Based on the various studies and experience of the GHD team working in southern Senegal, a number of lessons are identified that have wide application for other programs addressing GHD across Africa and elsewhere in the Global South where societies are hierarchically structured, elders are respected and have influence, and where grandmothers play a role in socializing and supporting adolescent girls.

1. In all African communities, elders have status and power over younger generations and determine

the social norms that structure family and community life. When an approach based on respect and dialogue is used, they are not automatically opposed to change.

2. When programs respect and build on cultural and religious roles and values that communities cherish, community actors are more receptive and more engaged. The opposite is also true.
3. In non-western cultural contexts, where extended family networks are stronger, grandmothers play a role in all aspects of the upbringing and development of children, especially girls. Using an assets-based approach, programs should acknowledge and build on this cultural resource.
4. Families are concerned about all facets of girls' upbringing and development. Communities are more receptive to programs that address various facets of girls' development, rather than single-issue strategies.
5. Community involvement in programs is greater when programs supporting girls' development address issues that are of concern to communities in addition to the priority concerns of development organizations.
6. Communication between three generations (elders, adults, and adolescents) should be strengthened in order to promote harmonious change within family and community systems rather than creating conflict between generations with differing opinions.
7. Both formal and informal leaders, of all three generations and both sexes, should be involved in all efforts to promote change in communities. Given their influence with their respective peer groups, they are powerful gatekeepers who can either support or block new ideas and behaviors.
8. Communication and education methods used with community groups should be based on adult education methods which elicit critical reflection among community actors rather than on persuasion and messages disseminated to passive beneficiaries, or audiences, to convince them to adopt expert-identified solutions.
9. Communities are more open and engaged in programs that adopt an asset-based approach where positive roles, values, and practices are encouraged and reinforced while harmful ones are discouraged. This lesson builds on Carl Rogers' concept of Unconditional Positive Regard.
10. In any program, it is important to determine at the outset what the roles and influence are of different family and community actors in order to involve all categories of people who influence or who could influence the issue being addressed.

Conclusion

The GHD Program was primarily initiated through the development of respectful relationships between GMP facilitators and community actors. These relationships served as a foundation for a series of dialogical activities addressing GHD. Intermediary results of the GHD Program were observed first, in terms of increased communication and social cohesion between generations and between the sexes. This work made us even more aware of an asset- versus deficit-based approach, no matter the context.

FROM THEORY TO PRACTICE REFLECTIONS AND QUESTIONS

- As you think through this case study, identify one or two ways it can be challenging to work alongside different generations of individuals and families.
- We all have differences of opinions and worldviews on social issues facing our world. What are your thoughts on how we advance social and racial justice internationally when worldviews diverge regarding what is culturally appropriate?
- We believe that all work involving social and racial justice should begin with engaging in introspection and self-awareness processes. What are some ways you have engaged in self-reflection concerning working across groups who have different customs and beliefs from your own? Share at least two ways you will do so moving forward.
- The Girls' Holistic Development Program was developed and implemented in Senegal. We believe that the concepts and methods used in Senegal are relevant to other African settings and that many are relevant to other contexts in the non-western world and also to communities in the global north.

References

Airhihenbuwa, C. O. (1995). *Health and culture: Beyond the western paradigm*. Sage Publications, Inc.

Aubel, J. & Rychtarik, A. (2015) Focus on Family and Culture. Grandmother Project – Change through Culture for TOPS project funded by USAID, Washington D.C.

Brookfield, S. D. (1991) *Developing critical thinkers: Challenging adults to explore alternative ways of thinking and acting.* Jossey-Bass.

Chaskin, R.J., Brown, P. Venkatesh, S., & Vidal, A. (2001) *Building community capacity*. Aldine De Gruyer.

Foster-Fishman, P. G., Nowell, B., & Yang, H. (2007). Putting the system back into systems change: A framework for understanding and changing organizational and community systems. *American Journal of Community Psychology 39,* 197-215. https://doi.org/10.1007/s10464-007-9109-0

Freire, P. (1970) *Pedagogy of the oppressed*. Continuum.

Hartman, A. & Laird, J. (1983). *Family-centered social work practice*. Free Press.

Hawe, P., Shiell, A. & Riley, T. (2009). Theorizing interventions as events in systems. *American Journal of Community Psychology, 43,* 267-276. https://doi.org/10.1007/s10464-009-9229-9

Institute of Reproductive Health, Georgetown University (2019) Grandmother Project – Change through Culture: Program for Girls' Holistic Development: Qualitative Research Report. Washington D.C., for USAID.

Institute of Reproductive Health, Georgetown University (2019) Grandmother Project – Change through

Culture: Program for Girls' Holistic Development: Quantitative Research Report. Washington D.C., for USAID.

Lasker, R.D. & Weiss, E.S. (2003). Broadening participation in community problem solving: A multidisciplinary model to support collaborative practice and research. *Journal of Urban Health. 80* (1) 14-60.

O'Donnell, C. R. & R.G. Tharp (2011), Integrating cultural community psychology: Activity settings and the shared meanings of intersubjectivity. *American Journal of Community Psychology*. https://doi.org/10.1007/s10464-011-9434-1

Rogers, C. (1980). *A way of being*. Houghton Mifflin.

Schensul, J. J. & Trickett, E. (2009). Introduction to multi-level community based culturally situated interventions. *American Journal of Community Psychology 43,* 232-240. DOI 10.1007/s10464-009-9238-8

Trickett, E. et al. (2011). Advancing the science of community-level interventions. *American Journal of Public Health 101*(8),1410-1419. https://doi.org/10.2105/AJPH.2010.300113

White, S.A. (1999). *The art of facilitating participation*. Sage Publications, Inc.

Note

*All photographs are courtesy of Dr. Judi Aubel

7

Proclaiming Our Roots: Centering Afro-Indigenous Voices Through Community Storytelling

ANN MARIE BEALS, CIANN L WILSON, THE POR PROJECT TEAM

INTRODUCTION

In this chapter, we explore the Proclaiming Our Roots (POR) project, an arts-based, community-led initiative focused on the lived experiences of Afro-Indigenous Peoples in what is now called Canada. Afro-Indigenous Peoples have both Indigenous ancestry from Turtle Island and African ancestry from the trans-Atlantic African diaspora. Despite their longstanding presence and connections to land and community, Afro-Indigenous stories are often left out of public conversations about Indigeneity and Black identity.

In Proclaiming Our Roots – a community-based participatory action research project – the POR Project Team held workshops from 2017-2024 to gather digital oral stories, develop community maps to negate Afro-Indigenous erasure, and hold sharing circles to honour lived experiences and realities, build relationships across generations, and reclaim futures for generations yet to come. These stories, maps, and conversations are shared on the ProclaimingOurRoots.com website, to support the collective resistance of Afro-Indigenous, Black, and Indigenous Peoples across Turtle Island and all around Mother Earth.

This chapter highlights how community storytelling, through digital media, oral histories, and visual art, can support healing, reclaim erased histories and make visible Afro-Indigenous Peoples, while promoting transformative social change. We show how POR uses methods and theories from Community Psychology to raise awareness, empower communities, and challenge systems of oppression.

Warm-up Questions

As you begin this chapter, take a moment to reflect on the following questions:

1. What stories have shaped your sense of identity, community, and belonging?
2. How do systems like colonialism, capitalism, or anti-Black racism show up in your life or work?

3. What does healing mean to you, and how might it happen collectively?
4. Have you ever questioned a category or label related to race, culture, or Indigeneity assigned to you or others? Why does it matter?

Learning Objectives

By the end of this chapter, you will be able to:

- Define the term *Afro-Indigenous* and describe how these identities have been shaped by colonialism, racism, erasure, and dual exclusion from Black and Indigenous communities
- Explain how storytelling is used in Proclaiming Our Roots as a tool for healing, empowerment, and reclaiming knowledge
- Identify the main goals, approaches, and methods of the Proclaiming Our Roots project
- Understand how community-led, arts-based research can support cultural identity, wellbeing, and social change
- Connect the Proclaiming Our Roots project to key ideas in Community Psychology, including critical consciousness, empowerment, and systemic transformation

This chapter demonstrates how the Proclaiming Our Roots project brings key ideas in Community Psychology to life through community-led, arts-based research. You will explore how Afro-Indigenous identity, storytelling, and cultural continuity are connected to collective healing, resistance, and systems change. The following sections outline the POR Project Team, and then draw on community stories, research methods, and project insights to show how these commitments are put into practice.

Proclaiming Our Roots Team

The Proclaiming Our Roots project was made possible through the care, knowledge, and collaboration of Elders, community members, researchers, artists, and advisory council members. Key contributors to the project include Kayla Webber, Ryan Neepin, Sarah Flicker, and Rachel Persaud, as well as artist facilitators, Anique Jordan and Melisse Watson, whose commitment to relational accountability[1], community-engaged research[2], and resistance to Afro-Indigenous erasure shaped every stage of this work. Community members played a central role by sharing their stories, insights, and lived experiences. Their voices are at the heart of the POR project. These contributions continue to guide learning and strengthen the project's commitment to Afro-Indigenous presence, memory, and community connection.

The POR team honours Creator, the Ancestors who walk with us, and the lands that have held this work.

1. Relational accountability is a principle in Indigenous ways of being and knowing and acting, that emphasizes responsibility to the people, lands, and relationships involved in knowledge-sharing. It requires researchers to act with respect, honesty, and reciprocity.
2. Community-engaged research, such as community-based participatory action research (CBPAR) is an approach where researchers and community members work together at various stages of a project. It prioritizes shared knowledge, mutual benefit, and the lived experiences of the community involved.

The Land, our first teacher, offers guidance, nourishment, care, and the wisdom of interconnectedness. The POR team recognizes that our Earth Mother is under ongoing threat from extraction, exploitation, and environmental harm driven by colonial and capitalist systems. Honouring Mother Earth means actively working to protect her wellbeing, knowing that community survival and the continuation of story are inseparable from the health of the Land.

Wela'lin, thank you, to all those involved in Proclaiming Our Roots – for your teachings, your trust, and the reminder that stories are not only memories of the past, but living knowledge for today and for generations to come.

Proclaiming Our Roots Project



Proclaiming Our Roots Logo Designed by Melisse "Coyote" Watson

Since 2017, the Proclaiming Our Roots (POR) project has used arts-based research to amplify the stories and histories of Afro-Indigenous Peoples in Northern Turtle Island (Canada). Central to this work are digital oral storytelling workshops and gatherings, which have been held in Tkaronto (Toronto), Kjipuktuk (Halifax), and Wiinibiig (Winnipeg), as well as on the territories of the Mississaugas of the Credit First Nation and Six Nations of the Grand River.

These workshops and gatherings included two four-day sessions in Tkaronto and Kjipuktuk, a digital story presentation in Wiinibiig, three community launches, and a two-day retreat followed by a community gathering. Each event created space for Afro-Indigenous community members to share their stories, build relationships, and reflect on the impacts of colonization, anti-Blackness, and land disconnection.

Using methods grounded in arts-informed community-based participatory action research (CBPAR), community members engaged in storytelling through video, photography, and community mapping. These approaches supported healing, cultural reconnection, and the creation of a growing digital archive that affirms Afro-Indigenous knowledge, presence, and resistance.

Centering Community

Essential to the POR project are the community members themselves. They actively contribute knowledge, make decisions, and shape the direction of the research. This collaborative approach ensures that community insights directly inform the design of storytelling workshops and the creation of digital platforms where Afro-Indigenous narratives can be reclaimed and shared.

As a result, community members not only build new skills in, for instance, multimedia storytelling, but also access mentorship and take part in shaping public conversations about Afro-Indigenous identity. This

co-creation of knowledge furthers intergenerational connections and ensures that the project's outcomes, such as digital oral stories and educational materials, remain meaningful and accessible to Afro-Indigenous, Black, and Indigenous communities.

Proclaiming Our Roots is grounded in global Indigenous ways of knowing and being, particularly through oral and artistic traditions (Knudson, 2015; Manuelito, 2015). The project uses arts-based methods such as digital oral storytelling, community mapping, sharing circles, and semi-structured interviews to support critical consciousness-raising[3] (Freire, 1970). These approaches encourage Afro-Indigenous placemaking[4] by weaving personal and collective stories into the cultural and geographical fabric of community life. In doing so, Proclaiming Our Roots disrupts colonial narratives and contributes to a more accurate and inclusive representation of Afro-Indigenous experiences (Etowa et al., 2007).

This work is ongoing. As researchers and community members gather to share truths, memories, and insights, they reshape the historical and geographical narratives that have excluded Afro-Indigenous voices. POR continues to archive local knowledge for future generations, while building deeper understandings of how colonialism[5] has shaped and continues to impact Afro-Indigenous identity.

The stories and teachings emerging from Proclaiming Our Roots are now accessible to community members, educators, and advocates. They serve as living knowledge in guiding conversations about identity, survivance[6], and justice. By preserving and amplifying these voices, POR strengthens the foundations for more equitable, inclusive, and relational futures.

3. Critical consciousness is the ability to recognize and analyze systems of oppression and take action against them. It involves becoming aware of how social, political, and economic forces shape personal and collective experiences.
4. Placemaking, in this context, refers to the process by which Afro-Indigenous Peoples assert belonging and cultural presence through stories, relationships, and connections to land and community. It challenges colonial erasure by affirming place-based identities.
5. Colonialism refers to a system of domination through which foreign powers control land, resources, and people. In what is now called Canada, colonialism includes the theft of Indigenous lands, the destruction of cultures and languages, and policies such as the Indian Act and Indian Residential Schools that work to erase Indigenous identities.
6. Survivance is a term introduced by Anishinaabe scholar Gerald Vizenor (1999). It goes beyond survival to describe active presence, resistance, and cultural continuity in the face of colonial violence. It emphasizes that Indigenous Peoples are not just surviving oppression, but also asserting their stories, identities, and ways of being.



A compilation of Digital Oral Stories from the POR Archive (2025).
To view these digital oral stories, please visit ProclaimingOurRoots.com.

THE PROCESS OF PROCLAIMING OUR ROOTS

Storytelling and Digital Archiving

The storytelling process in the Proclaiming Our Roots project was designed to center the voices and lived realities of Afro-Indigenous community members. During the workshops, community members reclaimed personal and ancestral stories that had become obscured or erased by settler colonial systems[7]. These narratives challenged dominant narratives, i.e., dominant discourses[8] that often erase or simplify Afro-Indigenous identities and dismiss Afro-Indigenous lives. Sharing stories supported healing by allowing community members to confront marginalization, affirm survival, and build connections rooted in strength and cultural memory.

Storytelling helps carry cultural identity forward, and this can be a powerful and protective factor against the forces of systemic erasure and disconnection. As Black feminist scholar Tiffany Lethabo King (2019)

7. Settler colonial systems refer to ongoing structures of power designed to permanently occupy Indigenous lands and erase Indigenous Peoples through assimilation, removal, and replacement.
8. Dominant discourses are widely accepted social descriptions that reflect the perspectives of those in power and often misrepresent or exclude the lived experiences and realities of marginalized people and groups.

notes, cultural identity holds belonging, lineage, and intergenerational knowledge. In POR, storytelling is not just a research method – it is a relational and political act – a social movement that honours Afro-Indigenous histories, proclaims presence, and sustains community continuity.

Alongside digital oral storytelling, the workshops included sharing circles[9]. These circles created space for listening, reflection, and reciprocal learning, guided by Indigenous ways of being in relationship. They helped nurture trust and accountability within the group, allowing community members to speak openly, connect across experiences, and support one another throughout the process.

To extend the stories shared in the workshops, we also held semi-structured interviews with community members who chose to participate. Not everyone who created a digital oral story took part in an interview. Those who did were invited to reflect more fully on their identities, relationships with land and community, and the systemic barriers they face. The interviews were open-ended but grounded in key themes. We asked questions like: How do you identify culturally and spiritually? What challenges or supports have you experienced when trying to access social services? What does healing mean to you? What does being Afro-Indigenous mean in your life today? This flexible approach allowed community members to shape the conversation, while still engaging shared experiences of anti-Blackness, Indigenous erasure, cultural disconnection, systemic racism, and survivance.

The digital oral stories continue to live in a growing digital archive shaped by the people and places it represents. This archive makes space for education, advocacy, and cultural continuity, and holds the voices, truths, and creative expressions of Afro-Indigenous community members. It contributes to conversations in community, academic, and policy spaces by bringing forward experiences that have long been left out or erased. The website includes not only digital stories but also a community map, where community member locations and home territories are linked to their stories. This mapping allows for a visual and narrative connection to land and place, challenging static colonial borders and showing how identity and geography are interwoven.

More than a collection, the Proclaiming Our Roots archive is a tool for knowledge mobilization. It supports educators, service providers, researchers, and community members in understanding the impacts of colonialism, anti-Blackness, and Indigenous erasure. At the same time, it offers Afro-Indigenous community members a way to see their stories made visible in their own way. The archive helps sustain conversations about justice, land, wellbeing, and survivance, while creating room for ongoing reflection, resistance, healing, and community-led engagement. The digital oral stories and the interactive map can be accessed at ProclaimingOurRoots.com.

These shared stories show that storytelling in Proclaiming Our Roots is not just about documentation; it is a process of healing, empowerment, and reclaiming knowledge. Through narrating, witnessing, and archiving, community members resist erasure, affirm identity, and rebuild intergenerational and cultural

9. A Sharing Circle is an Indigenous practice used to support respectful listening, storytelling, and relationship-building. Everyone in the circle has an opportunity to speak without interruption, often using a talking piece to signal turns. Sharing circles are commonly used among Anishinaabe communities and have also been embraced by Mi'kmaq scholars and community researchers as a relational and culturally grounded research method.

relationships. Storytelling becomes a practice of presence and connection, supporting personal and collective strength while asserting Afro-Indigenous knowledge in ways that challenge colonial systems of oppression.

HOW PROCLAIMING OUR ROOTS CONNECTS TO COMMUNITY PSYCHOLOGY

To understand why the Proclaiming Our Roots project belongs in a Community Psychology textbook, it's important to see how POR goals and methods reflect the key ideas of the field. Community Psychology is about justice, collective wellbeing, and community-led change, especially for communities harmed by systems like colonialism, racism, and capitalism. POR reflects these commitments.

The following core concepts in Community Psychology are illustrated through the Proclaiming Our Roots project:

Critical Consciousness Raising: a core principle in amplifying the voices and experiences of Afro-Indigenous, Black, and Indigenous Peoples navigating erasure, racism, and colonialism. Through storytelling, dialogue, and collective reflection, POR increases awareness of intersecting histories and systemic injustices. This process supports identity, while also mobilizing action toward justice and reclamation (Freire, 1970).

Empowerment and Prevention: by addressing the systemic erasure of Afro-Indigenous identity, POR helps prevent further harm while supporting community members to reclaim their stories. Storytelling becomes a powerful tool for raising consciousness and building strength at both individual and collective levels.

Arts-Based and Community-Led Methods: are central to how POR supports healing, self-determination, and cultural continuity. Through digital oral stories, community mapping, and visual art, POR uses creative approaches that are meaningful and accessible to community members.

Challenging Colonial Frameworks: by centring Afro-Indigenous, Indigenous, and Black knowledge systems and lived realities. POR disrupts dominant narratives about identity and belonging, while affirming community knowledge and resistance.

Community Organizing and Relationship Building: through workshops, gatherings, and digital storytelling, POR strengthens intergenerational connections and supports community care, advocacy, and healing. This aligns well with the Community Psychology focus on relational accountability and collective wellbeing.

Policy and Systems Change: POR contributes to broader efforts for equity, reconciliation, and justice by engaging with educators, service providers, and policymakers. POR's findings call attention to structural harm and push for systemic change that reflects Afro-Indigenous leadership and experience.

Together, these elements show how Community Psychology can be practiced through creative, relational, and justice-oriented methods, especially when guided by communities themselves.

NAMING SHARED PRIORITIES: INSIGHTS FROM AFRO-INDIGENOUS COMMUNITY MEMBERS

The following section highlights key themes that emerged through thematic analyses of digital oral stories,

sharing circles, and semi-structured interviews from the Proclaiming Our Roots project. These themes reflect the lived experiences and priorities of Afro-Indigenous community members who participated in workshops and gatherings across different territories on Northern Turtle Island. Transcripts, recordings, and community reflections were reviewed to identify recurring concerns that spoke to shared realities.

This section focuses on five themes that were most consistently named: (1) Identity, (2) Recognition and Validation, (3) Access to Culturally Relevant Resources, (4) Healing Spaces, and (5) Advocacy and Meaningful Representation. It is important to note that these themes are not presented as abstract topics but as interconnected experiences shaped by colonialism, anti-Black racism, and systemic exclusion. Each theme offers insight into the everyday conditions Afro-Indigenous community members navigate, and the kinds of change they are actively working to bring about.

These priorities reflect the lasting impacts of colonialism, including the erasure of Afro-Indigenous histories, disconnection from land and culture, and exclusion from institutional decision-making. Community members emphasized that visibility alone is not enough – what is needed is voice, dignity, and the power to shape their own futures. Their stories point to a broader movement to reclaim Afro-Indigenous presence, rebuild intergenerational connections, and protect cultural knowledge. This work is already underway through Proclaiming Our Roots, carried forward in land-based practices, community-led research, and storytelling rooted in relationship.

The following section details the five themes and interconnected experiences:

1. Identity: Afro-Indigenous Communities

Afro-Indigenous Peoples are people with both Indigenous ancestry from Turtle Island[10] and African ancestry from the global African diaspora[11]. These communities may identify in many ways, including (but not limited to) Indigenous-Black, Afro-Indigenous, or Urban Black Native. Although these identities overlap, they are shaped by different histories, locations or geographies, and cultural contexts. What they share are experiences of being made invisible both within broader Canadian society and within Black and Indigenous communities (Beals & Wilson, 2020).

In what is now called Canada, Afro-Indigenous Peoples have long been connected to the land and involved in resistance to colonialism and slavery. Despite this history of over 400 years, their voices are often excluded from mainstream discussions about who is considered Indigenous. These discussions are frequently shaped by narrow ideas about physical appearance, i.e.,

10. Turtle Island refers to the lands now known as North America, including the Caribbean. The term originates from several Indigenous creation stories in which the world is formed on the back of a turtle. It is widely used by Indigenous Peoples, such as the Haudenosaunee, to affirm their worldviews and resist colonial naming.
11. African diaspora refers to communities around the world that descend from African Peoples displaced by the trans-Atlantic slave trade holocaust, colonialism, and ongoing global anti-Black racism. This includes people in the Americas, the Caribbean, Europe, and elsewhere.

phenotype[12], blood quantum[13], or one-drop rules[14] – social constructs and laws rooted in colonial systems of classification and control (Mills-Proctor, 2010). Such framings often acknowledge mixed Indigenous and European heritage, yet rarely recognize Afro-Indigenous identities. This selective recognition reproduces colonial hierarchies of classification, where certain mixtures are legitimized while others are erased, thereby upholding systems that privilege proximity to whiteness (Lawrence, 2004).

This kind of exclusion has considerable consequences. Afro-Indigenous Peoples often face barriers when trying to access social services, cultural spaces, or recognition in public policy. They may not be seen as fully belonging in either Black or Indigenous communities. As a result, many face systemic inequities and a loss of connection to family, land, and identity.

These erasures are not accidental. They are the result of settler colonial laws, policies, and practices that have divided communities and reinforced racial hierarchies (Fanon, 1963)[15]. Over time, these systems have marginalized Afro-Indigenous people and made their experiences less visible in both social justice work on Turtle Island, and academic research.

In response to this ongoing invisibilization, the Proclaiming Our Roots team formed to center Afro-Indigenous voices and create space for their stories, relationships, and resistances.

2. Recognition and Validation

Community members, throughout eight years (to date) of workshops and community sessions, highlighted the need for acknowledgment of their dual heritage within both Indigenous and Black communities. The historical and ongoing exclusion of Afro-Indigenous identities from dominant narratives has created a sense of invisibility, leaving people to navigate fractured identities and social rejection both inside and outside their communities. Within Indigenous

12. Phenotype refers to the observable physical characteristics of a person, such as skin colour, hair texture, and facial features. These traits are often used by colonial systems to classify and police racial identities, despite not accurately reflecting a person's cultural or ancestral background.
13. Blood quantum is a colonial system used to measure Indigenous ancestry by calculating the "percentage" of a person's Indigenous blood. It was/is imposed through laws and policies, such as, in Canada, the Indian Act of 1876, to determine eligibility for legal recognition and rights, often with the goal of erasing Indigenous identity over generations.
14. One-drop rule is a racial classification system that emerged during slavery and segregation. It defined anyone with even "one drop" of Black ancestry as legally and socially Black. This rule reinforced anti-Black racism and denied mixed-heritage people access to rights and resources afforded to white people.
15. Racial hierarchies refer to systems of power that rank people based on perceived racial categories. In settler colonial societies such as Canada and the US, these hierarchies are designed to uphold white supremacy by giving social, political, and economic advantages to white people, while systematically disadvantaging Indigenous, Black, and Afro-Indigenous communities. These hierarchies shape everything from citizenship laws to access to land, education, and health services.

spaces, community members may face anti-Blackness, where phenotypical traits or blood quantum rules are used to question their "authenticity" as Indigenous. As noted by a POR community member in their digital story,

> [Indian Act 1876][16] Bill C-31 allow my siblings and me to inherit my mother's six-one statute. However, my kids have six-two status because their father is Black, and their kids will have no status if their partners are not Indigenous. Breeding out the Native blood, but Indigenous identity isn't about blood. It's about the culture that you can't dilute no matter the colour of your skin. (Proclaiming Our Roots Digital Oral Stories)

Conversely, in Black spaces, anti-Indigeneity can lead to the dismissal or devaluing of Indigenous heritage. This dual erasure leaves Afro-Indigenous people feeling sometimes excluded from cultural, social, and political spaces, where they should otherwise find belonging. Recognition and validation are thus not just symbolic; they are essential for restoring a sense of identity, dignity, and wellbeing.

Colonial systems have long imposed rigid categorizations of identity based on race and phenotype, reinforcing binary structures that erased mixed Black and Indigenous blood. Afro-Indigeneity was either rendered invisible or misrepresented, with government documents, census records, and archives created to uphold colonial systems of racial control rather than accurately reflecting the lived realities of Afro-Indigenous communities. This systemic omission not only erased Afro-Indigenous contributions and histories but also fractured families and severed many from their cultural inheritance and kinship ties.

16. The British North America Act of 1867 (BNA), enacted by the imperialist British Empire, laid the foundation for Canadian federal authority over Indigenous Peoples and their lands, which was later solidified through the Indian Act of 1876. The Indian Act remains Canadian law today, continuing to regulate aspects of Indigenous identity, governance, and land use. It is an existing law of domination and control. Its ongoing enforcement reflects the enduring presence of colonial control, despite the colonial settler nation-state's public commitments to reconciliation and Indigenous rights.



Person wearing tan fringed moccasins stepping during ceremony at Six Nations

Nonetheless, through the Proclaiming Our Roots project, community members were able to reclaim these lost connections by sharing their stories and uncovering histories obscured by colonial systems. Storytelling became and is an act of resistance against erasure, as community members voiced their experiences and challenged the silences imposed by colonial narratives. For many, this process was transformative, enabling them to process intergenerational trauma and build meaningful relationships with others who shared similar identities and struggles. By reclaiming their narratives, community members also began to piece together the connections that colonial systems had worked to sever, adopting a transformed sense of belonging and healing. As noted by POR community members,

> You come from a long line of warriors and chiefs, no matter what Canada tries to tell you, you are the child of many Ancestors that fought for you to be here and to live in freedom. My hope is that you call on them and gather strength from them for they will protect you as they have protected me on my journey, this is my history but more importantly this is your history. I would stand up using something like my father would say, "Get back up and give your best left hook!" I kept that quote and I still give my best left hook, I got my strength from my family and my extended family, and friends. I pass that same strength to my children and my grandchildren. I finally have a sense of belonging and I finally realized through my journey that I am stronger than I think but even more importantly, I am a strong, Black and Indigenous woman. This is a lifelong journey of learning, and I am looking forward to each step I will be taking (Proclaiming Our Roots Digital Oral Stories).

Recognition must also extend to policy and institutional frameworks, which often fail to reflect the realities of Afro-Indigenous Peoples. Community members expressed frustration with being overlooked in Truth and Reconciliation[17] efforts, and the continued defining of Indigeneity in ways that exclude Afro-Indigenous histories and realities. Validation, then, requires expanding institutional and societal understandings of Indigeneity to include the layered and complex experiences of those whose roots stretch across both Indigenous Turtle Island and Indigenous Motherland Africa.

17. Truth and Reconciliation refers to the process initiated by the Truth and Reconciliation Commission of Canada (2008–2015), which documented the history and lasting impacts of the Indian Residential School system. The Commission's 94 Calls to Action urge governments, institutions, and all Canadians to recognize past harms and actively work toward justice, healing, and meaningful relationships with Indigenous Peoples.

3. Culturally Relevant Resources

Proclaiming Our Roots community members emphasized the importance of accessing resources and services that reflect and respond to the intersectional challenges of living with dual identities. Many existing programs and services are designed with either Indigenous or Black communities in mind, which means they often fail to meet the overlapping and specific needs of Afro-Indigenous people. This gap leaves community members without culturally safe spaces where they can seek support – whether for mental health, education, community engagement, or ceremony.

For example, community members spoke of the need for mental health services that recognize the compounded trauma of colonialism, anti-Black racism, and cultural erasure. Such services must go beyond standard approaches by integrating an understanding of intergenerational trauma, land-based healing, and collective care, while also addressing the ongoing psychological impact of systemic anti-Black racism.

Educational resources are another key area, as community members highlighted the lack of representation in curricula and public discourse about the contributions and histories of Afro-Indigenous Peoples. Without these resources, Afro-Indigenous people are left to navigate systems that do not reflect their identities or lived realities.

Culturally relevant resources also include policymaking and advocacy tools. POR community members stressed the need for spaces where they can co-create solutions to the issues they face, ensuring that their unique perspectives are not only heard, but integrated into action.

4. Healing Spaces

The co-creation of knowledge through the Proclaiming Our Roots project highlights the real need for healing spaces where Afro-Indigenous people can engage in community building, storytelling, and collective healing. These spaces are essential to countering the systemic erasure and dehumanization they face in their daily lives. Storytelling emerged as a transformative tool for reconnecting with identity, affirming cultural belonging, and building relationships across shared experiences. By sharing their community stories, many reclaimed long-silenced parts of themselves and discovered connections with previously unknown relatives.

Through POR, community members shared stories that uncovered histories deliberately obscured by colonial systems. These narratives challenged imposed silences and revealed the layered impacts of erasure, disconnection, and dual Black and Indigenous exclusion. For many, the process of creating and sharing their digital oral stories opened space to process intergenerational trauma, rebuild fractured relationships, and connect with others navigating similar struggles. One community member reflected that they had never felt fully recognized in either Black or Indigenous spaces until participating in a POR storytelling workshop. Tracing their lineage across both Turtle Island and the Motherland, they reconnected with distant relatives and embraced their Afro-Indigenous identity for the first time. This process not only affirmed their belonging, but reshaped how they introduced themselves in public and ceremonial contexts.

As noted, the reason why Afro-Indigenous people may not know their relatives is due to historical colonial practices of documenting – or deliberately not documenting – Afro-Indigenous identities, which has played

a significant role in Afro-Indigenous separation and marginalization. The colonial system intentionally erased or misrepresented Afro-Indigenous identities by prioritizing rigid categorizations based on race and phenotype. This was reinforced through policies and practices that categorized children of Black and Indigenous parents and caregivers as "Black," "Mulatto," or "Other," often denying acknowledgment of Indigenous heritage (Beals & Wilson, 2020). Yet in some cases, these categorizations inadvertently offered a form of protection. By "hiding" in Black communities, some children were less likely to be forcibly taken to Indian Residential Schools.[18] This strategy of survival, however, came at great cost. Children were sometimes separated from their Indigenous heritage, stripped of cultural connections, and further marginalized within both Black and Indigenous communities (Beals & Wilson, 2020).

As one Proclaiming Our Roots community member reflected on their healing journey and reclamation of identity:

> *It wasn't until I embraced my Native self that I truly understood who I was as an Indigenous-Black woman. It was then that I started healing, and I picked up a brush and started painting, and for the first time, I realized what artists mean when they say you work better through pain. Artwork for me has been my therapy. I never thought so many would understand my voice through visual art – I was wrong. At 42 years old I started a whole new career but I'm thriving in it* (Proclaiming Our Roots Digital Oral Stories).



POR Community Member Digital Oral Story
Kjipuktuk

Healing spaces must also account for the ongoing impacts of colonial binary gender systems which continue to harm Afro-Indigenous, Black, and Indigenous women, girls, Two-Spirit[19], and transgender

18. Indian Residential Schools were government- and church-run institutions in Canada that operated from the 1880s until the late 1990s. They were designed to forcibly assimilate Indigenous children by removing them from their families, languages, and cultures. Many children experienced neglect, abuse, and loss of life within these institutions. The residential school system is now widely recognized as a tool of cultural genocide with lasting current intergenerational impacts on Indigenous communities.
19. Two-Spirit is a term used by some Indigenous Peoples to describe gender, sexual, and spiritual identities outside colonial binaries, grounded in specific cultural teachings and roles.

community members. As shared by many in the POR project, reclaiming identity also means resisting gendered violence and restoring Indigenous understandings of gender and relationship.

The imposition of the hierarchical gender binary system is a direct legacy of European imperialism, which sought to dismantle Indigenous ways of knowing and being by enforcing rigid, patriarchal[20] structures that served the colonial agenda. Prior to colonization, many Indigenous Nations in Northern Turtle Island recognized and honoured gender fluidity, understanding gender as a diverse and relational concept rather than a fixed 'man-woman' binary. However, through Christian missionary efforts, Indian Residential Schools, and colonial legal systems, a dominant gender framework was imposed that erased these understandings, enforcing cis-heteronormativity[21] and policing Indigenous bodies to fit within eurocentric categories of man and woman – with Afro-Indigenous women and girls and Two-Spirits and other gender expressions rendered subjugated, invisible, deviant, and expendable (Fisk, 1991; Lezard et al., 2021). This colonial violence continues to shape contemporary gendered violence for Afro-Indigenous, Black, and Indigenous women, girls, Two-Spirit and transgender people, making it very necessary for healing spaces and ceremony to actively resist these binaries and restore Indigenous governance, creating room for Two-Spirit people and all those whose identities defy imposed colonial binary norms.



Ceremony Six Nations of the Grand River

In creating these spaces, we work to provide an opportunity for intergenerational transmission of knowledges, ensuring that Afro-Indigenous histories, traditions, and strengths are preserved and celebrated. Community members emphasized that healing is not just an individual process but a collective one, rooted in community solidarity and mutual support. Additionally, healing spaces are essential for promoting empowerment. By creating environments where Afro-Indigenous people can see their experiences reflected and valued, these spaces help counteract the psychological effects of systemic marginalization and support holistic wellbeing.

5. Advocacy and Representation

Community members identified the need for greater inclusion in broader conversations about reconciliation, equity, and systemic change. Too often, Afro-Indigenous voices are absent from these discussions, even though they are directly impacted by the policies and practices being debated. For example, national

20. Patriarchy refers to a system of power that privileges men and masculine identities by reinforcing gender hierarchies and control over social, political, and cultural life. It is upheld not only by men, but also by women and others who participate in and/or benefit from its norms and structures. Under colonialism, patriarchal systems were/are imposed to replace Indigenous gender relations, often enforcing rigid binaries and undermining relational and fluid understandings of gender and governance.
21. Cis-heteronormativity is a dominant narrative that assumes being cisgender, that is identifying with the gender assigned at birth, and heterosexual, that is attraction to a different gender, are the natural, normal, or preferred ways of being. This western dominant discourse devalues and erases other identities and relationships, causing harm by upholding systemic oppression, justifying exclusion, and normalizing the marginalization and violence experienced by those who do not conform to cis-heteronormativity.

reconciliation efforts in Canada often overlook the unique challenges faced by Afro-Indigenous communities, framing Indigeneity in ways that exclude their experiences and contributions (Beals &Wilson, 2020).

Advocacy efforts must address this gap by amplifying Afro-Indigenous voices and ensuring their perspectives are included in policymaking, education, and media narratives. Representation in leadership positions and decision-making bodies is not simply symbolic, it is essential for structural change. POR community members emphasized that representation must include real power to be able to influence the systems that affect their lives.

This means creating intentional pathways for Afro-Indigenous individuals to access, shape, and lead in spaces where decisions about reconciliation, education, health, and governance are made. Representation is not just about inclusion, but about ensuring that Afro-Indigenous communities have the power to shape the narratives and policies that affect their lives. This requires deliberate, sustained efforts to dismantle systemic barriers and support Afro-Indigenous leadership, knowledge, and self-determination across sectors.

POTENTIAL OF COMMUNITY-BASED RESEARCH



Handwritten notes and materials spread across a blanket during a POR retreat

The Proclaiming Our Roots project has had a significant and ongoing impact on Afro-Indigenous communities in Northern Turtle Island, addressing the systemic erasure of Afro-Indigenous voices and histories. By centering the lived experiences of POR community members through storytelling and arts-based methods, the project has nurtured meaningful connections, supported healing, and contributed to critical conversations about identity, justice, and social change. It also engages in the reversal of the colonial gaze[22] as survivance – that is the active process of resisting and reinterpreting imposed colonial narratives by reclaiming Afro-Indigenous histories, knowledges, and identities.

Survivance goes beyond survival. It is about presence, resistance, and the refusal to disappear. Survivance counters dominant narratives of victimhood by affirming Indigenous agency, identity, and continuity. It is enacted through stories, art, and everyday acts of resilience. In Proclaiming Our Roots, community members practice survivance by telling their truths, reclaiming erased histories, and living in ways that honour their

22. Colonial Gaze, aka the white gaze, refers to the way colonial powers observe, represent, and control and dominate Indigenous, Black, and Afro-Indigenous Peoples through distorted, hierarchical, and dehumanizing frameworks that serve colonial interests.

Ancestors from many lands. Survivance is resistance and a commitment to dignity, self-determination, and relational accountability (Vizenor, 1999).

IMPACT OF THE POR PROJECT

Community Empowerment and Identity Affirmation

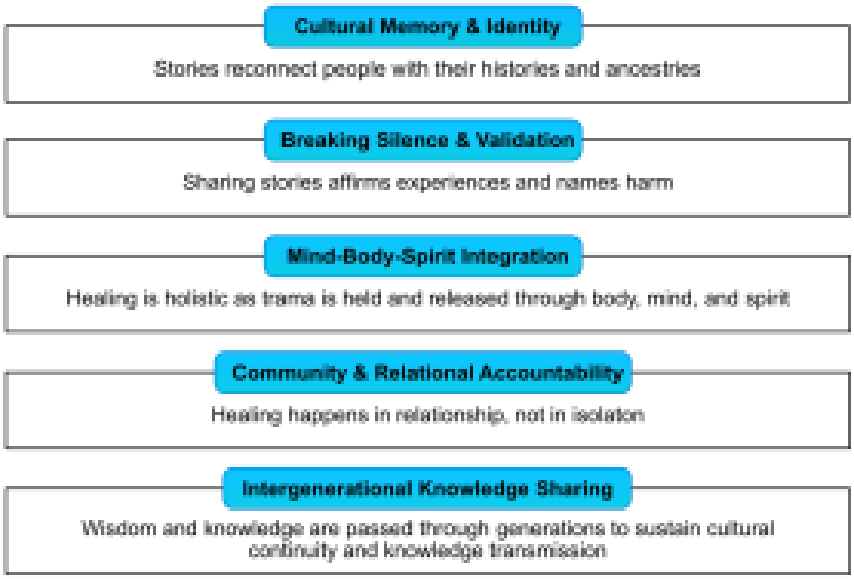
A foremost impact of the POR project has been the affirmation of Afro-Indigenous identities. Community members expressed feeling seen, heard, and validated – often for the first time – as their dual heritage is recognized and honoured. This affirmation counters the effects of colonial erasure and systemic exclusion, allowing community members to reclaim their narratives and reconnect with both their Turtle Island and African roots. Through digital oral stories, they shared a renewed sense of pride and belonging, strengthening their capacity for advocacy, self-determination, and community care.

Healing and Collective Wellbeing

Storytelling and sharing circles created safe spaces for community members to process intergenerational trauma and confront historical harm. In Proclaiming Our Roots, each workshop and gathering opened and closed with sharing circles held in person and sometimes virtually, depending on location and access and pandemics. These circles followed Indigenous principles of relational accountability: everyone sat in a circle, took turns speaking, and listened without interruption. No one was required to share. Instead, space was held with care and consent. Community members set their own boundaries and shared in ways that felt right to them. These practices were not added to the project – they were a key foundational piece.

For many, this was a path to healing that restored cultural memory, affirmed identity, and broke silence. Stories helped name harm, release pain, and reconnect with lineage and land. As Resmaa Menakem (2017) writes, trauma lives in the body, not just the mind. In POR, storytelling engaged mind, body, spirit, and community. Speaking truth in the presence of others helped process trauma and reconnect with self and Ancestors. Proclaiming Our Roots emphasized relationships across generations, which supported knowledge sharing and community care grounded in Indigenous ways of being and knowing. These healing spaces affirmed intergenerational dialogue as central to cultural continuity and critical consciousness.

The visual below summarizes five interrelated ways storytelling supports healing in Proclaiming Our Roots:



These community-rooted practices remind us that healing is not a solitary journey, but a collective process grounded in story, presence, and relationship.

Relational Research in Practice: Insights from the Continuing Journey

Up to this point, this chapter has highlighted key themes shared by Afro-Indigenous community members through storytelling: identity, healing, and the effects of systemic exclusion. These stories are powerful not only for what they reveal, but for how they were shared. The following section shifts focus to the research process itself – the choices, tensions, and insights that shaped how Proclaiming Our Roots unfolded as a community-led, arts-based project.

For students of Community Psychology, this section demonstrates how ethical frameworks, relational accountability, and community priorities are applied in practice. These reflections also help explain how the POR Project Team worked to honour the stories and relationships at the center of the work, including by prioritizing community knowledge-sharing before academic writing and upholding community members' ownership of their stories.

Navigating Complex and Layered Identities

Supporting identity development requires spaces where individuals can safely explore the multiple and sometimes conflicting parts of who they are. Afro-Indigenous identity is never singular. It is shaped by overlapping experiences of displacement, survivance, and cultural continuity and is further complicated by intersecting identities such as being Two-Spirit, queer, nonbinary, or of mixed descent that extends beyond being solely Black and Indigenous. These complexities are often erased by colonial systems that impose rigid definitions of race, culture, and gender.

Community members spoke about being questioned or excluded in both Black and Indigenous spaces,

while also expressing pride in carrying the strength and knowledge of both lineages. Proclaiming Our Roots created space to name and explore these tensions collectively. Through storytelling and community dialogue, community members reflected on how colonial systems continue to divide and disconnect, while also affirming shared experiences and cultural reconnection.

The Importance of Ethical Storytelling

Ethical storytelling extends beyond following formal research protocols. Within Proclaiming Our Roots, it was grounded in relational accountability, requiring care, responsibility, and ongoing consent. Community members emphasized the importance of protecting their stories from being taken, misused, or reshaped to serve academic or institutional goals. These sacred stories were not treated as research data, but as teachings and lived experiences, shared with trust and intention.

From the beginning, community members retained ownership of their digital oral stories. They decided whether stories would be public, private, or password-protected and these preferences were respected on the project's digital platform. The POR Project Team remained committed to honouring these decisions in all academic and public contexts, ensuring that stories were only shared with permission and used in ways that reflected the storytellers' intentions.

Knowledge mobilization began not with publications, but by sharing the work back with POR community members through exhibitions, workshops, and digital access shaped by their priorities. These commitments to autonomy and respect continue to guide how the project operates today.

Sustainability Challenges

Ensuring the long-term sustainability of Proclaiming Our Roots goes beyond maintaining momentum – it means actively working against systems that continue to deprioritize community-led, arts-based, and culturally-grounded work. Despite its demonstrated impact, Proclaiming Our Roots remains situated within institutional structures that continue to resist the redistribution of power and resources, even in the face of innovative, community-led approaches like POR.

Sustainability here is not only about funding, but also about ensuring that Afro-Indigenous, Indigenous, and Black communities can maintain control over their stories, spaces, and knowledge production. While the project has created curriculum, digital archives, and knowledge-sharing events, sustaining this work requires dedicated infrastructure and long-term commitment from educational institutions, funders, and policy bodies.

More than anything, sustainability must reflect the relational nature of this work. That includes continued care for the people involved, space for evolving community needs, and processes that honour story ownership, privacy, and cultural protocols. This also means building capacity for members of communities to lead, adapt, and guide the work as it grows…on their own terms.

Knowledge Production and Public Awareness

The Proclaiming Our Roots digital archive contributes to a growing body of knowledge that centers

Afro-Indigenous voices, presence, and histories. It offers a resource for educators, community organizers, and policymakers working to understand the ongoing impacts of colonialism and the realities of Afro-Indigenous experiences. The archive includes digital oral stories, mapping tools, and other materials created by community members themselves as well as the POR Project Team. The archive challenges narrow definitions of Indigeneity and Blackness by affirming identity as knowledge.

The archive is publicly accessible at ProclaimingOurRoots.com.

POR's findings continue to inform public discourse and policy conversations. The findings bring visibility to intersectional harms and highlight the need for culturally relevant supports shaped by and for Afro-Indigenous communities.

Policy Influence and Advocacy

Proclaiming Our Roots has contributed to policy conversations around reconciliation, equity, and systemic change. The project's insights align with and expand on the Truth and Reconciliation Commission of Canada (TRC) (2015) and the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) (2019), particularly around representation, cultural continuity, and the need for Afro-Indigenous-specific supports. The TRC calls for inclusive narratives that reflect the diversity of Indigenous experiences. MMIWG emphasizes the need for culturally grounded supports and the recognition of intersecting forms of gendered violence. POR responds to both by naming erasure, affirming identity, and creating space for community-led healing and advocacy.

Project findings are shared through community reports, public presentations, academic publications, and the digital archive. Knowledge sharing is not one directional, however; community feedback, dialogue, and continued engagement are central. Community members have offered reflections during and after workshops, gatherings, and launches, shaping how the work is carried forward – and the work is carried forward. Educators, service providers, and policy actors are invited into conversation, not just as recipients of information, but as participants in collective learning and accountability.

The Proclaiming Our Roots project shows how storytelling can drive community empowerment, reclaim history, and support transformative social change. Its impact continues to resonate across Afro-Indigenous communities and within broader Canadian society and globally, laying groundwork for advocacy, education, and collective healing. By amplifying voices long silenced, Proclaiming Our Roots preserves vital histories and inspires future generations to continue the work of resistance, healing, and relational care.

Looking Forward: Knowledge Mobilization and Curriculum Development

This final section outlines how community-led, arts-based research in Proclaiming Our Roots continues beyond storytelling workshops to support cultural identity, wellbeing, and social change. The current phase (2025) focuses on expanding reach through curriculum development, digital archiving, and broader knowledge mobilization. These stories and insights are not unchanging; they are living knowledges that reshape how we understand identity, history, and community care across education, policy, and community spaces.

Expanding Community Knowledge Through Digital Platforms

Proclaiming Our Roots has created an accessible online platform, which it continues to expand, to share digital oral stories with a broader audience. This platform serves as a repository for community knowledge and member achievements, while acting as an interactive learning space for educators, students, and community members. By making these stories readily available, the project supports intergenerational learning, challenges dominant colonial narratives, and promotes ongoing dialogue about Afro-Indigenous, Indigenous, and Black identities and experiences.

Curriculum Development Grounded in Afro-Indigenous Perspectives

The current phase of the POR project focuses on expanding reach through curriculum development, knowledge mobilization, and continued community engagement. The curriculum is grounded in the stories shared by community members and reflects themes of identity, survivance, healing, and relational accountability.

Resources are being designed for use across multiple educational levels, including elementary, secondary, post-secondary, and community-based learning environments. Formats will include downloadable toolkits and web-based modules. Where possible, materials will be offered as Open Educational Resources (OER), hosted on the ProclaimingOurRoots.com website to ensure accessibility and community ownership. This approach supports wide access and reflects POR's commitment to collective learning and community benefit.

Key interconnected curriculum domains include:



This curriculum is not just a resource. It is a continuation of the stories, relationships, and resistance that shape the ongoing work of Proclaiming Our Roots.

Mobilizing Knowledge and Advocating for Systems Change

The Proclaiming Our Roots project continues to mobilize knowledge across education, policy, and community spaces. Insights generated through storytelling have been shared through community presentations, workshops, and publications that invite conversation, action, and accountability. These efforts are not just about sharing findings… they are about shifting systems.

Researchers and community members actively engage with policymakers to confront systemic inequities identified through Proclaiming Our Roots. Afro-Indigenous voices must be central to discussions on reconciliation, education, health, and cultural preservation. The project advocates for policy changes that reflect Afro-Indigenous realities, support dedicated funding for Afro-Indigenous-led initiatives, and ensure inclusion in Indigenous and Black governance structures.

This work reinforces the importance of community-led solutions in shaping systemic change. Afro-Indigenous perspectives must be present not only in consultation, but in leadership and decision-making roles. Representation alone is not enough though – representation must come with the power to influence systems that impact community wellbeing. By translating lived experiences into tools for action, Proclaiming Our Roots supports a broader and more grounded understanding of reconciliation – one that affirms Afro-Indigenous presence, priorities, and leadership in shaping just futures.



Sustaining Community-Led Work

Sustaining the work of Proclaiming Our Roots takes more than passion and commitment. It requires long-term support and changes to how institutions value community-led, arts-based projects grounded in Afro-Indigenous, Black, and Indigenous ways of knowing. As this project has shown, the work builds strong relationships, keeps culture alive, and creates tools for healing and social change.

Projects like POR often face challenges when trying to secure funding, especially if they do not follow mainstream or western research models and/or frameworks. Supporting sustainability means recognizing

that this work isn't extra, or optional. POR plays an important role in strengthening cultural identity, community wellbeing, and the reclaiming of Afro-Indigenous stories and knowledges. It also creates space for community members to maintain their stories and to shape their futures in their own way, beyond the constraints of colonial systems.

The digital stories, community gatherings, and curriculum materials are not finished products; they are part of an ongoing process. They hold stories of survival, identity, and care. To keep this work going, we must continue supporting the relationships, teachings, and commitments built through the POR project. This includes developing new educational resources, keeping digital stories accessible, and sharing knowledge in ways that support community control and benefit. Long-term sustainability means more than short-term support. It requires ongoing investment in the people and processes that keep this work alive, with a real commitment to justice, healing, and collective wellbeing.

Recommendations for Sustained Community Engagement and Systemic Change

The following discussion provides recommendations for sustained community engagement and systemic change:

Supporting Community-Driven Research

Investing in initiatives that center the voices, knowledges, and lived experiences of communities marginalized by entrenched systems of oppression such as colonialism, patriarchy, and capitalism cannot be understated. Funding should support research that not only documents these impacts, but also challenges systems while uplifting community-led solutions. Funding should be directed toward research approaches that are co-created with communities, ensuring that findings are relevant, accessible, and actionable for those directly impacted.

Adoption of Intersectional Approaches

Adopting intersectional approaches requires policies and programs that respond to the complexity of peoples' identities, challenging practices that reduce individuals to a single story. The intersections of race, gender, class, sexuality, ability, age, and other social factors shape how individuals experience and navigate systems of oppression. An intersectional lens should always be applied in Community Psychology, as it helps uncover how power operates through these intersecting systems to privilege some while marginalizing others. Understanding these dynamics is crucial for addressing structural inequities, disrupting oppressive power structures, and promoting collective wellbeing across many communities.

Strengthening Collaborative Networks

A core element is establishing and maintaining partnerships between academic institutions, community organizations, and local leaders to build meaningful, reciprocal relationships that honour Indigenous, Black, and Afro-Indigenous knowledge systems. Collaborative, long-term relationships ensure that the work remains grounded in community realities while improving the reach and sustainability of initiatives. These

networks must be built on trust, mutual respect, and a commitment to shared goals rather than extractive practices. Community-engaged research requires ongoing dialogue, transparency, and relational accountability, knowing that the voices and priorities of community members guide the work. Strengthening these collaborative networks not only improves the relevance and impact of initiatives, but also contributes to dismantling hierarchical, colonial structures that have historically marginalized Indigenous, Black, and Afro-Indigenous communities. Through sustained partnerships, we co-create pathways toward justice, equity, and collective wellbeing.

Promoting Education and Awareness

It is essential to promote ongoing resistance to erasure and engage in intentional efforts to create learning spaces grounded in justice and relational care. This means integrating the histories, contributions, and experiences of Afro-Indigenous, Indigenous, and Black Peoples into public education, curriculum development, and reconciliation efforts. Purposefully, these histories are left out of mainstream narratives, reduced to footnotes, or framed through a colonial gaze that erases the depth of community contributions and experiences. To reiterate, these omissions are not incidental; they reflect a broader pattern of systemic erasure that disconnects the past from the present, leaving critical context out of discussions about identity, land, and power. As Mingo, Balthazar, and Olson (2021) argue, this reflects the Premise of Persistence – the assumption that colonial systems will continue unchecked, limiting the imagination of liberatory futures. Through community storytelling, we challenge that premise and assert Afro-Indigenous presence, resistance, and accountability.

WHAT WILL YOU CARRY FORWARD?

History does not exist in isolation – it directly shapes contemporary social, political, and cultural realities. The enduring impacts of colonialism, the slavery holocaust, violent Indigenous displacement, racist systemic exclusion, assimilation, genocides, and destruction of land continue to manifest in present-day inequities, making it imperative to teach these histories with accuracy, care, and relational accountability. When educational systems leave out the histories and experiences of Indigenous, Black, and Afro-Indigenous Peoples, they reinforce harmful stereotypes and keep systems of oppression in place. As students, learning these histories isn't just about gaining knowledge – it's about understanding why things are the way they are today, and how we can work toward transformative change. When stories from Indigenous, Black, and Afro-Indigenous Nations are part of the curriculum, we gain tools to think critically about justice, reconciliation, and community wellbeing. In this way, education can be a powerful form of resistance as a way to honour the past and shape a more just future.

This matters now more than ever.

As efforts to censor truth-telling, dismantle equity initiatives, and erase community-led research grow, it becomes even more urgent to protect and share stories that reflect lived experience and intergenerational knowledge. Proclaiming Our Roots offers one example of how community-engaged research, grounded in

relationship and accountability, can push back against erasure and affirm the presence, priorities, and power of Afro-Indigenous Peoples.

As students of Community Psychology, you are not just learning about these issues, you are joining a shared path of learning, reflection, and action. What you choose to listen to, question, carry forward, and act upon will shape not only your learning, but the futures we are all responsible for building. Carry the stories shared through Proclaiming Our Roots with care, because the relationality created through this work now calls on you to act with integrity, stay accountable to community, and honour the relationships that co-create and sustain knowledges. Let these stories move through you as you take up your responsibility to advocate for justice, healing, and collective care in the spaces you enter.

> *One of the most vital ways we sustain ourselves is by building communities of resistance, places we know we are not alone.*
> *~ bell hooks Yearning: Race, Gender, and Cultural Politics (2014)*

REFERENCES

Beals, A. M., & Wilson, C. L. (2020). Mixed-blood: Indigenous-Black identity in colonial Canada. AlterNative, 16(1), 29-37. https://doi.org/10.1177/1177180119890141

Bombay, A., Matheson, K., & Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. International Journal of Indigenous Health, 5, 6-47. https://doi.org/10.18357/IJIH53200912337

Etowa, J., Bernard, W. T., Oyinsan, B., & Clow, B. (2007). Participatory action research (PAR): An approach for improving Black women's health in rural and remote communities. Journal of Transcultural Nursing, 18(4), 349-357. https://doi.org/10.1177/1043659607305195

Fanon, F. (1963). The wretched of the earth. Grove Press.

Fiske, J. (1991). Colonization and the decline of women's status: The Tsimshian case. Feminist Studies, 17(3), 509-535. https://doi.org/10.2307/3178288

Freire, P. (1970). Pedagogy of the oppressed. Continuum.

Knudson, S. (2015). Integrating the self and the spirit: Strategies for aligning qualitative research teaching with Indigenous methods, methodologies, and epistemology. Forum: Qualitative Social Research, 16(3), 1-28.

Lawrence, B. (2004). 'Real' Indians and others: Mixed-blood urban Native Peoples and Indigenous nationhood. UBC Press.

Lethabo King, T. (2019). The Black Shoals: Offshore formations of Black and Native studies. Duke University Press.

Lezard, P., Prefontaine, Z., Cedarwall, D. M., Sparrow, C., Maracle, S., Beck, A., & McLeod, A. (2021). MMIWGSLGBTQQIA+ National Action Plan Final Report. 2SLGBTQQIA+ Sub-Working Group.

Manuelito, B. (2015). Creating space for an Indigenous approach to digital storytelling: "Living breath" of survivance within an Anishinaabe community in Northern Michigan. ProQuest Dissertations and Theses.

Menakem, R. (2017). My Grandmother's Hands: Racialized trauma and the pathway to mending our hearts and bodies. Central Recovery Press.

Mills-Proctor, D. (2010). Mixed-race identity and marginalization in Canada. Kola: International Journal of Afro-Asian Studies, 22(1), 44-137.

Mingo, E.D., Balthazar, C., & Olson, B. (2021). The premise of persistence: Deconstructing colonial authority in community psychology curricula and structures, toward liberative andragogy and practice. Global Journal of Community Psychology Practice, 12(3). https://doi.org/10.17161/gjcpp.v12i3.20637

MMIWG – National Inquiry into Missing and Murdered Indigenous Women and Girls. (2019). Reclaiming power and place. The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls. https://www.mmiwg-ffada.ca/

Truth and Reconciliation Commission of Canada. (2015). Honouring the truth, reconciling for the future summary of the Final Report of the Truth and Reconciliation Commission of Canada (IR4-7/2015E-PDF). Ottawa: Truth and Reconciliation Commission of Canada.

Vizenor, G. (1999). Manifest manners: Narratives on post Indian survivance. University of Nebraska Press.

PART III

Part Three: Evaluation Research



?QuestionPro refers to evaluation research, also known as program evaluation, as research purpose instead of a specific method. Evaluation research is the systematic assessment of the worth or merit of time, money, effort and resources spent in order to achieve a goal. Additionally, evaluation research is a type of applied research, and so it is intended to have some real-world effect. Many methods like surveys and experiments can be used to do evaluation research. The process of evaluation research consisting of data analysis and reporting is a rigorous, systematic process that involves collecting data about organizations, processes, projects, services, and/or resources. Evaluation research enhances knowledge and decision-making, and leads to practical applications.

The three case studies found in this section provide real-world evaluation research for you to see how community psychology practitioners conduct this work in community settings and subsequently determine the effects! In *Lessons from Conducting an Equity-Focused, Participatory Needs Assessment,* Brown et al. describe their process of engaging in community-based collaborative work with the LGBTQIA community in North Texas with a partnership that consisted of a full-time community psychology practitioner, an academic partner, and other stakeholders.

Program Evaluation: A Fundamental Component in Effective Community Practice contributed by Dr. Patricia O'Connor, expands the traditional single-case study format to include multiple mini-case studies from which "lessons learned" are highlighted through evaluation-based practice of community psychology (CP). In this study, CP practitioners and relevant stakeholders who work together to design and implement needed community-based programs.

Our third case story, *Showing up and Standing with: An Intersectional Approach to a Participatory Evaluation*

of a Housing First Program on O'ahu, contributed by Dr. Anna Pruitt takes us to the lovely O'ahu and captures the work conducted in an ongoing five-year participatory evaluation partnership between Housing First program participants, staff, and community psychologist evaluators in the multicultural context of the Island of O'ahu in Hawai'i. Using an intersectional lens (Crenshaw, 1989; Weber, 2009), this case study explores the challenges and successes of building this partnership among individuals from diverse racial and ethnic backgrounds with varying degrees of power, housing experiences, and mental and physical health issues.

8

Lessons from Conducting an Equity-Focused, Participatory Needs Assessment

KYRAH K. BROWN, PHD, SUSAN M. WOLFE, PHD, JUSTIN M. HENRY, MPH, CLAUDY JEAN PIERRE, BSPH, TAMAYA BAILEY, MSW, AND JERRISE SMITH

This case story focuses on the authors' work to conduct a comprehensive Ryan White HIV/AIDS needs assessment in North Texas. We highlight three key issues from a community psychology perspective.

THE BIG PICTURE



Image is a "word cloud" or collage with words such as identity, approaches, assessment structural, buy-in, and more.

In the United States, an estimated 1.2 million people are living with the human immunodeficiency virus (HIV). Men who have sex with men (MSM) and bisexual men of color, African American heterosexual women, and Latina heterosexual women continue to be disproportionately impacted by HIV. For thirty years, service organizations funded by the Ryan White HIV/AIDS program have been mandated to conduct comprehensive needs assessments every three years to help planning councils develop and implement strategies to improve access, reduce barriers, and enhance service delivery and satisfaction. This case story focuses on the authors' work to conduct a comprehensive Ryan White HIV/AIDS needs assessment in North Texas. We highlight three key issues from a community psychology perspective.

First, in most cases, previous needs assessments have consistently demonstrated needs and barriers influenced by structural or political forces; yet the service landscape largely focuses on first-order strategies whereby individual behaviors, knowledge and attitudes are the target of programs and services.

Second, consultants leading previous needs assessments in this community have rarely used participatory

approaches which are known to enhance buy-in, trust, and participation, especially among people living with HIV who are further marginalized based on race/ethnicity and/or gender identity.

Third, previous needs assessments have failed to incorporate an equity perspective that includes the impact of sexism, homophobia, racism, and intersectionality on prevention and intervention.

About the Community or Big Picture Concerns

In the United States (U.S), an estimated 1.2 million people are living with the human immunodeficiency virus (HIV). Although overall HIV rates have declined in the U.S., persistent disparities exist based on race/ethnicity, gender and gender identity, and sexual orientation. Black heterosexual women, transgender women of color, and others continue to be disproportionately impacted by HIV. For example, although Black people make up 13% of the U.S. population, 43% of U.S. adults living with HIV are Black and 42% of new HIV diagnoses are Black people. An estimated 14% of transgender women in the US are estimated to be living with HIV, for Black transgender women, the figure is 44% (Lancet, 2020).

Disparities persist within the HIV care system as well. For example, in the Dallas metropolitan area, 79% of people living with HIV were linked to care after diagnosis in 2018 (Wolfe & Brown, 2020). When disaggregated, fewer Black (76.3%) and Hispanic people (77.8%) were linked to care after diagnosis compared to White people (83.1%). In 2018, 72.9% of people living with HIV were retained in care, but lower retention rates were observed among Black people (68%), youth and young people (ages 13-24; 24-34), and people whose mode of transmission was intravenous drug use (67%). Retention in care is associated with viral suppression (i.e., the amount of HIV in the blood was at a very low level) and is an important determinant of health. Overall, 64% of people living with HIV in the Dallas metropolitan area were virally suppressed in 2018. Black (57%) and Hispanic (64%) were less likely to have viral suppression than White people (72%). Also, compared to men who have sex with men (66%), viral suppression was relatively lower among people whose mode of transmission was intravenous drug use (56%). Youth ages 13-24 (51%) and young adults ages 25-34 (57%) also had lower viral suppression compared to older adults and the overall population (Wolfe & Brown, 2020). Much of these disparities are attributable to system-wide inequities in access to health and behavioral health care (as well as gender-affirming care), housing stability, and economic stability (Lancet, 2020).



Image above medication bottom and pills and the words PrEP for HIV protection

In this work, it is important to recognize that systems of oppression (i.e., racism, classism, transphobia, homophobia) operate in a mutually reinforcing manner to produce inequities in HIV risk, testing, infection, and mortality (McGibbon, 2012; Ford, 2017; Gee & Ford, 2011; Wilson et al., 2016). Structural racism is a system of oppression and is a key driver of persistent poverty or pay inequity, unequal educational attainment, mass incarceration, residential segregation, and housing instability. In the U.S., Black people are less likely to be prescribed pre-exposure prophylaxis (PrEP), less likely to have access to healthcare, and underrepresented in clinical trials. Additionally, healthcare providers are less likely to discuss PrEP with Black patients. In addition, income inequality and socioeconomic deprivation are two key socioeconomic drivers for HIV diagnosis and transmission. The authors of a study (Ransome et al., 2016) found that income inequality and socioeconomic deprivation were associated with higher rates of late HIV diagnosis in unadjusted models. Black racial concentration robustly predicted late HIV diagnosis. Black residential segregation was positively correlated with HIV incidence. The white racial composition was among neighborhoods across quadrants of low-high inequality and HIV, neighborhoods with above 50% black racial concentration were in low inequity-high.

From a societal perspective, people living with HIV systematically experience disparate health and healthcare outcomes depending on their proximity to oppression and privilege (McGibbon, 2012). For example, in the U.S., Black men who have sex with men (MSM) are closer in proximity to systems of oppression based on race compared to white MSM; with white MSM systematically experience better health and health outcomes. Community psychologists have interrogated these systems by examining the historical narratives behind the HIV movement and the crediting of white gay men as the victors of the social and political response to the HIV epidemic (Wilson et al., 2016). Consequently, such narratives fail to acknowledge the diverse and intersectional identities (and experiences) of people living with HIV; and thus, these groups are further marginalized.

For thirty years, service organizations funded by the Ryan White HIV/AIDS program have been mandated to conduct comprehensive needs assessments every three years to help planning councils develop and implement strategies to improve access, reduce barriers, and enhance service delivery and satisfaction. Eligibility for Ryan White HIV/AIDS Program funding is based in part on the number of confirmed HIV/AIDS cases within a specified metropolitan area, which is characterized by a central urban area surrounded by other urban areas that work together economically or socially. The Dallas eligible metropolitan area includes eight counties with the city of Dallas representing the largest population of people living with diagnosed HIV infection.

The findings from a comprehensive needs assessment also helped to identify and address persistent health disparities in the population. In fact, the Ryan White HIV/AIDS program emphasizes the importance of

focusing on high-priority populations, such as Black MSM, heterosexual Black women, and transgender men and women, in the needs assessments.

The needs assessment we describe in this chapter includes a seven-county area, although the largest share of people living with HIV/AIDS (PLWHA) in North Texas reside in only one of the seven counties (Dallas County). This is likely attributable to resource allocation, whereby most of the services and specialized health care are in the City of Dallas, with little or no HIV/AIDS specific services available in the outlying, rural counties. In fact, in 2018, 81% of people living with HIV resided in Dallas County (Wolfe & Brown, 2020). Further, the Pew Research Center found increasing income and racial segregation over the past three decades in the Dallas Metro Area, with most low income, predominantly non-white households located in the southern part of the city of Dallas, particularly south of Interstate 30. Most of the health care and other services for PLWHA are located north of Interstate 30.



https://texasalmanac.com/topics/government/dallas-county – Image shows communities around the Dallas, Texas area.

Background of How We Came to Work with this Community Partner

Prior to receiving the contract to conduct the needs assessment, the community consultant (SMW) and academic partner (KKB), both trained community psychologists, had a history of strong relationships with organizations throughout the Dallas metropolitan area. In particular, the community consultant's company is a woman-owned firm located in the Dallas metropolitan area. For over 10 years, her firm has partnered with organizations and foundations in the area to build their capacity for evaluation, program development, and coalition building. In addition to having conducted resource and needs assessments in other communities, the community consultant had a history working with Dallas County HHS and the Dallas County public hospital system.

In early 2019, Ryan White HIV/AIDS Program (RWHAP) issued a request for proposals (RFP) for their 2019 Comprehensive HIV/AIDS Needs Assessment. After the initial deadline passed with no proposal submissions, the community consultant was informed by a community colleague that the RFP deadline was extended and encouraged her to submit a proposal. The community consultant invited an academic partner (also trained in community psychology) at a local university (KKB) to collaborate and form the evaluation team.

The evaluation team consisted of the:

- community consultant as the lead,

- the academic partner,
- three student assistants (TB, JS, & CJP) who worked as paid project assistants, and
- over 15 trained undergraduate and graduate public health students who assisted with needs assessment data collection and data entry.

Evaluation Team and Positionality

The **consultant** (SMW) is a white, cisgender, heterosexual woman from a blue-collar, working-class background with a PhD. She has over 35 years of experience working with programs and systems change initiatives that are addressing health, education, and other racial and ethnic disparities. She explicitly recognizes her positionality and privilege as she engages in this work.

The **academic partner** (KKB) is a Black, cisgender, heterosexual woman from a middle-class background. She has a PhD and over 10 years of experience working in diverse community and organizational settings as well as academic expertise in health equity, racial and ethnic health disparities, and women's health.

TB is a cis gender, heterosexual Black woman from a lower middle-class background. She has a Master's in Social Work with a concentration in Mental Health and Substance Abuse. Her background includes research surrounding maternal child health and postpartum depression. She also has experience in community health and mental health working with individuals living with HIV/AIDS. She previously served for seven years in the United States Air Force.

JS is a Black, heterosexual woman from a working-class background. She is an Air Force Veteran with eight years of exemplary service. Her experience includes qualitative research in maternal and infant health, food deserts, PTSD in low-income communities, and drug and alcohol abuse among veterans that received a dishonorable discharge.

CJP is a Black, cisgender, heterosexual man from a middle-class background. He has a Bachelor of Science in Public Health and is currently pursuing his Master's degree in Public Health. He has experience working with different populations including women's health and people living with HIV/AIDS. He also works internationally to help women in Haiti to engage in healthy behavior to prevent pregnancy complications.

Collaborative Partners and Our Approach to this Work

Dallas County Health and Human Services (DCHHS) Ryan White HIV/AIDS Program and the Ryan White Planning Council (RWPC) commissioned this needs assessment project. Therefore, our evaluation team worked closely with RWPC as its primary collaborative partner, which is a community group consisting of 33 people living with HIV (PLWH), an HIV service provider representative, and other community members. Our evaluation team also worked closely with the RWPC Health Planner (JMH) who shares responsibility with the RWPC to oversee the planning and implementation of the needs assessment. The RWPC's mission is to optimize the health and well-being of people living with HIV/AIDS through coordination, evaluation, and continuous planning to improve the North Texas regional system of medical, supportive, and prevention services. Our evaluation team met on a bi-weekly basis with the RWPC Health Planner and on a routine basis with the RWPC committee members based on their existing meeting schedule. Although not directly involved in the planning, there were also more than 60 individuals (many

of whom were PLWH) and HIV health and service organizations in the care continuum who assisted with implementation in many ways including scheduling of data collection activities, serving as points-of-contact for data collection activities, and sharing information about the needs assessment.

Through initial discussions, our evaluation team and the RWPC determined that a participatory evaluation approach, guided by the evaluation team, was most appropriate for this project. A participatory evaluation approach ensures that community partners are involved in a collaborative and meaningful way throughout every phase of the needs assessment. Our evaluation team did discuss the importance of an empowerment approach whereby community members and RWPC members could be trained and take ownership of needs assessment activities. However, the final decision for a participatory approach was made because the amount of time to complete the project was shortened due to system delays, the implications of not meeting the timeline (e.g., loss of federal funding), the RWPC's desire to be engaged in the planning and implementation in such a way that did not exceed their own capacity, and the fact that our evaluation team was hired to ensure the completion of the work as contracted. The RWPC was empowered in that they had the authority to fire us at any time during the process if we did not provide what they needed, and they had oversight authority for our work as well. We discuss the nature of this participatory approach later in this case study (also see Table 2).



https://www.cdc.gov/socialdeterminants/index.htm (Image shows diverse families with respect to ethnicity sitting in a park)

During the process of gathering background information in preparation for this collaborative work, our evaluation team reviewed the comprehensive HIV/AIDS needs assessment reports from the previous cycle (Dallas County Department of Health and Human Services, 2017). We identified three key shortcomings from a community psychology perspective and tailored our approach to addressing them.

First, the prior needs assessment failed to incorporate a health equity perspective, which involves understanding and acting on the relationships between social determinants of health, health inequities, and health disparities (or population-based differences in health outcomes). Health equity requires a justice orientation and commitment to addressing avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities. Community health needs assessments that lack a health equity perspective can unintentionally increase inequities (which result in greater disparities). Community health needs assessments are used to guide community action; and when the factors that drive inequities are

left unacknowledged, this can inadvertently lead to them being unaddressed. Consequently, our evaluation team applied a health equity lens by:

1. supporting honest dialogue with collaborative partners about the community's history and systems of oppression that marginalize various groups of people living with HIV,
2. engaging in informal conversations with marginalized consumers (e.g., Transpeople of color, heterosexual women) to ensure that their voices were included across multiple data sources and the final report, and
3. continuously framing the needs assessment within a health equity lens when engaging in conversations with providers and HIV service organizations.

Second, the prior needs assessment failed to frame the identified community assets and needs from an intersectional perspective. An intersectionality perspective holds that people's social and political identities (and the socially constructed meanings tied to those identities) interact to create contextualized experiences of oppression and privilege. This perspective holds that people's intersectional experience is "greater than the sum" of racism, sexism, classism, and other forms of oppression (Crenshaw, 1989). Accordingly, our evaluation team was committed to preparing a report and community presentation that explicitly considered how the lived experiences of people living with HIV is shaped by their proximity to oppression and privilege along the lines of health status, (dis)ability, gender identity, and expression, race, class, sexuality, language and so on. We used the available data to identify and report the varying needs of sub-populations of people living with HIV and provided tailored recommendations for these groups.

For example, we made sure to triangulate focus group data and consumer survey data to create an infographic of perceived assets and needs among the following priority sub-populations:

- Black men who have sex with men,
- cisgender heterosexual Black women,
- Latina/o/x people,
- Transgender people,
- youth and millennials,
- senior adults, and
- rural residents.

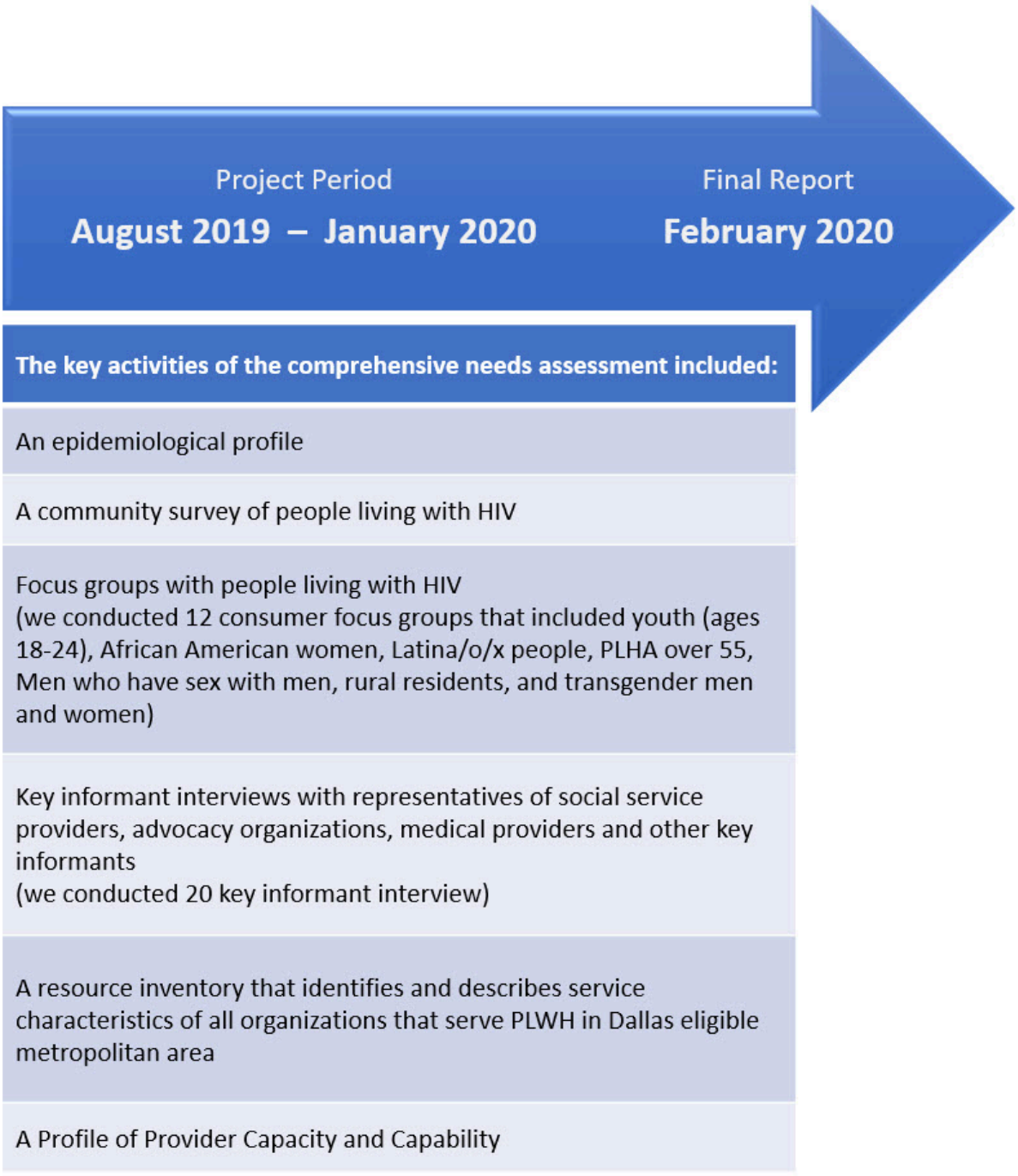
This approach was appreciated because early on in the process, we were informed by heterosexual Black women as well as Transgender women and advocates about concerns related to being unheard and overlooked in broader HIV prevention efforts.

Third, the prior needs assessment did document service needs and barriers shaped by structural and political factors. However, the discussion of these factors was perfunctory and recommendations focused heavily

on first-order rather than second-order changes. There was also no mention of structural oppression and its contribution to the disparities identified across populations. This is problematic because improvements in HIV prevention and treatment cannot be accomplished by focusing exclusively on the individual level (i.e., providers and consumers). There is a need for more enduring solutions situated in systems and policy. The social-ecological perspective recognizes individuals as embedded within larger social contexts and considers the complex interplay of individual, interpersonal, community, institutional, and societal factors (Bronfenbrenner, 1979; Lewin, 1936; Kelly, 1966). Accordingly, our team applied this perspective to frame the community assets and needs from the needs assessment. This was important because, in the HIV/AIDS health and social service system, the biomedical model of illness remains a predominant paradigm that often reinforces victim-blaming and fails to consider how institutions and systems shape health risk and health behaviors. It was important to our team to apply a social-ecological perspective to help us place more emphasis on the policies and systems beyond the individual that impact people living with HIV. Therefore, during the data analysis and reporting phase, we organized the results regarding assets and needs into three multi-level categories: individual/interpersonal level, socio-economic level, and systems and structural level. We also made sure that our recommendations were organized in this matter to assist the community partners with system-wide action planning.

Description of Project

At the beginning of August 2019, our evaluation team was awarded the contract to conduct the comprehensive HIV/AIDS Needs Assessment. The project period was August 2019 to January 2020 with the final report due in early February 2020. The image below highlights the report:



The figure above gives title captions for the project, the date of the final report and includes a list of key activities: an epidemiological profile, community survey of people living with HIV, focus group quantitative data, number of key informative interviews, a resource inventory, and a profile of provider capacity and capability.

Based on the scope of work, the project period for the comprehensive needs assessment needed to be at least 15 months. Our evaluation team communicated initial concerns about the timeline and the limitations of completing this amount of work within such a tight timeline. Under different circumstances, we would recommend re-scoping the work; however, our team agreed to take the project on because (1) the RWPC had prior experience and competence in planning and implementing a comprehensive needs assessment,

(2) our evaluation team had the human and material resources needed to accomplish the task, and (3) our participatory approach allowed for diffusion of some planning and implementation activities needed to get the work done.

Initial Planning Phase

Our first step was to convene the RWPC and other community partners to define roles for the project. During the planning phase of the HIV/AIDS needs assessment, we met with the RWPC, our primary collaborative partners, to identify their needs and assets. Our meetings focused on discussing the following questions: What did you dislike about the product or process of the last needs assessments? What does a successful needs assessment look like? How do you hope to be able to use the information from this needs assessment? What human, technical, or financial resources do you currently have that may help contribute to the success of the needs assessment? What additional human, technical, or financial resources are needed to make this needs assessment successful?

Our biggest surprise during this process was when we learned that the prior consultants, who were located in another state, had relied upon the RWPC and service providers to collect all of the needs assessment data. This included scheduling data collection activities, administering surveys at local sites, conducting the focus groups at sites, manually entering data from paper surveys. This process was problematic because it placed an undue burden on the community partners, which took away time from service and care provision. As we discussed assets and needs amongst ourselves, our evaluation team assured the community partners that our team would handle the 'heavy lifting' with these activities while emphasizing that they could be as involved in the process to the extent that they were able.

Based on discussions around these questions, our evaluation team was able to identify pertinent information about partners' perceived assets and needs which would help inform the planning and implementation of the needs assessment (see Table 1). The benefit of identifying assets and needs among community partners before the start of the needs assessment was that everyone on the team understood the strength that they brought to the team and was clear about what role they had on the project. After these initial discussions, our team drafted a document that outlined each partner's role on the project (see Table 1).

Table 1. Community Partner Assets and Needs

Assets	Needs
✓ The Ryan White program had a community advisory board which consisted of community members living with HIV/AIDS ✓ Ryan White program staff and community advisory board members had strong relationships within the community and among people who were out of care (not receiving HIV/AIDs care or services) ✓ Ryan White program staff and other partners had existing relationships with health and social service system provider sites where data collection could occur ✓ The Ryan White program had staff available who could support the coordination of site visits for data collection ✓ The Ryan White program had a budget and tracking system available for the discernment of gift cards for participants	The Ryan White program and stakeholders expressed a need for data collection software and analysis tools The Ryan White program and stakeholders expressed a need for technical expertise in data collection sampling and analysis The Ryan White program and stakeholders expressed a need for a needs assessment report that could be used to inform action by stakeholders

The image above is a two-column table comparing the assets (on left) and needs (on right) of the Ryan White Program. Five assets were identified and three needs.

Our community partners, the RWPC and the RWPC Health Planner had prior experience with planning and implementing needs assessments. They developed the survey questions and the focus group questions. Our team worked collaboratively with them to make modifications to the length, added skip-logic instructions, created an online version of the survey, and provided a Spanish version of the instruments and flyers. All final changes to the data collection tool and recruitment material were reviewed and approved by the collaborative partners before data collection started. The implementation of the needs assessment was characterized by our evaluation team and the community partners completing activities in a complementary manner (e.g., RWPC would help schedule and recruit people for focus groups; RWPC partners would provide trusted interpreters for data collection activities) and a collaborative manner (e.g., both RWPC partners and members of our evaluation team would set up at local sites to recruit for surveys or to conduct focus groups). Although the evaluation team took the lead on data analysis and preparing the report, the RWPC was involved via progress meetings to review the information and provide feedback along the way. Table 2 below provides a breakdown of the roles and responsibilities each of the partners played.

Table 2. Approach to Key Needs Assessment Activities

Key Activities	RWPC Partners	Our Evaluation Team
Bi-Weekly Meetings and Updates	✔	✔
Develop data collection tools (survey, key informant, focus group questions) and materials	✔	✔
Develop the Epidemiological Profile and Resource Inventory**		✔
Conduct key informant interviews		✔
Disseminate information about needs assessment (e.g., sharing flyers, word-of-mouth, social media posting	✔	✔
Coordinate incentive distribution (gift cards)	✔	
Scheduling and Making On-Site Visits for Data Collection	✔	✔
Data entry and management		✔
Data cleaning and analysis		✔
Report and presentation preparation (including provision of ongoing feedback)	✔	✔

Note: **There were partners who assisted with providing information needed to complete this task.

The table above shows a logic model which identifies the key activities in first column with the second and third models showing the responsible party with a checkmark for achieving the key activities.

During this comprehensive needs assessment, we sought to understand the diverse perspectives within the communities of people living with HIV by working closely with the local Ryan White planning council whose members included consumers. With any needs assessment, prior to starting data collection, it is important to ensure everyone shares common definitions of key terms. In this instance, we needed a clear definition and conceptualization of what we meant by "assets" and "needs."

Defining and Conceptualizing Assets and Needs

The field of community psychology emphasizes the importance of adopting an asset-based perspective, which means building on existing skills or resources rather than fixating on community deficits. Accordingly, we were intentional about balancing the discussion of community assets and needs in the HIV/AIDS needs assessment. To ensure a comprehensive understanding of need, our team incorporated Bradshaw's taxonomy of need [13]. According to this taxonomy, need may be defined based on (1) the

extent to which groups within a community meet a standard of health that has been established by experts (normative need), (2) the extent to which one group experiences a greater health burden compared to another group within a community (comparative need), (3) the extent to which groups within a community use (or do not use) available services or programs (expressed need), and (4) the explicit input from groups in the community who have a related lived experience (perceived need). For the HIV/AIDS needs assessment, our team collected a variety of primary and secondary data sources to capture the community assets and needs (see Table 3).

Table 3. Data Sources and Strategies

Data Source	Strategy
Assets/Strengths	Our team conducted a survey of Ryan White funded and non-Ryan White funded organizations to identify the scope of available services and capacity. We also conducted key informant interviews with Ryan White funded providers to gather additional information.
Normative Need	Our team used epidemiologic data collected from the department of state health services, the U.S. Census Bureau, the Centers for Disease Control and Prevention, and other official data sources to identify trends in HIV infection and mortality, and other health status indicators.
Comparative Need	Our team used epidemiologic and demographic data collected from the Texas Department of State Health Services, the U.S. Census Bureau, the Centers for Disease Control and Prevention, and other official data sources to identify disparities in HIV infection, mortality, modes of transmission, and other health status indicators. Our team conducted focus groups to gather additional information about groups that experienced a greater health burden compared to other groups within the community.
Expressed Need	Our team used epidemiologic and demographic data collected from the department of state health services to examine trends related to the number of people living with HIV/AIDS who were linked to care after diagnosis and were retained in medical care. Our team used survey data collected to understand what services consumers reported using.
Perceived Need	Our team used survey data collected from HIV/AIDS service providers to identify provider-reported needs such as barriers to successful linkages to care, and prevention challenges. Our team used targeted focus groups and survey data collected from people living with HIV to service utilization patterns, perceptions of most important services.

The table above shows the Data Source such as assets and strengths of the program, with a corresponding strategic detail of how the project was carried out from conducting surveys to using focus groups.

Conducting a Consumer Survey

The consumer survey was designed to collect information about socio-demographics, health history, medical

care, health behaviors, intimate relationships, use of prevention and intervention services, and barriers to services. A cover sheet explained the purpose of the survey, risks and benefits, planned data uses, and consent.

We calculated the sample size based on the current total HIV prevalence for the Dallas Eligible Metropolitan Area (2018), with a 95% confidence interval at a 5% margin of error. Eligibility criteria included individuals who were age 18 years or older, live in one of the Dallas EMA/HSDA counties, were diagnosed with HIV and/or AIDS, and have not already completed the survey. Efforts were taken to over-sample in rural locations, youth (via social media), and those out-of-care. However, the two-month timeframe for data collection presented a key challenge.

We administered consumer surveys at pre-scheduled sessions at Ryan White HIV/AIDS Program provider sites, housing facilities, and specific community locations and organizations. Staff contacts at each location were responsible for session promotion and participant recruitment. Out-of-care consumers were recruited through flyers, word-of-mouth, social media, and staff promotion. Surveys were self-administered in English and Spanish, with staff and interns available for verbal interviewing for individuals who needed assistance. There were also bilingual staff and/or interns who provided verbal interviewing when needed. Members of the evaluation team and RWPC administered surveys asked each survey participant if they would prefer to have the questions read to them or to complete the survey on their own. This ensured that individuals with literacy challenges or visual impairments would be able to participate without having to disclose their disabilities. In fact, during data collection, there were many instances of our teams assisting consumers with their surveys in this manner. Our evaluation team consisted of individuals who were fluent in English, Spanish, and French, and French-Creole. Participation was voluntary, anonymous, and monetarily incentivized ($15); and respondents were advised of these conditions verbally and in writing. Most surveys were completed in 20 to 30 minutes. Surveys were received on-site by trained staff, interns, and the evaluation team for completion and translation of written comments. Completed surveys were logged into a centralized survey database. Online survey participants were provided with an auto-generated unique code at the end of the completed survey. Participants were instructed to contact the Ryan White Planning Council Health Planner to provide the code and arrange a time to retrieve their gift cards.

In total, 421 consumer surveys were collected from December 2019 to January 2020 during 10 sessions at six survey sites (including one rural location and one housing facility). The final sample size was 392 after eliminating ineligible cases.

A major limitation was that we used a convenience sampling strategy, rather than random sampling, for this portion of the needs assessment. As a result, the majority of the sample represents PLWHA in urban settings (Dallas County) and in care receiving Ryan White Program services. This sample is less representative of youth (18 to 24-year-olds), transgender women and men, heterosexual women, individuals experiencing homelessness, and individuals living in rural settings. A longer project timeline would have allowed the team

to overcome these challenges. For example, our team had on-site visits in several rural communities where we would spend several hours set up to recruit individuals. But, those facilities had so few walk-in consumers that more visits would have been needed to recruit enough people from those communities.

Creating an Inventory of HIV Service Providers and Assessing Service Capacity

To conduct the inventory of HIV service providers, the evaluation team trained a group of five graduate public health students to generate a resource inventory of agencies serving people living with HIV and/or AIDS without Ryan White HIV/AIDS Program funding. These students were required to engage in this project for their graduate course and were able to fulfill their course requirements by completing this project. Using the resource inventory template, students performed internet searches and made phone calls to organizations to verify key information. The student team used a snowball sampling technique to identify additional organizations.

There were **four** key challenges during data collection: (1) two organizations with websites that contained incomplete information, (2) difficulty identifying and contacting personnel at five organizations, (3) two organizations had websites that were out of date, and (4) two organizations on the original list were no longer in business. The image below highlights these challenges.



Highlighted in the figure above are four challenges that surfaced during project implementation.

The Ryan White Planning Council Health Planner provided the evaluation team with a list of nine organizations funded by the Ryan White HIV/AIDS Program along with contact information. The Ryan White HIV Service Provider Capacity Survey was administered to these nine organizations. Eight of the nine organizations (88%) completed the survey. Once data collection was complete, services information from the non-Ryan White funded organizations was combined with services information obtained from the provider capacity survey.

The evaluation team experienced some challenges with obtaining responses from providers. It is possible that the nature of some of the questions (e.g., number of unduplicated clients served by service type) posed a challenge for respondents which delayed survey completion. Additionally, it is possible that some providers interpreted certain questions differently than others. For the next administration of the survey, the evaluation team will address survey question specificity and clarity. Also, the evaluation team used the provider capacity survey from previous years. This version of the survey does not capture detailed information about service capacity. Therefore, steps will be taken to ensure that the survey is designed to address this topic.

Key Informant Surveys

The Key Informant Surveys were conducted by the community consultant. The RWPC provided the community consultant with a list of organizations, contact names, and contact information for individuals who play a key role in the development and provision of services to PLWHA in the Dallas EMA. Organizations represented housing services, health care services, mental health services, children's health services, consumers, policy and advocacy services, transgender services, and other service providers serving PLWHA in the Dallas EMA. Nineteen respondents served Dallas County and one respondent served a rural area.

Email invitations were sent to individuals from 27 different organizations requesting their participation. Recipients were asked to click on a link to Sign-Up Genius to select a date and time slot to schedule their interview. Follow-up invitations were sent to non-respondents after the sign-up deadline passed. Twenty-three individuals responded and signed up to be interviewed. One individual was unable to participate at her designated time due to an unforeseen event; one had to cancel because of a conflict and did not reschedule, and another did not show at the scheduled time. The final number of interviews was 20 key informants.

The interview was conducted using a semi-structured interview protocol via Zoom conferencing technology on the computer or telephone. All Key Informants agreed to have their interviews recorded. Interviews averaged one hour. Three interviewees were unable to complete the entire interview because of scheduling conflicts or other time limitations.

We also prepared the focus group and key informant interview protocols using questions that were developed by the RWPC. Our goal was to ensure that we answered the questions they needed to be answered and obtained the information they needed for planning.

Consumer Focus Groups

We conducted 12 in-depth focus groups with various groups including transgender individuals, youth (18-24), Black heterosexual women, aging MSM, MSM of color, and Latina/o/x people to gain an understanding of their experiences and worldviews. A major gap in previous work has been a lack of participatory approaches, insufficient attention to African American and Latina heterosexual women and transgender individuals. For example, there are strong sentiments among African American women against being categorized as "women of color". Also, transgender individuals, especially transgender people of color, can be especially marginalized within the LGBTQIA+ community. Our partners provided an interpreter for the groups with Latina/o/x people since many spoke Spanish as their first or primary language. At the time this needs assessment was conducted, a number of Black transgender women had been murdered in this community, and therefore safety was a concern. Our team honored the need expressed by the Black transgender community to protect itself from the threats of structural violence and accepted that we would not be able to recruit many Black transgender women for focus groups. Although not a planned data collection strategy, our team did have informal conversations with some transgender women of color and advocates for the transgender community informally in an effort to capture their voices in this process. This

reality illustrates how systems of oppression shape marginalized communities' feelings of safety and ability to share their voices on matters that directly impact them.

To demonstrate respect for this community we were careful about language and dynamics within the community of PLWHA. We made sure to listen carefully to program staff and consumers about the language and focus that they desired for this needs assessment. Most importantly, we did not go in using our Dr. titles, nor did we position ourselves as "experts." We conducted focus groups at sites chosen by the group and at times that were most convenient for them, mostly during the evenings. Our partners provided snacks or meals (depending on the timing and the group) and we stayed to socialize when the group invited us.

Five of the focus groups were conducted by the Care Coordination Ad Hoc Committee or a researcher from the local public hospital system before the consultants were retained and the remaining seven focus groups were conducted by our team. All focus groups used a standard, semi-structured protocol. Eleven of the 12 focus groups were recorded. Participants were asked if they consented to record and one participant in one group asked that the focus group not be recorded. Participants were asked to sign an informed consent form and each participant received a gift card as compensation for their time and input. All focus groups were arranged by the RWPC in collaboration with service providers.

As mentioned earlier, one of the focus groups consisted of transgender men and women. The team member who facilitated the group was a heterosexual, white woman in her 60's. The facilitator built trust and comfort in several ways.

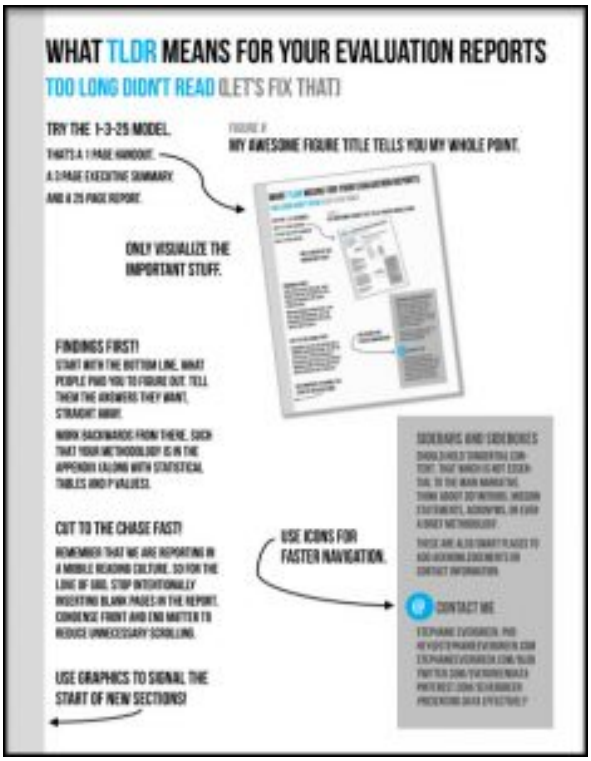
First, the group was arranged by a trusted health care provider in a space that was familiar to the group.

Second, the facilitator arrived early which offered an opportunity to engage in casual conversations with participants who arrived early. One was a transgender woman of a similar age, well-known and respected within the community, who had been an activist for the transgender community for many years. The facilitator enjoyed an opportunity to hear of the history of activism and the methods that had been employed, in addition to the rich stories that were shared. By the time the remaining three participants arrived, she had built rapport and trust with this key individual.

Third, the facilitator had many years of experience conducting such groups and interviewing individuals that were different than herself. She has developed the ability to listen carefully and a level of comfort with difficult conversations.

When the focus group was completed, she shared a meal with the participants and continued with more casual and social conversations about topics such as hobbies, jobs, and food.

Outcomes or Impact



Despite the challenges encountered during this needs assessment, we were able to successfully complete it on time. In alignment with our focus on health equity, we wanted to ensure that the needs assessment results were presented in a manner that was equitable so that anyone from the general community could consume the information. We accomplished this by delivering a user-focused needs assessment report that was informed by design best practices. During early conversations, our collaborative partners expressed their desire for a report that was easy to understand and navigate; and one that could be used to effectively inform action. Our team studied prior HIV/AIDS needs assessments completed by different consultants and reviewed examples from other communities. Our team initially planned to apply Stephanie Evergreen's 1-3-25 reporting model wherein reports consist of a one-page handout, a three-page executive summary, a 25-page report, and appendices that include more detailed information (i.e., description of the methodology, larger tables, and figures, etc.). While our team was unable to limit the report to 25-pages, we did limit it to 80 pages (162 pages including references and appendices). This was in stark contrast to prior needs assessments which had page counts that ranged from 300 to 400 pages in total.

We also divided the 80 pages into sections using additional design principles to facilitate easier reading and navigation. For example, we color coded sections so that headings, icons, and graphs within each section were the same color. We minimized text to the extent possible and used visual representations such as infographics and graphs wherever possible. We de-cluttered graphs as much as possible so results from quantitative data were easily digested. We also used data visualization design principles to create and present a presentation to community members. We created a presentation that showed easily interpreted graphs and key findings.

Finally, a student member of our team was producing Infographics to share with community members, but this work was disrupted when the student contracted COVID-19 and her recovery period went beyond the time period for this project. However, as of January 2021, our team is working to complete the infographics in collaboration with the RWPC partners.

The COVID-19 pandemic significantly disrupted action planning and community engagement activities based on the needs assessment. At this point, we are not able to necessarily assess the longer-term impact of the needs assessment. However, as of March 2021, the RWPC is preparing to engage in data-driven action planning using the data and recommendations provided in the needs assessment report. Also, our team

has maintained a relationship with the RWPC partners through ongoing communication, and hopefully, partnership in future needs assessment cycles.

The key findings and conclusions presented in this needs assessment were written to guide solutions targeting structural change and to address disparities at a systemic level. We described needs in a way that put the onus on the health care and service providers to make changes to improve access and availability, as well as to decrease stigma within healthcare systems and communities and to reduce other systemic barriers. We avoided describing our findings in ways that would suggest individual-focused interventions such as educating the PLWHA or changing their behaviors in some ways.

In terms of intermediate impacts, the needs assessment was effective to identify key findings that will help to guide further system-wide action planning. More information about the needs assessment is publicly available (Wolfe & Brown, 2020), we will share that the needs assessment did reveal the following key findings:

Key Findings

While HIV/AIDS rates were declining in the *larger Dallas eligible metropolitan area*, the following are rates of new diagnosis.

Living with HIV

Black people

OVER

5x

White people

Youth (ages 13 to 24)
Young people (ages 25-34)

HIGHER

vs

Other age groups

11%

Live at or below federal poverty level

72%

Living with HIV use Ryan White services live at or below federal poverty level

The most common mode of transmission was through men who have sex with men, followed by heterosexual sex, and with intravenous transmission remaining steady. In sum, the needs assessment data **highlighted racial, economic, age, and other disparities**.



There was a lack of data available on how many HIV-positive transgender individuals were living in the community, whether they were aware or using Ryan White services, and whether those services met their needs. Based on focus groups with transgender individuals, there were barriers related to a lack of data fields to document transgender individuals as well as limited providers that provide preventive and specialized care specifically for transgender individuals.

Identified Consumer-reported Barriers

- Stigma
- System-level issues (more likely to report):
  - amount of time it takes to get linked to care
  - paperwork burden
  - appointment wait times
  - lack of flexible hours
  - lack of clinic options with holistic care approaches (rather than treating only HIV)
  - lack of staff with cultural or linguistic competency, and geographic barriers related to transportation (urban and rural areas)
  - scarcity of services in suburban and rural areas
- Consumers also reported having higher order needs such as housing instability, unresolved trauma (mental health service needs) and transportation.

Identified Care Retention Efforts

Needed to be tailored for:

- Black people living with HIV
- Youth and millennials
- People who inject drugs
- Latina/o/x people

21

Organizations

Provided a spectrum of HIV-related services

Those funded by Ryan White provided:

- more flexible hours,
- extensive language services,
- diverse payment options,
- and services for youth

compared to those without Ryan White funding.

1

Organization

Provided language interpretation services

These results suggest that the Ryan White program support to organizations plays a crucial role in the provision of accessible and quality services.

The table above shows key findings of the project. They range from numeric data to qualitative data.

Lessons Learned

It is important to recognize that when community organizations such as local health departments commission the funding for projects they determine the timelines, plans, and resources. The Community Psychologist has to adhere to the designated timelines, resources, and plans. Our case study of this work has broader implications that can advance interdisciplinary work in community psychology and public health. Based on our work, we recommend that community psychologists conducting needs assessments (or other community-based evaluative work) advocate for longer timeframes if possible, to employ participatory and empowerment approaches and to build trusting relationships. There is a responsibility to educate communities about the time and resources that may be needed to undertake such work in a way that is truly inclusive.



Image by Dirk Wouters from Pixabay (Image shows a diagram of three components of evaluations: time, cost and quality.

The needs assessment covered a vast target area—much of it rural and without many resources or other centralized organizations where the target populations would be found. Additional time was needed to develop strategies and identify avenues to reach more PLWHA in the rural areas via surveys and focus groups.

It is also important to go beyond singular categories and recognize the role intersectionality impacts on needs and incorporate it into the data collection plan. As an example, if we had simply looked at males as a group, we would have missed all the unique needs of gay Black males, gay and straight Hispanic males, transgender individuals, and adolescent males.

We recognized the importance of acknowledging our own positionality as PhDs. The education level of our partners and the focal population varied widely. Even though the members of the RWPC had the authority to delegate responsibilities and even fire us, we still need to acknowledge the perception of the "expert" power we hold in this society. Additionally, the consultant is white. In the past, we relied on being "culturally competent" and more recently on exercising "cultural humility," and this is insufficient. As a white heterosexual woman working in LGBTQIA+ communities of color and Black communities, deep reflection and additional work was required. This includes developing a deep understanding of concepts that include white privilege and white fragility, heterosexual privilege, anti-racism, and the impact colonization practices have had on different communities. It also requires ongoing, consistent reflection of what this means, and how, as a white person, the consultant may be (even unintentionally) upholding systemic racism and supporting oppressive systems. Most importantly, it requires recognition that this learning and reflection isn't one-and-done. It is ongoing and must be persistent as no matter how "woke" we may be, we are all capable of saying or supporting racism, heterosexism, and other forms of oppression. We need to be ready to be called out, and when we are, acknowledge what we have said or done.

We also learned about the need to engage with and be present in the focal communities. This includes a need to spend more time in rural, outlying communities where LGBTQIA+ and HIV-positive individuals who need Ryan White services are not easily identified. There was little information obtained from six of the seven counties for this needs assessment. We were unsure whether it was because most of those who are affected by HIV or HIV positive reside in urban areas that are closer to services, or if the individuals are residing in rural areas, but remain hidden because of the stigma of HIV or being LGBTQIA+.

Recommendations

Be ready to start where the community is and adjust expectations to what is, not what should be in an ideal world. This project had a limited timeline which required our team to be less participative than desirable. We did not have time to pilot instruments and test strategies and had to hit the ground running with what we had. The budget was also limited which required that we find the best way to stretch the resources that were available.

Work with partners to teach them how they can get better results by engaging the consultant earlier. Spent time clearly defining roles and responsibilities. Provide partners with adequate resources so they are not overly burdened by adding needs assessment tasks to their already busy schedules.

Partner with community members and community-based organizations to reach populations that may be otherwise inaccessible. Consider the role of intersectionality when you are thinking of the different populations you need to reach. We found substantial differences between White and Black gay men and Black men and women in regard to needs and accessibility of assets, demonstrating that identifying by a single category will yield insufficient and potentially misleading results.

Ensure there are resources for translation services for surveys and to conduct focus groups and interviews. The prior needs assessment consumer survey was translated by a Spanish-speaking staff member at one of the partner organizations. RWPC members reported that it had not worked well because the individual had

translated using a local dialect rather than a universally understood standard Spanish language. It is important when selecting translation services that they are professional services with linguistic and cultural translation expertise.

Needs and Resources as Participatory Research Projects

Community needs and resources assessments have many uses across community psychology practice. They are frequently requirements of funders and the Affordable Care Act and produce information that is useful for planning and writing grant applications. They are also useful for identifying policy needs and developing policies to meet them. By focusing on disparities and inequity, they can also support anti-racism and racial justice initiatives. Community psychologists are specifically skilled at participatory methods. The participatory process ensures higher quality results. Consumers know how to best reach the focal population, can provide endorsements that help to build trust, and provide expert advice for everything from what questions to ask to how to word the questions so they are understandable.

This, and the majority of needs and resource assessments require interaction with multiple races, ethnicities, and cultures. Cultural humility ensures that questions are appropriate to the focal population; that participants are not subjected to macroaggressions and other discomfort or potentially traumatizing treatment; and that results are interpreted accurately. Additionally, community psychologists must be ready and willing to serve as advocates by consistently identifying and calling out racism, homophobia, coloniality, and other behaviors and practices that support oppressive structures. Doing so requires prior introspection and acknowledgment of their own positionality.

Looking Forward

In summary, needs and resources such as the one presented here present opportunities for community psychologists to conduct meaningful work that has potential for impact. The data gathered will be used as the basis for planning services in this community for PLWHA for the next three years while ensuring that the needs of specific groups are considered. We recommended that the RWPC retain a consultant and begin the work at least a year before the report is due, ideally 15-18 months before. With more time we would have been able to increase data collection efforts, engage graduate and undergraduate student interns, create course projects to provide more meaningful evaluation experiences and make more connections to generate a more representative sample.

Conclusion

Community psychologists work in a number of areas in the community, where many work within the research evaluation or program evaluation field. Organizations and companies call on community psychologists in this area because they have been trained to see through a lens of co-creating health and wellness together with others than being the expert in the space. With this framework community psychologists hold space for difference and play integral roles in the continuation of fostering and nurturing community resilience and healing.

FROM THEORY TO PRACTICE REFLECTIONS AND QUESTIONS

- In this case study, Brown et al. (2021) shared the importance of recognizing that systems of oppression (i.e., racism, classism, transphobia, homophobia) operate in a mutually reinforcing manner to produce inequities in HIV risk, testing, infection, and mortality (McGibbon, 2012; Ford, 2017; Gee & Ford, 2011; Wilson et al., 2016). When you consider this statement, share with others what immediately comes up for you.
- How, if at all, did this case story challenge your beliefs or thinking about people living with HIV or programs serving them?
- As you think through the importance of research or program evaluations, what new considerations will you take away from this case story?

References

Bradshaw, J. (1972). Taxonomy of social need. In: McLachlan, Gordon, (ed.) *Problems and progress in medical care: essays on current research*, 7th series (pp. 71–82), Oxford University Press.

Bronfenbrenner U. (1979). T*he ecology of human development.* Harvard University Press.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *University of Chicago Legal Forum, 139–67*

Dallas County Department of Health and Human Services. (2017). 2016 Comprehensive HIV/AIDS Needs Assessment. A report prepared for Dallas County Ryan White HIV/AIDS Program. Retrieved from: https://www.dallascounty.org/Assets/uploads/docs/rwpc/2016_Comprehensive_HIVAIDS_Needs_Assessment_FINAL.pdf

Ford, C.L. (2017). Notions of Blackness in the context of HIV/AIDS disparities and research. *The Black Scholar, 47*(4), 18–31. https://doi.org/10.1080/00064246.2017.1368064

Gee, G.C. & Ford, C.L. (2011). Structural racism and health inequities: Old issues, new directions. *Du Bois Review*, 8(1), 115–132. https://doi.org/10.1017/S1742058X11000130

Kelly, J.G. (1966). Ecological constraints on mental health services. *American Psychologist, 21*(6), 535–539. https://doi.org/10.1037/h0023598

Lancet (2020). Racial inequities in HIV. www.thelancet.com/hiv, 7, e449. Accessed on March 24, 2021 at https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(20)30173-9/fulltext

Lewin, K. (1936). *Principles of topological psychology.* (F. Heider & G.M. Heider, Trans.). McGraw-Hill.

McGibbon, E. (Ed). (2012). *Oppression: a social determinant of health.* Fernwood Publishing. https://doi.org/10.1037/10019-000.

Ransome, Y., Kawachi, I., Braunstein, S., & Nash, D. (2016). Structural inequalities drive late HIV diagnosis:

The role of black racial concentration, income inequality, socioeconomic deprivation, and HIV testing, *Health Place, 42*, 148-158. https://doi.org/10.1016/j.healthplace.2016.09.004

Wilson, C.L. Flicker, S. Restoule, J.P. and Furman. E. (2016). Narratives of resistance: (Re) Telling the story of the HIV/AIDS movement – Because the lives and legacies of Black, Indigenous, and people of colour communities depend on it. *Health Tomorrow: Interdisciplinarity and Internationality Journal. 4*(1): 1-35).

Wolfe, S.M. & Brown, K.K. (2020). Ryan White Planning Council of the Dallas Area 2019 Comprehensive HIV/AIDS Needs Assessment [A Report]. Dallas County Health and Human Services, Dallas, TX.

9

Program Evaluation: A Fundamental Component in Effective Community Practice

DR. PATRICIA O'CONNOR. PH.D.

This case story expands the traditional single-case study format to include multiple mini-case studies from which "lessons learned" are extracted through evaluation-based community psychology practice.

THE BIG PICTURE



pixabay.com (Image is the word "strategy.")

In this chapter I modify and expand the traditional single-case study format to include multiple mini-case studies from which I extract "lessons learned" through my evaluation-based practice of community psychology (CP).

Program evaluation plays an important, structural role in its contributions to the assessment of the

intervention work of change agents, here CP practitioners, and relevant stakeholders who work together to design and implement needed community-based programs. My aim here and in all of my work is to encourage an evaluation mentality in CP practitioner-change agents. If these change agents develop interventions with an evaluation mentality, that is, with program evaluation as a core part of planning, design, and implementation, the resulting evaluative feedback can provide validation of the effectiveness of programmatic efforts, and thus, of change agents, or illustrate the need for substantive changes in aspects of the intervention efforts. The inclusion of evaluation strategies can assist program implementers/change agents in identifying the critical elements to ensure meaningful interventions and to provide evidence of the viability of replication. Additionally, we must recognize both the CP-based values (social justice, sense of community, empowerment, etc.) which underlie the development of community practice interventions and the critically important role of a change agent who incorporates a program evaluation mentality into the design of those interventions. Program evaluation thus becomes an essential tool in the practice of CP.

The overall aim of community psychologists' work is the improvement of participants' quality of life; some examples include Beauregard et al. (2020), Lin et al. (2020), O'Connor (2013), O'Shaughnessy and Greenwood (2020), Stewart and Townley (2020), and Suarez-Balcazar (2020). Improving quality may range from enhancing individuals' sense of well-being to ensuring needed supports; some examples include DaViera et al. (2020), Goodkind et al. (2020), Maleki, et al. (2020), Shek et al. (2017), and Wadsworth et al. (2020). However, confirming the value of such work or appropriately modifying it can only be accomplished through the inclusion of community-based program evaluations. The essential questions for program implementers or change agents are whether a proposed program is appropriate, whether the implemented program is as planned or how it has changed, and whether the program outcomes are as hoped for or as expected. Thus, developing and implementing interventions must be paired with evaluating the initial designs, implementations, and/or outcomes of those programmatic interventions, all of which can improve participants' quality of life.

My work and my career focus have been two-fold: as a professor in a small college in upstate New York teaching a program evaluation course in a master's program, and as an evaluation consultant, engaging in numerous small, primarily local and large, state-based and national program evaluations. From that work, I have identified seven lessons regarding the use of program evaluation strategies that are offered as guides to those in the CP practice of evaluating community-based programs. I also provide three principles that serve as guides for program evaluators. The seven lessons, with illustrative mini-case studies, are based on two kinds of evaluation projects: student-based through my graduate program evaluation course and consultation-based through my CP practice. The former evaluations emerge from a course requirement for students to participate in the design and implementation of a group evaluation project and the latter projects include my consultation-based evaluations of specific programs or organizations. These mini-case studies, with their "lessons learned" immediately following, document that some efforts were successful and, not surprisingly, some were not.

Mini-Case Study One

The Executive Director (ED) of a human services agency that provides residential treatment for adolescents was interested in front-line employees' perceptions of their work environments. The ED, a manager, and an assistant met with the graduate students and me to discuss the ED's purpose for the evaluation: to learn how to make the organization a "best place" to work. We agreed that interviews with front-line workers would be the most appropriate way to collect data as there could be flexibility with open-ended questions. The manager would provide access to front-line workers. The meeting ended quite satisfactorily, with a potential schedule for the next steps, and the ED, manager, and assistant left.



Image by Clker-Free-Vector-Images from Pixabay Image shows people (clip art) sitting around a table.

Students walking down the hallway after the meeting overheard the manager say to the assistant, "They should just do their f*** jobs!" illustrating that the manager had little interest in soliciting feedback from employees. This attitude was reflected in the difficulty students had throughout the project, first in getting access to employees, and second, in having employees agree to be interviewed. Some employees expressed concern that their interview information might not remain anonymous; the manager was not considered trustworthy. Students completed interviews but fewer than expected and with less useful information than planned or expected. Seven overarching lessons learned are depicted in tables below.

Lesson Learned	
1	Success of an evaluation project relies on the effective participation of all levels of stakeholders, not just the leader or person seeking the evaluation.

Mini-Case Study Two

A local County Commissioner of Mental Health was interested in whether children's visits to an Emergency Department (ED) could have been avoided, particularly among those children receiving assistance from the County. The question was whether the children were in contact with any service agencies and whether that contact should have resulted in interventions that would have precluded the ED visit. Students in the graduate Program Evaluation class and I met with the Commissioner and formulated a plan for record reviews of intake information at the ED of the local hospital. Although students were reviewing unredacted records, Institutional Review Board (IRB) approval was not considered necessary; unpublished program evaluations do not require IRB review.

Students presented the results to the Commissioner who was able to work with the Department of Social Services to develop preventive interventions to reduce children's unnecessary use of the ED. The success of this project resulted in the Commissioner taking the methodology to the relevant State Offices and the data collection strategy was replicated in nine counties. Three factors led to this generalizability: the quality of the student-designed project, the Commissioner's appreciation of, and reliance on relevant data, and the Commissioner's interest in expanding the use of relevant methodologies and usable information as a foundation for decision-making.

Lesson Learned	
2	The generalizability of methodology and the usability of results rely on the involvement of appropriate policymakers.

A local prevention program focused on specific issues related to illegal substance use among younger people as required by their funding sources. Through my ongoing relationship with the program director as the program's evaluation consultant, we conducted multiple evaluations, including focus groups/interviews with key leaders in the community, an asset-liabilities assessment of a specific neighborhood, and pre-post surveys with a summer leadership program for high school students, among several other projects over a period of approximately six years. Below are examples of successful and not-so-successful implementations of those evaluations.

Mini-Case Study Three

In one particularly effective evaluation, students conducted an observational assessment of a neighborhood to identify both assets (open stores, schools, churches, shops, etc.) and liabilities (closed stores, vacant houses, empty lots with trash). Although the student evaluation groups typically included only five or six participants, this self-selected group comprised 14 very dedicated students, divided into seven pairs for the observations and interviews. The paired students divided the neighborhood into approximately equal manageable areas, did the observations in pairs, and conducted interviews (with a structured interview developed during class time) to obtain residents' perceptions of the neighborhood. The collected information enabled the program director to develop strategies to advocate for neighborhood improvements and to identify specific locations for program development. The degree of determined and dedicated student involvement led to the clear success of this evaluation effort.

Mini-Case Study Four

In another evaluation, the program director of the same substance abuse prevention program requested that students conduct interviews with people presumed to be key stakeholders to obtain their feedback on the program. Working with the program director, students identified approximately 40 locally based, potential stakeholders, including religious leaders, politicians, educators, local business owners, and others.

The project itself was built on the expectation that people in the community would be familiar with, if not involved in, the work of the project. However, these stakeholders-leaders, all of whom the students contacted directly, were not sufficiently knowledgeable about, or in some cases, invested in the work of the program to participate in the interview process, resulting in inadequate numbers of completed interviews and thus, inadequate feedback regarding program implementation. Here the lack of success seems tied to the lack of interest or commitment on the part of the external stakeholders, most of who did not view themselves as stakeholders at all.

Mini-Case Study Five

To evaluate a summer leadership program for high school students offered by the same substance abuse prevention program, the graduate students in the program evaluation course and I met with the program coordinator to identify the aims and activities of the program which would enable the students to develop pre-and post-surveys. The coordinator who reported to the program director did not seem particularly interested in any kind of evaluation. After the initial meeting, the students were virtually unable to connect with the program coordinator who simply did not respond to emails or phone calls. The students, under my direction, finally developed a draft survey to enable some completion of the project before the end of the semester. The lack of success here reflected the lack of commitment on the part of the internal stakeholder.

Mini-Case Study Six

In working with a program director in an agency that provides support to underserved, generally homeless, people, I suggested conducting a focus group with people who were receiving services to solicit their input in developing strategies to address their needs, which could result in modifications of existing programs. The program director asked approximately six or seven people to participate and four arrived at the designated time. Transportation costs in the form of bus passes and given gift certificates to a local chain were offered to encourage participation and to compensate for their time. However, the focus group did not achieve the expected outcome in that all participants had extensive experiences with such agencies/programs and were familiar with the kinds of questions that might be asked and with the range of what they perceived that agencies might consider acceptable responses. Thus, the circumstances under which the focus group was conducted, that is, in the agency itself with a peer as a co-facilitator, led to repetitions of stories and statements which only affirmed what was already happening, rather than suggestions for novel approaches to addressing the needs of program participants. Here the previous experiences of the participants framed and even limited the range of their contributions.

Lesson Learned	
3	The successes of community-based projects rely on the community psychologists and community stakeholder commitment or interest in the program.

Mini-Case Study Seven

As director of a graduate program in Community Psychology, I have consistently encouraged student-designed and implemented process and outcome evaluations of the program itself and of other offices at the College, for example, access to registration and financial aid offices, availability of library, and separately, food services.

The program-based evaluations provided useful and useable information, including:	
students' preferences regarding the timing of classes	... evenings
the development of a student organization	... organized, then dissolved
the availability of advisors	... more needed
the helpfulness of field placement coordinators	... helpful
the employment outcomes of graduates	... particularly useful for current students
suggestions for program improvement	... for example, add, modify, or eliminate courses, increase field placement experiences, add electives, etc.
	... and numerous other projects.

The above table provides information on the results of a program-based evaluation including students' preference, the availability of advisors, and suggestions for program improvements.

Participation in these kinds of evaluations provided the students with meaningful, hands-on experiences with the process of evaluation and with the programmatic commitment to assessing the usefulness and value of one's work. Only one among numerous CP program evaluations yielded a particularly negative response; when asked the reason for not continuing in the program, one person responded, "I hate [the program director who happens to be the author!]."

Lesson Learned	
4	Engaging in the evaluation of one's own program plays a critical role in establishing the legitimacy of program evaluation for internal and external audiences, including those in the program.

Several of my evaluation experiences have reinforced the importance of effective process evaluations, particularly of observation. Three mini-case studies below illustrate that importance, two from one setting and the third from another setting which is described below. The first setting was a well-funded arts-education program that comprised artists collaborating with teachers in the delivery of primary school curricula. Storytellers emphasize the logical progression of a story (beginning, middle, end) for kindergartners and first-graders and math operations (addition and subtraction) for second and third graders; dancers express the meaning of words in movement (lean forward, then backward for wax and wane or ebb and flow).

This arts-education collaboration can result in improved grades for students, which can be documented over time through appropriate outcome measures, for example, quarterly grades compared with the previous year, or compared with another no-arts unit. However, the actual viability and replicability of the program will depend on two factors: first, the support of the classroom teachers through their involvement in the collaborative process, and second, the actual use of the arts by the change-agent artists.

Mini-Case Study Eight

An illustration of the first factor, support of the classroom teacher, was my effort to observe both the teacher-artist collaboration and the actual artist's presence in the classroom with at least two observations of each teacher. One second grade teacher was determinedly not interested in participating in any aspect of the process, though expected to do so by the principal; the teacher even stated to me, "You can do your little [arts-education dance] program here [in the classroom] but I am not going to be involved." That teacher retired at the end of that school year. Most other observations were conducted with the enthusiastic involvement of teachers and artists. One other significant observation was of the grade-level teacher-artist planning meetings to select the curriculum for the artistic mode of delivery. After the first year of the program, the planning meetings became more about setting up the calendar than about modifying or expanding the content and mode of the artists' delivery of the curriculum. That focus, on the calendar rather than content, reflected the decreasing commitment of the teachers to effective participation in the process of teacher-artist collaboration.

Mini-Case Study Nine

An illustration of the second factor, actual use of the arts by the artist, an effective songwriter/poet/musician collaborated with a fourth-grade teacher in the delivery of a poetry unit with the expectation that the artist would use music to demonstrate the role of rhythm in poetry. In the observed classroom experience, the artist used her own skills in poetry-writing to deliver the lesson rather than her musical talent and musical instruments. The outcome of improved grades for the students was, in fact, related to the skill of the artist as a poet than to the artist as a musician in the delivery of the curriculum. This effectively precluded the presumed replicability of the teacher-artist collaboration. Although such a conclusion would not have been drawn without the evaluator's observation of the classroom exercise, there were also numerous observations of the effective and appropriate implementation of the collaboration as designed.

Mini-Case Study Ten



Image is decorative only and says "Observation" related to this mini-case study which used an observation methodology.

An entirely different example reflects the importance of observation in an entirely different setting, a national organization with a focus on a specific medical condition. The organization had developed an extensive curriculum, a set of nine chapters with accompanying slides, for medical professionals to bring current, in-depth information to those with the condition and to inform the general public about the condition. The aim of the evaluation was the assessment of the effectiveness and usefulness of this standardized curriculum. As the evaluator, I included observation of each of the three planned implementations of the curriculum, one in a rural setting with people with the condition, one in a university with providers, caretakers, and people with the condition, and a third in an urban setting with providers and caretakers, primarily parents and family members of children with the condition. The observation revealed that the actual use of the curriculum varied widely across the three settings. The physician-presenter in the rural setting discussed the first several chapters; the multiple presenters in the university setting each reviewed their own areas of expertise without reference to the curriculum, and the presenters in the urban/primarily family setting focused on one chapter in the curriculum which did not overlap at all with the rural presentation. Participants in each setting completed pre-post surveys which demonstrated some increase in knowledge about, and understanding of, the condition across the three settings but clearly those improvements were not related to the actual use of the curriculum. Again, the importance of observation is demonstrated in that the conclusion could only have emerged through my evaluator observation of each implementation.

Lesson Learned	
5	Program evaluations can identify successful programs which can be replicated; however, such programs require careful analyses, typically through observation, to ensure that the implementation processes are well-documented.

Mini-Case Study Eleven

In the mid-1990s a local philanthropic foundation began to support locally-based academic-community collaborations through mini-grants, and I applied for and received one of the first. Upon the completion of that grant, I was subsequently approached to collaborate with a variety of community-based programs and agencies over a period of years. These included focus groups with elderly residents of a public housing project to assess their satisfaction (which impacted planned renovations of the housing project), and observations of an advisory board for a child sexual abuse intervention program to identify strategies to enhance the Executive Director's success with the Advisory Board (one obstreperous person resigned;

the Chair reorganized meeting structure). The success of each led to my being contacted by subsequent community agencies and programs to participate in a joint submission to the funding source as the value and usefulness of engaging in evaluation activities became more evident. Here the overall success emerged out of my previous experiences and my local reputation.

Mini-Case Study Twelve

As part of an overall assessment, another national organization/foundation with a focus on differently-abled individuals was interested in whether locally-based programs which they funded were using strategies that matched the vision and mission of the national organization and whether the implementations were resulting in the desired outcomes. Most local program directors were understandably proud of their own efforts, the extent of local participation, and the outcomes of the programs. As the evaluator for the national organization, I undertook the task of assessing six of the local programs (somewhat randomly selected) to identify both aspects that were congruent with the national organization's goals and objectives and those that needed modification to increase their rates of success. These program directors were willing to participate in the evaluation activities but were also accustomed to receiving only praise for their efforts in initiating and managing their programs. My evaluation reports for each program documented their successes but also included recommendations for improvement. The reports were not well received; directors who had welcomed me, participated actively in the evaluation activities and seemed to accept and even welcome verbal recommendations at the end of each visit, did not appreciate having any of what they perceived as less than positive results in a written report. The outcome was the termination of the entire evaluation project.

Lesson Learned	
6	The value of program evaluations is learned primarily through the experience of having results that easily lead to program improvements, which highlight the usefulness of conducting assessments.

Mini-Case Study Thirteen

In one New York State-based evaluation, six counties were selected to participate in a public health intervention and were asked to different their own program designs in their efforts to achieve the desired public health outcome. At the end of the evaluation period, some strategies were clearly more effective than others which led to the adoption, or at least the encouragement of the adoption, of those strategies state-wide. As the evaluator I had assured each of the participating counties that their results would be anonymous, that is, the State as the funding source would not know which counties were successful and which were not. The need for that promise of anonymity was essential because the local staff was concerned that future funding could be affected by the State staff's knowledge of specific outcomes. At the end of the project, with positive results clearly disseminated, the State staff requested rather strongly that the anonymity be unveiled so that the successful and not so successful counties be identified. I refused, based on the ethics of my adhering to my promise. That ethical decision led to the termination of that relationship!

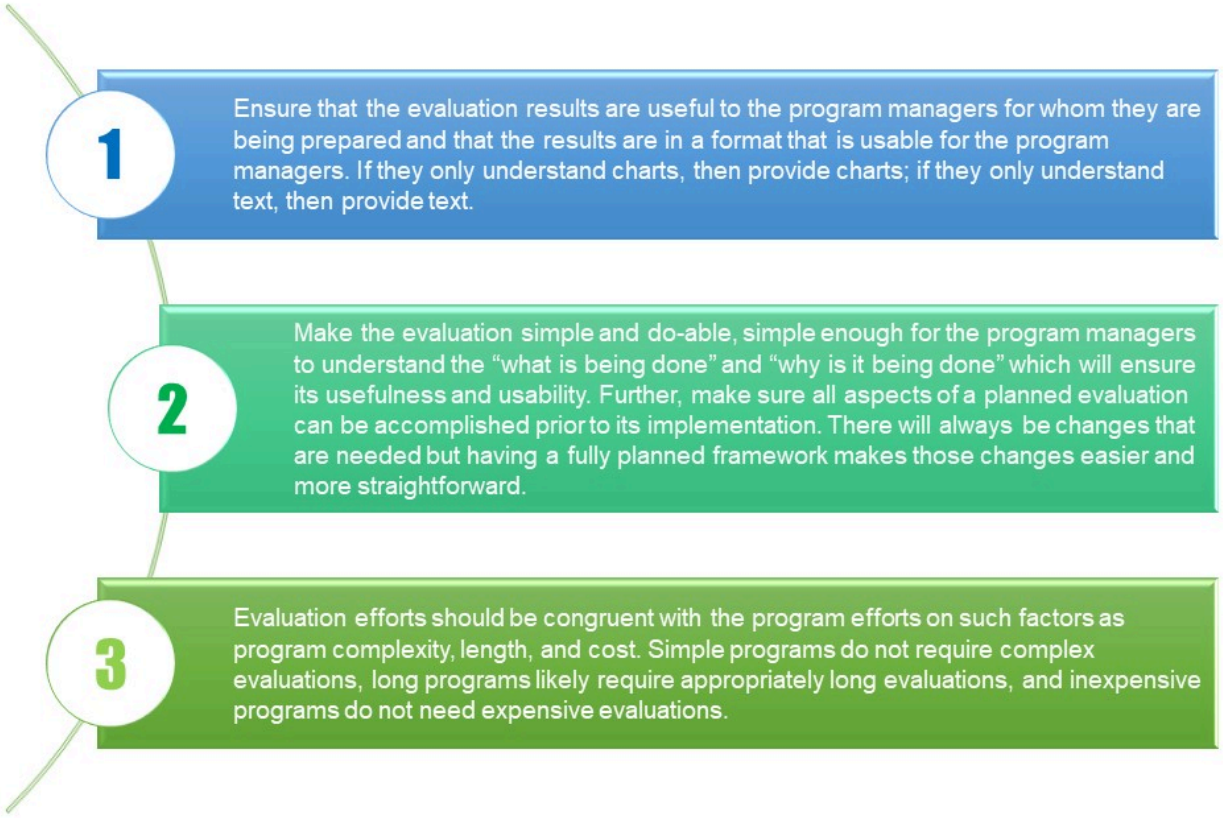
Mini-Case Study Fourteen

Another instance of ethical difficulties was in the final first-year evaluation report of two-year community-based, federally-funded project which required collaboration across multiple human service agencies. Funding for year two was based on the viability of the project and commitment of the agencies, both of which were to be documented in the evaluation report. A new project manager, who started just weeks before the first-year report was due, requested changes in the report which would enhance the appearance of a positive outcome for year two, but which somewhat misrepresented the actual data. Discussion ensued resulting in the project manager asserting her position as manager and me asserting my role as evaluator with my intention to adhere to the independence of the evaluation process and outcome. The awkwardness of the situation for me resulted in my submitting only a hard copy (in the days before electronic submissions) on the day the report was submitted, precluding the manager's interest in, and possibility of making changes in the report.

Lesson Learned	
7	Adhering to ethical boundaries can be difficult in some circumstances.

Conclusion

This was a series of mini-case studies to illustrate factors that can affect the critical role that program evaluation plays in the community-based practice of community psychology. Each of these factors emerges from my on-the-ground, in-the-trenches, front-line experiences of working with community-based agencies and programs that rely on county, state, and/or federal funding, that is, public monies, or on local, state-based, or national foundations for private money. Extracted from these seven "lessons learned" are three principles that have emerged as guides for my work in the field of program evaluation. They are: (1) ensuring that the evaluation results are useful, (2) making sure the evaluation is simple and doable, and (3) evaluation efforts are congruent with the program efforts. The figure below highlights these three principles:



The figure above highlights the three principles shown in text above and says the same thing.

Finally, program evaluation serves as a critical part of the practice of community psychology, providing essential information for funding sources, and crucial feedback for those aiming to improve individuals' quality of life and well-being. Those of us who work/practice in the community most assuredly value the consistencies and, at the same time, the idiosyncrasies of that work, as reflected in the seven takeaways and the illustrations of each. Those who are change agents or interventionists also intuitively or actually know the value of building assessments or measures into their change efforts from the beginning to identify both areas in need of improvement and areas of success. Using appropriate program evaluation strategies based on the three principles cited above will enhance the efficacy of community-based interventions.

FROM THEORY TO PRACTICE REFLECTIONS AND QUESTIONS

- Program evaluation plays an important, structural role in its contributions to the assessment of the intervention work of change agents, where community psychology practitioners and relevant stakeholders work together to design and implement needed community-based programs (O'Connor,

2021). What lens might a community psychologist bring to the table in a program evaluation? What lens would another psychologist bring (e.g. social psychologist or clinical psychologist)

- Describe why it is important when conducting program evaluations to analyze the data collected from an ecological level.
- What conceptions did you hold prior to reading this case story about program evaluations

---

References

Beauregard, C., Tremblay, J., Pomerleau, J., Simard, M., Bourgeois-Guerin, Lyke, C., Rousseau, C. (2020). Building communities in tense times: Fostering connectedness between cultures and generations through community arts. *American Journal of Community Psychology, 65*, 437-454. https://doi.org/10.1002/ajcp.12411

DaViera, A.L., Roy, A.L., Uriostegui, M., Fiesta, D. (2020). Safe spaces embedded in dangerous contexts: How Chicago youth navigate daily life and demonstrate resilience in high-crime neighborhoods. *American Journal of Community Psychology, 66*, 65-80. https://doi.org/10.1002/ajcp.12434

Goodkind, J.R., Bybee, D., Hess, J.M., Amer, S., Ndayisenga, M., Greene, R.N., Choe, R., Isakson, B., Baca, B., Pannah, M. (2020). Randomized controlled trial of a multilevel intervention to address social determinants of refugee mental health. *American Journal of Community Psychology, 65,* 272-289. https://doi-org.nl.idm.oclc.org/10.1002/ajcp.12418

Lin, E.S., Flanagan, S.K., Vargo, SM., Zaff, J.F., Margolius, M. (2020). The impact of comprehensive community initiatives on population-level child, youth, and family outcomes: A systematic review. *American Journal of Community Psychology, 65*, 479-503. https://doi.org/10.1002/ajcp.12398

Maleki, F.M., Massahikhaleghi, P., Tehrani-Banihasnemi, A., Davoudi, F. (2020). Community-based preventive interventions for depression and anxiety in women. *Archives of Iranian Medicine, 23*(3), 197-209.

O'Connor, B. (2013). From isolation to community: Exploratory study of a sense-of-community intervention. *Journal of Community Psychology, 41*(8), 973-991. https://doi.org/10.1002/jcop.21587

O'Shaughnessy, B.R., & Greenwood, R.M. (2020). Empowering features and outcomes of homeless interventions: A systematic review and narrative synthesis. *American Journal of Community Psychology, 66*, 144-165. https://doi.org/10.1002/ajcp.12422

Shek, D.T.L., Ma, C.M.S, Law, M.Y.M., & Zhao, Z. (2017). Evaluation of a community-based positive youth development program or adolescents with greater psychosocial needs: Views of the program participants. *International Journal of Disabilities and Human Development, 16*(4), 387-393. DOI 10.1515/ijdhd-2017-7007

Stewart, K., & Townley, G. (2020). How far have we come? An integrative review of the current literature on sense of community and well-being. *American Journal of Community Psychology, 66,* 166-189. https://doi.org/10.1002/ajcp.12456

Suarez-Balcazar, Y. (2020). Meaningful engagement in research: Community residents as co-creators of knowledge. *American Journal of Community Psychology, 66,* 261-271. https://doi.org/10.1002/ajcp.12414

Wadsworth, M.E., McDonald, A., Jones, C.M., Ablkvist, J.A., Perzow, S.E.D., Tilghman-Osborne, E.M., Creavey, K., & Brelsford, G.M. (2020). Reducing the biological and psychological toxicity of poverty-related stress: Initial efficacy of the BaSICS intervention of early adolescents. *American Journal of Community Psychology, 65*, 305-319. https://doi.org/10.1002/ajcp.12400

10

Showing up and Standing with: An Intersectional Approach to a Participatory Evaluation of a Housing First Program

ANNA S. PRUITT, EVA MCKINSEY, TIEN AUSTIN & JOHN P. BARILE

This case story describes the process of forming a five-year, ongoing participatory evaluation partnership between Housing First program participants, staff, and community psychologist evaluators in the multicultural context of the Island of Oʻahu in Hawaiʻi.

THE BIG PICTURE



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=175#oembed-1

This chapter describes the process of forming a five-year, ongoing participatory evaluation partnership between Housing First program participants, staff, and community psychologist evaluators in the multicultural context of the Island of Oʻahu in Hawaiʻi. Housing First is a community-based program that quickly provides permanent housing to individuals experiencing homelessness and emphasizes "consumer choice" in housing and service plans (Tsemberis, 2010). What started out as a top-down evaluation design conducted by traditional academic researchers became a weekly support group that engages in participatory research, often utilizing arts-based methods. Using an intersectional lens (Crenshaw, 1989; Weber, 2009), this case study explores the challenges and successes of building this partnership among individuals from diverse racial and ethnic backgrounds with varying degrees of power, housing experiences, and mental and physical health issues. While many members of the partnership experienced challenges that typically

deter traditional researchers from engaging in collaborative research, our partnership demonstrates many strengths, including valuable lived experience, resourcefulness, and critical insight that allowed for the creation of a space that is both supportive and conducive to rigorous participatory research and advocacy.

The main objectives of this case study are to demonstrate the application of community psychology values—particularly, respect for diversity, collaboration and participation, and historical context—in building research partnerships among individuals located at multiple axes of oppression. In particular, this case study demonstrates that respect for diversity is incomplete without attention to intersectionality and colonial trauma and argues for community psychology practice that is explicitly intersectional. Learning outcomes are shown below and include (1) gaining an awareness of the complexities of participatory research, (2) being able to recognize the steps taken in long-term participatory research, (3) critically examining the role that historical context plays in community-based participatory research, and (4) recognizing the value of going beyond respect for diversity in community psychology research and practice. The figure below highlights these learning outcomes:



In a multi-colored chart the above figure highlights the learning outcomes detailed in the written text above.

Intersectionality as Critical Praxis

Intersectionality is a field of study, an analytical strategy, and a critical praxis that understands race, ethnicity, class, gender, sexuality, age, ability, and other salient social categories as interconnected, reciprocal phenomena that interact to influence complex social inequalities (Collins, 2015). Within an intersectional framework, these identity categories are not mutually exclusive but rather are socially constructed categories

whose intersections manifest in experiences of oppression and privilege (Bilge, 2014; Collins, 2015). For example, an individual identifying as a white, heterosexual, low-income woman is privileged along lines of race and sexual orientation but potentially oppressed along lines of gender and class. Importantly, these identities are tied to systems of power that are embedded within specific geographic, social, political, and historical contexts that have implications for lived experiences (Weber, 2009). For example, a person living in the American South who identifies as a white woman will likely have different experiences than an individual identifying as a Black woman in the same context. And these experiences are likely to shift because identities—and different aspects of identities—have different meanings in different contexts. Indeed, a 20-year-old individual identifying as a Black woman in New York City has different experiences than an 80-year-old individual identifying as a Black woman in the rural American South. An intersectional approach challenges the notion that singular identities can explain lived experiences of oppression and directs attention to the interdependent and structural forces, processes, and practices that result in complex inequalities (Grzanka, 2020).

Fig. 1

HERstory of Intersectionality

Examples of Black women's and other women of colors' contributions to Intersectionality

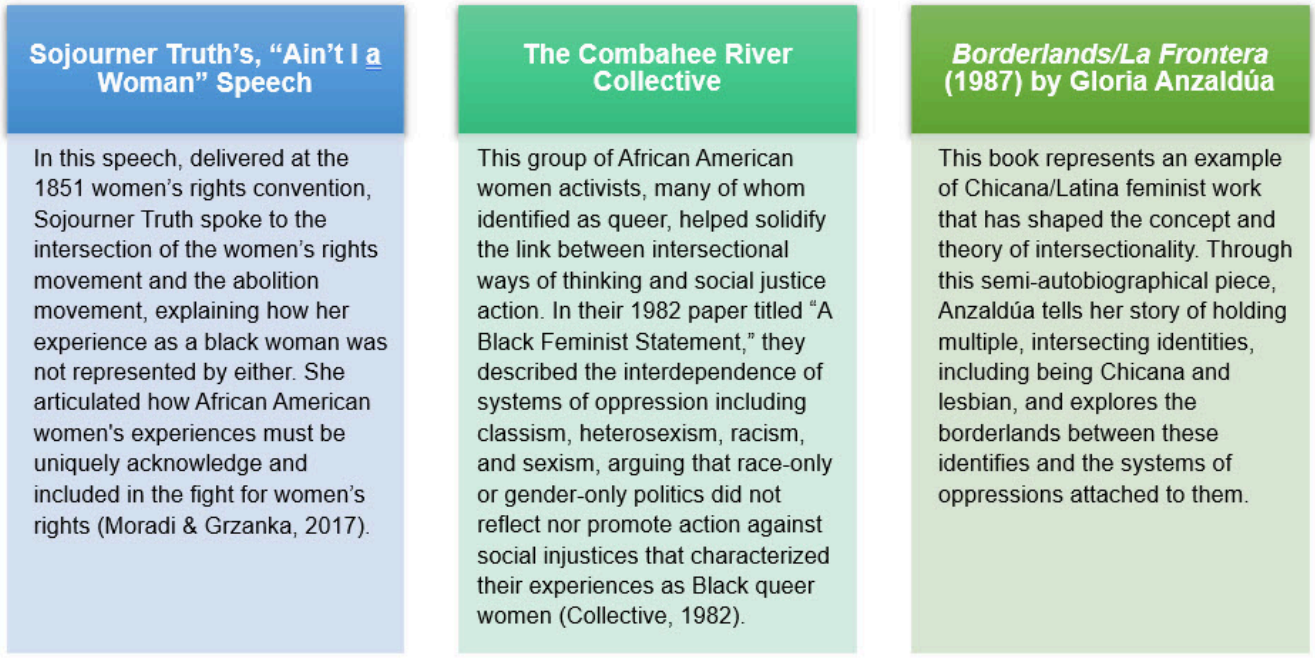


Image depicts concepts of intersectionality relevant to this case story.

Grounded in Black feminism, the concept and field of intersectionality were created and shaped by African American women and other women of color scholars and activists. In fact, the HERstory of intersectionality traces back centuries, with prominent contributions from Sojourner Truth, the Combahee River Collective, and Gloria Anzaldúa (see Fig. 1). In the late 1980s, Kimberlé Crenshaw applied the framework to

the legal realm and introduced the term "intersectionality" to describe the colliding systems of racism and sexism that Black women experience and that result in a unique form of oppression that single identity politics and legal protections had yet to address (Crenshaw, 1989; Crenshaw, 1991). For example, because Black women are discriminated against on the basis of race and gender, they often fall through the cracks in the legal system that implicitly assumes racism to affect Black men and sexism to affect White women.

Part of the ingenuity of this framework is that, despite its grounding in the experiences, scholarship, and activism of Black women and other women of color, it can be used in novel contexts and across diverse interpretive communities (Collins, 2015; Moradi & Grzanka, 2017).

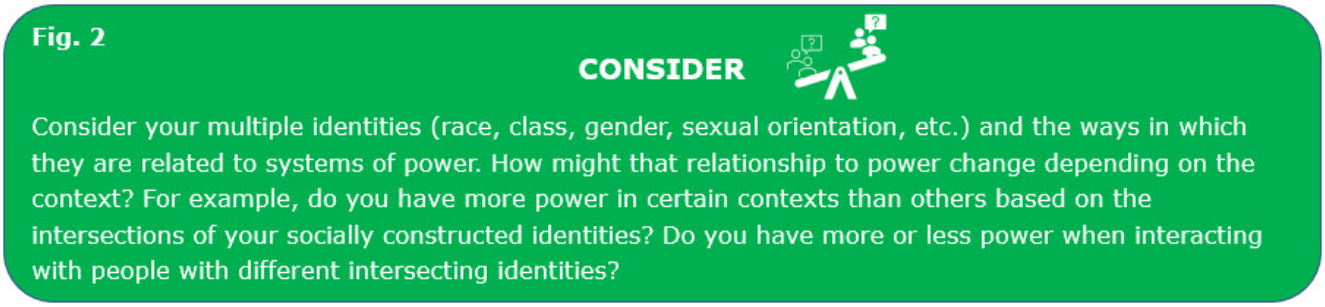


Image is a call-out box asking for you to consider your own multiple identities.

While this chapter relies on all three of these conceptualizations at times, intersectionality's conceptualization as a form of critical praxis is most relevant to this case study. Critical praxis refers to the merging of critical thinking and social and political activism, with the ultimate goal of transforming systems of oppression (Gramsci, 1971). As a form of critical praxis, intersectionality not only seeks to understand experiences resulting from interdependent identities and systems of oppression but also seeks to critique and change the systems we study in order to create more just systems (Collins, 2015; Grzanka, 2020). Through this conceptualization, authentic community engagement, social and political impact, and centering voices and stories of resistance becomes essential (Moradi & Grzanka, 2017). Indeed, this type of engagement and transformation were major goals of our evaluation partnership.

Intersectionality and Community Psychology

While community psychologists rarely refer to intersectionality explicitly in academic literature, the overlap between intersectionality and community psychology exists, and we (community psychologist evaluators) found that an intersectional approach was helpful in guiding our community psychology practice. From a theoretical standpoint, both intersectionality and community psychology emphasize the impacts of macro-level systems (e.g., policies, economic processes, etc.) on individuals and communities and the role of power in constructing lived experiences. Importantly, both recognize the interactions between macro-and micro-level processes, and both community psychology and intersectionality

emphasize the importance of social action and the potential of a collective power to respond to the inequities created by oppressive systems of power. Additionally, community psychology's focus on context is reminiscent of intersectional frameworks that highlight the interaction of individuals and their context and the fact that different identities and intersections are more or less salient in certain contexts (Weber, 2009). Community psychology has long argued that any community practice and research must begin with an understanding of the social and historical context. In fact, one of community psychology's four guiding principles is that social problems are best understood by viewing people within their social, cultural, economic, geographic, and historical contexts (SCRA, 2020).

In addition to understanding others in context, community psychologists should engage in ethical and reflective practice—a key competency for community psychologist practitioners (SCRA, 2011). Thus, it is important for community psychologists not only to understand the context that impacts community partners but also to reflect and understand their place within it. Intersectionality also highlights the necessity of the examination of one's own place within power structures (Weber, 2009). It is especially important for community psychologists to seek out such an understanding given our field's stated values of respect for diversity and inclusion (SCRA, 2020). We cannot live up to these values without an understanding as to what makes our social experiences diverse. As we turn to the project of focus, consider the potential systems of power interacting and impacting the ongoing partnership and resulting research. We start with attention to historical and sociopolitical context.

Community Context

This partnership takes place on the Island of Oʻahu in Hawaiʻi. Oʻahu, known as "The Gathering Place", is home to almost a million people, with approximately 115,000 tourists visiting the island on any given day, pre-COVID-19 (Hawaii Tourism Authority, 2019a). Hawaiʻi is one of the most diverse states in the United States, with no ethnic group holding a majority, and Oʻahu is the most diverse of the islands, with 43% of residents identifying as Asian, 23% identifying as multiracial, 10% Native Hawaiian or Other Pacific Islander, and only 22% identifying as White only, compared to 76% nationwide (US Census Bureau, 2019). The state capital, Honolulu, as well as the internationally-known tourist hotspot, Waikīkī, are located on Oʻahu. Not surprisingly, tourism is the major economic engine of the state. In 2019, the state brought in over 17 billion dollars in tourism monies and enjoyed one of the lowest unemployment rates in the nation (Hawaiʻi Tourism Authority, 2019b; US Bureau of Labor Statistics, 2020b). However, tourism also drives up the cost of living and reduces the affordable housing stock. As expensive apartments and tourist lodgings replace affordable housing, rental rates and housing costs increase, and local residents are "priced out" (Moore, 2019). Indeed, Hawaiʻi has both the highest cost of living and the lowest wages in the nation (after adjusting for said cost of living (HI Appleseed, 2019). Thus, despite its low rates of unemployment, Hawaiʻi has high rates of poverty and homelessness.

Homelessness in Hawaiʻi

Hawaiʻi has one of the highest homelessness rates in the United States. In 2019, Hawaiʻi had the 4th highest homelessness rate in the nation behind Washington D.C., Guam, and New York. Additionally,

its homelessness rate has grown since 2007, while the overall national homelessness rate has fallen during this same time period as reported by the National Alliance to End Homelessness. On any given night, approximately, 6,458 individuals were experiencing homelessness in Hawai'i in 2020 (State of Hawaii Homelessness Initiative, 2020). The majority—4,448 individuals—lived on O'ahu (Partners in Care, 2020). Notably, the majority of these individuals (53%) were living unsheltered (e.g., in parks, on beaches), making homelessness highly visible (Partners in Care, 2020). Additionally, between July 1, 2018 and June 30, 2019, a total of 16,527 people received some form of housing services or assessment, suggesting that homelessness affects a significant number of people in Hawai'i (Pruitt, 2019). Given the high visibility and its perceived impact on tourism, the "homelessness problem" is especially salient in local public policy and local media (Pruitt et al., 2020). Unfortunately, due to the economic fallout from the global pandemic, the homelessness rate is expected to increase, and 19,000 low-income people are projected to fall into poverty in the coming year (Hawai'i Data Collaborative, 2020; Partners in Care, 2020).

Decades of research reveal that homelessness in the United States results from a lack of affordable housing, high rates of poverty, and social exclusion on the basis of certain individual characteristics (Shinn & Khadduri, 2020). While certain individual characteristics are associated with increased risk for homelessness (e.g., experiencing mental illness, being a member of an ethnic or racial minority), social exclusions (e.g., racist housing policies, such as "redlining") actually "turn individual characteristics into vulnerabilities for homelessness" (Shinn & Khadduri, 2020, p. 52). Homelessness, in turn, exacerbates existing risk factors and can lead to further social exclusion and isolation from community support networks. From an intersectional perspective, individual characteristics interact to produce identities that are associated with different intersecting systems of power that lead to homelessness.

The local context of O'ahu reflects these research findings. Honolulu's high fair market rent rate is positively associated with its high homelessness rate (Barile & Pruitt, 2017). Importantly, not all residents are affected by poverty and homelessness equally. Despite prominent narratives that claim Hawai'i is a "racial paradise," stark inequalities exist related to race, class, and native ancestry. For example, Native Hawaiians are disproportionately represented in the island's homeless population, comprising 43 percent of individuals experiencing homelessness, while representing only 19 percent of the general population on O'ahu (OHA, 2019).

A recent racial equity report suggested that racial disparities may exist in housing services provisions as well (Pruitt, 2019). For example, Native Hawaiians and other Pacific Islanders were less likely to receive permanent supportive housing compared to whites and Asians. Additionally, Native Hawaiians make up a larger percentage of the unsheltered than sheltered homeless (Pruitt & Barile, 2020). In Hawai'i, large encampments of homeless communities are not uncommon, offering social support and a return to "kauhale" living. Disparities between social classes are prominent as well. Hawai'i was rated second of all states with the highest rates of taxes on low-income households, further increasing inequities between the wealthiest and the poorest residents (Institute for Taxation and Economic Policy, 2018). Class intersects with race and ethnicity as non-white and non-Asian groups are more likely to live in poverty and rely on housing subsidies.

Colonial History



http://www.hawaiihistory.org (Image of a short excerpt of Hawaii history).

Homelessness in Hawai‘i cannot be understood without an understanding of Hawai‘i’s colonial history. Prior to Western contact, Hawaiians—Kānaka Maoli—lived in kauhale living systems, sharing sleeping and living spaces, often under the stars (Watson, 2010). Each island was divided into ahupua‘a, wedged-shaped pieces of land that stretched from the mountains to the sea. These ahupua‘a were ruled by local chiefs, and each ahupua’a was meant to be self-sustaining, ensuring that everyone, including commoners (maka‘āinana), had necessary resources from both the land and sea (Minerbi, 1999).

Private land ownership did not exist within a Native Hawaiian system. Native Hawaiian homelessness has been attributed, in part, to two major historical events: The Great Mahele and the illegal overthrow of the Hawaiian Kingdom by the United States. With the dispossession of land and the fragmentation of Hawaiian communities, came Western homelessness. Even after contact with Western nations, The Kingdom of Hawai‘i remained a sovereign nation until the end of the 19th century (Goodyear-Ka‘ōpua, 2014). However, foreign pressures led to changes to the Hawaiian way of life. In 1848, under pressure from foreign advisors, King Kamehameha III introduced the Great Māhele (division of land), marking the beginning of private land ownership in Hawai‘i. To be awarded newly privatized land, maka‘āinana were required to file a claim, provide testimony, pay for a survey of the land to be completed, and obtain a Royal Patent. Only around 30% of maka‘āinana achieved all steps and were awarded on average 3.3 acres. Thus, the Great Māhele displaced a sizable number of maka āinana from their ancestral lands (Stover, 1997).

The late 19th century saw further challenges to the Hawaiian way of life and the sovereignty of the monarchy. In 1887, the Hawaiian League, a group of mostly White American businessmen, forced a new constitution upon King Kalākaua at gunpoint. This “Bayonet Constitution,” diminished the power of the monarchy (Osorio, 2001). In response to later attempts by the king’s successor, Queen Lili‘uokalani, to restore these powers, a group of European and American businessmen backed by the United States military overthrew the monarchy. On January 17th, 1893, Queen Lili‘uokalani surrendered in an effort to save lives and in hopes she would be reinstated. The Kingdom of Hawai‘i was proclaimed to be the “Republic of Hawai‘i” by coup members (“The Overthrow”, 1999).

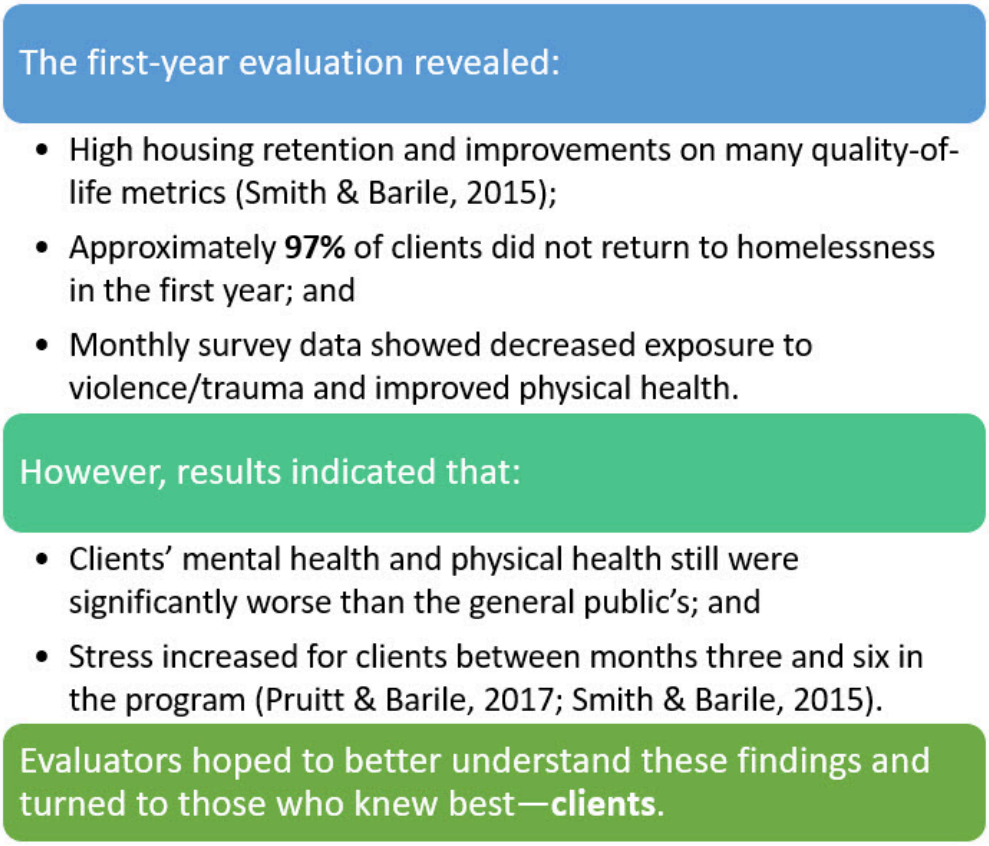
Since the Great Māhele and the illegal overthrow of the monarchy, Kānaka Maoli have fought to maintain their connection to the land. For example, in the 1970s, the rural communities of Waiāhole and Waikāne successfully resisted evictions meant to make room for suburban and tourism developments (Lasky, 2014). Local “houseless” communities on O‘ahu also continue to fight for their right to define community and access ancestral land. For example, Pu‘uhonua O Wai‘anae is a self-governed village, where on average 250 houseless people live, two-thirds of whom are Kānaka Maoli. What began as a village on the edge of the

Wai'anae Boat Harbor has transitioned into a permanent village community meant to be a place of refuge for all people who have been unable to afford the cost of living in Hawai'i. There, people have access to social services and a return to kauhale living. Other such communities exist on the Windward and South sides of the island, with Kānaka Maoli community leaders stepping in to address local homelessness. Building a Partnership

Housing First on O'ahu

In addition to local community leaders responding to the homelessness crisis, government officials have invested in solving the problem. In 2014, the City and County of Honolulu responded to O'ahu's increasing homelessness rates with a flurry of housing policies, including funding for a program based on the Pathways Housing First program model. In contrast to "treatment first" models which assume people need to be "housing ready" (e.g., achieving sobriety, employment, etc.) before "earning" housing, Housing First, as a philosophy and program model, consider homelessness to be primarily an affordable housing problem solved by providing individuals with housing quickly and then, providing wraparound services if desired by participants—or "clients" (Tsemberis, 2010). The approach had been successful in other major US cities, and Honolulu government officials hoped the model would have an impact on O'ahu.

Housing First Evaluation



The figure above shows that the first-year evaluation revealed high housing retention and improvements; 97% of clients did not return to homelessness, and decreased exposure to violence/trauma and improved physical health. Other results showed that stress increased among the clients and clients' mental health and physical health were still worse than the general public.

A local service agency implemented the program and contracted with community psychologist evaluators (Drs. Barile and Pruitt) to conduct an evaluation of the program. An evaluation is a systematic investigation of program merits, outcomes, and processes, using social science methodologies (Cousins & Chouinard, 2012). In particular, Drs. Pruitt and Barile were tasked with evaluating the program for fidelity to the model (i.e., how well does the program adhere to the original program model?), housing retention, and cost-benefit analysis (i.e., do the benefits outweigh the costs?). The original evaluation plan was a mixed-methods design, including staff and client interviews as well as monthly client surveys.

Participatory Evaluation

In an effort to better understand the experiences of individuals in the program, community psychologist evaluators decided to engage in a participatory evaluation, which engages non-evaluator stakeholders in the research and evaluation process (Cousins & Chouinard, 2012). Participatory evaluations can be grouped into practical participatory evaluations and transformative participatory evaluations (T-PE). Our project

falls within a transformative participatory evaluation approach, which aims to create conditions in which individuals who have traditionally had little access to power can empower themselves. Evaluators felt that T-PE would work well with the Housing First program philosophy, particularly the value of "consumer choice." By creating a new evaluation process in which the researched become co-researchers, T-PE allowed clients to have more say in the policies and research that affect them. Additionally, with its attention to power and explicit goal of transforming systems, T-PE complemented Dr. Pruitt's intersectional approach to research and evaluation. Finally, this approach seemed to fit better within the local context, which values cooperation and collaboration over power and competition and traditional hierarchical Western approaches.

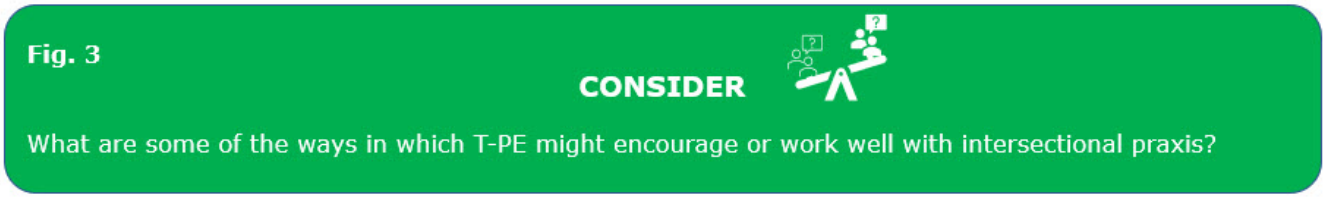


Image is a call-out asking the reader what are some ways they might encourage or work well with an intersectional praxis?

Collaborative Partners

In general, participatory evaluations focus on relationships as an important outcome, and this project, likewise, prioritized building relationships between partners. Collaborative partners have included program staff, community psychology evaluators, and program participants—"clients". While the individuals who hold these roles have changed over time, the partnership has remained stable. In particular, consistency in lead evaluators and a core group of clients has helped maintain the partnership even as case managers and other program staff have shifted. The initial community psychology evaluators consisted of Drs. Barile and Pruitt. Dr. Pruitt was in graduate school at the beginning of the partnership and has now taken on a leadership role in the project. Another community psychologist (McKinsey) joined in 2018 and, along with Dr. Pruitt, worked closely with community partners, attending weekly meetings. These two community psychologist evaluators—two White women in their 20s and 30s from the southern United States—had the most on-the-ground contact with partners. While evaluators stayed relatively stable, program staff has shifted over time. At any one time, program staff consisted of four case managers, two housing specialists, two administrative staff, and an interfaith chaplain/community liaison. However, the individuals who have served in these roles have changed over time. Clients involved in the partnership have also changed over time; however, for the most part, the core group of clients has remained consistent.

In evaluation, it is important to consider the ways in which different partners had different stakes in the project and varying levels of power. An intersectional approach to evaluation necessitates attention to power. In our partnership, clients had the least amount of power—both within the program and within the greater community—and also had the most at stake (e.g., their housing). Program staff also had much at stake (e.g., their jobs) but had considerably more power than clients. Various levels of power also existed among program staff. Case managers, for example, had less decision-making power than upper-level administration. While evaluators had significant power (e.g., determining what results and recommendations are passed

along to funders), they were under contract with the program and largely depended on program staff for access to data and ultimately, a successful evaluation project. For the partnership to be successful and equitable, evaluators knew they had to consider these dynamics and how they were informed by the larger socio-historical context. For example, as members of the colonizer group, the community psychologist evaluators were constantly considering the ways in which systems of power attached to their social identities were impacting the group dynamics. In this case, intersectionality was employed as an analytical tool.

Community Assets/Needs

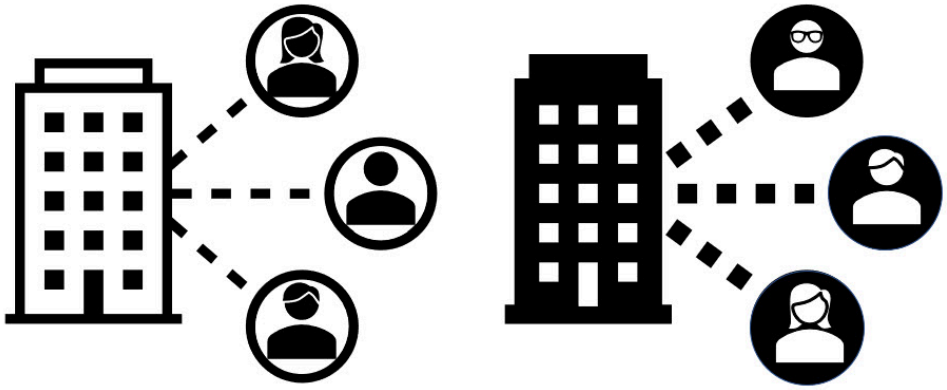


Image above titled "community needs assessment/needs" depicts two apartment buildings with six different types of residents to represent diverse perspectives.

Despite power differentials, the partnership offered the potential to meet the various needs of the diverse partners involved. The T-PE approach was embraced by the program, which was looking for a way to build client feedback into the program model. The participatory evaluation was one way to formalize that process. Additionally, community psychologist evaluators initially had difficulty accessing program data. Clients were hesitant to fill out monthly surveys and case managers were hesitant to encourage clients to complete them for fear of compromising program fidelity related to consumer choice. Case managers who were overburdened with high caseloads in the first year needed a way to see multiple clients at once (Smith & Barile, 2015). Clients expressed a desire for social support, community, structure, and something meaningful to do. The chaplain/community liaison was looking for a way to address these issues. Overall, community psychologist evaluators were looking for a way to better engage with the program without adding to the workload of program staff or stress of the clients.

Assets and Strengths

Thankfully, the partnership allowed for partners to meet these needs by capitalizing on the existing strengths and resources of various partners. For example, one of the biggest strengths was the ongoing commitment to building community and social support among program staff and clients as part of an optional weekly support group. Led by the chaplain/community liaison, the group met to discuss challenges with housing, to provide peer support, and to (re)learn "life" skills. Case managers also participated, some of them

having had experienced similar challenges in the past. Dr. Pruitt began attending the group as part of an initial Photovoice project aimed at engaging clients and staff in the evaluation through the use of photography. Building the project and partnership into an ongoing program component was beneficial in that trust between group members had already been established. Over the next five years, the Housing First Community Group, comprising HF clients, program staff, and community psychologist evaluators became an integral part of the program and evaluation design. Additional strengths included the fact that upper-level program staff had important contacts in the community that paved the way for future Photovoice exhibits and dissemination of evaluation findings. The program evaluators had training in participatory and arts-based methods and were able to use this training to inform the evaluation research project. Importantly, program staff and clients were open to collaboration, and all partners were committed to learning from each other from the start. Perhaps most notable were the clients' strengths. Rarely are individuals who have experience with homelessness or severe poverty considered to have strengths and assets that are beneficial to society. Our work together revealed that this is a significant miscalculation by "housed" individuals. We identified the following:

- Clients were resourceful and insightful, making connections between quantitative outcomes and qualitative outcomes.
- They helped case managers check in on other clients in the program who may have been dubious of case management.
- They assisted in outreach.
- They helped the evaluators interpret survey results and were invested in the evaluation process as a whole.

For example, when survey data showed a decrease in physical and mental wellbeing after six months of housing, program staff and evaluators assumed clients were struggling with transitioning to housed life and considered offering more "life skills" classes. However, the interpretations from the client co-researchers revealed a more complex story. They explained that it took many months of housing before they felt safe enough to come out of the constant state of "fight or flight" they experienced prior to housing. Once they emerged from this state, they were able to take stock of their wellbeing and recognize the trauma they had endured. Some described their reactions in terms similar to post-traumatic stress disorder. Due to their insights, the program was able to address this issue by providing more comprehensive services beyond life skills classes. The value of such contributions is often overlooked in evaluation projects that do not take a participatory approach, and the value of the contributions of those who have traditionally been excluded from the process cannot be overstated.

Participatory Research Project: Photovoice Studies

Throughout our partnership, the Community Group—or "the group"—has collectively produced multiple evaluation reports, participated in community arts projects, and conducted participatory research projects.

This section focuses on the two biggest projects which both used Photovoice, a participatory research methodology.

Photovoice Project One

In January 2016, the group chose to conduct a Photovoice project that examined clients' experiences in the program and gave them the opportunity to speak to the program and the larger community about these experiences. Photovoice seemed an appropriate choice given that it is a community-based participatory research method in which participants use photography to(a) identify and record their personal and community strengths and concerns;(b) engage in critical dialog about them; and(c) communicate these strengths and concerns to policymakers (Wang & Burris, 1997).

As a participatory method, all partners are involved at each stage of the research process, from the development of the research question to the dissemination of findings. Photovoice works to center the voices and experiences of individuals traditionally left out of the research process (Tsang, 2020; Wang, 1999). Thus, the method worked well with our T-PE and intersectional approach. Individuals experiencing homelessness, particularly those who also experience severe mental illness or chronic health conditions, rarely have a say in the research and policies that greatly impact them. This exclusion is largely due to social exclusionary policies and assumptions by the larger society that such individuals are incapable of meaningful contribution to research and practice. Photovoice allowed for both the creation of an inclusive space that centered on client voices and analysis of the processes that tend to restrict inclusion and voice.

As part of this initial three-month study, 18 Housing First clients and two case managers took more than 300 photographs over a four-week period. At that point, most clients had been housed less than a year, and thus, the group decided to focus on the initial transition from homelessness to housing. They took photographs in response to prompts aimed to examine this process (e.g., "How is your life different now?" "What is everyday life like for you?"). Each week, clients and case managers shared photographs with each other and discussed their relevance to the prompt and the overall research question. Then, the group collectively conducted participatory analysis on the photos (see Image 2) and reported the findings in the yearly evaluation report (Pruitt & Barile, 2017). After the conclusion of the Photovoice project, Dr. Pruitt continued attending the weekly community group. As staff turned over, she often took on a facilitator role. A core group of clients also continued to attend and contribute to group agendas. This commitment helped ensure the group continued even in the midst of staff turnover. As several clients noted, having that consistency was meaningful. Throughout the next year, the group engaged in continued participatory evaluation research and practice, assisting in evaluation reports, helping interpret evaluation results, providing peer support to others in the program, and assisting Dr. Pruitt in her research on local media coverage of homelessness. Importantly, the group co-authored an academic journal article in 2017.

Photovoice Project Two

In 2017, HF clients in the group asked Dr. Pruitt to help them design and conduct a follow-up Photovoice study. With increased knowledge of the research process, clients wanted to examine the long-term and

continuous nature of the recovery process from homelessness. The group applied for and was awarded a Society for Community Research and Action Mini-Grant to purchase higher-quality cameras. From August–November of 2018, 22 individuals participated in this project (15 clients, four staff members, and three evaluators), most of whom had participated in the 2016 study and had been housed for an average of 3.4 years.

Participatory Analysis

In both projects, the community group conducted a participatory analysis of the photos. During meetings, group members would select a few meaningful photos to share, with the photographer contextualizing the photo by describing where and when it was taken, why it was meaningful, and/or what it represented. The group, then, collectively analyzed the photos by identifying patterns in photos and drawing connections to previously shared photos. In 2018, the group coded photographs using large theme boards (see Image 3). The ultimate goal of the analysis was to identify key themes relevant to the long-term process of transitioning into housing and recovering from the trauma of homelessness. Based on the themes identified during the participatory analysis stage, community psychologist evaluators also conducted a secondary content analysis of all meeting transcripts. Content analysis is a classification process consisting of codifying and identifying themes within qualitative data (e.g., transcripts; Collins et al., 2016). The goal of the secondary analysis was to examine the unique contributions of the Photovoice method and to gain a comprehensive understanding of the recovery process.

Outcomes

Participatory and content analyses of the projects suggested that although housing brought stability to many aspects of life, challenges such as stress, stigma, and everyday struggles persisted for many clients once housed. Additionally, social support and community reintegration continuously appeared as prominent indicators and promoters of recovery from the trauma of homelessness. Other prominent themes identified as relevant to transition to housing and recovery included:

- the importance of projects, hobbies, and goals;
- appreciation of people and environment;
- the stigma surrounding homelessness; and
- reflection on life before and after housing.

While both studies demonstrated the difficulties clients faced with stigma, the first study found that clients felt that the level of the interpersonal stigma they experienced had been reduced with their housed status. However, the pain of previous treatment was still poignant. In the second study, clients continued to discuss stigma; this time, from a macro-level perspective. They discussed the stigma toward "the homeless" that they perceived in the media, local policies, and in the larger community's attitudes (see Image 4). Notably, they wanted to use the findings from these projects to try to address this stigma and advocate

for the homeless community. For more information on study findings, please visit our website at www.hf-photovoiceprojects.com (or see Pruitt et al., 2018).

Dissemination

With social and political transformation as central goals of Photovoice methodology, dissemination of findings was essential to the project. Further, clients consistently explained that part of their motivation for participating in the project was its potential to create social change. As such, extensive dissemination of findings is an important piece of these projects.



Photovoice Exhibit, Honolulu Hale (City hall), 2016
Photo courtesy of Dr. Anna Pruitt

Given that findings are informed by the lived experiences of individuals whose perspectives are rarely seen in the dominant public discourse, exhibits were one of the main dissemination tactics to reach a broad audience. In 2016, the group held an exhibit for the first Photovoice project's photos and findings at Honolulu Hale (City Hall) in collaboration with the program, the City and County of Honolulu, and the University of Hawai'i at Mānoa. The exhibit was also displayed at the university's Hamilton Library in November 2018, along with the second project's photos and findings. In 2019, the second project's exhibit was displayed at two other community events, including the Hawai'i Art and Mental Health Summit and the Homelessness Interfaith Summit. The goal was to reach diverse audiences with varying levels of power and stakes in the program and to center the perspectives of individuals from the margins. Findings have also been disseminated within the academic community. Throughout 2017, HF clients and program evaluators co-authored a research article that reported findings from the first project, which was published in the American Journal for Community Psychology in January 2018 (see Pruitt et al., 2018). Evaluators are currently in the process of preparing a manuscript that shares both participatory analysis findings of the second Photovoice project and secondary content analysis findings. Findings and corresponding recommendations have also been included in annual evaluation reports to the program. Lastly, evaluators developed a website detailing the PV process, projects, and findings.

Impact

The two Photovoice projects also resulted in varied impacts—transformative change, knowledge creation, and methodological insights:

Transformative impact: Both projects sought to achieve a transformative impact by providing a time and space for HF clients to actively reflect on their own lived experiences, offer feedback to the program, and to

engage in social action. Recognizing that they had "won the lottery" in being chosen for this pilot program, they wanted to help others by sharing findings from the studies in an effort to change the local homeless service system. Analysis of the impacts of the first Photovoice project revealed transformative change on the individual, program, community, and policy levels (see Table 1; Pruitt et al., 2018).

Table 1. Transformative Impacts

Level of Change	Examples of Change
Individual-level	Decreased perceived interpersonal stigma
Program-level	Increased client voice in program
Community-level	Community education on homelessness, mental illness, and Housing First
Policy-level	Extension of program funding and expansion of program to neighboring islands and adoption of Housing First as a statewide model

The two-column table above shows level of change and examples of change on the individual, program, community, and policy levels.

Knowledge Creation: The projects also built knowledge as a result of the lived experiences of the transition to housing and the recovery from homelessness by taking a phenomenological approach to community-based participatory research (Bush et al., 2019). Phenomenology is a research approach grounded in the belief that knowledge can be derived from experience (Racher & Robinson, 2003), and seeks to build knowledge by relying on the accounts of those experiencing the phenomenon of interest (Giorgi et al., 2017). Indeed, as the field of community psychology teaches, the true experts on any given issue are those most impacted by that issue.

Fig. 4

CONSIDER



How might knowledge of lived experiences connect to intersectional praxis? How might knowledge built on lived experience disrupt dominant systems of power?

Call-out box above asks the reader to consider how might knowledge of lived experiences connect to intersectional praxis and disrupt systems of power.

Methodological Insight: Lastly, the use of various research methods throughout the projects increased understanding of research approaches used to study lived experience. Intersectionality scholarship argues that research on any given issue calls for diverse approaches and methods (Moradi & Granzka, 2017). In line

with this argument, community psychologist evaluators conducted both participatory and content analysis to draw meaning from photos and discussions. Comparison of these methods further emphasized the need for multiple research approaches to comprehensively capture the essence of lived experience. For instance, evaluators found that some themes that were prevalent in photos were not frequently discussed and that some themes prevalent in discussions were not frequently photographed. These findings signal that some topics are hard to put into words, while others are hard to capture visually. Additionally, evaluators encountered difficulty interpreting themes identified through content analysis themselves, revealing how participation and insight from HF clients were crucial to being able to comprehensively and accurately analyze data generated from the projects.

Fig. 5

CONSIDER

How might method diversity help community psychologists understand complex phenomena like recovery from homelessness? How does intersectionality necessitate diverse methods?

Similar call-out box as Figure 4, but asks the question of how might method diversity help community psychologists understand complex factors like recovery from homelessness and how does intersectionality necessitate diverse methods.

Lessons Learned

Overall, this partnership has been a process of mutual learning for all partners, and this section details the lessons learned engaging in the participatory research process. Notably, this section reflects the lessons learned by the community psychology evaluators involved in the projects. The initial plan for this case study was to include the perspectives of all partners. However, due to COVID-19, this collaboration has not been possible. Thus, this section may be most useful for community psychologist evaluators working in multicultural environments with marginalized communities. We recognize that given the lack of our partners' voices, this section is necessarily incomplete. Perhaps the first lesson, then, is for community psychologists to be aware that our perspectives are not universal but are situated in a larger context informed by intersecting systems of power. One of the most important lessons included learning that taking on the researcher role could be difficult for clients.

While participatory researchers generally assume that more ownership of and voice in the research project is desirable and "empowering," our work showed that taking on this role comes with unique challenges (McKinsey & Pruitt, 2019). For example, clients did not take any photographs the first few weeks of the second Photovoice project, despite the fact that they had initiated the project themselves. While one staff member worried that this hesitancy meant they did not want to participate, group discussions suggested that clients were taking more time because they wanted to "do it right," and that they were extremely anxious about potentially making a mistake. Community psychologists working with marginalized groups should consider these challenges and address them throughout the project for some of the strategies we used to address these challenges).

Another lesson learned through the partnership is that dissemination can be one of the most power-

laden stages of research. For example, balancing power among stakeholders during exhibit planning proved difficult. During the first exhibit at Honolulu Hale (city hall) in 2016, homelessness was a hot topic in the local media, and the exhibit was taking place during an election year. The program also wanted to use the exhibit as an opportunity to educate the community on its other housing programs. Thus, many higher-powered stakeholders now had a vested interest in the project—which we acknowledged could be both advantageous and challenging for the group's goals. Beforehand, we talked as a group about the potential for the media or politicians to usurp our project to push agendas not necessarily in line with our own. The group collectively decided that the risk was worth the potential benefit of advocating for the program and others still experiencing homelessness. The exhibit received significant press coverage and was attended by the mayor and other prominent politicians, and the group was satisfied with the overall event. However, the negotiation and planning were daily stressors for evaluators, who served as mediators in these negotiations.

Additionally, the co-authoring of the journal article revealed the power dynamics inherent in academic writing. As hooks (1989) reminds us, the writing of research takes place within a context and that this context often supports white dominance. For example, hooks (1989) points out that White scholars make the mistake of not recognizing that writing occurs within a "culture of domination" and fail to understand power and context, and thus, their work often reinforces that domination. As White community psychologists, we found that we must be cognizant of the impact of this context at all stages of the research process if we were to (co)produce socially responsible research. In fact, researcher self-reflexivity, while necessary, was not enough. In addition to being aware of our own positionality within this web of power, we also needed to be critical of the very conventions that we relied upon and the process of power inherent in those conventions. We found that we needed to shift our focus from identity groups (based on race, gender, homeless status, etc.) to context or process.

Other lessons learned included learning to balance calling attention to differences among partners (e.g., related to power and skills) with recognizing our similarities. We also discovered that relationships were the most integral part of the research and knowledge-building process. It was clear that clients found the relationships they built with each other, the staff, and the evaluators to be most important to their continued investment in the partnership and even to their own recovery processes. Similarly, staff and evaluators found these relationships enriching and sustaining. Evaluators realized that they were as much a part of the group as any other members and found that to over-emphasize differences between them and the group members, however well-intentioned, could be offensive to some group members. For example, Dr. Pruitt found that calling attention to client "expertise" in understanding homelessness and the housing process served to distance herself from clients, and clients responded by emphasizing that they were more similar to her than different. One of the strategies that helped to reconstruct the assumed hierarchy of knowledge and skills (in any direction) was engaging in arts-based projects. With these projects, we were all simultaneously learning new skills and at times, learning from other clients with art backgrounds helped teach the group. In this way, clients, staff, and evaluators were on the same level, learning together.

Looking Forward



Image above of handmade artful sign that reads: Notes – The flowers are blooming for us! as part of the Positive Signs Project, 2019
Photo courtesy of Dr. Anna Pruitt

Recognizing the value of art in relationship-building, self-healing, and social action, at the conclusion of the second Photovoice project, the community group decided to form an arts hui (group) to learn various art techniques and to create art for themselves and for social action. For example, one of the art projects included a "positive signs project." During one of the Photovoice discussions on stigma, group members questioned why public signs were always so negative, saying "don't do this; don't do that." So, the group decided to engage in a sign project that distributes positive messages (see Image 7). For example, in response to signs instructing people not to sit or lie on public sidewalks (effectively criminalizing homelessness), one group member suggested the group make signs that inform people where they can sit (see Image 8). The group has also engaged in the art of cooking, learning new methods for creating affordable and healthy dishes.

Unfortunately, in March 2020, the COVID-19 Pandemic halted the weekly group meetings that have sustained this partnership. While all partners hope to continue the weekly meetings as soon as it is safe, it is unclear when or how to go about reconvening given the fact that many group members (including staff, clients, and evaluators) experience chronic health conditions that put them at risk for severe disease. While the group attempts to stay in contact via phone and email, many group members lack regular access to this technology. Some of us have remained in contact via the mail, and evaluators are working to build capacity to meet virtually. For now, however, the future of the group is uncertain although the overall partnership continues.



Image is a photograph of a young person holding up hand made sign stating "Please Sit! Anytime you want 24/7" as part of Positive Sign Project, 2019
Photo courtesy of Dr. Anna Pruitt

Recommendations

Based on this partnership experience, the community psychologist evaluators have recommendations for other community psychologists working in similar settings with similar groups—particularly those community psychologists interested in intersectional and participatory approaches. First, rigorous qualitative, quantitative, and mixed-methods research can be conducted collaboratively with individuals

who have significant housing, mental health, and physical health challenges. Even individuals with ongoing psychosis were significant and essential contributors to the research project and were core leaders in the partnership. Community psychology practitioners working with such groups should not discount the abilities of community partners, and rather, should consider amending their practice by:

- **Remaining flexible**. Always have a plan but be willing to change it based on partner needs or changes in the context. Importantly, be willing to try something new and continue to seek ways to use the strengths of the community in meeting the needs and goals of the partnership.
- **Thinking outside the box**. Consider multiple avenues for participation and contribution. For example, we found that having a non-hierarchical, flexible group format with less structure helped produce a more inclusive environment for individuals who may have mental health challenges. It was also more culturally appropriate. Additionally, consider alternative or innovative research methods and ways of disseminating findings. We have already pointed to the value of arts-based approaches when working to center voices typically overlooked in research and practice. Intersectional community psychology practice might consider engaging in similar methods.
- **Being willing to be wrong**. Rarely do we get it right the first time. Making mistakes and conflict is an unavoidable part of any partnership and indeed, any authentic relationship. We found that some of our community partners reacted to conflict differently and more subtly than we expected. This reaction was an interaction of power differentials and also cultural and class differences. Indeed, differences even existed amongst community psychologist evaluators. Therefore, we had to ask for input from partners regularly and to investigate acceptable ways to address conflict. Importantly, we had to be willing to be wrong and work toward making it right without being defensive.
- **Building authentic relationships**. Partnerships will be greatly enriched if they are built upon authentic relationships between people who genuinely enjoy each other's company. We found that laughing together, eating together, and being vulnerable with each other were important aspects of building relationships among partners.

Additionally, we encourage relying on intersectionality analysis and praxis at each stage of the partnership. This approach will likely require constant attention to power and researcher flexibility. Often our community contexts can unintentionally reinscribe hierarchical and oppressive structures. While partnerships consist of multiple and complex relationships, and these relationships worked together to produce new knowledge, community psychologists should consider how power affects the knowledge produced and what role they might be unintentionally playing in the reproduction of oppressive structures. With such attention to power, community psychologists can facilitate the co-production of meaningful, transformative knowledge which extends beyond the patronizing trope of researchers "giving voice" to marginalized groups. Of course, this approach will require flexibility. As TallBear asserts, "A researcher who

is willing to learn how to "stand with" […] is willing to be altered, to revise her stakes in the knowledge to be produced" (2014, p. 2). For community psychology practitioners, especially those working with marginalized populations, the importance of showing up and doing what you say you are going to do cannot be underestimated.

In Hawai'i, as in homelessness services, people come and go frequently. Hawaii sees high rates of turnover in residents and is said to be a "revolving door," and homeless services is a field notorious for high turnover in social workers, outreach workers, and case managers. Many clients simply expected evaluators and other group members to leave, and they frequently mentioned how much it meant to them that we continued to come every week. One of us (Dr. Pruitt) recalls how one of the core client members continued to be shocked that she remembered his name every week, more than 4 years into the project. In other words, consistency was key to building trust. One of the clients mentioned that it meant a lot to him to know that he was an important part of the group and that if he didn't show up, other group members would wonder where he was. Indeed, if someone did not show up for a couple of meetings in a row, the group would often designate someone to check in on them to see if they were doing alright. Showing up, while it may seem like the least we can do, makes all the difference in building a strong partnership among those who have been socially excluded.

The reframing of the role of the trained researcher from offering expertise and "teaching" to showing up, standing with, and learning from the community is central to achieving equitable engagement and partnerships. Indeed, it became abundantly clear early in the Photovoice projects that HF clients did not expect perfection from us (i.e., in the ways we facilitated discussions or explained certain research concepts), but they did expect us to be present. It was this shared dedication to the project's goals, commitment to showing up every week, and excitement in creating transformative change that strengthened the partnership most. Additionally, it can be easy to get caught up in the notion that trained researchers have something to teach community members, especially marginalized community members. However, it can be more difficult to see the ways in which traditional researchers can learn from community members. As trained researchers, we often left Photovoice sessions shaken and awakened by clients' insights.

Conclusion

We have found that when an alternative type of space is created, people and knowledge thrive, allowing us to move beyond respect for diversity. Going beyond respect for diversity, this project demonstrates a space in which individuals of multiple races, classes, and genders worked together to build community, conduct rigorous research, and advocate for social justice. Ultimately, this case study sought to emphasize how to use community psychology values to conduct rigorous, long-term participatory research using innovative methods, and we argue that community psychology practice is incomplete without an intersectional approach. Community psychologist researchers and practitioners should not assume that collaboration and participation are enough to overcome pre-existing power dynamics and oppressive structures. Instead, they should also engage in constant reflexivity and recognize moments of subtle resistance. We hope we have demonstrated in this case study that community psychology practice should involve an intersectional

critical praxis that investigates power dynamics related to various and intersecting oppressions and identities. *"Practitioners who would be drawn to intersectionality as critical praxis seek knowledge projects that take a stand; such projects would critique social injustices that characterize complex social inequalities, imagine alternatives, and/or propose viable action strategies for change." (Collins, 2015)*

For the detailed Field Notes and Reflections on Field Notes for this case study, please contact Dr. Anna Pruitt.

FROM THEORY TO PRACTICE REFLECTIONS AND QUESTIONS

- How is the theory of intersectionality helpful in a participatory evaluation process? What are other areas where using an intersectionality approach might be beneficial?
- Pruitt et al. (2021) shared, "We hope we have demonstrated in this case study that community psychology practice should involve an intersectional critical praxis that investigates power dynamics related to various and intersecting oppressions and identifies." Reflect on how "power dynamics" and research further what this means in general and provide a short statement.
- Name one way you can think outside of the box within your own work or area(s) of interest as a community psychologist or other field if not community psychology.

References

Anzaldúa, G. (1987). *Borderlands/La frontera: The new mestiza* (4th ed.).

Barile, J. P., & Pruitt, A. S. (2017). The impact of place and time on homelessness rates in major U.S. cities. Paper presented at the Society for Community Research and Action Biennial Conference, Ottawa, ON, Canada.

Bilge, S. (2014). Whitening intersectionality. In W. D. Hund and Lentin (Eds.). *Racism and sociology* (pp. 175-205). Münster, Germany: LIT Verlag.

Bush, E. J., Singh, R. L., & Kooienga, S. (2019). Lived experience of a community: Merging interpretive phenomenology and community-based participatory research. International *Journal of Qualitative Methods, 18*, 1-12. https://doi.org/10.1177/1609406919875891

Collective, C. R. (1982). A Black Feminist Statement: The Combahee River Collective. In G. T. Hull, P. Bell-Scott, & B. Smith (Eds.), *All the women are White, all the Blacks are men, But some of us are brave: Black women's studies* (pp. 13–22). The Feminist Press at CUNY.

Collins, P. H. (2015). Intersectionality's definitional dilemmas. *Annual Review of Sociology, 41*, 1-20. doi: 10.1146/annurev-soc-073014-112142

Collins, S. E., Jones, C. B., Hoffmann, G….& Clifasefi, S. L. (2016). In their own words: Content analysis

of pathways to recovery among individuals with the lived experience of homelessness and alcohol use disorders. *International Journal of Drug Policy*, 27, 89–96. https://doi.org/10.1016/j.drugpo.2015.08.003

Cousins, J. B., & Chouinard, J. A. (2012).*Participatory evaluation up close: An integration of research-based knowledge,* Information Age Publishing, Inc.

Crenshaw, K. W. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics. *University of Chicago Legal Forum*, 139–67.

Crenshaw, K. W. (1991).Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241-1299.

Giorgi, A. P., & Giorgi, B. M. (2003). The descriptive phenomenological psychological method. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (p. 243–273). American Psychological Association. https://doi.org/10.1037/10595-013

Gramsci, A. (1971). *Selections from the prison notebooks of Antonio Gramsci.* (Eds. and trans., Q. Hoare and G. Nowell Smith): International Publishers.

Grzanka, P. R. (2020). From buzzword to critical psychology: An invitation to take intersectionality seriously. *Women & Therapy*, 43(3–4), 244–261.https://doi.org/10.1080/02703149.2020.1729473

Goodyear-Kaʻōpua, N. (2014). Introduction. In N. Goodyear-Kaʻōpua, I. Hussey, & Wright, E. K. (eds.) *A nation rising: Hawaiian movements for life, land, and sovereignty.* Duke University Press.Hawai'i Data Collaborative (8 May 2020). (Updated) Modeling Suggests Substantial Increases in the Financial Vulnerability of Hawaii's Families. Retrieved from: https://www.hawaiidata.org/news/2020/5/8/updated-modeling-suggests-substantial-increases-in-the-financial-vulnerability-of-hawaiis-families

Hawai'i Tourism Authority. (2019a). 2019 Annual visitor research report. Retrieved from: https://files.hawaii.gov/dbedt/visitor/visitor-research/2019-annual-visitor.pdf

Hawai'i Tourism Authority. (2019b). Fact sheet: Benefits of Hawai'i's tourism economy. Retrieved from: https://www.hawaiitourismauthority.org/media/4167/hta-tourism-econ-impact-fact-sheet-december-2019.pdf

Books, B. (1989). *Talking back: thinking feminist. Thinking black.* South End Press.

Lasky, J. (2014). Waiāhole-Waikāne. *A nation rising: Hawaiian movements for life, land, and sovereignty.* Duke University Press. https://doi.org/10.1515/9780822376552-006

McKinsey, E., & Pruitt, A. S. (2019). "Am I doing this right?": Helping Housing First clients navigate difficulties conducting community-based participatory research. *The Community Psychologist, 52(*3), 65-68.

Minerbi, L. (1999). *Indigenous management models and protection of the Ahupua'a. The ethnic studies story: politics and social movements in Hawai'i.* University of Hawai'i Press.

Moradi, B., & Grzanka, P. R. (2017). Using intersectionality responsibly: Toward critical epistemology, structural analysis, and social justice activism. *Journal of Counseling Psychology*, 64(5), 500–513. https://doi.org/10.1037/cou0000203

National Alliance to End Homelessness. (2020). State of Homelessness: 2020 Edition. https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-2020/

Office of Hawaiian Affairs (OHA). (2019). Native Hawaiian homeless population on Oʻahu: Data from point-in-time count, January 2019. Presentation at the 2019 Homeless Awareness Conference, Honolulu, HI. https://doi.org/10.1007/978-3-030-44567-6_10

Osorio, J. K. (2001). "What kine Hawaiian are you?" A Moʻolelo about nationhood, race, history, and the contemporary sovereignty movement in Hawaiʻi. *The Contemporary Pacific,13*(2), 359-379. 10.1353/cp.2001.0064

Padgett, D., K. Henwood, B. F., & Tsemberis, S. J. (2016). Housing first: ending homelessness, transforming systems, and changing lives. Oxford University Press.

Partners in Care. (2020). 2020 Oahu Point in Time Count Comprehensive Report. https://static1.squarespace.com/static/5db76f1aadbeba4fb77280f1/t/5efa984a8ae4f774863509e8/1593481306526/PIC+2020+PIT+Count+Report+Final.pdf

Plunkett, R., Leipert, B. D., & Ray, S. L. (2012). Unspoken phenomena: using the photovoice method to enrich phenomenological inquiry. *Nursing Inquiry, 20*(2), 156-164. https://doi.org/10.1111/j.1440-1800.2012.00594.x

Pruitt, A. S. (2019).Racial Equity in Honolulu County Homelessness Services. Prepared for Partners in Care, Oʻahu's Continuum of Care, Honolulu, HI.

Pruitt, A. S., & Barile, J. P. (2017).Housing First program, year two evaluation. Prepared for the City and County of Honolulu and the Institute for Human Services, Honolulu, HI

Pruitt, A. S., & Barile, J. P. (2020). Unsheltered in Honolulu: Examining Unsheltered Homelessness in Honolulu from 2017-2020. Prepared for the City & County of Honolulu and Partners in Care, Honolulu, H.I.

Pruitt, A. S., Barile, J. P., Ogawa, T. Y., Peralta, N., Bugg, R., Lau, J., Lamberton, T., Hall, C., & Mori, V. (2018). Housing First and photovoice: Transforming lives, communities, and systems. *American Journal of Community Psychology, 6*1(1–2), 104–117.https://doi.org/10.1002/ajcp.12226

Pruitt, A. S., McKinsey, E., & Barile, J. P. (2020)."A State of Emergency": Dominant Cultural Narratives on Homelessness in Hawaiʻi. *Journal of Community Psychology, 48*(5), 1603-1619.

Racher, F. & Robinson, S. (2003). Are phenomenology and postpositivism strange bedfellows? *Western Journal of Nursing Research, 25*(5), 464-481. https://doi.org/10.1177/0193945903253909

Shinn, M., & Khadduri, J. (2020). *In the midst of plenty: Homelessness and what to do about it*: John Wiley & Sons Ltd.

Smith, A., & Barile, J. (2015).Housing First program one-year evaluation. Prepared for the City and County of Honolulu and the Institute for Human Services, Honolulu, HI

Society for Community Research and Action (SCRA). (2011). Competencies for Community Psychology Practice. http://scra27.org/what-we-do/practice/18-competencies-community-psychology-practice/

Society for Community Research and Action (SCRA). (2020). Who we are: Principles. http://scra27.org/who-we-are/

Stover, J. S. (1997). The Legacy of the 1848 Māhele and Kuleana act of 1850: A Case Study of the Lāʻie Wai and Lāʻie Maloʻo Ahupuaʻa, 1846-1930. [Masterʻs thesis, University of Hawaiʻi]. Scholar Space.

TallBear, K. (2014). Standing with and speaking as faith: A feminist-indigenous approach to inquiry [Research note]. *Journal of Research Practice, 10*(2), Article N17 http://jrp.icaap.org/index.php/jrp/article/view/405/371

The Overthrow. (1999, June 16). Star-Bulletin. http://archives.starbulletin.com/1999/06/16/millennium/story7.html

Truth, S. (1851). Ain't I a Woman? Ohio Women's Rights Convention, Akron, OH.

Tsang, K. K. (2020). Photovoice Data Analysis: Critical Approach, Phenomenological Approach, and Beyond. Beijing International Review of Education, 2(1), 136–152.https://doi.org/10.1163/25902539-00201009

Tsemberis, S. (2010). *Housing First: The pathways model to end homelessness for people with mental illness and addiction*. Hazelden.

US Bureau of Labor Statistics. (2020a).Economy at a glance. https://www.bls.gov/eag/eag.hi.htm

U.S. Bureau of Labor Statistics (2020b). Local area unemployment statistics. https://data.bls.gov/timeseries/LASST150000000000003?amp%253bdata_tool=XGtable&output_view=data&include_graphs=true

U.S. Census Bureau. (2019). American Community Survey, 2019. https://www.census.gov/quickfacts/honolulucountyhawaii

U.S. Department of Housing and Urban Development (HUD). (2012). Homeless Definition. https://files.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

Wang, C. C. (1999). Photovoice: A participatory action research strategy applied to women's health. *Journal of Women's Health, 8*(2), 185-192. http://doi.org/10.1089/jwh.1999.8.185

Wang, C., & Burris, M. A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education & Behavior, 24*(3):369-387. https://doi.org/10.1177%2F109019819702400309

Watson, T. K. (2010). *Homelessness*. In C. Howes & J. Osorio (eds.)*The value of Hawaii: Knowing the past, shaping the future*. University of Hawaii Press.

Weber, L. (2009). Understanding race, class, gender, and sexuality: A conceptual framework (2nd ed). Oxford University Press.

SEE CONTRIBUTORS PAGE FOR LIST OF AUTHORS (EDITED BY GERALDINE PALMER, TODD ROGERS, JUDAH VIOLA, AND MARONICA ENGEL)

PART IV

Part Four: Community and Public Health



Qimono@pixabay.com

The CDC Foundation defines public health as "the science of protecting and improving the health of people and their communities." You will find public health professionals working to prevent the spread of illness within large populations of people or smaller segments of people as in a single community. Further, their work revolves primarily around prevention, but they also attempt to understand how disease spreads and the effects on populations. Community health is similar and when working within communities, community psychologists have similar goals. However, they take a different approach such as focusing on the eradicating the impact of health disparities because of socioeconomic, cultural and ethnic factors.

The three case stories in this section will provide those interested in public and community health an excellent lens in which to see this type of work being done by three community psychologists. The first story *A Plan for Prevention: Measuring Equity from the Start* , contributed by Dr. Tonya Roberson focuses on a community-based participatory research (CPAR) methodology to promote health equities for African American students at an HBCU.

The second story *Working with Survivors of Gender-Based Violence* authored by Dr. Dessie Clark and Joshua Brown, LCSW tackle the task of bringing awareness to gender-based violence and working with survivors of this prevailing social issue, particularly those who might be living with traumatic brain injury as a result.

The third story*Journeying Past Hurt: Creating and Sustaining Trauma-Informed Healing Practices With Black Pregnant and Parenting Mothers* contributed by Dr. Deidra Somerville who centers her work on individual,

family, and community healing. The story provides an excellent narrative on how to incorporate the knowledge and experiences of Black pregnant and parenting mothers into training programs and curriculum designed to support family health and well-being.

11

A Plan for Prevention: Measuring Equity from the Start

TONYA S. ROBERSON, PH.D., MPH, DTR

This case study discusses using culturally tailored data collection tools when applying practical community-based participatory research methods to promote health equities for African American students at an HBCU.

THE BIG PICTURE



Image of girls or women with one jumping up to show happiness and health.

The United States has historically been a country struggling with racial and health disparities. Disparities in health outcomes and healthcare persist between racial, ethnic, and socioeconomic groups in the United States with African Americans (AA) suffering greater from chronic diseases such as cancer, heart disease, stroke, dementia, HIV/AIDS, diabetes, and the morbidity and mortality rates for African Americans far exceed that of White Americans (The State of Health Disparities). Working as a community psychologist and studying the impact of diseases and inconsistencies, I see patterns in health care inequities. African Americans get sicker and die at a younger age from preventable ailments and diseases than White Americans. Furthermore, the history of medical mistrust among African Americans has been justifiably consistent and long-lasting. In a 1966 speech on health care injustice to the Medical Committee for Human Rights, Dr. Martin Luther King Jr., an African American Baptist minister and activist at the time shared, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane". These inequities result from a combination of

individual and group behavior, lack of health and research knowledge, systemic inequality in economics, housing, and health care systems. African Americans have been underrepresented in medical research. Improving health disparities will require a methodical, purposeful, and sustainable effort to address issues including but not limited to health education and health literacy. The healthcare system cannot begin to address health issues or engage in prevention efforts if the patients do not understand what is being said to them. The patient needs to understand the information given to them to make informed decisions. Improved health education and health literacy will enable people to make informed decisions that lead to better health outcomes, family and social support, and access to health care which will ultimately help reduce disparities. The need to implement culturally specific research data collection tools to increase diversity and inclusion and increase the research participation of African Americans across ages to reduce the existing health inequities is imperative.

Dr. Martin Luther King Jr., an African American Baptist minister and activist at the time shared a profound remark, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane".

What Does Health Disparities Have to Do With It?

The United States (U.S.) government defines a health disparity as "a particular type of health difference that is closely linked with social or economic disadvantages. For example, did you know that in the U.S., Black adults are nearly twice as likely as White adults to develop type 2 diabetes? This racial health disparity has been rising over the last 30 years and continues to rise. Disparities exist in nearly every aspect of health, including quality of health care, access to care, utilization of health care, medication adherence, and health outcomes. These disparities are believed to be the result of the complex interaction among genetic variations, health literacy, environmental factors, existing zip codes, and specific health behaviors. Closing these multi-layered gaps in health outcomes is no easy task. Community Psychologists can better identify and address the needs of a diverse population when we consider health disparities. Solutions are more likely to endure if they address both the current cause of a given disparity as well as the circumstances that caused it to occur initially.

The most recent pandemic Covid-19 has heightened our awareness regarding health disparities in the United States. Drivers of health inequities have been debated through the years, but most notably include social determinants of health (SDOG) such as poverty, employment in low-wage, but essential worker jobs, and crowded housing situations (Riordan, Ford, & Matthews, 2020). In the public health arena, the importance of addressing all facets of SDOH to advance health equity has long been recognized and discussed. When developing solutions to health problems, community psychologists recognize the importance of culture and context rather than assuming a "one size fits all" will be effective. Often, adaptations are needed to fit individuals.

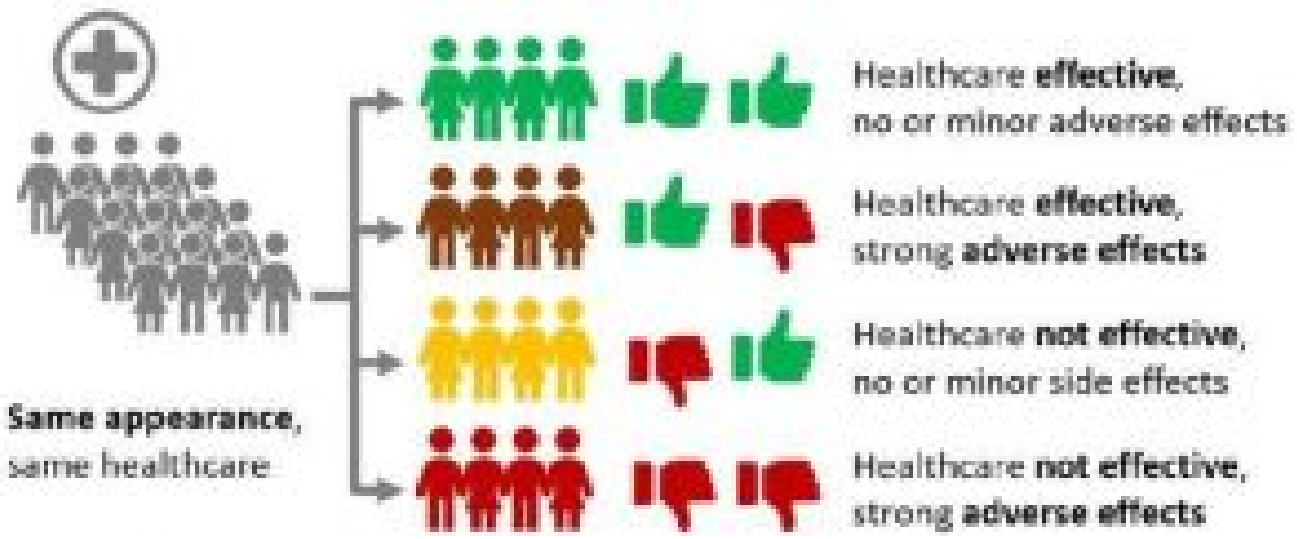


Figure 1 One-size-fits-all health may not fit all. (Research Gate). (Image showing the idea that one size doesn't fit all using images of people and thumbs up or thumbs down icons representing effectiveness and potential adverse effects of the approach).

Think Globally, Act Locally: Lived Experiences

I have always considered myself a public servant and have been inspired by the words and work of Dr. Martin Luther King Jr. The following quote is from a1965 speach in Selma, Alabama which speaks to the meaning of being a global citizen. "Our lives begin to end the day we become silent about the things that matter." I take this to statement mean that …those who recognize that a wrong is being committed and fail to make a change are not necessarily guilty of the wrongdoing, but neither are they acquitted of the harmful outcomes.

"Our lives begin to end the day we become silent about the things that matter."

When my mother, a former educator, was diagnosed with breast cancer during a routine mammogram I witnessed firsthand what health disparities look like. During her bout with breast cancer, she and our family faced many racial and cultural barriers, provider stereotyping, and communication difficulties between my mother and her provider. This experience made me think seriously about the other patients that did not have the capacity our family had to advocate for her, yet face the same challenging experiences. What was their outcome going to be? Will they live or die if they decide not to go through with suggested procedures because of feeling uncertainty, intimidation, or like a 'guinea pig'? Who was going to be the voice for them, and at that point, I said, "I WILL!" I began volunteering with community–based organizations and then working to conduct community-engaged research, recruiting research volunteers in underrepresented communities with large academic medical centers, healthcare organizations, and community-based settings. The more involved I became, the more I witnessed the medical mistrust that existed and the health and racial disparities. I started to focus on two important areas: health education and disease prevention strategies to promote improving the quality-of-care and quality-of-life of persons coping with a life-threatening illness.

Community Assets/Needs

"If we take the time to care about people, we can transform whole communities.
You never know how you can change someone's life by showing him or her that you care." – Rehema Ellis/NBC News

In my experience community-engaged research benefits from initially using a Community-Based Participatory Research (CBPR) approach. Community-Based Participatory Research involves an equitable partnership involving all research parties in all aspects of the research process from inception to dissemination. CBPR relies on "trust, transparency, dialogue, extending and building community capacity, and collaborative inquiry toward its goal of improving health and well-being" (Winkler & Wallerstein, 2003). I've found that "true" CBPR approaches in health disparities research take a least two years to develop and the process needs to be ongoing. CBPR combines the best of community and academic wisdom, experience, and knowledge to promote social change to improve community health and reduce disparities. The CBPR approach has been effective in impacting health outcomes such as asthma, diabetes, and cardiovascular disease (Israel, Eng, Minkler, & Parker, 2012).



Principles of CBPR image shows community-based participatory research (CBPR) at the center with eight elements contained in effective CBPR.

Within the last twenty years, CBPR has gained recognition within the public health sector and shown that community engagement is vital for effectively identifying and addressing health disparities. Many causes of health disparities and inequities include poor education, poor health behaviors of the group, poverty (inadequate financial resources), personal and environmental factors (USDHHS). Most of these factors are related to access. To impact health disparities and inequities we must strive toward holistic health equality for African Americans and other populations of color, the healthcare system must begin working to abolish the protracted consequences of racism. More meaningful data at the individual and cultural level should be collected among people of all ages, and then reviewed, and considered by both the members of the community and public health leaders and government decision-makers. This data and its review can be used to develop tailored health initiatives to improve health outcomes and increase equity. Including partnerships at the inception of the data collection process and culturally relevant data collection tools will increase the likelihood that the results are appropriately attained and accurately interpreted. The time has come for the political, economic, and social powers that have negatively impacted American medicine to reshape decisions

that affect African American health policies. Assessments are conducted for various audiences, including researchers, funding agencies, private agencies, and policymakers and they must be culturally tailored for the target group. Researchers must then report factual and credible findings. Only then can health disparities be addressed and measured thoroughly and accurately.

Why Culturally Tailored Interventions?

Often evidence-based interventions are not tested with culturally diverse populations. Distinct cultural groups have unique needs and often fall through the cracks of service and healthcare systems. Interventions tailored for specific populations, can address these needs and reduce disparities. In order to improve African Americans' health knowledge and willingness to participate in research, data collection instruments must be developed with the understanding that the respondents will only interpret questions and terms based on their own experience and context. Community psychologists working as researchers must aim to construct questions that are understandable and relevant to the group being studied to obtain the relevant information to combat the issue.



Image by Andrew Martin from Pixabay (Image above says "Mind the Gap")

Dr. Robert Williams, an African American psychologist and professor who created the Black Intelligence Test of Cultural Homogeneity (BITCH-100) in 1972 because he saw the bias in intelligence tests towards White Americans. Dr. Williams also saw this as a problem because low test scores among African Americans were hurting their chances to secure jobs, gain entrance to certain schools, and access other opportunities supporting academic and economic success. Furthermore, receiving low intelligence tests scores was affecting African Americans' self-esteem, confidence, and motivation to achieve and succeed. The test consisted of a multiple-choice questionnaire in which the examinee was asked to identify the meaning of 100 words as they were then used in what was labeled black ghettos. It took about two years for him to develop this culturally tailored test, and its purpose was to determine if his theory was correct. The results of the test showed that the Black group performed much better than their White counterparts. White students performed more poorly on this test than Black Americans, suggesting that there are important dissimilarities in the cultural backgrounds of Black and White participants. The results of these tests and examination of the BITCH-100 confirmed Robert Williams' belief that his intelligence test dealt with content material that was familiar to Blacks.

Where Do I Start?



Photo by Eran Becker from FreeImages (Image shows the word "start" with a line pointing outward).

I put on my community psychologist's hat and mulled over the fact that if Dr. Williams can prove that backgrounds are an essential part in the success of Black students and standardized testing, that background and culture are also vital in improving health outcomes and eradicating health disparities.

A Plan for Prevention

African American college students represent a unique population for promoting health. Although, African American research participation is restricted for relevant health disparities, especially among young African American adults. Limited data exist concerning the health of African Americans (AA). When health assessments are conducted at universities, AA students typically do not participate. Therefore, African American college students and further engaged research are necessary to collect accurate data. This additional data is vital in the development of health prevention and promotion interventions, activities, and services for this vulnerable student body. Armed with the data AA students can take on leadership roles and become advocates for health and peer-to-peer educators in eliminating racial/ethnic disparities and improving the quality of life of African Americans. Students at Historically Black Colleges and Universities (HBCUs) can serve as a model for promoting health equity and prevention, and HBCUs are in an ideal position to serve as excellent public health partners. Therefore, I developed a mixed-methods study, which was culturally tailored for Black college students at a private HBCU in Atlanta, Georgia. The study was designed to answer questions about health beliefs, health behaviors that tapped into the uniqueness related to the disparities in their health and wellness.

This study proposed to:

1. Access the participants' health perceptions, behaviors, and knowledge of Black college students at the HBCU,

2. Identify and define critical problems and barriers of health, and
3. Explore strategies to design sustainable health education and disease prevention interventions leading to better health.

Building Collective Impact



Photo by B S K from FreeImages (Image shows silhouettes of people linked together side by side over a map of the world).

Building a productive and collaborative team of research partners is just the beginning. The team members' ideas must be aligned, and promote sustainability. Many factors, such as identifying the right team members, building trust through good communication, and effective negotiation skills are needed to advance collaborative projects and to prevent and manage disputes and conflicts. I had to use my communication and interpersonal skills daily. I had to be open, forthcoming, and transparent while making a concerted effort not to over-deliver.

I conducted the study at Clark Atlanta University (CAU), an HBCU. Although I was from a different state, I was familiar with the operations, location, and culture of the school and campus because my daughter was a student. I strategically identified collaborative partners which included the Chicago local office of the American Heart Association, and a nearby Walmart Neighborhood Market to provide incentives for participants. Faculty members from Charles Drew University (another HBCU) and students helped with data collection. CAU-Research and Sponsored Programs provided leadership in the establishment of a partnership between a CAU research mentor, administering contracts, IRBs, faculty, staff and students, the institution, and its constituents. I further developed relationships at CAU with the PanHellenic Council (Greek Organizations), Student Affairs and Student Health and Wellness Center, and nurses. A unique approach was designed for this campus setting in Atlanta, Georgia to begin my work to identify and to increase student, faculty, and staff participation.

It became time to deliver. All hands were on deck! Initial recruitment relied on word of mouth until Student Affairs approved the recruitment flyer. Two to three weeks prior to the survey administration dates, the student health service director, the research mentor, eleven student volunteers, and I circulated recruitment flyers across the campus. Over 500 hundred flyers were posted in high traffic areas in program departments, classroom buildings, bus stops, dormitories, library, and student cafeteria. The Clark Atlanta University (CAU) administration also sent out a campus-wide email blast advertising and encouraging the students to participate. All college faculty members from various departments were contacted and asked to allow their classes to complete the 15-20 minute survey during class time. On the day of the survey collection, tables were set up, with volunteers and a variety of healthy snacks, in the Student Center; a heavy student traffic area. We offered incentives provided by the American Heart Association (ink pens, pedometers, towels, can strainers, and healthy cookbooks) given to each student that completed the survey. Upon completion of the survey, each student was also eligible to be entered into a raffle for $25 Walmart gift cards.



Recruitment day at CAU. (Image above is showing Dr. Roberson at the table to sign up participants at Clark Atlanta University, Atlanta, GA.)

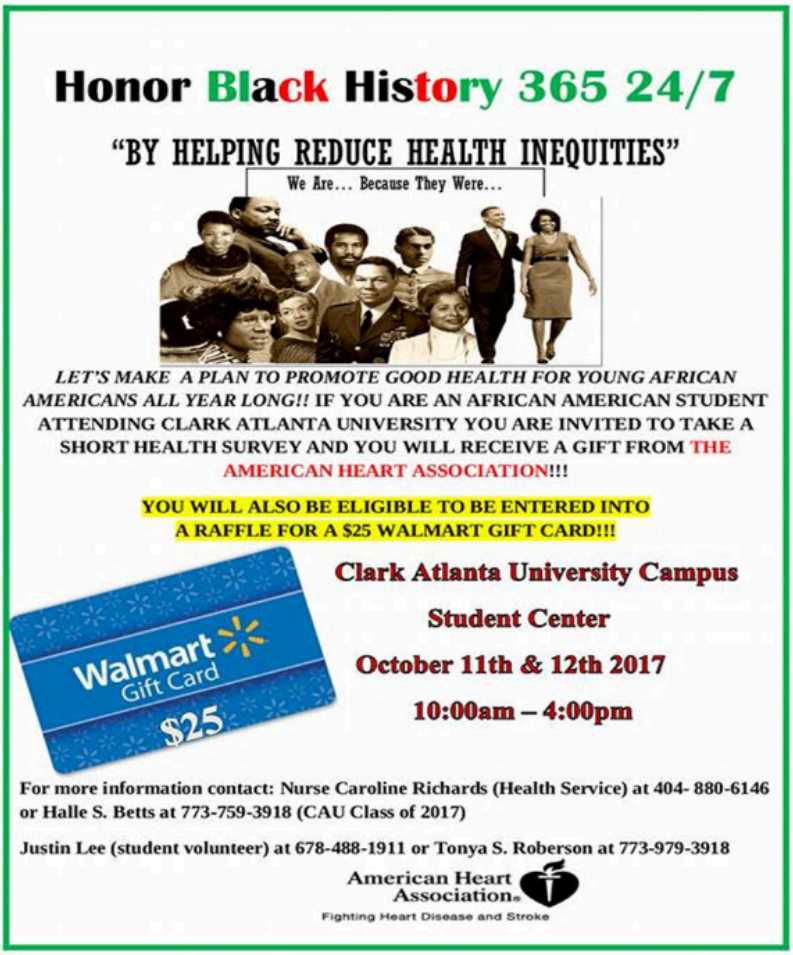


Image is showing the recruitment flyer Dr. Roberson used to recruit participants with the title, Honor Black History 365 24/7 by helping reduce health inequities.

Description of the Project/Engagement

"Identify your problems but give your power and energy to solutions." – Tony Robbins

My mom would always say, "There are a lot of problems but what are the solutions"? I believe that by conducting research in communities that emphasizes participation and action we can move toward developing effective solutions.

This project consisted of three main parts:

1. The first part was an overall attempt to understand the structure and organization of student health and counseling services at universities and colleges across the country.
2. Secondly, after reviewing this information, the task force identified university health centers defined as integrated and queried them more in-depth, focusing on the issue of integration.
3. The third part consisted of follow-up case study interviews with selected center directors. Using

the findings from the literature review, the task force developed a web survey including questions relevant to counseling, health perception, and knowledge.

Participatory Action Research Approach

Participatory Action Research (PAR) is useful as stakeholders seek to understand communities and help facilitate their advancement because its approach views:

- research as conducted *with* people not on, or for people; and
- embraces processes that include "bottom-up organizing".

To ensure an ethical stance is taken with this population, this study used a PAR approach. Unobservable community issues and problems can be identified through PAR. PAR usually involves any number of processes that include bottom-up organizing. PAR methods were used in every aspect of the development of this study including survey development, discussing the use of the data, and student interest in health promotion. Clark Atlanta University (CAU) students needed to be educated about the importance of participating in research, as there was limited data on the health of African American college students and further research was necessary to collect accurate and useful data. The goal was to use the data collected to develop sustainable, culturally-tailored programs to promote health equity on CAU's campus.

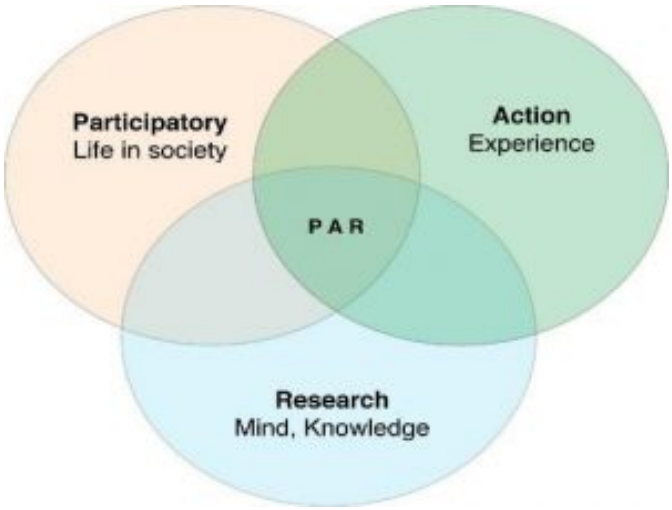


Image above shows a Venn Diagram with the three interconnecting elements of Participatory Action Research (PAR) (1) Life in society, (2) experience and (3) Mind, Knowledge.

Study Participants

Recruitment was remarkably successful. The participants (N=402) included CAU students 18 to 27 years old. Additional descriptive statistics are shown in Table 1 below.

Table 1: Demographics of the Participants

Classifications	Number of Participants
Freshman	68
Sophomore	103
Junior	92
Senior	100
Graduate/Professional	18
Not seeking a degree	12
Other	9

Case Study Methodology

Research suggests that to address and attempt to eliminate health disparities, studies must incorporate a broad range of methodological approaches and cultural issues regarding the collection of data from racial, ethnic, and socioeconomic participants and other hard-to-reach populations (Stewart & Napoles-Springer, 2003; Sue & Dhindsa, 2006).

Examples of the methodological approaches of the project include:

1. Mixed-method approaches to increase participation of otherwise hard-to-reach groups to provide context to quantitative data
2. Community-based participatory action research (CPAR); and
3. Collection of data across the life -course (Bulateo & Anderson, 2004; Halfon, Hochstein, 2002; Zarit & Pearlin, 2005).

Our survey also contained questions about the structure, rationale, and subsequent impact of integrating health and counseling services.

Survey Measures & Interview Protocol

The results from our study revealed the health perceptions, beliefs, and knowledge of this population. The analyses provided foundational information to strategize and design sustainable health education and disease prevention interventions for African Americans in the future.

The assessment contained demographic information as well as questions relevant to spirituality, family history, ethnic identity, HBCU culture, student's health perception, behavior, and willingness to participate in future health promotions. The survey also contained questions about racism, health disparities, and clinical trials. The focus group protocol was comprised of open-ended questions for the students to answer and their answers were expected to support the assessment's findings.

The complete culturally tailored survey questions were grouped into nine main domains:

1. Health, health education, Family History, and Safety

2. Alcohol, Tobacco, and Drugs
3. Sex Behavior & Contraception
4. Weight, Nutrition, and Exercise
5. Mental Health
6. Physical Health
7. Oral Health
8. Spirituality/Religiosity/Social Health
9. Academic Performance

Focus Groups



Image by Gerd Altmann from Pixabay Image is of a hand holding a magmagnafying glass "focusing in" on a group of people in the distance.

Through this exploratory pilot, a focus group interview protocol and health assessment inquiries on the health needs of AA students were designed to establish whether the tools used were reliable and valid instruments for Clark Atlanta University to use in the future to help inform and develop health interventions. Interviews were open-ended and responses appeared to be candid and were detailed. The data analysis process consisted of five stages (1) familiarization of transcripts, (2) identifying thematic structures, (3) interpretation and selective coding, and (4) formulating categories. A common set of techniques for identifying themes, patterns, and relationships were vital to this study. Unlike quantitative methods, in qualitative data analysis, there are no commonly valid procedures that can be applied to generate findings. The analytical and critical thinking skills of the researcher are needed. No qualitative study can be repeated to generate the exact same results. The final stage of the analysis included linking the research findings to the research questions. Our analyses identified five focus group themes derived from the most common responses during the discussion. In this data analysis step, participants' quotes were paired with the coded topic themes.

What Went Well

This project showcased positive collaboration building and teamwork. The communication was transparent and effective. This project set a pace for a truly equitable partnership. Buy-in from all parties: internal and external partners, faculty, staff, and students. Each party had ideas and a vision that aligned. The project involved collecting valuable information from and in partnership with a vulnerable population that could benefit from the results. The student volunteers as well as the student participants themselves were extremely

interested, recommended great ideas, and were eager to learn and contribute. The Greek organizations served as leaders to help spread the word to a target population that we may not have otherwise been able to capture. Such positive school connectedness and valuable student leadership to disseminate health information in the future. Word-of-mouth about this much-needed project circulated among many other HBCUs increasing awareness and concern for the issue of health disparities. Since the completion of this study, I have been approached by Charles Drew University College of Medicine and Science conducting a similar study and project with their students.

Lessons Learned

The current manner used to assess college student's health perception, beliefs and knowledge was developed and using The American College Health Association-National College Health Assessment (ACHA-NCHA) standards which do not provide a holistic, culturally tailored health report for people of color, especially African Americans. To reduce or eliminate health inequities and increase the overall quality of life, researchers must be able to identify which disparities need to be addressed and tailor data collection tools to do so. By regularly assessing, monitoring, and improving HBCU student's health, African American students can leap forward to increase research and improve health and health outcomes not only for their campus but their communities. Evaluation of this data led to conversations about continuing this work and developing a combined student and staff steering committee to design and develop a sustainable, culturally tailored, holistic health education and disease prevention initiative to promote health inequity.

Implications for Policy

The data collected in this study can be an important resource for government leaders, policymakers, philanthropic foundations, and community non-profit organizations that are seeking to impact health, end racial health inequities and improve health outcomes.

This case study focused on a collaborative study that explored disparities in selected specific health determinants and identified promising programs and interventions that might be effective in reducing disparities. Focusing public and policymaking attention on fewer, more critical disparities that are potentially modifiable by universal and targeted interventions, can help reduce disparities (Robert Hahn, CDC, personal communication, 2010). However, until more evidence of effectiveness is available, I suggest the following actions:

1. Increase community awareness of disparities as problems with solutions;
2. Sett priorities among disparities to be addressed at the federal, state, tribal, and local levels;
3. Articulate valid reasons to expend resources to reduce and ultimately eliminate priority disparities; and disadvantaged groups by allocating resources in proportion to need and a commitment to closing modifiable gaps in health, longevity, and quality of life among African Americans with the United States.

Relationship to Community Psychology Practice

This case study highlights the importance of more community-engaged initiatives for impacting health disparities and inequities among African Americans. Consistent with community psychology frameworks, community engagement activities are informed by local context and involve the community in problem identification and social justice action. Efforts to support and equip community members, leaders, and organizations to address the pressing and urgent needs of African American and minority families and communities are crucial.

Community psychologists can provide education and promote resilience with communities of color fostering proactivity regarding their personal and community health to reduce disparities and inequities. Partnerships are vital to the success of community psychology practice. When we seek to address problems through community interventions, we discover the importance of the environment and potential community partners (Shinn & Toohey, 2003). In other words, we need to understand the context of the neighborhoods and community settings where offer our thoughts on community interventions. Community psychologists can help develop culturally appropriate interventions that support and honor existing protective community practices, while helping to change those practices that may have a negative impact on health (Bronheim & Sockalingam, 2003). Thus, the community psychologist can act as a change-maker, health educator, and researcher to meet individuals and families where they are to promote health equity.

In general, health outcomes are inextricably linked with lifestyle choices, personal decisions, resources, and environmental factors and are influenced by culture, history, and values. Therefore, community-engaged interventions must focus on holistic development, community engagement in defining health promotion goals, and advocacy toward addressing the impact of racism and discrimination.

> Marquita (name changed) a program participant shared, "The survey was… informative, descriptive and was very specific! It inspired me to want to have seminars about all the topics that were included, and I realized how much knowledge I didn't have regarding the different types of health issues prevalent in the Black community. I feel that the survey will change the world!"



Image depicts Dr. Tonya Roberson and an assistant seated at a table with survey collection materials and participant incentives at Clark Atlanta University, Atlanta, Georgia

Conclusion

Community psychologists can use the advances in social sciences to provide education and support and build resiliency within communities regarding proactivity about their health to assist in reducing disparities and inequities. Health disparities ultimately impact everyone. It erodes human capital and the labor market suffers. As we have seen with the Covid-19 pandemic, the world is still trying to recover economically, culturally, politically, and environmentally. We can push forward a restored world when we work together. Partnerships are vital to the success of community psychology practice of co-creating spaces of health and wellness.

FROM THEORY TO PRACTICE REFLECTIONS AND QUESTIONS

- Improving health disparities will require methodical, purposeful, and sustainable efforts to address

issues such as health education and health literacy for individuals and families to foster informed decision-making processes that can lead to better health outcomes…(Roberson, 2021). What immediately comes up for you or resonates with you when reading this statement?

- How would you use the narrative in this case story to promote health equity among African Americans or other populations?
- Discuss your understanding of the term "health inequities" and how would you co-create equitable health with those impacted?

References

Bronheim, S., & Sockalingam, S. (2003). A guide to choosing and adapting culturally and linguistically competent health promotion materials. Washington, D.C.: National Center for Cultural Competence, Georgetown University Center for Child and Human Development https://nccc.georgetown.edu/documents/Materials_Guide.pdf

Bulateo, R.A., & Anderson, N.B. (2004) (Eds). Understanding racial and ethnic differences in health in late life. In National Research Council (US) Panel on Race, Ethnicity, and Health in Later Life: A Research Agenda. Washington (DC): National Academies Press (US); 2004. Available from: https://www.ncbi.nlm.nih.gov/books/NBK24692/ doi: 10.17226/11036 .

Halfon, N., & Hochstein, M. (2002). Life course health development: An integrated framework for developing health, policy, and research. *PubMed.* https://pubmed.ncbi.nlm.nih.gov/12233246/

Israel, B.A., Eng, E., Schulz, A.J., Parker, E.A. (2012). *Methods for community-based participatory research for health, 2nd edition.* Jossey- Bass.

Riordan, B.C., Ford, R., & Matthews, F. (2020). The COVID-19 pandemic and health inequalities. *Epidemiology & Community Health.* *https://jech.bmj.com/content/jech/74/11/964.full.pdf*

Shinn, M., & Toohey, S.M. (2003). Community contexts of human welfare. *Annual Review of Psychology 54*(1), 427-459. https://www.annualreviews.org/doi/10.1146/annurev.psych.54.101601.145052

Stewart, A.L, & Napoles-Springer, A.M. (2003). Advancing health disparities research: Can we afford to ignore measurement issues? *PubMed, 4*(11) 1207-1120. https://pubmed.ncbi.nlm.nih.gov/14583684/

Sue, S., & Dhindsa, M.K. (2006). Ethnic and racial health disparities research: Issues and problems. *PubMed, 33*(4), 459-469. https://pubmed.ncbi.nlm.nih.gov/16769755/

Zarit, S.H., & Pearlin, L.I., (2005). Special issue on health inequalities across the life course. *The Journals of Gerontology, 60*(2). https://academic.oup.com/psychsocgerontology/article/60/Special_Issue_2/S6/2965175

12

Working with Survivors of Gender-Based Violence

DESSIE CLARK, PH.D., & JOSHUA BROWN, LCSW

The purpose of this case study is to explore the process and outcomes of a collaboration between researchers and a community-based organization serving survivors of gender-based violence, Fort Bend Women's Center.

THE BIG PICTURE



pixabay.com (Image of girls of Color walking with arms linked).

Gender-based violence is a rapidly growing social concern and even more so as the world continues to grapple with the effects of Covid-19. The implications of gender-based violence are too numerous to name here, but there are several special considerations for this population, including attrition (this population can be more transient than others), high caseload and rate of burnout for front line workers, as well as the physical and psychological effects of abuse, including traumatic brain injury (TBI) and initial reluctance to trust others. Further, gaps in existing work with survivors of gender-based violence include a mismatch between the expectations of researchers and the realities of those who are on the frontlines in these organizations and the people that they serve. The purpose of this case study is to explore the process and outcomes of a collaboration between researchers and a community-based organization serving survivors of gender-based violence,Fort Bend Women's Center. We propose that focusing attention on communication, trust, buy-in, and burnout are critical for collaborations between researchers and community organizations that serve survivors of gender-based violence.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=179#oembed-1

It is important to understand that collaborations, such as the one detailed in this case study, do not begin by happenstance. Strong collaborations can take time to develop. For this reason, the authors find it important to explain the origins of this project. In 2012, Abeer Monem (now former) Chief Programs Officer of the Fort Bend Women's Center (FBWC) began to explore reasons why a portion of the agency's Intimate Partner Violence (IPV) survivors were struggling to progress toward self-sufficiency, despite the agency's existing program offerings such as case management and counseling. As the agency explored the reasons behind the lack of progress, it became clear that one of the main reasons could be potential traumatic brain injury (TBI) in the survivor population. Eager to confirm their suspicion, agency personnel embarked on the discovery and research phases of the intervention's lifecycle.

It was first deemed necessary to determine if agency survivors indeed exhibited a likelihood of traumatic brain injury. FBWC personnel began administering the HELPS Screening Tool for Traumatic Brain Injury (HELPS) (M. Picard, D. Scarisbrick, R. Paluck, International Center for the Disabled, TBI-NET, and U.S. Department of Education, Rehabilitation Services Administration). The HELPS Screening Tool is a simple tool designed to be given by professionals who are not TBI experts. FBWC personnel began by offering the HELPS upon intake to survivors seeking services. The initial findings found that over 50% of survivors screened positive for a potential brain injury incident. With this knowledge, FBWC program leadership began exploring neurofeedback as an innovative approach to assisting survivors exhibiting symptoms of TBI. FBWC approached another non-profit organization that was focused on researching and propagating neurofeedback in public school-based settings. After deliberations between leadership groups, a budget and project plan was finalized.

FBWC leadership began seeking funding from various sources and, after several attempts over approximately 18 months, two sources (one governmental, one non-governmental) agreed to fund the initial work of the neurofeedback project. Initial funding covered the neurofeedback equipment as well as the cost of setup, training, and mentoring by a board-certified neurofeedback clinician. In late 2014, FBWC began an initial pilot program to determine the impact and efficacy of a neurofeedback training program for Intimate Partner Violence (IPV) survivors with potential brain injury in an agency setting.

In 2017, I (Dessie Clark) traveled to Houston, Texas where she was introduced to Abeer Monem, the previous Chief Programs Officer of FBWC. During this meeting, Abeer shared information about an innovative neurofeedback program that was happening at FBWC. She described the approach and noted that they had been collecting data on the program to try to assess efficacy and impact. Dessie was intrigued and agreed to visit the site later that week. Upon arrival, Dessie was introduced to Joshua Brown, a board-certified neurofeedback clinician, who was the Director of Special Initiatives (now Chief Programs Officer)

and one of the founders of the neurofeedback program. After multiple discussions, an agreement was reached between the two parties to begin a collaboration.



Image above is a timeline of the project and what steps were taken to get started.

Community Assets & Needs

Fort Bend Women's Center provides comprehensive services for survivors such as emergency shelter, case management, counseling, housing services, and legal aid. It is important to acknowledge that there are components of Fort Bend Women's Center that are unique to the way the agency approaches service provision. Community assets will vary widely, even amongst similar populations. That being said, we believe the following assets are important to intimate partner violence survivors generally. First, FBWC emphasizes a trauma-informed care approach to working with survivors. The service model is voluntary (as opposed to other models that may have mandatory or compulsory services) and non-judgmental. Specifically, at FBWC, there was existing trust between staff and survivors. This is largely due to a rules reduction, trauma-informed care model that focuses on enhancing internal motivation in survivors and open and honest communication with staff. This helps to create a culture where survivors feel willing and able to be more open about their experiences and the challenges they are facing. Important elements of this model include the offering of voluntary services and non-judgmental advocacy. This model has led to survivors developing a vested interest in the success of FBWC as an agency. Many survivors participated in the research because they felt motivated to share with others their positive experiences at FBWC. Also, many survivors return to FBWC to volunteer following service provision. Please note that the intrinsic motivation to stay involved with FBWC is not a common phenomenon in this community. This illustrates the importance of continual work on trust, safety, and confidentiality.

The IPV survivor community has myriad needs, and no one IPV community will have the same needs. For this partnership, there were several key needs of the survivors at Fort Bend Women's Center that became vital to address in order to successfully implement the partnership. These needs included trust, safety, confidentiality, and adaptability. Given the trauma that survivors have experienced, these components need to be taken into consideration in interactions with other survivors, staff, and members of the research team.

Trust

The survivor population at Fort Bend Women's Center have experienced violence from a family member and/or sexual assault. FBWC data suggests that over half of the survivors seeking services at FBWC have experienced multiple traumatic experiences. Additionally, some survivors may have had difficult experiences with the justice system, the medical establishment, and other helping professionals. Experiences of trauma can cause distrust from the survivor when seeking services. Additionally, there is a high incidence of mental health disorders in survivors, including paranoia, that can impede the creation of a trusting relationship. Establishing trust became a vital step in survivor recruitment. For effective recruitment, it was imperative that survivors trusted that their information would be kept in confidence and that what they were being asked to participate in would not harm them. As previously mentioned, a culture of trust already existed between survivors and staff. The research team was able to build on this by including staff in the research collaboration. Staff members were included in project development, which allowed them to have a deeper understanding of the work. Staff's enthusiasm for the collaboration, which was shared with survivors, helped extend the pre-existing trust that survivors had with staff members to the research collaboration.



The Domestic Violence Power and Control Wheel-Developed by: Domestic Abuse Intervention Project

Safety

Safety is of utmost importance to survivors who are fleeing violence. While one might only think of physical safety with this population, it is also important to take psychological safety into account. Steps were taken in this program to ensure that participating survivors understood the likelihood of any psychological harm due to sharing their traumatic experiences. Mental health staff was identified on a rotating basis to act as an on-call resource should survivors need it.

Confidentiality

Confidentiality of personal information directly involves trust and safety. Many survivors in our program feared for their lives and did not want anyone to know where they were or what they were doing. It is important when working with this population to ensure confidentiality. This is not only ethically and

legally important, it is also important in building a long-lasting program. When thinking about effective confidentiality, one should consider their applicable agency, state, and federal confidentiality rules and regulations. At a minimum, it is important to execute a confidentiality agreement with the participant.

Collaborative Partners

To begin the process of engaging in effective research collaborations, it is often difficult to identify an effective community partner, and it is a somewhat arduous process. While individuals and organizations in academia understand the merits of research, this is not always the case for community organizations. Even in cases where community organizations recognize these benefits, there may be barriers, such as trust, due to historical harms done to communities by researchers. Additionally, community organizations often face strains due to limited resources or capacity to support research which researchers may fail to acknowledge or understand. These issues can create barriers for researchers who are interested in partnering with organizations that have survivor populations. This also causes issues for community organizations who may be less likely to have access to research, including best practices, given academic publishing practices.

Building understanding and trust between researchers and community partners is at the heart of a successful collaboration. A solid research partnership with a community organization requires buy-in from both sides. Whether from the perspective of the community organization or the researcher, it is imperative to find a partner that communicates effectively. This involves clearly defining each party's expectations upfront, making sure that the terms that are used are clearly understood (including any potential jargon), and discussing the importance of flexibility in timelines. A great example of the lack of work on building understanding and trust is the story of the (now-defunct) nonprofit Southwest Health Technology Foundation (SWHTF) in which one author, Joshua Brown, was an employee. SWHTF was a small organization that was focused on evaluating the effectiveness of neurofeedback in existing systems (such as public schools). SWHTF began several data-driven pilot projects without the assistance of a research partner. These data showed the potential positive effects of neurofeedback interventions on behavior and academic performance. However, these data never saw the light of day. SWHTF leadership attempted to partner with four different research institutions to analyze the data. All four attempts ultimately failed without yielding tangible results. This was due to a failure on the part of SWHTF and the researchers to build trust and understanding through defining clear expectations, clearly understanding each party's role, and agreeing on expected outcomes.

An important part of building trust is approaching a partnership with strategies that are aimed at the education of staff and survivors who will be involved.

While SWHTF is a relevant example, the focus of this case study is the project conducted with Fort Bend Women's Center (FBWC). We found the most effective approach to building trust and understanding was to focus on educating staff about our project first. We identified the case managers as those staff who have the most contact with survivors and have built up the most trust. When educating

staff members, we found that it wasn't as important that they fully understood all the specifics of the project but, rather, that they had enough of a basic level of knowledge about the project to introduce the information to the survivor. Because case managers had built up trust with the survivors, the survivors were much more likely to take the recommendation of the case manager and enroll in the program. Because our case managers were not subject experts, survivors were willing to speak to researchers even without an understanding of the specifics. The specifics were provided by researchers and program staff before enrollment.

In order to understand how a community navigates issues related to gender-based violence, it is important to understand the ways in which the culture of that community may impact their perspective. The key stakeholders in this project included the funding entities, the Chief Programs Officer, the Neurofeedback program Lead, and members of the Neurofeedback team. The population consisted of survivors of gender-based violence; both those who had completed a neurofeedback program and those who had not yet done so but desired to do so in the future. This research collaboration was between researchers at Michigan State University and Fort Bend Women's Center. The organization, which served as the primary setting for the project, provides emergency shelter, housing/rental assistance, and supportive services. The project was predominantly made up of those located within the agency as staff members while researchers at Michigan State University primarily served as guides and consultants for the research portion of the project. For this project, funders included the Texas Health and Human Services Commission, the George Foundation, the Simmons Foundation, and the Office for Victims of Crime.

Project Description

This case study involved a multi-year collaboration. During the initial six-months, a series of site visits were conducted with the goal of researchers getting to know staff members of the community organization, as well as the survivors who received services from the organization. Before engaging in any research, a multi-day feedback session was held in which staff members from the organization gave feedback on the research including the approach, questions, assessment tools, and logistics of how the research would be conducted. In these sessions, it became clear that given the population being served at this site, to include high numbers of disabled or immigrant survivors, there would need to be adjustments for accessibility and safety. Other barriers specific to this collaboration included staff burdens, the distance between researcher and community partner, and various considerations given the population such as trauma responses, trauma history, and the relatively transient nature of the population. Additionally, the research and data collection experience of the staff at the community organization was limited. These conversations were critical in helping the community organization familiarize themselves with the research and the researcher obtain a better understanding of the unique strains the organization was facing in conducting the research. As such, novel processes had to be developed and reinforced to ensure adequate data collection and analysis. We involved considerations for a variety of perspectives that may be shared by survivors in our data collection approach. We would do this in the future, with more frequent check-ins with participants and staff.

Outcomes

The collaboration consisted of frequent communication between the researchers and the organization. Additionally, site visits happened semi-annually. Key outcomes included – efficacy of the intervention was established, adaptive technology was created, and we found evidence of a successful collaboration. The neurofeedback intervention resulted in statistically significant decreases in depression, anxiety, PTSD, and disability symptomology for survivors. Survivors also experienced normalization of brain activity. This provides evidence that neurofeedback can benefit the well-being of survivors. Given the distance between Michigan and Texas, a system was created for checking in, transferring data, and ensuring that all necessary tasks were completed. A particularly novel component of this collaboration was the creation of an app for mobile phones that allowed for data to be transferred securely from Texas, in areas where Wi-Fi may not be present, to Michigan. The creation of a mobile phone app can be replicated. This was an important aspect of conducting research with a population where safety was critical, and Wi-Fi may not always be accessible. Finishing the project, and creating tools to do so, is in itself an indicator that the collaboration was successful. However, this project resulted in a host of other products such as publications, technical reports, presentations, and an awarded grant which also indicate that this collaboration produced well-recognized resources. Not a traditional metric, but one of great importance to the authors is the fact that both the agency and the researchers wish to work together in the future.

Lessons Learned

Over the course of the 3-year collaboration, we learned many lessons about conducting rigorous research with community partners who serve survivors of gender-based violence. However, we highlight the four biggest takeaways from our collaboration – (1) communication, (2) trust, (3) buy-in, and (4) resources. It's important to note that there is no such thing as a perfect collaboration. Collaborations can be successful, produce important results, and still face challenges. That is true of our collaboration, in which we did face challenges. For domestic violence agencies, there is one overarching consideration that impacts the four takeaways we will discuss below – turnover and movement of staff. Turnover and movement of staff is relatively common in community agencies and that means that there is a constant need to set and reset expectations to make sure everyone has the same information about the project and what is expected of them. These expectations need to be reinforced frequently to ensure there are no issues that need to be addressed. For example, in the first 3 years of our collaboration, we experienced 3 different neurofeedback team leads and have seen the neurofeedback clinical team have full turnover twice. Our experience underlines the importance of consistently resetting expectations.

It's important to note that there is no such thing as a perfect collaboration. Collaborations can be successful, produce important results, and still face challenges.

Communication

We have found in collaborations with multiple parties, particularly those that are conducted long-distance, communication is perhaps the most important ingredient for success. How do you work collaboratively when not in the same space? For us, it was critical to use technology. We used secure platforms to share information and have important conversations. However, having conversations is not enough. It is important these conversations do not use jargon. For example, there are certain technical terms that researchers or practitioners may use which are not clear and can lead to confusion. It's also important to share perspectives on what the priorities are for different parties. For example, researchers may be worried about things such as missing data whereas counselors may be more willing to collect minimal data in an effort to move on to the next survivor more quickly or to protect survivor confidentiality. Communication is complicated, especially at a distance. It's important to realize you may do the best you can and still have problems communicating. Defining modes of communication, and what expectations are, is also critical. For example, what constitutes an email versus a call, how frequent those communications will be, and what expectations are for when those communications will be returned.

Trust

It is critical that there is trust between all parties. The survivors must trust the community partner and the researchers, the community partners must trust the researchers, and the researchers must trust the community partners and the survivors. This can create a complex web of dynamics that can be vulnerable to changes and miscommunications. In our collaboration, there were moments where trust and understanding between the researchers and the community partners were limited. In retrospect, it was important for community partners and researchers to sit down and share their perspectives and approach to work. For example, researchers may be more focused on details like completing paperwork properly or recruitment and retention of participants. Whereas, community partners may be more focused on completing interventions or connecting survivors to resources. In both cases, these duties are appropriate for the position but given the rapidly changing needs of survivors, the priorities may not be in alignment across groups. It is critical for both parties to understand where the other is coming from and trust that the necessary steps for the project will be completed. Collaborations should tackle this issue by communicating freely and openly and not resulting in micromanaging or avoiding these issues. Collaborators must trust that all members of the collaboration will do their part and be transparent if and when issues arise. In our case, this impacted survivors' access to the project because at times, due to other survivor or agency demands, staff members were not actively talking to survivors about the project and what it may entail to become involved and learn more.

Buy-In

Ensuring that researchers, community stakeholders, and survivors have bought into the project and understand the project plan is important in ensuring things run smoothly. While the project itself may involve conducting research, it's important to elicit feedback from the other collaborators at all aspects of

the process. In our case, we asked staff members and survivors to provide feedback on the project design and survey. We hosted a multi-day training to talk through the process, the questions we were asking, and gather feedback on what we should know to inform the project moving forward. However, as referenced above, these agencies may experience frequent turnover of staff movement. As such, is it important to check in about buy-in over the course of the project – but particularly when there are transitions.

Resources

Working with community partners, who are often over-burdened and under-resourced, requires acknowledgment and supplementation from other collaborators. In our case, it was important for the researchers to design and adjust the project to best meet the needs of the community partner and survivors. We did this by:

1. Taking over aspects of the project like data collection to the extent that was allowable given distance and travel,
2. Hiring staff members as research assistants to help with data collection; and
3. Creating a phone application that allowed for information necessary for the project to be directly transmitted to a secure server at MSU.

Burnout

While for many of our lessons learned, we have concrete suggestions for future work, we do find ourselves with one lesson we have learned but have not solved. A constant challenge on this project was learning how to deal with staff burnout – both in their roles and in regard to the research project. For example, as we've mentioned staff at these agencies are often overburdened and under-resourced. Participating in research can exacerbate these issues and lead to a faster rate of burnout or what we observed and have called "research fatigue". We believe that having a place to vent frustrations about the research project so they may be dealt with is a promising thought. However, this is a bit complicated as it seems that staff may be unsure of the appropriate avenue to share these concerns – whether it should be their agency supervisor or a member of the research team.

Research Process

A relatively unique aspect of this project was the willingness of staff to engage in all aspects of the research process. Members of FBWC were engaged throughout the entire process from project conceptualization to dissemination of information. The key stakeholder, Joshua Brown, was eager to be involved in research. However, this was only possible because Dessie Clark suggested the possibility and Joshua didn't know that it is unusual for community partners to be involved. This highlights the importance for researchers and community partners to be talking about research, the degree to which each member wants to be involved, and what expectations will be. The authors of this chapter had many conversations about authorship on all the produced works and what workload and timeline would look like to live up to these expectations.

Looking Forward

As we continue to move forward, we would be remiss if we did not acknowledge the impacts of COVID-19 on the intimate partner survivors, the agencies (such as Fort Bend Women's Center) that serve them, and research for those housed in a University setting. Before COVID-19 we imagined continuing our work in many of the same ways. We had applied for future grants and dreamed of expanding our work to examine the children's neurofeedback program at Fort Bend Women's Center. While we hope that eventually conducting our work, in-person, will continue, it seems prudent to reimagine what working together will look like in our altered state. It is the intention of the authors to continue collaborating. However, this may require adjusting to continue working in a virtual matter. Given the fact that technology has already been an important part of our process as long-distance partners, we hope that future work uses those technologies (digital survey platform, phone app for information transfer, etc.) to continue to collect important information that ultimately benefits survivors and their communities.

Recommendations

While gender-based violence is often examined at the individual level, communities play an important role in how gender-based violence is addressed and how survivors are supported. Communities can be a tremendous source of support for survivors by providing social support through which these individuals can access resources, and connect to services. In this way, communities have the potential to be a tremendous source of support for survivors. Or, in contrast, communities can impose substantial barriers on survivors and their families. Since structurally, communities are located closest to survivors, understanding how gender-based violence is addressed by, and within, communities is important in understanding and confronting gender-based violence as a society. The nature of this work was relatively clinical in nature (e.g. neurofeedback) where community relationships and community-engaged research are not a typical fixture. This effort provides suggestions for how those in clinical disciplines, like clinical psychology or social work, may conduct work with community psychologists that are more interdisciplinary in nature.

Further recommendations include:

- Examining how those who do more clinical/individual work may engage with communities,
- The use of technology to conduct and engage in community work, and
- How researchers may do work in communities that is rigorous, such as the waitlist control trial done here, and is not limited to that which can be done inside a lab.

A frequent conversation between the authors of this article was about the wall that exists between researchers and communities. Often, it is assumed that communities do not value or understand research. Or, conversely, that any research that can be done in community settings is not rigorous or worthwhile. Our experiences show the inaccuracy of these assumptions. Fort Bend Women's Center created the neurofeedback program with research in mind. They implemented best practices and collected necessary data. While they didn't have the resources to compile and analyze the data in ways that could be presented to the scientific community –

they were certainly open and eager for the opportunity. Additionally, the research that has been done in this collaboration so far has been recognized widely and invited to contribute to special issues and conference keynotes – a marker of success in the scientific community. This was successful because people, located in very different spaces, were willing to discuss how they could meet in the middle to accomplish a common goal. The experiences of survivors happen in real-world settings and it was important to capture their lived experiences in that setting.

It is important to take the time on the front end to develop a plan. But, also, recognizing that plan likely will change. There should be explicit plans for action with turnover and communication. The priorities of the work should be established and reinforced. This includes defining what priorities are overlapping, and what priorities are important to researchers and community partners so they can work together effectively. Given the fluid nature of research, domestic violence organizations, and survivors it is important for everyone to be willing to adapt. Researchers may be forced to make changes to the research plan, particularly to meet staff and survivors' needs. The agency may need to adapt to ensure that the research components fit into their own expectations and be willing to give feedback if they do not so adjustments can be made.

Implications for Community Psychology

There has been a multitude of promising results from this project including, establishing the efficacy of the intervention, creation of adaptive technology, and evidence of successful collaboration. In our case, researchers and community partners have published and presented in academic spaces and created a technical report for practitioners. Community psychology theory often focuses on engaging local communities that are relatively close to the research team. This case study has implications for how to do community-engaged research over a long distance using various technologies. This has the potential to further the conversation on how we can engage and work with communities when physical access may not be possible. This is important as funding and travel can pose barriers to certain populations and novel ways of doing this work may present additional opportunities for other researchers.

Conclusion

The authors of this case story believe that finding creative ways to manage mostly virtual relationships, as we have done here, has always been a critical component of doing community psychology work. However, as we wrote this chapter during COVID-19 we realized that what has been important to those of us striving to reach vulnerable populations in hard-to-reach locations is now a standard challenge. While community psychology has always pushed innovative ways to do community work, limited conversations have evolved on how adaptive technology could and should be used to try to ensure successful collaborations, particularly collaborations across distance.

FROM THEORY TO PRACTICE REFLECTIONS AND QUESTIONS

- Gender-based violence is a rapidly growing social concern and even more so as the world continues to grapple with the effects of Covid-19 (Clark & Brown, 2021). How does the discussion in this case study challenge your thinking regarding traumatic brain injury (TBI) and gender-based violence?
- Reflect upon conversations you have heard and/or had on gender-based violence. List 3-5 statements you have heard. Based on these statements what would you consider about society's response to this issue? If you have not heard any stereotypical or other statements, research 3-5 statements and answer the same question.
- How would you go about creating an alternate setting to address this challenge in the community?

References

Domestic Abuse Intervention Project (n.d.).The Domestic Violence Power and Control Wheel https://www.thehotline.org/identify-abuse/power-and-control/

13

Journeying Past Hurt: Creating and Sustaining Trauma-Informed Healing Practices With Black Pregnant and Parenting Mothers

DR. DEIDRA SOMERVILLE, PH.D.

This chapter explores the process of development for the Journey's Curriculum, a program designed to center the voices and knowledge of Black pregnant and parenting mothers to support families.

THE BIG PICTURE



George Jr. Kamau@prexels.com (Image of a young woman who is laying in the grass and pregnant).

The Community Exodus

Chicagoans often tell the story of Chicago and Chicago's suburbs as if they are separate and apart, when their stories are intimately tied together. The fast-changing economic climate coupled with the unrelenting housing and employment discrimination practices affecting Chicago's Black families reached a boiling point that spilled over into a mass migration to quiet unsuspecting residents of the south suburbs, peaking in the early 1990s through 2010. Surges in crime in Chicago's Black neighborhoods were in part a result of the movement of jobs from the urban cities in America to urban cities in southeast Asian countries, disrupting and upending the economic fabric in rural communities in the outskirts of major cities in China, India, Malaysia, and Indonesia and shaking up the lives of Black men and women in Chicago's south and west side neighborhoods. For many Chicago families, moving to the south suburbs was a way to find jobs, safe neighborhoods, and schools with strong academic promise.

As Blacks fled south and further west, White families fled even further south and west, leaving their homes and careers largely in policing and teaching, with the perception that their communities would suffer some wrath untold from their new Black neighbors. Some Black families were able to make the migration work. As the south and west suburban communities changed, the necessary support systems found in large cities were not present in the suburbs. Their absence deeply impacted families, particularly young families. The project discussed in this chapter attempted to support these young families, primarily headed by young Black parenting and pregnant mothers, whose families moved to the south suburbs. They are the first generation of Black children born during the exodus to the south suburbs. They have learned to navigate the systems available to them, much in the way some of their parents did. The project is designed to help them to see the systems that drove their families to the south suburbs and to use different tools to navigate communities existing within persistent disinvestment, White flight, and scarcity. This project took place in a small town that is still working to establish adequate support systems for its largely Black and low-income population. This city is Dolton, IL.



Google Maps – showing the community of Dolton in Chicago's southland region.

How I (Dr. Somerville) Came Into This Work

My family was part of the mass migration to the south suburbs during the 1990s. Like many others, our family looked for a place that would offer a "good life" for children and a place with peace of mind for ourselves. We found it in South Holland, a neighboring suburb just east of Dolton. I've spent most of my waking days working, studying, organizing, and engaging in coordinated responses to oppressive systems affecting Black people and people of color in Chicago, leaving far less time to explore the ecosystem of support for families in my own community. This project presented a unique opportunity to change that. Through volunteering and some consulting work, I've come to know and learn more about the nonprofit organizations in the south suburbs. Many operate as storefronts, have offices in bank buildings as a result of community benefit agreements, or operate within churches. Very few grantmaking foundations fund outside of the city limits of Chicago, which means that many of the programs in the south suburbs are funded through fee-for-service contracts with the State of Illinois or large grants that fund federal programs within the local area. Healthcare Consortium of Illinois (HCI) is one of the federally funded operations in the suburbs that accompanied families to the south suburbs in the 1990s.

South Suburban Landscape: Community Needs

HCI is located in Dolton, IL, a village township located in the south suburbs of Cook County. Demographics of Dolton (2010) include the following:

- 88% of the population are African American

- 41% of the households have children under the age of 18; and
- 29% of the households earn less than $25,000 annually.

Like many south suburban Cook County communities, Dolton experienced a significant population shift during the 1990s which resulted in a large exodus of White, middle-income families and an influx of black middle-and lower-income families around the same time. During this shift, many families came to the south suburbs seeking employment and housing opportunities. The challenges with a tight job market, poor transportation options, and poor social service infrastructure made it difficult for many young, under-resourced families to transition well into communities designed to accommodate single-family, working and middle-income families with high degrees of self-sufficiency. According to data on local municipalities collected by the Metropolitan Planning Council of Chicago, low-income, single-parent families in Dolton spend 46% of their income on housing costs and 30% of their income on transportation costs. For mediate and moderate-income families, percentages were significantly lower for transportation costs, at 29% and 35%, respectively. Most residents within Dolton, regardless of their income, find employment in Chicago (39.4%). Unemployment is also much higher in Dolton at 24% compared to the rest of Cook County (10.7%) and the 7-county region (9.5%). HCI's Healthy Start families are in the eye of the storm of poverty, unemployment, and those overburdened with housing and transportation costs (Encyclopedia Chicago History).



Image above shows a type of gear cog with illustrations of people within each cog.

Residents and local leaders living together and working on issues impacting Black children and families in the south suburbs have relied on time-honored institutions within Black communities to address the gaps in resources in the absence of multi-million dollar foundations, corporation foundations, city budgets for supportive services, and a small pool of wealthy individual donors. Many churches have active community outreach ministries. Volunteerism is strong among churches and retirees. Schools and small community centers work with nonprofits and unincorporated organizations seeking collaborators to carry out services, space for programming, or distribute goods and services to the broader community. The web of connections among service providers is intact. Individuals who work for a nonprofit generally know who's who. There is a sensibility of a "small town" community feel that makes connecting across organizations and municipalities less difficult than for larger cities where there is competition for funding at every turn.

Community Partner: Healthcare Consortium of Illinois

The Healthcare Consortium of Illinois (HCI) is an organization located in Dolton, IL, of partners committed to developing and maintaining targeted, community-based, integrated health and human service delivery systems which increase the well-being of individuals, families, and communities throughout Illinois by means of advocacy, awareness, and action. HCI operates the Healthy Start Program, a federally funded system of services that promotes family-based education strategies that are intended to lead to positive health outcomes for pregnant and parenting mothers and their families. The Healthy Start Program serves neighborhoods on Chicago's southeast side and communities within south suburban Cook County. This project will focus service delivery on the needs of clients served by HCI's Healthy Start Southeast Chicago Program.

Development of the Journeys Curriculum

The engagement began in the fall of 2018 with a goal to identify how to best bring the knowledge and experiences of Black pregnant and parenting mothers into training programs for staffers and curriculum designed to support families to get them to the point of thriving. Caseworkers, doulas, lactation consultants, and program managers from the Healthy Start Southeast Chicago Program worked with clients to learn about ways to make sure that curriculum was more than just a way to change behavior, but to acknowledge the systems that are often hostile to clients. They realized that asking clients to constantly acquiesce to unjust systems was indeed unjust and did nothing to improve those systems for their clients. Healthy Start program staff hoped to identify key issues and solutions based on their knowledge of the populations they serve and responsiveness to their presenting issues. At an initial meeting held at the HCI offices with the Healthy Start team, the team shared their current challenges and concerns to develop a meaningful, useful, and relevant project that would best address their concerns together. One key issue found was current curriculum and staff training that focused on behavior modification left many unaddressed systemic issues that clients discussed with staff. The concerns were:



Johnhain@pixabay.com (Image is a cyclical flow showing the necessary components for engaging in healing practices).

- Case management strategies employed often focused on goal setting and implementing strategies for mobility, which are very often hard to obtain or achieve; and
- Barriers to success were often related to untreated trauma: childhood trauma, rape, prostitution,

and intergenerational family dysfunction.

Healthy Start professionals had existing training in several different curriculums over the years, all evidenced-based, as the Healthy Start Program is a federally funded program. The curriculum choices they had at their disposal are not designed to address what staff believes are the root causes that keep their clients from setting and achieving their program goals. They decided that a curriculum that helped to address this current gap in their program practices would be the most meaningful and relevant project to focus on. The staff discussed the curriculum options they used and how they are integral to their work as advocates. A curriculum development chart (see Figure 1) was developed and presented at a follow-up meeting to analyze the curriculum options with the team. The curriculum chart featured underlying treatment goals, curriculum outcomes based on what has been written in peer-reviewed literature, what works for the team, and what is missing. The staff had the final say in how this chart defined the treatment goals and curriculum outcomes. The Staff team also determined what they found most useful for the existing curriculum and what they wanted to see in the curriculum to be developed. Table 1 below shows the Curriculum Development Chart.

Table 1 – Curriculum Development Chart

Curriculum	Underlying Treatment Goal	Curriculum Outcomes	What Works?	What is Missing?
Mothers and Babies	Psychoeducation regarding depression, inner and outer reality management	Stress management Use of coping strategies	Decreases effects of depressive episodes Improves self-regulating behavior	The context for the reality management mothers define their coping. A trauma-in approach is not emp
Parents as Teachers	To improve health and early childhood education of children 0-5 years Improve parental engagement	Optimal early development of children Mothers practice the use of tools for self-regulation	Children are well monitored for health and development improvements	No acknowledgmen relationships betwee experienced by moth outcomes. No capac parents to understan current trauma and c their current reality
Proposed Journeys Curriculum	Treatment of past trauma and addressing current trauma Psychoeducation	Goal setting Placing experiences within the context of structural oppression and system navigation	Proposal: improved self-regulation; change in perception of the oppressive systems they navigate as reflected in the goals they set for themselves.	Proposal: child devel outcomes are not inc the curriculum.

Workshop Processes

The workshopping process involved setting time with the staff to discuss our collective experiences with the current curriculum targeting pregnant and parenting Black mothers. The staff identified the absence of a trauma-informed approach as a clear focus. The team consisted of the program director, 3 case managers, and 2 doulas. The program director and 2 case managers had recently gone through a trauma certification training together a few months prior and shared ideas on how to incorporate our knowledge of trauma-informed practice, both in terms of institutional responses and clinical responses. Staff members discussed the importance of holding space to acknowledge trauma in order to facilitate healing and the use of tools

to address trauma. The use of psychoeducation would be an important tool to address trauma and introduce the trauma-informed practice. The entire team acknowledged that they were unclear of the extent to which unaddressed trauma impacted their case management strategies with their clients. Putting together a curriculum with a trauma-informed approach (trauma-informed care) would help them to determine if addressing trauma would indeed have a positive outcome for their work with their clients. The opportunity to acknowledge the impact of intergenerational trauma and the legacy of white supremacy would bring a contextual reality to the curriculum that could inform their work with clients in more meaningful ways (Minnesota State Health Information)

Healthy Start staff were considered knowledgeable and experts in relation to their clients and the community. They were being consulted regarding the problem and issues affecting their clients and the solution that would best address it. The curriculum was designed to emphasize a strengths-based model that reflects aspects of psychological empowerment theory.

Empowerment Theory

There are many aspects to empowerment theory that can be applied to understanding an empowered setting. It is important to emphasize psychological empowerment in the lived experience of clients and Healthy Start staff. The curriculum draws from the four components of psychological empowerment: the emotional, cognitive, relational, and behavior components. Currently, Healthy Start staff saw many of their clients as not having control over their lives, due to all of the systems they must navigate for their daily survival. The curriculum was designed to facilitate the possibility for client participants to experience control and self-efficacy over their lives and relationships with their children. Their self-perception as competent and in control are considered to make a significant difference in how clients are able to make a life for themselves, despite the limitations that come with teenage motherhood.



The image shows a possible parent or caregiver with insets of children.

Intervention Strategies

As a community psychologist, I proposed a set of intervention strategies in response to the goals discussed in prior meetings and what the team felt was missing that needed to be integrated into the curriculum under development. I conducted research and drew from the bank of information that taken together, I was either exposed to or familiar with as part of our shared training in the treatment of trauma. I also

took into consideration the experiences discussed with HCI staff would be important to include as part of the curriculum: incorporation of movement (many of the group-based sessions we reviewed together only allowed for everyone to sit for an hour or more at a time, which everyone felt was not wholly conducive to their clients), incorporation of building rapport and connection among participants, and integrating aspects of African-centric practices that can support positive identity development.

The intervention strategies introduced to the HCI team were broken down into 3 pillars of intervention: therapeutic/healing, growth/change, and ritualistic/confronting complacency/waking up the spirit (see Figure 2). Each strategy introduced to the HCI team was discussed in order to introduce the relationship of the theories to the outcomes discussed in earlier conversations. This chart was introduced to begin to discuss the process by which the goals and outcomes would be obtained. This chart would help connect the dots between theory, practice and what HCI staff felt would help best support their current work with their clients. I endeavored to ensure that everyone involved in the decision-making process could see the connection between the "big picture" ideas we explored when looking at different curriculums and our thoughts about them to carve out more specific goals for this curriculum. This part of the journey brought up many feelings for all of us, reflecting on our own experiences in our own healing journeys. We realized that this was not only for clients but could also benefit HCI staff as well. Table 2 below shows the Interventions Strategy Chart.

Figure 2. Interventions Strategy Chart

Strategy	Reference	Intervention Goal	Intervention Outcomes
Liberation Education	Paolo Freire bell hooks	Growth/change: Engage through praxis and use of critical thinking	Participates in their own life sto healing
Re-Evaluation Counseling	Harvy Jenkins	Growth/change: To undermine the effects of traumatic events, affirm and evolve the psyche	Use different perspective to com own ideas about change
Rites of Passage	Indigenous African traditions	Ritualistic/confronting complacency/waking up the spirit and therapeutic healing: Restore harmony, justice, balance, and order	Begin to recognize their true se nurture and evolve beyond the around them
Radical group work – Circle Work	Kay Pranis Jennifer Ball	Mark and create sacred space to invoke ceremony, mutual exchange, and healing	Create grounding process to ens access to healing and participati
Narrative Therapy	Dubi	Therapeutic healing: To use storytelling as a means to address past trauma	Use an expressions to release all their ability to heal from trauma

The curriculum also aligns strongly with Bronfenbrenner's ecological systems theory. The curriculum aims to facilitate a process for clients to see the connections among how clients experience their families, community institutions, neighbors, and the macrosystems that support them. The curriculum helps to identify the barriers to healthy family relationships and the need to examine the systems that both impede

child and maternal health and support it. The curriculum builds upon HCI's integrative framework and supports each of its case managers as they work with clients to support their goal-setting towards education attainment, employment, and the emotional health of Black mothers and their children. The use of systems thinking was designed to help HCI staff and clients improve outcomes for mothers and their families.

The Role of Trust

The team members trust in my capacity to take their ideas and shape them into larger constructs that would inform the direction of the actual curriculum development was a bit daunting. I also felt that our conversations about what we would like to see were specific enough that I had a clear road map of how to further crystallize the ideas into an actionable plan and process. I use the term "we" very loosely, as my role during this part of the process was to listen, listen some more, ask clarifying questions, and present the ideas as I received them in order to receive feedback – and then start the process over again.

I did choose to engage HCI staff with my own experiences as well, as co-creators of this work, which is our community psychology approach, particularly when we shared how we each felt about the trauma certification program we experienced together. Thus, this process was largely reflective of their ideas and priorities for the curriculum. The development of trust was about trusting me and the process I provided for the development of the curriculum, but also, it was a process for HCI team members to trust themselves. As many team members have built a career in their roles as case managers, doulas, and in a leadership role of a case management team, they have been charged with implementing curriculum created by researchers/outsiders who generally don't consult with case managers or program directors, and certainly not doulas, when developing evidence-based curriculum. This was a new role for the team. As we continued to discuss ideas and plans, the ability to see the process move from an interest they shared to the possibility of having a direct impact on the families they served became more real.

The Journeys Curriculum

The curriculum became known as the Journeys Curriculum, a psychoeducation format to address previous trauma while also aligning with current case management strategies for each client/resident to support their individual goal setting. The curriculum was designed as modular to allow for flexibility in implementation, depending on time constraints, client needs, and team member observations of clients. The curriculum could be delivered over 6-12 weeks, 1-2 hours per session. The curriculum incorporated centering, diaphragmatic breathing, and introduction to more techniques over time as the group evolved. Diaphragmatic breathing is a mind-body practice used throughout the curriculum (at the beginning and ending of each session) to reduce stress and has been studied to have additional benefits (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5455070/). Self-regulation techniques were also shared, along with knowledge of how and why such self-regulation helps the body and mind. Each person visits their own family histories through stories about themselves and their families. This storytelling is interwoven throughout the curriculum.

The content of the curriculum allowed users to center their own stories, thereby having the opportunity to relive their journey with support and to gain conscious awareness of the contextual realities that informed

their past, that of their family members, ancestors, and that which impacts their relationship with their children. The stories served as the foundation upon which they viewed themselves and the systems they navigate, their relationships and how they've changed over time, through influence of external realities. Participants began to critically examine their relationships and goal setting, and how systems impact their relationship to both. They used a mapping exercise to visualize the systems in their lives and their connections to their children to determine whether they are navigating systems or whether systems are navigating their lives. Exploration of their bodies and how they relate to them – as mothers and as sexual partners, through the trauma they've experienced, exploitation, and their earliest memories of their awareness of their bodies was also explored. The curriculum also made space for taking back power from traumatic memories/experiences and connecting them to practices that acknowledge pain from past experiences and incorporate self-regulation exercises to support their healing and continued psycho-social-emotional development. After exposure to various trauma-informed techniques, participants identified which ones they planned to continue to use after the group ended. Affirmation exercises were also used throughout and at the end of each module along with bonding exercises that help to reaffirm and reconnect the group members to one another.

Connections of the Curriculum

Once the co-creation of the curriculum was complete, the staff requested that we go through the curriculum together before working with their clients. They immediately saw the connections between their own experiences and that of their clients, as many of them are also Black women, some with similar origin stories to their clients. Staff members were also moved by the opportunity to grow their knowledge and incorporation of trauma-informed practice into their own work with clients. They saw the modular nature of the curriculum to have a particular benefit in helping support flexibility in use with clients. The techniques also offered a unique opportunity to support staff in unique ways and address untreated trauma that they also experienced. The curriculum has made an impact on the ways that staff members see themselves in relation to their clients and has made room for their capacity to engage in this work for their clients and to find a road to healing for staff who are often tasked with supporting clients, even as their own needs to heal from trauma and past experiences remain unresolved.

We were excited to begin the Journeys Curriculum. However, unfortunately, the project with Healthy Start was sidelined with a number of the staff leaving the agency during the planned implementation period. But, the project has since been utilized with a residency program for Black pregnant and parenting women in Harvey, IL, a neighboring municipality to Dolton, IL. The engagement process is still currently underway, delayed due to mandated restrictions related to COVID-19. There are still plans in place to implement the curriculum.

Takeaways From the Project

This process began with a goal to impact clients of the Healthy Start Southeast Chicago Program. Consideration for the ways the Journeys Curriculum would support staff was not clear in the beginning.

Yet, the opportunity to see the project through to the end and evaluate the curriculum based on the client experience at Healthy Start was not realized. But this change in focus in the curriculum offered the opportunity to shine a light on an often overlooked topic in nonprofit settings: who heals the healers? Who provides support for the staff members of organizations working against considerable odds, navigating hostile systems, experiencing the long-standing effects of untreated trauma as they help their clients to strive and thrive? This question has sat with me for months since this engagement ended. When I work with new organizations interested in introducing this curriculum to their clients, I will think about how to bring the process that informed this curriculum to new collaborating partners, rather than focusing solely on the curriculum previously developed. I learned from the staff at Healthy Start that organizations I collaborate with may benefit from supporting healing for themselves as well as their clients. I've held several workshops since, focusing on untreated and unresolved trauma of staff working with clients navigating through the same choppy waters. What I've found in these workshops is that when given the opportunity to lift up and name trauma, the differences between many staff and clients may lie in their education, salary, role, and protective factors in relation to clients, but otherwise, there may be many other experiences they share in common. The role of community psychologists often requires us to be flexible, and remain open to the dynamics of communities as they are never static. This brings us to a related discussion on setting creation.

Sarason's (1972) initial work on the creation of settings and his reflective essays on the topic over the years bears mentioning here. Although his work has focused largely on education and education settings, I see the concepts he discussed in numerous essays and books as relevant to nonprofit settings. As Sarason explained, one of the challenges faced by organizations leading change efforts is the inability to fully appreciate the ways organizational leaders often aim to make change without changing how an organization functions. Leaders are socialized to set up new initiatives without questioning how the initiative is positioned to avoid the pitfalls of the previous ones, or what fail-safe measures are put in place to address unexpected shifts that inform what is deemed as successful. He makes the point in a reflective essay that personal motivation towards a goal often overshadows the need to fully appreciate and examine the process that informs it. As I look at my own process while working on this project, I acknowledged moments when I could have used my knowledge of Sarason's theory to engage with the process differently. I was personally excited to develop a trauma-informed curriculum with a diverse team willing to co-create the project, but did not question how introducing a new program into an established setting would avoid the same obstacles that hindered previous attempts to launch a new initiative. Seeing myself as an outsider with insider knowledge and experiences, I didn't fully appreciate the limitations of the setting to adapt to new ways of engaging in work, without any paradigmatic shift to support it. As you are learning, community psychologists are collectively learning to move to the "inside" of communities to see a different lens than an "outsider" would.

The Journey Ahead

Our work as community psychologists is always fluid. Thus I am working to address some of the areas that did not go well with this project. Having a contingency plan for implementation when key staff changes occur is one area of the project that will require better attention. I worked with a team but had only one project lead to support the organizing process with staff and clients. Once each project lead left HCI, the project lost momentum for a time and eventually was not able to meet the goal of completing the implementation of the curriculum with clients.



Photo by Clemens van Lay on Unsplash (Image is decorative and says "The Journey is On")

Clear timelines were set for each aspect of the months-long planning process and weeks-long training and implementation process, without a clear appreciation for how this planning impacted their work schedules. This is a common concern with the implementation of new programs that are not funded with dedicated staff. Programs developed under these circumstances engage staff who spend paid hours time away from funded projects to participate in the process. This made it difficult for team members who were very eager to participate and interested in the project to continue while managing competing priorities, particularly as they were under some pressure with funding for their programs being under threat due to a much more conservative Trump administration threatening to end such programs.

The work to refine the process of developing a trauma-informed curriculum for organizations serving Black pregnant and parenting mothers continues with Lakeside Incorporated, which serves clients living on Chicago's south side and south suburbs. The process involves revising the materials that support the development process, incorporating more materials that invoke questioning, training in trauma-informed care, and the use of liberation education. Another important takeaway is I didn't have awareness of the ways staff would find the curriculum helpful and useful to their own healing process during the initial creation. All work of this nature must begin with the 'healer'. That has since changed. I use that awareness to raise different opportunities for questioning for staff that can support a dialogue that focuses on how they see themselves on their own healing journeys with trauma. Research and further exploration of liberation-based healing has also provided more insights and potential tools that can be incorporated into the curriculum, particularly the work of Dr. Rhea Almeida.

Conclusion

As with any work in community psychology or other related fields, adaptability and flexibility are imperative—the very complex nature of communities and people's lives demands it. This case story is as

equally important as case stories that were successful in carrying out the original vision. The goal is for the reader to understand the work of community psychology practice is not set in stone or exists outside of the changes that occur in normal community living. This is what makes community psychology exciting is it moves with the changes of life and is never anti-thesis to the struggles of citizens navigating society to take back their sense of agency or engage in co-liberation!

FROM THEORY TO PRACTICE REFLECTIONS AND QUESTIONS

- Dr. Somerville (2021) shared "the opportunity to see the project through to the end and evaluate the curriculum based on the client experience at Healthy Start was not realized". What are examples of ways a deficit-based approach might explain this occurrence? What are additional ways outside of what has been identified by Dr. Somerville that the curriculum might still be used?
- Foundational to community psychology work is adaptability and flexibility. Share with your classmates or others a time when you had to demonstrate adaptability and what were the results.
- We know that community psychologists do not have the cure for social issues, but instead are co-creators for envisioning alternate settings. Think through a challenge in a community you are aware of. What might an alternate setting look like for this community challenge?

References

Sarason, S. B. (1972). *The creation of settings and future societies*. Brookline Books.

PART V

Part Five: Community Psychology Across Disciplines



Since the initial publication of Case Studies in Community Psychology Practice: A Global Lens in 2022, some things in our world have changed and some have stayed the same. For example, unfortunately we still engage in wars to settle differences, and equity for all people is not yet a reality. As much as things stayed the same, within three years, our world has also changed considerably! We have come through the Covid-19 pandemic, Russia's invasion of Ukraine, and Ketanji Brown was confirmed as the first Black woman to sit as a Supreme Court justice. Change is absolutely inevitable and no individual, family or community is exempt.

We pointed out in our Introduction that communities are living organisms and thus need certain nutrients to grow and flourish, and **Part Five** of our book is part of the change process. In the Introduction we shared in part… "we recognize that a community is a living organism and needs certain nutrients as all organisms do to convert to energy that of course, is used to develop and grow!" (Palmer, Viola, Rogers & Engel, 2022, para. 1). By situating community psychology in medicine and education, we seek to mimic the dynamic change process that communities undergo to grow and flourish by also changing and growing. After all, it is a book on community psychology practice, which should never be static.

In late 2024, an opportunity for expansion of our evocative e-textbook surfaced. We stepped into the change process—linking medicine, education and community psychology practice! We are thrilled to demonstrate how using a community psychology approach in the learning and practice of medicine not

only expands the depth and breadth of our book but also shows the malleability of such a discipline we have grown to love!

Collaborating with Charles Drew University College of Medicine (CDU), specifically faculty and students in its **Community Engagement Learning Opportunity (CELO)** program, we added six stories of medical students growing and learning to become physicians who are adept at not just treating illnesses but also addressing health disparities. thereby promoting, health equity. The cases highlighted in this section demonstrate using community engaged research as a means to create an academic and community knowledge-base that might address the challenges facing communities and identify feasible solutions by incorporating community psychology values and praxis.

As the program director, Dr. Noe Chavez called the project with CELO, a "*cross-pollination" of medicine and community*--this partnership is unparalleled and a model for the type of work we uphold and support. The six stories range from addressing childhood obesity to food insecurity to postpartum depression among new mothers. This section begins with the case story: *S.U.P.P.O.R.T. for Unhoused Individuals with Substance Use in Service Planning Area 6 in Los Angeles, California*. A model community-based research project, provided a comprehensive framework to assist physicians in determining how social determinants of health impact their patients. The second study, *Is Nutrition the Antidote to the Hypertension Epidemic in South Angeles* follows and continues to position the work of students in the CELO program as integral to advancing health equity among Black and Latinx communities in South Los Angeles, specifically around addressing hypertension. The students focused on increasing access to health foods, improving health literacy and fostering community engagement. A third study in this section *Beyond Birth – Unpacking Postpartum Depression (PPD) in SPA 6 and the Factors Driving Disparity,* explores the experiences of mothers in South Central Los Angeles who have experienced postpartum depression. An ever increasing health risk among Black and Latina mothers, this chapter importantly shares recommendations worthy of the read!

ABiopsychosocial Analysis of the Relationship Between Food Insecurity and Mental Health in South Los Angeles, the next case story is a strong reminder of the critical correlation between food insecurity and mental health outcomes. Read this great chapter on roles you might play in society to address this serious barrier to community mental health and well-being. A fifth study in Part Five, *Working Together: A Community Approach to Combat Pediatric Asthma in South Los Angeles,* is another strong reminder of a public health disparity that targets our children—pediatric asthma. The answer? Certainly creating seats at the table for families impacted most by this challenge cannot be understated. The sixth case story, *Breaking the Cycle: Community-Centered Solutions for Socioeconomic and Environmental Challenges that Drive Childhood Obesity in South Lost Angeles* is the last chapter in Part Five, but certainly not the least. The students and community partners highlight the socioecological model, a public health framework that point to the need for healthcare providers to deliver care that is culturally and linguistically sensitive, as essential, not an option to begin to address this health risk among children.

Part Five highlights the expansive reach of community psychology across disciplines and professional settings. The case studies presented here illustrate how community psychologists collaborate with partners in health, education, public policy, and community organizations to address complex social challenges.

Together, these chapters demonstrate that community psychology is not confined to a single field; rather, it is a dynamic, integrative approach that centers equity, participation, and collective well-being. By bridging disciplinary boundaries, these contributors show how community-engaged scholarship and practice can generate innovative solutions that strengthen communities and advance social justice across local and global contexts.

SEE CONTRIBUTORS PAGE FOR LIST OF AUTHORS (EDITED BY GERALDINE PALMER, TODD ROGERS, JUDAH VIOLA, AND MARONICA ENGEL)

14

Community Engaged Learning Opportunity (CELO): A Novel Approach to Community Engagement in Medical Education

INTRODUCTION

A new generation of medical trainees with an understanding of social determinants of health (SDOH) contextualized in community-engaged learning is key to producing a physician workforce that is more effective at addressing health inequities. This is particularly true of the physicians who will serve in health care systems with patients whose health outcomes are disproportionately shaped by structural/cultural determinants of health as well as systemic racial inequities, falling under the broad umbrella term of SDOH. Below, we describe a medical education course in which medical students in their first two years of training worked in teams to learn about social determinants of health in the context of prevalent and significant health concerns in the South Los Angeles communities around them. Community-engaged learning is important for medical students because such learning goes beyond classroom discussions and clinical training to connect students directly with community stakeholders in the communities where they live, study, and serve.

- First, we provide a brief background and discuss the common challenges of teaching SDOH components in medical education.
- Second, we introduce the institutional and community contexts of our medical program, which allows for the development of this unique course in medical education.
- Third, we describe the methodology of the course to make the process transparent for other educators to replicate.
- Fourth, we briefly highlight each of the six student projects and what community engagement yielded for them.
- Fifth, we briefly reflect on how this approach to community-engaged learning in medical education fits within the field of Community Psychology.

- Finally, as educators, we conclude with reflections on our experience of facilitating this course for the first time and lessons learned.

The Background of SDOH and Community-Engaged Learning in Medical Education

There is growing recognition in the field of medicine and public health that understanding and addressing SDOH and community-engaged learning are key to improving health outcomes and quality of care. (Doobay-Persaud et al., 2019; Lewis et al., 2020; Nour, Onchonga, Neville, O'Donnell, & Abdalla, 2024) Yet medical education, for the most part, has not caught up with this recognition since SDOH-related curricula still comprise a relatively small share of the total medical education curricular footprint (Solomon et al., 2025). While medical educational programs increasingly include some representation of SDOH and community-engaged learning related topics in their curricula, several studies based on nationally representative samples report on the variability of SDOH and community-engaged learning content, the level of prioritization in teaching this content, and the lack of consistent evaluation of these program elements (Campbell et al., 2022; Doobay-Persaud et al., 2019; Hunter & Thomson, 2019; Lewis et al., 2020; Nour et al., 2024; Sharma, Pinto, & Kumagai, 2018).



Social Determinants of Health (SDOH)

When it comes to SDOH and community-engaged learning training in medical education, medical students are exposed to these topics under varied terminology, for variable lengths of time, and using a variety of different approaches. Terminology such as population health (within health systems sciences), community-based care, or community-based service learning can all incorporate exposure to SDOH. The level of prioritization for such exposure can vary from a single lecture on the topic to year-long service-learning opportunities, to research theses. These variations notwithstanding, the dominant approach to teaching about SDOH and community-engaged learning within medical education in the 2010s and 2020s has been criticized for positioning them as a laundry list of "facts to be known" and likely addressed at an individual or interactional level (e.g., behavior-focused interventions, doctor-patient communication) rather than as "conditions to be challenged and changed" at the systemic and sociopolitical levels (Sharma et al., 2018).

There is a reason that medical education programs tend not to prioritize SDOH and community-engaged learning related curricula, which have been referred to as the "broccoli of medical education"(Gonzalo & Ogrinc, 2019). Like broccoli, SDOH and community-engaged learning are deemed beneficial for students but not sought after by most students, and not a high-priority component of many medical programs. While this type of learning has increasingly been incorporated among the required components for licensing by the Liaison Committee for Medical Education (LCME), SDOH and community-engaged learning concepts are minimally represented on NBME board and shelf exams (Lewis et al., 2020).

Additionally, few medical programs make space in their curricula to address such topics, and faculty often lack appropriate knowledge and skills to teach such materials. Therefore, students are left with the impression that this information is peripheral if not irrelevant, relative to building competency in basic science, organ systems, and clinical skills knowledge. Because students are not rigorously tested on this topic on certifying exams, they see SDOH and community-engaged learning and systems change as outside the realm of physician responsibility and not considered as "high yield" (Gonzalo & Ogrinc, 2019). Consequently, this learning is often not prioritized by both medical students and medical education programs alike. Despite these barriers, we were able to develop a community-engaged course focused on experiential learning in our new medical program at Charles R. Drew University.

Institutional and Community Contexts in South Los Angeles



LA-County-SPAs

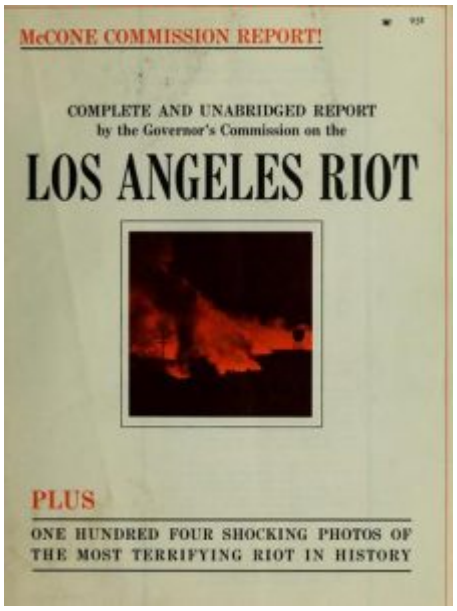
To understand how we came to teach community-engaged learning, we need to briefly share the context of South Los Angeles and the birth of our institution, Charles R. Drew University of Medicine and Science. Los Angeles County is the largest county in the nation, with nearly 13 million residents residing within it. For administrative and planning purposes, the county is divided into eight geographic regions of approximately equal population size called service planning areas (SPAs). South Los Angeles, while slightly ambiguous in definition, is a term colloquially used to describe a collection of LA city neighborhoods (e.g., Watts) as well as unincorporated regions of LA city (e.g., Willowbrook) and even independent cities (such as Compton).

Most of the geographic regions people consider South LA lie within LA County's Service Planning Area 6 (SPA 6), and for this chapter and other chapters in this textbook, we will use South LA and SPA 6 interchangeably. SPA 6 has a population of just over 1 million residents – a population comparable to the state populations of Rhode Island, Delaware, and North Dakota and South Dakota.

In 1965, Governor Jerry Brown appointed John McCone to chair a commission tasked with understanding the root causes of the deadly 1965 Watts riot. In the report, the commission cites several critical healthcare metrics about South Los Angeles as contributing to the uprising:

- an infant mortality rate 1.5 times greater than the county average,
- a "considerably shorter" lifespan,
- a population-to-physician ratio of 2,377 people/physician (the county ratio was three times lower), and
- a total of two hospitals in the area that met "minimum standards of professional quality" (California Governor's Commission on the Los Angeles Riots, 1965).

Given the discovered findings, the commission recommended the construction of a new county hospital. This hospital would later be known as the King-Drew Medical Center. At the same time, Charles R. Drew University (CDU) was established directly across the street from the hospital with the intention of training healthcare professionals to provide care in South Los Angeles.



McCone Commission Report

Two thousand and twenty-five marks the 60th anniversary of the issuing of the McCone commission report – and despite significant advances in medicine, public health, and health policy, the report remains uncomfortably relevant. The infant mortality rate remains consistent at 1.45 times greater than the county average. The average life expectancy in SPA 6 is 79.1 years, 3.3 years lower than the county average (Los Angeles County Dept of Public Health Office of Health Assessment and Epidemiology, 2017). While it's difficult to ascertain the current population-to-physician ratio in SPA 6, 32.5% of adults report difficulty accessing medical care – the highest rate reported in the county. (Los Angeles County Dept of Public Health Office of Health Assessment and Epidemiology, 2017). Finally, in 2007, the King-Drew Medical Center, the seminal achievement of the McCone Commission, was shut down. While it was eventually replaced with the establishment of MLK Community Hospital in 2014, this transition represents a decrease of 406 fewer hospital beds in the South LA region. These statistics, being so resistant to change, support the conclusion that meaningful, sustainable change in South Los Angeles is both complex and challenging.

With a vision of "excellent health and wellness for all in a world without disparities," CDU has continued to attract faculty, staff, and aspiring healthcare professionals with a shared goal of addressing these challenging disparities within lower-resource communities. In 2023, CDU launched its 4-year medical education program and is only the fourth medical program at a historically Black graduate institution in the United States. As a university, CDU has prioritized a focus on social and historical determinants of health across its programs, including in its brand-new medical education curriculum, because we train our students to provide care to the most under-resourced communities around us, like the ones in South Los Angeles.

Our student body also reflects this priority with 85% of the matriculating medical students reporting an intention to practice in an underserved community after graduation. It is significant to note that an overwhelming large percentage of our medical student body has lower financial resources and are first-generation. Likely, CDU's graduates will ultimately make up a large proportion of the safety-net healthcare workforce throughout Southern California. The Medical Education Program aspires to cultivate excellent clinical leaders in the community, with the ability to critically engage the community around pressing health issues as a focus for leadership skill development. Within this program, Medicine and Society is a course taken throughout the four years of the medical program, which was designed to include a Community-Engaged Learning Opportunity (CELO) in the first two pre-clerkship years.

Methods used in the development of the CELO Project

For their CELO projects, six groups comprised of ten medical students in each group were asked to complete the following six steps:

Step	Topic	Description
1	**Identify a health condition prevalent and significant to South Los Angeles**	We divided the 60 students randomly into six groups of ten students each. The students discussed their interests and together decided on some potential health conditions for consideration. With input from faculty mentors and directors, the groups refined and focused their topics through further discussion and confirmation of the prevalence and significance of the health condition in South LA to select their final topic.
2	**Develop a brief literature review and project plan**	Each student, in their groups of ten, reviewed peer-reviewed articles/governmental reports in order to develop a collective literature review of twenty articles to identify key domains. They also wrote a collective proposal that described their topic and research question, the prevalence and significance of the issue in South Los Angeles, identified any relevant local or national health policies that might shape this issue, and a plan in which each group member would interview one of ten stakeholders.
3	**Brief training in developing qualitative interviewing skills used in Social Science disciplines**	Students were introduced to in-depth interviewing techniques and script development through in-class workshops. Unlike clinical interviews that are therapeutic and goal-oriented, qualitative in-depth interviews are open-ended and usually utilize a semi-structured script of questions. Using a semi-structured script allows the interviewer to cover known domains of inquiry but also the flexibility to follow the lead of the interviewee into new domains not identified in the questions, thus allowing for discovery. The students worked in their groups to develop and refine interview scripts with input from faculty mentors. Faculty mentors and directors provided feedback on how to refine and tailor interview questions to match the type of stakeholder (e.g., patient/family member, CBO, healthcare provider, policy person/researcher, government or community leader) they were interviewing.
4	**Conduct in-depth qualitative interviews**	Each group of students was required to collectively interview at least ten community stakeholders, and each group member was required to conduct at least one interview. The three stakeholder categories were consistent with the socioecological model as follows: a) "patients/family/Community-based organizations" – those who received or facilitated health care, the community members most directly impacted by the topic of interest; b) "providers/health care teams" including social workers, community health workers, nutritionists, and care providers, etc. – those who provided health and social services to those directly impacted by the topic of interest; and c) "policy makers/researchers/governmental representatives" – those who made or implemented health policy or studied the topic of interest. Students were primarily tasked with identifying community-based organizations that addressed their topic of interest in South Los Angeles, as well as providers, patients, researchers, and policymakers. This allowed students to directly learn about who the key actors and decision-makers are for their topic of interest and directly probe them on the challenges and needs faced by such diverse community stakeholders. Faculty mentors and directors also supported the teams in identifying appropriate interviewees.
5	**Summarize and analyze their interviews**	Students used automated transcription software to transcribe their interviews. Each student analyzed the transcript of the interview they conducted for themes identified in the literature review and for new themes that emerged from their interviews. They analyzed the transcripts and created summaries with regard to what they learned in the interview, considering the broader questions being asked in their overall project. Then, they were asked to form sub-groups based on the three stakeholder categories (i.e., patients, providers, and policymakers). All group members who interviewed a certain type of stakeholder were placed in one sub-group. Within each sub-group, they read each other's summaries and created a summary analysis for each sub-group of stakeholders, identifying key themes that emerged across their transcripts. (For example, what did the three different types of providers (physician, dietician, and community health worker) interviewed say about the provision of health care in South LA around the selected topic? How did their views concur or differ? etc.). They also identified key quotes that illustrated their most interesting findings. Then each subgroup presented their findings to the other stakeholder subgroups and vice versa, so they could all learn about the differences in perspectives of those receiving/facilitating care, those providing care, and those creating policy or researching about the topic of interest. By pooling and analyzing their interview transcripts together in their subgroups and large groups, they were able to identify key themes and both patterns of similarities and divergences across their collective interviews, which is a main strength of qualitative interviews.

Faculty mentors and directors provided the

Step	Topic	Description
6	**Develop a presentation**	Finally, each of the teams worked together across the subgroups to develop a collaborative analysis and a collective presentation. They worked together to develop a comprehensive presentation that discussed: a) the problem, its significance and relevance to South Los Angeles; b) how their literature review shaped their questions and identified gaps in our collective knowledge; c) What they learned about the issue and implications for South Los Angeles, some potential solutions to the identified problems, and future directions, and d) Reflections on their community stakeholder interview strategies and what they learned from their stakeholders, and what they learned about themselves in the process. The student groups presented their analyses and competed for first, second, and third place prizes with their final presentations. They were assessed by three judges from outside the program using the rubric provided in Appendix A.

eedback and support throughout the process, including in the selection and focusing of the topic, on their literature reviews and project proposals, their interview script development and revisions, in identifying interview participants, in their data collection and development of analyses, and culminating in their final presentations.

OUTCOMES AND IMPACT

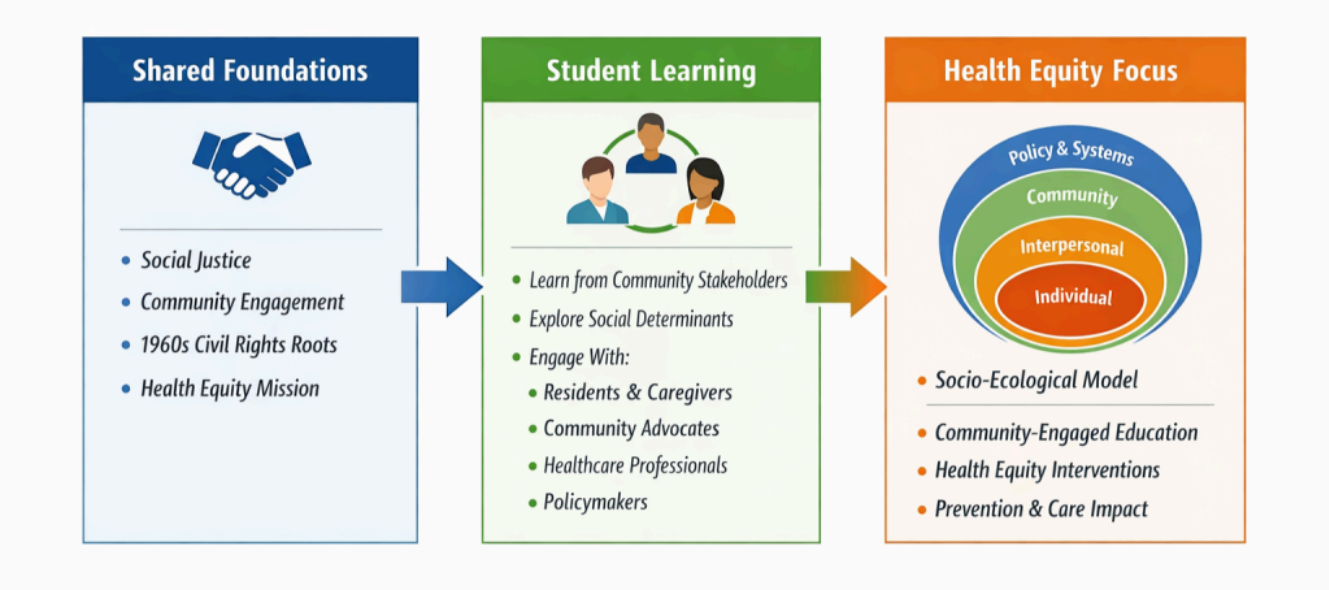
In the following chapters, the six groups of medical students describe their CELO projects, lessons learned, and recommendations to address the challenges of their respective health issues. The topics of their projects included the following: 1) prevention of childhood obesity, 2) pediatric asthma, 3) food insecurity, depression, and the gut-brain axis, 4) substance use among the unhoused, 5) inequities in hypertension, and 6) reproductive justice in maternal and infant mortality.

Group	Topic	Description
1 – Hamideh et al	**Prevention of childhood obesity**	Focused on understanding the inequities in childhood obesity for Black and Latinx descent communities in South LA. Their interviews with diverse stakeholders, including physicians, dieticians, community advocates, and parents, highlighted varied factors interrelated with childhood obesity in South LA communities. Four common themes that emerged included improving culturally and linguistically grounded nutrition education, offering community support to improve access to health education and resources, improving the safety of environments for exercising and building community, and policy changes to make all these new resources possible.
2 – Argueta et al	**Pediatric asthma**	Examined inequities in asthma rates in Black and Latinx children and adolescents in South LA communities. The students interviewed mothers of pediatric patients with asthma, children/youth with asthma, pediatricians, community advocates, and policy makers. The interviews highlighted the following themes: a) disparities in exposure to indoor and outdoor air pollution, b) parental difficulties in the management of children's asthma, c) access to emotional support and education in pediatric asthma, d) complex challenges in improving insurance coverage, and e) effective medication and treatment for pediatric asthma. Potential solutions, centered on funding for community organizations for parental support and education on pediatric management, policies for mitigating air pollution, education and access to healthy diets, and improving equitable access to specialized and quality treatment.
3 – Peña-Garcia et al	**Food insecurity, depression, and the gut-brain axis**	Explored the role of food insecurity and healthy food deserts with depression and the gut-brain axis in South LA communities. The group interviewed diverse stakeholders, including a community member who experienced depression and food scarcity; a local farmer's market manager; a community resident; providers, including a primary physician, a psychiatrist, and a dietician; a researcher; a public health advocate; and a policy maker. The main themes from their interviews underscored the significant scarcity of healthy foods in South LA, the extensive consumption of ultra-processed foods, limited access to culturally responsive mental health services, the need for integrating nutrition knowledge in medical education, and the need to increase knowledge of food and the gut-brain axis. This group's work highlighted the interconnections among multiple factors influencing depression, supporting the application of biopsychosocial and ecological frameworks in developing solutions.
4 – Lopez et al	**Substance use among the unhoused**	Tackled the problem of substance use in the unhoused in South LA by interviewing diverse experts. Like the other projects, this project applied a holistic lens to better understand the complexity of structural factors impacting substance use in one of the most marginalized and vulnerable populations. Particularly, the medical students sought to create a holistic model that captured the multifaceted challenges of systems change to provide support to the unhoused. Their SUPPORT model (Stigma, Understanding, Prevention, Policy, Outreach, Roof/Refuge, and Transformation) was intentionally created to ground their work in the community-centered approaches of Housing First and the decriminalization of the unhoused populations.
5 – Deshields et al	**Inequities in hypertension**	Examined one of the most rampant health inequities faced by Black and Latinx communities, hypertension, which stems from multiple socio-cultural and economic factors, and is one of the leading causes of morbidity and mortality. The students focused on how nutrition interconnects with various factors, such as poverty, cultural practices, food systems, and education. They interviewed diverse stakeholders, including Black and Latinx patients, community activists, and healthcare providers with expertise in hypertension. The interview findings highlighted the importance of understanding the historical, cultural, psychological, and economic contexts of food practices. To address hypertension, interventions should engage diverse community members, such as community health workers, faith-based leaders, residents/patients, to develop culturally and linguistically responsive community interventions integrated within the medical education and patient-care systems.

Group	Topic	Description
6 – Watat et al	**Reproductive justice in maternal and infant mortality**	Examined the inequities in maternal and infant mortality in South LA. The students explored the birthing and postpartum experiences, including depression, of minoritized women. The students applied a Reproductive Justice framework to explore the structural roots of the inequities experienced by women, such as systemic racism and economic instability. The diverse stakeholders they interviewed – patient mothers, healthcare providers, researchers, and maternal health advocates- informed a three-tiered framework of potential solutions – 1. Improved patient-care and advocacy, 2. Improving healthcare systems and processes, and 3. Reproductive justice to advance maternal equity. The framework promotes a humanized, justice-centered, culturally rooted, trauma-informed, centering mothers' voices, and empowering approach.

HOW THE CELO CURRICULUM ALIGNS WITH COMMUNITY PSYCHOLOGY

The mission of our university is focused on social justice and community engagement, reflecting two core principles of community psychology. CDU was founded in 1966, while the field of community psychology in the United States started in 1965. Both the university and the disciplinary field emerged in the context of powerful civil rights movements fighting against racial oppression and driving attention toward solving the complex social determinants of health and well-being. In their projects, our medical students learned directly from community representatives about the various social determinants and inequities affecting the South LA communities' experiences on a diversity of health issues. They utilized the socio-ecological or biopsychosocial model to organize the diversity of community stakeholder interviews, representing the different ecological levels or settings, from community residents or patients, caregivers, community advocates, to healthcare professionals, researchers/academics, and policymakers. These projects contribute knowledge on the limited scholarship in community-engaged medical education and aim to advance community interventions for prevention and promotion of health equity in under-resourced communities. The principles of community psychology can aid in further improving our healthcare education and practices in a community-engaged manner.



CELO Alignment with Community Psychology

CONCLUSION

Reflections on Lessons Learned and Future Directions

We end with some reflections on the process of implementing this community-engaged approach in medical education. Through this process, we learned that it was possible to teach medical students about community-engaged ways of inquiry. Many of them became invested in the health conditions of the communities around them, engaging with both individual stakeholders and community organizations/leaders, and learning techniques of inquiry that were unfamiliar to them and not traditionally taught in medical education. As teachers, it was a joy to see them develop and grow through this experience.

Several factors enabled us to pilot this curriculum successfully. Being in a large metropolitan area allowed a diversity of views to be captured in the stakeholder interviews. This context and ecology allowed our students to learn from diverse perspectives. An intentional engagement of stakeholders across the socioecological spectrum by medical students to obtain a holistic understanding of their selected health issue counters the predominant narrative in medicine that the doctor-patient interaction begins and ends within the clinical walls. It was valuable to use qualitative open-ended interviewing methods to expand epistemological tools available to medical students – to teach them that meaning-making is subjective and collaborative. This allowed for an expansion of what is acceptable evidence, beyond the gold standard of randomized clinical trials, to include their own reflexivity and lived experiences on data collected from a range of stakeholders. Finally, our curriculum benefited from the general support of the university community:

1) the absolute commitment and support of our institution and the medical program administrators who believed in the importance of this education,

2) the commitment of our students to equip themselves to be the best healthcare providers for the communities they aim to serve; and

3) the dedication of our interdisciplinary faculty (clinicians and social scientists/ community leaders) who brought wisdom and passion to this endeavor.

With that said, there are several challenges (noted in previous sections) that may result in difficulty for another medical education program to reproduce a similar curriculum and results. This type of learning, using questions to explore ideas inductively and without clearly defined answers, is very different from the rest of a typical medical curriculum. Medicine, being a profession that inherently carries high risk and a low tolerance for error, results in training that prioritizes knowledge that is extremely well-defined, reproducible, and evidence-based, with little room for subjectivity or reflexivity. Consequently, we learned that championing this type of learning, which contrasted with most medical educational goals, was quite challenging. First, it was difficult to implement this learning among medical students, who are overwhelmed with the many other requirements of medical education, when the knowledge from this learning is not tested by medical accrediting bodies.



We also received feedback from several students at the end of the year, noting that our choice to randomly assign students into groups of ten resulted in project topic selection that did not adequately align with the interests of some individuals in the groups. Another challenge we faced was assisting students in successfully identifying potential stakeholders to interview. Students who were assigned to interview healthcare providers faced the greatest challenge, which we suspect is due to healthcare providers typically having impacted schedules.

Subsequent Changes and Future Directions

With these strengths and challenges in mind, we made several changes to the curriculum between the pilot year and the second year of running the course. Instead of randomly assigning students into groups of ten, we developed a sorting process that allowed for better alignment of individual student interests with small group interests. In the first phase of topic identification, we asked all 60 students to get accounts on a digital whiteboard (https://miro.com/index/), which allowed them to share ideas for topics virtually as well as provide input to the topic ideas posted by their colleagues. Once they put their ideas online, the directors of the course categorized their ideas by main topics and sub-topics.

In the second phase of idea refinement and topic selection, students voted for their top three main topics of interest. The directors picked the six topics most voted for and implemented a Google survey with those topics that the students ranked from 1 – 6, which allowed the use of an algorithm to place each student into one of six topic groups with ten students in each group, based on their ranking of topics. With input from faculty mentors and directors, the groups refined and focused their topics through further discussion. We believe that this change allowed for better alignment of the interests of individuals placed in each group.

We also adjusted the timeline of the curriculum to allow for more time for the students to identify and conduct their stakeholder interviews. Additionally, the faculty team developed a repository of potential stakeholders – particularly healthcare providers – for students to interview, depending on selected topics.

In conclusion, we hope this curriculum provides an example of how medical education programs could incorporate community-engaged ways of learning into their curricula. We hope that this effort contributes to existing scholarship on community-engaged medical education and advances academic and community efforts to motivate future collaborations between community psychologists, medical researchers, and healthcare professionals. Furthermore, we hope these projects and student reflections on what they learned can motivate more medical education and interdisciplinary approaches in community psychology, public health, and community health to engage various community representatives more fully in not only learning about the health issues in communities but also taking action to inform interventions and policies guided by diverse voices and lived experiences. To solve the growing health inequities, our medical systems and training of future healthcare providers should move beyond the individual, treatment, and pathology focus

of biomedical frameworks, to develop and implement more approaches centered on ecological, prevention, and strengths-based/wellbeing perspectives.

ACKNOWLEDGMENTS

We extend our deepest gratitude to the patients, family members, health care providers, researchers, policy makers, community leaders, and organizational stakeholders who generously shared their time, experiences, and insights with our medical students. Your willingness to participate in interviews and contribute critical information made this work possible and profoundly enriched each project.

We also sincerely thank the editors who guided the development of this compendium, as well as the many reviewers who provided careful, thoughtful, and iterative feedback on each chapter. Your engagement strengthened the quality, clarity, and rigor of every contribution.

We acknowledge the medical student authors whose dedication, collaboration, and perseverance shaped the heart of this work. Your commitment to designing and implementing each project and to thoughtfully addressing reviewer comments significantly enhanced the final manuscripts and reflects the best of scholarly teamwork.

Finally, we would be remiss to not mention the many allies who have supported this effort. Your unwavering support, both material and intangible, was essential to the success of the Community Engaged Learning Opportunity (CELO) that led to this publication. We thank our CDU Medical program and Dr. Dean Deborah Prothrow Stith and Associated Dean Dr. Arthur Gomez for giving us precious real estate in the program to focus on community-engaged learning. We thank the sponsors of cash prizes for the winning teams of the presentation competition – Dr. Lance Williams and The Russell Stoval Foundation, Professor Aziza Lucas-Wright Varnado and The New Vision Church of Jesus Christ, and Dr. Stephen Greene, a member of the first graduating class of CDU physicians. We thank Drs. Schetema Nealy, Noe Chavez, Lance Williams, and Professor Aziza Lucas-Wright Varnado, the CELO faculty mentors who guided our students through these projects. We also thank Drs. Lola Ogunyemi, Homero Del Piño, and Lejeune Lockett for dedicating their time and effort as judges for the students' presentation competition.

REFERENCES

California Governor's Commission on the Los Angeles Riots, J. M. (1965). Violence in the City–an End Or a Beginning?: A Report: The Commission.

Campbell, M., Liveris, M., Caruso Brown, A. E., Williams, A.-L., Ngongo, W., Persell, S., . . . Adler, M. D. (2022). Assessment and evaluation in social determinants of health education: a national survey of US medical schools and physician assistant programs. Journal of general internal medicine, 37(9), 2180-2186.

Doobay-Persaud, A., Adler, M. D., Bartell, T. R., Sheneman, N. E., Martinez, M. D., Mangold, K. A., . .

. Sheehan, K. M. (2019). Teaching the social determinants of health in undergraduate medical education: a scoping review. Journal of general internal medicine, 34, 720-730.

Gonzalo, J. D., & Ogrinc, G. (2019). Health systems science: the "broccoli" of undergraduate medical education. Academic medicine, 94(10), 1425-1432.

Hunter, K., & Thomson, B. (2019). A scoping review of social determinants of health curricula in post-graduate medical education. Canadian medical education journal, 10(3), e61.

Lewis, J. H., Lage, O. G., Grant, B. K., Rajasekaran, S. K., Gemeda, M., Like, R. C., . . . Dekhtyar, M. (2020). Addressing the social determinants of health in undergraduate medical education curricula: a survey report. Advances in Medical Education and Practice, 369-377.

Los Angeles County Dept of Public Health Office of Health Assessment and Epidemiology, L. A. (2017). Key indicators of health by service planning area: Los Angeles County Department of Health Services.

Nour, N., Onchonga, D., Neville, S., O'Donnell, P., & Abdalla, M. E. (2024). Integrating the social determinants of health into graduate medical education training: a scoping review. BMC Medical Education, 24(1), 565.

Sharma, M., Pinto, A. D., & Kumagai, A. K. (2018). Teaching the social determinants of health: a path to equity or a road to nowhere? Academic medicine, 93(1), 25-30.

Solomon, L. S., Nocon, R. S., Jimenez, J., Johnson, R. E., Lupi, C., Xu, J., . . . Cohen, C. (2025). What Are We Teaching Medical Students and Physician Learners About the Social Determinants of Health? A Scoping Review. Academic medicine, 100(1), 103-112. doi:10.1097/acm.0000000000005795

APPENDIX: FINAL PRESENTATION RUBRIC

GROUP #/PROJECT NAME:		**NAME OF JUDGE:**	**PAGE #**	
Criteria	**Needs Improvement (1-2 points)**	**Meets Expectations (3-4 points)**	**Advanced Proficiency (5 points)**	**Points**
01: Introduction	Introduction lacks clarity, fails to set context effectively.	Provides basic context but lacks creativity.	Effectively sets stage, grabs attention, outlines purpose clearly.	
Comments				
Demonstration of Relevance of Health Issue	Limited demonstration of prevalence, significance, and impact on subpopulation.	Provides some evidence but lacks depth.	Demonstrates thorough understanding with clear and compelling evidence.	
Comments				
How Existing Knowledge Shapes Questions Asked	Fails to integrate literature effectively; questions lack depth.	Integrates some literature but lacks depth in shaping insightful and/or thought-provoking questions.	Clear understanding of literature's influence is evident; questions are insightful and inspire deeper thought.	
Comments				

GROUP #/PROJECT NAME:		**NAME OF JUDGE:**	**PAGE #**	
Criteria	**Needs Improvement (1-2 points)**	**Meets Expectations (3-4 points)**	**Advanced Proficiency (5 points)**	**Points**
Community Stakeholder Engagement Strategy (3 key subgroups)- 1) Those who receive healthcare; 2) Those who provide healthcare; and 3) Those who address healthcare challenges at policy/research levels	Provided no clear strategy for how they engaged a diverse range of stakeholders including: 1. patients/family members and community-based organizations (CBOs), 2. clinical care providers, other health care team members, and 3. government organizations, and researchers/policy experts.	Strategy present but lacks depth or clarity.	Comprehensive, well-thought out and intentional strategy representing diverse perspectives.	
Comments				
Stakeholder subgroup Perspectives	Minimal presentation of perspectives with few supporting quotes, lacks depth or credibility.	Presents perspectives with relevant quotes but lacks depth or integration.	Presents perspectives from all 3 stakeholder subgroups with compelling quotes that offer depth, insight, and clear connections to the relevance of health issues.	
Comments				

GROUP #/PROJECT NAME:		**NAME OF JUDGE:**	**PAGE #**	
Criteria	**Needs Improvement (1-2 points)**	**Meets Expectations (3-4 points)**	**Advanced Proficiency (5 points)**	**Points**
Identification and Analysis of at least 3 Key Challenges and Solutions	Analysis is superficial or absent; lacks depth or originality.	Provides some analysis but lacks depth or innovation.	Offers insightful analysis with evidence and critical thinking; wholistically assesses challenges/ solutions across stakeholder subgroups.	
Comments				
Implications for South LA and future directions vis-à-vis health policy	Implications of findings for South LA and future directions on health policy unclear or underdeveloped.	Provides some insight but lacks depth or originality.	Presents clear and compelling implications of findings for South LA and future directions with regards to health policy	
Comments				
Group's Reflections on Process of Community Engagement and personal impact	Reflections fail to address community-engaged learning approach; lacks depth or authenticity; fails to assess own growth.	Provides some reflections but lacks depth or critical analysis.	Offers thoughtful reflections, deep understanding about personal growth and process of learning through community engagement.	
Comments				

GROUP #/PROJECT NAME:		**NAME OF JUDGE:**		**PAGE #**
Criteria	**Needs Improvement (1-2 points)**	**Meets Expectations (3-4 points)**	**Advanced Proficiency (5 points)**	**Points**
Effective Use of Slideshow and Quality of Presentation	Slideshow is disorganized or distracting; presentation lacks clarity.	Slideshow is organized but lacks creativity or appeal. Minimally fosters audience engagement.	Slideshow is well-organized, visually appealing, and enhances timely delivery. Demonstrates creativity and precision in design, fostering audience engagement.	
Comments				
Overall Holistic Score	Format, presentation, and content lack coherence, organization, and clarity.	Format, presentation, and content are adequate but lack polish or originality.	Format, presentation, and content are exceptional, demonstrating coherence, creativity, and depth.	
Comments				
			Total Points out of 60 possible points	

Please provide notes so we can provide feedback to the group:

15

S.U.P.P.O.R.T. for Unhoused Individuals with Substance Use in Service Planning Area 6 in Los Angeles, California

SEE CONTRIBUTORS PAGE FOR LIST OF AUTHORS (EDITED BY GERALDINE PALMER, TODD ROGERS, JUDAH VIOLA, AND MARONICA ENGEL)

BRIANA LOPEZ, STEPHANIA LUNA, MADILYNN REYNOSO, NGOZI ALIA, JALEN CASTILLE, AUSTIN HUDSON, FATIMATOU SAKA, NYOKO BROWN, ALEXANDER AFEWERKI, DAVID HEREDIA

Big Picture/ Background of How We Came to Work with This Community

The United States has experienced 50,000 drug overdose-related deaths and approximately 140,000 substance-abuse related visits to the emergency department, annually (Han et al., 2022). People experiencing homelessness, or PEH, are at an increased risk of this alarming statistic because of the structural barriers that would otherwise reduce overdose-related deaths and co-morbidities (Han et al., 2022). Structural barriers including unstable housing, criminal justice involvement, and access to medications for opioid use disorder (MOUD) (Han et al., 2022), have led to discourse amongst experts on how the U.S. should implement national efforts to ease the burden for PEH with lived experiences of substance use disorders (SUDs).

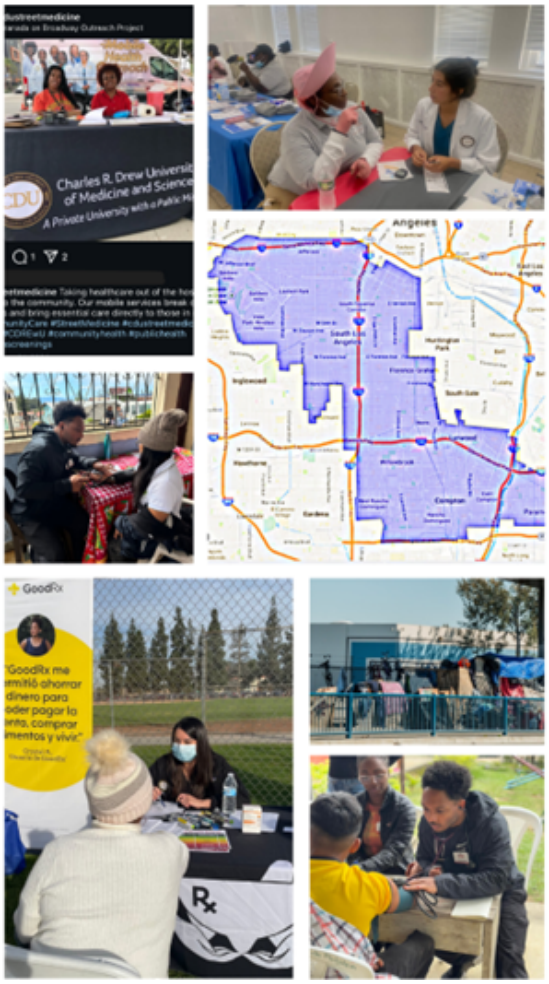


Figure 1. Map of Service Planning Area 6 in Los Angeles, California, highlighting the work of our team members Stephania Luna, Madilynn Reynoso, and Jalen Castille.

A 2022 study by Han et al., found that between 2013 and 2017 SUDs among PEH had increased, and that first-time SUD treatment admissions in the United States were predominantly among males who injected substances such as methamphetamine and cocaine. PEH were also less likely to receive outpatient treatment or receive MOUD (Han et al., 2022). In addition, Han et al. showed that there was a statistically significant increase in co-occurring psychological issues, or mental health, and methamphetamine use in PEH (Han et al., 2022). Although the study acknowledges that there was increased use of residential detox facilities and long-term facilities amongst PEH in 2017, there remains an issue of PEH receiving MOUD in comparison to non-PEH (Han et al., 2022). This disproportionate use of long-term facilities for treatment is believed to occur because of the need for housing (Han et al., 2022).



Person Experiencing Homelessness

This national trend has been reflected similarly in publicly funded SUD treatment for PEH in California. Padwa et al.'s 2022 observational study highlighted the importance of appropriate treatment for SUDs. By analyzing the California Outcomes Measurement System, a database of reported publicly funded SUD treatment services delivered in California from 2016 to 2019, Padwa et al. (2022) found that there was co-use of substances, such as methamphetamine and heroin, and identified barriers such as criminal justice and mental health diagnoses, underscoring the need for appropriate interventions while treating the SUDs itself. In addition, PEH were likely to receive residential treatment but experienced a lack of outpatient treatment. Although effective treatments for SUDs exist (however, not widely available) there remains the issue of housing insecurity, as Padwa et al. highlighted.

Models such as the "Housing First," which originated by Dr. Sam Tsemberis, the founder of Pathways to Housing, who pioneered the model in the early 1990s, can allow for PEH to receive housing without any prior requirement of rehab or treatment for mental health disorders to help minimize barriers to housing (Davidson et al., 2014). The model focuses on a "client-centered approach" that empowers open communication and does not require participation in supplemental rehab treatment to yield autonomy to the individual, a requirement in the traditional shelter-based model. (Davidson et al., 2014). There is concern that the open housing approach could harm other individuals in the same housing and on their journey for SUD recovery and that stable housing wouldn't treat the substance use disorder; however, this model is also cost-saving for the government and believed to at least stabilize or improve SUD (Davidson et al., 2014). This nationwide issue of housing instability and substance use disorder among PEH is also experienced in Service Planning Area (SPA) 6 of Los Angeles, California where us we medical students are conducting our medical training at Charles R. Drew University of Medicine and Science

Service Planning Areas (SPAs) are divisions within Los Angeles County that aids the Department of Public Health in determining what public health services and clinical services would benefit the specific needs of residents in each region ("Service Planning Areas," n.d.). Los Angeles County is divided into 8 SPAs, with SPA 6 serving Athens, Compton, Crenshaw, Florence, Hyde Park, Lynwood, Paramount, and Watts, pictured in Figure 1 ("Service Planning Area 6," n.d.).

According to the 2024 Greater Los Angeles Homeless Count Report, conducted by the Los Angeles Homeless Services Authority (LAHSA), the annual point-in-time count of people experiencing homelessness in LA County was 75,312 (2024). Additionally, the LAHSA report estimated a total of 8,682 persons experiencing homelessness (PEH) in SPA 6, which ranks behind SPA 4, or the Metro Area, with 12,185 PEH (2024). Notably, the report also documented that 54% of the newly unhoused population attributed their housing status to economic hardship (LAHSA, 2024). The LAHSA report indicated that 27% of PEH self-reported a substance use disorder (2024). In a separate data summary published by LAHSA that further

breaks down PEH characteristics, 2305 individuals self-reported a SUD in SPA 6 ("HC2024 Data Summary," 2024). However, as stated in the LAHSA Greater Los Angeles Homeless Count Report, these numbers are "imprecise estimates" that are dependent on shelter bed counts, self-reported data, and only comprise a snapshot of one day in Los Angeles (2024). See Figure 2 summarized statistics.



Person Experiencing Homeless during COVID

The most recent report from the Department of Health Services of County Los Angeles, published in 2002, that monitored community health indicated that SPA 6 had the highest rate of drug-related death among adults ("Key Indicators of Health," 2002). According to the Los Angeles County Substance Abuse Prevention and Control (SAPC) Program, of the patients who received treatment from publicly funded treatment programs in Los Angeles County, 11,464 were unhoused, which accounts for 33.9% of patients from 2021-2022 ("Annual Overview," 2023). It has also been noted by the SAPC that these reflected percentages may be underestimated due to the COVID-19 impact ("Annual Overview," 2023). Furthermore, among residents of SPA 6 who received SUD treatment, there were 3,497 patients, making up a total of 10% of the patients treated ("Annual Overview," 2023). However, there was not a breakdown of how many of the SPA 6 residents were unhoused at time of treatment. In addition, this doesn't include PEH that have not been able to seek treatment.

Overall, these findings emphasize the need for research and support measures that focus on the underserved community of SPA 6 so that this area can see the true impact of SUDs among PEH and better adjust resources to helping these vulnerable members of our community. As mentioned above, since SPA 6 is the home to our medical school, Charles R. Drew University of Medicine and Science, SPA 6 and its community are the driving force for us medical students at the College of Medicine to address health inequities and leverage changes to support PEH and those affected by a SUDs.

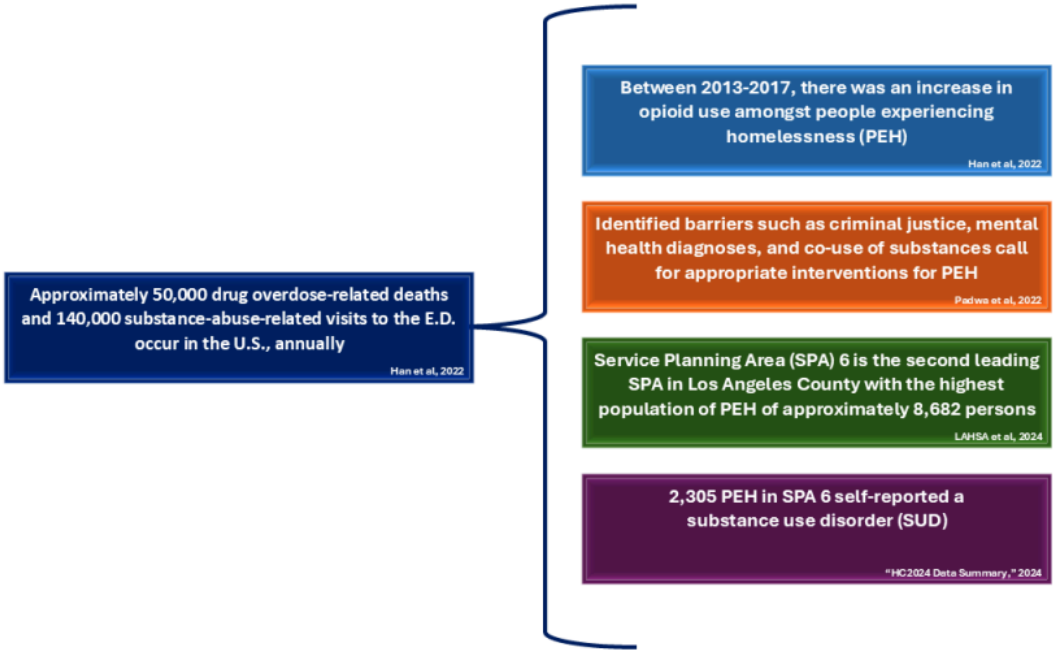


Figure 2. Summarized statistics referring to people experiencing homelessness (PEH) and substance use orders (SUD) in the United States and Service Planning Area (SPA) 6.

Description of the Framework Developed

The aim of this research project is to provide a framework that gives a comprehensive analysis of Los Angeles County's SPA 6 demographic data, health data, and social conditions to underscore the urgent need for targeted intervention strategies that can help physicians implement a comprehensive strategy that addresses the unique challenges faced by PEH struggling with SUDs in SPA 6.

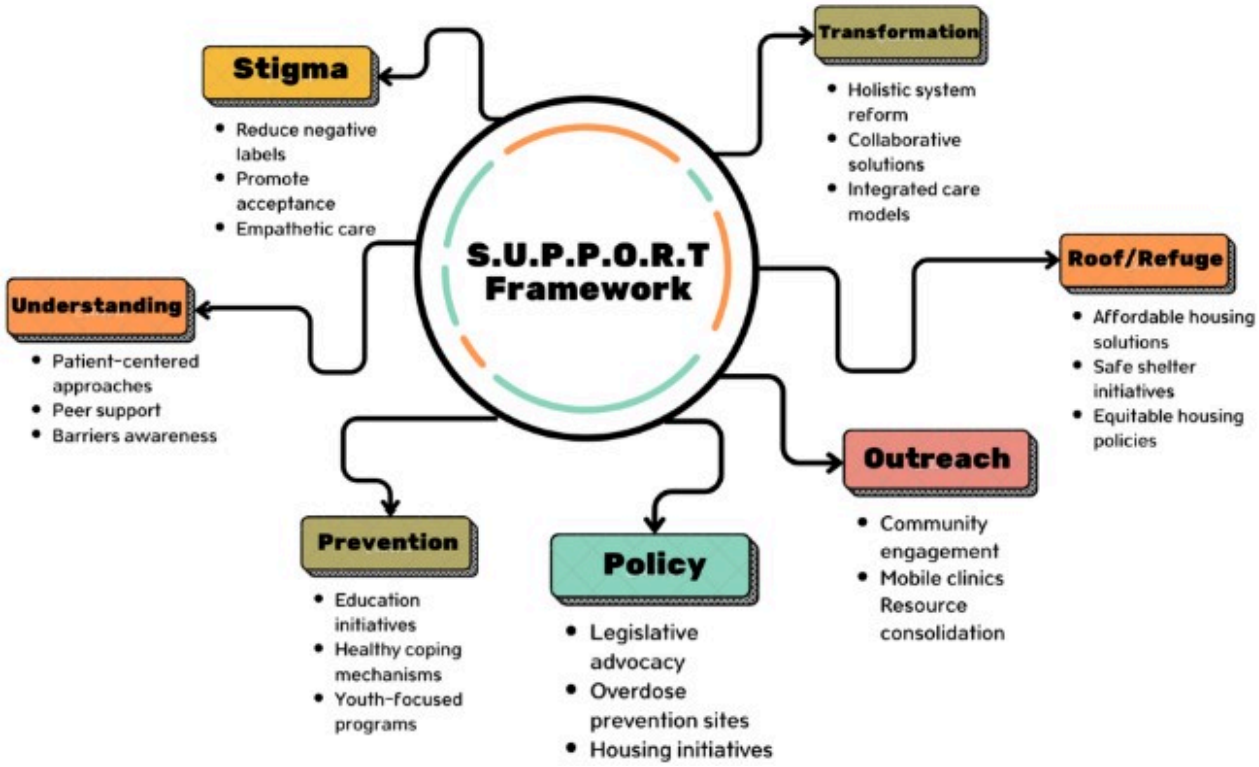


Figure 3. The S.U.P.P.O.R.T. framework upon which this paper ties together different modalities for supporting PEH with SUDs to provide comprehensive approach to care.

The "S.U.P.P.O.R.T. for Unhoused Individuals with Substance Use in SPA 6" framework (Figure 3) provides the following pillars to understand the complex links between homelessness and SUDs in our community of SPA 6.

Due to the widespread health and social inequities present in SPA 6, the S.U.P.P.O.R.T. framework above was created after seeing it as a necessity to link the relevant literature on what has been successful for tackling SUDs in other regions among PEH, what SPA 6's community advocates find is needed, and what can work for our specific community members here in SPA 6. This framework was intended to understand and inform physicians working within our community of SPA 6 on how the complexities of social determinants of health can lead their patients into experiencing homelessness and dealing with SUDs.

Given that the S.U.P.P.O.R.T. framework was a novel concept developed by our team of medical students, it makes up the backbone of how we approached our research project. It spearheaded the discussions we had with community advocates so that we could find commonality between the factors that contribute to, and the factors that can mitigate, substance use among PEH. By using the S.U.P.P.O.R.T. framework to organize our findings, we wanted to create a clear link between why we chose this population for our community engagement research project and the insights we collected. Talking with a wide range of people, such as healthcare workers, those who have lived experience with SUDs and homelessness, and people from law enforcement, and community-based organizations, created a deeper understanding of key themes impacting PEH with SUDs in SPA 6. Through our research, we discovered just how strongly

stigma affects communities, how vital culturally sensitive outreach is, and why integrated policy efforts really matter. This feedback helped us fine-tune our framework, spotlighting the main obstacles that could guide physicians on future strategies or policy work.

Importantly, we do not see the S.U.P.P.O.R.T. framework as something ready to bring to the community just yet, but more as a resource that gives physicians insight into how social determinants of health (SDOH) impact their patients with hopes that it will spearhead future community efforts. We see S.U.P.P.O.R.T. as a concept-driven tool shaped by previous research and the valuable stories we heard through our interviews with community advocates. This gives a solid starting point for future studies to dig deeper, test, and improve on the framework. Our ultimate aim is to craft specific, evidence-based solutions that can help PEH with SUDs overcome the challenges they face.



Figure 4. Pillars to understand links between homelessness and SUDs in SPA 6 community.

Community Needs

> ***"This is a medical condition; you're dependent on a substance that has altered your brain chemistry. the substance does not define you."***
>
> **- Physician working SPA 6**

When given the opportunity to converse with experts on the matter such as a family medicine physician and addiction medicine specialist working in SPA 6, one can appreciate the role health disparities play in addiction medicine. The dialogue with this physician analyzes the strategies and challenges involved in providing care for individuals with SUDs. Their insights shed light on the practical needs of their patients and underscored the importance of patient navigators in connecting unhoused patients with essential resources, highlighting the lack of consolidation of services in SPA 6. For the reasons listed above, they advocate for harm reduction initiatives and emphasize the need for tailored support and addressing housing instability. Moreover, they stress the significance of relatability and nonjudgmental support in effective care from physicians. This dialogue highlights the

importance of empathy, language, and community collaboration in treating SUDs and improving healthcare access for affected individuals.

Additionally, patients may not feel comfortable seeking care due to stigmatizing language and/or not being acknowledged at care sites. Finally, services are often interrupted due to funding for these programs or a patient's own inadequate access to health insurance. In addition to barriers to receiving treatment, care may not be individualized enough to the patient's needs. The family medicine physician we spoke to highlighted how women specifically face persistent gender-specific challenges and societal expectations to be stronger than their challenges, further complicating their ability to receive treatment. Still, a hopeful sentiment came from our interview, which was that effective treatment is available, but to address these disparities, there has to be an expansion of harm reduction efforts, an increase in the number of patient navigators, and a shift in the narrative surrounding SUDs. These efforts provide a step towards equitable care for patients with SUDs.



Medical care given to woman living in homeless encampment.

To further highlight the community needs and to gain insight from someone with lived experience in SPA 6, we interviewed someone from SPA 6 who has experienced using substances while experiencing homelessness. They discussed the difficulty of accessing resources without legal system involvement. This reliance on the judicial system highlights gaps in outreach and accessibility. Research supports patient-centered approaches for better engagement and outcomes (SAMHSA, 2019). They also emphasized the importance of peer support in recovery, stating, "They need support, monitoring, and people around…it's also about accountability." Research confirms that peer-led interventions improve recovery by fostering relatable success stories and empathetic support (Tracy & Wallace, 2016). Such models empower individuals and reduce stigma, creating a more inclusive recovery environment.

"They need support, monitoring, and people around...it's also about accountability."

"The county options are...not sufficient. I would never send anybody to a county facility like that...it was so bad...what we have is...not working."

The interview further revealed major shortcomings in county-run facilities. Anonymous criticized their effectiveness, stating, "The county options are…not sufficient. I would never send anybody to a county facility like that…it was so bad…what we have is…not working." While some argue for incremental improvements, research suggests a need for systemic overhaul, especially for marginalized populations (Padgett et al., 2016). Based on these insights, key recommendations include expanding outreach programs to proactively connect with PEH, increasing affordable treatment options through policy changes, and implementing educational initiatives to inform communities about SUDs. Additionally, improving county-

managed treatment facilities could provide more dignified and effective care, addressing the systemic failures identified in our research.

Collaborative Partners



Healthcare on Wheels – Homeless Initiative

To effectively combat the substance use crisis among PEH in SPA 6's, physicians must utilize a multi-pronged approach. First, physicians must advocate for public policy and speak to local governments for increased funding at city and county levels for programs addressing prevention, treatment, harm reduction, and recovery for SUDs. Additionally, physicians should try to lobby for the passage of the Modernizing Opioid Treatment (MOTA) Act at the federal level to significantly improve access to methadone treatment. Secondly, implementing Dr. Hurley's, an addiction medicine physician, the Medical Director for Los Angeles County's SAPC, and the President of the American Society of Addiction Medicine (ASAM)'s, suggestion of bringing treatment directly to unhoused communities is crucial. This can involve mobile clinics stationed in high-need areas, alongside partnerships with shelters, and outreach programs to ensure easy access.

Finally, addressing the lack of perceived need identified by Dr. Hurley requires focused outreach and engagement with PEH. Physicians should try to provide clear information to their patients about substance use, highlight the benefits of treatment, and dispel misconceptions to encourage help-seeking behavior. By implementing these steps, we can create a more comprehensive and accessible system of care for SPA 6's PEH struggling with SUDs. To appropriately address the issue of substance use in PEH in SPA 6, housing must be seen as a harm reduction approach, which can be addressed through housing initiatives, to minimize the negative consequences of substance use through non-judgmental, evidence-based strategies, prioritizing safety, health, and well-being over the immediate need to get sober.

Furthermore, in the pursuit of effective interventions for PEH struggling with SUDs in SPA 6, engaging community experts through targeted interviews is essential. These interviews serve as a platform to gather insights and perspectives from those directly involved in addressing these pressing issues. By formulating key questions, establishing clear goals and objectives, and fostering collaborative partnerships, we can create a comprehensive strategy that meets the unique needs of this vulnerable population.

To gain a deeper understanding of the challenges and needs within SPA 6, it is crucial to ask community experts a series of targeted questions. First, we must explore the primary challenges they face in addressing homelessness and SUDs. Questions such as:

- What are the primary challenges you encounter in your work?
- How do you perceive the current support systems for PEH?

These types of questions can elicit valuable insights into the systemic barriers that hinder effective intervention.

In order to address these barriers, they must first be understood. Additionally, understanding resource allocation is vital. Community partners should be asked about the resources they believe are most critical for supporting PEH and how funding can be better allocated to meet these needs. Furthermore, inquiries regarding the effectiveness of existing policies and programs can reveal which initiatives are working and which require reform. Questions like:

- What are the trends of PEH with SUDs, do we have less PEH with SUDs or are the numbers increasing?
- Which existing policies do you find effective, and which do you think need reform?

These types of questions can guide discussions toward actionable solutions.

Finally, exploring collaboration and communication is essential. Community partners should be prompted to share their thoughts on how different organizations, such as community clinics, criminal justice systems, and community-based organizations, can improve collaboration by identifying promising partnerships, seeing how communication strategies have proven effective in engaging the community and improving outcomes for our community members experiencing homelessness with SUDs. This dialogue can uncover opportunities for enhanced cooperation among various entities working toward a common goal. The overarching goal of these interviews is to gather insights that will inform the development of effective interventions for PEH with SUDs. To achieve this goal, several specific objectives must be established:

- First, it is important to identify the specific needs and challenges faced by community partners in addressing homelessness and substance use. Understanding these challenges will provide a foundation for developing targeted interventions.
- Second, the interviews aim to assess the effectiveness of current policies and programs from the perspective of those on the front lines. By gathering feedback on existing initiatives, we can identify areas for improvement and reform.
- Third, exploring opportunities for collaboration and resource sharing among community experts will enhance the collective impact of our efforts.
- Finally, gathering recommendations for policy reforms and program development will ensure that our strategies are informed by the experiences and insights of those directly involved in the field.

Building collaborative partnerships is a critical component of addressing the intertwined issues of homelessness and substance use. Engaging with community leaders and organizations that have established trust with PEH is a vital first step. These leaders can provide valuable insights and facilitate better outreach and support.

Fostering trust among community experts is equally important. Open dialogue, transparency, and respect are essential in building relationships that encourage collaboration. By engaging community partners in

discussions about their experiences and needs, we can ensure they feel heard and valued, which can lead to stronger partnerships. Establishing shared goals and a common vision is another key aspect of collaboration. By working together to define shared objectives, community experts can enhance their commitment and cooperation.

Regular communication is also crucial; establishing consistent meetings and communication channels will keep all partners informed and engaged, allowing for updates on progress, challenges, and opportunities for collaboration. Encouraging resource sharing among community partners can lead to more effective interventions. By leveraging the strengths of different organizations, we can create a robust support network for PEH. Additionally, developing joint initiatives or programs can enhance impact and provide comprehensive support to individuals in need.

In conclusion, addressing homelessness and substance use disorders in SPA 6 requires a multifaceted approach that includes:

- Engaging community experts through targeted interviews,
- Establishing clear goals and objectives, and
- Fostering collaborative partnerships.

By focusing on these areas, we can gather valuable insights, enhance cooperation among organizations, and ultimately create a more effective support system for PEH struggling with SUDs (Alderwick, 2021).

Expert Perspectives

Dr. Ricky Bluthenthal, Associate Dean for Social Justice and Vice Chair for Diversity, Equity, and Inclusion at USC's Keck School of Medicine in Los Angeles, discussed with us the harmful effects that the public news, performative politics, and the scattered legal and social systems have on the health of PEH, and specifically those with substance use.

"There's this bill to [...] require businesses to carry naloxone. There's nothing wrong with the bill. It's not a bad thing but it doesn't [...] result in a lot of reversal of overdoses. [...] You'd almost be better spending that political energy on doing something like having overdose prevention sites started."

- Dr. Blythenthal, Keck School of Medicine, Los Angeles California



Police officers arrest a homeless man for possession of a stolen shopping cart during a sweep of Skid Row in downtown Los Angeles.

As we continue to read how the local news criminalizes and negatively portrays PEH in SPA 6, we witness how this can promote fear in the public and unjustly influence politics. As California has seen an increase in methamphetamine and heroin use amongst PEH and receiving publicly funded treatment for substance use disorders, this highlights the importance of investing in evidence-based treatments that would not only treat SUDs, but also consider co-use of substances (Pawda et al., 2022). In addition to co-use of substances, PEHs are more likely than those not experiencing homelessness to encounter co-occurring mental health diagnoses (Pawda et al., 2022). However, there continues to be much debate amongst literature about whether policy should focus funding and efforts on housing or substance use services first.

The Housing First approach, mentioned previously, aims to end homelessness by providing permanent housing to individuals without requirements such as sobriety or treatment participation. This is based on the philosophy that stable housing is a necessary foundation to successfully address other issues. It is supported as being the most effective means to improve housing retention and reduce the utilization of public resources. However, it is also argued that this model overlooks underlying problems, such as substance use, by not incorporating treatment as a requirement. Similarly, harm reduction strategies (i.e. needle exchange programs) aim to reduce the risk of overdose and blood-borne disease spread; this, too, has its criticism as it could simply enable drug use rather than directly addressing the root cause. Both philosophies reflect a larger tension between providing immediate safety and supporting long-term behavioral change and recovery.

Similarly, Dr. Bluthenthal introduced the Trieste Model, an individualized holistic substance use treatment infrastructure set in northern Italy's city Trieste, described as "radical hospitality" (Heart Forward, 2024). The philosophy is to assist someone in returning to society and their lives by asking them what they need, whether they may need financial assistance first, housing or treatment, and includes readily available psychiatric help (Heart Forward, 2024). As this model cannot be implemented overnight, in effort to close the gap in care, Dr. Bluthenthal encourages continuous active screening for SUDs and mental health conditions, particularly in PEH, and proactively connecting them with resources such as housing assistance, mental health services, and substance use treatment programs. It is imperative for physicians to actively engage with the unhoused patients and communities, to work to dispel



Images showing dollar bills (financial); housing; Doctor (treatment)

misconceptions about SUDs and raise awareness about available treatment options. He also recommends that all community experts work alongside street medicine teams, to listen to the stories of PEH with SUDs, emphasizing the value of firsthand experience when shaping effective interventions and policy.

> ***"Everyone assumes that once people are housed, their problems should go away. But what we've learned is that providing housing, food, clothing are just the beginning. We need to do more. Actively accompany them and stand in pragmatic solidarity as they unpack their years of trauma and find a new way of being to move from surviving to thriving."***
>
> ***- Dr. Heidi Behforouz, Chief Medical Officer, Housing for Health***

Dr. Heidi Behforouz – a physician, social justice warrior, and the current Medical Director of Housing for Health (HFH) at the Los Angeles County Department of Health Services (LACDHS) – discussed with us her current project: implementing contingency pilot programs for individuals using meth and establishing harm reduction health hubs in Skid Row. She is also a massive proponent of the Housing First model and advocates for developing programming that prioritizes safety first. On a governmental level, she appeals for the expansion of low-income housing and improvements in the SDOH that can severely impact people of color, struggling with housing insecurity and substance use.

The systemic challenges surrounding substance use and homelessness require a holistic treatment approach that goes beyond addressing one issue alone. It is essential to recognize the interconnected issues of housing, economic stability, and mental health. Individuals experiencing housing insecurity often turn to substances as a coping mechanism for the hardships they face, creating an unfortunate cycle where substance use exacerbates housing instability and other social problems. Mental health disorders frequently coexist with homelessness and substance use, adding another layer of complexity and highlighting the need for comprehensive interventions that holistically treat and support patients.

Lessons Learned

- **Collaboration is Crucial –** partnerships with community organizations are essential to create a comprehensive system of care and develop programming that meets the unique needs of individuals and families.
- **Patient-Centered Care Matters –** actively listening to a patient's story, respecting their perspective, and tailoring treatment plans to their individual needs.
- **Addressing Barriers to Treatment –** lack of perceived need, rather than lack of awareness of services, can be a primary barrier to treatment for many PEH. To provide quality care as physicians, it is necessary to understand each patient's situation and customize interventions accordingly.
- **Advocacy is Key to Change –**bridging the gap between the perception of substance use as a health issue and the policies governing its treatment and pushing for reform that addresses the systemic factors that contribute to SUDs in PEH, bridging the gap between the perception of substance use as a health issue and the policies governing its treatment.
- **Engagement with Unhoused Communities is Essential –** Dr. Hurley emphasizes the

importance of healthcare professionals actively engaging with unhoused communities, dispelling misconceptions about SUDs, and raising awareness about available treatment options. Similarly, Dr. Bluthenthal's recommendation to work alongside street medicine teams and listen to the stories of PEH illustrates the value of firsthand experience in shaping effective interventions.

- **Multi-Faceted Approach is Necessary –** These experiences provide invaluable insights into the specific needs of the community. These insights have profound implications for our role as physicians. The knowledge gained from Dr. Hurley's interview and Dr. Bluthenthal's recommendations underscores **the importance of adopting a multi-faceted approach to patient care**.
- **Innovative Solutions Improve Access –** connecting PEH with resources such as housing assistance, mental health services, and substance use treatment programs like Dr. Hurley's Medications for Addiction Treatment (MAT) program, which utilizes phone consultations to expand access to care, demonstrate leveraging technology to expand access to care.

Looking Forward and Recommendations

The traditional models of addressing SUD in PEH have shown to be insufficient for addressing the unique needs of PEH, particularly in regions such as SPA 6, where unstable housing and limited access to rehabilitation services create significant barriers. Moving forward, the imperative is clear: resources and information must flow seamlessly within SPA 6 to empower providers to be able to adequately support and provide holistic care for patients with SUDs amidst housing insecurity. To address these challenges, a multifaceted approach is necessary, combining innovative care models, policy reform, and community engagement to focus on prevention and treatment. Therefore, we derived the following recommendations from the interviews with community experts and analysis of the literature.

Care Models

- Physicians should consider how SDOH are impacting patients and use this information to provide the necessary resources in their clinics that can provide information on housing, education opportunities, transportation services, etc.
- Look into implementing the Trieste Model or prioritize housing first, so patients' foundational need for safety and security can be met. This includes removing sobriety as a prerequisite for programs that supply housing.
- Expand the use of mobile health clinics in SPA 6, to remove transportation and distance barriers for patients. This allows care to be delivered directly to PEH.



Family waiting for services at mobile health clinic.

- Expand the use of social workers and patient navigators to assist patients with administrative burden during treatment and recovery.
- Integrate peer support programs into treatment plans to assist with patient accountability and support.

Policy Reform

- Increase funding at city and county levels for integrated programs that address prevention, treatment, and recovery for those with SUDs.
- Fund housing first initiatives and support legislation such as the MOTA Act to expand access to Medication-Assisted Treatment (MAT) (Davidson, 2014).
- Advocate for the use of harm reduction as a stepping-stone in treatment and recovery.
- Advocate for policies that contribute to changing the narrative around SUDs and PEH to reduce the negative effects of associated stigma that prevent people from asking for help.



Group of diverse people advocating for policy reform.

Community Engagement

- Leverage technology, such as a phone application with available resources and an open forum for suggestions and questions, to strengthen collaboration and communication between community organizations, providers, and social services to ensure a seamless continuum of care from outreach to long-term support.
- Physicians should help to educate patients on the resources and programs available. Anyone who comes into contact with patients should know and have access to several resources available. Patients' sources of information and programs available should not only be coming from law enforcement or the criminal justice system.
- Community organizations can place information pamphlets in healthcare facilities. Physicians can ensure patients are linked with social services or community organizations.



Community engaging with homeless, sharing a meal.

By integrating innovative and holistic care models, policy reforms, and community-based strategies, we can create long-term, effective solutions that significantly improve the health and well-being of PEH struggling with SUDs in SPA 6.

"Meeting people where they are at" is the distinct embodiment that the S.U.P.P.O.R.T framework proposes in providing services to PEH with SUDs in SPA 6, who more than likely do not have access to

traditional healthcare settings. Understanding and acknowledging an individual or a community's health capacity and vulnerabilities facilitates care on an individual's or a community's terms. This allows for collaborative relationships still rooted in patient autonomy and increases and promotes treatment and program adherence.



Homeless Encampment

Furthermore, SDOH represents macroscopically how factors such as community safety, access to treatment, and housing significantly intertwine a community on an individual level. Consequently, addressing the broader and societal environmental factors like stigma, housing insecurity, and economic instability that negatively impact PEH with SUDs is essential. Part of the psychiatric treatment for our targeted population requires addressing one of the most prominent SDOH— housing. Consequently, continued advocacy for policy reform that improves access to SUD treatment and Housing –First and Trieste models serves as a backbone in providing and encouraging the utilization of health services. It also aligns with promoting accessibility and goes hand in hand with the expansion of mobile health services and peer support programs that further address the needs of PEH within SPA 6.

The emphasis on collaboration within the S.U.P.P.O.R.T framework from local physicians, community organizations, policymakers, and PEH with SUDs bridges the gap between creating and implementing interventions tailored to SPA 6. Collaboration entails working with all community experts and PEH with SUDs to develop goals and review interventions. Transparent conversations and data collection about the personal experiences of the PEH with SUDs are also necessary as they serve as the foundational block in achieving program and treatment adherence. Coordinated efforts and centralized locations between mobile clinics, shelters, and harm reduction programs are a physical embodiment of collaboration as they actively work to remove structural barriers to care. Lastly, insight and a particular focus on the knowledge of current and forthcoming legislation, health interventions, and the beliefs of PEH with SUDs allow for the design of a model that not only takes a holistic and synergistic approach but is also effective.

Overall, the S.U.P.P.O.R.T framework addresses accessibility and utilizes a comprehensive health approach to provide an innovative solution to a complex problem. The premise of the framework is based on collaboration and addressing the SDOH on an individual, communal, and governmental level. By

identifying the intersection between SDOH and the multiple sectors, the S.U.P.P.O.R.T framework offers hope and a fair opportunity for all individuals to achieve optimal health.

References

Alderwick, H., Hutchings, A., Briggs, A., & Mays, N. (2021). The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: a systematic review of reviews. BMC public health, 21, 1-16.

Baggett, T. P., Hwang, S. W., O'Connell, J. J., Porneala, B. C., Stringfellow, E. J., Orav, E. J., & Singer, D. E. (2013). Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. JAMA Internal Medicine, 173(3), 189–195.

California Health Care Foundation. (2020). Substance Use in California: A Look at Addiction and Treatment. Retrieved from https://www.chcf.org/publication/2020-edition-substance-use-california/

Centers for Disease Control and Prevention. (2021). HIV and Injection Drug Use. Retrieved from https://www.cdc.gov/hiv/basics/hiv-transmission/injection-drug-use.html

Cheng, H., McGovern, M. P., Garneau, H. C., Hurley, B., Fisher, T., Copeland, M., & Almirall, D. (2022). Expanding access to medications for opioid use disorder in primary care clinics: an evaluation of common implementation strategies and outcomes. Implementation Science Communications, 3(1), 72. https://doi.org/10.1186/s43058-022-00306-1

Chiang, J.C., Bluthenthal, R.N., Wenger, L.D. et al. Health risk associated with residential relocation among people who inject drugs in Los Angeles and San Francisco, CA: a cross sectional study. BMC Public Health 22, 823 (2022). https://doi.org/10.1186/s12889-022-13227-4

County Los Angeles Public Health Community. (n.d.). Service Planning Areas. LA County Department of Public Health and Field Services Division. http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm

County of Los Angeles Public Health Community and Field Services Division. (n.d.-b). Service Planning Area 6. LA County Department of Public Health. http://publichealth.lacounty.gov/chs/spa6/

County of Los Angeles Public Health. (2023, May). Annual Overview: Patients in Publicly Funded Substance Use Disorder Treatment Programs in Los Angeles County 2021-2022 Fiscal Year Health Outcomes and Data Analytics. LA County Department of Public Health. http://publichealth.lacounty.gov/sapc/MDU/SpecialReport/AnnualTxReportFY2122.pdf

Davidson, C., Neighbors, C., Hall, G., Hogue, A., Cho, R., Kutner, B., & Morgenstern, J. (2014). Association of Housing First implementation and key outcomes among homeless persons with problematic substance use. Psychiatric Services, 65(11), 1318-1324. 10.1176/appi.ps.201300195

Gelberg, L., Andersen, R. M., & Leake, B. D. (2007). The Behavioral Model for Vulnerable Populations: application to medical care use and outcomes for homeless people. Health Services Research, 34(6), 1273–1302.

Han, B. H., Doran, K. M., & Krawczyk, N. (2022). National trends in substance use treatment admissions

for opioid use disorder among adults experiencing homelessness. Journal of substance abuse treatment, 132, 108504. https://doi.org/10.1016/j.jsat.2021.108504

Jones, K. F., & Mason, D. J. (2022). The False Dichotomy of Pain and Opioid Use Disorder. JAMA Health Forum, 3(4), e221406. https://doi.org/10.1001/jamahealthforum.2022.1406

Los Angeles County Department of Health Services Public Health. (2002). Key Indicators of Health By Service Planning Area. lapublichealth.org. http://lapublichealth.org/wwwfiles/ph/hae/ha/keyhealth.pdf

Los Angeles County Department of Public Health. (2022). Opioid Response Strategic Plan. Retrieved from http://publichealth.lacounty.gov/sapc/MDU/MDBrief/OpioidResponsePlan.pdf

Los Angeles Homeless Services Authority. (2021). 2021 Greater Los Angeles Homeless Count Results. Retrieved from https://www.lahsa.org/documents?id=4555-2021-greater-los-angeles-homeless-count-results.pdf

Los Angeles Homeless Services Authority. (2024, June 27). SPA 6 HC2024 Data Summary. Los Angeles Homeless Services Authority. https://www.lahsa.org/documents?id=8158-spa-6-hc2024-data-summary

Los Angeles Homeless Services Authority. (2024, June 28). 2024 Greater Los Angeles Homeless Count Results (Long Version). Los Angeles Homeless Services Authority. https://www.lahsa.org/documents?id=8164-2024-greater-los-angeles-homeless-count-results-long-version-.pdf

Mackey, K., Veazie, S., Anderson, J., Bourne, D., & Peterson, K. (2020, December). Barriers and facilitators to the use of medications for opioid use disorder: A rapid review. Journal of general internal medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7728943/

Manhica, H., Straatmann, V. S., Lundin, A., Agardh, E., & Danielsson, A. K. (2021). Association between poverty exposure during childhood and adolescence, and drug use disorders and drug-related crimes later in life. Addiction (Abingdon, England), 116(7), 1747–1756. https://doi.org/10.1111/add.15336

Miele, G. M., Caton, L., Freese, T. E., McGovern, M., Darfler, K., Antonini, V. P., Perez, M., & Rawson, R. (2020). Implementation of the hub and spoke model for opioid use disorders in California: Rationale, design, and anticipated impact. Journal of Substance Abuse Treatment, 108, 20–25. https://doi.org/10.1016/j.jsat.2019.07.013

Miler, J. A., Carver, H., Masterton, W., Parkes, T., Maden, M., Jones, L., & Sumnall, H. (2021). What treatment and services are effective for people who are homeless and use drugs? A systematic review of reviews. PLOS ONE, 16(7), e0254729. https://doi.org/10.1371/journal.pone.0254729

Osilla, K. C., Dopp, A. R., Watkins, K. E., Ceballos, V., Hurley, B., Meredith, L. S., Leamon, I., Jacobsohn, V., & Komaromy, M. (2022). Collaboration Leading to Addiction Treatment and Recovery from Other Stresses (CLARO): process of adapting collaborative care for co-occurring opioid use and mental disorders. Addiction Science & Clinical Practice, 17(1), 25. https://doi.org/10.1186/s13722-022-00302-9

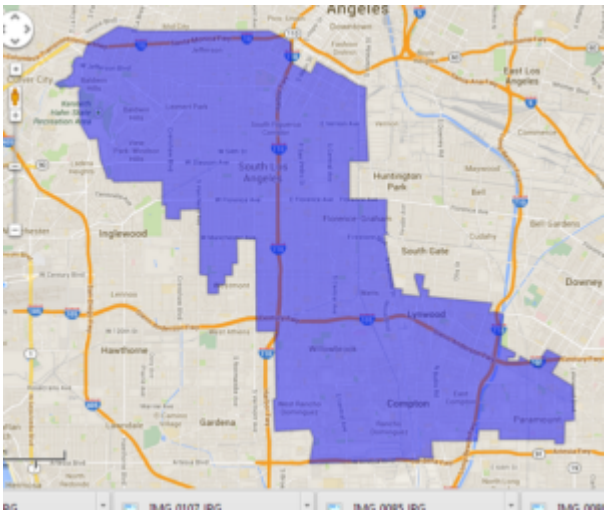
Padgett, D. K., Henwood, B., & Tiderington, E. (2016). A qualitative study of structural barriers to the effectiveness of SUD care systems. Journal of Substance Abuse Treatment, 91, 95-101.

16

Is Nutrition the Antidote to the Hypertension Epidemic in South Los Angeles?

LULE DESHIELDS, CHRYSTAL KUMAR, SABRINA MONTGOMERY, NICOLAS BAUTISTA, MUBARAK SANNI, KEVIN ARTIGA, CHIDI EZEOFOR, MARTIN VAZQUEZ, FERDINAND ANOKWURU, ALAN NGUYEN

About the Community

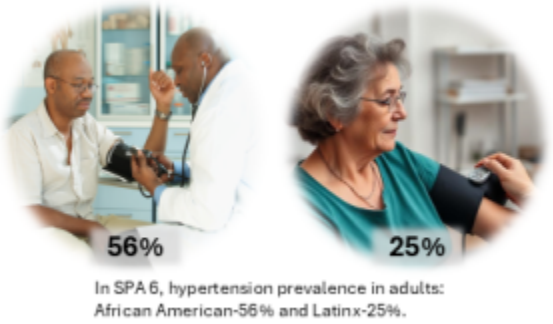


Map of South Los Angeles Service Planning Area 6 (SPA 6)

South Los Angeles, particularly Service Planning Area 6 (SPA 6), is a vibrant and culturally rich region predominantly inhabited by Black and Latinx communities. This area, home to approximately 1.2 million residents, is characterized by a unique blend of cultural heritage, resilience, and community spirit. However, it faces significant public health challenges, particularly concerning hypertension. Black adults have a higher prevalence of hypertension, with approximately 56% affected, due to factors such as genetic predisposition, obesity, diabetes, and socioeconomic stress (Thomas, 2018). Adults with hypertension are also more likely to experience severe complications like stroke, heart disease, and kidney failure due to the complications of associated microvascular and macrovascular disorders (Long & Dagogo-Jack, 2011). Although less prevalent in Latinx adults, with about 25% affected, hypertension remains a significant concern due to acculturation stress, dietary habits, and higher diabetes rates, leading to lower blood pressure control and increased end-organ damage (County of Los Angeles Department of Public Health, 2023).

SPA 6 faces higher hypertension rates than the national average due to socioeconomic disparities, limited

healthcare access, and a higher rate of uninsured individuals (Harding, 2017). These health disparities largely stem from socioeconomic factors such as poverty, limited access to healthcare, food deserts, and a lack of educational resources. This underscores a dire need for culturally relevant public health interventions to address the pressing health concerns in these communities.



(Left) Black adult male having blood pressure taken; (Right) Latinx adult female having blood pressure taken

The cultural ties and historical contexts of the residents play a critical role in shaping dietary habits and health behaviors. Traditional dietary practices rooted in Black and Latinx heritage often include high-sodium foods or dishes lacking in essential nutrients (Airhihenbuwa, C. O., 2010 & Elfassy, 2019). These cultural preferences can create barriers to dietary changes, complicating efforts to manage health conditions such as hypertension (Satia, 2010). The need for culturally sensitive approaches to nutrition education and community-based interventions is paramount. These approaches must honor the unique traditions and experiences of the community while fostering awareness of healthier food options and lifestyle choices.

How Our Work with the Community Began

Our journey into this community began with a growing recognition of the health disparities impacting Black and Latinx populations in South Los Angeles. All members of our team know someone who has been impacted by hypertension. It is a condition that we have seen that can impact someone's quality of life significantly when not managed correctly. This inspired us to learn more about the different holistic approaches to medicine that can help manage such a prevalent condition like hypertension. We settled on nutrition because we were interested in getting a better understanding of the cultural implications that nutrition holds in the African American and Latinx communities. Further, we wanted to also understand the nutrition-related challenges faced within SPA 6.



Three Diverse Focus Groups

We did this through reviewing literature and conducting interviews with local healthcare providers, community organizations, and residents. Throughout the project, we listened to the voices of community members through interviews and focus groups that allowed us to gather rich qualitative data, illuminating their experiences, cultural perspectives, and willingness to adopt dietary changes. In talking to community-based organizations like *Food Access LA* and *It's Bigger Than Us*, who both aim to provide resources and support to low-income communities, we sought to engage directly with residents to identify their unique needs and barriers related to hypertension management and dietary choices.

Moreover, our commitment to culturally sensitive health interventions was enhanced by understanding the historical and socioeconomic contexts that influence dietary habits. By establishing relationships with leaders and organizations within the community, we were able to assess existing resources, gaps in support, and opportunities for impactful interventions.

Project Description

The project was designed as a multifaceted initiative aimed at understanding hypertension management through culturally relevant nutrition education and resource mobilization in South Los Angeles. Our primary goals included:

- increasing access to healthy foods,
- improving health literacy, and
- fostering community engagement.

We did this through a systematic review and interviews with patients, community organizers, and physicians.

Components of the Project

1 - Systematic Review
We conducted a review utilizing sources like PubMed and Google Scholar to obtain research articles about hypertension and nutrition-related interventions in African American and Latinx communities. We aimed to establish that there was a gap in research that looks at how cultural food practices within the African American and Latinx communities of Service Planning Area 6 (SPA 6) can play a role in the ability of patients with hypertension to adopt holistic approaches to care.
2 - Community Partners Interviews
We conducted interviews with four patients who were deemed our community partners with the goal of learning more about the different dietary patterns of both African American and Latinx patients who live in SPA 6 and who have hypertension. Two patients were African American, and two were Latinx.
3 - Community-based Organizations Interviews
We interviewed the leaders of two community-based organizations that share the mission of providing access to healthy foods, nutritional education, and support services to the community of South Los Angeles: Food Access LA and It's Bigger Than Us.
4 - Health Care Providers Interviews
We conducted interviews with a physician who practiced at Martin Luther King Jr. Community Hospital and a nurse from St. Francis Medical Center to gain insight on how healthcare providers approach the treatment and education of patients with hypertension.

Table: Components of the Project

By engaging with the South Los Angeles community and recognizing the multi-factorial influences on health outcomes, our project sought to create sustainable, positive impacts on dietary practices and overall health in SPA 6.

Understanding the intersection of cultural practices and dietary habits is key to developing interventions that resonate with the Latinx and Black populations. Ultimately, the findings from this research could inform policy recommendations to improve food environments and support long-term health improvements in South Los Angeles. By focusing on this high-risk population, we can help reduce preventable deaths and improve long-term health outcomes, ultimately contributing to health equity in marginalized communities.

Outcomes

Culturally relevant and community-engaged initiatives in South Los Angeles are vital for effective dietary changes. The resources currently available to patients differ considerably based on economic factors, geographic location, cultural relevance, and healthcare infrastructure. Economically, many South Los Angeles residents rely on supplemental food programs like EBT (Electronic Benefit Transfer) also known as CalFresh in California. These programs provide supplemental income to individuals and families that are at or below the 200% federal poverty line. With California making budget cuts, programs that benefit those who use supplemental food programs are on the brink of being closed. In our interview with Summer Walker, the manager of Food Access LA, she stated that:

> *"[Budget cuts] are going to affect not only just our markets, but it's going to affect all low-income, mid-income communities throughout Los Angeles because they heavily rely on these extra incentives to feed their families. And while EBT and Cal*

Fresh are never going to be going away at our markets, having this extra subsidy is something that could potentially go away. And right now, we're trying to get the word out about that. So, people aren't impacted."



Farmers Market

Programs like the market match (where families with EBT are given extra vouchers to purchase strictly fresh fruit and vegetables) available in farmers' markets, are essential for low-income families, contrasting sharply with more affluent neighborhoods where residents have better access to fresh produce without needing subsidies. Geographically, the presence of food deserts and food swamps in South Los Angeles restricts access to healthy food options. In areas defined as food deserts and food swamps, grocery stores offering affordable fresh produce are scarce and there is an overabundance of unhealthy fast-food options, contributing to poor health outcomes. In comparison, other neighborhoods with numerous supermarkets provide a stark contrast, highlighting the geographical disparities in food access.

Organizations like Food Access LA prioritize cultural relevance in their programs, ensuring that the food provided meets the community's cultural preferences. For example, along with offering Farmer's Markets to low-income communities they also implement Teaching kitchens that teach community members how to make their favorite cultural meals healthier while also incorporating fruits and vegetables sold at the market. In contrast, other regions might not emphasize cultural relevance, leading to less effective interventions. Globally, some health systems integrate cultural practices better than others, showing varying success in addressing food insecurity. The healthcare infrastructure in South Los Angeles includes initiatives to address food insecurity through community health programs. However, resource allocation can be uneven. Comparatively, some countries have robust public health frameworks that systematically address food insecurity through national policies, while others face challenges similar to those in South Los Angeles. Brazil for example in 2003 launched their Fome Zero (Zero Hunger) program to systematically addressed food insecurity. Through policies like Bolsa Família, a conditional cash transfer program, and the National School Feeding Program (PNAE), which provided nutritious meals to students while supporting local farmers (FAO, 2014). These initiatives significantly reduced hunger, leading to Brazil's removal from the UN's Hunger Map in 2014 (FAO, 2014).

One of the most impactful aspects of our research project was understanding the deep-rooted historical context of food insecurity and its connection to systemic oppression within the Black community. In our conversation with a community leader at It's Bigger Than Us, we discussed the legacy of slavery. They stated:

This is a simulated reading of the paragraph below. Click [Play] to begin, and [Pause] to stop at any time.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3212#audio-3212-1

"Cultural norms are different for folks, of what we've been raised to eat regularly within our diet. You know, for me, it's gumbo and chitlins and fried chicken and all of these different things, and for, Black African Americans, it stems back to slavery where, you know, you're, the slave owners or masters would give the leftovers to folks on, you know, at the end of the week and it would, it would have to make something out of nothing. And eventually, that tradition just kept going."

Enslaved people were forced to eat discarded food, and this unfortunate practice continues to influence dietary habits and health outcomes today (Roussel, 2021). This historical context highlights the complexity of food insecurity, revealing that it is not just an issue of access but also cultural and psychological significance. Learning about the critical role of culturally relevant food interventions was eye-opening. The success of programs incorporating cultural sensitivity underscores the importance of meeting communities where they are and respecting their heritage and preferences. This approach is crucial not only for creating sustainable and effective health interventions at a community level but also for establishing trust-building clinical interactions between health care teams and patients from such communities.

To understand the impact of policy on food disparities, we interviewed a lawyer who was executive director of the Office of Civil rights in the U.S Department of Health and Human Services. They mentioned that in South Los Angeles, they saw many community members with chronic diseases such as hypertension and diabetes, who did not have access to healthier foods since the community was a food desert. To combat this disparity, they founded the South Los Angeles Community kitchen, which helped teach cooking skills to the community members. The community Kitchen was an effective way to integrate nutritional education along with cultural foods of the community members. They emphasized the importance of such initiatives by stating,



Mobile Community Kitchen

"I got to participate in these programs that honored and recognized community-based nutritional efforts, cultural sensitivity, and how to make healthy eating fun and accessible."

They demonstrated the effectiveness of implementing policies and programs that benefit the community.

Patient Interviews

Four patients were also interviewed to better understand their journey in receiving healthcare in South Los Angeles and explore their needs.



African American Woman in late 50's

The first patient we interviewed was an African American woman in her late 50's with controlled hypertension who is an Inglewood native, currently employed living with one of her two daughters. She noted that a potential barrier for people within the African American community to eating healthy could be found in the traditional food dishes.

A key article by Swierad et al. (2017) echoes this sentiment when they stated:

"Most African Americans realize that some aspects of their traditional cuisine are unhealthy, ethnic food is comforting and allows for connectedness, expression of one's cultural identity, and the connection to African American culture." (Swierad, 2017)

While our first patient noted this as a potential barrier, it is essential to all to highlight that she personally did not experience the lack of unhealthy options when eating what she considered her traditional cuisine. This patient noted that she was able to change her diet on her own time with the motivation of her children. With this motivation, she has effectively lowered her blood pressure. This was a critical phenomenon to note because it presented an opportunity to learn more about effective ways to motivate patients to create long-lasting diet changes.

In their important study, Lynch EB et al. (year) aimed to build a connection between spiritual and health values to encourage healthy lifestyle changes (Lynch, 2023). Using community health workers, the church-based intervention showed potential for behavior change in African American communities. Learning more about different multi-factorial techniques that address the complexities of this community can lead to policy recommendations that are more effective in casting a wider net of change. Despite reporting a healthy diet, Patient 1's experiences revealed a potential healthcare system gap. When asked:

"Have you ever received advice or recommendations from health care providers about dietary changes to manage or prevent hypertension?" She said, "No."

This patient had to independently seek out information regarding how to eat healthier to improve her blood pressure without guidance from her provider. This also leaves organizations open to creating nutrition interventions tailored to patients' motivations.

Patient two was an African American male. Patient 2's interview offered a compelling glimpse into the intersection of cultural influences, dietary habits, and potential gaps in healthcare experiences in managing hypertension. He emphasized that preparing meals rooted in soul food traditions reflects the significance of cultural heritage in shaping dietary choices. His incorporation of vegetables, greens, and grilled meats showcases a blend of traditional flavors and health-conscious cooking practices. From a health provider perspective of addressing the healthcare system, Horowitz et al. state:



African American man

> *"Our goal is to promote healthy diets that are consistent with people's cultures so that they willingly adopt and maintain these diets over time." (Horowitz, 2004).*

Horowitz et al. noted that:

> *"These diets were often considered expensive, an unwelcome departure from traditional and preferred diets, socially isolating, and not effective enough to obviate the need for medications." (Horowitz, 2004)*



Mexican man, aged 73, on dialysis

The third patient we interviewed was a 73-year-old Mexican male from the Martin Luther King Outpatient Center who had lived in South Los Angeles since childhood. Currently, he is on dialysis due to his chronic kidney disease and was diagnosed with hypertension in 1998. When asked about his medical care and barriers, he said:

> *"Only linguistic. Only the language, I don't understand the doctor sometimes because it is in English and understanding what the doctor is saying."*

This shows that he not only suffered from the language barrier but also health literacy, and compelling evidence that should implore doctors to ensure patient's understand their health care and plans of action. This could have led to a disconnect between the physician and the patient. This miscommunication could have led to a decline in patient-centered comprehensive treatment and care. According to the California's Physician Shortage White Paper:

> *"By 2050, Latinos are estimated to represent 44.5% of the state's population. While the Latino population continues to grow, the supply of Latino physicians has not caught up." (Vargas Bustamante, 2020)*

This finding underscored the importance that we, as future physicians, must be mindful of the patient population we serve and find ways to communicate with patients in their native language, ensuring cultural competency is the norm in medical practice. With medical schools like Charles R. Drew University of

Medicine and Science College of Medicine whose is qualified as a Hispanic serving institution, they are combating this Latinx physician shortage with a medical student class of nearly 25% students who identify as Latinx.

In asking this patient about his diet growing up, we were also able to learn more about his culture. He described his typical breakfast: *"Mexican tortillas and beans, and eggs."* This diet is typically seen in Latinx households because they are staple foods that have been ingrained since childhood. Then, when asked how culture can influence food choices, he said:

"It can be bad because there are not many vegetables since childhood." Eventually, he reflected, "Mexican meals lead to diseases like diabetes and hypertension due to not eating vegetables."



Mexican tortillas and beans, and eggs

The powerful self-realization that traditionally Mexican foods might not be the most nutritious is an important first step in breaking cultural food norms, though the road ahead will be difficult and challenging.

According to the Hypertension in Hispanics/Latinos: Epidemiology and Considerations for Management, they found:

"Culture is an important determinant of behavior and influences many of the lifestyle factors that contribute to the development and management of hypertension." (Thomas, 2019)

Culture is extremely important for patient-centered care, and we must become more cognizant of having more culturally aware physicians. By addressing these medical issues earlier on since diagnosis and applying culturally sensitive care, we might be able to see a decline in hypertension in all populations. This means that the physicians and their team can go the extra mile and offer healthier meal substitutions to the traditional Latinx and African American cultural food.



Salvadoran man, 83-year-old, retired

Our fourth patient, an 83-year-old retired Salvadoran patient from MLK Outpatient Center who has lived in South Los Angeles for over 44 years, expressed significant challenges in managing his hypertension due to cultural dietary preferences and a lack of trust in healthcare professionals. He shared, *"I want someone who understands that I can't cut out certain foods,"* highlighting the cultural importance of certain foods that he finds challenging to eliminate. The Hispanic Community Health Study/Study of Latinos reveals that hypertension is prevalent among Hispanics/Latinos, with lower rates of awareness, treatment, and control compared to non-Hispanic whites. The study states:

"These findings indicate a significant deficit in treatment and control of hypertension among Hispanics/Latinos residing in the United States, particularly those without health insurance." (Sorlie, 2014)

This underscores the critical need for healthcare systems to develop culturally sensitive approaches that address these gaps in care. By understanding and integrating cultural dietary habits into hypertension management plans, healthcare providers can improve patient trust and adherence to dietary guidelines and health outcomes.

His reluctance to use translators and preference for his daughter's assistance during medical visits point to a significant barrier in healthcare communication. *"I don't like it when a translator is in the room. I trust my daughter more than the doctors,"* he says, illustrating a common issue of mistrust and cultural disconnect between patients and healthcare providers. Research on neighborhood social organizations in Los Angeles has shown that social and cultural factors significantly impact hypertension risk and management among racial and ethnic minorities. In their study on the impact of neighborhood social organization, Sharp & Carpiano state:

> *"Our findings reveal that neighborhood organizational participation is associated with a lower probability of being hypertensive. This suggests that living in neighborhoods where people are involved in informal and formal organizations and associations (e.g., neighborhood watch, civic groups, ethnic pride organizations) may protect residents against excessive exposure to area stressors that can elevate the risks of developing high blood pressure." (Sharp, 2023)*

This highlights the importance of integrating community-based strategies to enhance trust and communication between patients and healthcare providers. By fostering a sense of community and understanding, these interventions can reduce barriers to effective hypertension management and improve health outcomes for minority populations.

Moreover, dietary practices rooted in Salvadoran culture pose another challenge for this patient. *"Vegetables are not the usual part of our diet,"* he explains, which aligns with findings from the National Health and Nutrition Examination Survey (NHANES) that indicate lower intake of fruits and vegetables among Hispanic/Latino men compared to women.

> *"Poor dietary quality and practices among Latino adults may have a strong impact on younger generations within the family unit, given long-held beliefs, traditions, and sociocultural influences persistent in Latino culture." (Overcash, 2021)*

This statement emphasizes the inter-generational impact of dietary habits and the importance of addressing these practices in health interventions. Healthcare providers should consider community-based interventions and educational programs that respect and integrate cultural dietary habits. Additionally, increasing accessibility to culturally relevant health education and services could enhance healthcare literacy and improve hypertension management in Hispanic/Latino populations.



Nutritionist with Patient and Caregiver

Of all the patient interviews, the interviews that stood out the most were with Patients 2 and 4. The interviews with the patients reveal a common theme: the need for culturally sensitive healthcare approaches addressing diverse dietary practices and health challenges in minority communities. Each patient's story highlights barriers tied to cultural food traditions, health literacy, and communication gaps between patients and providers. For the interviewees, healthcare interventions must go beyond standard recommendations and consider the deep-rooted cultural, familial, and social influences that shape dietary choices and health behaviors. Community-based programs, family involvement, and improved access to culturally competent healthcare professionals are essential to creating sustainable health improvements. By addressing these needs, healthcare systems can better support patients in managing chronic conditions like hypertension, ensuring that dietary changes and healthcare advice resonate with their cultural values and everyday lives.

Patient 2's ability to navigate meal preparation without significant barriers contrasts with the challenges highlighted by Horowitz et al. regarding the perceived difficulties in following clinician-recommended diets. This contrast underscores the importance of considering individual circumstances and cultural preferences when promoting dietary changes for hypertension management. Patient 3's positive experiences with accessing healthcare and receiving advice on nutritional changes stand out in contrast to broader narratives of healthcare disparities within minority populations. His proactive stance towards lifestyle modifications and preventive care aligns with the recommendations highlighted in the research article, emphasizing the importance of tailored interventions that consider cultural nuances and individual motivations.

Patient 2's comments on nutritional beliefs within his community highlight the shift towards healthier eating among younger generations and the complex interplay between cultural norms, health beliefs, and dietary choices. He noted:

> *"The older generation has hypertension because we're eating a lot of foods that we grew up on and believed in, but as we get older, we see the younger people, and they're changing how they eat."*

Understanding these factors is essential for addressing disparities in hypertension prevalence. Incorporating his perspectives into the broader discussion on nutrition and hypertension prevalence among minority populations in South Los Angeles provides a nuanced understanding of the multifaceted factors influencing dietary choices and health outcomes. While the patient's experience offers valuable qualitative insights, further research involving diverse individuals is essential to capture the full spectrum of beliefs, practices, and challenges related to nutrition and hypertension management. By combining qualitative narratives like patient 3 with quantitative data on nutrition habits and healthcare utilization patterns, a more comprehensive approach can be developed to address hypertension disparities effectively in culturally diverse communities.

Patient 4's story underscores several key themes relevant to hypertension management among Hispanic/

Latino populations. A shared barrier to dietary change is the struggle with breaking entrenched habits and overcoming psychological barriers associated with dietary change. Whether it's:

- the attachment to familiar comfort foods,
- the challenge of resisting cravings, or
- the fear of missing out on social experiences centered around food,

these factors represent significant hurdles. His experience illustrates the universal nature of this barrier in the journey toward improved nutrition. Furthermore, the need for healthcare providers who understand the patient's language and culture is critical. This need for culturally competent healthcare providers who can effectively communicate and empathize with patients' cultural backgrounds is paramount. Addressing these shared barriers through culturally sensitive interventions and community engagement can significantly enhance dietary compliance and overall health outcomes for our patients.

Collaborative Partners

In South Los Angeles, community-based organizations such as Food Access LA and It's Bigger Than Us are pivotal in providing access to healthy foods, nutritional education, and support services. Food Access LA provides SPA 6 and other food-insecure areas in South Los Angeles with access to nutritious foods.



Food Access LA Farmers Markets at various locations.

The program's mission is entirely focused on access to healthy foods and the sustainability of those foods within families. This is shown through the platform that they give local farmers and businesses to sell at their markets, accepting EBT and implementing market match programs, which provide people using EBT more money to specifically buy fruits and vegetables, free nutritional teaching kitchen programming, and curbside pick-up at the markets. They also offer different incentives based on where their farmer's markets are located. Their teaching kitchens and nutritional department work together to teach the community how to implement the foods they sell into their everyday lives. People who come to the farmers' market learn more about the food system and the seasonality of food. They also notice a change in their palate preferences based on trying fresh, healthy foods in peak season.



It's Bigger Than Us Community Event

On the other hand, It's Bigger Than Us focuses on solution-based resources for all communities to thrive. In line with this mission, they specialize in creating community activities centered around addressing health inequities through food distributions, resource distributions, and school programs. They have significant staple events like their back-to-school or Christmas events, with a turnout of about 5,000 to 10,000 people. The actions behind everything they do is centered around helping individuals live a stronger, better, healthier life.

Conclusions



African American Adults
17-20 years old

A significant barrier to improving outcomes in patients with hypertension is patient education that is culturally relevant and culturally competent. In an analysis conducted in the southeastern United States, young African American adults, 17-20 years old, were interviewed to determine their knowledge of hypertension prevention strategies (Savoca et al). Both males and females reported little to no formal education about hypertension. Thus, the authors of this study advocated for more relevant health education to be given throughout high school. Moreover, observational studies have shown that doctor-patient communication can have a strong impact on health outcomes (Auerbach 2012). The two healthcare providers we interviewed who practice in SPA 6 noted that while patients are aware of their health conditions, they are not always aware of the gravity of their predisposition to its potentially severe consequences. The providers we interviewed were culturally competent meaning they understood their patients' respective cultures and thus were able to communicate their concerns to their patients in an effective manner.

For example, one provider was born and raised in Los Angeles and understands the specific struggles of living in an under-resourced community giving them a unique ability to emphasize with their patients and provide realistic recommendations to their patients. Furthermore, the nurse we interviewed noted that health literacy is a challenge that "cuts across all social classes," requiring integrated healthcare teams to provide proper health education to all individuals regardless of class, age, or ethnic background.



Latinx Doctor and Patient

When assessing the importance of medication management, it was found that this was not a point of contention from the perspective of the healthcare providers we interviewed. For example, the physician we interviewed stated that access to clinics and medications is available, but more personnel are needed.



African American Man on Exercise Bike

The healthcare providers also mentioned that exercising to ensure a patient's heartbeat reaches 140 bpm for half an hour daily, five days a week, is crucial to managing hypertension. Most patients with labor-intensive jobs do not have their heart rate reach that threshold because their bodies adapt to their workload and thus decrease their demand for higher cardiac output. It is also crucial to note that the benefits of exercising extend beyond just losing weight, as it will, over time, systematically change how a person's body functions metabolically. In all, the providers noted that working with a patient's culture and approaching their condition on an individual level may lead to improved hypertension control. Although these points are pertinent, implementing feasible solutions to address all these needs is still in question.

The most striking challenge that continues to be at the root of addressing chronic diseases like hypertension is creating optimal policies aimed at patient outreach and support. Potential solutions to improve access and delivery of care for hypertension involve policy, health literacy, and increased access to healthier food options. Different neighborhoods have variances in public programs. For example, parks are less plentiful in some areas, and people work multiple jobs to make ends meet. Having more free resources to encourage improved physical health would ease some of the health issues this population is facing. To address this, one of the policy experts interviewed stated:

> *"I think there is a need to have people at the table, who are from those communities, who have a vested interest in supporting it as opposed to policymakers/academicians who have good intent but may not be at the ground level with the community-based advocates and faith-based leaders."*

There is also a need to incentivize policy to fund public programs at parks, such as exercise programs and informational sessions. Increased access to healthier foods can be addressed by implementing farmers' markets that are open after regular business hours to allow those who work during the day to still have

access to better foods. Health literacy can also be improved by having dedicated consultations with patients and their families, where the health professional can help them select better foods from places they dine at, or teach them how to make healthier alternatives to foods they usually cook. This integrated approach has been shown to be effective by Himmelafarb et al. (2016), who found that nurses who expanded their hypertension care to include education, counseling, coordinating care, and performance measurement significantly improved outcomes. Overall, all the policy recommendations can be implemented at different levels of government and can have profound results in communities adversely affected by hypertension.

Lessons Learned

There were many lessons learned through the interviews conducted. Such as the heterogeneity within African American and Latinx food culture. The different patient experiences illustrated showed how diverse cultural backgrounds can influence dietary choices. These findings underscore the need for culturally sensitive approaches when developing nutrition interventions.

Some potential barriers noted for people within the African American community to eating healthy could be found in the traditional food dishes. An article found that:

> *"…although most African Americans realize that some aspects of their traditional cuisine are unhealthy, ethnic food is comforting and allows for connectedness, expression of one's cultural identity, and the connection to African American culture (Swierad et al. 2017)."*



Fried Chicken, Greens, Mac and Cheese, Cornbread

It is essential to note that physicians need to understand the reasoning why different group's cultural identity influences what they are used to eating.

We also saw the intersection of cultural influences, dietary habits, and healthcare experiences in managing hypertension. The article *"How do Urban African Americans and Latinos View the Influence of Diet on Hypertension"* by Horowitz et al. states:

> *"Our goal is to promote healthy diets that are consistent with people's cultures so that they willingly adopt and maintain these diets over time." (Horowitz, 2004)*

The emphasis on preparing meals rooted in soul food traditions reflects the significance of cultural heritage in shaping dietary choices. Incorporation of vegetables, greens, and grilled meats showcases a blend of traditional flavors and health-conscious cooking practices. Some patients might report no barriers, it is possible that some patients, including him, may not fully recognize or be aware of the challenges they face. For example, limited health literacy might prevent patients from fully understanding medical advice. Additionally, subtle cultural or socioeconomic factors could influence dietary choices and access to healthcare, even if they aren't explicitly identified as barriers. Like many others may encounter difficulties related to these factors without realizing their impact on his health outcomes.

Another barrier that we saw is not only the language barrier but also health literacy. This could lead to a

disconnect between the physician and the patient. This miscommunication could lead to a decline in patient-centered comprehensive treatment and care. According to the California's Physician Shortage White Paper:

> *"By 2050, Latinos are estimated to represent 44.5% of the state's population. While the Latino population continues to grow, the supply of Latino physicians has not caught up." (Vargas Bustamante, 2020)*



Doctor with Patient

This is alarming because we need future physicians to reflect the patient population and speak their native language so that they can go the extra mile and offer comprehensive and culturally aware treatment and care. Charles R. Drew University of Medicine and Science College of Medicine is combating this Latinx physician shortage because currently, nearly 25% of the class size of 60 students identify as Latinx medical students. We are hopeful that future cohorts will surpass this percentage in aid to help combat the Latinx physician shortage not only in California but also in the United States.

Another important key theme relevant to hypertension management among Hispanic/Latino populations is a shared barrier to dietary change which is a struggle with breaking entrenched habits and overcoming psychological barriers associated with dietary change. Whether it is the attachment to familiar comfort foods, the challenge of resisting cravings, or the fear of missing out on social experiences centered around food, these factors represent significant hurdles. These experiences illustrate the universal nature of this barrier in the journey toward improved nutrition. Furthermore, the need for healthcare providers who understand the patient's language and culture is critical. This need for culturally competent healthcare providers who can effectively communicate and empathize with patients' cultural backgrounds is paramount. Addressing these shared barriers through culturally sensitive interventions and community engagement can significantly enhance dietary compliance and overall health outcomes for our patients.

Looking Forward

To tailor to the Black and Latinx populations of South Los Angeles, future efforts could focus on designing community-driven interventions tailored to this community. Working together with health care providers, community organizations, and public health officials, we hope to establish programs that educate community members on nutritional information and provide access to affordable and healthy foods. To achieve this, one focus is on the creation of partnerships with farmers' markets to increase the availability of fresh produce. Another focus will be on ensuring dietary recommendations are respectful of cultural food traditions and bringing people together around food this will hopefully build healthy familial traditions.



Cultural Market

More importantly, this research project can serve as a foundation for policy advocacy:

- pushing for structural changes that address food deserts,
- improve public health infrastructure, and
- incentivize healthier food options in low-income areas.

The ultimate goal is to develop long-term solutions that can be applied not only in South Los Angeles, but also in similar marginalized communities across the country. Through collaboration and education, this research seeks to contribute to a future where hypertension is no longer disproportionately prevalent in marginalized communities.

Recommendations

Our study concludes with several recommendations that could be implemented as solutions to the lack of optimal nutritional access and culturally-congruent guidance and influences for South Los Angeles residents, resulting in higher levels of hypertension prevalence in this population. By engaging with the literature, community partners, and community organizations we have come to understand that to improve access and delivery of care for food insecurity in the South Los Angeles community, there needs to be a multi-faceted approach, addressing local, regional, and national levels from various perspectives.



Community Garden

One effective solution is the establishment of community gardens and farmers' markets. These initiatives provide fresh produce directly to residents, empowering them to participate in their own food production and access affordable, healthy options. A study found that by involving community members in the cultivation and distribution of fresh produce, these programs can create a sense of ownership and pride while simultaneously addressing food insecurity (Twiss, 2003). Additionally, community gardens and farmers' markets foster community engagement and education about nutrition, promoting healthier eating habits in a culturally relevant manner. Strengthening partnerships between local farmers and community organizations can also enhance the availability of fresh, culturally relevant foods at lower costs (Reddy, 2004). Another solution is the deployment of teach-in kitchens equipped with nutritional counseling services.



Farmers Market

These sessions can bridge the gap for residents who lack access to nutritional education and resources by offering personalized care and distributing healthy food options directly to underserved neighborhoods.

At the regional and national levels, advocating for stable funding of food subsidy programs like the market match program is crucial. Ensuring continuous support for low-income families can mitigate the adverse effects of economic instability. Another crucial strategy is expanding the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Enhancing these programs with increased funding, broader eligibility criteria, and incentives for purchasing fruits and vegetables can significantly improve access to healthy foods for low-income families. These enhancements can make a substantial difference in the dietary habits of families who rely on these programs for their nutritional needs, helping to reduce food insecurity and promote healthier eating patterns. Additionally, implementing regional public health campaigns to raise awareness about food insecurity and its health impacts can mobilize resources and support from broader communities and policymakers (Reddy, 2004).

Within the healthcare system, integrating nutritional services into primary care offerings is essential. Physicians should provide dietary counseling and information on access to healthy foods through on-site farmers' markets or partnerships with food distribution programs. Investing in research to identify effective interventions and training healthcare providers on the importance of culturally relevant nutritional guidance can also improve patient outcomes.

How This Study Informs Community-Based Practice

The focus of this particular case study, which follows the social health theory, would classify it as a community psychology practice since it aims at reducing health inequities and improving the well-being of overburdened populations. However, Community Psychologists do not expect the community to be passive – it is about cooperating, understanding what leads certain communities to have social and health-related issues and what can be done about it to enrich the community at large.

This case study examines how such policies translate into practices, which are rooted in the community and society. It further demonstrates that such stressors lead to a higher prevalence of conditions like

hypertension amongst Black and Latinx populations in South Los Angeles. Such policies do not exist in an ideological vacuum; the case shows how people live in an extrinsic context to which such policies are somehow relevant.

Food Access LA and It's Bigger Than Us after all address the needs of the local community and meet the expectations of the Community Psychology model which suggests that the design of the intervention makes every effort to be appropriate for the characteristics of a particular group. Understanding food choices within communities should always consider cultural history as well as the effects of oppression and poverty experienced by those communities. This is crucial in addressing food preferences and in promoting better food consumption practices.

Working with communities, institutions and professionals to bring about change in addressable issues is one of the aspects that Community Psychology supports. As it has been shown in the case study, Food Access LA and other community-based organizations, health providers, and even policymakers were able to span hypertension through prevention of food insecurity. Working with such partners enables addressing the different dimensions of health by combining different skills and resources and involving the residents.

The case study includes multi-level interventions classifying them into three levels, which are local, regional, and national. Community Psychology promotes solving problems on different levels to achieve long term solutions. For instance, such measures as increasing the scale of urban agriculture, creating demand for food subsidy programs and protecting harmful practices within healthcare service integration depict this multifaceted approach. The integration of community-owned strategies with health policy as envisaged is a true reflection of community psychology's prevention of the problem and its social causal factors.



Multi-level interventions to achieve long term solutions.

Among many objectives of Community Psychology, a fundamental one is to help oppressed groups to speak for themselves. The case study endorses the empowerment of the people by promoting nutrition, making them active and responsible food consumers, and bringing together public health professionals

and community representatives. Activities such as teaching kitchens and market match initiatives allow community members to take active steps in improving their health and are consistent with promoting self-efficacy and resilience amongst the community being the objectives of community psychologists.

The case reflects the principles of community psychology, for example, an illustration of the historical factors that contributed to the development of negative eating practices in the Black community. The story of food insecurity that has sought systemic racism and discrimination explains the ill-health of individuals as part of social structures, which is one of the principles of community psychology in addressing the root causes of social problems.



It's Bigger Than Us

The role of the community in the case study is through interviews and involvement of local organizations in the research process, thus making the case a typical example of community engaged approach, a key methodology in community psychology. The community engaged approach focuses on engaging community partners in the knowledge-building processes to ensure that programs and strategies are based on the realities and requirements of the community.

References

1. Auerbach, S.M. The Impact on Patient Health Outcomes of Interventions Targeting the Patient-Physician Relationship. Patient-Patient-Centered-Outcome-Res 2, 77–84 (2009). https://doi.org/10.2165/01312067-200902020-00003

2. County of Los Angeles Department of Public Health. 2023 Los Angeles County Health Survey. Published online 2023.

3. Harding C, Los Angeles County Department of Public Health. Key Indicators of Health by Service Planning Area. Published online January 2017.

4. Himmelfarb, C. R. D., Commodore-Mensah, Y., & Hill, M. N. (2016). Expanding the Role of Nurses to Improve Hypertension Care and Control Globally. Annals of Global Health, 82(2), 243. https://doi.org/10.1016/j.aogh.2016.02.003

5. Horowitz, C. R., Tuzzio, L., Rojas, M., Monteith, S. A., & Sisk, J. E. (2004). How do urban African Americans and Latinos view the influence of diet on hypertension?. Journal of health care for the poor and underserved, 15(4), 631–644. https://doi.org/10.1353/hpu.2004.0061

6. Long, A. N., & Dagogo-Jack, S. (2011). Comorbidities of diabetes and hypertension: mechanisms and approach to target organ protection. J Clin Hypertens (Greenwich), 13(4), 244-251. https://doi.org/10.1111/j.1751-7176.2011.00434.x

7. Lynch EB, Tangney C, Ruppar T, Zimmermann L, Williams J, Jenkins L, Epting S, Avery E, Olinger T, Berumen T, Skoller M, Wornhoff R. Heart 2 Heart: Pilot Study of a Church-Based Community Health Worker Intervention for African Americans with Hypertension. Prev Sci. 2023 Jul 7. doi: 10.1007/s11121-023-01553-x. Epub ahead of print. PMID: 37418177.

8. Mills KT, Stefanescu A, He J. The global epidemiology of hypertension. Nature Reviews Nephrology. 2020;16(4):223-37.

9. Orzech, Kathryn M., et al. "Diet and exercise adherence and practices among medically underserved patients with chronic disease: variation across four ethnic groups." Health Education & Behavior 40.1 (2013): 56-66.

10. Overcash, F., & Reicks, M. (2021). Diet quality and eating practices among Hispanic/latino men and women: Nhanes 2011–2016. International Journal of Environmental Research and Public Health, 18(3), 1302.

11. Reddy KS, Katan MB. Diet, nutrition and the prevention of hypertension and cardiovascular diseases. Public Health Nutrition. 2004;7(1a):167-186. doi:10.1079/PHN2003587.

12. Roussel S. The Carrot Is the Stick: Food as a Weapon of Systemic Oppression for Black Consumers and the Disenfranchisement of Black Farmers. Journal of Environmental Law and Litigation. 2021;36(129):129-154.

13. Savoca MR, Quandt SA, Evans CD, Flint TL, Bradfield AG, Morton TB, Harshfield GA, Ludwig DA. Views of hypertension among young African Americans who vary in their risk of developing hypertension. Ethn Dis. 2009 Winter;19(1):28-34. PMID: 19341160.

14. Sharp, G., & Carpiano, R. M. (2023). Neighborhood Social Organization exposures and racial/ethnic disparities in hypertension risk in Los Angeles. PLOS ONE, 18(3).

15. Sorlie, P. D., Allison, M. A., Aviles-Santa, M. L., Cai, J., Daviglus, M. L., Howard, A. G., Kaplan, R., LaVange, L. M., Raij, L., Schneiderman, N., Wassertheil-Smoller, S., & Talavera, G. A. (2014). Prevalence of hypertension, awareness, treatment, and control in the Hispanic Community Health Study/ Study of Latinos. American Journal of Hypertension, 27(6), 793–800.

16. Swierad, Ewelina M., et al. "The Influence of Ethnic and Mainstream Cultures on African Americans' Health Behaviors:A Qualitative Study." Behavioural Sciences (Basel), vol. 7, no. 3, 2017, pp. 49-doi:10.3390/bs7030049.

17. Thomas, I.C., Allison, M.A. Hypertension in Hispanics/Latinos: Epidemiology and Considerations for Management. Curr Hypertens Rep 21, 43 (2019). https://doi-org.cdrewu.idm.oclc.org/10.1007/s11906-019-0947-6.

18. Thomas SJ, Booth JN, Dai C, Li X, Allen N, Calhoun D, et al. Cumulative Incidence of Hypertension by 55 Years of Age in Blacks and Whites: The CARDIA Study. Journal of the American Heart Association. 2018;7(14):e007988.

19. Twiss, J., Dickinson, J., Duma, S., Kleinman, T., Paulsen, H., & Rilveria, L. (2003). Community gardens: lessons learned from California Healthy Cities and Communities. American journal of public health, 93(9), 1435–1438. https://doi.org/10.2105/ajph.93.9.1435

20. Vargas Bustamante, A., Martinez, L., & Anaya, Y. B.-M. (2020). CALIFORNIA'S PHYSICIAN SHORTAGE White Paper.

21. Villalona S, Ortiz V, Castillo WJ, Garcia Laumbach S. Cultural Relevancy of Culinary and Nutritional Medicine Interventions: A Scoping Review. Am J Lifestyle Med. 2021 May 3;16(6):663-671. doi:10.1177/15598276211006342. PMID: 36389044; PMCID: PMC9644144.

17

Beyond Birth – Unpacking Postpartum Depression (PPD) in SPA 6 and the Factors Driving Disparity

MONIKA WATAT, MAKEEN YASAR, ABDELKADER AWAD, RANIA BERKANE, SIGRY ORTIZ FLORES, JOSUE FRAGA, HARNEEL GILL, AMINA LATIF, DAPHNE OKORO, AND KAYLAH WADE

THE BIG PICTURE – POSTPARTUM DEPRESSION (PPD) IN SOUTH LA

Important Note: In this paper, we primarily use the term *"mothers"* to align with the language used in most of the research and data cited. However, we acknowledge that the term may not fully encompass the diverse experiences of all birthing people. Birthing people, including those who do not identify as mothers or who represent a variety of gender identities, are an important part of the conversation surrounding postpartum mental health. While our use of *"mothers"* reflects the scope of the data available, we remain committed to inclusivity and recognize the need for language that reflects the diversity of all individuals who give birth.



A woman who recently gave birth comes into the outpatient clinic presenting with depressive symptoms for four weeks and fatigue after having a healthy baby six weeks ago. Her first full-term birth, she recounts how beautiful it was to hear her son's lungs inhaling their first breath, "a new cry echoing into the world all sacred and scared." And then, how she, while holding her child across their chest, cried tears of relief knowing that her child made it, that their life was one to be cherished and loved.



But since then, things have not been easy. In a stifled, almost sobbing voice, she shares just how difficult things had been taking care of the baby. That even amidst congratulations from friends and family, she felt incredibly alone in trying to be a good mother. That most days she felt like she wasn't, that she felt something must be wrong with her. And, amidst the weight of that admission, holding in tears, she makes the simple request: "I think I could use some help."

Vignette describing a classic case of Postpartum Depression (PPD)

The above vignette is a classic case of postpartum depression (PPD), a mental health condition attributable to new mothers often within 4 weeks of delivery. PPD is characterized by persistent symptoms of depression, including sadness, lack of interest, low self-esteem, sleep disturbances, appetite changes, anxiety, self-blame, and difficulty bonding with the baby (Robertson et al., 2004).

Often, when we think of birth, we imagine the delivery itself rather than the care that follows. Medical training typically focuses on pregnancy and labor, leaving a lingering and seldom-answered question: What happens to the one who gives birth after delivery? And what does that look like in a city like Los Angeles's most diverse, vibrant, and under-resourced community?



Two women sitting at a table during a BHCME event

This study explores the experiences of mothers in South Central Los Angeles who have experienced postpartum depression. Our goal is to illuminate not only the social barriers driving disparity but also the structural systems that shape care. By gathering perspectives from patients, providers, researchers, and public officials, we identified actionable recommendations to improve direct patient care, healthcare systems, and the broader strategies needed to advance maternal equity.

Community Context – South Central LA and Maternal Health Disparities

The area commonly known as South Central LA is defined by the LA County Department of Public Health as Service Planning Area 6 (SPA 6). South of the 10 Freeway and Downtown LA's gleaming skyline, SPA 6 includes neighborhoods such as Athens, Baldwin Hills, Crenshaw, Hyde Park, and Watts, with Willowbrook and Compton forming its southernmost edges.

SPA 6 is racially and culturally diverse, home to a predominantly Latine population (68%) and the largest Black/African American community in Los Angeles County (28%). This demographic landscape reflects a rich history of migration, particularly the Great Migration, during which Black Americans fled Jim Crow-era violence in the South in pursuit of safety, opportunity, and stability in cities like Los Angeles.

Despite this cultural wealth, SPA 6 remains heavily impacted by systemic inequities. The region experiences higher rates of poverty and lower access to healthcare compared to other parts of LA. According to the LA County Department of Public Health, 31% of families in SPA 6 live in poverty—nearly double the county average. These social drivers of health deeply impact both maternal and infant outcomes.

The 2023 MLK Community Healthcare Needs Assessment put it plainly:

This is a simulated reading of the paragraph below. Click [Play] to begin, and [Pause] to stop at any time.

—

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3287#audio-3287-1

"Maternal and infant health disparities are directly related to the underlying social and economic inequities that exist in our community. In 2021, South Los Angeles had 11.2 births per 1,000 (14,938 live births) compared to 9.6 births per 1,000 population in Los Angeles County. [Additionally] our community experienced almost double the rate of infant deaths per 1,000 compared to Los Angeles County during that same year."



Woman holding baby

When it comes to postpartum depression, SPA 6 remains underserved and under-researched. The Los Angeles Mommy and Baby (LAMB) Survey conducted in 2016 found that SPA 6 had the highest reported PPD rates in the county, with a 12% disparity between SPA 6 and SPA 5, the most affluent region. Yet no new data has been collected since, leaving a critical gap in understanding how PPD manifests in this community today.

This is where Charles R. Drew University of Medicine and Science (CDU) plays a pivotal role. Founded in 1966 following the Watts Rebellion, CDU is a historically Black graduate institution committed to health equity and social justice. The university trains healthcare professionals to serve underserved communities and actively works to reduce maternal mortality, particularly among Black women, through targeted research and culturally competent care.

In light of SPA 6's compounded vulnerabilities—racial, economic, and systemic—it is essential to listen directly to the voices of mothers in this community. As one patient shared:

This is a simulated reading of the paragraph below. Click [Play] to begin, and [Pause] to stop at any time.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3287#audio-3287-2

"Growing up, I didn't know anyone who would openly say they were depressed… even now, a lot of my family… they are not seeking therapy, even though they're dealing with grief and loss and just post-traumatic stress of all the things going on."

Without updated, community-specific data, it's impossible to develop targeted interventions. Research must be a foundation for action. The LAMB survey once prompted the formation of the LA County Preconception Health Collaborative, which improved mental health screening and support for expecting mothers. Updated data from SPA 6 could catalyze similarly impactful changes today.

As time has shown, this community needs—and deserves—advocates who are willing to ask the right questions, listen with intention, and work collectively toward a future where maternal mental health is prioritized and protected.

METHODOLOGY

This study utilized a Community-Engaged Research Project (CERP) approach—a participatory research model involving collaboration with community stakeholders at every phase. The goal was to ensure that the study was deeply informed by the lived realities of those directly impacted by postpartum depression in SPA 6.

Our approach began with an internal group assessment involving student researchers and long-standing community faculty members. This assessment helped identify a research topic that was both urgent and resonant. To establish a foundation for the study, we conducted an in-depth literature review examining factors that contribute to or exacerbate PPD. This informed the structure and scope of our own exploratory work.

Over the following two months, we conducted outreach to identify and recruit stakeholders with either lived or professional experience related to postpartum depression. This effort was carried out in partnership with the Black Maternal Health Center of Excellence (BMHCE), a trusted organization committed to reproductive justice and culturally responsive maternity care. BMHCE not only helped us connect with mothers in the community but also emphasized the importance of compensating participants for their time and emotional labor.



Members of BMHCE, a trusted organization committed to reproductive justice and culturally responsive maternity care.

With participants identified, we conducted in-depth interviews using open-ended questions. These conversations took place in settings chosen by the participants, such as homes, clinics, or community spaces, helping ensure safety and comfort. The interview process emphasized storytelling and vulnerability, encouraging participants to express their experiences in their own words.

After interviews were completed, our team analyzed the data by coding responses and identifying central themes. These included barriers to care, cultural and structural contributors to PPD, and gaps in support systems. These insights informed our final recommendations to improve care, strengthen advocacy, and apply reproductive justice principles to maternal health.

As one participant noted:

This is a simulated reading of the paragraph below. Click [Play] to begin, and [Pause] to stop at any time.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3287#audio-3287-3

"I feel like if I knew that I had that mental support beforehand…I could have reached out sooner."

That insight, among many others, reinforced the need for a proactive, inclusive, and community-centered research model that listens first—and acts second.

Theoretical Framework: Why Reproductive Justice Matters

To understand the root causes of postpartum depression (PPD) in South LA and how to address them

equitably, this study was grounded in a reproductive justice framework. Reproductive justice, as defined by the SisterSong Women of Color Reproductive Health Collective, is:

> *"the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."*

This framework was developed in the 1990s by Black women leaders such as Loretta Ross as a response to the limitations of the mainstream reproductive rights movement, which primarily emphasized legal access to abortion and contraception. Ross and others argued that true reproductive freedom cannot be achieved without addressing the social conditions that shape a person's ability to make reproductive choices—conditions like poverty, racism, immigration status, and access to healthcare.

As one BMHCE research expert we interviewed noted:

This is a simulated reading of the paragraph below. Click [Play] to begin, and [Pause] to stop at any time.



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3287#audio-3287-4

> *"We're not just talking about access. We're talking about systems that weren't built for us. Reproductive justice asks what it means to be able to give birth—and live well after giving birth—as a Black woman in America."*

Applying this lens allowed us to look beyond individual mental health histories and examine how broader social and structural forces, such as systemic racism, housing instability, food insecurity, and provider bias, contribute to PPD in SPA 6.

Through this framework, we explored not only whether care was available but also whether it was respectful, culturally affirming, continuous, and safe. Reproductive justice calls on us to ask:

- Who is most vulnerable?
- Who is not being heard?
- What do they need to thrive?

In our study, the reproductive justice framework functioned as both a guide and a goal—helping us design a study rooted in dignity, equity, and collective liberation, and pointing us toward the kind of structural transformation needed to truly support mothers in SPA 6.

PARTICIPANT DEMOGRAPHICS

Patient Participants

Patient One: A 37-year-old married Filipino American woman



- First-generation immigrant from a Hispanic community in Southern California
- Holds Sociology and Psychology degrees from UCLA
- Experienced postpartum depression after her second child

Patient Two: A 35-year-old married Black American woman



- Lives in South LA and works in public health
- Developed PPD after the birth of her second child during COVID-19
- Symptoms intensified by her mother's cancer diagnosis and the stillbirth of her third child

Patient Three: A 34-year-old single Black American woman



- Mother of four living in SPA 6
- Intensifying her experience with PPD, she faced challenges with:
  - Accessing healthcare,
  - Navigating insurance, and
  - Financial stressors

Patient Four: A 35-year-old Black American woman



- Mother of two, born and raised in South LA
- No PPD after first child; developed symptoms after second
- Shares ongoing concerns about raising a Black son in her community

Patient Demographics – Photos representing four patient participants with a description noting their PPD experience

Healthcare Providers

OB/GYN



- Shared perspectives on patient hesitancy toward medications and disruptions in postpartum care
- Emphasized importance of patient-centered approaches and greater awareness to effectively address issues

Psychiatrist



- Discussed cultural and religious barriers to seeking mental health care, such as stigma, shame, and fear
- Highlighted fragmented U.S. healthcare system, limiting coordination between providers

Nurse Practitioner / Doula



- Emphasized systemic barriers such as insurance complications and shortage of mental health professionals
- Stressed the value of in-hospital screenings and early social service referrals to support new mothers

Lactation Consultant



- Described the complex relationship between breastfeeding and PPD
- Emphasized the need for improved prenatal education and postpartum support to address misconceptions

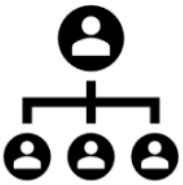
Healthcare Providers – Photos representing four healthcare professionals who support mothers with PPD

Community Stakeholders



Research Expert from the Black Maternal Health Center of Excellence (BMHCE)

- Spoke about the principles of reproductive justice and the role of structural racism in shaping maternal outcomes
- The expert underscored the importance of culturally rooted care models, including the use of midwives and doulas



Director of a County-Level Maternal and Child Health Department:

- Offered insight into systemic contributors to maternal health disparities
- The director emphasized the importance of community-driven strategies and culturally tailored interventions to better support new mothers in historically marginalized communities

Perspectives from the BMHCE Research Expert and the County-Level Maternal and Child Health Department Director

ETHICAL CONSIDERATIONS

Ethical integrity was central to the design and execution of this study. Given the sensitive nature of postpartum depression (PPD) and the vulnerability of the population involved, multiple safeguards were implemented to ensure the research was conducted responsibly and respectfully.

Informed consent was obtained from all participants, who were fully informed about the study's purpose, their rights, and the voluntary nature of their involvement. They were reminded that they could withdraw at any time without penalty. To protect privacy, all personal information was anonymized, and data were de-identified.

Patient participants received compensation to acknowledge their time and emotional labor and to reduce financial barriers to participation. Interviewers were prepared to offer referrals to mental health resources if needed, and participants could skip any questions they were uncomfortable answering.

The research team also maintained close communication with community partners to ensure the study remained aligned with community priorities.

OUTCOMES AND FINDINGS

This section presents findings from both the literature review and the qualitative interviews conducted with birthing people, mothers, healthcare providers, and public health stakeholders. We organize the findings into three key components:

I. Themes from the literature

II. Themes from patients

III. Themes from provider perspectives

This layered analysis offers a picture of how systemic barriers, cultural factors, and interpersonal dynamics shape postpartum mental health in SPA 6, and what opportunities exist for change.

I. Literature Review Themes

Our literature review highlighted four broad and interrelated risk domains for postpartum depression (PPD), particularly among Black and Latina mothers:

	Risk Domains	Explanation
1	**Structural Vulnerabilities**	SPA 6 residents face overlapping systemic challenges such as unstable housing, lack of insurance, poverty, and low access to consistent care. One report found that nearly 19% of Black mothers in SPA 6 experienced homelessness during pregnancy, and 41% of Latina mothers lacked insurance in the six months before conception (LACDPH, 2016). These conditions are not only risk factors for poor maternal health outcomes but also create chronic stress that may compound during the postpartum period.
2	**Social Stressors and Isolation**	PPD is significantly more likely in the context of intimate partner violence, poor social support, and ongoing food insecurity (Silverman et al., 2006; Chung et al., 2004). The loss of communal caregiving networks due to migration, incarceration, or displacement was a recurring theme in the literature.
3	**Barriers to Mental Health Care**	Women with disabilities and those from racially marginalized groups experience lower rates of PPD diagnosis and treatment, in part due to stigma, provider bias, and inaccessible mental health services (Wisdom et al., 2010; Abrams et al., 2009). Even when care is available, it often lacks cultural alignment and trauma-informed practices.
4	**Insufficient Parental Leave and Economic Stress**	Lack of paid maternity leave is correlated with increased postpartum distress and reduced bonding (Dagher et al., 2014; Chatterji & Markowitz, 2005). Economic precarity forces some mothers to return to work within days or weeks of childbirth, disrupting recovery and amplifying mental health risks.

While these studies identify significant predictors of PPD, they often lack qualitative nuance and cultural specificity. To address this gap, our project intentionally centers on the lived experiences and community voices.

II. Patient Perspectives: Themes from Interviews with Mothers

Our interviews with mothers in SPA 6 revealed three key themes:

1. Cultural and Emotional Barriers to Seeking Help
2. Gaps in Postpartum Care and Provider Awareness
3. Healing through Culturally Rooted and Peer-Based Support

Theme 1: Cultural and Emotional Barriers to Seeking Help

Many participants struggled to name what they were going through and described intense guilt, shame, and emotional suppression. In Black and immigrant communities, they said, mental illness is often downplayed or interpreted as weakness. Several mothers shared that they didn't feel permission to express their distress because of internalized and external expectations to "be strong."

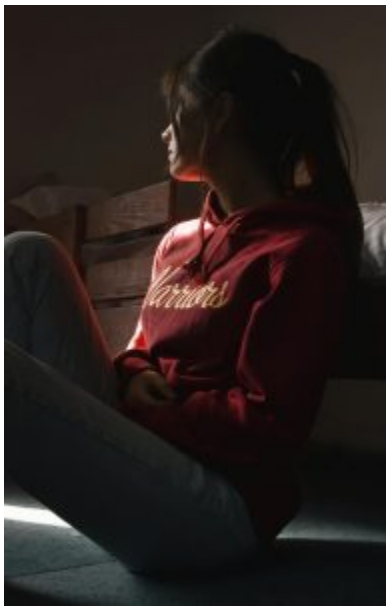
"Growing up, I didn't know anyone who would openly say they were depressed… Even now, a lot of my family, they are not seeking therapy, even though they're dealing with grief and loss and just post-traumatic stress of all the things going on."

A Filipina mother described feeling numb and disconnected:

This is a simulated reading of the paragraph below. Click [Play] to begin, and [Pause] to stop at any time.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3287#audio-3287-5

"I feel like the minute that I took the baby home, I was just more withdrawn. I didn't care about him, honestly… It was to the point I didn't care when my baby was crying."



A woman feeling sad or depressed

Even when mothers recognized that something was wrong, they often didn't know where to go or whom to trust. The fear of being judged—or worse, having their child taken away—further discouraged them from seeking help.

Theme 2: Gaps in Postpartum Care and Provider Awareness

Mothers repeatedly described postpartum checkups as rushed and transactional, with the focus almost entirely on the baby's physical health. Many said that no one screened them for depression, asked about their emotions, or followed up about their well-being—even when they raised concerns themselves.

This is a simulated reading of the paragraph below. Click [Play] to begin, and [Pause] to stop at any time.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3287#audio-3287-6

"She was just trying to make sure that because I'm 35 that my health didn't take a turn…I would go, we'd do an ultrasound, she'd look at my baby, and that was it."

Others said they were referred to therapists who lacked expertise in maternal mental health or who weren't culturally sensitive. One participant shared:

This is a simulated reading of the paragraph below. Click [Play] to begin, and [Pause] to stop at any time.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3287#audio-3287-7

"[The psychologist] wasn't trained in postpartum depression… I had to get reassigned."

This aligns with literature identifying the underdiagnosis and mistreatment of PPD due to provider inexperience and health system fragmentation.

Theme 3: Healing through Culturally Rooted and Peer-Based Support



Snapshots from a community baby shower event hosted by the BMHCE

For many mothers, the turning point came when they found peer-led support groups, especially those designed for Black women or facilitated by doulas and community-based organizations. These spaces allowed them to speak freely, cry without shame, and understand that what they were experiencing was not a personal failure.

This is a simulated reading of the paragraph below. Click [Play] to begin, and [Pause] to stop at any time.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3287#audio-3287-8

"I found out about the resources after, and I felt like I had already started to spiral…I think that making sure people know that postpartum depression can manifest in different ways [is crucial]."

Participants emphasized that education and emotional preparation should start during pregnancy, not after the crisis begins. They expressed strong interest in programs that combine prenatal education, postpartum check-ins, and peer mentorship.



Community members at a Diner en Blanc event hosted by the BMHCE at CDU.

III. Provider Perspectives: Themes from Stakeholder Interviews

Healthcare providers, mental health clinicians, and public health leaders echoed many of the same concerns. Their insights fell into four thematic categories:

1. Cultural Stigma and Trust Barriers
2. Disjointed Healthcare Systems and Siloed Care
3. Provider Shortages and Gaps in Training

4. Value of Culturally Grounded, Community-Based Models

Theme 1: Cultural Stigma and Trust Barriers

Providers reported that many patients delay seeking care out of fear and shame. A psychiatrist reflected:

> *"There's a lot of shame and embarrassment… And if the provider doesn't look like them or doesn't understand where they're coming from, they're even less likely to open up."*

Clinicians emphasized the importance of cultural humility and relational trust as foundational to effective care.

Theme 2: Disjointed Healthcare Systems and Siloed Care

Providers described how postpartum mothers often stop seeing their OB/GYN but continue attending pediatric visits—yet pediatricians are not trained to assess maternal mental health.

> *"Mothers will stop coming to follow-up appointments, but they'll be […] seeing the child's pediatrician."*

Another psychiatrist offered a stark breakdown:

> *"33% of my patients are only seeing a psychiatrist regularly, 33% are only seeing their primary care physician regularly, and 33% are seeing both."*

This fragmentation leads to missed opportunities for screening, follow-up, and holistic support.

Theme 3: Provider Shortages and Gaps in Training

One doula explained that mental health referrals are often ineffective because there are so few providers trained in perinatal mood and anxiety disorders (PMADs). Insurance navigation was also cited as a significant barrier.

> *"People are getting referred to therapists who don't even know what PMADs are."*

This lack of expertise directly contributes to delayed or inappropriate care, particularly for Medicaid patients.

Theme 4: Value of Culturally Grounded, Community-Based Models

Stakeholders overwhelmingly endorsed programs like the AAIMM Doula Initiative, which embeds care in culturally relevant practices. A lactation consultant highlighted how breastfeeding difficulties are often intertwined with postpartum depression—yet rarely addressed in prenatal education.

A BMHCE leader put it bluntly:

This is a simulated reading of the paragraph below. Click [Play] to begin, and [Pause] to stop at any time.



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3287#audio-3287-9

"We need to acknowledge how white supremacy and racism impact maternal health. This isn't just about clinics or hospitals—it's about systems that weren't built for Black women."

The Director of the Maternal and Child Health Department praised county-level programs but noted that they remain too small and underfunded to meet the scale of the crisis. She called for policy changes that invest in workforce diversity, expand Medicaid coverage for mental health, and ensure early, continuous, and culturally respectful care.

Together, these provider perspectives reinforce the idea that postpartum depression cannot be treated in isolation. It must be approached as a public health concern that intersects with racism, poverty, fragmentation in care delivery, and cultural exclusion. Integrating community wisdom, shared responsibility, and trauma-informed practices is essential for systemic change.



Family at Diner en Blanc event hosted on CDU's campus

RECOMMENDATIONS

The insights shared by mothers and providers across SPA 6 make one thing clear: postpartum depression cannot be treated in isolation. It is not just a clinical diagnosis—it is a symptom of deeper systemic failures, including fragmented care, cultural disconnection, and the lack of sustained emotional support during the postpartum period.

And yet, the solutions are within reach. The stories we heard point to what works: culturally rooted care, peer-led spaces, and systems that listen. Based on these findings, we offer the following recommendations:

1. Normalize Mental Health as Part of Maternal Health

Mental health screenings should begin during pregnancy and continue beyond the standard 6-week postpartum visit. Pediatricians, OB/GYNs, primary care providers, and doulas should all be equipped to screen, respond to, and refer mothers experiencing postpartum depression. Integrating mental health into every stage of perinatal care ensures that no concern is dismissed, and no mother falls through the cracks.

2. Invest in Peer Support and Culturally Grounded Models

Mothers in this study consistently emphasized the transformative power of being seen and heard by someone who understands. Peer support groups, culturally matched doulas, and community-rooted education programs create safe spaces where mothers can speak openly without shame. Initiatives like the AAIMM Doula Program and BMHCE's group sessions must be expanded and sustainably funded to reach more families.

3. Improve Collaboration Across Systems of Care

Too often, providers work in silos—missing opportunities to share information and coordinate care. A mother may see her child's pediatrician regularly but have no continued contact with her OB/GYN or mental health provider. Strengthening communication between all touchpoints in the maternal care journey is critical. Shared records, collaborative protocols, and interdisciplinary training can create a seamless support network for new parents.

4. Train Providers in Cultural Humility and Perinatal Mental Health

Training should go beyond screening tools—it must include culturally responsive communication, trauma-informed practices, and awareness of the unique challenges facing Black and Brown birthing people. At the same time, we must invest in building a more diverse workforce that reflects the communities being served. Representation builds trust, and trust improves outcomes.

5. Center Community Voice in Program and Policy Design

The people most affected by postpartum depression must have a central role in shaping the systems intended to support them. This includes actively involving mothers, doulas, peer leaders, and trusted community stakeholders in program development, public health messaging, and outcome evaluation. Their lived experiences are not only valid—they are vital to creating care that is responsive, respectful, and effective.

These recommendations are not just a summary of what we heard; they are an affirmation of what communities have long known. The path to equitable maternal mental health does not begin in a boardroom or clinical office—it begins by listening deeply to those who live the reality every day. Meaningful change will only come when their voices are not only heard but also lead.

CONCLUSION

Postpartum depression does not occur in a vacuum. It is shaped by the systems, relationships, and conditions that surround a mother—and too often, those systems fall short. In SPA 6, the mothers and providers we spoke to revealed a shared truth: while the clinical language of depression may be universal, the experience of it is deeply contextual, and the pathways to healing must be equally nuanced.

This study offers both a mirror and a roadmap. It reflects the barriers faced by so many—dismissed symptoms, siloed care, cultural disconnection—but it also highlights what's possible when care is community-informed, peer-supported, and culturally grounded.

We began this chapter with the story of a mother who left her appointment feeling unseen and unheard. While she is a composite of many voices, her journey represents something very real. What if she finally connected with a doula program that centered her story, validated her feelings, and gave her tools to heal? Everything changed. She would no longer be alone—and that could make all the difference.

Her story reminds us that healing is not only possible, but within reach—when we choose to build systems that listen.



Pictures from a holiday giveaway event

REFERENCES

Robertson, E., Grace, S., Wallington, T., & Stewart, D. E. (2004). Antenatal risk factors for postpartum depression: A synthesis of recent literature. General Hospital Psychiatry, 26(4), 289–295. https://doi.org/10.1016/j.genhosppsych.2004.02.006

Los Angeles County Department of Public Health. (2023). Service Planning Area (SPA) 6 profile: Community health indicators. http://publichealth.lacounty.gov/chs/spa/spa6.htm

Martin Luther King Jr. Community Healthcare. (2023). Community health needs assessment 2023. https://mlkch.org/community-health-needs-assessment

Los Angeles County Department of Public Health. (2016). Los Angeles Mommy and Baby (LAMB) Project 2016 survey. http://publichealth.lacounty.gov/mch/lamb

Black Maternal Health Center of Excellence. (n.d.). Home. https://www.bmhce.org/

SisterSong Women of Color Reproductive Justice Collective. (n.d.). What is reproductive justice? https://www.sistersong.net/reproductive-justice

Silverman, J. G., Decker, M. R., Reed, E., & Raj, A. (2006). Intimate partner violence around the time of pregnancy: Association with breastfeeding behavior. Journal of Women's Health, 15(8), 934–940. https://doi.org/10.1089/jwh.2006.15.934

Chung, E.K., McCollum, K.F., Elo, I.T., Lee, H.J., & Culhane, J.F. (2004). Maternal depressive symptoms and infant health practices among low-income women. Pediatrics, 113(6), e523–e529. https://doi.org/10.1542/peds.113.6.e523

Wisdom, J. P., McGee, M. G., Horner-Johnson, W., Michael, Y. L., Adams, E., & Berlin, M. (2010).

Health disparities between women with and without disabilities: a review of the research. Social work in public health, 25(3), 368–386. https://doi.org/10.1080/19371910903240969

Abrams, L. S., Dornig, K., & Curran, L. (2009). Barriers to service use for postpartum depression symptoms among low-income ethnic minority mothers in the United States. Qualitative Health Research, 19(4), 535–551. https://doi.org/10.1177/1049732309332794

Dagher, R. K., McGovern, P. M., & Dowd, B. E. (2014). Maternity leave duration and postpartum mental and physical health: Implications for leave policies. Journal of Health Politics, Policy and Law, 39(2), 369–416. https://doi.org/10.1215/03616878-2416247

Chatterji, P., & Markowitz, S. (2005). Does the length of maternity leave affect maternal health? Southern Economic Journal, 72(1), 16–41. https://doi.org/10.1002/j.2325-8012.2005.tb00686.x

18

A Biopsychosocial Analysis of the Relationship Between Food Insecurity and Mental Health in South Los Angeles

VANESSA PEÑA-GARCIA, MATTHIAS OJO, SHERIN LAJEVARDI, ETHAN LAWRENCE, NAIMA BATSON, SELOM STACEY GBEWONYO, ESINAM ATTIPOE, DARRIN S. WARD, DENISE WILLOUGHBY, ERIC GOMEZ

ABOUT THE COMMUNITY

Los Angeles is an economically diverse city where extreme wealth and financial hardship coexist. Los Angeles county is divided into eight service plannings areas (SPAs) which are geographic regions that are used for healthcare planning and resource distribution. Due to years of systemic racism and resource misallocation, significant inequities exist across the various SPAs. South Los Angeles, specifically service planning area 6 (SPA-6), is home to predominantly Black and Latinx communities, and has been marginalized and historically disinvested in, facing significant health inequities. Data from the 2017 LA County Key Indicators of Health Report showed concerning trends in SPA-6, including the second-highest rate of food insecurity among low-income households participating in the Supplemental Nutrition Assistance Program (SNAP), the highest prevalence of daily soda consumption among adults, the lowest consumption of fruits and vegetables, and the highest percentage of adults at risk for major depression within LA County. These findings may suggest a potential relationship between dietary practices and mental health in this community. One mechanism by which diet is linked with mental health is through the gut-brain axis. For example, research suggests a healthy gut microbiome, cultivated through a balanced diet, is linked to a positive mental well-being and robust immune system (Appleton, 2018). Part of our immune system resides in the gut, and inflammation due to an unhealthy diet, can lead to a disruption and imbalance of our normal, healthy bacteria which studies have shown to be associated with mental health disorders (Clapp, 2017). However, the biological mechanism of the gut-brain axis happens in a broader context, with social, political, and economic factors shaping people's diets.

Currently, food systems in the United States fail to provide equitable access to healthy food across all communities. This systemic inequity disproportionately affects low-income and often overlooked

neighborhoods like SPA-6. SPA-6 residents face a food swamp environment, an area with an abundance of unhealthy fast-food outlets and convenience stores, and food desert which has limited access to supermarkets and fresh produce vendors. This lack of access to healthy food, coupled with social determinants of health (SDOH) like racism, poverty, and redlining, have historically produced segregated communities, making it difficult to increase healthy food options for residents (Smith et al., 2021).

The goal of our project was to explore, through interviewing diverse community representatives, the multiple factors influencing the relationship between food and mental health. As medical students, we were interested also in the role of the gut-brain axis, given our biomedical training, however, based on our lived experiences and commitment to address the social determinants of health, our guiding framework is the biopsychosocial model. The gut brain axis is defined as the two-way complex connection between the gut bacteria and brain that is vital for homeostasis of the gastrointestinal and central nervous system through the biological networks of chemical transmitters and neuronal pathways (Morais, Schreiber IV, & Mazmanian, 2021). There is a significant relationship between food insecurity, malnutrition, and imbalance of the gut microbiome, which is associated with negative impacts on the gut-brain axis and thereby our mental health (Christian, 2020). As future physicians committed to health equity, we wanted to explore the connection between biological processes, such as the gut-brain axis and mental health, in the context of our local communities and the inequities they face. Therefore, we applied the biopsychosocial model (Papadimitriou, 2017) to guide our approach, allowing us to explore the connection of biological processes psychological health, and social determinants of health, such as access to healthy food. Figure 1 below illustrates a social ecological model, including the components of the biopsychosocial framework, with individual biology/gut-microbiome and mental health interconnected with multiple community and structural systems. This model highlights the micro and macro level factors in the ecology of food and mental health (i.e., depression), resonating with the ecological model of community psychology.

[ECOLOGY OF FOOD AND MENTAL HEALTH INFOGRAPHIC]

Figure 1 illustrates the Ecology of Food and Mental Health, a model parallel to the ecological model of community psychology. Created in https://BioRender.com.

The project focused on adults (ages 18-45) in SPA-6, in recognition of the need for further research on the impact of food insecurity on their mental health. At the root of food insecurity is often the inability to access healthy foods. "Food swamps" are defined as neighborhoods with a prevalence of unhealthy foods establishments selling ultra-processed foods, compared to food establishments with healthier choices including grocery stores with fresh produce (De França et al., 2024). South LA's food swamp environment is a potential risk factor for negative mental health, such as depression.

Biological Level

Current scientific literature suggests psychological and physiological connections to the food we eat and the biological foundations of the gut-brain axis (Berding et al., 2020; Doenyas et al., 2025; Patil & Mehdi, 2025). Unhealthy eating habits have direct negative consequences, affecting the gut microbiome, our stomach and natural intestinal environment, consisting of a delicate balance between different types of bacteria, and

potentially leading to other chronic diseases that may further deteriorate mental health (Vijay & Valdes, 2022). On the other hand, sustaining a healthy diet can do the opposite – stimulating several physiological and immunological mechanisms linked to increasing positive mental well-being.

Psychological Level

Ultimately, the complex relationship between biological mechanisms and diet goes beyond individual health choices. For example, the stress of living in a food desert, an area with a lack of access to fresh and healthy foods, struggling to obtain healthy food for oneself and one's family, can negatively impact mental health. This stress can also lead to a variety of unhealthy coping mechanisms, such as relying on fast and available, processed foods, which exacerbate the existing biological and psychological problems – creating a vicious cycle of stress, unhealthy food choices, an imbalanced gut microbiome, and negative mental health outcomes. Mental health is often influenced by numerous factors, including diet, access to healthcare, and environmental stressors. Recent research efforts have suggested that the gut-brain axis dysfunction may be involved in the pathophysiology of several mental health disorders such as depression, anxiety, schizophrenia, addiction, neurodegenerative diseases as well as age-related cognitive decline (Rogers et.al, 2016; Sherwin et.al, 2018). By recognizing that mental health cannot be separated from physical health, and viewing health through the lens of a biopsychosocial model, we can develop a more holistic approach to prevention and treatment of mental health.

Social Level

In addition to the biological and psychological levels of the biopsychosocial model, we must address the social level of the model and address the challenges of accessing not just healthy food but mental health services in South LA. Limited services, especially culturally responsive services, a lack of understanding about mental health, and stigma surrounding mental health, create significant barriers for individuals seeking and accessing support. Research shows concerning inequities in mental health access for Black and Latinx communities, highlighting the need for culturally and community responsive interventions (Alegría, Alvarez, Ishikawa, DiMarzio, & McPeck, 2016). Our project seeks to illuminate the impact of the flawed food system on mental health in South LA.

HOW WE CAME TO WORK WITH THIS COMMUNITY

As current medical students at Charles R. Drew University of Medicine and Science (CDU) located in South LA, some of us grew up in South LA, have family in the area, or grew up with lived experiences very similar to the neighborhoods in South LA. Our experiences with inequities further drive us to serve and address gaps impacting the communities in South LA. For example, one of our group member's experiences with health inequities like the ones the community of South LA faces, motivates them to practice as a physician in these communities. Due to growing up without medical insurance, they remember having to wait long hours at their local community clinic along with what felt like 'the entire city' because of the high volume of clients frequenting the clinic. Experiencing a lack of access to medical care, financial hardship, and knowing

that many other members of their community face the same struggles, they are motivated to address these societal issues as a future physician.

PROJECT DESCRIPTION

Our project is part of a larger medicine and society course that focuses on the social issues and inequities in medicine. Our team was composed of ten medical students, who combined their passion for nutrition, cooking, mental health, research, and commitment to health equity with our communities, to engage diverse local representatives in learning more about the biopsychosocial factors influencing the relationship between healthy food access and mental health.

METHODOLOGY

To capture a variety of perspectives within the communities of SPA-6, we interviewed the following categories of community representatives: (1) patients, family members, and community-based organizations/ advocates, (2) Healthcare providers and team members, and (3) government officials, researchers, and policy experts. Subsequently, this led to discussions on what organizations and/or individuals would best represent our topic and the communities of SPA-6. The community representatives included: a. a staff member from the Community Healing Center of the Los Angeles County Department of Public Health, b. a staff member from the Compton Community Garden, c. a university professor and community advocate, d. a manager from a community-based farmers market, e. a community member with a history of depression, f. a family medicine physician, g. a psychiatrist, h. a nutritionist, i. a government representative at CalFresh-California's Supplemental Nutrition Assistance Program, j. a California State Assembly representative, k. and a gut microbiome researcher. Our questions addressed the following key areas: 1. Perspectives or experiences with inequities in healthy food access and mental health, 2. Awareness or experiences with policies or interventions addressing healthy food access and mental health, 3. Perspectives or experiences with solutions to inequities in healthy food access and mental health. Additionally, we structured our questions to be relevant to the specific interviewee – community member, community advocate, policy maker, researcher, or healthcare professional. After conducting all interviews, we met as a team to analyze the transcripts of the interviews for key themes.

COMMUNITY NEEDS

Access to healthy food options in South LA is hindered by large "food deserts," in which there is a significant lack of access to fresh nutritious foods. Lack of access, on the other hand, can contribute notably to poor general well-being of the community, due to stress, anxiety, or depression. Furthermore, limited access to mental health resources in communities such as SPA-6 adds even more to the problem.

This factor further crystallized the urgency to bridge the gap between healthy food access and mental well-being. As future physicians, we are conscious of how health care providers have a significant role and responsibility to advocate for policies and programs that assure better access to healthy foods and mental health for particularly under-resourced communities, such as in South LA. Addressing community needs in South LA goes beyond increased food access. Increased funding of culturally responsive mental health

services and embedding them within existing primary care clinics may decrease the stigma and barriers to patients seeking and obtaining mental health support.

In other words, what is needed is collaboration between health professional groups, community organizations, and policy makers. Such interdisciplinary teams to help find solutions to this issue and provide healthy meals could include Chefs to End Hunger and programs offered through food reclamation under Senate Bill 1383. California Senate Bill 1383 is a climate law increasing statewide organic waste recycling and mandating businesses to donate surplus food instead of tossing it (Harrison et al., 2024). It is through such investments that communities experiencing food deserts will be in a better position to collaborate with health systems and organizations to address these complex needs.

COMMUNITY REPRESENTATIVES

With support from our course faculty and their networks we were able to connect with and interview eight community representatives. The community representatives included an NIH researcher, a psychiatrist, a family medicine physician, a dietician, a non-profit organization building sustainable food systems, a community garden representative, a community healing center, an LA county department of public health representative, a California state assembly representative, and a patient who previously received mental health services.

LEARNING FROM COMMUNITY REPRESENTATIVES – OUTCOMES AND IMPACT

Our thematic analyses of the diverse interviews yielded the following three key themes and associated subthemes: (1) food access and security (challenges and approaches to improvement), (2) the impact of food on health (community context and gut-brain axis), and (3) social determinants of health (structural racism and policy decision-making). The theme of food access and security is highlighted by the area of SPA-6 qualifying as a food desert, lacking readily available fresh produce options. The theme of food's impact on health is explored through the discussion of community context, and the gut-brain axis. Lastly, the theme of social determinants of health is related to the first two themes and also highlights the challenges of structural racism and policy decision-making.

Theme 1: Food Access and Security – Challenges and Approaches to Improvement

Challenges: A significant portion of our immune system resides in our gut-microbiome, and inflammation there can lead to an increase of pro-inflammatory cytokines, triggering an immune system response, which has been associated with mental health disorders (Clapp M, 2017). "Addictions, depression, mental health disorders are serious but treatable conditions, but treatable means having access to treatment", said the NIH researcher. As the quotes suggest, mental health conditions are treatable, but access to treatment is a significant barrier, especially for under-resourced communities. "In underserved populations, we know that the access to treatment on its own is very challenging. So it really becomes a catch-22 because you can possibly be in an environment that is already exposing you more to that". This quote highlights the "catch-22" faced by these populations: limited access to mental health treatment coexists with environmental

factors that increase the risk of mental health disorders. The NIH researcher emphasizes the first theme of food access and security through the challenges faced by underresourced communities in accessing treatment for mental health challenges. These challenges can then be exacerbated by the negative societal conditions already faced, such as limited healthy food options, creating a vicious cycle of lack of access and depression.

Our research aimed to capture the patient's perspective for insights into SPA-6 community health experiences. We interviewed a local resident who had completed a two-month therapy program following an assessment for Adverse Childhood Experiences (ACES). The patient emphasized how their neighborhood was considered a food desert, discussing the impact of fast-food availability versus grocery stores and the reliance on liquor stores for essentials. Although research shows a correlation between food insecurity and depression — with greater insecurity correlating with a higher likelihood of depression (Reeder et al., 2021) — the interviewed patient did not perceive a personal connection between their mental health and their dietary choices. However, the patient recognized how unhealthy food options contribute to higher health costs: "A lot of our community members rely on little markets… It's a reason why we don't have grocery stores. It contributes to paying higher medical bills." This interview emphasizes the theme of challenges with food access and security through discussing the prevalence of fast food and liquor stores over grocery stores.

Approaches to Improvement: Many of the barriers to connecting the community to these resources is partly due to the bureaucracy of either applying to federal financial support programs, like CalFresh, or signing up to be a vendor at the local Farmers' Markets. Their efforts have helped to alleviate much of this burden by aiding both parties with their respective applications. Additionally, Food Access LA has been working with the community by offering healthy cooking classes and delivery to community members who are physically unable to make it to the market, highlighting the theme of food access and security.

Collaborating with DPSS revealed the importance of community collaboration in tackling issues like food insecurity. The work DPSS does with its partner organizations demonstrates that addressing social challenges requires not just government efforts, but a broad, community-engaged approach that includes local agencies, educational institutions, and community organizations. DPSS has implemented collaborations with over 300 community-based organizations, colleges, food banks, and homeless shelters to further improve access and ensure that people in need are connected to the resources available to them. By working together, these groups create a network of support that ensures that vulnerable populations—such as low-income families, students, and the unhoused—can access resources like food assistance, underscoring the theme of food access and security as well.

Theme 2: The Impact of Food on Health – Community Context and Gut-Brain Axis

Community Context: The CDU professor spoke about her current battle against food insecurity in SPA-6 by partnering with local churches. She strives to make food access more participant-driven through the creation of community gardens where residents can grow produce for themselves, thus combating the food desert that many residents in SPA-6 experience. She explains "Community gardens empower the community; they let them know that they can make a difference in terms of health challenges they face. She explains, "communities that are medically underserved and face barriers to them living healthy lives, like

structural racism"," further reiterating, "If you don't have access to good foods to improve diet, health won't improve lots of grocery store vegetables have mold on them in these communities: how can you change your life and alter health outcomes if you don't have alternative choices to what's available to you." The interview with the CDU professor emphasizes the impact of activism at the grass roots level on community health. She also recognizes the detrimental impact of certain foods on illnesses that disproportionately impact SPA-6 residents. The interview indirectly highlighted the gut-brain axis by discussing the critical need for nutrient dense food to improve mental health and overall wellbeing through empowering local communities with food education and improved access.

Gut-Brain Axis: In addition, through an interview with a nutritionist, we gained further insight into the connection between the gut-brain axis as well as the state of food insecurity in communities like South LA. They highlighted the physiological and psychological effects of food insecurity, specifically how such factors lead to the development of chronic diseases such as reactive hypoglycemia, iron deficiency anemia, leptin resistance, obesity, and renal failure. Furthermore, they explained that over time, patients with such chronic diseases develop inflammatory states which have been linked to the development of mood disorders such as depression. This interview also underscored the effects of processed foods on mental health. They pointed out, "Many processed foods have inflammatory effects on the body. Processed foods often contain high levels of sugar, unhealthy fats, and salt, but also lack essential nutrients like vitamins, minerals, and fiber which can lead to mood disorders and depression." They further explained, "Consuming a diet high in processed foods can also disrupt the balance of gut microbiota, leading to inflammation and changes in neurotransmitter levels, which are associated with mood disorders." Overall, the interview further shed light on the complexity of the gut-brain axis and how its disruption can have significant consequences on a physiological, but also psychological level, highlighting the theme of the impact of food on health.

Theme 3: Social Determinants of Health – Addressing Structural Racism and Policy Decision-Making

Addressing Structural Racism: Gaining insights from a psychiatrist specializing in trauma, gave us critical insights into the indirect role of food insecurity on mental health, specifically in Black and Brown populations. They emphasized that "It's really about the whole food versus the processed foods, and unfortunately a lot of foods in the [U.S.] that are accessible, especially in communities that don't have a lot of resources, are processed foods". They ended the interview by stressing the importance of food education, access to healthy options through farmers markets/food pantries and combating structural racism in food systems, underscoring all three key themes and especially the root problem of structural racism.

In addition to grassroots efforts to tackle inequities in healthy food access, improving healthy food access and mental health necessitate addressing entrenched issues such as structural racism and redlining that have impacted marginalized communities for generations. The director of the Los Angeles County Department of Public Health emphasized that without significant strides in poverty alleviation, progress in combating food insecurity will remain limited. Creating public-private partnerships to increase access to healthy foods in underserved areas is essential to improving environmental justice, reducing neighborhood inequities, promoting healthy eating habits, and providing better healthcare (Hilmers et al., 2012). As was stated, we

must continue "lifting up community voices, supporting communities, having programs that come out of cities, counties that really have an equity lens, which is addressed to providing additional resources for communities that need them to help improve healthy food access".

Policy Decision-Making: Insights from the representative of the California State Assembly showed that "big grocers do not want to invest in the area because of its financial liability." They mentioned, "the cost to protect against crime and vandalism is not worth the investment." Moreover, their main agenda is gun control, impacting the attention needed to more directly address the issue of accessing healthy foods. At the same time, he understands the need for change in nutrition and food deserts. They focus on getting ghost guns off the street and making their district safer for constituents, highlighting the complexity of the theme of social determinants of health, particularly how other competing social priorities, such as gun violence, can influence decision-making around policy actions addressing food and health issues.

Regarding healthcare professionals' role in addressing food-related health inequities, the healthcare provider we interviewed emphasized the importance of community engagement, advocacy, and research. They underscored the significance of understanding community needs and involving stakeholders in decision-making processes to enact effective policies and interventions. There is a need for a multi-level approach involving decision-making by healthcare providers, community organizations, policymakers, and researchers to tackle food access inequities and promote better gastrointestinal health and overall well-being in under-resourced communities like SPA-6. Initiatives such as community gardens and educational programs can empower individuals and families to take actions to solve the community inequities affecting healthy food access.

LESSONS LEARNED

- The following are some main lessons learned: Addressing structural racism through collaborating with community stakeholders that specialize in different areas is a holistic approach to making a societal impact on under-resourced communities.
- An additional avenue to addressing food insecurity in South Los Angeles from a more macro level is to integrate nutritional education from an ecological lens and its relationship to mental health in the medical education of students.
- Patients and community residents should have access to education on how food and nutritional inequities affects mental health, particularly regarding the gut-brain axis, highlighting the detrimental impact of unhealthy/ultra processed food on mental health.
- Enhancing awareness about community-based resources, such as community gardens or farmer's markets or other ways to tackle systemic barriers to accessing healthy foods.
- There are significant challenges involved in organizing and sustaining a farmer's market including finding vendors, establishing vendors, and creating affordable prices.
- To create effective solutions, it is crucial to involve the community and leverage local knowledge and resources.

- As we reflect on the challenges people face in accessing basic necessities like food, we realize how critical it is for physicians to advocate for their patients beyond the clinical setting.
- Change needs to occur at the policy level to make a difference in the community, enhancing the medical perspective when decisions about patients are being made in ways that are grounded in the community.

LOOKING FORWARD

Looking forward, addressing mental health in communities like SPA-6, one that is considered both a food swamp and a food desert, will require leveraging community resources. Community leaders, those that oversee making key decisions for community members, must hold a space where all can convene and bring all aspects of the biopsychosocial model of mental health together. Leveraging health counselors and community health workers who come from the community and can connect community members with various resources is one way to provide culturally relevant support and facilitate access to healthy food choices and mental health services. In a study focused on addressing food insecurity in low-income adults with hypertension using a community health worker-delivered nutrition intervention, patients responded favorably to simplified nutrition guidance and educational materials using traffic light nutrition ranking where food is categorized into 3 color-coded categories: most healthy (green), medium healthy (yellow), or least healthy (red) food items based on national guidelines (Rivera et al., 2019; Gu et al., 2024). Similarly, one solution to addressing food insecurity and mental health is to provide nutritional education provided by community members who understand the context of their community.

Ultra-processed foods that are industrially processed and often pre-packaged, convenient, energy-dense, and nutrient-poor contribute to non-communicable diseases such as diabetes and cardiovascular disease and induce changes in the gut microbiome (Brichacek et al. 2024). On a macro level, there is a need for policymakers to revise dietary guidelines to limit ultra-processed foods and emphasize a wider variety of gut-friendly options. One way to increase access to gut-friendly foods is by encouraging policymakers to ensure that grocery stores known to promote more gut-friendly foods are intentionally placed in areas with the highest need for this type of food, including areas like SPA-6. This could help foster food policies that prioritize the health of vulnerable populations and can ultimately lead to improved mental health outcomes related to nutrition and diet. Furthermore, increasing research funding for microbiome-based interventions is vital for increasing our knowledge of the extent to which gut health impacts mental health. Microbiome-based interventions that inform dietary strategies can transform the landscape of mental health care for food-insecure populations. Finally, we should continue to honor the life-long work of scholars and community participants that emphasize the importance of investigating systemic injustices present in our food systems across the United States. This work highlights the critical need to understand the intersectionality of socioeconomic status, race, and geographic location to develop comprehensive interventions that specifically target the root of food insecurity and, ultimately, negative mental health outcomes. In a systematic review of 39 trials of evidence-based mental health interventions for under-resourced communities, the majority of trials found that community health worker-delivered interventions

reduced symptoms of depression by outreaching to facilitate entry into provider settings, providing auxiliary support through case management and promoting patient adherence, and providing lower levels of care to patients with less intensive needs (Barnett et al., 2018). Addressing the mental health component of the biopsychosocial model using community health workers is one way to address the comprehensive needs of individuals in SPA-6 and beyond. Further research should continue to explore barriers to health, which often include political and systemic aspects of health. By shedding light on multiple complexities, we can create and advocate for specialized policies that create healthier communities by alleviating food insecurity and promoting equity in mental health care.

RELEVANCE TO COMMUNITY PSYCHOLOGY

Community psychology focuses on how individual well-being is shaped by social, economic, cultural, political, and environmental influences within communities. This research project allowed us to see the individual, community, and structural factors that influence the relationship of food and mental health in the South Los Angeles community. The Ecology of Food and Mental Health model illustrated in Figure 1 aligns with community's psychology's holistic approach to health. Diet influences mental health through the gut-brain axis which is closely linked with stress, depression, and anxiety. Social determinants of health, including systemic barriers such as poverty and food deserts, compound biological and psychological factors. Community psychology's emphasis on community-driven solutions and advocacy are essential in addressing the complexities of the interactions between food insecurity, the gut-brain axis, and mental health.

On an individual level, access to healthy foods often begins with the ability to afford healthy meals. According to the U.S. Department of Agriculture's Food and Nutrition Service, 18 percent of people who are eligible for the Supplemental Nutrition Assistance Program are not participating (2018). One tangible way to be involved in the community is to partner with community-based organizations to support individuals with the CalFresh benefits application process. By partnering with grassroots efforts that see the needs of the community on a day-to-day basis, we can better understand the advocacy necessary at the neighborhood level, reflecting the community psychology goal of implementing and supporting policies that address individual and systemic challenges. Community gardens and farmer's markets are offering avenues for increased access to fresh and healthy produce. They are also empowering communities and individuals as seen by (Weight, 2023) students at California State University San Marcos, who after attending a course on food inequalities became more comfortable utilizing CalFresh services and the on campus food pantry, and providing culturally relevant foods, indirectly tackling macro-level forces of unjust food systems (Weight, 2023)

Overall, we need to enhance the collaboration amongst community members, physicians, community-based organizations, government agencies and healthcare systems to improve food security and access to healthy foods in under resourced communities. In addition, challenging traditional medical education to be more inclusive of the ecological contexts of community psychology would allow for a more multi-level holistic view of nutrition and mental health. Systemic change necessitates collaboration among different levels of community representatives and community residents to better understand the biological, psychological, and social factors shaping the access of healthy foods and mental well-being support.

REFERENCES

Alegría, M., Alvarez, K., Ishikawa, R. Z., DiMarzio, K., & McPeck, S. (2016). Removing obstacles to eliminating racial and ethnic disparities in behavioral health care. Health affairs, 35(6), 991-999.

Appleton J. The Gut-Brain Axis: Influence of Microbiota on Mood and Mental Health. Integr Med (Encinitas). 2018 Aug;17(4):28-32. PMID: 31043907; PMCID: PMC6469458.

Barnett, M. L., Gonzalez, A., Miranda, J., Chavira, D. A., & Lau, A. S. (2018). Mobilizing Community Health Workers to Address Mental Health Disparities for Underserved Populations: A Systematic Review. Administration and policy in mental health, 45(2), 195–211. https://doi.org/10.1007/s10488-017-0815-0

Berding, K., Vlckova, K., Marx, W., Schellekens, H., Stanton, C., Clarke, G., Jacka, F., Dinan, T. G., & Cryan, J. F. (2020). Diet and the Microbiota–Gut–Brain axis: sowing the seeds of good mental health. Advances in Nutrition, 12(4), 1239–1285. https://doi.org/10.1093/advances/nmaa181

Brichacek, A. L., Florkowski, M., Abiona, E., & Frank, K. M. (2024). Ultra-Processed Foods: A Narrative Review of the Impact on the Human Gut Microbiome and Variations in Classification Methods. Nutrients, 16(11), 1738. https://doi.org/10.3390/nu16111738

Christian VJ, Miller KR, Martindale RG. Food Insecurity, Malnutrition, and the Microbiome. Curr Nutr Rep. 2020 Dec;9(4):356-360. doi: 10.1007/s13668-020-00342-0. Epub 2020 Nov 10. PMID: 33170435; PMCID: PMC7653216.

Clapp M, Aurora N, Herrera L, Bhatia M, Wilen E, Wakefield S. Gut microbiota's effect on mental health: The gut-brain axis. Clin Pract. 2017 Sep 15;7(4):987. doi: 10.4081/cp.2017.987. PMID: 29071061; PMCID: PMC5641835.

Doenyas, C., Clarke, G., & Cserjési, R. (2025). Gut–brain axis and neuropsychiatric health: recent advances. Scientific Reports, 15(1), 3415. https://doi.org/10.1038/s41598-025-86858-3

França, F. C. O., Zandonadi, R. P., Moreira, I. M. A., da Silva, I. C. R., & Akutsu, R. C. C. A. (2024). Deserts, Swamps and Food Oases: Mapping around the Schools in Bahia, Brazil and Implications for Ensuring Food and Nutritional Security. Nutrients, 16(1), 156. https://doi.org/10.3390/nu16010156Góralczyk-Bińkowska, A., Szmajda-Krygier, D., & Kozłowska, E. (2022). The microbiota–gut–brain Axis in psychiatric disorders. International journal of molecular sciences, 23(19), 11245.

Gu, K. D., Cheng, J., Malone, A., Faulkner, K. C., Bejarano, O., Gelsomin, E., & Thorndike, A. N. (2024). Patient and Community Health Worker (CHW) Perspectives on a CHW-delivered Nutrition Intervention for Low-Income Adults with Hypertension: A Qualitative Study. Journal of primary care & community health, 15, 21501319241285855. https://doi.org/10.1177/21501319241285855

Harrison, B. P., McNeil, W. H., Dai, T., Campbell, J. E., & Scown, C. D. (2024). Site suitability and air pollution impacts of composting infrastructure for California's Organic Waste Diversion Law. Environmental Science & Technology, 58(45), 19913–19924. https://doi.org/10.1021/acs.est.4c06371

Hilmers A, Hilmers DC, Dave J. Neighborhood disparities in access to healthy foods and their effects on environmental justice. Am J Public Health. 2012 Sep;102(9):1644-54. doi: 10.2105/AJPH.2012.300865. Epub 2012 Jul 19. PMID: 22813465; PMCID: PMC3482049.

Larrivee, S., Greenway, F. L., & Johnson, W. D. (2015). A Statistical Analysis of a Traffic-Light Food Rating System to Promote Healthy Nutrition and Body Weight. Journal of diabetes science and technology, 9(6), 1336–1341. https://doi.org/10.1177/1932296815592408

Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. Key Indicators of Health by Service Planning Area; January 2017.

Morais, L. H., Schreiber IV, H. L., & Mazmanian, S. K. (2021). The gut microbiota–brain axis in behaviour and brain disorders. Nature Reviews Microbiology, 19(4), 241-255., Chicago,

Lucas, G. (2018). Gut thinking: the gut microbiome and mental health beyond the head. Microbial Ecology in Health and Disease, 29(2), 1548250. Papadimitriou, G. (2017). The" Biopsychosocial Model": 40 years of application in Psychiatry. Psychiatrike= Psychiatriki, 28(2), 107-110.

Patil, S., & Mehdi, S. S. (2025). The Gut-Brain Axis and Mental Health: How Diet Shapes our Cognitive and Emotional Well-Being. Cureus, 17(7), e88420. https://doi.org/10.7759/cureus.88420

Reaching those in need: Estimates of State SNAP participation rates in 2018. Food and Nutrition Service U.S. Department of Agriculture. https://www.fns.usda.gov/research/snap/reaching-those-need-estimates-state-2018

Reeder, N., Tolar-Peterson, T., Bailey, R. H., Cheng, W. H., & Evans, M. W., Jr (2022). Food Insecurity and Depression among US Adults: NHANES 2005-2016. Nutrients, 14(15), 3081. https://doi.org/10.3390/nu14153081

Rogers, G. B., Keating, D. J., Young, R. L., Wong, M. L., Licinio, J., & Wesselingh, S. (2016). From gut dysbiosis to altered brain function and mental illness: mechanisms and pathways. Molecular psychiatry, 21(6), 738-748.

Sherwin, E., Dinan, T. G., & Cryan, J. F. (2018). Recent developments in understanding the role of the gut microbiota in brain health and disease. Annals of the New York Academy of Sciences, 1420(1), 5-25.

Smith, L., Il Shin, J., McDermott, D., Jacob, L., Barnett, Y., López-Sánchez, G. F., … & Koyanagi, A. (2021). Association between food insecurity and depression among older adults from low-and middle-income countries. Depression and anxiety, 38(4), 439-446.

Vijay, A., & Valdes, A. M. (2022). Role of the gut microbiome in chronic diseases: a narrative. European journal of clinical nutrition, 76, 489-501.

19

Working Together: A Community Approach to Combat Pediatric Asthma in South Los Angeles

CHRIS ARGUETA, BERENICE ELIZARRARAZ, AKIRA FÉLIZ, AARIN HUFFMAN, CLARENCE SAMS,

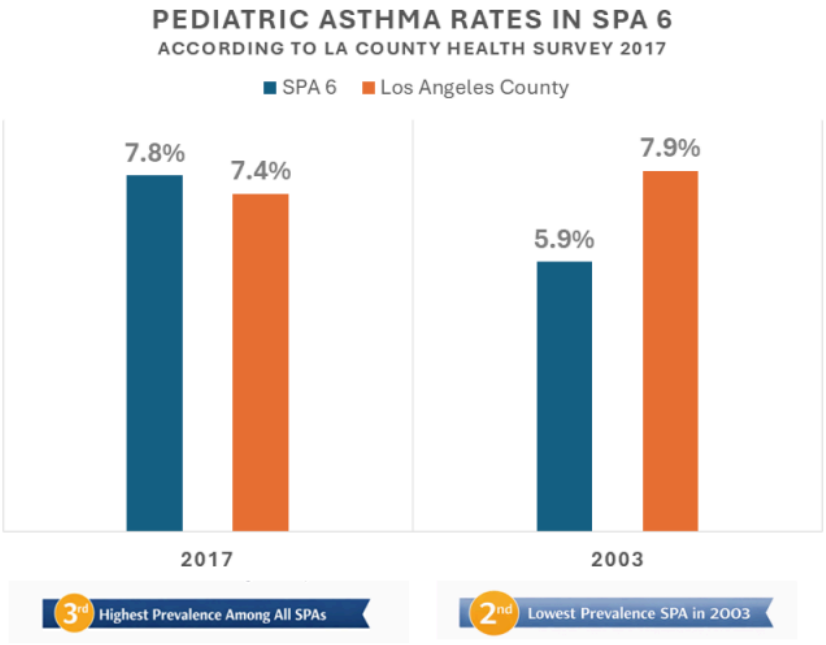
LILLY JIMOH, WANJIKU DYER, TOBENNA OBI, FATIMA AMIN, ERVA TATLILIOGLU

SUMMARY

This case study investigated the implementation of community-based participatory research methods to identify the key drivers and areas for improvement in addressing pediatric asthma disparities in the South Los Angeles Service Planning Area (SPA 6).

Background and Introduction to Pediatric Asthma in South Los Angeles

South Los Angeles, specifically Service Planning Area 6 (SPA 6), is a predominantly Black and Latino community facing significant health disparities and socioeconomic challenges. Over the years, SPA 6 has struggled with persistent health disparities such as higher rates of chronic diseases, including asthma, diabetes, and hypertension, which are all further exacerbated by limited access to care. The area's complex health landscape has been shaped by disparities arising from historical injustices and systemic racism. According to the Los Angeles County Health Survey 2017, SPA 6's pediatric asthma prevalence has risen to 7.8%, surpassing the LA County average of 7.4% and ranking as the third highest among all SPAs.[(1)] This increase is particularly striking given that in 2003, SPA 6 had the second-lowest prevalence of asthma among children ages 0–17 at 5.9%, compared to the LA County average of 7.9%. [(1)]



The rise in pediatric asthma prevalence cannot be discussed without examining the historical context of systemic racism and environmental injustices. Practices such as redlining, beginning in the 1930s, institutionalized racial segregation and economic inequality by formalizing racial bias in lending practices that impact communities to this day. This historical neglect has resulted in the following, but not limited to:

- *Environmental racism*: SPA 6 continues to be disproportionately impacted by pollution due to its proximity to busy highways.
- *Limited access to healthcare*: a decrease in investment has led to a shortage of medical facilities and access to specialists in the area.
- *Economic disparities*: the creation of wealth gaps through historical racisms has affected families' ability to afford preventative care and asthma management.

Anti-Black racism is also instrumental in shaping the current landscape of communities alike SPA 6. There are discriminatory practices in healthcare, education, and employment towards Black communities that create barriers to health equity. Similarly, xenophobia impacts immigrant communities, leading to reduced access to healthcare due to distrust, fear, and language barriers.

Despite these challenges, the community has demonstrated remarkable resilience. Local leaders, community organizations, and residents have worked tirelessly to advocate for improvements in healthcare, education, and social services, showcasing the strength and determination of SPA 6's population.

As medical students at Charles R Drew University of Medicine and Science, one of four Historically Black Colleges and Universities (HBCUs) in the country, we had the opportunity to learn about the health challenges faced by communities in South Los Angeles. Our diverse group of 10 students, representing a

variety of social and ethnic backgrounds, saw this project as an opportunity to help bridge the gap between medical education and community needs. We do so by applying our developing knowledge to explore the current disparities affecting SPA 6, particularly for the patients, families, and medical team impacted by pediatric asthma. By taking part in this community-based research, we sought to gain a robust understanding of health-related inequalities through collaboration with patients, their family members, community-based organizations, and healthcare workers. In addition, we sought to understand whether there was alignment in perspectives within the community regarding these disparities.

This research can serve as a valuable resource for healthcare providers, community-based organizations, and policymakers who are working to address the healthcare disparities surrounding pediatric asthma in communities such as SPA 6. Additionally, our research can serve as an example of the potential that physicians in training can have to elevate community health promotion through community-engaged research. We identified pediatric asthma as a crucial disparity, then synthesized published literature on pediatric asthma, and sought unique insight about this disparity from various community stakeholders. In doing so, our research offers a comprehensive overview of the challenges and opportunities in managing pediatric asthma in communities alike.

We highlight the key insights gained from the community, such as the importance of considering socioeconomic and environmental factors driven by systemic racism, with some examples being

- health education delivery,
- health literacy,
- air pollution,
- mold, and
- second-hand smoke.

We also emphasize key areas where our medical practice can improve in our service to diverse populations, such as addressing insurance barriers and improving access to specialized care.

The Focus on Pediatric Asthma: Rationale and Project Objectives

Several compelling factors drive our focus on pediatric asthma in SPA 6. The 27.7% increase in asthma prevalence since 2003 represents the largest percentage rise among all SPAs, signaling an urgent need for intervention.[1] Complications from pediatric asthma can be severe, including emergency treatments, hospitalizations, permanent lung function decline, missed school days, poor sleep, and limited participation in activities.[2] These complications are exacerbated by additional challenges faced in SPA 6. For example, the area has the highest percentage of children (15%) and adults (32.5%) reporting difficulty accessing medical care among all SPAs. (1)

Moreover, SPA 6 has the second-highest percentage (23.7%) of households with children regularly exposed to tobacco smoke, a known risk factor for asthma development and exacerbation. (1,2) The interplay between asthma and other respiratory conditions is also concerning. Research by the American Lung

Association indicates that people with asthma are at higher risk of developing pneumonia due to lung damage or weakness caused by asthma. (2) This is particularly alarming given that SPA 6 has the highest pneumonia/influenza mortality rate (31.1 per 100,000) among all SPAs. (1)

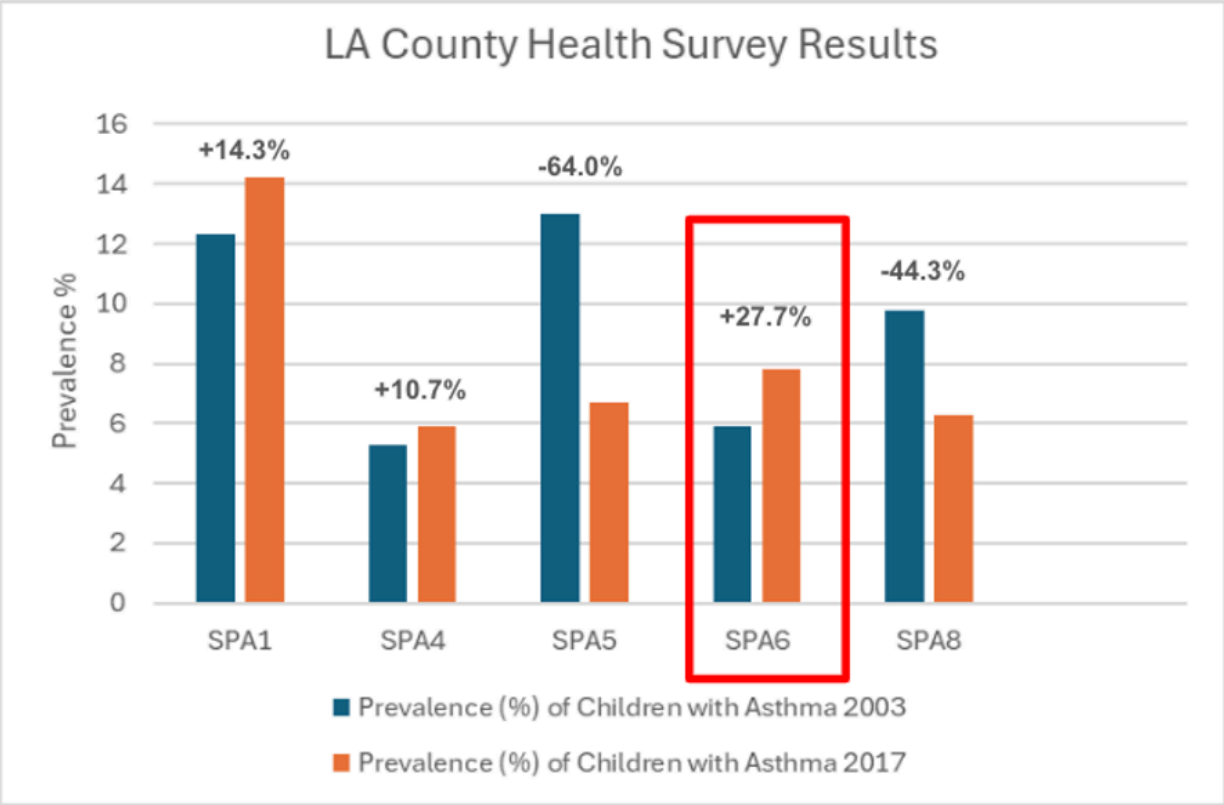


Figure 1: LA County Health Survey Results (2003 and 2017)

Our project aims to explore the drivers and sentiments surrounding the rising pediatric asthma prevalence in SPA 6. After investigating the intertwining of environmental risks, such as air quality, with limited healthcare access, we sought to paint a comprehensive picture of the challenges faced by this community. Our goal was to highlight the importance of continued community-focused research and provide community-based recommendations to address this growing health concern. Through this project, we aspire to contribute to the development of targeted public health interventions and robust support systems that can mitigate these growing health disparities. By focusing on pediatric asthma, we hope to catalyze positive changes that will improve the overall health and well-being of children and families in SPA 6.

Research Study Methods

Study Design and Participants

This study employed a multi-stakeholder approach to investigate pediatric asthma prevalence in SPA 6 of Los Angeles County. We conducted focused video interviews with four distinct groups: patients and caregivers, healthcare providers, community-based organizations (CBOs), and policymakers. We intentionally sought out participants from these four distinct groups in an attempt to gain a well-rounded

perspective of pediatric asthma. Methods for stakeholder selection were designed to allow for focused one-on-one interviews, ensuring that participants could provide in-depth, relevant insights into the pediatric asthma landscape in SPA 6.

Participant Selection

Patients and Caregivers: Eligible participants included primary caregivers of children aged 5 to 17 years with a known history of asthma residing in SPA 6 or from low socioeconomic status (SES) backgrounds. This age range was chosen to focus on school-aged children and adolescents with asthma who would be representative of the same age range and asthma diagnosis identified in the LA County Health Survey. (1)



Patient, Caregiver, Healthcare Provider

Healthcare Providers: We recruited healthcare providers based on their specialized knowledge in pediatrics, pulmonology, or asthma management. Additionally, providers were selected for their personal or professional affiliations within SPA 6, ensuring familiarity with the unique health challenges of the area.



CBO and Policymakers

Community-Based Organizations and Policymakers: CBOs were identified and selected based on their proactive efforts in environmental and health initiatives specifically tailored to alleviate conditions such as asthma within marginalized communities like SPA. The CBO selection process involved a review of the organization's track record with health advocacy and demonstration of community engagement with previous projects addressing the needs of communities alike SPA 6. Policymakers with influence over health and environmental policies affecting SPA 6 were also included in the study. It is important to recognize the role of policymakers with influence over health and environmental policies affecting SPA 6. Their inclusion is instrumental in bridging the gap between research outcomes and policy implementation based on outcomes.

Data Collection

Interviews were conducted and transcribed via Zoom and Microsoft Teams over three months from December 2023 to February 2024. Zoom and Microsoft Teams were used specifically to be accommodating to participants who may not have had the ability or additional time to conduct an in-person interview. Our stage of training in medicine was explained to all participants, along with a mention to participants on how the mission of our medical program entails helping serve our SPA 6 community and communities alike.

A semi-structured interview guide was developed, featuring open-ended questions in layman's terms to reach all levels of health literacy, organized around key domains relevant to pediatric asthma in South Los Angeles. To ensure a diversity of curiosity in the interviews, all 10 medical students contributed questions of interest toward an interview guide covering themes such as community health challenges, environmental factors, healthcare access, and potential interventions. Each medical student was then assigned to interview a community stakeholder and accordingly tailor their questions to each interviewee's occupation, experience and expertise. Interview durations ranged from 30 minutes to 1.5 hours, allowing for in-depth exploration of participants' perspectives and experiences. This approach provided flexibility to delve into emerging topics while ensuring consistency across interviews. This multi-faceted approach, coupled with focused interview techniques, allowed us to gather comprehensive and targeted insights from various perspectives, providing a holistic understanding of the pediatric asthma landscape in SPA 6.

Ethical Considerations

No Institutional Review Board (IRB) approval was required. Verbal consent was obtained before participant interviews, with the study's nature thoroughly explained to selected participants; pseudo-names for patients are used throughout the paper.

A Community-Engaged Approach Allowed for Community-Specific Recommendations



Community-Engaged Approach

In addressing the rising prevalence of pediatric asthma in Service Planning Area (SPA) 6 of Los Angeles County, a community-engaged approach is crucial, as it has a patient-centered and community approach to

address certain health disparities. Moreover, given the unique demographic composition of SPA 6, with its predominantly Hispanic and African American population, culturally tailored interventions are essential for effective asthma management and prevention.

Our research team spoke to local healthcare providers, community residents such as caregivers of pediatric patients, pediatricians, policymakers, and community-based organizations, to grow a more comprehensive framework on the multifaceted factors contributing to asthma disparities in SPA 6. By engaging community members in the interview component of our research, we were able to determine pertinent themes that can be used to create actionable plans. For example, lack of parental education, environmental triggers, and economic barriers, all of which ensured that our interventions are relevant and wanted within SPA 6.

This community-engaged framework allowed us to combine academic expertise with community wisdom, ultimately working towards reducing asthma-related health disparities and improving overall respiratory health in this vulnerable population. parental education, environmental triggers such as smog, and economic barriers.

Community Stakeholders Interviewed

Patients and Caregivers

Pediatric Asthma Patients and Their Caregivers:

- 13-year-old James* and mother, Linda*
- 8-year-old Cori* and foster mother, Taylor*
- 12-year-old Nick* and mother, Olivia*

* pseudo-name

Healthcare Providers

Physicians:

- Pediatrician
- Internist
- Pediatric Pulmonologist

Other Healthcare Professionals:

- Pediatric Physician Assistant
- Registered Nurse

Community-Based Organizations and Policy Makers

- Healthy African American Families (HAAF)
- Air Quality District Manager

Outcomes, Impacts, Challenges, and Future Directions from Multiple Perspectives Within SPA 6

The following interviews and discussions highlight a complex web of challenges in managing pediatric asthma within SPA 6. To address these issues effectively, solutions must be multifaceted and consider the perspectives of physicians, patients, and community-based organizations (CBOs).

Families Want Improved Emotional Support, Health Education, and Healthcare Access

The experience of managing pediatric asthma, as shared by patient James and his mother Linda, highlighted the multifaceted challenges faced by families in underserved communities. Difficulties in managing pediatric asthma illuminated a significant need for comprehensive guidance for families managing chronic diseases. Linda's reliance on internet resources for asthma management underscores the gap in accessible and comprehensive healthcare support.

The following are simulated readings of the quoted paragraphs below. Click [Play] to begin, and [Pause] to stop at any time.



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3462#audio-3462-1

"We learned everything on the internet ourselves and tried to help our child that way."

Linda recounted, reflecting on their determination despite the lack of formal guidance. The psychological toll on the family was evident when Linda shared:



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3462#audio-3462-2

"It was hard for us to see our child like that, but we tried to stand strong next to him; we had no other choice. It's psychologically challenging to see your child like that; it hurts your heart, and you can't do anything."

Linda further expressed a poignant wish:



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3462#audio-3462-3

"We did not receive any guidance; we wish there were such an opportunity. It would have helped us a lot in this journey; we felt very alone. We learned everything and explained it to our child. We think there should be special guidance for children and families with chronic diseases."

This project emphasizes the importance of comprehensive healthcare support and education for families dealing with pediatric asthma. It highlights the critical need for improved access to healthcare services, educational resources, and community support.

Our interview with Taylor, a 43-year-old foster mother of 8-year-old Cori with asthma, provided further valuable insights into the challenges and experiences of managing pediatric asthma in South LA's SPA 6 region. Taylor's candid reflection on managing asthma attacks exemplifies the emotional toll on caregivers:



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3462#audio-3462-4

"Well, they are pretty scary because I don't know what to do. I just feel like, oh, my God, what if he stops breathing or what if I'm not doing something correctly? Or what if the medication stops working? Those are my worries. Because it's so new to us, but I try to take charge and not to freak out and just give it to him."

This quote highlights the constant fear and uncertainty caregivers face, while also demonstrating their resilience and determination. The interview also revealed how caregivers can gain new insights during such discussions, as evidenced by Taylor's realization about school air quality:



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3462#audio-3462-5

"We may have, now that you mentioned, I am going to check with the school, see what their air conditioning looks like, if they have filtration, or how often they clean it."

This exchange underscores the need for better communication of asthma-related policies and practices to affected families. The conversation touched on various aspects of asthma management in SPA 6, including environmental challenges like proximity to freeways and smog exposure, accessibility of medications, and the availability of asthma information for families. This comprehensive discussion served as a reminder of the complex interplay between healthcare, environment, and policy in managing pediatric asthma, particularly in underserved areas like SPA 6.

Olivia, mother of 12-year-old Nick, also provided unique insights into difficulties managing pediatric asthma in South LA. Diagnosed in 2018, Nick's asthma symptoms worsened during a brief stay in Las Vegas, highlighting the impact of environmental factors on his condition. While Olivia feels comfortable managing her son's asthma, she expressed significant frustration with the current inhaler system. She stated:



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3462#audio-3462-6

"I don't think they (inhalers) are that good because it's 200 pumps and once you're out of that, like you have to wait a long time. You know, probably a month just to get a new one. So, I mean, that's the only downfall I see."

This limitation in medication availability poses a serious challenge to consistent asthma management. The interview also touched on other factors influencing Nick's condition, including his weight, participation in soccer, and the crucial role of Medi-Cal in providing access to inhalers. The discussion highlighted the complex interplay between environmental conditions, healthcare access, and individual health factors in managing pediatric asthma, emphasizing the need for more comprehensive and accessible asthma care solutions.

The discussion also touched on other determinants of Nick's health, including his weight, participation in soccer, and the crucial role of Medi-Cal in providing access to inhalers. These factors illustrate how an interplay of individual health, environmental conditions, and systemic healthcare policies influences pediatric asthma management. Addressing these issues requires a shift from placing responsibility solely on caregivers to advocating for institutional accountability, including insurance reforms, increased funding for healthcare infrastructure, and improved access to medication.



Healthcare Equity and Policy Reform

By framing these findings through a systemic lens, this project contributes to a broader discourse on healthcare equity and policy reform. Rather than focusing exclusively on parental education as a solution, these insights highlight the need for transformative change through community engagement, policy advocacy, and institutional accountability. Expanding Medicaid coverage, improving access to preventive care, and integrating asthma education into public school curricula are necessary steps toward dismantling the systemic inequities that perpetuate healthcare disparities in underserved communities. This project not only informs practical interventions but also can serve as a foundation for policy advocacy aimed at achieving long-term, structural change in pediatric asthma management.

Challenges and Future Directions for Patients

An identified challenge from a patient perspective is improving comprehensive healthcare coverage, access to specialty care, and health education for pediatric patients with asthma. As Linda expressed, the lack of guidance and support can leave families feeling alone and reliant on internet resources.

Future Directions

TOPIC	DESCRIPTION
Expand Insurance Coverage	Include pulmonary or allergy specialists in insurance coverage protocols to ensure that chronic conditions such as asthma are appropriately managed without insurance serving as a barrier to care. As Olivia noted, the limitations and delays in obtaining inhaler refills pose a significant challenge.
Streamline Specialist Access	Eliminating patient medical insurance preauthorization for specialist visits can improve management of the disease in SPA 6. Also, asthma medication preauthorizations or limits on medication refills can be eased to support disease management.
Increase Specialty Care Centers	Addressing asthma disease underdiagnosis and high emergency department visits for respiratory distress by increasing specialty pediatric pulmonary centers in SPA 6 can be helpful. Increasing federal or state funding for building more specialty centers in SPA 6 and increasing Medi-Cal reimbursement rates can attract more specialists to the area.
Enhance Patient Education	Improving asthma health education by providers distributing asthma disease bulletins to their patients or directing them to asthma educational workshops can relieve disease burden and help manage disease triggers.

Healthcare Providers Face Significant Systemic Challenges in the Management of Asthma and Patient Education

Difficulties in the management of asthma were highlighted by several healthcare providers, including a pediatric pulmonologist at UCLA Health, who illuminated the significant challenges in managing asthma among young patients, particularly regarding medication accessibility and insurance barriers. She emphasized the critical need for age-appropriate medications, noting that many children are discharged on inhalers they cannot effectively use, stating:



Flexhaler

"They were discharged on inhalers they can't use because it's like a dry powder inhaler for a 2-year-old, like on a flex-haler.

They have to follow commands and deep inhale, and it's way different because there are only a few inhalers kids can use."

This highlights the disconnect between prescribed treatments and the actual capabilities of young patients, which can compromise their asthma management.

Additionally, she pointed out that insurance companies often fail to consider age-specific needs when approving medications, leading to delays in care. For instance, while common inhalers like Proair are covered by most insurances, their usage requirements can be challenging for toddlers. Furthermore, she emphasized disparities in access to pediatric pulmonology care, as many families in SPA 6 face significant barriers due to the lack of nearby specialty clinics, including none specifically in SPA 6. The doctor's insights underscore the urgent need for systemic changes to ensure that all children receive appropriate asthma care and support tailored to their developmental stages.

Additionally, a pediatrician and CDU College of Medicine faculty member highlighted the multifaceted challenges in managing pediatric asthma in South Los Angeles. These included complex environmental factors, care coordination, parental education, systemic barriers to healthcare access, medication availability and affordability, health literacy, and addressing biases and ethical issues. This pediatrician emphasized the critical role of parental engagement, stating:



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3462#audio-3462-7

"A lot of it is just frequent reminders to parents, but it's vital they grasp their role in managing childhood asthma. Parental education and support are crucial for implementing treatment plans and recognizing early signs of exacerbations. With open communication and support, healthcare providers can empower parents to monitor and control their child's asthma effectively."

This underscores the importance of ongoing support and tailored educational interventions. The challenges extend to systemic issues such as transportation difficulties, limited clinic hours, and socioeconomic disparities that disproportionately affect underserved communities. Addressing these complex issues requires a comprehensive approach involving improvements in healthcare infrastructure, enhanced patient education, and community engagement to ensure equitable and effective asthma management for all children in the area.

A Pediatric Physician Assistant (PA) provided further insights into various systemic difficulties of pediatric asthma management, centered around environmental factors, social determinants of health, and the often-overlooked role of nutrition. While acknowledging the potential benefits of a diet rich in vegetables, fruits, and seeds for children with asthma, she highlighted that current clinical practice primarily emphasizes symptom control through medication and environmental management. She stated:



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3462#audio-3462-8

"… So, we classify their asthma severity as either intermittent or mild, moderate, or severe, right? And then based on the classification, we follow asthma guidelines. So again, you can see that the focus is on management, right? As opposed to nutrition per se…"

This perspective underscores the disparity between symptom management and nutritional considerations

in asthma care. Importantly, an improved diet can decrease obesity, a known risk factor for childhood asthma, and in children with asthma, obesity increases asthma severity and morbidity. Despite this connection, nutrition often receives less attention compared to factors like environmental or chemical exposures. The discussion also touched on promoting healthy eating habits in under-resourced areas, medication use, and the potential benefits of breastfeeding in asthma prevention. The PA observation that medicine tends to be more reactive than proactive highlights the need for a more holistic approach to patient care, integrating nutrition, lifestyle improvements, enhanced access to care, better air quality, and sound policy implementation to elevate the standard of care for pediatric asthma patients, particularly in underserved areas like SPA 6.



Healthcare Providers Role

Healthcare providers play a crucial role in managing asthma, especially in communities with lower socioeconomic status, where economic barriers can significantly exacerbate health risks. A nurse at Torrance Memorial explored various aspects of asthma management, including the challenges posed by documentation barriers for health insurance, state funding issues, and the importance of educational initiatives. The nurse poignantly emphasized the need to identify and avoid triggers, stating:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3462#audio-3462-9

"When it comes to patients who deal with asthma, the most important thing is to be able to identify triggers and then take steps to stay away from said triggers. Patients run into issues when they come across their triggers often, or they are ultimately not able to avoid them."

This insight resonated deeply, highlighting how critical it is for patients to recognize their specific triggers to improve their quality of life. The conversation also shed light on the profound impact of environmental factors, particularly pollution, on respiratory health and underscored the necessity of robust electronic documentation systems to enhance patient care. Community outreach programs and the vital role of case managers in supporting asthma patients were discussed, alongside the inherent challenges in accurately diagnosing asthma and differentiating it from other respiratory conditions. Ultimately, this interview reinforced the complexity of asthma management and the urgent need for a comprehensive

approach that integrates patient education, environmental awareness, and effective healthcare systems to foster better outcomes for those living with asthma.

Lastly, an Internal Medicine physician at UCLA Medical Center provided valuable insights into systemic challenges and opportunities in managing pediatric asthma, particularly in underserved areas like SPA 6. He emphasized the critical importance of health education and proper medication adherence, illustrating this with a tragic case involving a young relative of a patient who relied solely on short-acting medication for their severe asthma, leading to an unfortunate fatal outcome. He stated:



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3462#audio-3462-10

"She was underestimating how severe this was and was only taking the albuterol and totally relying on that, and had a bad attack. It didn't do the job, and she ended up passing away. So I think it has been a challenge."

This heartbreaking example underscores the need for comprehensive patient education, especially regarding long-acting medications, as he noted:



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3462#audio-3462-11

"I think human beings in general just don't like to take medicine every day if they feel good."

Additionally, he raised concerns about the potential underestimation of asthma prevalence in SPA 6 due to limited access to care and formal diagnoses, drawing a parallel with autism rates. He emphasized the necessity for children in these areas to receive proper care, stating:

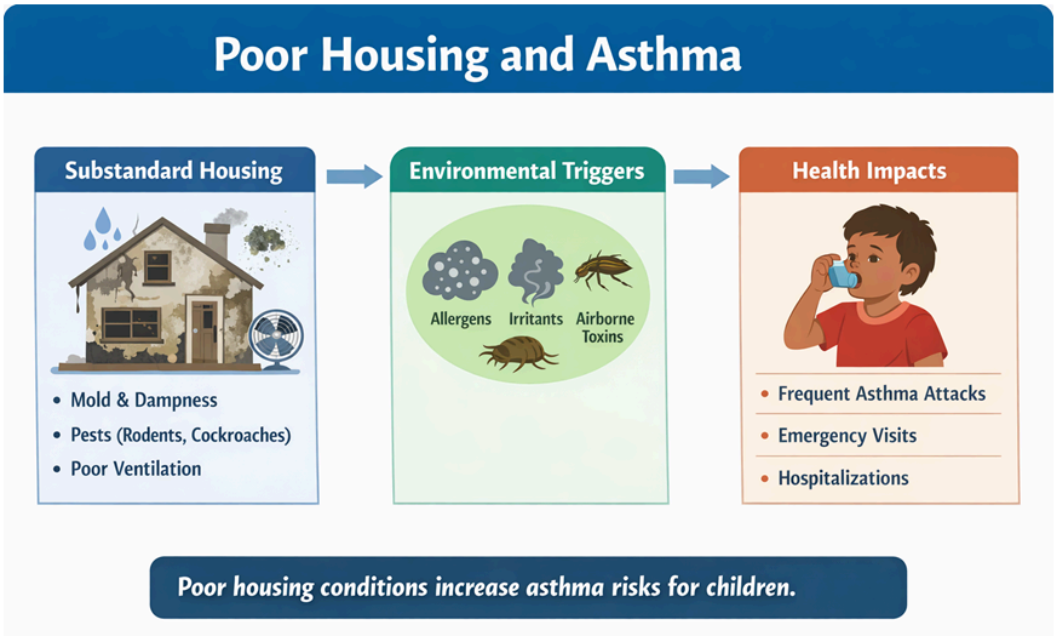


One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=3462#audio-3462-12

"One thing is to make sure that they're actually seeing these kids and seeing doctors that are attuned to the diagnosis

of this, because, for example, autism rates, if you look at straight diagnosis, they are much higher in affluent areas, but likely because the parents are very diligent about going to get their kids evaluated."

This observation highlights the importance of improving access to care and ensuring physicians in SPA 6 are attuned to diagnosing asthma in pediatric patients. Furthermore, he discussed the role physicians can play as patient advocates by addressing environmental risk factors for asthma through communication with landlords and involving social workers to enhance living conditions, which can sometimes be more impactful than prescriptions alone.



Challenges and Future Directions for Healthcare Providers

A significant challenge faced by physicians in SPA 6 is knowing how to become more attuned to the diagnosis of asthma in pediatric patients, especially given the limited access to care in the area. Meticulous physician training in asthma disease is therefore integral and needed in SPA 6. As a UCLA internal medicine physician mentioned, the potential underestimation of asthma prevalence due to limited access to care is a serious concern.

Future Directions

TOPIC	DESCRIPTION
Integrate Local Health Data into Training	Educate every physician in training on the LA County Health Survey results to understand the most pertinent health disparities faced in the community they are serving. Incorporate LA Health County Survey results into annual training at LA County medical centers to reinforce awareness of disparities faced in SPAs.
Improve Early Detection Skills	Effectively train physicians who practice in SPA 6 on knowing how to identify early disease manifestation and symptoms. Implement thorough training during pediatric, internal medicine, or family medicine residency years.
Reduce Disease Sequelae	An increase in efficient diagnosis of asthma symptoms can potentially decrease rates of disease sequelae such as pneumonia in children.

Community-Based Organizations Are Making Continued Efforts to Address This Disparity

Pediatric asthma does not appear to be a silent issue, as community-based programs such as Healthy African American Families (HAAF) are making proactive efforts to address such disparities (for additional info HAAF Project – PMC). HAAF highlighted the critical role community-based organizations play in addressing asthma in underserved areas like SPA 6. She emphasized the importance of community-driven research and education initiatives, stating:

"It's more partner-driven, meaning everyone has a voice at the table from the initial start of a thought, and the idea, and they're engaged all the way throughout a project to the end of the project."

This quote underscores the empowering nature of involving the community in health initiatives, fostering a sense of ownership and collaboration. HAAF focuses on tailored support to meet the unique needs of these communities, offering workshops to raise awareness about asthma triggers and management while advocating for improved environmental conditions and healthcare resources. In 2018, HAAF implemented an asthma education program across 25 charter schools to equip children with essential knowledge about inhaler usage, which is vital for reducing exacerbations in socioeconomically disadvantaged communities. Her insights reflect a broader understanding that effective asthma management requires genuine collaboration between communities and researchers to address health disparities, ultimately enhancing self-efficacy among asthma patients and leading to better health outcomes.

Additionally, a District Manager from the South Coast Air Quality Management District (AQMD) provided valuable efforts from their end, including insights into the environmental determinants of air quality in South Los Angeles, particularly regarding asthma management. Alatorre emphasized the significant impact of vehicle emissions on children's asthma, especially in areas with heavy traffic, such as routes near the 710 freeway. To combat this issue, the AQMD has implemented various incentive programs aimed at reducing emissions, including the "Replace Your Ride" initiative, which encourages the adoption of cleaner vehicles. In discussing additional programs aimed at prevention and reducing asthma exacerbations, he noted:

"Actually, it's a very good program for schools; we are replacing HEPA filters inside classrooms, especially in SPA 6 communities, when there's a lot of pollution. So at least when the kids are inside the classroom, they're breathing cleaner air."

This initiative highlights the AQMD's commitment to improving air quality in educational settings, ensuring that children have a healthier environment while learning. Additionally, Alatorre's insights broaden the discussion to include everyday sources of pollution and their direct linkage to health outcomes like asthma, suggesting new avenues for research into these impacts. Overall, his emphasis on community initiatives and cleaner technologies reflects a multifaceted strategy to enhance air quality and address asthma in underserved areas like South Los Angeles.

Challenges and Future Directions for Community-Based Organizations

Community-based organizations are faced with the challenge of currently requiring more funding to significantly enhance the distribution of health educational resources and programs in underserved areas like SPA 6. As HAAF emphasized, community-driven initiatives are crucial for addressing health disparities.

Future Directions

TOPIC	DESCRIPTION
Expand Community Service Block Grants	Expanding the allocation of Community Service Block Grant (CSBG) to organizations like Healthy African American Families (HAAF) can improve the distribution of health education resources in SPA 6.
Create Federal Grants	Create more federal grants to fund health organizations that serve low-resourced areas like SPA 6.
Lobby Local Government	Engaging in lobbying efforts of local government to increase funding of CBOs focused on community health education and support can ameliorate health disparities. In areas like SPA 6, where funding is scarce, funding CBOs is imperative for the future health of local communities.
Advocate for Systemic Change	Restructuring at the federal level would be required for real change to occur in our healthcare system, and CBOs can aid in this change. Whether it is creating universal healthcare or changing the allocation of public healthcare funds, a need for increase in public healthcare funding is necessary to provide more access in communities that are underserved, like SPA 6.
Address Systemic Barriers	CBOs could also advocate or lobby for structural change through the Department of Health and Human Services to lessen systemic barriers that exist because of the privatization of our healthcare system.
Collaborate with Environmental Agencies	CBOs may additionally collaborate with the Environmental Protection Agency to establish stringent environmental regulations in areas with increased air pollution rates. As AQMD mentioned, addressing environmental factors is critical for asthma management.

By addressing these challenges through collaborative, multi-faceted strategies, it is possible to significantly improve the lives of children with asthma and their families in SPA 6.

There is Optimism in Addressing and Closing the Pediatric Asthma Disparity in SPA 6



Smog and Pollution – 710 Freeway

Our research on pediatric asthma prevalence in Service Planning Area (SPA) 6, South Los Angeles, revealed critical insights into how socioeconomic and environmental factors intertwine to exacerbate health disparities in this underserved community. For example, despite ongoing efforts to reduce emissions in Southern California, regions like SPA 6 remain highly vulnerable due to persistent smog and pollution, particularly in areas with heavy traffic, such as the vicinity of the 710 freeway (3). The connection between air pollution and increased asthma rates underscores the need for stringent environmental regulations and proactive measures to protect vulnerable populations. The role of community-based organizations like HAAF has now been highlighted as essential in this context. These organizations not only provide critical education on asthma management but also play a pivotal role in empowering communities by addressing the social determinants of health that contribute to asthma exacerbations. (4) The educational programs implemented by HAAF, such as those focusing on proper inhaler use, are particularly valuable in reducing emergency department visits and improving long-term health outcomes in communities where healthcare access is often limited.

Moreover, our research illuminated the pervasive challenges in healthcare access and the broader implications of social determinants for pediatric asthma management. Interviews with medical doctors, such as a Pediatrician at Kaiser Permanente and an Internist at UCLA Medical Center, revealed systemic barriers that continue to impede effective asthma care. These include limited clinic hours, transportation difficulties, and the affordability of medications, all of which disproportionately affect low-income families in SPA 6. These barriers underscore the critical need for a comprehensive approach to healthcare that not only focuses on medical treatment but also addresses the underlying social and economic factors contributing to health disparities. Furthermore, the issue of under-diagnosis in these communities suggests that the true prevalence of pediatric asthma may be higher than reported, particularly in areas with limited access to healthcare. This insight is vital as it emphasizes the need for improved diagnostic services and more proactive healthcare interventions in underserved areas.

The lessons learned from our research highlight the importance of integrating healthcare with policy advocacy and community engagement. Effective asthma management in communities like SPA 6 requires a multifaceted approach that includes stricter environmental policies to reduce exposure to pollutants, better access to healthcare services, and ongoing community education to empower families to manage asthma effectively. However, reflecting on the research process, it is important to critically evaluate whether power imbalances between researchers and community members were sufficiently addressed and whether the project incorporated cultural humility and systemic accountability throughout its implementation. To ensure systemic accountability and cultural humility, future iterations of the project should prioritize community

leadership in decision-making. This can include engaging community leaders as co-researchers, ensuring they have equal influence over project design, implementation, and evaluation. Feedback mechanisms should be formalized to allow community members and partners to voice concerns and provide input throughout the research process.

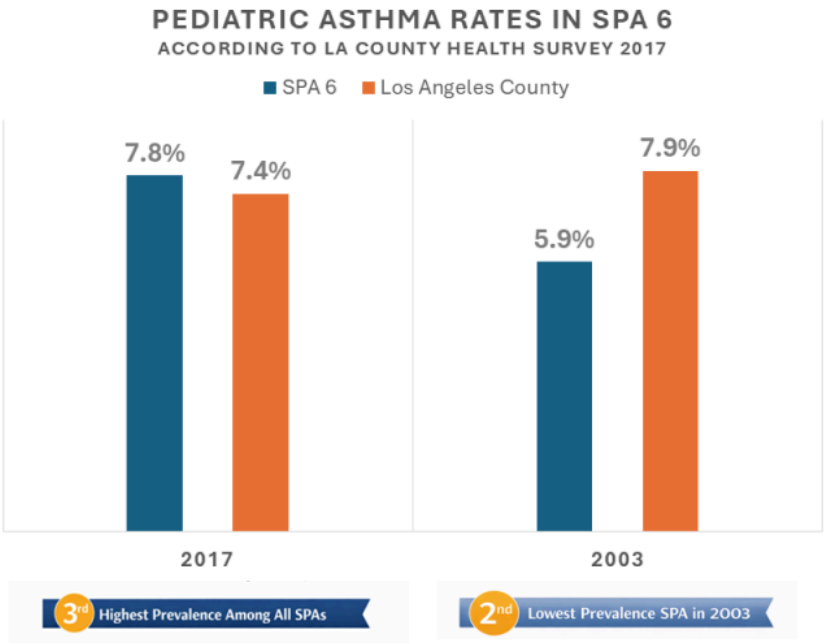


Policy Advocacy and Community Engagement

Specific strategies to make the project more community-led and explicitly anti-oppressive include recruiting community members to leadership roles to ensure the research reflects their priorities, establishing continuous feedback mechanisms like surveys and town hall meetings, and addressing systemic issues such as housing quality and pollution through collaboration with policymakers. Tailoring educational programs to the cultural and linguistic needs of SPA 6 residents with trusted local organizations can further enhance participation and impact. Additionally, integrating nutritional counseling into asthma management could be an underutilized strategy that may offer significant benefits, especially in terms of reducing inflammation and improving overall respiratory health. The insights gained from interviews with healthcare providers and community leaders suggest this as a valuable addition to asthma management strategies.

Finally, this project underscores the critical need for continued research and investment in community-based solutions to address the rising prevalence of pediatric asthma in SPA 6. The sharp increase in asthma rates between 2003 and 2017, along with the associated increase in pneumonia/influenza mortality rates, indicates a pressing need for targeted interventions that address the specific needs of this community. (1) The interviews conducted with families, healthcare providers, and community leaders provide a comprehensive understanding of the challenges faced by residents of SPA 6 and offer valuable insights into potential solutions. For example, the partnership between community-based organizations and local schools has

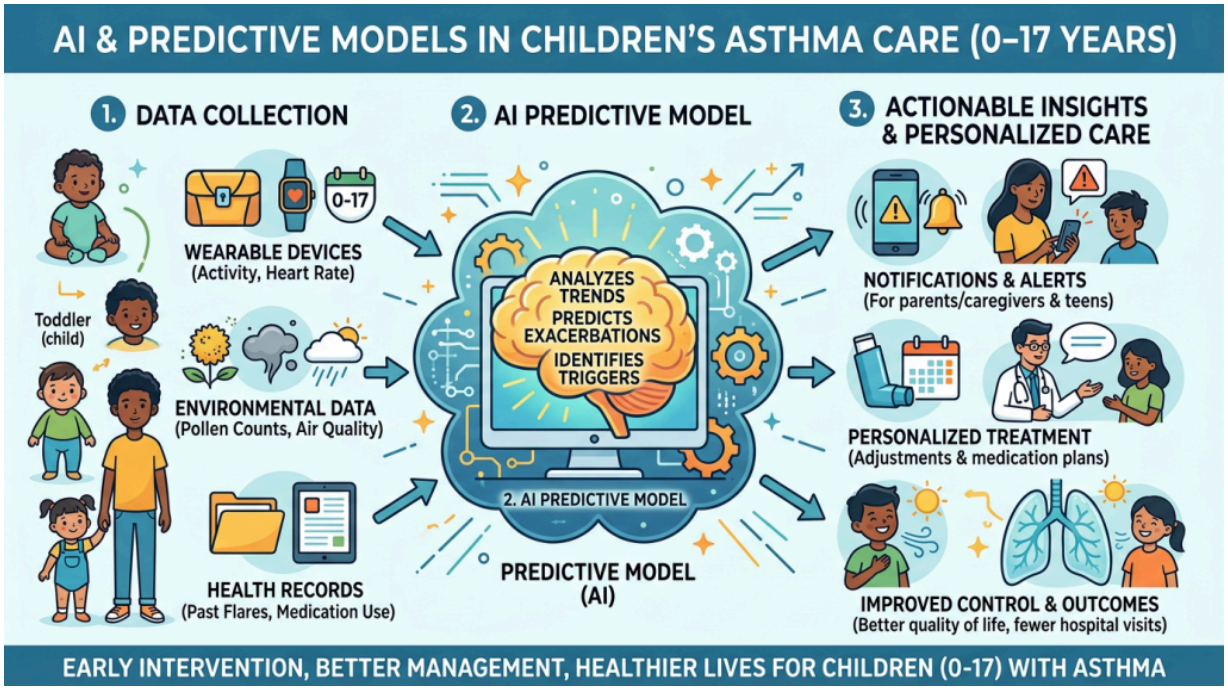
shown promise in improving asthma management through education and early intervention. By building on these insights and continuing to engage with the community, stakeholders can develop more effective strategies to reduce asthma-related health disparities and improve the overall quality of life for children living in SPA 6.



Pediatric Asthma Rates in SPA

AI and Predictive Models Have Potential to Improve SPA 6 Asthma Management

As medical students at CDU, our research on pediatric asthma in SPA 6 revealed significant disparities and challenges in managing this condition. We recognized the need for more efficient and accurate methods to predict and manage asthma exacerbations, particularly in underserved communities. Given that the field of medicine is moving towards the use of AI to develop solutions in healthcare, this led us to explore recent advancements in healthcare technology, specifically the application of Artificial Intelligence (AI) in asthma care. Given the high prevalence of asthma in SPA 6 and the need for improved management strategies, we believe that integrating AI and predictive models could significantly enhance asthma care in our community, addressing some of the key challenges we observed during our study.



The future of medicine is moving towards the use of AI to create solutions in healthcare. AI predictive models can facilitate analyzing patient data to predict asthma exacerbations, personalize treatment plans, and improve medication adherence to enhance disease management. By investigating factors like environmental triggers and patient history, these models can provide valuable information that can lead to improving patient outcomes, creating timely interventions, and reducing hospital visits. Although a potential pitfall of the use of AI predictive models can be biases in the data, which can lead to inequity. To limit the bias of AI predictive models, it would be beneficial to have such models intentionally focused on being trained with diverse communities. Additionally, community input when designing or implementing the models that will be used will be of great assistance, as it may also serve as an opportunity to educate underserved communities on how AI can be used to improve outcomes pertinent to their health. Moreover, there may also be a role for AI predictive models in shortening the pre-approval time for specific prescriptions based on asthma severity risk. Potential models may be able to better identify risk for pediatric patients and potentially be utilized to expedite insurance pre-approval processes for medications, particularly for specific age groups.

Community-Based Recommendations to Improve Pediatric Asthma Disparities in SPA 6

Environmental Factors

TOPIC	DESCRIPTION
Smoking Reduction	Smoking is a primary risk factor for asthma development and exacerbations. Implementing community-wide smoking cessation programs can significantly reduce exposure to secondhand smoke, particularly for children living in the same households or buildings.
Indoor Air Quality	Living conditions can also contribute to asthma attacks. Addressing issues like mold, insects, and proximity to high-traffic areas can help minimize exposure to inflammatory triggers. Regular cleaning, ventilation, and pest control are essential steps in maintaining healthy indoor environments.
Outdoor Air Pollution	Air quality is a critical factor for individuals with and without respiratory diseases. Reducing emissions from vehicles, factories, and other sources can improve air quality, especially in urban areas. Living near freeways or other high-traffic areas can increase exposure to harmful pollutants, emphasizing the need for targeted interventions in these communities.

Healthcare Access and Education

TOPIC	DESCRIPTION
Increased Access to Medications	Ensuring affordable and accessible asthma medications is crucial for effective management. This includes working with insurance companies to improve coverage, reducing out-of-pocket costs, and exploring alternative funding sources for low-income patients.
Enhanced Caregiver and Physician Education	Providing education on proper asthma management practices, medication use, and the importance of early intervention can empower caregivers and healthcare providers to improve patient outcomes. Collaborations between primary care physicians and specialists can ensure that patients receive timely and appropriate care.

Preventive Measures

TOPIC	DESCRIPTION
Diet and Obesity	Obesity is a risk factor for asthma and can exacerbate symptoms. Promoting healthy eating habits and encouraging physical activity can help reduce obesity rates and improve overall health.
Reduced Hospitalizations	Increasing access to specialized care, especially in underserved communities, can help prevent unnecessary emergency room visits and hospitalizations. This may involve expanding the availability of asthma clinics, telemedicine services, and medication access in schools.

Future Research Directions

To further inform effective interventions, additional research is needed to explore the specific factors contributing to asthma disparities in low-income communities. Comparative analyses across different regions can help identify systemic trends and inform policy decisions. Community-based participatory research can also provide valuable insights into the lived experiences of individuals with asthma and their families. By addressing these key areas, we can work towards reducing the burden of asthma and improving the health and well-being of children in vulnerable communities.

We Need to Uplift All Those Involved in Addressing Pediatric Asthma in SPA 6

Our research on pediatric asthma in Service Planning Area 6 (SPA 6) of Los Angeles County exemplifies key principles of community psychology in practice. By employing community-engaged methods, the

study embodies the field's core values of collaboration, empowerment, and an ecological perspective. The community-engaged approach aligns closely with community psychology's emphasis on collaborative engagement, involving community members, researchers, and stakeholders as equal partners. It recognizes and leverages the unique knowledge and capabilities of community members while focusing on prevention by identifying key drivers and areas for improvement to reduce the future burden of asthma. Additionally, it considers multiple levels of influence on health outcomes, reflecting an ecological approach.

The findings from this study have the potential to influence local health policies, demonstrating community psychology's commitment to translating research into actionable change. This aligns with the field's focus on systems-level interventions that advocate for changes in healthcare delivery, environmental regulations, and resource allocation. Moreover, the study fosters community capacity building by encouraging engagement and collective action among diverse stakeholders.



A crucial aspect of this study is its exploration of the significant mental health impact on caregivers, physicians, and healthcare providers in SPA 6. This focus aligns with community psychology's holistic approach to well-being and social justice. Caregivers of children with asthma often experience heightened stress levels and an increased risk of depression and anxiety, which can diminish their capacity for effective asthma management. These challenges create a cyclical problem that exacerbates both the caregiver's mental health and the child's asthma outcomes. This interplay exemplifies the systemic nature of health issues that community psychology seeks to address. Most importantly, we hope to provide a sense of optimism to the SPA 6 community, particularly the caregivers of pediatric asthma patients, who often feel isolated and unheard. Our research aimed to amplify their voices while also bringing to light the varying efforts and compassion felt by those providing care on an individual and community level.

This is particularly important as healthcare providers in SPA 6 face unique psychological challenges as well. They are at risk for burnout due to high patient loads and limited resources, alongside experiencing compassion fatigue from the emotional toll of treating chronic conditions in vulnerable populations. Additionally, they may suffer from moral distress arising from their inability to provide optimal care due to systemic constraints. These issues reflect community psychology's concern with the well-being of all community members, including those in helping professions.

The diverse community of SPA 6 presents additional psychological stressors for healthcare providers. Acculturative stress can arise as they navigate cultural differences in health beliefs and practices, while communication anxiety may stem from language barriers and potential misunderstandings. Implicit bias can also affect care quality and patient trust, further complicating interactions between providers and patients. Addressing these challenges aligns with community psychology's emphasis on cultural competence and social justice.

To combat these mental health challenges, community psychologists can advocate for and implement various strategies. Establishing support systems such as peer support groups for caregivers and providers can foster a sense of community and shared experience. Providing stress management resources like mindfulness training and resilience-building programs can help mitigate burnout and improve coping skills. Enhancing cultural competency through training will empower providers to work effectively across cultures, while accessible, culturally appropriate mental health services will ensure that all stakeholders receive the support they need.

By recognizing and addressing the psychological toll on caregivers, physicians, and providers, this study embodies community psychology's commitment to holistic, systemic change. It demonstrates how attending to the mental health of all stakeholders can enhance overall care quality and improve outcomes for children with asthma in SPA 6 while advancing broader goals of health equity and community well-being.

ACKNOWLEDGEMENT

College of Medicine, Charles R. Drew University of Medicine & Science, Medicine and Society Faculty

REFERENCES

1. Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. Key Indicators of Health by Service Planning Area; January 2017.
2. Association, American Lung. "Pneumonia and Asthma… Why Should I Worry?" American Lung Association, American Lung Association, www.lung.org/blog/pneumonia-and-asthma#:~:text=People%20with%20asthma%20have%20a,hospitalization%20in%20children%20and%20adults. Accessed 30 May 2024.
3. Barboza, T. (2017, November 15). Southern California smog worsens for second straight year despite reduced emissions. Los Angeles Times.
4. Bryant-Stephens TC, Strane D, Robinson EK, Bhambhani S, Kenyon CC. Housing and asthma

disparities. J Allergy Clin Immunol. 2021 Nov;148(5):1121-1129. doi: 10.1016/j.jaci.2021.09.023. Epub 2021 Sep 29. PMID: 34599980; PMCID: PMC9809049.

5. Azmeh R, Greydanus DE, Agana MG, Dickson CA, Patel DR, Ischander MM, Lloyd RD Jr. Update in Pediatric Asthma: Selected Issues. Dis Mon. 2020 Apr;66(4):100886. doi: 10.1016/j.disamonth.2019.100886. Epub 2019 Sep 27. PMID: 31570159.
6. Chen AY, Escarce JJ. Family structure and the treatment of childhood asthma. Med Care. 2008 Feb;46(2):174-84. doi: 10.1097/MLR.0b013e318156ff20. PMID: 18219246.
7. Clausing ES, Tomlinson CJ, Non AL. Epigenetics and social inequalities in asthma and allergy. J Allergy Clin Immunol. 2023 Jun;151(6):1468-1470. doi: 10.1016/j.jaci.2023.01.032. Epub 2023 Feb 18. PMID: 36804452.
8. Current California Legislation surrounding Albuterol access https://legiscan.com/CA/text/AB1283/id/2838348#:~:text=(a)%20School%20districts%2C%20county,or%20trained%20personnel%20may%20use
9. Expert Panel Working Group of the National Heart, Lung, and Blood Institute (NHLBI) administered and coordinated National Asthma Education and Prevention Program Coordinating Committee (NAEPPCC); Cloutier MM, Baptist AP, Blake KV, Brooks EG, Bryant-Stephens T, DiMango E, Dixon AE, Elward KS, Hartert T, Krishnan JA, Lemanske RF Jr, Ouellette DR, Pace WD, Schatz M, Skolnik NS, Stout JW, Teach SJ, Umscheid CA, Walsh CG. 2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group. J Allergy Clin Immunol. 2020 Dec;146(6):1217-1270. doi: 10.1016/j.jaci.2020.10.003. Erratum in: J Allergy Clin Immunol. 2021 Apr;147(4):1528-1530. PMID: 33280709; PMCID: PMC7924476.
10. Figdor, E. and Chausow, Lara (2004). Danger in the Air: Unhealthy Levels of Air Pollution in 2003. Washington, D.C.: U.S. PIRG Education Fund.
11. Forno E, Ortega VE, Celedón JC. Asthma and Chronic Obstructive Pulmonary Disease. Clin Chest Med. 2023 Sep;44(3):519-530. doi: 10.1016/j.ccm.2023.03.008. Epub 2023 May 9. PMID: 37517832.
12. Grant T, Croce E, Matsui EC.. Ann Allergy Asthma Immunol. 2022 Jan;128(1):5-11. doi: 10.1016/j.anai.2021.10.002. Epub 2021 Oct 19. PMID: 34673220; PMCID: PMC8671352.
13. Horner SD. Examining Social Determinants of Health in Childhood Asthma Management. Clin Nurse Spec. 2020 Sep/Oct;34(5):222-230. doi: 10.1097/NUR.0000000000000542. PMID: 32796383; PMCID: PMC8881794.
14. Loftus PA, Wise SK. Epidemiology and economic burden of asthma. Int Forum Allergy Rhinol. 2015 Sep;5 Suppl 1:S7-10. doi: 10.1002/alr.21547. Epub 2015 May 23. PMID: 26010063.

15. Lowe AA, Onge IS, Trivedi M. Updates in school-based asthma management. Curr Opin Allergy Clin Immunol. 2023 Apr 1;23(2):119-131. doi: 10.1097/ACI.0000000000000883. Epub 2022 Nov 24. PMID: 36730215; PMCID: PMC9974735.

16. Nardone A, Casey JA, Morello-Frosch R, Mujahid M, Balmes JR, Thakur N. Associations between historical residential redlining and current age-adjusted rates of emergency department visits due to asthma across eight cities in California: an ecological study. Lancet Planet Health. 2020 Jan;4(1):e24-e31. doi: 10.1016/S2542-5196(19)30241-4. PMID: 31999951; PMCID: PMC10018700.

17. National Asthma Education and Prevention Program. Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma-Summary Report 2007. J Allergy Clin Immunol. 2007 Nov;120(5 Suppl): S94-138. doi: 10.1016/j.jaci.2007.09.043. Erratum in: J Allergy Clin Immunol. 2008 Jun;121(6):1330. PMID: 17983880.

18. Navarro RP, Parasuraman B. Cost effectiveness of asthma controller therapies: influence of disease severity and other variables. Manag Care Interface. 2005 Jun;18(6):31-40. PMID: 16018297.

19. NIH. (2024, April 17). What is Asthma? Retrieved from NIH: National Heart, Lung, and Blood Institute: https://www.nhlbi.nih.gov/health/asthma

20. NOAA. (2004). Southern California Wildfires October 20 to November 3, 2003. California : National Weather Service.

21. Nurmagambetov T, Kuwahara R, Garbe P. The Economic Burden of Asthma in the United States, 2008-2013. Ann Am Thorac Soc. 2018 Mar;15(3):348-356. doi: 10.1513/AnnalsATS.201703-259OC. PMID: 29323930.

22. Perez L, Lurmann F, Wilson J, Pastor M, Brandt SJ, Künzli N, McConnell R. Near-roadway pollution and childhood asthma: implications for developing "win-win" compact urban development and clean vehicle strategies. Environ Health Perspect. 2012 Nov;120(11):1619-26. doi: 10.1289/ehp.1104785. Epub 2012 Sep 24. PMID: 23008270; PMCID: PMC3556611.

23. Robinson LD Jr, Calmes DP, Bazargan M. The impact of literacy enhancement on asthma-related outcomes among underserved children. J Natl Med Assoc. 2008 Aug;100(8):892-6. doi: 10.1016/s0027-9684(15)31401-2. PMID: 18717138.

24. Swope CB, Hernández D, Cushing LJ. The Relationship of Historical Redlining with Present-Day Neighborhood Environmental and Health Outcomes: A Scoping Review and Conceptual Model. J Urban Health. 2022 Dec;99(6):959-983. doi: 10.1007/s11524-022-00665-z. Epub 2022 Aug 1. PMID: 35915192; PMCID: PMC9342590.

25. Walter H, Sadeque-Iqbal F, Ulysse R, Castillo D, Fitzpatrick A, Singleton J. The effectiveness of school-based family asthma educational programs on the quality of life and number of asthma exacerbations of children aged five to 18 years diagnosed with asthma: a systematic review

protocol. JBI Database System Rev Implement Rep. 2015 Oct;13(10):69-81. doi: 10.11124/jbisrir-2015-2335. PMID: 26571284.

26. Weitzman M, Baten A, Rosenthal DG, Hoshino R, Tohn E, Jacobs DE. Housing and child health. Curr Probl Pediatr Adolesc Health Care. 2013 Sep;43(8):187-224. doi: 10.1016/j.cppeds.2013.06.001. PMID: 23953987.
27. Zaeh SE, McCormack MC, Eakin MN. Key policies to support asthma medication management for children. Ann Allergy Asthma Immunol. 2019 Nov;123(5):428-429. doi: 10.1016/j.anai.2019.07.019. Epub 2019 Jul 26. PMID: 31351981; PMCID: PMC6825544.
28. Zanobetti A, Ryan PH, Coull B, Brokamp C, Datta S, Blossom J, Lothrop N, Miller RL, Beamer PI, Visness CM, Andrews H, Bacharier LB, Hartert T, Johnson CC, Ownby D, Khurana Hershey GK, Joseph C, Yiqiang S, Mendonça EA, Jackson DJ, Luttmann-Gibson H, Zoratti EM, Wright AL, Martinez FD, Seroogy CM, Gern JE, Gold DR; Children's Respiratory and Environmental Workgroup (CREW) Consortium. Childhood Asthma Incidence, Early and Persistent Wheeze, and Neighborhood Socioeconomic Factors in the ECHO/CREW Consortium. JAMA Pediatr. 2022 Aug 1;176(8):759-767. doi: 10.1001/jamapediatrics.2022.1446. Erratum in: JAMA Pediatr. 2022 Aug 1;176(8):829. PMID: 35604671; PMCID: PMC9127710.
29. Swope, C.B., Hernández, D. & Cushing, L.J. The Relationship of Historical Redlining with Present-Day Neighborhood Environmental and Health Outcomes: A Scoping Review and Conceptual Model. J Urban Health 99, 959–983 (2022). https://doi.org/10.1007/s11524-022-00665-z
30. Silva, T. M., Cade, M. V., Figueiras, A., Roque, F., Herdeiro, M. T., & Devakumar, D. (2022). Impact of infectious disease epidemics on xenophobia: A systematic review. Journal of Migration and Health, 5, 100085. https://doi.org/10.1016/j.jmh.2022.100085
31. Fletcher, F. E., Ray, K. S., Brown, V. A., & Smith, P. T. Addressing Anti-Black Racism in Bioethics: Responding to the Call. Hastings Center Report, 52, S3-S11. https://doi.org/10.1002/hast.1360

20

Breaking the Cycle: Community-Centered Solutions for Socioeconomic and Environmental Challenges that Drive Childhood Obesity in South Los Angeles

AUTHORS: JENEANE HAMIDEH, SYDNEY Y.K. BROWN, MARTHA ROMERO, KEVIN LOPEZ, PAOLA HERNANDEZ, VISHAL RAO, SANAM AHADI, LAILA CROSS, RUTHA ADHANOM, TAYLOR MITCHELL

THE BIG PICTURE

The prevalence of childhood obesity has escalated in the United States, and particularly in children of African American and Latinx descent (Ogden et al., 2022). Nationally, race, birthweight, parental smoking, and not having family meals have been linked with higher rates of obesity (Williams et al., 2018). South Los Angeles (LA) faces a particularly severe burden due to compounding socioeconomic and environmental factors. Communities such as Watts-Willowbrook, located in South LA, with predominantly African American and Latinx populations, experience disproportionately high obesity rates (Lutfiyya et al., 2008). These are driven by structural challenges, such as poverty and lower educational levels, exacerbating the situation for children in these areas (Browne et al., 2021). Compared to other regions in Los Angeles, residents of South LA experience higher obesity rates also due to practical challenges including limited access to healthy foods and inadequate spaces for opportunities for physical activity (Tester et al., 2020). This carries profound implications, emphasizing the need for systemic changes to address the social, economic, and environmental factors that contribute to health inequities in South LA.

The consequences of childhood obesity in South LA impact not only the health and well-being of individuals but also the broader community (Balasundaram & Krishna, 2023). Obesity is associated with a range of chronic health conditions, including Type 2 diabetes, cardiovascular disease, and certain cancers (National Institutes of Health, 2019). These conditions can lead to decreased quality of life, increased healthcare costs, and reduced life expectancy. In addition to the physical health impacts (Smith et al., 2020), obesity can affect mental health, contributing to conditions like depression and anxiety (Halfon et al.,

2013; Harrist et al., 2016). Through conducting literature review, statistics, serving the community and most importantly, coming from a similar upbringing led the team to gain further insight into the complex relationships between childhood obesity and the socioeconomic drivers within South LA.

HOW WE CAME TO WORK WITH THE COMMUNITY OF SOUTH LOS ANGELES

Amid the civil unrest of the Watts Rebellion in 1965, a moment of profound racial and social upheaval, the seeds of a new mission emerged. The McCone Commission report revealed identified poor health outcomes and limited access to care as key contributors to the unrest, catalyzing a commitment to address these disparities. Today, Charles R. Drew University (CDU) continues that mission with the establishment of an independent MD program—the first such Historically Black program in over 40 years and the only one of its kind west of the Mississippi. This milestone affirms our dedication to equity and excellence in healthcare for underserved communities. Situated in the heart of the Watts-Willowbrook community, CDU remains deeply committed to addressing the health challenges faced by our neighbors. One such challenge, childhood obesity, disproportionately affects our community, threatening the health and future of our youth. By combining our focus on health equity with innovative research, education, and outreach, CDU is dedicated to empowering the next generation of physicians to confront this epidemic and create healthier futures for the communities we serve. As medical students at Charles R Drew University in Watts-Willowbrook, South LA, many of us (the authors) grew up in communities similar to Watts-Willowbrook and have been directly exposed social and health inequities that have shaped out commitment to addressing health disparities. Childhood obesity is a significant health disparity that we have identified as a dire concern, as evidenced through literature review, quantifiable data and through first-hand witnessing this health concern when serving the community in medical practice. We also found that childhood obesity in South LA is significantly pronounced when compared to other communities in Los Angeles. To investigate our topic, we engaged with our community physicians, faculty, and mentors to identify and prioritize the leading health challenges for South Los Angeles. These critical discussions further reinforced our decision to pursue childhood obesity as our topic.

At the national level, childhood obesity is a significant public health concern. According to Centers for Disease Control and Prevention (CDC), approximately 19.7% of children aged 2-19 in the United States are affected by obesity, particularly affecting some groups more than others, including adolescents, Hispanic and non-Hispanic Black children, and children in families with lower incomes (CDC,2023). Within Los Angeles County, 36.1% of children aged 2-11 in Watts-Willowbrook are overweight for their age, compared to 12.5% in Los Angeles County overall. Additionally, 49.9% of teens aged 12-17 in Watts-Willowbrook are overweight or obese, significantly higher than the 34.4% reported for Los Angeles County (Los Angeles County Department of Public Health 2023).

The magnitude of childhood obesity is a matter of urgent concern in Watts-Willowbrook, South LA. To better understand this deep-seated issue, our project adopted a community-engaged approach, engaging stakeholders, families, community, and healthcare providers directly to understand the relevant issues and create culturally sensitive, sustainable solutions. Our community-engaged approach was inspired by the model implemented at Charles R. Drew University, which contained the essential elements; mutual respect,

shared decision making, and a focus on measurable changes in the community rather than conducting research solely for hypothesis testing (del Pino et al., 2016). This approach, as medical students in South LA, allows us to gain a deeper understanding of childhood obesity through the lens of both patients and key stakeholders.

DESCRIPTION OF PROJECT

The study on childhood obesity in Watts-Willowbrook, South Los Angeles, was rooted in a community-engaged approach, emphasizing participatory research that involved various stakeholders, including families, community members, and healthcare providers. Our project specifically aimed to answer the research question: "What are the driving forces of obesity in elementary school-aged children in Watts-Willowbrook, CA?" Through this inquiry, we sought to assess the prevalence and impact of childhood obesity while exploring community perspectives and experiences related to the issue. Partnering with Dr. Angela Venegas-Murillo from the MLK Pediatrics Medical Home Clinic, we conducted a series of interviews with key stakeholders, such as registered dietitian Joselin Berdugo from the Gasol Foundation, family physician Dr. Alexander Rodgers, and pediatrician Dr. Shanika Boyce.

The methodology involved qualitative data collection through semi-structured interviews designed to gather a diverse range of insights. Our initial step was to create a literature review where we outlined a series of five main domains from this review: diet and nutrition, exercise, family and community support, healthcare and prevention, and environment. Following this process, we created an interview script that emphasized the five domains and identified key stakeholders to interview. We interviewed two people from the following groups: patients/family members, clinical health care providers, other health care team members (e.g., dieticians), community-based organizations, government organizations, and research/health policy experts. After these interviews, we analyzed the content of our interviews and extrapolated recurrent themes across all stakeholder interviews. This process allowed us to extract quotes which provided a unique and personal basis to highlight the complexity of our domains and how we can create targeted interventions.

COMMUNITY NEEDS

Watts-Willowbrook is a vibrant, multicultural community with a variety of unique needs that are influenced by the local socio-cultural environment. There are many families and children living in the area who experience limited access to food, green space, culturally competent medical professionals and financial resources. It is crucial to address these needs to combat childhood obesity in Watts-Willowbrook and ensure that families can build and maintain healthy lifestyles. A primary challenge in the community of Watts-Willowbrook is access to nutritious food at an affordable price. There is a great need for affordable produce, high-quality protein and other nutrient dense staples that form the foundation of a healthy diet. Currently, there are some food banks and farmers' markets that meet this need, but more are needed to provide sufficient food options for the entire population across the entire geographic area.

Opportunities for physical education is another significant need within the Watts-Willowbrook community. Many freeways bisect this area of Los Angeles, vastly limiting resident's access to green space where they can practice recreation and physical activity. Additionally, Watts-Willowbrook has a noticeable

paucity of fields, recreational swimming pools and similar facilities which leaves children with limited options for physical activity. There is also a lack of community initiatives promoting healthy lifestyles for youth – presumably due to lack of funding.

South LA is also an area that has historically had a lack of medical facilities, from primary care to acute care services, and unfortunately Watts-Willowbrook continues to be a medically underserved area. This leaves residents with limited options if they choose to seek treatment for childhood obesity – particularly if they are requesting the assistance of specialized healthcare professionals whose services are often not covered by Medicaid. The community as a whole could benefit immensely from registered dieticians and mental health counselors as it takes on the epidemic of childhood obesity and the behaviors that perpetuate the cycle of obesity within families. The children affected by childhood obesity in Watts-Willowbrook could significantly benefit from a specialized, multidisciplinary clinic designed to help them achieve a healthy weight by targeting the plethora of physical and psychological factors that contribute to obesity.

Additionally, as a multicultural community with a high proportion of residents who speak English as a second language, Watts-Willowbrook needs all services designed to combat childhood obesity to be provided in multiple languages, particularly Spanish. Furthermore, any healthcare professionals involved in the treatment of patients experiencing childhood obesity should have a high level of cultural competency and be able to meet the language and communication needs of their diverse patient population. Overall, Watts-Willowbrook has a number of needs that require our support in order to continue combatting childhood obesity. This includes improved access to healthy food, more areas for residents to do physical activity and a need for highly-trained, culturally aware healthcare resources for obese children.

COLLABORATIVE PARTNERS

We created questions based on the domains: diet/ nutrition (Anderson et al. 2019, Gato-Moreno et al. 2021, Liu et al. 2019), exercise (Anderson et al. 2019), family (Liu et al 2019, Smith et al. 2020) and community support (Smith et al 2020), healthcare and prevention (smith et al 2020), and environment (liu et al 2018, Reis et al 2020). Based on the domains and with guidance from our mentor, we identified partnerships such as pediatric and family medicine doctors, community promotoras, researchers, previous employees at the Los Angeles Public Health Department and community-based organizations such as the Lundquist WIC program and Gasol Foundation. Each student was assigned an identified collaborate partner to coordinate and schedule an interview. Prior to the interview, a document with background, project information, and interview questions were provided. All interviews were conducted via Zoom or teams' calls, which were recorded. In addition, a verbal agreement was provided during the meeting. No documentation was requested from the representatives of the organizations. We submitted the recording for transcription using AI parrot. We summarized the key points for submission to our course directors. In addition, each group member presented a slide that summarized the interview findings to the other group members which helped capture the major themes and trends that play a role in childhood obesity in Watts-Willowbrook across the various domains.

For nutrition experts, we interviewed Joselin Berdugo, a registered dietitian at the Gasol Foundation. Berdugo focused on delivering culturally sensitive dietary advice that resonated with the community's

cultural practices, making healthier eating more accessible to low-income families. For healthcare professionals, we interviewed Dr. Shanika Boyce, a pediatrician who played crucial roles in addressing childhood obesity through nutrition education in South Los Angeles. Dr. Alexander Rodgers, a family medicine doctor, emphasized family-centered nutritional practices, such as cooking demonstrations and visual aids like portioned plates, to help families adopt balanced eating habits. Their combined efforts highlight the importance of culturally relevant approaches to promote healthier lifestyles. We had the pleasure to speak with Michael Prelip, a scientist specializing in health promotion interventions, stresses the importance of the physical environment in promoting healthy lifestyles.

Community program coordinators and health educators worked on enhancing physical activity in Watts-Willowbrook, addressing barriers such as safety concerns. Nova Green, a High-Risk Program Training Coordinator at the Lundquist WIC program, identified the need for safer environments to encourage outdoor activities. Gigi de La Haza, a Nutrition Education and Training Coordinator, provided practical resources and guidance to families, helping them find local opportunities for physical activity. These partners focused on making physical activity more accessible and safer for the community. Aiziti Magana, formerly of the LA County Health Department, advocated for improved infrastructure, such as shaded areas and hydration stations, to support safe exercise.

Family and community representatives, like Mariela Rodriguez, a local mother, played an essential role in highlighting the social aspects of obesity. Rodriguez shared her personal experiences of modeling healthy behaviors for her daughter, emphasizing the influence of family support on weight management. Community insights from representatives helped tailor interventions to be more relatable and effective, underscoring the importance of family dynamics and community involvement in addressing childhood obesity.

OUTCOMES AND IMPACT

The “Breaking the Cycle” project, led by the authors, aimed to address childhood obesity in the Watts-Willowbrook community through an initial exploratory community-based approach. This exploratory endeavor aimed to tackle the multifaceted nature of childhood obesity by focusing on diet and nutrition, exercise, healthcare experiences, family and community support, and environmental factors. The project aimed to provide a framework to facilitate enhanced nutritional education and resources within the community. By integrating insights from local clinicians, community members, and policymakers, our team proposed actionable strategies. Strategies included: Culturally sensitive programs, including teaching kitchens, dietary counseling, visual aids and supporting families in making healthier food choices. This effort resulted in a significant increase in awareness about healthy eating practices, particularly through culturally relevant strategies and practical tools like online resources and dietary apps.

In addition to improving nutrition, the project addressed barriers to physical activity. These barriers included safety concerns and a lack of shaded areas, which were mitigated through the promotion of local recreational activities and improved access to physical activity resources. Partnerships with local organizations played a crucial role in overcoming challenges related to transportation and safety, thereby increasing opportunities for physical activity

The "Breaking the Cycle" project, led by the authors, aimed to address childhood obesity in the Watts-Willowbrook community through a comprehensive, community-based approach. This initiative tackled the multifaceted nature of childhood obesity by focusing on diet and nutrition, exercise, healthcare experiences, family and community support, and environmental factors. By integrating insights from local clinicians, community members, and policymakers, the project developed actionable strategies that led to several key outcomes. The project aimed to provide a framework to facilitate enhanced nutritional education and resources within the community. Culturally sensitive programs, including teaching kitchens, dietary counseling, and visual aids, supported families in making healthier food choices. This effort resulted in a significant increase in awareness about healthy eating practices, particularly through culturally relevant strategies and practical tools like online resources and dietary apps.

In addition to improving nutrition, the project addressed barriers to physical activity. These barriers included safety concerns and a lack of shaded areas, which were mitigated through the promotion of local recreational activities and improved access to physical activity resources. Partnerships with local organizations played a crucial role in overcoming challenges related to transportation and safety, thereby increasing opportunities for physical activity.

LESSONS LEARNED

Through our community-engaged research project (CERP), we have gained a deeper understanding of the complex factors surrounding childhood obesity in the larger South LA area and, more specifically, the Watts-Willowbrook area. Our research team chose this topic because we want to be champions of health in our careers as physicians, and one challenge we have seen impacting our community's health in many ways is a preventable one – childhood obesity. Many in our team have experienced growing up in low-income, resource-poor areas and know that a disproportionate number of obstacles are impacting access to healthy food and safe environments to exercise in these areas. Powered with Charles R. Drew University's vision to provide "excellent health and wellness for all in a world without health disparities," we identified driving forces influencing childhood obesity in ages 5-11. The goal of our project is to provide insight that will inform future interventions to eliminate childhood obesity, especially in underserved communities like Watts-Willowbrook.

We are proud of our work and the valuable tools we have developed that will continue to serve us as we advocate for health equity in our communities as medical students, researchers, and community members. One of the most fulfilling lessons we learned was how to facilitate a culturally informed research project. Too often, researchers may view communities merely as a source of data without inviting them to play a collaborative role in the research. We are proud that our project partnered with community members and stakeholders to give a voice to the Watts-Willowbrook community. This experience taught us that trust, collaboration, and cultural humility are important when addressing health disparities that we have personally experienced and witnessed firsthand. Our project has challenged us to reflect on how we, as future physicians, can make a meaningful impact in our communities through advocating for health equity. By staying actively engaged with the community and prioritizing culturally informed research strategies, we

are better equipped to empower communities towards health and wellness in ways that are sustainable and transformative.

LOOKING FORWARD

Looking forward, there is a continued focus on training culturally competent healthcare professionals and leveraging social media as a platform for positive change. Family involvement remains a priority in interventions aimed at breaking the generational cycles of poor health. Addressing environmental determinants of health, such as advocating for improved neighborhood safety, access to fresh foods, and recreational facilities is essential. Additionally, staying informed about evolving health factors is crucial to ensure that interventions remain relevant and effective. Future initiatives will adopt a comprehensive approach that integrates cultural sensitivity, community empowerment, and systemic change to promote healthier communities.

RECOMMENDATIONS

Addressing childhood obesity in Watts–Willowbrook requires a comprehensive, multi-level approach grounded in Bronfenbrenner's socioecological model. The socioecological model is a public health framework that examines how multiple levels of influence– individual, interpersonal, community, and policy—interact to shape individual, interpersonal, community, and policy—interact to shape At the patient level, culturally relevant education is crucial to helping families make healthier food choices while respecting and preserving long-standing eating traditions. Equally important are programs that promote positive body image in children through school and community initiatives, shifting the focus from weight to overall well-being to reduce stigma and empower self-confidence. Engaging parents is another vital component; workshops centered on nutrition education and physical activity can foster sustainable healthy habits within households. To support these efforts, healthcare providers must be trained to deliver care that is culturally and linguistically sensitive, ensuring that interventions are both respectful of families' needs and effective in overcoming the unique barriers they face.

At the community level, improving access to affordable, fresh produce is a top priority. Efforts should include collaborating with local stores, farmers' markets, and urban agriculture programs to address food insecurity while considering the cultural context of the neighborhood. Enhancing safe recreational spaces, such as parks and playgrounds, is also vital to providing children with opportunities for physical activity. Involving community members in these initiatives ensures that solutions are inclusive, practical, and tailored to local needs.

Finally, structural and policy-level changes are essential to sustain progress. Expanding school-based services, such as nutritional guidance and obesity screenings, can help identify at-risk children early and connect them to resources. Advocacy for policies that increase funding for parks, community health programs, and broader infrastructure improvements is critical to creating a supportive environment for long-term health. Together, these strategies offer a comprehensive approach to reducing childhood obesity and promoting health equity in Watts–Willowbrook.

COMMUNITY PSYCHOLOGY IN ADDRESSING CHILDHOOD OBESITY: WEIGHT MANAGEMENT, PREVENTION, EMPOWERMENT AND SYSTEMS CHANGE

Engaging stakeholders in community-based participatory research can aid in creating sustainable interventions to address childhood obesity by offering opinions through lived experiences. Interviews with various stakeholders revealed four common themes: nutrition, community support, environment, and policy change. The first three themes emerge in Samantha's and Mariela's story as they overcome obstacles to achieve a healthy lifestyle change. The last theme encompasses suggestions from dieticians, providers, and public health officials with a vested interest in the people.

Nutrition must incorporate culturally and linguistically sensitive instruction and proper food access to extend its reach to diverse populations. Hosting bilingual nutrition classes at community centers, such as schools or churches, can expand access to local families, providing them with an additional resource to aid in their child's weight management. As shown in Samantha's and Mariela's story, engaging entire families in healthy eating practices is essential to creating lasting, multigenerational change.

At the intersection of community support and environment lies the common theme of exercise. In terms of community support, offering free recreational courses for children and their families allows the child to be active while developing healthy exercise habits. Healthcare providers must establish rapport with families to harness trust so patients feel comfortable asking for guidance and confident knowing their doctor will steer them on the right path. For example, Mariela turned to Samantha's pediatrician to ask for help addressing her child's weight and was provided with a list of nearby recreational facilities where Samantha could enroll. These classes also offered a safe environment where Samantha could exercise and build community.

An unexpected influence emerged in the social media environment during Samantha's interview. She shared that she contemplated purchasing weight loss supplements to gain control over her weight. Fortunately, her mother, having gone through a weight loss journey herself, told Samantha that that was an unhealthy approach to losing weight. That's when Mariela counseled Samantha about establishing healthy eating habits and being more active to aid in her weight loss goal. This provides a great example of how educating parents about proper weight loss and healthy eating trickles down to the next generation, creating healthy multigenerational lifestyles.

When looking at policy, dieticians, providers, and public health officials offered suggestions based on personal experiences with patients. A major suggestion involved the need for a policy that allocates resources toward safe recreational areas in the communities. This includes ensuring proper lighting, maintained walkways, and security patrols or cameras. It is vital to create these spaces where people can be physically active at any time of the day.

Samantha's and Mariela's story is a unique example of how addressing nutrition, exercise, community support, environment, and policy can positively impact the lives of children and their families. It shows us how tackling childhood obesity requires a multidisciplinary approach that intersects public health, sociology, and education. Establishing provider trust, offering culturally and linguistically sensitive nutrition classes, and providing access to recreational spaces promotes individual and family well-being and improves the broader health of communities.

SEE CONTRIBUTORS PAGE FOR LIST OF AUTHORS (EDITED BY GERALDINE PALMER, TODD ROGERS, JUDAH VIOLA, AND MARONICA ENGEL)

Editors' Notes

The development of this book has been a labor of love for all of us. We are thrilled to have the opportunity to share the stories of colleagues engaged in applied community psychology around the globe. What you have read thus far and what you are reading right now is a "living document". Rather than waiting until we felt that the book was perfectly complete before sharing it with you, we decided that we would do our best to continually make improvements and updates along the way. This whole process of soliciting cases, facilitating peer reviews, adding content, formatting, and copy editing has been a collaborative process and will continue as a work in progress. Our goal was to share engaging content with students and the public through developing an Online Educational Resource (OER) book that would increase awareness of what community psychology in action looks like. These cases are not polished to make the authors or their projects or partners appear infallible. Rather, we want readers to view the cases and lessons learned both from the successes and challenges faced within the cases. In addition, we are looking to amplify the voices of BIPOC authors whose work in various communities may have been excluded from more traditional publication outlets.

Now we'd love to get you involved in this collaboration. Please use the form provided to share feedback and suggestions for improvement. If you also have concerns or challenges with digital accessibility, please use this form to let us know. Also, reach out to us if you have a case that you'd like added to the book. Thank you!

Feedback Form: Case Studies in Community Psychology: A Global Lens



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=2377

Adoption Form



One or more interactive elements has been excluded from this version of the text. You can view them online here: https://press.rebus.community/communitypsychologypractice/?p=2379

Licensing and Attribution Information

This book is licensed under a Creative Commons Attribution 4.0 license except where otherwise noted. This license allows for reuse, adaptation, remixing, and redistribution of content, so long as you attribute it to the original authors, indicate if changes are made, and link to the original, free content, found at https://press.rebus.community/the-rebus-guide-to-publishing-opentextbooks/.

PLEASE CREDIT AS FOLLOWS:

Redistributing the book verbatim: This book is authored by Contributors, edited by Geraldine Palmer, Todd Rogers, Judah Viola, and Maronica Engel, and produced with support from the Rebus Community. The original is freely available under the terms of the CC BY 4.0 license at https://press.rebus.community/communitypsychologypractice/

Revised or adapted versions: This book is based on original content authored by Contributors, edited by Geraldine Palmer, Todd Rogers, Judah Viola, Maronica Engel, and produced with support from the Rebus Community. The original is freely available under the terms of the CC BY 4.0 license at https://press.rebus.community/communitypsychologypractice/.

Individual chapters or excerpts: This book is [created by OR based on original content authored by] Contributors, edited by Geraldine Palmer, Todd Rogers, Judah Viola, Maronica Engel, and produced with support from the Rebus Community. The original is freely available under the terms of the CC BY 4.0 license at https://press.rebus.community/communitypsychologypractice/.

Peer-Review Statement

SEE CONTRIBUTORS PAGE FOR LIST OF AUTHORS (EDITED BY GERALDINE PALMER, TODD ROGERS, JUDAH VIOLA, AND MARONICA ENGEL)

Case Studies in Community Psychology Practice: A Global Lens was produced with support from the Rebus Community, a non-profit organization building a new, collaborative model for publishing open textbooks. Critical to the success of this approach is including mechanisms to ensure that open textbooks produced with the Community are high quality, and meet the needs of all students who will one day use them. Rebus books undergo both peer review from faculty subject matter experts and beta testing in classrooms, where student and instructor feedback is collected.

This book has been peer reviewed by fifteen peer-reviewers (subject experts) from over five higher education institutions, corporations and non-profit organizations working in communities. Each chapter received a double-blind review from 2-3 reviewer, based on their area of expertise. The reviewers were largely academic professionals, graduate students, and community practitioners, with knowledge of the publishing process, authors or co-authors of scholarly manuscripts with required specialist knowledge in community psychology and allied disciplines.

Reviews were structured around considerations of the intended audience of the book, and examined the comprehensiveness, accuracy, and relevance of content. Reviews were also focused on relevance longevity, clarity, consistency, organization structure flow, grammatical errors, and cultural relevance. Changes suggested by the reviewers covered numerous areas and were incorporated by all contributing authors.

The authors, editors and the team at Rebus would like to thank the anonymous review team for the time, care and commitment they contributed to the project. We recognize that peer reviewing is a generous act of service on their part. This book would not be the robust, valuable resource that it is were it not for their feedback and input.

SEE CONTRIBUTORS PAGE FOR LIST OF AUTHORS (EDITED BY GERALDINE PALMER, TODD ROGERS, JUDAH VIOLA, AND MARONICA ENGEL)

Accessibility Assessment

A NOTE FROM THE REBUS COMMUNITY

We are working to create a new, collaborative model for publishing open textbooks. Critical to our success in reaching this goal is to ensure that all books produced using that model meet the needs of all those who will one day use them. To us, open means inclusive, so for a book to be open, it must also be accessible.

As a result, we are working with accessibility experts and others in the OER community to develop best practices for creating accessible open textbooks, and are building those practices into the Rebus model of publishing. By doing this, we hope to ensure that all books produced using the Rebus Community are accessible by default, and require an absolute minimum of remediation or adaptation to meet any individual reader's needs.

While we work on developing guidelines and implementing support for authoring accessible content, we are making a good faith effort to ensure that books produced with our support meet accessibility standards wherever possible, and to highlight areas where we know there is work to do. It is our hope that by being transparent on our current books, we can begin the process of making sure that accessibility is top of mind for all authors, adopters, students, and contributors of all kinds on all our open textbook projects.

Below is a short assessment of eight key areas that have been assessed during the production process. The checklist has been drawn from the BCcampus Open Education Accessibility Toolkit. While a checklist such as this is just one part of a holistic approach to accessibility, it is one way to begin our work on embedded good accessibility practices in the books we support.

Wherever possible, we have identified ways in which anyone may contribute their expertise to improve the accessibility of this text. We also welcome any feedback from anyone who encounters the book and identifies an issue that needs resolving. This book is an ongoing project and will be updated as needed. If you would like to submit a correction or suggestion, please do so using the Rebus Community Accessibility Suggestions form.

Version History

This page provides a record of edits and changes made to this book since its initial publication. Whenever edits or updates are made in the text, we provide a record and description of those changes here. If the change is minor, the version number increases by 0.1. If the edits involve substantial updates, the edition number increases to the next whole number. The files posted alongside this book always reflect the most recent version. If you find an error in this book, please let us know in the Rebus Community project home.

Version History

Version	Date	Change	Affected Web Page
1.0		Original	