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Witnessing for Black mental health: Formative steps for designing a community-based mental health education intervention

Hollen N. Reischer,[1] Sarah M. Taber-Thomas,[1] Esther Turay,[1] Detric Johnson,[2] Brittney Greene,[1] Cassy Dauphin,[2,3] Deborah O. Erwin,[2] Rebecca L. Ashare[1]

[1]Department of Psychology, University at Buffalo

[2]The National Witness Project, Buffalo, New York

[3]Department of Community Health and Health Behavior, University at Buffalo

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Correspondence concerning this article should be addressed to Hollen N. Reischer at hollen@buffalo.edu.

Abstract

Objectives: Following the May 2022 racially motivated mass shooting in Buffalo, New York, mental health care was found to be the most frequently endorsed unmet need among local Black community members surveyed. In response, a community-university partnership formed in pursuit of developing culturally tailored mental health programming. To inform program development, the partnership conducted community-engaged research to understand diverse stakeholders' relevant concerns, beliefs, and preferences. **Methods:** In Study 1, community health workers (n=13; 92% Black; 100% women; 23–78 years old, M_{age}=52) participated in one-on-one semi-structured interviews. In Study 2, community members (n=54; 100% Black; 63% women, 31% men, 6% gender not reported; 18–91 years old) participated in focus groups. In both studies, transcripts were coded using descriptive, semantic, realist thematic analysis. Member checks were conducted with organizational leadership, study participants, and broader members of the community. **Results:** Across both studies, participants described cultural (e.g., stigma) and material (e.g., insurance) barriers to care; systematic (e.g., poverty) and interpersonal (e.g., lack of social support) mental health risks; willingness to discuss mental health (e.g., increasing over time); and preferences for mental health education and services (e.g., provider authenticity). Individual study results and convergences and divergences across studies are detailed. **Conclusions:** Results informed the development of a pilot mental health education program, "Witnessing for Mental Health." The community health worker–delivered program addresses participant-identified cultural, tangible, and systemic barriers to mental health care and leverages increasing community openness and interest in discussing mental health.

Keywords: qualitative, mental health, social determinants of health, community health workers, African American

Public Significance Statement

Black American community members and community health workers reported oppressive forces such as the COVID-19 pandemic, a local racially motivated mass shooting, and social determinants of health leading to an urgent need for culturally competent mental health care. Despite longstanding, complex barriers to equitable mental health care, participants described an increased community willingness to discuss mental health issues with each other and with trustworthy providers. Participants were particularly interested in increasing personal knowledge of promoting mental well-being and participating in community storytelling and listening.

> This specific term *mental health* didn't come up as much in our [organizational] conversations…I think we were so focused on…other aspects of social determinants of health…and because we also knew the stigma in our community. It was something that we just didn't really push the envelope on too much. But…after the pandemic, and then coupled with the tragedy that happened with the shooting …it became such an identifiable need…. [We thought] we really can't, like, avoid this conversation at this point, especially because all of us were dealing with all types of aspects of just mental health challenges….We knew we had to do something. (Carmen,[1] 32, National Witness Project Community Health Worker)

On May 14, 2022, Buffalo, New York, was the site of a racially motivated massacre on Black lives. Ten individuals were murdered and three injured as they grocery shopped in an East Buffalo store serving a primarily Black clientele. In response to deep community pain among Black Buffalonians, National Witness Project (NWP), a national community-based health organization founded in Arkansas in 1991 and headquartered in Buffalo since 2006, surveyed members of Buffalo's Black East Side to identify urgent community needs. NWP leaders were surprised to find 38% (75 of 200 surveyed) indicated mental health was their most important unmet need.

The willingness of community members to disclose this vulnerability was perceived to be paradigm-shift for Black adults, given longstanding stigma around mental health treatment among this population (Gary, 2005; Ward et al., 2013). As Carmen describes in the opening quote, NWP leaders found mental health needs had become too substantial to ignore, ultimately leading to the development of a community-academic partnership between NWP and the University at Buffalo (UB) Psychology Department to address these needs. The present article

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[1] All participant names are pseudonyms.

situates the contemporary story of mental health disparities within the Black American context before describing formative research conducted to inform mental health program development.

Context of Contemporary Mental Health Disparities

Thoits (2010) provides a clear overview of the ways in which stressors (negative events, chronic strains, and trauma) are unevenly distributed across different racial groups, exacerbated by discrimination stress in marginalized groups, and compounded across individual lifetimes and generations to create ever-widening gaps in mental health disparities. For example, mass incarceration of Black men (Wildeman et al., 2018) and health disparities which lead to early mortality (Dwyer-Lindgren et al., 2022) have ripple effects on the mental health of individuals, families, and communities (Umberson, 2017).

Decades of research on mental health disparities show that compared to White Americans, Black Americans are less likely to receive mental health treatment, especially evidence-based treatment; are more likely to be misdiagnosed; experience higher severity and chronicity of mental illness; are more likely to have police involvement in mental health crises; and have little access to culturally competent mental health care services (McGuire & Miranda, 2008; Office of the Surgeon General (US) et al., 2001).

Stories About Black Mental Health

The “Black-White mental health paradox” is used to describe a commonly reported finding that while on average Black individuals experience more life stressors and worse physical health outcomes than White individuals, they appear to have lower rates of mental health problems than White individuals, particularly for depression (D. M. Barnes & Bates, 2017). Importantly, it is unknown whether this paradox represents true differences in prevalence rates versus other factors such as cultural idioms of distress that may not pattern neatly onto diagnostic criteria (Pamplin &

Bates, 2021; D. R. Williams, 2018). The finding of lower depression rates among Black adults has often been used as evidence of enhanced resilience in the population (Keyes, 2009). And while the enduring resilience of Black Americans is a vital cultural asset that may play an important role in mental health maintenance, such an explanation has also been used to undermine the need for research and treatment related to Black mental health (Hamilton-Mason et al., 2009). In fact, this strengths-based explanation is linked to an insidious slavery-era narrative conveying Black people were less than fully human and therefore impervious to psychological distress (Suite et al., 2007).

Such narratives about the diminished humanity of Black people have long been used to justify institutionalized violence and discrimination. During the time of slavery, racist myths masquerading as contemporary science also claimed African slaves were of inherently lower intellect than other races and had an instinct toward submission. Individuals who demonstrated resistance to enslavement were labeled as mentally ill, as this was said to be against their nature (Suite et al., 2007).

Taken together, these narratives suggested Black people’s mental health is not a matter of concern because Black people are apt to both *underreact* and *overreact* to psychological stressors. In recent decades, a plethora of research has demonstrated how these twin myths of under- and over-reactivity have been instantiated in modern psychological practice: Black adults are *underdiagnosed* with depression, as described above, and *overdiagnosed* with schizophrenia (Bailey et al., 2019; Neighbors et al., 1989; Olbert et al., 2018; Strakowski et al., 2003). Black patients are diagnosed with psychotic disorders at an alarming rate of three times that of White patients (Schwartz & Blankenship, 2014) despite little evidence that this reflects true differences in underlying genetic vulnerability or prevalence across racial groups. Instead, these disproportionate rates may be the result of factors such as diagnosticians' beliefs about clients' race or perceptions of patients' honesty (A. Barnes, 2008; Eack et al., 2012). These findings are aligned with the broader literature demonstrating that healthcare providers disregard the first-person testimonies of Black patients more often than they do White patients (Beverley & Hurley, 2021; Fricker, 2007).

The skepticism and invalidation Black individuals often encounter in healthcare settings, paired with a long history of medical racism and exploitation of Black communities, suggests the well-documented mistrust of White medical providers among Black communities has likely been adaptive for Black Americans. Unfortunately, limited availability of Black providers further contributes to mental health disparities.

Limited Access to Treatment

Though 14.4% of the U.S. population is Black (Moslimani et al., 2024), Black providers are underrepresented in most mental health professions, making up just 4% of psychologists, 2% of psychiatrists, 7% marriage and family therapists, and 11% of counselors (Hill, 2022). In addition to well-documented disparities in access to evidence-based treatments for Black individuals (Hankerson et al., 2015; Jimenez et al., 2022; Kozhimannil et al., 2011), there is concern about the cultural appropriateness of such interventions (French et al., 2020) and standardized clinical measures (Adams et al., 2021; Kim et al., 2011). Finally, other social determinants of health, such as increased poverty, lower rates of being insured, limited access to childcare, and less access to transportation, also contribute to disparities in access (Kawaii-Bogue et al., 2017; Office of the Surgeon General (US) et al., 2001).

Context of Present Community-Academic Partnership

The present research is one outcome of an ongoing community-academic partnership which emerged in response to the need to address these mental health disparities in our local community. The community partner, NWP, reduces Black health disparities through a “witness” storytelling model using community health workers to educate community members and navigate them to services (Erwin et al., 2003; Schoenfeld et al., 2006). Author DOE, co-founder of NWP, and Author DJ, National Executive Director of NWP, are both founding members of the UB Psychological Services Center’s Community Advisory Board (CAB). The CAB was established in February 2022 by authors SMT and RLA to better serve the mental health needs of the local community. Though NWP’s content expertise lies in early cancer detection, their work always centers the lived experience of community members in pursuing health equity; mental health was conceptualized as a potentially feasible new service line. NWP has an extensive history of maintaining successful community-based participatory research (CBPR) partnerships for behavioral health intervention development (Ochs-Balcom et al., 2011; Rodriguez et al., 2020; Shelton et al., 2021), and several elements of CBPR are employed in this research. Accordingly, our first step in program development was to understand community members’ perspectives on mental health and associated needs, desires, barriers, and opportunities.

Method

In Study 1, we describe interviews with NWP’s community health workers (CHWs). In Study 2, we describe focus groups with community members across the adult lifespan. Studies were conducted sequentially. Methods relevant to both are described first; individual methods follow. Both studies were deemed exempt by the UB IRB (#00006930).

Analysis

Qualitative Coding Approach

Both studies followed the same inductive analytic approach. Interviewers (Study 1: HNR, SMT, RLA; Study 2: ET, BG, HNR, SMT, RLA) also served as coders. HNR, whose research is rooted in qualitative and mixed methods, supervised the coding process. SMT and RLA have prior qualitative analysis experience; ET and BG received training prior to analysis. Coders used a descriptive, semantic, realist reflexive thematic analysis approach to analysis (Braun & Clarke, 2006), noting potential key themes and paradigmatic interview examples. Each transcript was reviewed in its entirety by two coders. Following open coding, coders met to compare notes, identify common themes, and explore interpretive differences.

Validity Checks

Following initial analysis in each study, coders presented tentative results to NWP leaders DJ and DOE, and integrated feedback into analyses as appropriate. One Study 1 participant, CD, provided feedback as a form of member checking. In two listening sessions open to Study 2 focus group participants and other community members, the study team shared tentative findings from both studies and solicited attendees' perspectives (e.g., resonant or divergent and why). Finally, a draft of the full manuscript was shared with all co-authors for feedback and revision.

Positionality

Our team includes White and Black cisgender women residing in Buffalo from birth to as few as two years. Our education ranges from bachelor's degree to professor emeritus. Across the group we have expertise in clinical psychology, community health science, and intervention development, implementation, and dissemination. Approximately half of the research team have novice to expert knowledge of mental health, but relatively limited knowledge of the community in focus; the other half have expert knowledge of the community in focus and community health, but relatively little mental health expertise.

Authors affiliated with both UB and NWP collaborated at every stage of the research process, including sharing reflexive reflections and discussing how positionality might influence the research. This process enriched our research by enabling us to utilize our diverse expertise while challenging expert assumptions.

Relationships Among Researchers and Community

The UB team members had not met any participants prior to data collection. In contrast, DJ is well-known to CHWs and community members. She supervises CHWs and was not present for any CHW interviews. She was present at Study 2 focus groups and follow-up listening sessions. Another co-author is an NWP CHW. She served as a Study 1 participant but was not present at any Study 2 activities.

Transparency

We closely followed the Journal Article Reporting Standards for qualitative research to promote rigor and transparency in reporting analyses (Levitt et al., 2018). Study measures are available at https://osf.io/tafcq/?view_only=162b7c39ae8f4972ae528fea0e9ab8ac. No data is available to the public due to ethical concerns related to participant privacy and confidentiality.

Study 1: Understanding CHW's Knowledge of and Perspectives on Mental Health

CHWs are trusted members of the community who serve as frontline representatives of community-based health organizations such as NWP. CHWs bridge research-to-community gaps by effectively delivering evidence-based therapies with high cultural competence (Fisher et al., 2014; Medicaid and CHIP Payment Access Commission, 2022). We conducted a series of interviews with CHWs to understand their knowledge of and experiences with mental health, and ideas about program development and delivery.

Method

Recruitment

The pool of active CHWs (≈60) were made aware of the opportunity to participate in interviews about their experiences with community mental health. We set an initial target of 15 interviews, and CHWs with interest and availability to participate were scheduled on a rolling basis. The study team met weekly during data collection to share initial impressions of interview themes and representative diversity of perspectives. Data collection was halted once the team agreed saturation was reached.

Participants

Participants were 13 CHWs with at least five years of NWP experience. Participants were M_{age}=52 (*SD*=19.87; 23–78); 100% cisgender women; 92% Black, and 8% White. While participants were not asked to disclose mental health diagnoses, immigration history, or socioeconomic status, as community members themselves, these characteristics likely reflect their community descriptions (see Results).

Interviews

Prior to interviews, participants received consent forms to review at their leisure; key consent issues were reviewed face-to-face before interviews began. Individual semi-structured interviews ranging from 50–109 minutes (*M*=67, *SD*=19) took place January–March 2023. Participants were interviewed via Zoom (*n*=11) and in person (*n*=2). Interviewers were three White women in their 30s and 40s (authors HNR, SMT, and RLA). Interviews were transcribed automatically using Zoom software and checked for accuracy by ET and BG. Participants were compensated $25.

The interview protocol was developed in collaboration between NWP and UB, with questions ranging from “What does ‘mental health’ or ‘mental illness’ mean to you?” to “How can we increase awareness of mental health services and encourage community members to seek out mental health care when needed? What should we avoid?"

Results

CHWs were asked to focus on their own experiences and the experiences of the communities they live in and serve as CHWs, which they described as "underserved and never-served," mostly Black Americans, and mostly low-income. Findings are presented under four broad topics: 1) mental health needs, 2) barriers to mental health care, 3) willingness to discuss mental health, and 4) critical components for future mental health programming.

Heterogenous Mental Health Needs Influenced by Diverse Local, Global, and Developmental Factors

CHWs perceived community members' mental health concerns as anxiety, depression, loneliness, isolation, grief, anger, fear, and substance dependence and abuse. These problems were described as affecting adults across the lifespan and were understood to arise in response to acute or chronic exposure to trauma, unmanaged or unmodifiable life stressors, and lack of social and instrumental resources. CHWs also encountered community members struggling with suicidality, psychosis, and mania, though these problems were seen as less prevalent.

In addition, CHWs described community members as frequently exposed to racial violence (e.g., disproportionate incarceration rates) and interpersonal violence (e.g., intimate partner violence), leading to persistent fear ("Fear, fear, fear. Just being afraid all the time," Ellen, 73) and grief ("It's kind of hard to be positive when everything around you is so negative," Mary, 64).

Tipping Points. CHWs saw recent, unprecedented events as exacerbating baseline distress. Having endured nearly three years of social isolation, illness and loss, and increased internal and external health surveillance during the COVID-19 pandemic, many community members were “angry because of what they’ve been through—the lockdown that they were in. They already was going through issues [before the pandemic], and [the pandemic] just didn’t help it. It may be a bit more people are into their feelings” and difficult to reach emotionally due to these experiences (Brenda, 69).

Just as the U.S. began to lift pandemic restrictions, Buffalo was visited by racially motivated mass gun violence. CHW interviews took place less than one year following the May 14, 2022 massacre in Buffalo, which they identified as another possible mental health tipping point. Ellen, 73, explained that a Black man from the community had been interviewed in the days following the massacre:

> He said this young man that did the shooting, he sat on a bench and talked with him like the day before. Can you imagine? “I’m sitting here talking to a mass shooter. He's picking my brain. But I’m just a friendly guy. I'm not thinking he wants to harm me.” That messes with your psyche a little bit. So now I’m afraid to talk to people. I’m afraid to be friendly…It makes you closed off from people.

Finally, in December 2022, a historic blizzard brought power outages, cold injuries, hunger, and tragically, 47 lost lives, further traumatizing Buffalo and surrounding towns. A disproportionate number of the deceased and injured were Black and low-income (Kaufman et al., 2023), underscoring the under-resourced, marginalized status of Buffalo’s Black community. This series of extreme events were described by CHWs as contributing to an overall sense of loneliness and isolation among Buffalo’s Black community members. In turn, loneliness and isolation were conceptualized as both symptomatic of and causing further mental health distress.

Antecedent Risk Factors and Causes. Brenda, 69, described how loneliness and isolation exacerbated mental health problems: “You going through something. Maybe [you do] not know how to deal with it. Holding stuff inside. Silence. Silence. Breakdown!” Similarly, individuals transitioning into the community following incarceration were seen as having no support in adjusting to community life, resulting in increased interpersonal problems and difficulty establishing personal stability. CHWs identified fewer available services for low-income individuals, LGBTQ individuals, people with disabilities, and homeless individuals. Lack of social support and mental health education were also described as root causes of widespread use of alcohol and street drugs to self-medicate in response to trauma or psychopathology. As Carmen, 32, put it, “People just know to go to what they're comfortable with—there's a liquor store on every street, even if you can't find a psychologist.”

CHWs were particularly concerned with untreated mental health problems among younger adults (adolescents and twenties) and older adults (roughly sixty and up). Several CHWs identified a tendency toward short-term thinking among *younger adults*. While late adolescence and early adulthood are generally seen as developmental periods characterized by more short-term thinking (Icenogle & Cauffman, 2021), CHWs described this phenomenon as paired with a hopelessness consistent with a foreshortened future. Ellen, 73, explained, “I think that the reason a lot of these kids do the things that they do—is because they don't plan for the future. They just live for today.” CHWs of all ages attributed this to a lack of positive support as children, high exposure to violence, and urgent concerns associated with childrearing, financial insecurity, and interpersonal domestic problems.

Older adults were also highlighted as in greater need of mental health services. Herself an older adult, Ellen, 73, described a pattern she observed in which overwhelming stressors and fear lead to mutually reinforcing and escalating “confusion” and social isolation: “You’re not thinking clearly. You're thinking in so many different patterns…to the point where…you might harm yourself.” So when “confusion of why things that you want for your life [aren’t] falling into place” raises questions like, “Why can’t I have this? Why is it this way?” and “those questions are not answered”:

> You kind of grasp on to something that is not reality, and I think that contributes to your confusion....So then you're like, “I don't feel good...I don't know what's wrong with me.” But physically you're not really hurting anywhere. I think part of it is…they want the help, but they are embarrassed….the first time you say [to them], “Well, maybe you need to talk to somebody.” [They say] “I don't need to talk to anybody—I’m not crazy!”

Barriers to Mental Health Care: Cultural and Material

CHWs identified intertwined cultural and material barriers to receiving mental health care operating on individual, family, and community levels.

Cultural Hesitance to Disclose Problems to Outsiders. CHWs described long-standing community hesitance to engage outside of the family to resolve mental health concerns. Worries centered around emotional safety and threats to future medical care if providers were to weaponize patients’ mental health help-seeking. These concerns arose in the context of community members’ awareness of historical medical racism, as well as first and second-hand negative personal experiences. Revealing mental health concerns was also understood by some to carry risk of being labeled with a stigmatized identity amplified in the context of minoritized racial identity (Gary, 2005). Gloria, 78, described an interaction with a community member she was urging to seek mental health care:

> This one lady did tell me, she says, “I don't want that on my medical record, because then they're going to look at me like…I'm not worthy”…And she used the word *worthy*, and I was surprised…because that should have nothing to do with your mental health, and I explain that to her. I says, “No, you could only get help if you express what you need.” And that's the issue [I see] in most of the underserved communities.

Further, interactions with outsiders was sometimes seen as intrusive and threatening to personal agency. Jessica, 32, explained that for some community members, the idea of talking to a therapist is “like a death sentence for them....‘There’s gonna be this person who’s gonna get like super close and personal with my life, and they’re gonna tell me what to do.’” CHWs also described community members’ worries that treatment would be ineffective or low-quality, given their awareness of the limited availability of providers with racial concordance, shared lived experience, or cultural competence. Many CHWs had themselves experienced and heard stories about mental health providers not listening to clients or following up appropriately. Finally, concerns about psychiatric medication were prominent, including worries that inappropriate medications might be prescribed, and that taking medication could lead to dependence or addiction.

It is important to note that the tendency for Black Americans to keep mental health problems private or shared with trusted confidantes reflects not just skepticism toward providers, but also the sense that one’s family, particularly elders, could provide adequate mental health support. Taylor, 32, shared that when she and her friends were teens struggling with suicidal thoughts,

> The best coping for us was…“praying grandmothers”…We knew somebody was in our corner…And for me, I would say what really kept me from spiraling super to rock bottom was…I didn’t want to hurt my family by hurting myself….[I knew] somebody's listening.

> Somebody is watching. [The message is] “I'm here. I recognize something is going on. I'm not going to force you to talk about it. I'm not going to force you to take the help. But I’m here.”

Material. Four material barriers to accessing treatment were described frequently across CHW interviews. First, a belief that there are *too few providers* reflected both a modest number of local providers and a lack of awareness of all providers. In particular, certain large local providers were often perceived by community members to provide only substance use treatment rather than broader mental health services, which led to reluctance to engage with such providers due to substance use treatment stigma.

Second, lack of personal *transportation* or cost of parking, limited public transportation, and unreliability of paratransit for older or disabled adults made scheduling in-person healthcare appointments onerous. Third, *time constraints* arose around low provider availability outside of the traditional workday; taking time off work, especially on a regular basis, is not feasible for many. Lack of childcare at any time of day posed further constraints. Finally, *financial* barriers applied to both psychotherapy and medication, and included individuals being uninsured or underinsured and a limited number of providers accepting insurance or offering sliding scale fees. These material concerns were seen as mental health stressors unto themselves. Taylor, 32, explained:

> Sometimes people open up…that they are struggling, but they don’t deal with it. So they have like the weight of the world on their shoulders. But if they stop to acknowledge it, it feels like it’s gonna crush them…They’re like…“I just got this diagnosis…My dad just passed…My kids need this paid for. I’m trying to keep food in the house.” And you can tell they’re just kinda either ignoring their issues and their problems, which is causing them

> to…become numb to things and putting themselves in a depressive state, or they…[don't] have that mental capacity to be able to stop, take a moment, think things through.

These stressors were described as piling up such that seeking care feels insurmountable. As Bianca, 24, described, "They've been through so much, they done tried so much, so they at they [wit's] ends like, 'Hey, this doesn't work for me.' You know? They've been disappointed so much."

Increased Willingness to Discuss Mental Health: A New Trend

Across interviews, CHWs described the need for community members to have opportunities to "just be heard" and "be with others," and indeed they had observed a recent increase in community members' willingness to talk about mental health and seek support. Carmen, 32, described the shift as:

> In the past…it was really more of a hush, hush thing…That taboo still exists [but]…before it would be like maybe 85–95% of people are like, "I'm not interested in talking to *anybody* about *anything*." It's more like 50-50 now, or like even…60% are like, "No, I wouldn't mind talking to someone if you can get me connected to somebody that I feel like I can build that conversation with."

Two potential causes were identified. First is the *mental health tipping point*—the supposition that the pandemic and increased racial violence both caused new problems and exacerbated existing problems, leading to a spillover of need. Carmen, 32, described it vividly: "You're witnessing family members die from COVID. You're scared to have your sons out in the street at certain times…It just became too much." Ellen, 73, took a slightly difference stance, expressing her frustration: "No, no, no, no, no! It's not because of the pandemic—we were feeling this way before! [The pandemic] made it more visible because you...didn't have the social connections that you had previously."

Second, CHWs observed *generational differences* in perceptions of mental health; those in their 30s and younger seemed to hold less stigmatized views of mental illness and have greater willingness to discuss mental health topics openly. This was attributed to more education around mental health as well as young parents' desires to "break the cycle" for the next generation. Taylor, 32, described this evolution as building on foundations of family and faith:

> We depend on each other. We lean on each other…The community aspect is very important…You handle it, you know, "in house." So you go talk to your grandmother, your grandfather…your pastor, your missionaries, your elders at church….Prayer is absolutely a necessity. But I also believe God gives us tools [such as psychotherapy] to manage and maintain this walk that we have to take.

Trust, Accessibility, and Visibility: Keys to Successful Mental Health Programming

CHWs were clear that future programming should "meet people where they're at," both psychologically and physically. CHWs reported too many instances of organizations and individuals coming to "help" the community, but with agendas that were out-of-sync with community needs or time-limited due to lack of sustained funding or staffing.

Provider Credibility. Establishing the trustworthiness of mental health providers was described as paramount. CHWs stated "warm hand-offs" from trusted sources, such as one's primary care provider, community center staff, church leader, or friend, are valuable—and building credibility through behavior is necessary. Ellen, 73, illustrated:

> Doctors used to tell me all the time, "People tell you stuff that they don't tell me. Why is that?" Because they feel like you're not listening to them! When I'm talking to a [community

> member], I listen...I wait...to give a suggestion [and make it clear], “This is not a path you have to go down. This is just something you can think about.”

She pointed out it is crucial for providers to center clients’ lived experiences and let patients lead encounters without imposing their own beliefs or treating clients impersonally. Providers’ inattentiveness can have deleterious effects. Gloria, 78, described:

> Just recently this young lady needed…mental health [support]…She needed someone to really sit and talk with her, and she [said] no one wanted to be bothered at her primary care. She says, “Nobody is interested in my well-being…I just wanna go in the corner and not talk to anybody anymore.’”

This exchange exemplified Gloria’s assertion that “especially in the Black community, most of the people feel there isn't a relationship [with providers]—they're just doing their job. ‘They don't care about me. It's just the numbers, or the insurance company is just trying to get paid.’”

Keep Showing Up Authentically. CHWs noted that in their current roles as cancer care educators and navigators, relationships are cultivated through listening to others authentically and sharing authentically of themselves, and this is similarly important in the context of mental health. Geraldine, 72, explained:

> I just tell them some of my business from my past, because I’m transparent like that….Sometimes they…walk away saying, “Her? She went through that.” And that's what it's all about—getting them to know that “it's not only you.” You know, I can't make them come out of hiding; I can't make them share. But as long as they leave with a different head space and knowledge for better, they'll go home and they're better, too, whether they realize it or not.

CHWs also made clear that dependability was key to promoting trust. Carmen, 32, suggested giving out fridge magnets stating clear expectations, such as, “We come…every third Thursday.” She asked the interviewer to imagine:

> You show up every third Thursday. And nobody comes. Then it means *still* showing up every third Thursday until people start to come....It’s not that they don’t want it. It’s just like they don’t know who you are, and...don’t know if you’re here for one time and... you’re not coming back...It goes...back to...meeting people where they are...like, ‘This is your neighborhood clinic.’

She added that showing up meant simply listening “until that trust and rapport is built. And then you can start to kind of incrementally add….‘I’m here…just checking in with you. See how you’re doing. Are there different things you want to address now?’”

Bringing Care to the Community. CHWs urged creativity and attentiveness to cultural and practical preferences when considering locations for mental health care delivery. For example, they suggested bringing care to non-traditional settings such as salons and barber shops, corner stores, senior housing residences, and high-stress workplaces. Taylor, 32, offered, “Even if it was like a kitchen [setting]…That’s where we gather to meet, hang out…We break bread together, and then we talk about what’s going on.”

Some CHWs suggested engaging community members through volunteerism, such as implementing a block club model in which community members would check in on their neighbors or through person-to-person door-knocking campaigns—both strategies already utilized effectively by NWP.

Finally, CHWs advised meeting people “where they are” involves avoiding alienating or excluding community members through highfalutin language or burdensome program requirements. For example, some warned that program recruitment material drawing attention to the university might repel community members. They also stressed the importance of brief, simple recruitment and clinic materials and processes to decrease time and cognitive burdens.

Study 2: Focus Groups

We next sought to invite the voices of community members served by NWP through focus groups. This format was selected both to reach a greater number of community members and to echo familiar NWP group programming.

Method

Recruitment

We aimed to recruit 10–15 participants per focus group, seeking diversity in age and life experience. Prior to focus group meetings, CHWs and residential/program staff invited all Black adult (18+) members of a given constituency (e.g., building residents) to participate in a focus group about Black mental health led by an NWP-UB team. Sample size was therefore determined by the number of those invited who were interested and available to participate.

Participants

Across four focus groups ranging from 7–23 participants each, participants (*n*=54) were 18 to 91 years old and included 34 cisgender women, 17 cisgender men, and 3 who did not report gender. Participants were not asked to share ethnicity, nativity, or clinical diagnoses, but almost all participants identified as Black; participants were not asked to disclose socioeconomic status, but most were recruited through low-income residences.

Procedure

Two focus groups with residents of low-income housing were held in building community rooms. One focus group with women experiencing housing instability took place in a social service agency’s residential building. One focus group with community-dwelling young adults was held in the community engagement center where NWP is headquartered.

Open-ended focus group questions were informed by analyses of Study 1 CHW interviews and a community needs assessment survey (Turay et al., 2024). Groups were facilitated by two young Black women psychology research assistants (ET and BG) with support from HNR, SMT, DJ, RLA, and other NWP staff. Prior to beginning, participants were reminded participation was voluntary and they could leave at any time without consequences. They were informed staying in the group was tantamount to consent to participate, including being audio recorded. Focus groups were 1–1.5 hours each; participants were compensated with $30 prepaid debit cards. Focus group recordings were transcribed and checked for accuracy prior to analysis.

Results

Results are organized to reflect our main categories of inquiry: challenges faced by the community, barriers to mental health care, hopes and preferences for community mental health care programming, and willingness to discuss mental health. Unless indicated otherwise, results were common across all focus groups.

Main Challenges Faced by Community

Focus group participants identified a variety of structural and interpersonal challenges as relevant to mental health.

Structural Challenges. Social determinants of health appeared to be core contributors to mental health symptoms and concerns, showing up as overwhelming stressors or lack of access to basic resources. Tina, 51, stated:

> As soon as I go to my doctor, I drop a tear that quick because I be in so much pain. He looks at me and he goes, “Tina, you’re stressed. You’re literally stressed…Go up to [the hospital

> psychiatric ward] in a white jacket truck.” Don't even worry about the white jacket! Just give me the key where I can let myself in. If I don't call you, don't call me…. That's how I feel because…I'm taking care of 10,000 different things.…I'm so stressed half the time I'm just confused…. I feel my mind just stuck in one spot and I can't think, and I cry so bad.

Participants pointed to lack of tangible resources (e.g., money, housing, and transportation) as hampering their ability to bring about desired changes. For example, Sylvia, 86, stated, “Boredom—not having enough to do” was a major challenge made worse by lack of transportation: “Even though we're seniors and retired, sometimes we just want to be more active and do more things and…if we don't have cars, we can't do a lot of stuff.” Similarly, a lack of power to gather together with other building residents in community spaces was described by Martha, 63, as “not fair to us and our community. It's very, very depressing too. It keeps you from being able to be social.”

Harmful Interpersonal Relationships. Participants sometimes felt mental health problems were exacerbated by invalidating peers and family members. Parent and grandparent participants were highly concerned about growing mental health concerns among their children and grandchildren resulting from bullying, infrequent opportunities for positive socialization, and little support from school staff and other professionals. Further, participants described fear of being alone as linked to the maintenance of mental health problems. For example, Ernest, 73, explained that when people try to get support from friends, “They get judged by somebody that's—they straight, they clean—and they judge, ‘Man, you shouldn't do this or you shouldn't do that because I don't do that’….And then you float away…because he gave you negative vibes.” He then described how this leads to seeking “positive vibes” from “the wrong person, but birds of the feather flock together.” Vincent, 70, agreed: “I've been through the gangs….I lived it all…I've seen the separation in people. Because why? Because every time somebody seen somebody get up, it was like…they could pull them back down like a barrel of crabs."

Tina, 51, described the seeming intractability of such patterns: "Nine times out of 10, when you bring [someone who had been receiving treatment] back into [their previous environment], they're going to relapse anyway because of the environment, their loved ones, and so-called friends." The sense that even loved ones were not always trustworthy emerged as a major theme across focus groups. Among young adults there was a sense that this extended more globally. Destiny, 23, had found "you can't really trust nobody…I wouldn't even trust to tell people how I feel [because] sometimes I don't feel heard. They'll take what I said and then they'll make it about them."

Barriers to Mental Health Treatment

Mistrust of interpersonal relationships, as well as institutions, indeed became obstacles to mental health treatment.

Fear of Backlash from Close Relationships. When prompted to describe who they might ask for mental health support from, Keith, 66, noted, "It takes a lot of courage to reach out for help. A person would just rather try to deal with it on their own." Similarly, Destiny, 23, said "I don't like asking for help. If I'm going through something, I like talk to somebody about it, but that's not really solving any issue." Other participants described themselves as "too prideful" and concerned about becoming "a burden" to ask for help (Samuel, 21), or worried others might "end up rubbing it in my face" (Monica, 26). Tammy, 62, stated:

> I can't talk to my sister because she seems like she wants to go [tell] another [about my problems]…I help them out with food and everything, and they want to talk to me dirty. I'm not a dog. I'm a human being.

Mistrust of Providers. Healthcare providers were also seen as dehumanizing to vulnerable people in their care. Barry, 70, powerfully described his fury after doctors kept changing his diagnoses and prescriptions:

> I said…"This is *my* body, why y'all playing with me? Why y'all doing this to me? I'm taking 13 pills a day!" I take so many pills I don't even think about eating no food sometimes…They done had me on a ping-pong table for years. It does something to you, mentally *and* physically…They. Don't. Care! They make you out of a guinea pig. They don't care. They don't care!

Barry described feeling like a guinea pig because doctors behaved as though they were thinking:

> I'm going to give him this here, and if it works with him, I'll give it to somebody else. But if it don't work with him, and he start getting the shakes, I know I'm not going to give it to that other person [that] got that *excellent* insurance.

Unfortunately, Barry's experience was not unique. Most participants described having healthcare experiences that led them to believe many providers do not care about patients or about providing good care, and that treatment decisions were motivated by selfish interests such as making money. As Paula, 64, quipped, "It's all about that mighty dollar. The more prescriptions he writes, the fatter his pocket gets. He's…more concerned about that than he is about people's lives."

Providers were also described as often being *out of sync with patients' lived experience*. Ernest, 73, described his frustration after attending many different community health fairs and programs that felt ineffective, and then seeing the providers "coming out, getting in they

Mercedes and they Audis and stuff. Because it was just their job….'Let me get back in the suburbs.'"

Concerns about medication were particularly prominent. Participants saw many providers as prescribing medications as a first line treatment, without considering alternatives. Robin, 56, stated the hospital she works at is "short staffed, [so] they have people not trained to deal with mental health" working in mental health care. As a result, "they just push the pills." Participants worried about serious side effects such as mental fog and worsening mental health problems (e.g., increased suicidal ideation). It seemed to Marvin, 75, that taking too many medications can cause "mental anguish." He continued:

> And by you being an older citizen, you going to take what the doctor give you! And…it's 15 side effects….Then it could be affecting [you] mentally, and all of a sudden…[people start asking,] "What's wrong with you? Why you sluggish and sleep all the time?" This is from this medicine…being given.

Medication concerns were one of several types of inappropriate care described, including differential treatment by income/insurance status; not enough time for appointments; and a "revolving door" that simply pushes people out without follow-up care.

Hopes and Preferences for Future Community-Based Mental Health Programming

Participants were asked about the features they would like to see in future mental health programming.

Community-Based, Creative Care. Participants requested greater access to providers within their own communities. Robin, 56, shared, "If…I'm like, 'Lord, I don't know which way to go. I'm stressed with the life, the job, the home. I'm stranded,'" she would prefer help from a community-based organization because staff are more likely to "have integrity [and] empathy."

Virtual mental health visits were suggested by some participants as promoting greater access, and most were more open to this idea. Some raised the possibility of home visits to increase opportunities for care, especially for children and adolescents. Participants also suggested alternative forms of care including nature walks, music therapy, and support groups in informal settings such as barber shops.

Education on Identifying Warning Signs. Many participants were interested in increasing basic mental health knowledge, including signs that someone may need support or be experiencing a crisis, and where to go for help. Russell, 78, offered:

> Most of us, we wouldn't recognize the red flags even within ourselves. Which is why this mental health thing is so prevalent.…Just like they give you the warning signs for strokes…. You might have to set up some of the guidelines so that people can see it…enough to recognize, “Oh! Well. That sounds like me a little bit.”

Participants were also interested in learning how to distinguish mental health problems from personality quirks or developmentally normative behaviors. Sylvia, 86, observed people will “see somebody acting up” and incorrectly assume “because they're living in a senior citizens apartment building…‘She's just old.’ They don't think that maybe that person needs help.”

Authentically Caring Providers. Most of all, participants described a desire for providers to genuinely care about the community and provide high-quality care, highlighting that participants were not wary of mental health care altogether, but rather of being disappointed or harmed through poor care. Vincent, 70, was direct: “Got to teach health professionals to really come to care, not *act* like they care, but really care.” Denise, 73, offered an impromptu testimony about the power of working with a mental health provider who authentically cared:

> Now I’m going to say this and I thank God for it. The psychiatrist that I used to go to when I was a kid….She said, “You could come in here and you could talk to me. Your mother can stay out there…What we talk about, it’ll be between me and you”.…If you can get that relationship with that one person, I’m telling y’all, I was so free. I couldn’t wait to go see my psychiatrist to talk to her and tell her what I was experiencing, what I was feeling. It helps.

Willingness to Talk About Mental Health

Participants were keenly aware of mental health stigma, while acknowledging its somewhat diminishing power.

Stigma. Participants identified reluctance to speak about mental health concerns as stemming from internalized stigma (feeling one should be able to handle problems on one’s own), mental health stigma (concerns they or their loved ones—especially children—might be labeled as “crazy” or “slow”), and social stigma (fear of judgement, gossip, or rejection). Carl, 68, raised the concern, “If people did have problems, they really feel bad about it. I don’t think they would come out and say it in front of this group…There’s a lot of people that gossip.” But he continued, “We wish somebody [in that situation] could get in touch with y’all [psychologists] and tell you how they feel and how you can help them better.” This desire to connect reflects an openness to disclose to an “outsider” deemed trustworthy.

Participants roundly agreed they observed increasing openness to talking about mental health in the community. Older adults tended to credit this phenomenon to young people. Denise, 73, said there “wasn't a lot of talk about mental health when I was coming up….Now I notice that everything is mental health, mental health, mental health.”

Interest in Community Dialogue. There was interest in *intergenerational dialogue* among both younger and older adults. Older adults were interested in sharing wisdom and hearing new perspectives from young people. Russell, 78, addressed his peers, "It's a good thing to learn from them babies….Respect them because they here and they powerful, just like her *[gesturing at moderator, ET]*….She's a baby and she can teach people a lot of things." Similarly, young adults were open to learning from older adults. "It don't matter who I'm around, like how old they are, or their race…as long as they're not judging…I'm like, 'Tell me what I can do better'" (Courtney, 27).

There was *variation in perspectives around the idea of community dialogues*. Some participants indicated they would feel more comfortable sharing mental health concerns among friends, whereas others preferred the idea of dialoguing with strangers. Some participants were concerned that listening to others' problems could trigger problems in listeners; others noted listeners could be motivated to seek needed support.

Participants observed sharing one's story could be *healing to the storyteller*, which we witnessed play out in real time. Within each focus group, there were a handful of participants who shared their personal, difficult experiences with mental health or other life stressors. Other focus group members tended to be supportive. Tina, 51, shared several personal stories. At the end of the group she reflected, "This right here has helped me. It has helped me vent and bring out a lot of stressful things that was bothering me. Not just in the community but in my life as well." Her peers responded with words of affirmation: "I know I was there before!" and "Your story might stop [others] from doing something similar." The predominant atmosphere of the focus groups was nonjudgmental, seemingly holding those group members who shared personal experiences and opinions in equal esteem with those who shared little or were silent. This echoed encouragement from Denise, 73, to create space for those community members who were not obviously engaged:

> I think what you're doing right here, putting that information out there—whether they [seem to] receive it or not, it might be…like, "You know what? I was at a meeting the other day and they gave out some information," and they'll go pick it up and use it.

General Discussion

Major Content Takeaways Across Studies

Areas of Convergence

Findings from CHW interviews and focus groups were largely aligned. Both samples identified similar segments of the community particularly in need of support (young adults, older adults, those coping with multiple forms of oppression), barriers to care (distrust of outsiders, significant wariness around psychiatric medication), and increased community willingness to discuss mental health issues.

There were also several areas of convergence relating to planning for future programming. First was the idea that trust is built over time, accrued through dependability and willingness on the part of providers to *meet participants where they are*, including respect for individuals' readiness for mental health support. This was also a practical concern about increasing effectiveness: meeting community members in the spaces they live, work, and play increases convenience and feelings of psychological safety. In addition, participants advised providers have a responsibility to not just flee "back to the suburbs" after making a community appearance. This point was dramatically illustrated in the following exchange with a focus group member, Carl, 68:

> CARL: Do y'all know the next time you all come here, just offhand?
>
> MODERATOR: We don't have a date yet, but we will be back.
>
> CARL: So y'all don't have a date?

MODERATOR: We don’t have a date yet, but we will be back.

CARL: That’s a killer right there—that’s a killer right there.

Though a productive conversation followed, including providing readily available resources and referrals, Carl’s response reflected the frustration many participants had with past providers they perceived to be uncommitted to the community. At the same time, participants conveyed a lack of shared community membership and lived experience could be mitigated through cultivating *authentic care* and *genuine empathy*.

Finally, both samples described a benefit to *just being together* and *witnessing and being witnessed*. While there was mixed interest in sharing personal stories, there was more uniform support shown for those who made sensitive personal disclosures—through the nonjudgmental way CHWs described their experiences with community members, and through the validation and respect focus group participants gave to each other.

Areas of Nuance or Divergence

There was variation between CHWs interviews and focus groups, as well as across focus groups. CHWs tended to include more speculation regarding the *why*s of various phenomena, likely because of the “outsider/insider” perspective invited during interviews, their knowledge of social determinants of health, and more extensive speaking turns in interviews. For example, focus group participants had observed recent changes in willingness to discuss mental health, but did not attribute these to specific causes in the way several CHWs did (pointing to the pandemic and May 14 massacre as tipping points). Similarly, whereas focus group participants described individual consequences of internalized stigma and social stigma, CHWs raised more concern about institutional discrimination (e.g., through healthcare providers), likely because of their experiences witnessing such discrimination first- and second-hand.

Another interesting contrast was how CHWs and focus group participants discussed resource constraints encountered in daily living. CHWs described these factors as sometimes so crushing they both caused mental distress and rendered treatment-seeking practically and psychologically infeasible (e.g., unreliable transportation makes keeping appointments difficult and may be one of many competing concerns so treatment is not prioritized). In a subtly different way, focus group participants tended to describe these factors as thwarting their personal agency (e.g., Sylvia's explanation that a lack of transportation limited her ability to actively engage in the world).

Although the topic of *trust* was prominent across both samples, CHWs tended to focus on how *institutional mistrust* is maintained within the community while focus group participants were more focused on *interpersonal mistrust*. Several CHWs provided vivid personal examples of feeling supported by friends and family in their own mental health struggles. In contrast, many focus groups members described personal relationships strongly characterized by mistrust and lack of support, noting that experiences with negligent or even malicious friends and family perpetuated a fear of disclosing mental health concerns. In facilitating the young adult focus group in particular, authors sensed overwhelming global mistrust among the participants. In the exchange below, four young adults seem to agree they have learned trusting others can be dangerous, and withdrawing from relationships is an important tool to protect oneself:

> MODERATOR: I want to elaborate on this trust thing that I heard from you…What has made life for you as young people so overbearing that you guys don't trust people? Is it your pride, or have you been mistreated, or—?
>
> SAMANTHA (25): Being let down. I don't want to get into too much detail—but being mistreated.

DEVIN (19): Also just our own pride sometimes…Because, shit, you can give all you got to a person and they don't give nothing in return….Some people are too ignorant to see who you trust or you don't trust…I've had friends…go right behind your back and [talk about you].

SAMUEL (21): …Me personally, I prefer to be with who I grew up with. Like people I've gone to high school with—I've seen 'em mad, I've seen 'em at their best…but like I said, people change over time too…

MONICA (26): That is true, boo. I feel like that's when—we was talking about the loneliness coming—you've got to take a step back and see your surroundings…

DEVIN (19): ...That's when to the point where we talked about "let's step back"….You want to step back *before* anything happens to you.

Though the described cycle of hurt, mistrust, and withdrawal was linked to isolation and negative mental health repercussions, we also underscore our earlier observation that these participants built a genuine rapport over the course of the hour, suggesting the possibility of trust remained.

Setting the Stage for "Witnessing for Mental Health"

In two listening sessions, we presented and sought community feedback on our findings. While space constraints prevent lengthy discussion of these listening sessions, participants roundly indicated our findings resonated with their lived experience. Listening session members conveyed interest and curiosity about discussing mental health issues and an eagerness for new programming. Our findings suggested the basic structure of existing NWP programming could be adapted to the topic of mental health to fulfill at least some community needs and allow CHWs to "hit the ground running" because of their familiarity with program structure.

“Witnessing for Mental Health” (WMH) Program Structure

The adapted NWP program, WMH, will follow a standard NWP program structure. Prayers or hymns, offered by a CHW or community member volunteer, always open and close programs. A CHW trained in personal storytelling will serve as a “witness role model,” sharing their lived experience with mental health challenges and successes. Focus group participant Denise’s testimony about her childhood psychiatrist is paradigmatic of such “witnessing.” The bulk of the program involves an interactive CHW-led educational presentation about mental health. Example planned topics include mental health basics, social isolation and depression, coping with stress, and understanding psychiatric medication. Program content and structure are expected to evolve as we iterate in response to ongoing assessment. At the conclusion of the program, attendees will complete a brief mental health screener and interest form to indicate desire for mental health care navigation. All attendees will receive resource lists related to Black mental health, local mental health services, and local opportunities for community connectedness and engagement.

Consistent with the literature (Anglin et al., 2008; Jang et al., 2015; Ward et al., 2013), NWP has found it is crucial to offer both *evidence-based health education* with *resource navigation*. Therefore prior to the launch of WMH, CHWs will receive extensive training in Psychological First Aid, mental health education, and navigation for mental health needs, so they are not only prepared to lead programs, but to navigate participants through screening, treatment-seeking, and crisis response. Our team is working to develop a stepped-care model that connects individuals to the appropriate level of care using “warm hand-offs” to culturally competent providers. This includes navigation to community resources, single-session interventions (Schleider & Beidas, 2022), traditional psychotherapy, psychiatric care (Essien et al., 2021), or acute crisis care.

Limitations and Future Directions

Our ability to engage with diverse stakeholders using multiple data collection methods was a key strength in informing the development of WMH. However, we had relative difficulty recruiting young adults (*n*=7) and did not meet our recruitment goal for that age group. While this echoes the broader age distribution of adults served by NWP, it limits the generalizability of our claims. In addition, we note by virtue of their interest and ability to attend focus groups, Study 2 participants may be more willing than other community members to discuss mental health and may have a higher level of functioning. Our team continues to seek to identify and learn from community voices we have not yet heard.

WMH does not meet all of participants' desires identified in the present research; we are therefore exploring additional program types. For example, to meet community members' need to "just be heard" and "just be together" in more open, relaxed settings, we may develop personal writing workshops or facilitated dialogue programs. We also continue to learn from existing mental health programming tailored to diverse Black American communities (e.g., Mance et al., 2010; Mbilishaka, 2018; L. Williams et al., 2014) and are working to secure funding that will sustain our partnership.

Constraints on Generality

We believe our findings might be most "generalizable" (Simons et al., 2017) to other Black, low-income communities in American cities, with relatively less generalizability moving from more to less marginalized social positions across these dimensions. We believe our semi-structured interview could be readily adapted for use in other communities experiencing mental health disparities.

As with most community-engaged, qualitative research, our aim was to produce research that both reflects community members' lived experiences and resonates meaningfully in a way that is “recognizable” to a broader audience. The present research was conceived of, collected, and interpreted through a local lens; indeed, it was prompted by a heinous act of violence that left permanent scars on the history of Black Buffalo. Even with these deep wounds, NWP leaders were surprised that in the immediate aftermath, so many community members would forthrightly acknowledge their desire for mental health support. Our research suggests this disclosure may have been brought about by unprecedented stressors (i.e., mass shooting; pandemic) layered on top of ongoing inequities, as well as cultural and generational shifts toward a more positive view of talking about mental health. In some ways these factors are plainly—and importantly—local, allowing us to gain an understanding of the local instantiation of broader patterns in Black American mental health. At the same time, we suggest these same findings might reverberate in unique ways among other researchers and community leaders, leading to culturally grounded mental health research urgently needed in so many communities.

Conclusion

Our partnership of community-based health experts and academic clinical psychologists embarked on a year-long process of identifying the mental health needs and preferences of low-income Black adults in Buffalo. We found participants’ first-person perspectives added important depth and specificity to past research about racial inequities in mental health treatment, severity, and chronicity. For example, many participants echoed oft-reported mistrust and subsequent avoidance of healthcare providers (Suite et al., 2007; Whaley, 2001), and also introduced concerns about trusting peers, neighbors, and even family members, leading to social isolation. At the same time, CHWs’ and community members’ converging views on the possibility and promise of gathering in community to learn about and discuss mental health provides important motivation for psychological researchers and community health organizations to work toward creating safe community spaces that promote trust, dialogue, and education.

In an incisive commentary titled “African Americans and the reluctance to seek [mental health] treatment,” Patricia Whitfield (2021) writes, “African Americans have lived for more than 400 years in a kind of psychological fun house with mirrors that reflect everything in exaggerated shapes. The message: ‘Your life experience does not matter.’” Through gathering and validating first-person perspectives as we conduct research, and by being accountable to those perspectives in the development and delivery of Witnessing for Mental Health, we aspire to demonstrate to Black Buffalonians that their lived experiences indeed matter deeply. We further hope to underscore the value of these lived experiences by ensuring they are represented in the scientific literature, informing research and practice to improve mental health disparities.

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