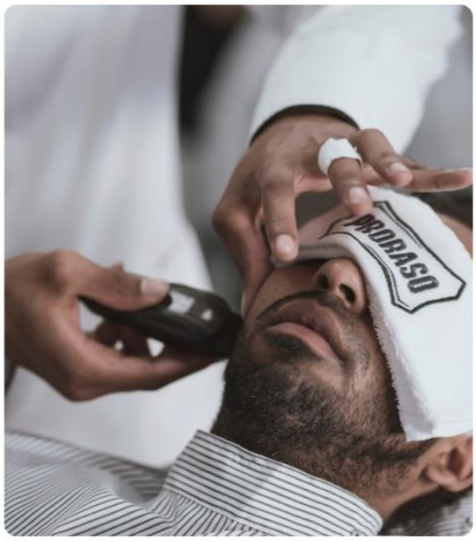
CLINICAL SCHOLARS

A Robert Wood Johnson Foundation program



Toolkit for Mental Health Improvement Through Study, Teaching, Rebranding, Embedded Education, and Technology (MHI STREET)

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ABOUT THE PROGRAM

Clinical Scholars is a national leadership program of the Robert Wood Johnson Foundation led by the University of North Carolina at Chapel Hill. Learn more about RWJF's Leadership for Better Health programs by visiting: rwjf.org/leadershipforbetterhealth

ABOUT THE TOOLKIT

This toolkit can be used as a guide for practitioners interested in positively influencing mental health outcomes, increasing mental health literacy, and an example of embedded education in action. For more information, contact: healthymind@mhistreet.com

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Toolkit for Mental Health Improvement Through Study, Teaching, Rebranding, Embedded Education, and Technology (MHI STREET)

In the District of Columbia (DC), Black Americans (BA) are twice as likely as other races to report a serious mental health (MH) disorder especially if they live in poverty and did not complete high school.[1] In MHISTREET's service area of Ward 8 in Southeast DC, more than 95% of the population is BA, 38% of the population lives in poverty, and only 55% completed high school.[1,2] There is evidence that common MH disorders are distributed according to a gradient of economic disadvantage across society; the poor and disadvantaged suffer disproportionately from common MH disorders and their adverse consequences.[3] It is therefore expected the negative impact on MH is compounded by the geographic concentration of underemployment, lack of economic opportunity and poverty in Southeast DC.

In the United States, BA men are 30% more likely than non-Hispanic white men to be diagnosed with MH disorder [3] and 60% more likely to attempt suicide than white males.[3] Despite the disproportionate experience of MH disorders, associated morbidity and adverse behavioral changes less than 25% of BA men seek MH care. The reasons for both the higher morbidity and low care-seeking include racism discrimination, stigma, distrust of the healthcare system and low MH literacy.

- Over 1 in 4 U.S. adults experience a mental health disorder in their lifetime
- Black Americans are more likely than other ethnic groups to report morbidity from mental health disorders but less than 25% seek care
- Higher morbidity and non-care seeking behavior are often due to racism, discrimination, stigma, health system distrust and low mental health literacy (knowledge, behavior, and attitude around MH)
- In Southeast DC this is exacerbated by the geographic concentration of poverty and underemployment

Influencing Community Mental Health Literacy

The purpose of the MHI-STREET Barbershop Embedded Education (BEE) initiative is to positively influence mental health (MH) in black men by increasing the mental health literacy (MHL) of black barbers and their black male clients with a specific focus on Southeast DC.

MHL is the knowledge, attitudes and behaviors around mental health and mental health services. The intent is to increase MHL through embedded education in non-traditional spaces such as barbershops. Embedded education, a recognized innovation in governance, is the practice of educating people through everyday interpersonal encounters within organizations that exist for non-educational purposes. MHI STREET is partnering with barbers and men with other lived experience to encourage conversations in local barbershops in order to increase MHL and bridge connections to MH services.

Planning

1. **Choosing the issue** – With 30 years of combined clinical experience, the team often observed patient engagement impeded by unaddressed mental health needs such as depression, trauma, stress and adverse childhood experiences. The decision to focus on MH literacy was reinforced and reaffirmed by a rigorous review of literature, quantitative and qualitative data collection, extensive community engagement, and consultation with community stakeholders.
2. **Choice of sub-population** – Black American (BA) men are 30% more likely than non-Hispanic white men to report having a mental illness and experience greater morbidity. In addition, suicide attempts among BA men are 1.6 times higher than white men. Despite this higher morbidity, less than 25% of BA seek MH care.
3. **Neighborhood selection** – Across DC, BAs are twice as likely than other races to report a serious MH disorder especially if they live in poverty and did not complete high school. In the team's clinical practice area in Ward 8, more than 95% of the population is BA, 38% lives in poverty, and only 55% completed high school. The team concluded that that the negative impact on MH was likely compounded by the geographic concentration of underemployment, lack of economic opportunity, and poverty.
4. **Approach selection** – The approach dramatically changed over the first few months of the program. The team drew from community-based participation research principles and used the five-step action research methodology: problem identification; organization of a plan of action; data collection, including triangulation of data; organization and analysis of data; and planning for future action. Through the iterative action research process (Fig. 1), the program was refined and redirected to meet the needs of the sub-population.
5. **Anchor institution** – Emerging literature has highlighted the power and potential of institutions with long-term, rooted investments in a particular location to transform neighborhoods, cities, and regions. After much exploration (detailed on page 5), barbershops were selected as the anchor institution. Unlike healthcare sites and religious organizations, they were regarded as a trusted and equalizing space and barbers as trusted members of the community.

RATIONALE

- **Black Barbershop**: A Third Space (neither work nor home)
- **Black Barbers:** Trusted members of the community
- **Peer Education:** Way of rebranding MH and changing the conversation around MH to reduce fears and stigma to increase feelings of safety and trust
- **Embedded Education:** Providing education in non-educational spaces to fill in the gaps where the health system fails to reach certain populations
- **Storytelling:** An evidence-based education method that increases the likelihood of change in one's attitudes, beliefs, and behavior

TEAM COMPOSITION

- Dr. Erin Athey*
- Dr. Nnemdi Elias*
- Pearly Ittickathra – Program Coordination
- Dr. Kevin Washington – Clinical Psychologist & Curriculum Development
- Alfred Graham – Master Barber
- Tony Dugger – DC Commissioner for Fathers, Men and Boys
- Lorenzo Lewis – Confess Project
- George Washington University public health students
- Dr. Brian Kelley – Innovative Funding Partners
- The Ward 8 Mental Health Subcommittee

**Clinical Scholars Fellows*

KEY SKILL SETS

- Creating and leveraging new partnerships and relationships.
- Community engagement and community collaboration.
- Data collection, curriculum development and facilitation skills.

Project work

FORMATION OF COMMUNITY ADVISORY BOARD

Drs. Athey and Elias were regular attendees of the Ward 8 Health Council meetings. The council was created by a former mayor of D.C. to convene stakeholders committed to improving the health of Ward 8 residents. It consists of D.C. residents and representatives from local managed care associations, hospitals, universities and community-based organizations who meet monthly to share information and ideas. Poor and unaddressed MH was continually raised as a serious issue.

Based on their interest and consistency with the council, they were invited by one the Chairmen to create a MH sub-committee. Its mission was to promote and enhance policies and practices which increase access to mental and behavioral health services, decrease stigma in MH, promote MH wellness and improve mental health literacy and outcomes for individuals living in Ward 8. The sub-committee members reflected the diversity of the council. This council influenced the decision to change the original project design.

PRE-IMPLEMENTATION DATA COLLECTION

Through the team's rigorous review of the literature, consultation with the MH committee and other community input, the program evolved to focus solely on the community. It was important to the team to reach residents that were not engaged with the traditional health system.

- **Quantitative Data Collection:** The team developed an academic partnership with the public health school of a local university. Through this partnership, they served as site directors for several master's level research projects. These projects were designed to gain a better understanding of the MH landscape in Southeast D.C. The projects included MH knowledge, behavior and attitude surveys of private primary care providers and patients in Southeast D.C.; the use of GIS mapping data to analyze the reasons for frequent use of the UMC's emergency room and a sub-analysis of those patients who were found to have co-occurring MH disorders; systematic literature reviews on topics such as health programming in barbershops and black American perceptions of mental health.
- **Qualitative Data Collection:** The team conducted a listening tour and hosted several community engaged studios and informational interviews to hear various perspectives on MH from various community stakeholders. These meetings were conducted with church leaders, health department officials, local residents, medical professionals, the D.C. Chapter of the National Association on Mental Illness and local core service agencies (outpatient MH clinics).

Ward 8 Mental Health Subcommittee Mission:

To promote and enhance policies and practices which increase access to mental and behavioral health (MBH) services, decrease MBH stigma, promote MBH wellness, and improve MBH literacy and outcomes for individuals living in Ward 8 of Washington D.C.

SELECTION OF MENTAL HEALTH LITERACY AS CORE INTERVENTION

As a result of strong community input and data collection, increasing MHL became the goal of the intervention. The community advisors felt addressing this gap was essential to improve community mental health.

MHL is the "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention" and may include attitudes, stigma, positive mental health, and help-seeking efficacy related to help-seeking and mental illness.

SELECTION OF ANCHOR INSTITUTION

The team understood that an anchor institution was critical to successful program implementation. The term "anchor institution" was coined by Michael Porter in 2002. Emerging literature has highlighted the power and potential of universities, hospitals, and other institutions with long-term, rooted investments in a particular location to transform neighborhoods, cities, and regions.

Originally, the team thought that the local hospital in the community would serve as the anchor institution due to their association to the hospital and its connection to health. However, that idea was abandoned due to the reputation of the hospital and the desire to reach further into the community.

The team then explored the black church, given its role and historical importance to the black community. In a search for successful and replicable models, they engaged with PEWS (Promoting Emotional Wellness and Spirituality) at the Mental Health Association of New Jersey. PEWS trained faith leaders in mental health to better address the need within their congregations. The team also engaged with the local D.C. Department of Behavioral Health's faith-based director to explore replicating a similar model in Southeast D.C. It was discovered that there was already a nascent program, but more importantly, the committee advised that there were large segments of the population that would not be reached through religious organizations.

After extensive consultation, barber shops were selected as the anchor institution to implement mental health literacy programming. Unlike healthcare sites and religious organizations, barber shops were regarded as a trusted and equalizing space and barbers as trusted members of the community. In addition, they were non-medical settings with no "negative psychological baggage."

USE OF BLACK BABERSHOP FOR MENTAL HEALTH LITERACY

Within black communities, the black barbershop has long served an important social and cultural purpose. It has been a safe gathering place for black men. It is where people have received their news, registered to vote, and shared their personal struggles. The barber is often not just the person who cuts hair but serves as a confidant.

This connection between barber and client in black communities places the barber in a unique position to be a strong partner and leader in increasing MH literacy, specifically among black men. In addition, the black barbershops place in the community enables interaction with women and children so health interventions will impact families and the broader community.

After the barbershop was selected as the anchor institution, the team conducted a systematic review of barbershop interventions to evaluate their effectiveness. In addition, they sought best practices from several existing barbershop programs in the U.S. and abroad. In the United Kingdom, they consulted specifically with the Lion's Den, a barber shop MH program recognized by Prime Minister Theresa May and Prince William.

USE OF EMBEDDED EDUCATION FOR MENTAL HEALTH LITERACY

The team chose this recognized innovation in governance tool to deliver MH information. Embedded education is the practice of educating people through everyday interpersonal encounters within organizations that exist for non-educational purposes.

Embedded education uses existing social relationships and trust between individuals and organizations or within social networks to deliver content that learners can immediately use and share. The purpose is to enable people to make informed choices that can improve well-being using efficient and effective new modes of education. By using the existing trust environment of the barbershop and minimal supplies, MHI STREET's barbershop approach provides the potential to reach a MH service neglected population.

As a barbershop client waited for or received services, he became a learner in a health-related educational encounter. The encounters occurred between the barbers and their clients and/or between the community residents/peer educators and the clients. The educational content is MH information transmitted via conversations between the barber and the client or between the community resident/peer educator and the clients.

BARBERSHOP EMBEDDED EDUCATION CURRICULUM DEVELOPMENT

With guidance from multi-disciplinary community partners on the MH sub-committee, the authors created a culturally relevant MH curriculum for embedded education in barbershops. It was based on the previous work of a collaborating partner, Dr. Kevin Washington, then a professor of psychology at a local university. He had developed a MH curriculum that was specifically designed for BA men.

The team met with the MH sub-committee over several weeks. The final product was a six-module curriculum that incorporated pop-culture, race, and social justice themes. It contained interactive lessons, music, video, and audio presentations.

BARBERSHOP EMBEDDED EDUCATION TRAINING

The project structure for the Barbershop Embedded Education has three parts: barbers are trained on MH using the curriculum; barbers engage with clients; and barbers share resource information with interested clients. The team partnered with a local Master Barber who championed the embedded education concept and recruited the first barbers for training.

In 2018, a pilot cohort of barbers were trained using this curriculum once a week over six weeks. The sessions lasted approximately 2 hours and included lunch and refreshments. At the conclusion of the training, focus groups were conducted with the barbers to obtain structured feedback. The barbers shared that the training was beneficial to them. Feedback included:

- "This was great, I hear people's problems all the time and I didn't know how to help them!"
- "I used to think people's issues were too big to overcome and now I know there is help out there."
- "I did not realize that there is help out there for my brothers."

At the conclusion of the training, focus groups were conducted with the barbers to obtain structured feedback. The barbers shared that the training, though beneficial, was too long. It interfered with their work schedules and led to a loss of earnings. The financial incentive provided for attendance was not enough to counterbalance this.

PROGRAM REDESIGN AND USE OF STORYTELLING

With the barber feedback and input from community advisors, the team understood the program needed to modified. Serendipitously, the team found and engaged with the Confess Project in Arkansas. In this project, a community MH advocate, Lorenzo Lewis, shares his powerful story of adversity and the benefit received from mental health counseling within black barbershops. Through storytelling he increases the MHL of barbers and their clients.

Using their original barber training curriculum as a guide, the team redesign the program based on the Confess Project. This redesigned program has three parts: a) recruit a cohort of community members b) train them on MH and storytelling to share their own stories of using MH services and supports c) deploy them into barbershops as mental health peer advocates.

The decision to use the ancient and powerful vehicle of storytelling was drawn from the structure of the Confess Project. Storytelling is an evidence- based education method that increases the likelihood of behavior change based on the activation of neurotransmitters in the brain responsible for concentration, empathy and connection. Storytelling, particularly stories that resonate individually, has the ability to change one's attitudes, beliefs, and behavior and can be a powerful vehicle for change.

REDESIGNED PROGRAM IMPLEMENTATION

In partnership with the Confess Project, members of the original advisory committee and the DC Commission for Fatherhood, Men and Boys, the team hosted an inaugural training event for the new iteration of the project.

A one-day training conference yielded a robust audience of 40 men from the community. A subset of those declared interest beyond the initial training and stated a willingness to share their stories in barbershops and connect people to resources.

The scholars met monthly over several months with the cohort of community members affectionately referred to as the "BEE Squad". In these meetings, the BEE squad learned more about MH, practiced storytelling and facilitation of group discussions.

In between these monthly sessions, the team visited all barbershops in Southeast D.C. to share information about the project. For those that showed interest, the team organized the logistics for the BEE Squad to perform the intervention.

Evaluation and dissemination

The RE-AIM Framework (Fig. 1) and Kirkpatrick Model (Fig. 2) were used to evaluate the project. The RE-AIM Framework was developed in the late 1990s. It has been more recently applied to the planning and evaluation of behavioral, policy, systems, and environmental changes. The framework includes five core elements corresponding to the letters in the name:

- **Reach:** How do I reach the target population (barbers, & community residents/peer educators & barbershop clients)?
- **Effectiveness:** How do I know the intervention is working?
- **Adoption:** How to develop organizational/setting support to deliver intervention?
- **Implementation:** How do I ensure it is delivered properly?
- **Maintenance:** How do you incorporate the intervention so it is delivered over the long-term?

The team used Kirkpatrick's Four Level Evaluation Model as the methodology for assessing learning processes. It considers any style of training, both informal or formal, to determine aptitude based on four criteria:

1. **Reaction: What learners thought or felt about the training**
   - The team administered post-training session evaluations for the first cohort of barbers and the first cohort of the MH peer advocates. This served to evaluate the **immediate-term** reaction to the training. The data is summarized in the image below.
2. **Learning: To what degree the learners acquired intended knowledge**
   - The team administered pre and post-training session quantitative evaluations for the first cohort of barbers and the first cohort of the MH peer advocates. This served to evaluate the **short-term** effectiveness of the training in transmitting knowledge and changing their attitudes about MH.
   - Using direct observation post-session, the peer advocates storytelling and facilitation ability was assessed.
3. **Behavior: To what degree they applied what they learned; extent of behavior and capability improvement and implementation/application.**
   - The team administered post-training session quantitative and qualitative evaluations for the first cohort of barbers and the first cohort of the MH peer advocates. The served to evaluate the **short-term likelihood of behavior change** as a result of MH education. Ultimately however, actual behavior change for the client audience will be an intermediate measure.
   - Using post-session informational questionnaires, the first cohort of barbers were surveyed to assess degree of implementation.
   - Using direct observation, the peer advocates storytelling and facilitation skills were assessed within the barbershop.
4. **Results: The effects on the business or environment resulting from the learner's performance.**
   - The team intended to assess the client's **perception and awareness of MH and MH services.** However, they found there was resistance to in-shop surveys, both written and oral.
   - **Facilitation of connections to mental health services**
   - The long-term effectiveness, measured as **increased access and utilization of MH services** would require several years of data.

Figure 1:

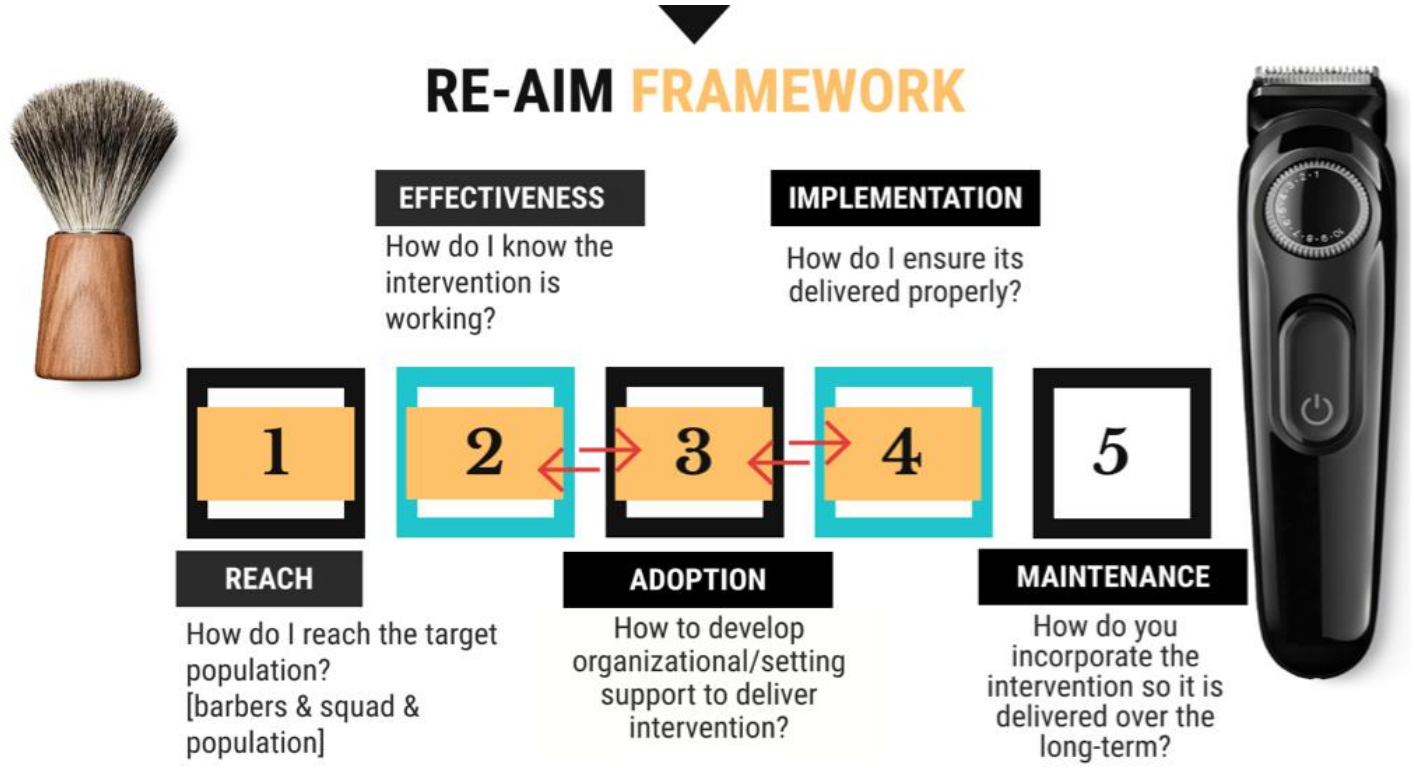

Figure 2:

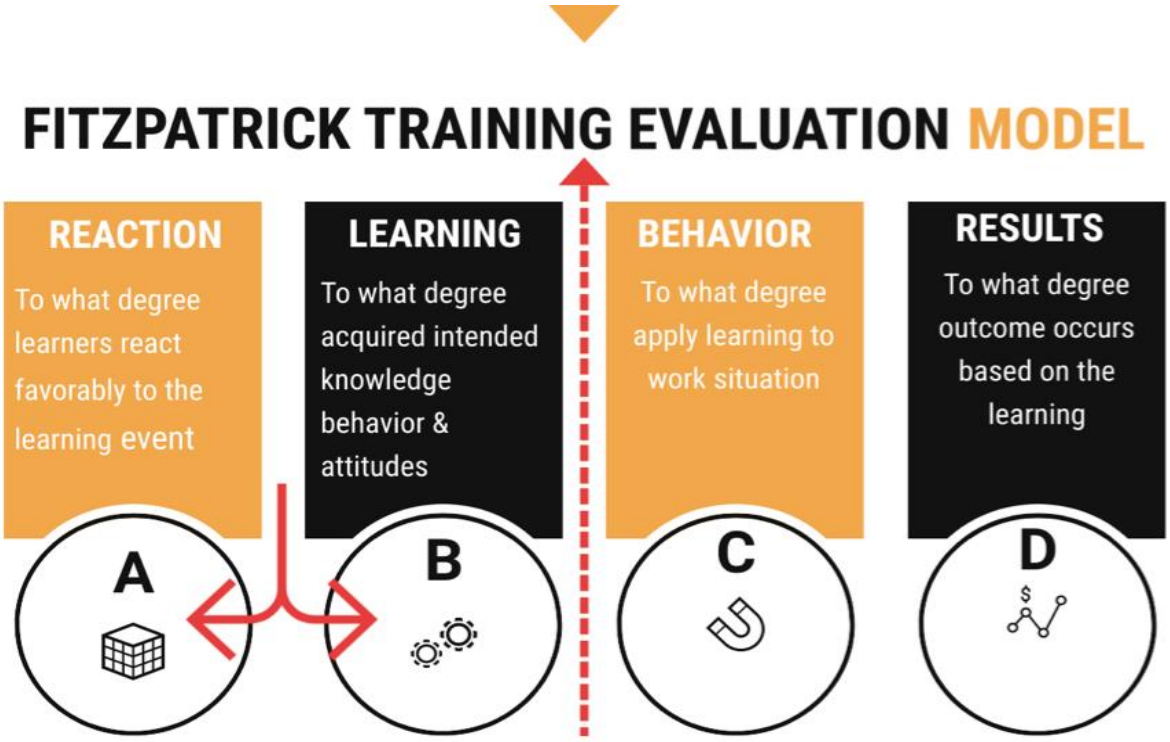

Figure 3:

Figure 4:

KEY MESSAGES

- The mental health of blacks and especially black men are negatively affected by social and structural factors. However, less than 25% seek mental health care.
- An important factor to stimulate the use of mental health service use is by increasing MHL – the knowledge, behavior and attitude regarding mental health.
- It is essential to use innovative methods to increase MHL in this population as several social and structural factors impede their access to the health system.

Challenges, successes, and lessons learned

One of the project's strengths was building an engaged network of professionals, community-based leaders and organizations to inform the program.

By creating and leading the Mental Health Sub-Committee Advisory Group (MHS) of the Ward 8 Health Council, it allowed access to the insight and knowledge of thought leaders. It generated several active collaborations and a deeper awareness of local strengths, resources and needs. It was through the work of this entity and other stakeholders that the decision to select barbershops as the anchor institution was made and curriculum developed.

The team approached all barbershops in Ward 8 through door-to-door visits and was able to collaborate with over 90% of them on the program. Also, a non-profit corporation was established for program sustainability.

CHALLENGES

- Infrastructure: Loss of the team's anchor institution
- Funding: Lack of funding to compensate and retain the peer advocates
- Personnel: Logistics and coordination across barbershops
- Time: Amount involved in developing a new program

SHIFTS IN THINKING

A shift in thinking for the team was the choice of anchor institution. The team originally thought the local hospital or the black church could fulfill this role. After extensive community consultation, it was determined that social and structural factors such as health system mistrust and stigma impeded access to the mental health system for many. Regarding the church, it was determined that large segments of the population would not be reached through religious organizations. This led to the selection of barbershops as a safe, culturally appropriate space.

LESSONS LEARNED

- **Building Trust:** A critical aspect of the work is building trust with the community. Being a professional and a healthcare provider does not automatically engender trust. However, keeping commitments and listening with humility is important.

"WHEN YOU HAVE A GUN, YOU HAVE THE POWER – PEOPLE HAVE TO DO WHAT YOU WANT."

This statement was from Gil, a member of the BEE Squad who was sharing his life story. He shared how he felt as a young man walking the streets of SE D.C. He was unaware of his own internalized trauma in addition to his own need for safety and emotional and mental wellbeing.

It was not until he went away (his euphemism for incarceration) that he realized how isolated and confused he felt. He shared that when he returned to society "that you have to let go of what you have learned, it is a re-education process." In doing so, he sought support for his unresolved trauma. He shared that the stigma and "being less than a man" almost prevented his doing so. He wanted to be part of the MHI STREET initiative to share his story to benefit others.

- **Cross-Sector Partnerships and Networking:** A diversity of perspectives, sectors and disciplines is essential for innovation, growth and sustainability. These lead to new insights and ideas.
- **Adaptability and Patience:** New, community-based programs require comfort with ambiguity. Progress can be very slow and non-linear. Theoretical models may fail. Changing direction mid-course will often be necessary. A flexible approach is key.
- **Community Engagement:** The strength of this program and similar ones is the voice of the community. Although cliché, this work cannot be accomplished by outsiders. The invaluable insight and collaboration of people who live, work and play in the community of interest is vital.

Recommendations

If tackling this issue in community, the first thing to do is to conduct a series of informational interviews and meet with several stakeholders and community leaders. One cannot proceed without understanding their concerns and confirming that one's ideas align with theirs.

If tackling this issue in community, it is not recommended to have too wide a scope in the beginning if starting a new program. Narrow may seem unimaginative but one can always build on and expand the program after it has begun.

BEST PRACTICES

What we wish we would have known from the beginning:

- How much time and energy it takes to start a new community-based project! It literally takes an (organized!) village.
- How important funding is to the success of a program. It is important that everyone is compensated for their time. One cannot assume otherwise.

The best pieces of advice we can give:

- Be very thoughtful and realistic about the amount of time, effort and energy you can give to the project and openly communicate this with your team members from the beginning!
- Form several partnerships and collaborations so one can accomplish much more than the team would do alone.

ADDITIONAL RESOURCES

MHIStreet

- Website: **MHISTREET.com**
- Instagram: **MHISTREET**
- DCist Article: **This Program Uses Black Barbershops As Ground Zero To Quash Stigma Behind Mental Healthcare**