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#BlackGirlsTalk: A Pilot Program to Raise Awareness about Depression among African-American Women in Baltimore, MD

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An abstract of
A thesis submitted to the Faculty of the
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Abstract

#BlackGirlsTalk: A Pilot Program to Raise Awareness about Depression among African-American Women in Baltimore, MD

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Major depression is one of the most common mental disorders in the U.S and the second most common cause of disability-adjusted life years (DALYs) lost from ages 15-44. It causes severe symptoms that affect how one feels and thinks, interfering with their ability to carry out daily activities such as sleeping, eating, working or studying. Some symptoms of depression include persistent sadness or emptiness, feelings of hopelessness or worthlessness, loss of interest in hobbies, decreased energy or fatigue, difficulty concentrating, and difficulty sleeping. It is projected that by 2030, depression will be among the top three leading causes of burden of disease. African Americans make up approximately 13% of the U.S. population, yet they account for 18.6% of those affected by mental illness. On the 2016 Behavioral Risk Factor Surveillance System Survey, 34.7% of African American adults reported poor mental health status. Despite these findings, African-Americans are least likely to receive treatment for depression and other mental illnesses. African-American women, in particular, are among the most undertreated groups for depression in the country. They are at a higher risk for developing mental illness and have a higher prevalence of depression than men. Through a tailored, public health education campaign, the #BlackGirlsTalk program seeks to address some of the individual and systemic-level barriers to help-seeking among this population. These barriers, which will be further described later in this application, include stigma, cultural beliefs and attitudes, stereotypes, preferred coping strategies, and lack of awareness/knowledge. Education campaigns targeting the African American community should address common depression- and treatment-related beliefs using culturally appropriate images and language. Additionally, funding from this grant will be used to enhance the mobile application, “The Safe Place”, which is a mental health tool designed to educate and raise awareness about mental illness in the African American community. We will build a database into the application that will allow users to locate African American therapists in Maryland, increasing awareness about culturally appropriate psychotherapy services that are available.

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CHAPTER I: INTRODUCTION

Major or clinical depression is one of the most common mental disorders in the U.S and the second most common cause of disability-adjusted life years (DALYs) lost from ages 15-44 (SAMHSA, 2017; Pascual & Rosenberg, 2015). Disability from this disorder is associated with lower educational attainment, lower levels of income, work absenteeism, and reduced productivity. It is also associated with suicide and a variety of chronic diseases, including diabetes and heart disease (Hudson et al, 2016). Depression causes severe symptoms that affect how one feels and thinks, interfering with their ability to carry out daily activities such as sleeping, eating, working or studying (NIMH, 2016). Some symptoms of depression include persistent sadness or emptiness, feelings of hopelessness or worthlessness, loss of interest in hobbies, decreased energy or fatigue, difficulty concentrating, and difficulty sleeping. Symptoms must be present most of the day, nearly every day for at least 2 weeks in order for someone to be diagnosed with depression (NIMH, 2016). Some Individuals have one only occurrence of depression during their lifetime, however it is more common to have several episodes. Depression is most commonly treated with medications or antidepressants, psychotherapy, or a combination of both methods (NIMH, 2016). If left untreated, depression can lead to poor quality of life, self-injury or suicide, substance abuse, increased absenteeism and academic/occupational impairment (Sohail, Bailey & Richie, 2014).

It is projected that by 2030, depression will be among the top three leading burden of disease causes (Mathers & Loncar, 2006). In 2016, about 16.2 million adults aged 18 and older (6.7% of all U.S. adults) experienced at least one major depressive episode (MDE). Of this group, nearly two-thirds had an MDE with severe impairment, which means these individuals had difficulty managing at home, managing well at work, maintaining relationships with others or maintaining a social life (SAMHSA, 2017). Data from the National Health and Nutrition Examination Survey (NHANES) showed that during 2013-2016, 8.1% of American adults 20 years of age and older experienced depression in a given 2-week period. Results also revealed that major depressive disorder is more prevalent among women than in men in every age group and across all racial/ethnic groups, except non-Hispanic Asian. In fact, during 2013-2016, women (10.4%) were almost twice as likely as men (5.5%) to have depression (NCHS, 2018). Earlier results from the 2009-2012 NHANES indicated that African-Americans had higher rates of mild, moderate and severe depressive symptoms than whites (NCHS, 2014).

Problem Statement

African Americans make up approximately 13% of the U.S. population, yet they account for 18.6% of those affected by mental illness (U.S. Census Bureau, 2016; NAMI, 2015). On the 2016 Behavioral Risk Factor Surveillance System Survey, 34.7% of African American adults reported poor mental health status (KFF, 2016). Despite these findings, African-Americans are least likely to receive treatment for depression and other mental illnesses (Gonzalez et al, 2010). African-American women, in particular, are among the most undertreated groups for depression in the United States. They are at a higher risk for developing mental illness and have a higher prevalence of depression than men (Ward, 2009). A 2007 study showed that African-American women had a prevalence rate of 13.1% compared to 7.0% among African American men (Williams et al., 2007).

African Americans have long experienced significant health disparities and poorer health outcomes compared to other racial groups (Riley, Hayes & Ryan, 2016). Barriers to mental health service utilization among African Americans are multifaceted and deeply rooted in their history of adverse experiences. African Americans were subjected to slavery, segregation, oppression, racism and social/institutional inequality. Because of these experiences, African Americans have sustained or remained subject to traumatic psychological and emotional injury (Hackett, 2014; Sotero, 2006). Additionally, the exploitation of black people in scientific and medical research, such as the Tuskegee Syphilis Study, has fostered a legacy of distrust in the healthcare system among African Americans.

Systemic barriers to quality and culturally appropriate mental health services may be inherently entrenched in U.S. health care delivery systems (Davis & Ford, 2004). There is a growing body of literature indicating significant disparities between the quality of mental health services provided to African Americans and the quality of services provided to others. Some of these disparities include under-diagnosis and ineffective treatment of affective disorders (i.e. depression and anxiety), over-diagnosis and overtreatment of psychotic disorders (i.e. schizophrenia), prescribing of older and/or less utilized antidepressant medications, which typically have more side effects, and disparities in evidence-based care that is in keeping with professional treatment guidelines (Holden & Xanthos, 2009). Factors that contribute to the poorer quality of mental health care provided to African Americans are lack of African American providers, lack of cultural competency and culturally appropriate assessments; and clinical bias.

Program Description and Purpose

Through a tailored, public health education campaign, the proposed #BlackGirlsTalk program seeks to address some of the individual and systemic-level barriers to help-seeking among this population. These barriers, which will be further described in the next chapter, include stigma, cultural beliefs and attitudes, stereotypes, preferred coping strategies, and lack of awareness/knowledge. Research demonstrates that increasing knowledge and awareness about mental health illnesses and treatment options is fundamental to increasing mental health service utilization, especially among racial/ethnic minorities (Conner et al., 2010). Education campaigns targeting the African American community should address common depression- and treatment-related beliefs using culturally appropriate images and language (Conner et al., 2010). Additionally, funding from this application will be used to enhance the mobile application, "The Safe Place", which is a mental health tool designed to educate and raise awareness about mental illness in the African American community. The application will include a built-in database that will allow users to locate African American therapists in Maryland, thereby increasing awareness about available culturally appropriate psychotherapy services.

Information gathered from the pilot campaign will be used to finalize the campaign products; inform the development of the #BlackGirlsTalk Campaign Toolkit; further develop "The Safe Place" application to include a nationwide mental health directory of African-American therapists; and implement a statewide campaign to reduce stigma and discrimination related to depression, improve attitudes and behaviors toward mental health service utilization, and create more supportive communities for African American women in Maryland.

Program Objectives

The #BlackGirlsTalk Program intends to:

1. ***Raise awareness about depression, including risk factors, identification of symptoms, healthy coping strategies, and treatment options.***

Information will be shared through social media, and local media outlets (radio and print) targeting African-Americans. Promotional materials, such as brochures and fact sheets, will be disseminated through community partners, including churches, community centers, and local businesses.

2. ***Modify beliefs, attitudes/stigmas and practices around depression and treatment.*** By working with local mental health service providers, members of the target population receiving treatment for depression will be recruited to develop radio and print public service announcements (PSAs) sharing their personal experiences with depression and treatment successes.
3. ***Determine the effectiveness of the program by conducting an outcome evaluation.*** Pre-campaign telephone and paper surveys will be administered to establish baseline data on depression-related knowledge, attitudes and practices. Post-campaign surveys will be administered to estimate exposure to the campaign among the target population and determine how exposure influenced their knowledge, attitudes, and practices, as well as intentions to seek help for depression. Post-campaign focus groups will be conducted to further explore these indicators and ensure that campaign messages and materials were culturally appropriate and appreciated among the target population.

Theoretical Framework

Theories and models of change should inform health communication strategies that offer different perspectives on the target audience and the actions needed to change behavior (National Cancer Institute, 2004). By combining theories to address the individual-level barriers of help-seeking among African American women, we are more likely to succeed. The development of the #BlackGirlsTalk Campaign will be guided by the Health Belief Model (HBM) and the Theory of Planned Behavior (TPB). Both theories are applied at the individual level to help health practitioners explain and influence the behaviors of individuals, while giving special attention to intrapersonal factors such as knowledge, attitudes, beliefs and motivation (National Cancer Institute, 2005).

Health Belief Model (HBM). The Health Belief Model (HBM)advances one of the most widely recognized theories in health promotion practice. It is comprised of six main constructs that explain or predict what motivates people to take action to prevent, screen for and control illness: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cue to action and self-efficacy (National Cancer Institute, 2005). This conceptual framework states that health behavior change is a function of both knowledge and motivation (National Cancer Institute, 2004). When applying HBM, it is assumed that individuals are more likely to take health-related action if they believe that they are susceptible to an illness, that the illness poses a serious risk, that there are various beneficial options available to them to reduce those risks, and that expected benefits outweigh barriers to action (Glanz, Rimer, Viswanath & Orleans, 2008). In order to achieve the goals of increasing depression awareness and help-seeking behaviors among African American women, we will consider specific communication strategies to increase individual perceptions of susceptibility to depression, decrease the psychological and cultural barriers to help-seeking, and increase the perceived benefits of help-seeking.

Theory of Planned Behavior (TPB). The Theory of Planned Behavior (TPB) focuses on individual motivational factors as predictors of behavior, holding behavior intention as the most important predictor of behavior (Glanz, Rimer, Viswanath & Orleans, 2008; National

Cancer Institute, 2005). In the context of addressing mental health, the theory assumes that an individual's attitude toward the behavior and beliefs about whether people most important to them approve or disapprove of the behavior (subjective norm) influence any decision to seek or reject mental health services (National Cancer Institute, 2005). It also states that perceived behavioral control or the belief that an individual has control over performing a behavior may influence relevant decisions and actions. (National Cancer Institute, 2005). According to TPB, attitudes toward behavior are influenced by an individual's personal beliefs and evaluation of the behavior and its outcomes. Social normative beliefs and motivation to comply affect subjective norms. Perceived behavioral control is influenced by the presence or absence of factors that will make it easier or more difficult to perform the behavior. In turn, these three constructs, attitudes toward behavior, subjective norms, and perceived behavioral control, all influence behavioral intention, which ultimately drives behavior (National Cancer Institute, 2005). This model has been successfully used to predict and explain various health behaviors and intentions, including health services utilization, which therefore, recommends it as a powerful development guide to planning of the #BlackGirlsTalk campaign. This tool should lead to insight into African American women's knowledge and attitudes around mental health, which, in turn will allow us to develop campaign messages and materials that will encourage our audience to identify symptoms of depression and seek help. Using this model, we predict that African American women are more likely to engage in seeking treatment for depression if they have positive attitudes toward help-seeking, believe that treatment is acceptable to key people in their lives, and feel that they have control over their decision to seek treatment.

Significance Statement

Major depression has significant and severe individual and societal consequences, including increased disability, morbidity and mortality. Although research shows that African-American women are disproportionally affected by the disorder, additional research is needed to develop and evaluate the effectiveness of interventions that aim to reduce stigma and address other major barriers to help-seeking and treatment among this population (Ward et al, 2009). Intervention programs like #BlackGirlsTalk, that are designed to increase awareness about depression and treatment, while breaking down stigma and common misconceptions associated with the disorder, can be integral in increasing treatment-seeking behaviors and reducing mental health disparities among the targeted group. Findings from the program's evaluation will contribute to the knowledge base of mental health and inform future research and interventions for African-American women.

Definition of Key Terms

Depression (Major Depressive Disorder or Clinical Depression)

According to the National Institute of Mental Health, depression is a common mood disorder that causes severe symptoms that affect how one feels and thinks, interfering with their ability to carry out daily activities such as sleeping, eating, working or studying. Some symptoms of depression include persistent sadness or emptiness, feelings of hopelessness or worthlessness, loss of interest in hobbies, decreased energy or fatigue, difficulty concentrating, and difficulty sleeping. Symptoms must be present most of the day, nearly every day for at least 2 weeks in order for someone to be diagnosed with depression (NIHM, 2016).

Help-Seeking

In this context, help-seeking is defined as any action of getting guidance, treatment, or general support for mental health issues from professional mental health service providers, such as a psychiatrist, psychologist, general practitioner, mental health nurse, etc. (Rickwood & Thomas, 2012; Umubyeyi et al, 2015).

Mental Health

This paper uses the World Health Organization’s definition of mental health, which is a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO, 2014).

Mental Health Services

Mental Health Services are defined as the assessment, diagnosis, treatment or counseling in a professional relationship to assist an individual or group in alleviating mental or emotional illness, symptoms, conditions or disorders.

Mental Illness

According to the Centers for Disease Control and Prevention, mental illness refers collectively to all diagnosable mental disorders and is characterized by sustained, abnormal alterations in thinking, mood, or behavior associated with distress and impaired functioning (CDC,2011).

Racism

Racism is defined in this paper as a system of structuring opportunity and assigning value based on race that unfairly disadvantages some individuals and communities and unfairly advantages other individuals and communities (Jones, 2002).

Stigma

In this paper, stigma is referred to as the negative perceptions of societal beliefs (stereotypes), feelings (prejudice), and behaviors (discrimination) toward individuals with mental illness, as well as the process whereby individuals with mental illness judge themselves (Fox et al, 2018; Overton & Medina, 2008).

CHAPTER II: LITERATURE REVIEW

A. Historical Barriers and the Legacy of Distrust

Historical trauma is defined as “the cumulative and collective psychological and emotional injury sustained over a lifetime and across generations resulting from massive group trauma experiences” (Heart, 2003). Due to the collective nature of this phenomenon, descendants or children of the affected group who were not directly exposed to the traumatic stressor, can still exhibit trauma-related symptoms (Mohatt et al, 2014; Simmons, 2017). The barriers to mental health service utilization among African Americans are multifaceted and deeply rooted in a history of adverse experiences. African Americans were subjected to slavery, segregation, oppression, racism and social/institutional inequality. As a result of this trauma, African Americans have sustained or remain subject to traumatic psychological and emotional injury (Hackett, 2014; Sotero, 2006).

The struggles of this population started with the enslavement of Africans, which was grounded on the belief that black people were inherently and genetically inferior to whites (Leary, 2005). There is evidence to support that the legacy of slavery, and the pain and suffering that followed has continued to severely and negatively affect African Americans’ well-being. (Leary, 2005). Racism of all forms has made its mark on the psyche of the African American community, which has been manifested through poor mental and physical health, amongst other maladaptive behaviors and social issues (Woods, King, Hanna & Murray, 2012). In order to fully understand mental health among African Americans and provide insights for eliminating health disparities, it is important to recognize how the historical trauma they faced influences their current mental and behavioral health.

History of Medical Experimentation on African Americans

During the antebellum era and beyond, the medical world regarded African Americans as a lower order of human beings. Medical experts believed African Americans were untrustworthy, sexually promiscuous, submissive by nature, and not appropriately suited to take on intellectually challenging tasks. These characterizations, among other racist sentiments, made them the preferred targets for heinous medical research experiments (Suite et al, 2007).

The Tuskegee Syphilis Study is perhaps the most widely recognized notorious medical experiment in African American history and a classic case of overt government-sanctioned racism. It was conducted by the United States Public Health Service from 1932-1972 to study the progression of untreated syphilis among 400 African American male subjects in Macon County, Alabama (Kennedy, Mathis & Woods, 2007). The study participants were never informed that they had the disease, and researchers withheld treatment from them even after penicillin became widely available as the standard of care for syphilis (Freimuth et al., 2001; Kennedy, Mathis & Woods, 2007). It is estimated that 28 to 100 men died as a result of the disease (Freimuth et al., 2001). Because of the degree and duration of deceit and mistreatment, this study has become a central focal point to explain African American's cultural mistrust of the health care system.

The Tuskegee study was not the only case where black people were exploited in medical research. Cultural mistrust of the health care system started long before the Tuskegee experiment. Another classic example of unethical use of black people for medical research is the experimentations of J. Marion Sims, the "father of gynecology". From 1845-1849, Sims used enslaved, African American women as his experimental subjects to find a cure for vesico-vaginal fistula (VVF) (Ojanuga, 1993). These female slaves were brought to Sims by their masters because with their condition, they were unable to fulfill their duties. Due to their lack of power and agency over their bodies, these women were involuntarily operated on without anesthetics. They endured extreme pain and suffering as a result of these operations, with some nearly losing their lives (Ojanuga, 1993). It was not until Sims perfected his procedure that he attempted it on white women, with anesthesia (Gamble, 1997).

Other acts of medical mistreatment are illustrated by the involuntary sterilization of African American women in the 1960s to 1970s (Okeke, 2013). During the peak of the eugenics era, poor black women were subject to sterilization procedures, also known as “Mississippi appendectomies”, against their consent or without their knowledge ("The Immortal Life of Henrietta Lacks", 2011). These examples illustrate the unethical utilization of black bodies for scientific and medical breakthrough, fostering a legacy of distrust in the healthcare system among African Americans.

History of Racism and Racial Bias in Mental Health

In addition to medical and scientific research, there has also been a history of racism and racial bias in mental health. In 1797, Benjamin Rush, the father of American psychology, declared that African Americans suffered from a rare, inherited disease called “Negritude”, which was considered a mild form of leprosy (Hackett, 2014; CCHR, 2004). According to Rush, the only cure for the disease was to become white. This so-called disease was used to justify segregation, in order to keep whites from getting infected (CCHR, 2004).

An 1840 U.S. Census Report deliberately falsified insanity rates to show that northern free blacks were 11 times more likely to be insane than southern slaves (CCHR, 2004; Forret, 2016).

This false evidence was used to support the view that blacks were not equipped to handle freedom and that slavery was necessary and good for them (CCHR, 2004; Forret, 2016).

In 1851, Dr. Samuel Cartwright, a well-known physician from Louisiana and a leading thinker in the proslavery movement, diagnosed two mental health disorders that were exclusive to African Americans, “Drapetomia” and “Dysaethesia Aethiopica” (Jackson, 2013). Cartwright described Drapetomia as a disease of the mind that caused slaves to run away from their slave owners. He identified “whipping the devil out of them” as the primary intervention for the condition and suggested that blacks be kept in a submissive state and treated like children to keep them from running away (CCHR, 2004; Jackson, 2013; Hackett, 2014). Additionally, Cartwright concluded that Dysaethesia Aethiopica affected both the mind and body of blacks, claiming that symptoms included physical signs and lesions (CCHR, 2004; Jackson, 2013). He suggested that whipping could be a cure for that disorder as well (Jackson, 2013).

Furthermore, in 1968, New York psychiatrists Walter Bromberg and Franck Simon established “Protest Psychosis” to suggest that the Black Power Movement drove “Negro men” to insanity (Hazin, 2011; Hackett, 2014). The condition was later identified as schizophrenia, which almost instantly went from a disease that primarily affected middle-class white women unable to fulfill their household and maternal duties, to a disease of violent, black men (Hazin, 2011). To the present time, African Americans remain three times more likely to receive a schizophrenia diagnosis than whites (Escobar, 2012).

The legacy of mistrust of the healthcare system by the African American community is deeply grounded in the history of slavery, racism and oppression. Well-known historical experiments of profound racism like the Tuskegee Study significantly contribute to African American's negative attitudes about seeking health care services (Ward et al, 2009).

B. Individual-Level Barriers

There is a growing body of literature that highlights the many barriers to African Americans seeking treatment. Individual-level barriers (interpersonal and intrapersonal) refer to how individuals view and experience their encounters with the systems designed to provide mental health services (Davis & Ford, 2004).

Stigma

Stigma associated with mental illness has been identified as the most significant and pervasive barrier within the African American community, discouraging those in need of mental health services from seeking treatment (Ward et al, 2009; Davis & Ford, 2004). In this paper, stigma is referred to as the negative perceptions of societal beliefs (stereotypes), feelings (prejudice), and behaviors (discrimination) toward individuals with mental illness, as well as the process whereby individuals with mental illness judge themselves (Fox et al, 2018; Overton & Medina, 2008). In the early 1980s, a study found that African Americans, more than any other racial/ethnic group, held the most pervasive negative attitudes toward persons with mental illness (Ward et al, 2009). A public opinion poll in the 1990s showed that 63% of African Americans believed that depression was a personal weakness and only 31% believed it was a real health problem (Ward et al, 2009). Later research found that in the African American community, mental illness is associated with shame and embarrassment, and both affected individuals and their families hide their illness (Thompson et al, 2004). Consequences associated with the stigma of mental illness among African Americans include social distance or rejection, loss of relationships, loss of social or “normal” status, and the appearance of being weak (Matthews et al, 2006; Mishra, 2009).

Cultural Beliefs and Attitudes

Cultural beliefs prevalent within the African American community can also serve as barriers to diagnosis and treatment. A common belief among African Americans is that mental illness is something that does not affect black people (Okeke, 2013). Furthermore, many believe that family concerns should be resolved within the family and that African Americans should always demonstrate strength (Thompson et al, 2004). This expectation partly stems from the historical adversity that African Americans endured, which led to the belief that black people will always be at a disadvantage. Therefore, they have to be tough and resilient. As a result of this thinking, seeking treatment, such as psychotherapy, is often associated with weakness and diminished pride (Thompson, et al , 2004).

Other common cultural stereotypes or myths that contribute to stigma in the African American community include the assumptions that mental illness is contagious, that people with mental illnesses are dangerous and unpredictable, and that affected people are hopeless and have no chance for recovery. Due to these assumptions and the fear of stigma, many African Americans who need help, hide their distress, cover up their symptoms, and avoid seeking help or treatment, leading to worsened mental health outcomes (Mishra et al, 2009).

The “Strong Black Woman” Stereotype (SBW)

For women, in particular, there is also the stereotype of the “Strong Black Woman”, which describes the societal place of black women and the need for them to possess strength to carry them through adversity. The underlying expectation is that black women have “built-in capacities to deal with all manner of hardship without breaking down, physically or mentally" (Okeke, 2013). This ideology is problematic as it can be understood and internalized as the super-human capacity to withstand excessive amounts of stress, leading suppressed emotions and adverse health outcomes among black women (Woods-Giscombé, 2010). As revealed through focus groups from a 2010 study, many black women feel obliged to manifest strength for the sake of their family and friends, to internalize or suppress emotions, to meet the needs of others, to be resistant to vulnerability or dependency, and to succeed despite having limited resources (Woods-Giscombé, 2010). The pressure to maintain the image of the strong black woman has been shown to interfere with treatment seeking behaviors among African American women (Ward, 2009).

Preferred Coping Strategies (Faith, Spirituality, and Community)

Spirituality is a core component of the American-American belief system and a survival mechanism that has helped African Americans cope with the psychological pain of racism, discrimination and oppression (Hackett, 2014; Davis & Ford, 2004). Many African Americans view mental illness and emotional distress through the lens of religion and spirituality, rather than health (Mishra et al, 2009). Defining mental illness as a spiritual problem places greater value on solutions within the spiritual framework, sometimes rejecting other frameworks (such as mental health) and their suggested treatments (Mishra et al, 2009).

To cope with mental health issues, African Americans tend to rely on informal supports, such as the church, family, friends and community resources (Hackett, 2014). Women, in particular, are more likely to use religious practices, such as praying or talking to their pastor, instead of seeking formal help from mental health professionals (Ward, 2009). This high reliance on spiritual and other informal supports has contributed to the underutilization of mental health services among African Americans (Hackett, 2014).

Lack of Knowledge or Awareness

Lack of knowledge or awareness about mental health issues and available resources present additional obstacles to treatment within the African American community. A 2004 study found that many African Americans, even those with higher levels of education, lack adequate knowledge about mental illnesses to accurately identify signs and symptoms. They found that it was especially challenging for some to recognize at which point it was necessary to seek professional services. This lack of knowledge often leads African Americans to consult churches for information or referrals, as well as emergency rooms for help (Thompson et al, 2004). In another study, participants discussed not knowing that the problems they were experiencing were considered mental health issues. They assumed that the problems were normal responses to the difficulties of life and that they just needed to keep persevering. As their problems worsened and affected their ability to function normally, the participants expressed feeling ill-equipped to identify appropriate strategies and resources (Hines-Martin et al, 2003).

C. Economic Barriers

For many African Americans, access to mental health services is often limited by financial resources and the availability of services. Research has identified key economic barriers among this population, which include but are not limited to insufficient monetary resources, lack of adequate insurance coverage or no insurance coverage of any kind, high hourly fees, and location of residence (Davis & Ford, 2004; Thompson et al, 2004; Mishra et al, 2009). African Americans have some of the lowest incomes among racial/ethnic groups in the U.S., and due to low socioeconomic status, are often forced to live in poor, inner city communities with few mental health resources (Holden & Xanthos, 2009; Davis & Ford, 2004). Rural communities also often lack of mental health care providers. Thus, African American residents of these resource-poor communities are faced with additional transportation expenses and sometimes extended time off from work in order to obtain mental health services (Davis & Ford, 2004).

D. Systemic Barriers

Systemic barriers to quality and culturally appropriate mental health services may be inherent to health care delivery systems (Davis & Ford, 2004). There is a growing body of literature indicating significant disparities between the quality of mental health services provided to African Americans and the quality of services provided to whites. Some of these disparities include under-diagnosis and ineffective treatment of affective disorders (i.e. depression and anxiety), over-diagnosis and overtreatment of psychotic disorders (i.e. schizophrenia), prescribing of older and/or less utilized antidepressant medications, which typically have more side effects, and disparities in evidence-based care that is in keeping with professional treatment guidelines (Holden & Xanthos, 2009). Factors that contribute to the poorer quality of mental health care provided to African Americans are lack of African American providers, lack of cultural competency and culturally appropriate assessments; and clinical bias.

Insufficient Number of African American Providers

The low percentages of African American providers in the mental health care system presents another barrier to treatment for many African Americans. Statistics from a 2012 SAMHSA workforce report indicated that approximately 55.8% of mental/behavioral health professionals are non-Hispanic white and 27.9% of the behavior healthcare workforce is black/African American. Across the different disciplines, it was estimated that racial and ethnic minorities make up 19.2% of all psychiatrists, 5.1% of psychologists, 17.5% of social workers, 10.3% of counselors, and 7.8% of marriage and family therapists (SAMHSA, 2013). The National Alliance on Mental Illness (NAMI) reported that only 2% of psychiatrists, 2% of psychologists and 4% of social workers in the United States were African Americans (NAMI, 2009). Given the current needs and projected demographic growth of people of color in the U.S, these numbers are significantly inadequate (Smith, 2015).

Cultural Competence and Clinical Bias

Cultural competence has been defined as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations” (Brach & Fraserirector, 2000). This concept encompasses clinicians’ cultural awareness or sensitivity, cultural knowledge and respect for different cultural beliefs, and the ability to effectively implement cultural competency techniques in cross-cultural situations (Brach & Fraserirector, 2000). It is well-documented that there is a lack of cultural competency in mental health services, preventing African Americans from seeking and receiving appropriate mental health treatment (Holden & Xanthos, 2009; Hackett, 2014). Research has shown that lack of cultural competence in care has major implications for African Americans, as it affects assessment, diagnosis and treatment in clinical practice (Hackett, 2014).

Clinical bias, for example, occurs when “clinicians’ perceptions of African American clients are influenced by prejudices and/or stereotypes, or when African American clients are judged against the cultural norms of Caucasians” (Davis & Ford, 2004). This could result in inappropriate clinical decision making around diagnosis and treatment for African Americans (Holden & Xanthos, 2009; Davis & Ford, 2004). Additionally, African Americans who are suffering from mental illness may present symptoms differently from what most clinicians are trained to expect, which could lead to diagnostic and treatment planning problems if these differences overlooked (Holden & Xanthos, 2009).

Use of Culturally Inappropriate Assessments

The use of culturally inappropriate measurement instruments in mental health settings presents additional issues for African Americans. Standard assessment instruments do not take into account cultural differences, which can affect the accuracy of assessment and diagnoses processes, as well as treatment planning (Holden & Xanthos, 2009; Davis & Ford, 2004). African Americans, as with any other racial or ethnic group, have unique cultural characteristics which encompass their values, norms, attitudes and expectancies. It should not be assumed that these concepts can be measured in the same way across the spectrum of racial and ethnic groups (Davis & Ford, 2004). As previously noted, symptoms of psychological distress among African Americans may be expressed differently than those of whites. Therefore, as previously pointed out, many assessment instruments may be invalid when administered to African Americans, resulting in the under-diagnosis of affective disorders and the over-diagnosis of psychotic disorders, as described earlier (Davis & Ford, 2004).

CHAPTER III: METHODOLOGY

Review of Relevant Funding Agencies

The federal government is a major source of funding for mental health services and research, creating a number of opportunities to better understand mental health disorders and improve interventions, treatment and future research. The two main federal agencies that support work in this area are The Substance Abuse and Mental Health Services Administration (SAMHSA) and The National Institute of Mental Health (NIMH).

The Substance Abuse and Mental Health Services Administration (SAMHSA) is a branch of the U.S. Department of Health and Human Services, which is charged with leading public health efforts to improve the behavioral health of the nation. Its mission is to reduce the impact of substance abuse and mental illness on America's communities by improving the quality and availability of prevention, treatment, and recovery support services for behavioral health. The agency makes grants available through the Center for Substance Abuse Prevention (CSAP), the Center for Substance Abuse Treatment (CSAT), and the Center for Mental Health Services (CMHS). Grants through the CMHS are most relevant to the proposed program, as the center's primarily supports efforts to promote the prevention and treatment of mental disorders (SAMHSA, 2018).

The National Institute of Mental Health (NIMH) is the lead federal agency and largest funder of research on mental disorders, globally. The agency is part of the National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services. Its mission is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. The agency provides funding for projects that fall under their priority research areas: neuroscience and basic behavioral science; translational research; services and intervention research; aids research; research training and career development; small business research opportunities; technology development and coordination; genomics research coordination; and research on disparities and global mental health (NIMH, 2018).

Though this agency does not focus primarily on mental health, the National Institute of Minority Health and Health Disparities (NIMHD) supports projects that improve minority health and reduce health disparities, which makes it relevant to the proposed project. NIMHD is another one of NIH's agencies whose work impacts millions of Americans who are burdened by disparities in health status and health care delivery, including racial and ethnic minority groups, rural populations, populations with low socioeconomic status, and other population groups. The agency has three main research priorities that focus on impacting the health determinants that contribute to poor health outcomes and to health disparity conditions: Clinical and Health Services Research, Integrative Biological and Behavioral Research, and Community Health and Population Sciences. NIMHD provides funding for a variety of research, training, infrastructure development, and outreach and information dissemination projects that fall under these main research priorities.

In additional to federal agencies, there are a number of foundations, charities and non-profit organizations, such as the Brain & Behavior Research Foundation and The Mental Health Foundation**,** that fund mental health research and programs. For some of these organizations, mental health research is not a primary area of focus for their funding; however, they still commit a substantial amount of money to mental health research (Wooding, 2016).

Summary of Grant Announcement

The NIH Funding Opportunity, entitled Innovations for Healthy Living - Improving Minority Health and Eliminating Health Disparities, is a Small Business Innovation Research (SBIR) grant that seeks to fund projects aimed at the development of innovative products (i.e. diagnostics, treatments, and prevention strategies, etc.) and making these products available and accessible to racial and ethnic minority populations or other health disparity populations. Ideally, the proposed product will provide increased and more attractive opportunities for improved and better health, preventing and treating disease, and maintaining a long and healthy lifestyle. Specific areas of research interest, as it pertains to the proposed project, are: culturally appropriate, evidence-based health empowering promotion and disease prevention educational media such as software, informational videos, printed materials for health disparities populations and disadvantaged communities; and culturally attuned behavioral interventions or low-cost tools and technologies (e.g. software apps for mobile devices) that empower and promote opportunities for individuals and communities to engage in health-seeking behaviors (diet choice, exercise/physical activity, oral hygiene, medication adherence, child immunizations, etc.) and to avoid risky behaviors (smoking, alcohol/drug misuse, unsafe sex, etc.).

Total funding for this type of grant typically does not exceed $150,000 for new applications. Congress allows awards to surpass this amount up to a hard cap of $225,000; however, due to a budget waiver that NIH received from the Small Business Administration, awards can exceed the hard cap for certain approved topics. Only small business concerns

(SBCs) operating in the United States are eligible to apply for this grant. Specific criteria for SBCs are described in detail in the FOA.

Grant Review Criteria and Process

Reviewers were provided with the review criteria that were outlined in the grant FOA for their guidance. They were asked to consider the significance of the project to the field and to the reduction of health disparities; the suitability and background experience of the investigators; the utilization of novel ideas or innovative approaches; the feasibility and appropriateness of the overall project approach; and supports of the project environment that contribute to the success of the project. The review committee provided feedback that reflected their assessment of the likelihood for the project to have a sustained, powerful influence on the research field involved, in consideration of the review criteria described above.

Description of Grant Proposal Reviewers

The reviewers for this grant proposal included my EMPH thesis chair, my thesis field advisor, and three external reviewers. A brief description of each reviewer and their relevant expertise is outlined below.

Daniel (Dan) C. Rutz, MPH

Dan Rutz is a Health Communication Specialist who has 47 years of experience in combining media, emergency preparedness, academics, and behavior change science to advance public health goals through respectful audience engagement. He is an adjunct professor with the Emory University Rollins School of Public Health, teaching Communication Strategy in the Executive Master of Public Health Program and advising students in their thesis research projects. Since retiring from CDC in December 2016, Rutz has established a consulting firm to expand on his previous work with the Division of Global HIV/AIDS, where his HIV prevention efforts focused on creating demand for voluntary medical male circumcision (VMMC), specifically in countries of southern and eastern Africa. Trained in domestic violence prevention, Rutz also volunteers in the Atlanta area to advance community awareness and counsel men with histories of abuse of women and girls.

Iris E. Smith, MPH, PhD

Dr. Smith is an Associate Professor in the Behavioral Sciences and Health Education Department at Emory University’s Rollins School of Public Health where she has taught graduate courses in Program Evaluation, Substance Abuse, Social Determinants of Health, and Mental Health Capstone course. She brings over three decades of experience directing programs and evaluation studies in substance abuse prevention and treatment. She has extensive experience in the administration, design, and evaluation of public health interventions, with deep expertise in training service providers in cultural competence.

Chantea Williams, PhD

Dr. Williams is a psychologist in the Atlanta area, who has experience providing individual and couples therapy to adolescents and adults. She also facilitates therapy groups that address relationship issues, anxiety and depression, procrastination and performance anxiety, and culture and identity. Dr. Williams has an M.S. from Georgia State University and her PhD in Counseling Psychology from Columbia University. Her research focuses on psychophysiology and health psychology, anxiety and depressed mood, adaptive coping, microaggressions, diversity, and cross-cultural competence.

Mahlet Endale, PhD.

Dr. Mahlet Endale is a psychologist who has been licensed in Georgia since 2008. She is in private practice in Peachtree Corners, GA. In her counseling work, Dr. Endale starts with a foundation of Cognitive Behavioral and multicultural framework. She strives to help clients feel heard and empowered to find the right path that works for them specifically. Dr. Endale especially appreciates working with individuals facing stress associated with how their intersecting identities come together to inform their day to day life.

Tene T. Lewis, PhD

Dr. Lewis is an Associate Professor in the Department of Epidemiology at Emory University's Rollins School of Public Health, whose work has demonstrated a deep commitment to the health issues of African American women and families. Dr. Lewis' primary area of research is in the area of psychosocial epidemiology, with an emphasis on cardiovascular disease (CVD) in women. She has a particular interest in understanding how social and psychological factors contribute to the disproportionately high rates of CVD morbidity and mortality observed in African-American women compared to women of other racial/ethnic groups. Dr. Lewis' scientific work in this area has received honors from the American Psychosomatic Society and the Health Psychology Division of the American Psychological Association.

CHAPTER IV: REVIEWER COMMENTS

This chapter will provide an overview of the feedback that was provided from reviewers in response to the grant's evaluation criteria. The time, effort and expertise that each reviewer devoted to this evaluation process was invaluable to this project.

I. Reviewer 1: Dan Rutz, MPH comments

A. Overview – Project Rationale, Intervention, and Presentation

Strengths

i. Data demonstrating disparity in the rate of mental disorder between African American adults as a subset of the US population quickly establish and verify a public health gap and a rationale for intervention. The case is convincingly advanced with references to increased risk in women over men and reduced access to care.

ii. The proposal is sensitive to unique attributes among the primary target audience, e.g., cultural beliefs, stereotypes, ignorance, and attitudes. Emphasis of these issues conveys respect for these audiences and assures that a well-intentioned initiative is less likely to incidentally invoke paternalistic or condescending audience perceptions.

iii. The "Safe Place" resource demonstrates novel selection of contemporary, practical, and familiar communication channels.

iv. The inclusion of a database that facilitates users' contacts with care providers proves an empathetic engagement with the target audience by recognizing and accommodating the challenges persons' struggling with mental illness face in seeking the help they need.

v. The goal toward developing a broadly-useful approach to addressing mental health issues in the primary target audience, from this pilot project, stands as a major "selling point" for approval and implementation.

vi. Under "Place" you appropriately include a host of key influencers, including churches. See recommendation 3.

Recommendations

i. Assure that key factual assertions are supported by formal citations; e.g., "African Americans are least likely to receive treatment for depression and other mental illness."

ii. Flesh out evaluation components with further elaboration of sampling and survey methods. Consider novel approaches, including the "Safe Place" App as a possible evaluation tool or component.

iii. The research strategy (A – Significance) provides rich descriptions of relevant cultural considerations. Some are clearly portrayed as "negatives", e.g., stigma. Others, e.g., "Strong Black Woman" stereotype and "Preferred Coping Strategies" appear to combine both toxic and positive attributes. Consider leveraging these elements, e.g., faith, spirituality, as bridges to the science-based resources. In this way you can further demonstrate empathy for the primary target audience and likely enlist influential stakeholders in the process.

iv. Among your “4 Ps”, the fifth product bullet, “to improve social and emotional well-being” is most relevant to the target audience; consider listing it first. Throughout the paper, think first, of what your audience values most. For example, they are not interested in increasing mental health service use. They just want to feel good again.

B. Impressions

i. The applicant demonstrates significance through a detailed description of target audience needs and current disparities. The pilot project is intended to demonstrate effectiveness of concepts, which could be tailored to general use among similar target populations elsewhere. The work is well founded in theory, practical application, ethical sensitivity, and incorporation of both professional and community assets.

ii. The investigators are adequately presented, highlighting relevant credentials and experience. Staffing appears sufficient to assure a realistic sharing of responsibilities for the efficient advancement of the project.

iii. The incorporation of digital application together with community-based professional and non-health related assets illustrates the innovative aspects of this proposal and further shows a familiarity with target audience reliance on these assets in their daily lives.

iv. As a pilot project this proposal appropriately details a robust evaluation scheme and thereby builds confidence in the findings, whether positive, neutral, or negative. The choice of Baltimore for the project reflects both pressing need and the availability of complementary resources that can contribute to success. The project reflects an appreciation for these resources, respect for the unique attributes of the target audience community, a willingness to introduce evidence-based interventions without disparaging traditional approaches to mental health support structures, and respect for the community as well as those specifically targeted for assistance through this initiative. The potential to apply findings from this project generally represents a potential quantum leap in addressing a key contributor to human distress.

Response to Reviewer, Dan Rutz, MPH comments

The document was updated to include the missing formal citations. According to the NIH application guidelines, references are not needed for the abstract as it needs to be very succinct (30 lines). Additionally, the evaluation plan has been expounded upon to include additional information on the sampling and survey methods.

Leaders of local predominantly black churches will be key stakeholders in this program. They will be involved in the development, implementation and evaluation of campaign messages and materials. Given the significance of spirituality and faith as preferred coping strategies among the target population, these elements will be necessary to include as part of our campaign strategy.

II. Reviewer 2: Iris Smith, MPH, PhD comments

A. Significance and Overall Approach

Strengths

i. This application provides a strong argument for addressing the prevalence and seriousness of depression among African American women. Cultural barriers are well described including stigma, cultural stereotypes, beliefs and culturally influenced patterns of help-seeking behaviors in this group. The lack of culturally appropriate treatment options and increased accessibility to resources which do exist is clearly an unmet need. A strong justification for the selection of Baltimore as a pilot site is also provided.

ii. The application also proposes to collaborate with a number of community partners many of which serve as gatekeepers to the intended audience of African American women. In addition to maximizing the exposure within the focus population, the proposed collaboration may raise awareness among practitioners, clergy, other gatekeepers and opinion leaders in the community. This could increase the overall impact of the intervention.

iii. The application of technology to a social marketing communication strategy is also a strength of this application. The multifaceted approach using social media, printed educational materials and other communication channels should maximize the program's reach. The development of the Safe Place application is an excellent way to increase the accessibility of information for the target population- especially among younger women. It also has the potential for commercial distribution once the pilot is completed which will also increase the potential for sustainability.

iv. The employment of focus groups to enhance understanding of the barriers and stigma attached to mental health help seeking behaviors may reveal issues not presently addressed in the research literature. The wide age range targeted by the intervention may yield important differences in attitudes and perceptions based on education, age, and income.

v. The mixed method approach to evaluation using pre/post focus groups as well as a quantifiable community survey should provide useful feedback for the investigators that can be used to further refine the mobile application and other materials developed by the program.

Improvements to Consider

i. The discussion of the approach is somewhat lacking in detail sufficient for a thorough evaluation of the applications merit. For example, elaboration of the sampling strategy for both the focus groups and distribution of materials would be helpful.

ii. Community-wide information campaigns can be challenging to evaluation. While the mixed method approach described in this application is commendable. However, it is unclear how the pre/post survey will be conducted. More discussion on whether the intent is to distribute paper surveys through the community partners or use an online survey application for distribution. How will the surveys be compiled and analyzed? It is also not clear how potential subjects would be contacted and what safeguards would be in place to protect confidentiality and to secure informed consent from participants.

iii. As mentioned earlier in this review, collaboration with such a diverse group of community partners may also increase awareness among practitioners, gatekeepers and community opinion leaders. It would be worthwhile to capture the impact of their exposure and participation in the pilot. This is particularly important given the lack of culturally appropriate treatment approaches and attitudes within the mental health field. The sustainability of the program will depend to some extent, upon the "buy-in" of many of these organizations and individuals. It may be equally important to gather some information on the perceptions, attitudes and perceived barriers from their perspective.

iv. The proposed intervention strategy is firmly grounded in theories for individual behavior change. There is an implicit assumption that it is necessary to change the individual in order to address the problem, rather than address the deficiencies in the system. The application includes discussion on some of the barriers inherent in the system – for example provider attitudes/beliefs, the lack of African American practitioners, etc. Moreover, it may be equally important to identify and strengthen culturally preferred resources being utilized by many African American women.

B. Investigators

The investigators are well suited to execute the proposed project. The Principal Investigator, although still in the early stages of her career has the requisite training and education to serve as the lead investigator. Her CV is impressive with relevant publication and research experience. The team as a whole possesses considerable expertise in health disparities and health research on ethnic and racial minorities.

C. Environment

The proposed study is a collaboration of the University of Maryland School of Public Health, Maryland Department of Health, Office of Minority Health and Health Disparities and Cardinal Health Research and Communications, Inc. The resources available through these organizations are adequate to support the project. However, the application does not discuss the respective roles/contributions of each of these partnering agencies. The lack of this information makes it difficult to fully evaluate the adequacy of the research environment.

Response to Reviewer, Iris Smith, MPH, PhD comments

The document was updated to include the missing formal citations. According to the NIH application guidelines, references are not needed for the abstract as it needs to be very succinct (30 lines). Additionally, the evaluation plan has been expounded upon to include additional information on the sampling and survey methods and analysis. In-depth interviews with stakeholders have also been included to capture the impact of their exposure and participation in the campaign. Following the pilot project duration, program staff will apply for the Phase II grant, which will allow for scale-up of this campaign. With that additional funding, we can expand the program to include culturally preferred resources being used by the target audience. The Budget Justification includes more in-depth information about the roles of the collaborating agencies.

III. Reviewer 3: Chantea Williams, PhD. comments

A. Significance

The proposal identifies a critical need to address the underutilization of mental healthcare by African American women living with depression, and seeks to address this problem in a modern way with the inclusion of a smartphone application to be tailored to the needs of African American women with mental health needs. While I deemed this a strong proposal supported by peer review research findings, I recommend the following be considered for inclusion in the literature review as well.

i. Research on how depression manifests for African American women vs other cultural groups (physical vs emotional complaints)

ii. Consider including other contributors to disparities in healthcare (e.g., location of facilities/clinics, affordability, transportation, etc.)

iii. Consider including research on perceptions of mental health needs vs. physical health needs

iv. You mention discrimination in your discussion on stereotypes but did not elaborate on this as a cultural consideration/barrier to mental health. Consider including research on disability discrimination and ableist language that hinders one from seeking help for mental health concerns.

B. Investigators

Ms. Gitukui, PD/PI, and contributing investigators appear to be well-suited for the project based on their experience, training, and records of accomplishments in the field.

C. Innovation

The proposal appears to meet the criteria for innovation based on its use of instrumentation (smart phones) and social marketing approaches to reach its target population of African American women. It could be strengthened with its expansion to social media platforms as Black Americans are the top users of social media for communication, engagement with others, and information dispersion.

D. Approach

The overall strategy, methodology, and analyses are appropriate to accomplish the specific aims of the project.

E. Environment

The scientific environment will contribute to the probability of success based on the institutional support and other resources available to the investigators.

Response to Reviewer, Chantea Williams, PhD comments

The formative stage of the campaign now includes an extensive literature review, which will include research on how depression manifests for African American women vs other cultural groups (physical vs emotional complaints), other factors that contribute to disparities in healthcare, research on perceptions of mental health needs vs. physical health needs, and research on disability discrimination and ableist language that hinders one from seeking help for mental health concerns.

IV. Reviewer 4: Mahlet Endale, PhD. comments

A. Significance

This project addresses a very important problem - getting black women the mental health care they need. As you've laid out, there are a lot of barriers to black women seeking out mental health care. I don't have research to cite, but anecdotal feedback is that the current climate in this country has only exacerbated the stress level and mental health needs of this population as the current administration is speaking about and implementing policies that negatively impact people of color and women. So the population you are seeking to help sits right in the middle of that intersection of identities.

If the aims of this project are achieved, it will empower black women to have the knowledge they need to understand and respond to their mental health needs in the most effective ways possible. This knowledge will be helpful in selfcare, but also in supporting and advocating for other black women in their lives.

This approach will be especially helpful for this population because it will provide mental health information and care in a culture informed manner. That makes it more likely that the target population being able to receive, understand, and access care.

There are different organizations and systems working to provide this type of information/care to this population, but more is needed. This program would help fill in gaps in this collective goal. I especially like that it is targeting a local community by and for people of that same community.

Based on outcomes, this project has commercial potential and could be packaged and sold with instructions on how to replicate in other communities across the country.

B. Investigator(s)

The PI and collaborators are well suited for the project. I especially appreciate the intent to invest in working with local collaborators as they will have a better understanding of the community this project hopes to serve. Additionally, the collaborators are well established entities with extensive records of accomplishments that have advanced their fields. They also have complementary and integrated expertise.

I would recommend one additional collaborator in this project - a local mental health provider who is well versed in local legal and ethics expectations for clinicians in the area. One aspect of the project involves recruiting participants from client pools of local mental health treatment providers. There may be license specific boundaries and ethical expectations around this. Having a mental health provider who is aware of the requirements and expectations of clinicians (which may vary license to license - ex: LCSW vs. LPC VS. PhD vs. LMFT) can help navigate how to do this with area mental health care providers without putting them in an ethical dilemma.

C. Innovation

This program is innovative in that it is multidisciplinary, it weds research and service provision within one project, aims to work with local professionals, and specifically aim to support the mental health need of local black women and girls. I am not aware of any program that includes all of the above components.

D. Approach

I appreciate the thoughtful strategy proposed for this project. It goes from doing local needs assessment within the target population, to program development to meet the needs of the local community, to implementation of the program, to program evaluation. Therefore, the proposed approach and product are informed by the lived experiences and needs of the black women and girls it hopes to eventually serve. The partnerships proposed are appropriate in the goal of improving the health of the target population.

As mentioned in section 2 above, my only point of constructive feedback in the process proposed is to have a clinician involved who can help ensure that the asks you make of mental health clinicians can be obtained in an ethical way.

E. Environment

The scientific environments in which the work will be done will contribute to the probability of success. The institutional support, equipment, and other resources are adequate for the project proposed. The project will most benefit by it being a local community of professionals working together to serve a local community of black women and girls.

<u>Response to Reviewer, Mahlet Endale PhD comments</u>

The Behavioral Health Administration at the Maryland Department of Health has been included as a key partner in this project to help navigate potential legal and ethical issues that may arise during certain aspects of this program.

V. Reviewer 5: Tene T. Lewis, PhD comments

The proposed project addresses a significant Public Health problem (depression) in a vulnerable population (African-American Women). The proposal is interesting, important and well written. The scientific premise for developing a culturally specific intervention for African-American women is generally strong; however a more nuanced review of the literature on depression among African-Americans is warranted. James Jackson's entire environmental affordances model is based on the fact that a number of studies found that African-Americans had lower levels of major depression compared to Whites. Thus, some acknowledgement that not all studies find higher rates of depression among African-Americans compared to Whites is needed.

A major strength of the approach is the incorporation of culturally relevant constructs, such as Strong Black Women Stereotype/Superwoman Schema and Stigma. However, these were mentioned in the background section, but did not feature prominently in the intervention and there was no mention of how these constructs might interact with the traditional theoretical models guiding the intervention (e.g. the Health Belief Model and Theory of Planned Behavior).

The Investigators report that they will hire facilitators and recruiters from the target population and mention that they will partner with HBCUs, sororities, etc. It would also be helpful to have letters of support from individuals in leadership positions at organizations that serve the target population.

Response to Reviewer, Tene T. Lewis, PhD comments

The formative stage of the campaign now includes an extensive literature review, which will include studies that found that African Americans had lower levels of major depression compared to Whites. It will also include a review of these culturally relevant constructs, which will be used to guide the development of the survey and focus group data collection tools, as well as inform the campaign design. Additionally, letters of support will be requested from key leaders of partnering organizations that serve the target population.

CHAPTER V: FINAL GRANT PROPOSAL

The following is the final submission of the #BlackGirlsTalk Program grant proposal, which followed the application guidelines for NIH funding opportunity, Innovations for Healthy Living-Improving Minority Health and Eliminating Health Disparities (R43/R44). The proposal was updated to include the suggested edits by the thesis committee chair, thesis field advisor, and three external reviewers.

ABSTRACT. Major depression is one of the most common mental disorders in the U.S and the second most common cause of disability-adjusted life years (DALYs) lost from ages 15-44. It causes severe symptoms that affect how one feels and thinks, interfering with their ability to carry out daily activities such as sleeping, eating, working or studying. Some symptoms of depression include persistent sadness or emptiness, feelings of hopelessness or worthlessness, loss of interest in hobbies, decreased energy or fatigue, difficulty concentrating, and difficulty sleeping. It is projected that by 2030, depression will be among the top three leading causes of burden of disease. African Americans make up approximately 13% of the U.S. population, yet they account for 18.6% of those affected by mental illness. On the 2016 Behavioral Risk Factor Surveillance System Survey, 34.7% of African American adults reported poor mental health status. Despite these findings, African-Americans are least likely to receive treatment for depression and other mental illnesses. African-American women, in particular, are among the most undertreated groups for depression in the country. They are at a higher risk for developing mental illness and have a higher prevalence of depression than men. Through a tailored, public health education campaign, the #BlackGirlsTalk program seeks to address some of the individual and systemic-level barriers to help-seeking among this population. These barriers, which will be further described later in this application, include stigma, cultural beliefs and attitudes, stereotypes, preferred coping strategies, and lack of awareness/knowledge. Education campaigns targeting the African American community should address common depression- and treatment-related beliefs using culturally appropriate images and language. Additionally, funding from this grant will be used to enhance the mobile application, “The Safe Place”, which is a mental health tool designed to educate and raise awareness about mental

illness in the African American community. We will build a database into the application that will allow users to locate African American therapists in Maryland, increasing awareness about culturally appropriate psychotherapy services that are available.

PROJECT NARRATIVE

Depression, one of the most common mental illnesses, is often under-recognized and under-treated among African-Americans in the United States. This pilot program is relevant to public health as it seeks to reduce mental health disparities among African-American women, particularly, by addressing key individual-level barriers to mental health service utilization, such as lack of knowledge/awareness, cultural beliefs and attitudes, and stigmas. Upon completion, this project will provide the field with culturally-appropriate health communication strategies that can be implemented among larger populations and adapted for other health conditions.

FACILITIES, EQUIPMENT, AND OTHER RESOURCES

Cardinal Health Research and Communications, Inc (CHRC) is a professional services and consulting firm that is committed to investigating complex public health issues, developing and evaluating innovative solutions, and disseminating evidence-based programs that impact our three areas of focus: behavioral health, minority health & health equity, and reproductive & sexual health. Our key executives and staff have extensive experience and advanced degrees in social and behavioral sciences, health communications, epidemiology, and public health program management. We are passionate about providing top quality services to our clients and working collaboratively with local, national and international partners across public health and other relevant disciplines.

The CHRC main office in Hyattsville, MD occupies about 4,500 sq. ft. of space, which includes a front desk/reception area, several offices and cubicles, a break room with a fully equipped kitchen, and two conference rooms. Each team member has a Windows-based laptop and workstation with two monitors, a docking station, and phone. All laptops have large storage capacity and high-performance RAM, data exchange, management, and analytic capabilities, internet accessibility, networking and security systems (i.e. VPN remote connectivity, firewalls, etc.), and communication services. Additionally, the machines are equipped with the Microsoft Office Suite (Word, Access, Excel, PowerPoint, Publisher, and Outlook), SAS, STATA, SPSS, R, MAXQDA Plus, NVivo, and ArcGIS. A number of tablets are also available for field data collection. The CHRC office also maintains a full array of high-speed color and black/white printing, scanning, faxing and copying devices available to all users.

The Maryland Department of Health, Office of Minority Health and Health Disparities (MHHD), located in downtown Baltimore, works with a network of over 3,500 organizations, groups and individuals to reduce health disparities that affect racial and ethnic communities throughout the state of Maryland. Responsibilities of MHHD include minority outreach, increasing diversity and cultural competency of health workforce, and the operation of a health information website and data center. The staff occupy 12,428 square feet of office space, which includes a number of furnished offices and cubicles, two conference rooms, a large training room which can be converted into a large open meeting space, a fully equipped kitchen and break room and two large copy/storage rooms. This space may be used for trainings, stakeholder/team meetings and focus groups. MHHD also has access to a wide range of research support services, including participant recruitment and tracking, research design, quantitative and qualitative data collection and management, data cleaning and analysis, survey distribution and reporting.

The University of Maryland School of Public Health (UMSPH), Maryland Center for Health Equity (M-CHE) provides support for wide range of multidisciplinary innovative research initiatives that advance the elimination of health disparities and achievement of health equity. The center was designated a ***Center of Excellence in Race, Ethnicity, and Health Disparities Research*** by the NIH's National Institute on Minority Health and Health Disparities in 2012. Committed to improving the health of all Maryland residents, the M-CHE team has cultivated key relationships throughout the state, allowing them to develop an infrastructure that will sustain community-based participatory research, while providing community members with the necessary information and resources to improve their health and wellbeing. We will leverage the work they have done to build community capacity and trust between researchers and minority groups through their Maryland Community Research Advisory Board (MD-CRAB). This group is comprised of diverse individuals (health professionals, retirees from the federal government and representatives from community-based organizations, community health centers, faith-based organizations and hospitals) who review research projects and provide feedback to researchers at all stages of their community engaged research activities. Additionally, their Health Advocates In-Reach and Research (HAIR) network of barbershops and salons, which have been transformed into community venues for the delivery of health-related information and services, will be an integral part of our #BlackGirlsTalk communications campaign.

OMB No. 0925-0001 and 0925-0002 (Rev. 09/17 Approved Through 03/31/2020)

BIOGRAPHICAL SKETCH

NAME: Gitukui, Stephanie W.

eRA COMMONS USER NAME (credential, e.g., agency login): sgitukui

POSITION TITLE: Principal Research Associate

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	Completion Date MM/YYYY	FIELD OF STUDY
University of Maryland, Baltimore County	B.A.	12/2010	Health Administration and Public Policy
Rollins School of Public Health, Emory University Atlanta, GA	MPH	12/2018	Public Health/ Prevention Science

A. Personal Statement

For the proposed project, I am assuming the role of the Primary PD/PI. Given my education, experience, and leadership, I am equipped with the necessary skills to effectively carry out the activities of this project and work collaboratively with my co-PIs and other partnering organizations. I have an extensive background in public health, with a special focus on social and behavioral research. I have successfully implemented other NIH-funded research projects that investigated underlying mechanisms of behavior change in response to intervention, with the goal of translating the findings to programs designed to prevent emotional and behavioral health issues. Throughout the duration of these projects, I was integrally involved in research methods and protocol development, budget management, staffing, IRB submissions and reviews, data dissemination and reporting, and manuscript development. My long-term career goal is to utilize evidence-based knowledge generated by public health research to develop effective and culturally-appropriate interventions that address the social determinants of health, eliminate health disparities, and ultimately, improve the health and wellbeing of disadvantaged populations. Presently, my MPH training at Emory University focuses on prevention science, which concerns epidemiology, understanding lifespan development, and designing and implementing interventions for the prevention of a wide variety of health and social problems. Throughout my educational and professional career, I have worked with minority and underserved populations, seeking to understand the psychosocial, socio-cultural, environmental and systemic factors that influence their health and behaviors. The proposed activities in this application build upon this work, which has prepared me to be a suitable leader for this project.

B. Positions and Honors

Positions and Employment

2007-2010	Research Associate, Transdisciplinary Science and Translational Prevention Program, RTI International
2011-2013	Research Project Manager, Transdisciplinary Science and Translational Prevention Program, RTI International
2013-2014	Senior Research Analyst, University of Maryland, School of Medicine
2014-	Health Communications and Research Consultant, Public Health Strategies
2014-2016	Program Administrator, Prince George's County Health Department, MD
2016-	Principal Research Associate, Cardinal Health Research and Communications, Inc.

Other Experience and Professional Memberships

2007-	Member, American Public Health Association
2007-	Member, Maryland Public Health Association
2010-	Member, Society for Prevention Research
2013-	Member, National Prevention Science Coalition

C. Contributions to Science

During the earlier stages of my career, I was intimately involved in social-behavioral research that sought to understand that underlying neurocognitive mechanisms that affect how individuals respond to short-term intervention programs, particularly elementary-aged children in high-risk urban areas. Our findings suggested that children who receive short-term intervention programs are more likely to experience significant improvements in their social, emotional, relational, and cognitive outcomes than children who do not receive the intervention. This research contributes to the field of prevention science, the knowledge base on neurocognitive processes and intervention efficacy, and informs the design of future social-behavioral intervention programs.

Relevant Publications

Fishbein, D.H., Domitrovich, C., Williams, J., **Gitukui, S.,** Shapiro, D., Greenberg, M. (2016) Short-Term Intervention Effects of the PATHS Curriculum in Young Low Income Children: Capitalizing on Plasticity. Journal of Primary Prevention 37: 493-511.

Gatzke-Kopp, L., Andersen, S.A., Chaffkin, J., Williams, J., **Gitukui, S**., Shapiro, D., Fishbein, D. (in review). Social and Physiological Risk Factors for Peer Rejection among Kindergarten Children in High-Risk Urban Contexts.

D. **Additional Information: Research Support and/or Scholastic Performance**

Scholastic Performance

Ayantunji, R., **Gitukui, S**., Lyles, F., Padgett, K. Williams, D. (November 2016) *Public Health Communications Campaign: Colorectal Cancer Screening (CRC) of African-American Men (Ages 50 or Older).* Emory University - Rollins School of Public Health. PRS505D: Integrated Communication Strategies.

Gitukui, S. (May 2016 - November 2016). Practicum Experience and Poster Presentation: *Assessing the Impact of Food Pantries on the Lives of Food Insecure Individuals and Families.* Practicum Site: The Atlanta Community Food Bank. Practicum Advisor: Alexis Weaver, MS.

Bell-Banks, C; **Gitukui, S**.; Lyles, F. (April 2016). The Georgia Campaign for Adolescent Power & Potential Evaluation Report. Emory University - Rollins School of Public Health. PRS541D: Planning and Performance Measures.

Battles, N.; Bell-Banks, C.; **Gitukui, S**.; Knight, T.; Meyers, S.; Padgett, K.; Taawab, N. (November 2015). *Community Needs Assessment - Shelby County, Tennessee*. Emory University - Rollins School of Public Health. PRS538D: Community Needs Assessment.

Ayantunji, R., **Gitukui, S.**, Greenlea-Taylor, J., Illieva-Hughes, E., Padgett, K., (July 2015). *Evaluation Plan Proposal for the North Georgia Integrated Health Network*. Emory University - Rollins School of Public Health. PRS 540D: Conduct of Evaluation Research.

Completed Research Support:

2014
Needs Assessment for the Living Classrooms Foundation
France Merrick Foundation
Role: Project Manager

2010-2015
Transdisciplinary Approach to Understand Variability in Preventive Intervention Outcomes
National Institute on Drug Abuse, R01
Role: Project Manager

BUDGET

Budget for Full Project Period (12 months)	Total
Salaries	
Principal Investigator/Project Director	$10,000
Co-Principal Investigator/Project Director	$10,000
Program Manager	$50,000
Post-Doctoral Associate/Data Analyst	$50,000
Research Assistants (2)	$30,000
Total Salaries	**$150,000**
Fringe Benefits (20% of salary)	
Principal Investigator/Project Director	$2,000
Co-Principal Investigator/Project Director	$2,000
Program Manager	$10,000
Post-Doctoral Associate/Data Analyst	$10,000
Total Fringe Benefits	**$24,000**
Domestic Travel	$2,000
Total Travel	**$2,000**
Participant Support Costs	
Other – Incentives	$2,800
Total Participant Support Costs	**$2,800**
Other Direct Costs	
Materials & Supplies	$5,000
Consulting or Contracted Services	$78,000
Publication Cost/Documentation	$3,000
Total Other Direct Costs	**$86,000**
Total Project Costs	**$264,800**

BUDGET JUSTIFICATION

A. Personnel

Stephanie Gitukui, MPH* (PD/PI, effort = 2.0 calendar months):

Ms. Gitukui is the Principal Research Associate at Cardinal Health Research and Communication, Inc. As the Project Director, she will provide oversight and supervision of all aspects of the pilot project, including fiscal and personnel management; overseeing program design, implementation, and evaluation activities; data analysis and management; reporting and dissemination.

Natalie Moss, PhD* (Co-PD/PI, effort = 2.0 calendar months):

Dr. Moss is the Health Disparities Initiatives Director at the Maryland Department of Public Health. She will collaborate with the Primary PD on all programmatic/analytical aspects of this grant, including personnel training and management, program monitoring and evaluation, and reporting.

Michelle Bowie, MPH* (Program Manager, effort = 12.0 calendar months):

Ms. Bowie is the Program Manager at the Maryland Center for Health Equity, University of Maryland, School of Public Health, and her role is to support the project directors in ensuring successful and timely completion of the proposed project. She will be responsible for overseeing the day-to-day activities of each program phase, including survey and focus group data collection, the development of campaign messages and materials, campaign rollout and monitoring, and post-campaign evaluation activities. Ms. Bowie will contribute to the development of research protocols, data collection tools (survey instruments, focus group discussion guide, etc.) and manuscripts, in addition to conducting statistical analyses, managing data, and preparing reports and presentations. She will also serve as a liaison to partner organizations and community stakeholders.

B. Other Personnel

TBA*, Post-Doctoral Associate/Data Analyst (effort = 12 Calendar Months effort):

This individual will be primarily responsible for data monitoring and analysis, which encompasses cleaning the data, assessing data quality, conducting qualitative and quantitative analyses, assisting with the development of reports and visual representations of the data, and developing and/or maintain databases.

TBA, Research Assistant x 2 (effort = 6 Calendar Months):

These individuals will assist with participant recruitment, focus group and survey administration, data entry, transcribing and coding focus group data, campaign outreach activities, and other duties as needed.

*** Fringe benefits are requested to cover medical, dental, and vision coverage for all key personnel and post-doctoral associates, which are calculated at 20% of direct labor costs.**

C. Equipment

None requested.

D. Travel

D.1 Domestic Travel Costs. Travel funds are requested to support project staff's mileage to and from stakeholder meetings and project sites during data collection and campaign activities. The travel estimate is based on average distance between the Cardinal Health office and project sites. Mileage rate is based on Privately Owned Vehicle (POV) reimbursement rate.

E. Participant/Trainee Support Costs

E.5 Other (Incentives). Participants will be provided with $35 gift cards as an incentive for their participation in the focus group discussions. We plan to conduct a total of eight focus groups during the formative, program development and evaluation phases of the project. We anticipate having 8-10 participants per group.

F. Other Direct Costs

F.1 Materials and Supplies. General office supplies are used by project staff to carry out daily activities of the program. Office supplies include paper, printer cartridges, binders, letterhead paper, and envelopes, and is expected to cost about $100 per month.

F.2 Publication Costs

Funds are being requested for the publishing costs associated with disseminating findings following completion of the proposed program through conference presentations and publications in journals.

F.3 Consultant Services

TBA Focus Group Moderator, Consultant:

This individual will work with the project team to design and lead focus group discussions during the formative research, program development, and evaluation phases of the program. It is expected that this individual will have previous experience facilitating focus groups on sensitive health topics with members of the African-American community. The moderator will be paid $1200 per focus group, plus associated travel expenses.

Jasmin Pierre, Mobile Application Developer, Consultant:

Ms. Pierre is the developer of “The Safe Place” mobile application and she will be responsible for the enhancements made to the app. Her duties will include collaborating with mental health organizations to compile a list of African-American mental health professionals that will be added as a directory into the mobile application. The estimated cost of the enhancements is about $10,000.

Langley & Co, Baltimore Marketing and Advertising Agency, Contract:

Langley & Co. will work with program staff to design and implement a media plan for the #BlackGirlsTalk campaign, encompassing social media, radio advertising, audio/video production, digital marketing, and graphic design. This contract will also cover all production costs for printed materials (posters, pamphlets, fact sheets, etc). The agency provided the program with a quote of $58,000 for all of the work described above.

SPECIFIC AIMS

African Americans make up approximately 13% of the U.S. population, yet they account for 18.6% of those affected by mental illness (U.S. Census Bureau, 2016; NAMI, 2015). African-American women, in particular, are among the most undertreated groups for depression in the country (Ward, 2009). Stigma associated with mental illness has been identified as the most significant and pervasive barrier within the African American community, discouraging those in need of mental health services from seeking treatment (Ward et al, 2009; Davis & Ford, 2004). Other barriers, on the individual-level, include shame and embarrassment, lack of knowledge, and cultural norms and stereotypes (i.e. Strong Black Woman stereotype). For these reasons, depression is often undiagnosed and untreated, leaving many African-American women suffering in silence. Culturally appropriate intervention strategies are needed to reach African-American women with information related to depression and to encourage them to use mental health services.

The objective of this application to develop a tailored, public health education campaign that will increase awareness about depression and improve attitudes and behaviors toward the use of mental health services among African-American women ages 18 and older in Baltimore, MD. Using both community-based participatory and social marketing approaches, the #BlackGirlsTalk project prioritizes community involvement throughout the duration of the program, as well as culturally-specific communication strategies that will increase community awareness and set the agenda for change. Key messages of the campaign will be intensively communicated through the 6-month pilot phase using media and institutional channels with large African American audiences.

Aim 1: To raise awareness about depression, including risk factors, identification of symptoms, healthy coping strategies, and treatment options. Information will be shared through social media, and local media outlets (radio and print) targeting African-Americans. Promotional materials, such as brochures and fact sheets, will be disseminated through community partners, including churches, community centers, and local businesses.

Aim 2: To modify beliefs, attitudes/stigmas and practices around depression and treatment. By working with local mental health service providers, members of the target population receiving treatment for depression will be recruited to develop radio, print and social media public service announcements (PSAs) highlighting their personal experiences with depression and successes with treatment.

Aim 3: To determine the effectiveness of the program by conducting evaluation activities throughout the duration of the program. Pre-campaign, in-person surveys will be administered to establish baseline data on depression-related knowledge, attitudes and practices. Post-campaign surveys will be administered to estimate exposure to the campaign among the target population and determine how exposure influenced their knowledge, attitudes, and practices, as well as intentions to seek help for depression. Post-campaign focus groups will be conducted to further explore the above indicators and ensure that campaign messages and materials were culturally appropriate and well-received among the target population. Process evaluation measures will also be conducted to ensure the campaign's activities are carried out as intended and to monitor campaign exposure.

Information gathered from the pilot campaign will be used to finalize the campaign products; inform the development of the #BlackGirlsTalk Campaign Toolkit; and implement a statewide campaign to reduce stigma and discrimination related to depression, improve attitudes and behaviors toward mental health service utilization, and create more supportive communities for African American women in Maryland.

RESEARCH STRATEGY

A. SIGNIFICANCE

Major depression is one of the most common mental disorders in the U.S and the second most common cause of disability-adjusted life years (DALYs) lost from ages 15-44 (SAMHSA, 2017; Pascual & Rosenberg, 2015). It causes severe symptoms that affect how one feels and thinks, interfering with their ability to carry out daily activities such as sleeping, eating, working or studying (NIMH, 2016). Some symptoms of depression include persistent sadness or emptiness, feelings of hopelessness or worthlessness, loss of interest in hobbies, decreased energy or fatigue, difficulty concentrating, and difficulty sleeping. Symptoms must be present most of the day, nearly every day for at least 2 weeks in order for someone to be diagnosed with depression (NIMH, 2016). Individuals can have one only episode of depression during their lifetime, however it is more common to have multiple episodes. Depression is most commonly treated with medications or antidepressants, psychotherapy, or a combination of both methods (NIMH, 2016). If left untreated, depression can lead to poor quality of life, which may be evidenced by substance abuse, increased absenteeism, academic or occupational impairment, self-injury or suicide (Sohail, Bailey & Richie, 2014).

It is projected that by 2030, depression will be among the top three contributors to burden of disease (Mathers & Loncar, 2006). In 2016, about 16.2 million adults aged 18 and older (6.7% of all U.S. adults) experienced at least one major depressive episode (MDE) (SAMHSA, 2017). Of this group, nearly two-thirds had an MDE with severe impairment, which means these individuals had difficulty managing at home, managing well at work, maintaining relationships or maintaining a social life (SAMHSA, 2017). Research conducted by the Centers for Disease Control and Prevention revealed that major depressive disorder is more prevalent among women than in men across every age group. It was also found that African-Americans had higher rates of mild, moderate and severe depressive symptoms than whites (NCHS, 2014).

African Americans make up approximately 13% of the U.S. population, yet they account for 18.6% of those affected by mental illness (U.S. Census Bureau, 2016; NAMI, 2015). On the 2016 Behavioral Risk Factor Surveillance System Survey, 34.7% of African American adults reported poor mental health status (KFF, 2016). Despite these findings, African-Americans are least likely to receive treatment for depression and other mental illnesses (Gonzalez et al, 2010). African-American women, in particular, are among the most undertreated groups for depression in the country. They are at a higher risk for developing mental illness and have a higher prevalence of depression than men (Ward, 2009). A 2007 study showed that African-

American women had a prevalence rate of 13.1% compared to 7.0% among African American men (Williams et al., 2007).

African Americans have long experienced significant health disparities and poorer health outcomes compared to other racial groups (Riley, Hayes & Ryan, 2016). Barriers to mental health service utilization among African Americans are multifaceted and deeply rooted in their history of adverse experiences. African Americans were subjected to slavery, segregation, oppression, racism and social/institutional inequality. Because of these experiences, African Americans have sustained or remained subject to traumatic psychological and emotional injury (Hackett, 2014; Sotero, 2006). Additionally, the unethical use of black adults for scientific and medical breakthrough, such as the Tuskegee Syphilis Study, has fostered a legacy of distrust in the healthcare system among generations of African Americans.

Systemic barriers to quality and culturally appropriate mental health services may be inherent to health care delivery systems (Davis & Ford, 2004). There is a growing body of literature indicating significant disparities between the quality of mental health services provided to African Americans and the quality of services provided to whites. Some of these disparities include under-diagnosis and ineffective treatment of affective disorders (i.e. depression and anxiety), over-diagnosis and overtreatment of psychotic disorders (i.e. schizophrenia), prescribing of older and/or less utilized antidepressant medications, which typically have more side effects, and disparities in evidence-based care that is in keeping with professional treatment guidelines (Holden & Xanthos, 2009). Factors that contribute to the poorer quality of mental health care provided to African Americans are lack of African American providers, lack of cultural competency and culturally appropriate assessments; and clinical bias (Davis & Ford, 2004).

Through a tailored, public health education campaign, the #BlackGirlsTalk program seeks to address some of the individual and systemic-level barriers to help-seeking among this population. These barriers, which will be further described in this application, include stigma, cultural beliefs and attitudes, stereotypes, preferred coping strategies, and lack of awareness/knowledge. Research demonstrates that increasing knowledge and awareness about mental health illnesses and treatment options is fundamental to increasing mental health service utilization, especially among racial/ethnic minorities (Conner et al., 2010). Education campaigns targeting the African American community should address common depression- and treatment-related beliefs using culturally appropriate images and language (Conner et al., 2010). Additionally, funding from this application will be used to enhance the mobile application, “The Safe Place”, which is a mental health tool designed to educate and raise awareness about mental illness in the African American community. We will build a database into the application that will allow users to locate African American therapists in Maryland, thereby increasing awareness about culturally appropriate psychotherapy services that are available.

Information gathered from the pilot campaign will be used to finalize the campaign products; inform the development of the #BlackGirlsTalk Campaign Toolkit; further develop “The Safe Place” application to include a nationwide mental health directory of African-American therapists; and implement a statewide campaign to reduce stigma and discrimination related to depression, improve attitudes and behaviors toward mental health service utilization, and create more supportive communities for African American women in Maryland.

Cultural Considerations. To increase the effectiveness of the #BlackGirlsTalk Campaign, key cultural factors will be considered throughout the development and implementation of the program:

Stigma. Stigma associated with mental illness has been identified as the most significant and pervasive barrier within the African American community, discouraging those in need of mental health services from seeking treatment (Ward et al, 2009; Davis & Ford, 2004). Stigma is defined as “a collection of negative attitudes, beliefs, thoughts, and behaviors that influence the individual, or the general public, to fear, reject, avoid, be prejudiced, and discriminate against” (Gary, 2005). In the early 1980s, a study found that African Americans, more than any other racial/ethnic group, held the most pervasive negative attitudes toward persons with mental illness (Ward et al, 2009). A public opinion poll in the 1990s showed that 63% of African Americans believed that depression was a personal weakness and only 31% believed it was a real health problem (Ward et al, 2009). Later research found that in the African American community, mental illness is associated with shame and embarrassment, and both affected individuals and their families hide their illness (Thompson et al, 2004). Consequences associated with the stigma of mental illness among African Americans include social distance or rejection, loss of relationships, loss of social or “normal” status, and the appearance of being weak (Matthews et al, 2006; Mishra, 2009).

Cultural Beliefs and Attitudes. Cultural beliefs prevalent within the African American community can also serve as barriers to diagnosis and treatment. A common belief among African Americans is that mental illness is something that does not affect black people (Okeke, 2013). Furthermore, many believe that family concerns should be resolved within the family and that African Americans should always demonstrate strength (Thompson et al, 2004). This expectation partly stems from the historical adversity that African Americans endured, which led to the belief that black people will always be at a disadvantage. Therefore, they have to be tough and resilient. As a result of this thinking, seeking treatment, such as psychotherapy, is often associated with weakness and diminished pride (Thompson et al, 2004).

Other common cultural stereotypes or myths that contribute to stigma in the African American community include the assumptions that mental illness is contagious, that people with mental illnesses are dangerous and unpredictable, and that affected people are hopeless and have no chance for recovery. Due to these assumptions and the fear of stigma, many African Americans who need help, hide their distress, cover up their symptoms, and avoid seeking help or treatment, leading to worsened mental health outcomes (Mishra et al, 2009).

The "Strong Black Woman" Stereotype (SBW). For women, in particular, there is also the stereotype of the "Strong Black Woman", which describes the societal place of black women and the need for them to possess strength to carry them through adversity. The underlying expectation is that black women have "built-in capacities to deal with all manner of hardship without breaking down, physically or mentally" (Okeke, 2013). This ideology is problematic as it can be understood and internalized as the super-human capacity to withstand excessive amounts of stress, leading suppressed emotions and adverse health outcomes among black women (Woods-Giscombé, 2010). As revealed through focus groups from a 2010 study, many black women feel obliged to manifest strength for the sake of their family and friends, to internalize or suppress emotions, to meet the needs of others, to be resistant to vulnerability or dependency, and to succeed despite having limited resources (Woods-Giscombé, 2010). The pressure to maintain the image of the strong black woman has been shown to interfere with treatment seeking behaviors among African American women (Ward, 2009).

Lack of Knowledge or Awareness. Lack of knowledge or awareness about mental health issues and available resources present additional obstacles to treatment within the African American community. A 2004 study found that many African Americans, even those with higher levels of education, lack adequate knowledge about mental illnesses to accurately identify signs and symptoms. They found that it was especially challenging for some to recognize at which point it was necessary to seek professional services. This lack of knowledge often leads African Americans to consult churches for information or referrals, as well as emergency rooms for help (Thompson et al, 2004). In another study, participants discussed not knowing that the problems they were experiencing were considered mental health issues. They assumed that the problems were normal responses to the difficulties of life and that they just needed to keep persevering. As their problems worsened and affected their ability to function normally, the participants expressed feeling ill-equipped to identify appropriate strategies and resources (Hines-Martin et al, 2003).

Preferred Coping Strategies (Faith, Spirituality, and Community). Spirituality is a core component of the American-American belief system and a survival mechanism that has helped African Americans cope with the psychological pain of racism, discrimination and oppression

(Hackett, 2014; Davis & Ford, 2004). Many African Americans view mental illness and emotional distress through the lens of religion and spirituality, rather than health (Mishra et al, 2009). Defining mental illness as a spiritual problem places greater value on solutions within the spiritual framework, sometimes rejecting other frameworks (such as mental health) and their suggested treatments (Mishra et al, 2009). To cope with mental health issues, African Americans tend to rely on informal supports, such as the church, family, friends and community resources (Hackett, 2014). Women, in particular, are more likely to use religious practices, such as praying or talking to their pastor, instead of seeking formal help from mental health professionals (Ward, 2009). This high reliance on spiritual and other informal supports has contributed to the underutilization of mental health services among African Americans (Hackett, 2014).

B. INNOVATION

In order to achieve its objectives, the #BlackGirlsTalk Campaign will employ a social marketing approach for promoting voluntary behavior change through comprehensive, multifaceted marketing techniques targeted at specific audiences (NCI, 2005). Social marketing differs from commercial marketing in that it seeks to influence human behavior in order to improve health or benefit society rather than to change behavior for the benefit of the marketer (CDC, 2011; Community Tool Box, 2018). Social marketing techniques have proven useful in ensuring that the audience of interest is reached through effective channels of communication (Rienks & Oliva, 2012). For example, radio stations that target and reach African American audiences are culturally appropriate communication channels that should be used to disseminate health messages to the African American community (Hall, Rim, Johnson-Turbes, Vanderpool & Kamalu, 2012). Using this approach will help to create greater and more sustainable behavior change among the intended audience.

Social marketing is based on four basic principles or the "4 Ps" – product, price, place and promotion. Ideally, this marketing mix maximizes benefits, reduces barriers and provides accessible and convenient options. The 4 P's for the #BlackGirlTalk Campaign are outlined in the following table.

#BlackGirlTalk Campaign 4 P's

Product	• To improve social and emotional well-being • To increase mental health service utilization. • To increase awareness about signs and symptoms of depression. • To increase awareness about healthy coping strategies and treatment options. • To reduce stigma around depression and help-seeking • Safe Place App with a directory of culturally appropriate mental health services
Price	• Cost of mental health services • Stigma/Social exclusion
Place	• HBCUs/Social Networks • Churches • Local Media • Local Businesses • Local Mental Health Service Providers • Social Media
Promotion	• PSAs on black radio and news outlets • Printed educational materials (brochures and fact sheets) • Social media engagement (Facebook, Instagram and Twitter) • Ads in printed media • Safe Place App

Theories and models of change should inform health communication strategies that offer different perspectives on the target audience and the actions needed to change behavior (National Cancer Institute, 2004). By combining theories to address the individual-level barriers of help-seeking among African American women, we are more likely to succeed. The development of the #BlackGirlsTalk Campaign will be guided by the Health Belief Model (HBM) and the Theory of Planned Behavior (TPB). Both theories are applied at the individual level to help health practitioners explain and influence the behaviors of individuals, while giving special attention to intrapersonal factors such as knowledge, attitudes, beliefs and motivation (National Cancer Institute, 2005).

Health Belief Model (HBM). The Health Belief Model (HBM) is one of the most widely recognized theories in health promotion practice. It is comprised of six main constructs that explain or predict what motivates people to take action to prevent, screen for and control illness: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cue to action and self-efficacy (National Cancer Institute, 2005). This conceptual framework states that health behavior change is a function of both knowledge and motivation (National Cancer Institute, 2004). When applying HBM, it is assumed that individuals are more likely to take health-related action if they believe that they are susceptible to an illness, that the illness poses a serious risk, that there are various beneficial actions available to them to reduce those risks, and that expected benefits outweigh barriers to action (Glanz, Rimer, Viswanath & Orleans, 2008). In order to achieve the goals of increasing depression awareness and help-seeking behaviors among African American women, we will consider specific communication strategies to increase individual perceptions of susceptibility to depression, decrease the psychological and cultural barriers to help-seeking, and increase the perceived benefits of help-seeking.

Theory of Planned Behavior (TPB). The Theory of Planned Behavior (TPB) focuses on individual motivational factors as predictors of behavior, holding behavior intention as the most important predictor of behavior (Glanz, Rimer, Viswanath & Orleans, 2008; National Cancer Institute, 2005). In the context of addressing mental health, the theory assumes that an individual's attitude toward the behavior and beliefs about whether people most important to them approve or disapprove of the behavior (subjective norm) influence any decision to seek or reject mental health services (National Cancer Institute, 2005). It also states that perceived behavioral control or the belief that an individual has control over performing a behavior may influence relevant decisions and actions. (National Cancer Institute, 2005). According to TPB, attitudes toward behavior are influenced by an individual's personal beliefs and evaluation of the behavior and its outcomes. Social normative beliefs and motivation to comply affect subjective norms. Perceived behavioral control is influenced by the presence or absence of factors that will make it easier or more difficult to perform the behavior. In turn, these three constructs, attitudes toward behavior, subjective norms, and perceived behavioral control, all influence behavioral intention, which ultimately drives behavior (National Cancer Institute, 2005). This model has been successfully used to predict and explain various health behaviors and intentions, including health services utilization, which therefore, recommends it as a powerful development guide to planning of the #BlackGirlsTalk campaign. This tool should lead to insight into African American women's knowledge and attitudes around mental health, which, in turn will allow us to develop campaign messages and materials that will encourage our audience to identify symptoms of depression and seek help. Using this model, we predict that African American women are more likely to engage in seeking treatment for depression if they have positive attitudes toward help-seeking, believe that treatment is acceptable to key people in their lives, and feel that they have control over their decision to seek treatment.

"The Safe Place" App. A key component of the #BlackGirlsTalk Program is the enhancement and promotion of the "The Safe Place" App, which seeks to educate and increase awareness about mental health issues among African Americans. Among other helpful features, the tool was designed to convey basic information about mental health illnesses, mental health statistics among the Black population, self-care advice, mental health resources, and an open group forum. Through collaboration with African American mental health organizations, such as the Association of Black Psychologists and the Black Mental Health Alliance, we will add to the tool a directory of African American mental health professionals. We predict members of our target population who are ready to seek help will find this tool to be useful, especially since according to the Pew Research Center, 94% of Americans aged 18-29, 89% of Americans aged 30-49, and 75% of African Americans own smartphones (Pew Research Center, 2018).

C. APPROACH

Using both community-based participatory and social marketing approaches, the #BlackGirlsTalk project prioritizes community involvement, as well as culturally-specific communication strategies to increase community awareness and facilitate change. Through a 24-week pilot phase, key messages will be intensively communicated via media and other institutional channels with large African American audiences.

Target Audience. The #BlackGirlsTalk Campaign will focus outreach efforts toward its primary audience, which is African American women ages 18-64 years residing in Baltimore, Maryland, and secondary audiences, comprised of African American men and family, friends and colleagues of the primary target audience. We will work with program partners, including local health departments, local mental health service providers, community organizations and local media outlets, to reach these audiences.

Site Selection. Baltimore is chosen as the pilot site for this campaign due to its demographic make-up and disproportionately poor state of health. Fifty-three percent of the city's population is female and 63% is Black or African American (U.S. Census Bureau, 2017). And among jurisdictions in Maryland, Baltimore ranks last on key health outcomes. Despite the decline in the city's overall mortality rate over the past decade, its current age-adjusted mortality rate is still 40% higher than the rest of the state. Additionally, Baltimore residents account for 30% of the state's inpatient mental illness hospital admissions, even though the city makes up only 11% of Maryland's total population (Baltimore City Health Department, 2017). In 2013, 20.6% of Non-Hispanic Blacks in Baltimore reported their mental health was not good for 8 or more days out of the past 30 days, compared to 10.2% of Non-Hispanic Whites (Baltimore City Health Department, 2016). In 2012, 22.4% of women reported their mental health was not good for 8 or more days out of the past 30 days, compared to 6.52% of men (Baltimore City Health Department, 2014).

In August 2016, the Baltimore City Health Department launched its strategic plan, Healthy Baltimore 2020, to cut health disparities in Baltimore by half over 10 years. The first core value of the plan addresses major health disparities attributable to the city's history of structural discrimination, racism, poverty and practices of exclusion. The second core value focuses on barriers to overall well-being, including promoting healing and awareness. The plan highlights the importance of addressing unmet mental health needs by providing education to reduce stigma and improving access to mental health services (Baltimore City Health Department, 2017). The #BlackGirlsTalk Campaign supports the strategic goals of the Baltimore City Health Department.

Program Implementation. The #BlackGirlsTalk Campaign will be implemented in four phases: (1) conduct formative research to assess the target population's knowledge, attitudes and beliefs around depression and treatment, understand current coping strategies, and investigate health communication preferences, (2) develop culturally appropriate campaign messages and promotional materials, (3) implement the campaign strategy across the sites, and (4) evaluate the effectiveness of the campaign to reach and positively influence target audiences.

Phase I – Formative and Baseline Research. Phase I of this project will begin with an extensive literature review to better understand the campaign's target audience, African American women ages 18-64 years in Baltimore, MD. This review will inform the development of the data collection materials that will be used to gather information directly from the target population. In-person surveys via tablets and focus groups will be conducted to assess participants' knowledge, attitudes and beliefs about depression and treatment, their health communication preferences and the best ways to frame key messages. Per the HBM and TPB frameworks, the focus group discussions will also explore perceived susceptibility to depression, perceived severity of depression, perceived benefits to seeking treatment, perceived barriers to treatment, cues to action, intentions to seek treatment, attitudes toward seeking treatment, subjective norms, and perceived behavioral control.

African-American women from the target population will be hired to recruit focus groups participants. Local mental health providers will also help recruit women from their facilities, in compliance with HIPAA patient confidentiality regulations. Other sites for recruitment will include local, Black-owned businesses, such as hair salons, local historically black colleges and universities (HBCUs), and local churches. Plans call for 35-40 African American women to take part in the focus groups. Participants will include those who have been diagnosed with or have a history of depression and women who have never been diagnosed with depression. Focus groups will be led by an African-American, female facilitator experienced in moderating focus groups on mental health topics within the African-American community. Additional personnel will transcribe focus group discussions and analyze data to identify themes, patterns and interrelationships. Each focus group participant will provide demographic information (i.e. age, level of education, employment status, occupation, marital status, children) and describe their access to and use of various communication channels.

Phase II – Program Development. During this phase, campaign concepts, and culturally appropriate messages and materials will be developed based on focus group findings from Phase I. Additional focus groups will be conducted to test and evaluate the campaign materials before pilot phase launch. Results from the groups will be used to further refine the campaign and develop additional materials, as necessary. Furthermore, enhancements to “The Safe Place” mobile application will be carried out during this phase.

Phase III –Program Implementation. The #BlackGirlsTalk Campaign will be piloted for 6 months in Baltimore, Maryland using the messages and materials developed in Phase II. Anticipated partners in program development and implementation Include:

- Baltimore City Health Department
- Maryland Department of Health
- Behavioral Health Administration
- Black Mental Health Alliance
- Local African-American media outlets (radio, TV and newspapers)
- Local Churches
- Behavioral Health System Baltimore
- University of Maryland, School of Public Health
- Local Mental Health Service Providers
- Local, black-owned businesses (barbershops and salons)
- Local Historically Black Colleges and Universities
- Black Sororities and Fraternities

Phase IV – Program Evaluation. During the duration of the program, formative, process and outcome evaluation activities will be undertaken. As mentioned previously, we will conduct formative research through an extensive literature review, and the use of surveys and focus groups to assess the target population’s knowledge, attitudes and beliefs around depression and treatment, understand current coping strategies, and investigate health communication preferences. In-person surveys will be administered via tablets to residents in Baltimore before any campaign-related activities take place. Recruitment sites for the focus groups and surveys will include local, Black-owned businesses, such as hair salons, local historically black colleges and universities (HBCUs), local churches, as well as other establishments that serve a high volume of African Americans. We will ask for consent from each participant to do continued follow-up throughout the campaign. Findings from these methods will provide us with baseline data and inform the development of the campaign materials. This formative stage will also include conducting additional focus groups with members of the target audience to pilot test the messages and strategies before the campaign is launched.

A process evaluation will be conducted to ensure the campaign's activities are carried out as intended and to monitor campaign exposure. This will involve documenting all of the activities as they occur, including the distribution of campaign materials to the various sites, the PSAs on local black radio and news outlets, the printed ads, social media engagement, etc. We will also track the number of paid advertisements, the number of education materials distributed, the estimated number of viewers reached through the paid advertising, the number of views, likes, and shares of social media posts, the number of downloads of "The Safe Place" mobile application, and other necessary indicators. Baseline survey participants will also be asked to participate in a mid-point survey, around 3 months into the campaign, to estimate their awareness and understanding of the campaign. Another important aspect of this process evaluation will involve conducting in-depth interviews with our community partners and stakeholders to capture the impact of exposure and participation in the campaign. All of these activities will allow the program team to monitor and track the campaign's reach and make adjustments, as needed, to the messages and marketing strategies.

As part of the outcome evaluation, follow-up in-person surveys via tablets will be conducted immediately following the campaign to estimate exposure to campaign materials and the mobile application, and to determine how exposure influenced their knowledge, attitudes, and practices, and intentions to seek help for depression. At least two post-campaign focus groups will be conducted to further explore these indicators and examine the extent to which campaign messages and materials were culturally appropriate and received among the target populations. To capture the campaign reach, follow-up surveys will include questions about the sources from which participants received information. We will also work with local mental health service providers to compare service utilization rates among African American women before, during and after the campaign.

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