Research Article

Using Deliberative and Qualitative Methods to Mobilize Community Around the Mental Health Needs of Rural African Americans

Ann Marie Cheney1,* Tiffany F. Haynes2, Mary Olson3, Naomi Cottoms3, Kenesha Bryant2, Christina M. Reaves4, Michael R. Reich5, Geoffrey M. Curran6 and Greer Sullivan1

1Social Medicine and Population Health, University of California Riverside, Riverside, CA, USA
2College of Public Health–Health Behavior and Health Education, University of Arkansas for Medical Sciences, Little Rock, AR, USA
3Tri-County Rural Health Network, Inc., Helena–West Helena, AR, USA
4Center for Healthy Communities, University of California, Riverside School of Medicine, Riverside, CA, USA
5Department of Global Health and Population, Harvard T. H. Chan School of Public Health, Boston, MA, USA
6Department of Pharmacy Practice, College of Pharmacy, University of Arkansas for Medical Sciences, Little Rock, AR, USA

Abstract—Deliberative methods obtain informed and well-reasoned public input on health topics but are rarely accompanied by rigorous qualitative methods that can ground findings in community members’ shared experiences. In this project, we used Deliberative Democracy Forums, a deliberative process, to bring diverse community members together to collectively discuss mental health among rural African Americans, brainstorm solutions to address mental health needs, deliberate alternate solutions, and indicate steps for future action. By using rigorous qualitative methods to document the deliberative process and analyze deliberative dialogue, we produced a strong evidence base to inform future health care policy and research. In this article, we document our approach, present forum findings, and discuss the impact of deliberation on policy and research. We conclude that the combination of deliberative process and qualitative methods used in our project can produce a deeply contextualized understanding of mental health and identify community-initiated solutions to address mental health needs in resource-poor communities, which can help guide public health research and provide an evidence base for public health policy.

INTRODUCTION

Since the early 1990s, deliberative methods (e.g., citizens’ panels and issue forums) have been used to obtain input on health care policy reform.1 Deliberative methods are designed to obtain informed public input on health issues requiring consideration of competing solutions2,3 and
provide public space for community members to discuss and deliberate shared concerns. These methods are especially effective in capturing the perspectives of disadvantaged and minority groups, including rural residents. In this study, we used deliberative methods to generate community-initiated solutions to address mental health among rural African Americans.

Deliberative approaches to obtain community input use different methods to obtain specific results. Examples include citizens’ juries, which involve in-person meetings of 12 to 24 participants over several days and are designed to engage the broader public in deliberating value-laden issues (e.g., stem cell research), or planning cells, which involve in-person meetings with 25 purposively selected stakeholders and are useful for focused conversations and policy creation. All deliberative methods, however, follow certain core principles, including exchange of information, discussion of alternate choices/options, and consensus building.

In this study, we used Deliberative Democracy Forums (DDFs). This approach has been developed and refined over many years by the Kettering Foundation (a nonprofit organization engaging citizens in collective action) and follows well-established procedures to prepare for forums (i.e., “framing” sessions), facilitate deliberation (i.e., weighing the pros and cons of alternate choices/solutions), find common ground (i.e., shared values), and identify collective and individual action. This method is designed to initiate community mobilization around a shared public concern.

The topic of deliberation for this project was the increasing concern about mental health problems among African Americans in rural areas of the Arkansas Delta. Though rural African Americans suffer from mental health problems at rates similar to, or slightly greater than, the rest of the population, they are less likely to seek mental health treatment. Rural African Americans in the Arkansas Delta arguably face greater challenges to seeking mental health care because of disparities in health care access such as limited available services and no health insurance coverage. These health care disparities are exacerbated by geography and race. African Americans in this region historically have lived in rural and impoverished communities where they have experienced decades of race-based discrimination and oppression.

This article shows how deliberative methods can be used to engage disadvantaged communities in a process to discuss shared public health concerns, identify community-initiated solutions, and initiate change. The analysis presented in this article was part of a larger pragmatic trial comparing focus groups with Deliberative Democracy Forums in content, intervention recommendations, and implications. As reported in the study’s main outcome paper, focus groups emphasized individual health behaviors and interventions involving health care systems, whereas DDFs emphasized social determinants in community health and community-initiated solutions.

Deliberative Democracy Theory

Deliberative democracy theory is underpinned by the idea that public dialogue is needed for democracy to work. Unlike traditional democratic theory, which emphasizes independent decision making and voting, deliberative democracy theory posits that deliberation, specifically a collective weighing of alternate solutions among citizens of diverse backgrounds, is critical to decision making. In this theory, deliberation creates a neutral space—one void of power imbalances—where individuals whose experiences differ (e.g., by race/ethnicity, class, faith, education, and occupation) can come together to share and learn about differing viewpoints, find a shared sense of purpose, and build consensus for civic action. Within this space, citizens are expected to confront, as a collective body, tensions that may arise when individuals with common concerns but different experiences and perspectives come together. The purpose is to produce informed, well-reasoned, and fair public decisions that can inform collective action.

This political theory is translated into practice during community forums. Forums such as Kettering’s Deliberative Democracy Forums create spaces where private troubles are transformed into public health issues and citizens deliberate by exchanging information and identifying solutions. Public deliberation is distinct from other methods that obtain public input because it asks participants to publicly discuss and develop solutions for societal problems. Participants are faced with carefully considering diverse and potentially competing arguments on moral, social, and value-laden issues. They are also asked to consider what is good for themselves, their communities, and society. Thus, public deliberation encourages participants to shift from the individual (e.g., What am I concerned about?) to collective (e.g., What are we concerned about?). This approach means that participants draw on their individual experiences as well as knowledge of the collective or public experience.

Putting deliberative democracy theory to practice may help to empower communities and inform health care policy change. Through deliberative approaches, citizens and communities have had a voice in local, regional, and national health care policy making. For example, in rural Australia,
deliberative forums provided a venue for adolescents in drought-affected areas to articulate their concerns about the impact of drought on their futures, families, communities, and mental health, as well as inform new policy for tailored interventions incorporating rural youths’ experiences. In Korea, deliberative forums enabled citizens to collectively discuss benefit coverage for National Health Insurance and contribute to incorporating social value judgements (e.g., what is best for all) into health care coverage. In the United States, deliberative forums provided low-income communities an opportunity to set local priorities for interventions to mitigate social and economic factors on health. In all of these cases, participants engaged in a process of information exchange and deliberation of alternate priorities or solutions.

METHODS

Prior to the start of the research, the Institutional Review Board at University of Arkansas for Medical Sciences approved the study. This project involved a collaborative partnership between a multidisciplinary team of academics (i.e., anthropologist, clinical psychologist, doctoral-level nurse, medical sociologist, and psychiatrist) and a community partner, Tri-County Rural Health Network (TriCounty). This partnership began in 2010 when TriCounty, a nonprofit organization that trains community members to link rural residents to needed health care resources, requested support in addressing mental health concerns among rural African Americans. The academic partners brought expertise in mental health and mental health services research, and the leaders of TriCounty brought Kettering Foundation–trained expertise in DDFs, including service as DDF national trainers.

We convened a Community Advisory Board (CAB) of nine members, including community leaders, college students, mental health providers, community health workers, and persons with mental illnesses, to guide the research process. CAB members provided insight on presenting the research to the community, including what language to use, how to recruit participants to forums, and where and how to disseminate findings. They also validated our analyses and interpretation of forum data.

Setting

The academic–community team selected Jefferson County, Arkansas, considered the gateway to the Arkansas Mississippi Delta region, as the study site. Historically, this county has a majority (~55.4%) African American population who experience significant health disparities. Nearly a quarter of persons (23.9%) in Jefferson County live at or below the poverty level, with African Americans disproportionally represented. High incarceration rates among African American men in this region contribute to 47% of African American households in Jefferson County being headed by single women. Over a third of all African American children live in single female-run-households (38.6%) and live below poverty. However, Jefferson County has a relatively strong health care infrastructure, ranking 12th among 75 Arkansas counties.

Recruitment

The community partners worked closely with CAB members and TriCounty community connectors, trained community members who link Delta residents to health care resources, to use social networks and word of mouth to recruit community members residing in Jefferson County to forums. TriCounty and its connectors are well embedded within African American communities in Jefferson County and have connections with both grassroots and grasstops. At the start of all research activities, participants were informed that they were participating in research and that their participation was voluntary, and verbal consent was obtained. Forum participants were informed that discussions would be tape recorded with assurance their names would never be connected with the content of recordings.

Data Collection and Analysis

Qualitative methods can offer a rigorous approach to documenting the deliberation process and produce analyses grounded in individual and collective experience to inform future health care policy direction. However, applying rigorous qualitative methods to collect and analyze deliberative democracy forum data is challenging and not usually done. Methods used to ensure quality data collection, such as audio- or video-recording devices and notetakers, may be intrusive and opposed by community-based collaborators and may not accurately capture group dialogue. Furthermore, rigorous qualitative methods of data analysis (e.g., theme identification) are time-consuming techniques and are not amenable to rapid dissemination of results. For these reasons, these methods are not often used together.

In this study, we employed an innovative approach of using rigorous qualitative methods in combination with Deliberative Democracy Forums. Throughout the research, we documented the DDF process, including discussion in CAB meetings and the framing sessions, forums, and dissemination activities in regular team meeting minutes and field notes. To increase accuracy of forum data, we trained team
members to take field notes to (1) capture key themes and group dynamics and (2) serve as backup if participants chose to not be audio recorded. We also placed several audio recorders around the room and selected the best recording for professional transcription. Forum data were imported into a qualitative data analysis software program for coding and analysis. We used existing codes from our deliberative framework (discussed below) and identified emergent themes related to ways to address mental health through a close reading of the transcripts. Finally, we developed a codebook, obtained agreement on code application, and coded and analyzed the data using an iterative approach.

THE DELIBERATIVE DEMOCRACY FORUM PROCESS

Figure 1 outlines the process we followed to develop the framework that guided deliberation during the forums, as well as the qualitative methods used to collect and analyze the deliberative process. The Kettering model requires considerable preparation leading up to community forums, including a naming and framing process in which a select group of community members convenes prior to forums, describes the issue in a way that makes sense to them, and identifies potential choices or approaches to address the problem during forums. We consider this approach ground-up and community driven, rather than top-down and researcher driven.

Naming the Issue

The academic–community team first met with CAB members to determine the most effective way to discuss mental health. CAB members felt that the word mental carried stigma and suggested that few community members would agree to participate in “mental health” forums. After these discussions, we selected the terms emotional wellness and emotional unwellness as more acceptable than mental health to the community.

FIGURE 1. Combining Rigorous Qualitative Methods with the Deliberative Process to Identify Community-Initiated Solutions
Framing the Issue

The academic–community team conducted two framing sessions, one that included health care providers, members of faith communities, students, and university administrators (n = 10) and a second that included CAB members, community members, and researchers (n = 12). Framing sessions began with facilitators asking participants to list all of the things that came to mind when they heard the phrase emotional wellness. As participants listed their responses, the facilitators recorded them on large sticky notes. After developing an exhaustive list of responses, the facilitators then asked each participant to write down the top three most important points or themes that emerged from the listed responses. Participants then placed a sticker next to a response that matched up with each of their three themes.

Next, the facilitators asked participants to discuss the themes and reflect on how they were connected to addressing emotional wellness among rural African Americans. Facilitators identified three ways to address emotional wellness among this population: (1) reduce stigma, bias, and discrimination; (2) increase access to mental health resources; and (3) build community support systems. These bias, and discrimination; (2) increase access to mental health

Writing the Issue Book

Issue books contain background information on the topic of deliberation and outline three or more solutions. The material is developed following the naming and framing phase, intended to be “nonpartisan and nonprescriptive,” and designed to provide forum participants with enough knowledge to engage in productive deliberations. Our issue book was developed by the forum facilitators (the community leaders of this project), who live in the Delta and serve African Americans in this area. The material in the issue book was informed by their conversations with community members and framing participants, as well as county-level data on mental health prevalence and mental health care services use. Following standard guidelines, the issue book included five elements—a descriptive title (i.e., Emotional Wellness: How Can African Americans Achieve It in Rural Areas?) and background information outlining common struggles that African Americans face living in the South (e.g., history of oppression, racism, limited access to resources)—and described the three choices or approaches determined to be relevant during the framing session to address the problem and outlined their pros and cons. These choices form the basis of the deliberation during forums.

Conducting the Deliberative Democracy Forums

We conducted seven 90-minute forums in communities in both the largest city and smaller towns within Jefferson County between May and October 2013. We held forums in public spaces (i.e., town halls, restaurants, churches) ranging between ten and ~100 participants. A total of 233 residents of Jefferson County between the ages of 18 to 59 participated in the forums. Forum attendees were predominantly African American (94%) and women (71%). However, they represented diverse backgrounds and professions, including clergy (8%), disabled persons (25%), health care providers (29%), homemakers (24%), military veterans (9%), retirees (16%), students (23%), and individuals accessing mental health services (38%). Forum attendees also included elected officials (i.e., local, county, and state political leaders) and school administrators.

At the beginning of Deliberative Democracy Forums, facilitators usually provide a hardcopy of the issue book to participants. However, because of low literacy rates among the population involved in the study, the facilitators verbally presented information in the issue book before initiating the forums. To bring home the ideas presented in the issue book, the facilitators asked participants to share stories of emotional wellness and un-wellness. Participants first responded to the facilitators’ prompt: “times when you [participants] feel really good about ourselves and others.” They shared stories about experiencing emotional wellness when caring for, listening to, or helping/supporting others. This was followed by participant responses to the facilitators’ prompt: “times when you were struggling with emotional wellness.” These stories included retelling of personal experiences of depression, anxiety, and posttraumatic stress disorder or of the impact of life struggles such as job loss, drug abuse, incarceration, and exposure to violence (e.g., domestic abuse) on emotional wellness.

With these stories in mind, facilitators then asked participants to weigh the pros and cons of each choice. During the choice work, facilitators asked, for each choice, “What are the benefits and drawbacks of this choice?” Facilitators first asked about the positive aspects of the choice and then moved on to its drawbacks. Facilitators encouraged participants to be respectful of individual responses and to build on or critique existing discussion points. Below we
highlight key points discussed for each choice across the forums.

For Choice 1, *reduce stigma, bias, and discrimination*, participants emphasized education as a way to reduce stigmatizing attitudes around mental health, particularly depression. They also suggested renaming existing facilities and co-locating mental health services in primary care facilities or community locations (e.g., recreational centers). For Choice 2, *increase access to mental health resources*, participants indicated that outreach and educational events were needed to increase awareness of availability, location, and types of care offered. They also discussed placing mental health professionals in places people are likely to want, or be triggered to need, help—including prisons and unemployment and public assistance offices. Furthermore, they indicated the need for culturally competent care. For Choice 3, *build support systems*, participants indicated that supportive networks (e.g., peer support), support services (e.g., linkage programs for people exiting penitentiary system), and community activities (e.g., public gardens) were needed.

**COMMON GROUND AND ACTION**

Near the end of each forum, facilitators asked participants to identify common ground or themes present during the forum. Facilitators asked: “What have we heard over and over again no matter which choice we were discussing?” Across the forums, participants stressed education on the signs and symptoms of emotional health, knowledge about available mental health services, and access to resources and people in position of influence (e.g., political leaders). After discerning common ground, facilitators then asked: “What action could you as an individual take?” and “What action as a group or community could you take?” to achieve emotional wellness. Many were eager to become involved in the community as a mentor or role model; others indicated that they would encourage community members to become politically active around emotional wellness. Participants also identified various forms of community action, including collaborative work, prevention efforts, supportive services, and a community-wide mental health literacy campaign (see Table 1 for examples).

**DISCUSSION**

Our study shows the value of public deliberation in identifying potential solutions to address the mental health of rural African Americans. This deliberative process brought diverse community members together to collectively identify, brainstorm, consider alternate solutions (i.e., deliberate), and set actions for achieving emotional wellness. This deliberative process, more so than other methods that collect narrative data (e.g., focus groups), creates a space for community to identify the structural factors (e.g., racism, poverty, and employment) that affect both individual and collective emotional wellness and voice community-initiated solutions that can be adopted through public policy.1 Our work provides an example of deliberative democracy theory in action.

The findings highlight how the theory underpinning Deliberative Democracy Forums united participants around a shared sense of purpose (i.e., achieve emotional wellness) and moved them toward civic action. Participants emphasized the need for public health interventions to benefit vulnerable groups (e.g., homeless, children, single mothers, incarcerated). For instance, participants talked about creating community gardens and coalitions and signing community petitions—these activities, which are civic oriented, involve organizing interested people, planning a committee, identifying resources, and accessing political resources (e.g., sponsorship). They also discussed improving access to resources and support, such as for those exiting the penal system, building influence and wealth through skill development and networks, and creating opportunity structures as ways to improve emotional wellness. The findings show how the deliberative process has the potential to mobilize community around shared public health concerns, as well as provide an evidence base for public health research and policy development.

In addition to showing the value of deliberation in community activation and mobilization, our study points to the usefulness of qualitative methods for collecting and analyzing deliberative dialogue. This work provides an alternative model that combines deliberative methods with rigorous qualitative data collection and analysis, yielding more sensitive results and arguably a stronger evidence base for public health research and policy.

Typically, community facilitators trained in deliberative methods conduct forums and write a moderator report at the conclusion of data collection, which includes an overview of key observations, participant quotes, and the moderator’s summary.34 Though important, these reports provide an overview of the process and general findings; they do not present a robust evidence base to inform public health research or health policy. On the other hand, researchers who employ deliberative methods often struggle to meet the somewhat conflicting objectives of both deliberation (e.g., rapid dissemination of results) and research (e.g., scholarly dissemination). Deliberative dialogue collected via notes or audio
recordings is often analyzed using a deductive approach that applies preexisting concepts to data, rather than using a ground-up approach to identify new or emerging concepts. Such approaches fall short because they neither address the complexities of public health issues nor provide a deeply contextualized evidence base.\textsuperscript{2,3}

Though our findings generated a strong evidence base for future policy and research, several limitations should be considered. First, forum participants included elected officials (i.e., local, county, and state political leaders), educators, service providers, persons accessing mental health care services, and concerned community members; however, the most frequent speakers were community members who had personally experienced anxiety, depression, or posttraumatic stress disorder; had close relatives or friends with mental illness; or were mental health or substance use service providers. Participants were also disproportionately middle-age African American women. It is likely that this group was especially motivated to participate in the forums on mental health because they felt that the topic affected them, their families, or communities.

Second, qualitative methods offer a rigorous approach to document the deliberation process and produce analyses grounded in individual and collective experience to inform future health care policy direction;\textsuperscript{3} yet digital recorders can be intrusive and analyses are time consuming and can inhibit quick dissemination of the results. First, data analysis showed that mid-sized forums (~20–25 participants) produced the

| Action | Description | Specific Examples |
|--------|-------------|-------------------|
| Individual-level | | |
| Support | Support and positively influence others | Car wash; farmers’ market; mentor; volunteer; openly discuss health issues; donate needed items; help with childcare |
| Share knowledge and resources | Disseminate mental health knowledge and connect community members to resources | Encourage others to seek help; disseminate information in local media sources (newspaper); provide free meeting space; transport people to meetings |
| Respect | Respect and care for all | Stop labeling others (“crazy”); be kind to everyone; love one another; listen to and pray for others; share financial resources; feed the homeless |
| Have faith | Have faith in divine intervention | Attend church; pray for others; have faith in God’s abilities |
| Community-level | | |
| Collaboration | Hold group discussions and collaborate to set goals and act | Work together and plan collaboratively; share ideas; create a sense of ownership and responsibility; use existing resources/services; develop a coalition of experts |
| Prevention efforts | Create economic and social opportunity through job training and skill building | Create programs/services to help incarcerated persons reintegrate into the community and their family; instill purpose through church and community organizing; promote harmony and stability in the home; build a resource-building/community center; create youth support systems; create jobs; improve educational system; create support systems for parents |
| Mental health literacy campaign | Provide public education on mental health and promote community wellness | Campaign for community wellness; disseminate information about mental health and treatment; advertise collective efforts to promote community wellness; educate the general public on the signs and symptoms of mental illness |

| TABLE 1. Individual and Community Action to Address Mental Health |

14 Health Systems & Reform, Vol. 4 (2018), No. 1
best quality transcripts and field notes and that the field notes provided critical information, in some cases corroborating the transcriptionists’ interpretations of the digital recording or providing missing data. Second, because we used rigorous methods that involved preliminary data analysis through codebook development, we were able to disseminate initial findings to community members and decision makers during dissemination events as well as to researchers and practitioners at national conferences. We then engaged in a more time-intensive analytic approach of theme identification to more fully understand the nuances of the data and its implications for dissemination and next steps.

**DISSEMINATION: IMPACTS ON POLICY AND RESEARCH**

This project generated a common language of engagement, emotional wellness, which informed our approach to engaging communities around mental health. We used this language to engage community in the two summits, as well as in submitted and current federally funded projects that address the mental health needs of African Americans in the Delta (e.g., FAITH in the Delta). Below, we discuss dissemination of study findings.

At the end of the study, we disseminated the findings to health services providers, clergy, community leaders, and local politicians who could use the evidence to develop public health policy. We reached over 200 individuals from our targeted stakeholder groups. These dissemination efforts served to raise awareness about the mental health needs of rural African Americans among local stakeholder groups. However, our CAB felt strongly that we needed to broaden the scope of our dissemination plan and engage (1) individuals who are involved in the development of mental health policy at the state level (e.g., state legislators, mental health advocacy groups, state organizations of mental health providers) and (2) other stakeholder groups that interact with individuals living with psychiatric illness, such as police.

We view the CAB’s recommendation to engage policy makers as prompted by the forum findings. Forum participants identified collaboration and the development of coalition of experts as one way to address mental health among African Americans in their communities (see Table 1). In partnerships with local, state, and national leaders in mental health, we held two emotional wellness summits to engage diverse stakeholders, build new partnerships, and advance collaborative efforts.

In 2015, the Patient-Centered Outcomes Research Institute (PCORI) provided funds to disseminate our findings more broadly. Because many participants in our initial dissemination sessions expressed an interest in talking more about ways to practically implement findings in their community and health care systems, we held a one-day emotional wellness summit during which we engaged new stakeholder groups with a special interest in improving the mental health of rural African Americans. As a result of this summit, we engaged approximately 100 community members, including members of law enforcement, the Arkansas Minority Health Commission, elected officials, health providers, and members of the faith community. In 2017, we held a second emotional wellness summit that focused on the faith community. More than 150 community members attended, including state- and national-level advocacy groups (i.e., National Alliance for Mental Illness), whose presentations focused on advancing mental health care policy change.

Our goal of engaging these stakeholder groups was to increase awareness of mental illnesses among relevant stakeholders in Jefferson County and Arkansas and gain greater involvement of important stakeholders who were not involved in our original project.

Additionally, the evidence base from this project informed a grant application on depression and mental health literacy that was submitted to PCORI. Forum participants stressed the need for a community-wide mental health literature campaign (see Table 1). Mental health literacy campaigns, which focus on mental health knowledge and beliefs as well as symptom recognition, treatment, and prevention, can help community members better recognize and manage mental health symptoms and increase help-seeking behaviors. This grant submission proposed to develop and implement both a culturally appropriate community mental health literacy campaign and stigma reduction intervention and then compare the effectiveness of the stigma reduction intervention alone to the effectiveness of the mental health awareness campaign in combination with the stigma reduction intervention. This application was not funded; yet, we continue to hold conversations with the community regarding the community-initiated solutions generated in this project and are refining ideas for a future resubmission.

We recognize that the intervention we proposed (i.e., mental health literacy campaign) does not have the transformative impact that policy advocacy (for increasing coverage for mental health services) may have on health outcomes. This may reflect our limitations as researchers with expertise in mental health care services research and underscores the importance of interdisciplinary research. Deliberative Democracy Forums can mobilize communities around public health concerns and put them on the path toward policy change. However, to move this process forward, it is important to collaborate with experts.
in applied policy analysis who know how to adapt and implement policy.

PUBLIC HEALTH IMPLICATIONS

This study presents a process—a combination of deliberative methods and qualitative data collection and analysis—to identify solutions and produce evidence grounded in individual and collective experience. Though the deliberative process described in this article transformed private troubles into public health issues, the method does not propose detailed policy options, analyze stakeholder investment, or mobilize policy adoption, which are needed to advance the public health policy process.44

Combining deliberative and qualitative methods represents an important contribution to the process of helping communities articulate their public health needs and transform those private troubles into documented evidence that can inform the public health policy process. Our experience suggests that well-trained community activists can effectively use deliberative methods to mobilize community members toward action. However, if the end goal is to engage in a systematic process to produce evidence and drive the reform of public health policy, then we believe that an effective approach involves community–academic partnerships with expertise in both deliberative and qualitative methods, as described in this article, as well as applied policy analysis.

COMPLIANCE WITH ETHICAL STANDARDS—INFORMED CONSENT

All participants were informed that they were participating in research and their participation was voluntary. Consent was assumed by community members’ decisions to stay and participate in forums. Forum participants were informed that discussions were tape recorded with assurance that their names would never be connected with the content of recordings. The Institutional Review Board at the University of Arkansas for Medical Sciences approved the study.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

The authors declare that they have no conflict of interest.

FUNDING

This study was funded by the Patient-Centered Outcomes Research Institute (pilot study award 1IP2PI000338-01DS), Patient-Centered Outcomes Research Institute Eugene Washington PCORI Engagement Award (EAIN 2975), and the UAMS Translational Research Institute through the National Institute of Health’s National Center for Research Resources and National Center for Advancing Translational Sciences (Grant UL1TR000039).

REFERENCES

[1] Carman KL, Heeringa JW, Heil SKR, Garfinkel S, Windham A, Gilmore D, Ginsburg M, Sofaer S, Gold M, Pathak-Sen E. The use of public deliberation in eliciting public input: Findings from a literature review. Rockville (MD): American Institutes for Research; 2013 [accessed 2017 Oct 1]. http://www.effectivehealthcare.ahrq.gov
[2] Abelson J, Forest PG, Eyles J, Smith P, Martin E, Gauvin FP. Deliberations about deliberative methods: issues in the design and evaluation of public participation processes. Soc Sci Med. 2003;57(2):239–251. doi:10.1016/S0277-9536(02)00343-X
[3] Abelson J. Using qualitative research methods to inform health policy: the case of public deliberation. In: Bourgeault I, Dingswall R, De Vries R, editors. The Sage handbook of qualitative methods in health research. London (UK): SAGE Publications; 2010. p. 606–620.
[4] Button M, Ryfe DM. What can we learn from the practice of deliberative democracy? In: Gastil J, Levine P, editors. The deliberative democracy handbook: strategies for effective civic engagement in the twenty-first century. San Francisco (CA): Jossey-Bass; 2005. p. 20–36.
[5] Flynn B. Planning cells and citizen juries in environmental policy: deliberation and its limits. In: Coenen FHJM, editor. Public participation and better environmental decisions: the promise and limits of participatory processes for the quality of environmentally related decision-making. Dordrecht (Netherlands): Springer; 2008. p. 57–71.
[6] Siegel JE, Heeringa JW, Carman KL. Public deliberation in decisions about health research. Virtual Mentor. 2013;15(1):56–64. doi:10.1001/virtualmentor.2013.15.1.pfor2-1301
[7] Gastil J, Levine P. The deliberative democracy handbook: strategies for effective civic engagement in the twenty-first century. San Francisco (CA): John Wiley & Sons; 2005.
[8] Naylor PJ, Wharf-Higgins J, Blair L, Green L, O’Connor B. Evaluating the participatory process in a community-based heart health project. Soc Sci Med. 2002;55(7):1173–1187. doi:10.1016/S0277-9536(01)00247-7
[9] Centers for Disease Control and Prevention. Mental health: depression. Atlanta (GA): Centers for Disease Control and Prevention; 2016 March 30. [accessed 2017 Nov 1]. https://www.cdc.gov/mentalhealth/basics/mental-illness/depression.htm
[10] Neighbors HW, Caldwell C, Williams DR, Nesse R, Taylor RJ, Bullard KM, Torres M, Jackson JS. Race, ethnicity, and the use of services for mental disorders: results from the national survey of American life. Arch Gen Psychiatry. 2007;64(4):485–494. doi:10.1001/archpsyc.64.4.485
[11] Felix H, Stewart MK. Health status in the Mississippi River Delta region. South Med J. 2005;98(2):149–154. doi:10.1097/01.SMJ.0000145304.68009.02.
[12] Maulden J, Goodell M, Phillips MM. Health status of African Americans in Arkansas. Little Rock (AR): Arkansas Minority Health Commission; 2012.

[13] Rogers KL. Life and death in the delta: African American narratives of violence, resilience, and social change. New York (NY): Palgrave Macmillan; 2006.

[14] Sullivan G, Cheney A, Olson M, Haynes T, Bryant K, Cottons N, Reaves C, Curran G. Rural African Americans’ perspectives on mental health: comparing focus groups and deliberative democracy forums. J Health Care Poor Underserved. 2017;28(1):548–565. doi:10.1353/hpu.2017.0039.

[15] Dryzek JS. Deliberative democracy and beyond: liberals, critics, contestations. New York (NY): Oxford University Press; 2000.

[16] Kingston RJ. Citizens, deliberation, and the practice of democracy: a tryptych from the Kettering Review. Dayton (OH): Kettering Foundation Press; 2012.

[17] McLeod JM, Scheufele DA, Moy P, Horowitz EM, Holbert RL, Zhang WW, Zubric S, Zubric J. Understanding deliberation—the effects of discussion networks on participation in a public forum. Commun Res. 1999;26(6):743–774. doi:10.1177/009365099026006005.

[18] Delli Carpini MX, Cook FL, Jacobs LR. Public deliberation, discursive participation, and citizen engagement: a review of the empirical literature. Annu Rev Poli Sci. 2004;7(1):315–344. doi:10.1146/annurev.polsici.7.121003.091630.

[19] Muse WV. Public deliberation: the Kettering Foundation’s experience and opportunities for the engaged university. J High Educ Outreach Engagem. 2009;13(3):61–63 [accessed 2017 Oct 1]. http://openjournals.lib.uga.edu/index.php/jhoe/article/view/68/56.

[20] Solomon S, Abelson J. Why and when should we use public deliberation? Hastings Cent Rep. 2012;42(2):17–20. doi:10.1002/hast.27.

[21] Carnie TL, Berry HL, Blinkhorn SA, Hart CR. In their own words: young people’s mental health in drought-affected rural and remote NSW. Aust J Rural Health. 2011;19(5):244–248. doi:10.1111/j.1440-1440.2011.02224.x.

[22] Oh J, Ko Y, Alley AB, Swon S. Participation of lay public in decision-making for benefit coverage of national health insurance in South Korea. Health Syst Ref. 2015;1(1):62–71. http://dx.doi.org/10.4162/23288604.2014.991218.

[23] Pesce JE, Kpaduwa CS, Danis M. Deliberation to enhance awareness of and prioritize socioeconomic interventions for health. Soc Sci Med. 2011;72(5):789–797. doi:10.1016/j.socscimed.2011.01.002.

[24] Olson M, Cottons N, Sullivan G. Engaging underrepresented minorities in research: our vision for a “research-friendly community.” Prog Community Health Partnersh. 2015;9(4):595–598. doi:10.1353/cpr.2015.0073.

[25] Brown D. The delta initiatives: realizing the dream… fulfilling the potential. Memphis (TN): Lower Mississippi Delta Development Commission; 1990.

[26] U.S. Census Bureau. American Community Survey; 2015 [accessed 2017 Oct 12]. http://www.census.gov/acs/www/

[27] VERB1 GmbH. MAXQDA software for qualitative data analysis, Version 12.3.1 [software]. Berlin (Germany): Verbi Software-Consult; 2017.

[28] Bradley EH, Curry LA, Devers KJ. Qualitative data analysis for health services research: developing taxonomy, themes, and theory. Health Serv Res. 2007;42(4):1758–1772. doi:10.1111/j.1475-6773.2006.00684.x.

[29] Corbin JM, Strauss AL. Basics of qualitative research: techniques and procedures for developing grounded theory. Los Angeles (CA): SAGE Publications; 2015.

[30] MacQueen KM, McEllan E, Kay K, Milstein B. Codebook development for team-based qualitative analysis. Cultural Anthropology Methods. 1998;10(2):31–36.

[31] National Issues Forums. Naming and framing local issues for public deliberation; 2010 [accessed 2017 Nov 1]. http://conncert.ala.org/files/2139/naming_and_framing_issues_for_public_deliberation_18235.pdf.

[32] Tai-Seale M, Sullivan G, Cheney A, Thomas K, Frosch D. The language of engagement: “aha!” moments from engaging patients and community partners in two pilot projects of the Patient-Centered Outcomes Research Institute. Perm J. 2016;20(2):89–92. doi:10.7812/TPP/15-123.

[33] Rourke B. Developing materials for deliberative forums. Issue Lab. 2014 [accessed 2017 December 23]. https://www.isseulab.org/resources/21495/21495.pdf.

[34] Pratt J. Capturing public thinking: authentic reporting on public forums. Charleston, WV: West Virginia Center for Civic Life; 2016 [accessed 2017 Oct 1]. http://commons.kettering.org/system/files/documents/Capturing%20Public%20Thinking%20revised%202016.pdf.

[35] Haynes T. 2017. Addressing mental health in African Americans through faith. Washington (DC): National Institute on Minority Health and Health Disparities Insights; 2017 Feb 21 [accessed 2017 Nov 1]. https://nimhd.blogs.govdelivery.com/2017/02/21/addressing-mental-health-in-african-americans-through-faith/.

[36] Robinson D. National Institute of Health funds UAMS study of depression program in Delta. Little Rock (AR): University of Arkansas for Medical Sciences; 2016 [accessed 2017 Nov 1]. https://uamshealth.com/news/2016/06/02/nih-funds-uams-study-of-depression-program-in-delta/.

[37] Turner J, Smith J, Bryant K, Haynes T, Stewart MK, Kuo DZ, Harris K, McCoy S, Lovelady N, Sullivan G, et al. Community building community: the distinct benefits of community partners building other communities’ capacity to conduct health research. Prog Community Health Partnersh. 2017;11(1):81–86. doi:10.1353/cpr.2017.0010.

[38] Sullivan JG. Pilot project: methods to identify community priorities for mental health care. Washington (DC): Patient Centered Outcomes Research Institute; 2017 [accessed 2017 Oct 12]. https://www.pcori.org/research-results/2012/pilot-project-methods-identify-community-priorities-mental-health-care.

[39] Bryant-Moore K. Emotional wellness: what can the faith community do? Conference agenda for Healthy People, Healthy Communities Conference. 2017 Sept 9; Little Rock, AR.

[40] Altweck L, Marshall TC, Ferenczi N, Lefringhausen K. Mental health literacy: a cross-cultural approach to knowledge and beliefs about depression, schizophrenia and generalized anxiety disorder. Front Psychol. 2015;6:1–17. doi:10.3389/fpsyg.2015.01272.
[41] Jorm AF, Korten AE, Jacomb PA, Christensen H, Rodgers B, Pollitt P. “Mental health literacy”: a survey of the public’s ability to recognise mental disorders and their beliefs about the effectiveness of treatment. Med J Aust. 1997;166(4):182–186.

[42] Rochlen AB, McKelley RA, Pituch KA. A preliminary examination of the “Real Men. Real Depression” campaign. Psychol Men Masc. 2006;7(1):1–13. doi:10.1037/1524-9220.7.1.1

[43] Rochlen AB, Whilde MR, Hoyer WD. The Real Men. Real Depression campaign: overview, theoretical implications, and research considerations. Psychol Men Masc. 2005;6(3):186–194. doi:10.1037/1524-9220.6.3.186

[44] Reich MR. The politics of reforming health policies. Promot Educ. 2002;9(4):138–142.