Rise Above Stigma Project

Mid-Year Evaluation Report July 1 – December 31, 2021

Project conducted on behalf of the Northeast Delta Human Services Authority (NEDHSA)

Report prepared by The Measurement Group LLC for SheRay's & Associates under contract to NEDHSA

January 2022

Message from the NEDHSA Executive Director Dr. Monteic A. Sizer

We accepted and embraced the challenge to help increase access to mental health and addiction treatment, provide evidence-based prevention and environmental wellness strategies, and successfully help vulnerable communities navigate the often complex behavioral and primary healthcare system. For six months, we examined the region using educationally, culturally, disability-based, and linguistically appropriate tools and information.

We recognize this project's potential impact on our region, state, and nation and believe it will be a blueprint on how service innovations and community connections can transcend brokenness and various forms of division.

We know that to transform the way health and human services are delivered in our region and improve population health, we must reduce negative social determinants of health.

Our Rise Above Stigma project has allowed us to look more closely at population risk factors. We understand there are many systemic barriers to health-seeking behaviors in rural communities. We also understand that these barriers are rooted in history, mistrust, inefficient delivery systems, pain, and broken promises.

This project specifically explores those non-medical factors that influence adverse health outcomes and stigmas such as income, education, unemployment, food insecurity, housing, technology, and transportation.

In this six-month report, you will find that we have not been disconnected from the needs of our region. You will find that we have been committed and consistent in creating services, resources, initiatives, and programs to address many of the challenges our region face.

We know that no single program or agency has all the answers, so we must work hard to remove community obstacles, overcome governmental silos, and provide access to programs and services to meet people where they are. Therefore, we will work closely with those willing to help reimagine what is possible in our region. We must see a new reality and then work collectively to make it happen.

To say we understand is one thing; to show it is another. As we continue to build a unified region and serve as a catalyst to help individuals reach their full human potential, we at Northeast Delta Human Services Authority (NEDHSA) are moving more into reducing negative social determinants of primary and behavioral health care. This is how we will help our region rise.

~ Dr. Monteic A. Sizer, Executive Director
Northeast Delta Human Services Authority

Evaluator's Foreword

In July 2021, the Northeast Delta Human Services Authority (NEDHSA) contracted with SheRay's & Associates to facilitate and evaluate the development and implementation of Stigma Reduction Plans for each of the 12 parishes in Louisiana Region 8. This report summarizes the progress, achievements, success, and challenges experienced in this work over a six-month period from July 1 through December 31, 2021.

The stigma reduction project was originally conceptualized as a two-year process based largely on SAMHSA's Strategic Prevention Framework. As the scope of work was developed, the timeframe for the work was compressed to one year. As planned, this report serves as a mid-year progress report to help show what was accomplished in the first six months of this process. It is designed to support data-informed decision-making moving forward. The scope of work was particularly ambitious, especially given an aggressive time frame for achieving measurable change in the use of behavioral health services in the region.

Despite the challenges faced in achieving the goals of this project, we have already begun to observe evidence of progress in engaging parish members at the grass roots level in working to address behavioral health stigma in their communities.

Lisa A. Melchior, PhD
President, The Measurement Group LLC
on behalf of SheRay's & Associates, LLC

January 2022

Note: This is an independent evaluation report prepared by The Measurement Group on behalf of SheRay's & Associates in support of NEDHSA's Rise Above Stigma project. The opinions expressed in this report are those of the evaluation team and may not necessarily represent those of NEDHSA or SheRay's & Associates.

Executive Summary

In July 2021, the Northeast Delta Human Services Authority (NEDHSA) undertook an ambitious project. **Rise Above Stigma** aimed to increase awareness of behavioral health issues and increase access to services among residents of Louisiana's Northeast Delta region. NEDHSA contracted with SheRay's & Associates to carry out a process that would engage parish members in addressing community perceptions of behavioral health and encourage uptake of behavioral health services.

From July 1 through December 31, 2021, The Rise Above Stigma project went from project start-up to working with a group of six parishes identified for the first phase of developing and implementing parish-specific Stigma Reduction Plans. The project was built upon the BAMM BH Model (**B**reak the Stigma, **A**sk for Help, **M**ake the Call, **M**ake the Change: **B**ehavioral **H**ealth).

Progress was made in several areas, specifically those that were planned for the first half of the year-long project period. Parish Implementation Teams were formed, Town Hall meetings were planned, with two such meetings implemented in December 2021. Work towards achieving many of the objectives was planned for the second half of the project, which is outside the scope of this mid-year report.

The Rise Above Stigma project had extremely ambitious goals, especially given a timeframe of just 12 months. Stigma and related attitudes can be deeply entrenched; effecting change in long-held attitudes and behaviors is not easy. In addition, the project encountered some serious challenges which affected timely implementation. Yet despite these obstacles, the beginnings of a mechanism for stigma reduction in the Northeast Delta region were achieved. Anti-stigma messaging was shared widely across a range of platforms; budding community coalitions were created or renewed via the Parish Implementation Teams.

The work accomplished in this six-month period has created a foundation for community transformation, whatever direction stigma reduction efforts take in the Northeast Delta region in the future.

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About the Rise Above Stigma Project

In July 2021, the Northeast Delta Human Services Authority (NEDHSA) launched the *Rise Above Stigma* project. With the goal of collaborating with community-based organizations and stakeholders within the twelve parishes of the Northeast Delta region (Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Tensas Morehouse, Ouachita, Richland, Union and West Carroll), *Rise Above Stigma* focused on health stigma reduction to increase access to mental health and addiction services.

Funded by a grant from both the Office of Behavioral Health of theLouisiana Department of Health (LDH-OBH) and the Substance Abuse and Mental Health Services Administration (SAMHSA), the overall goals of the project included understanding parish-specific barriers to behavioral health access and uptake. This would be accomplished through community Town Hall meetings, creating plans to reduce stigma within each parish, and disseminating culturally and linguistically relevant information about behavioral health services to increase the number of people receiving services.

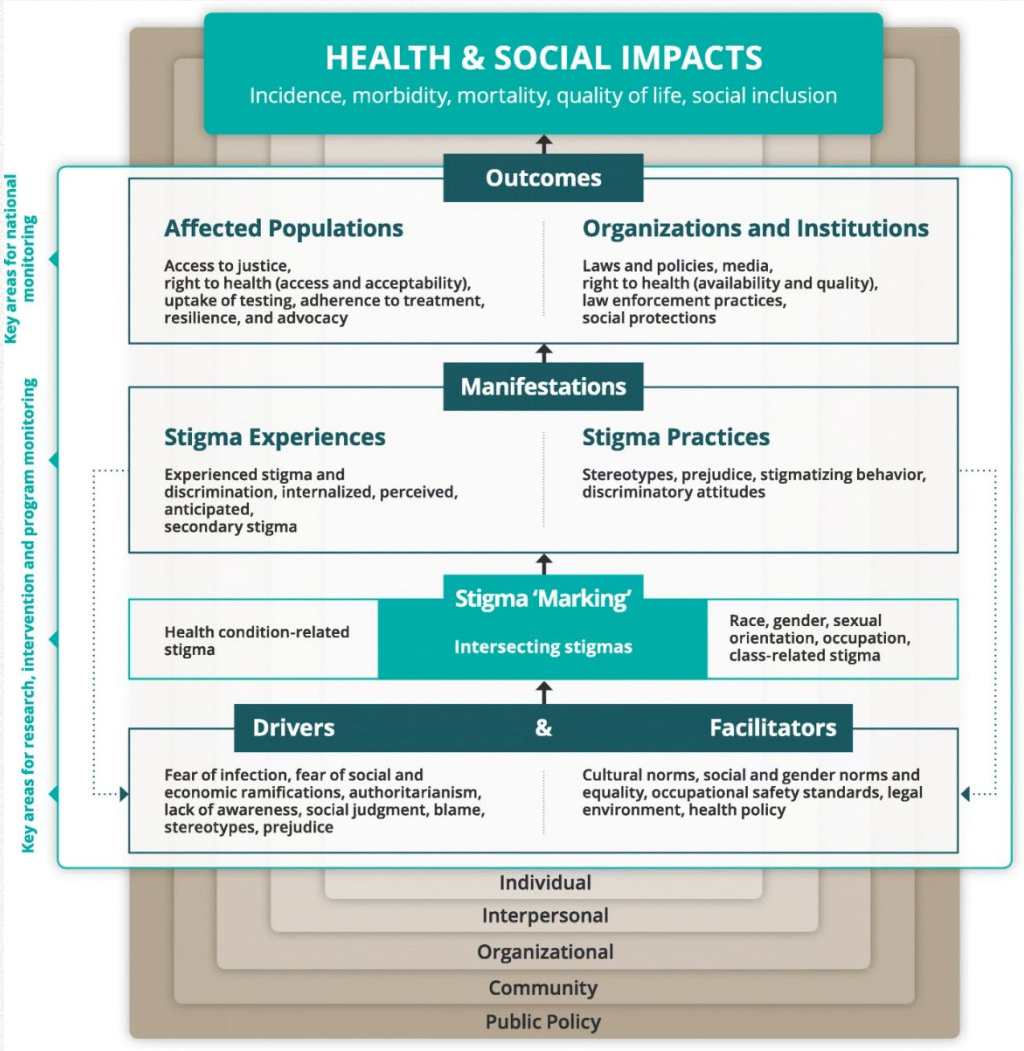
The project was implemented through a partnership with SheRay's and Associates, LLC – employing their model, *Break the Stigma, Ask for Help, Make the Call, Make the Change Behavioral Health (B.A.M.M. BH)* to guide development of the parish Stigma Reduction Plans. In turn, each Stigma Reduction Plan was a collaboration between SheRay's and local community partners – Parish Implementation Teams – in each parish.

Understanding the systematic barriers and stigmas that prevent individuals from seeking behavioral health services, *Rise Above Stigma* sought to energize and engage communities in creating a roadmap to increasing awareness of and access to behavioral health services in rural regions such as the Northeast Delta.

The Health Stigma and Discrimination Framework

The Health Stigma & Discrimination Framework (Stangl et al., 2019) formed the basis of the work underlying this project.

The framework's authors specifically cited mental health as an example for its application to health-related stigmas. The framework also can be used to address intersecting stigmas related to attributes such as race, gender, sexual orientation, class, and occupation.



Stangl, A.L., Earnshaw, V.A., Logie, C.H. *et al.* The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Med* **17,** 31 (2019). https://doi.org/10.1186/s12916-019-1271-3

BAMM BH: A Model to Address Behavioral Health Stigma

SheRay's & Associates used its BAMM BH model to guide the development of Stigma Reduction Plans for the participating parishes.

BAMM BH stands for: B. (Break the Stigma) A. (Ask for help) M. (Make the call) and M. (Make the change) for Behavior Health (BH)

BAMM BH is a customized behavioral health prevention process which engages community members directly to impact behavior change. BAMM BH consists of environmental and capacity building strategies to tackle behavioral concerns in a targeted area (i.e., increase in suicide, violence, opioid and other addictions, etc.). These strategies are important to use to address the identified issue of the community to make a systemic impact in the environment and with the community at large (youth, adults, and professionals).

BAMM BH is grounded in a culturally inclusive systems thinking approach to understanding and identifying the concerns, stigmas, and barriers of the community and developing community data-driven solutions utilizing a proven strategy in collaboration with local expertise.

BAMM BH is a SheRay's & Associates/TTJ Group, LLC customized behavioral health prevention process which is a method to engage community members directly to impact behavior change.

Implementation Phasing by Parish

The Northeast Delta Region 8 includes 12 parishes. A set of six parishes was identified as a focus of the early phase of the project, to be followed by the remaining six parishes. The assignment of parishes to project phases was done as a collaboration between the project team and NEDHSA.

Phase One Parishes

East Carroll*
Jackson
Lincoln
Madison
Morehouse
Ouachita

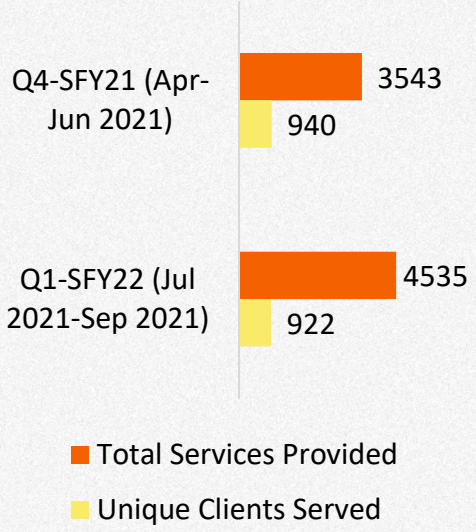
Phase Two Parishes

Caldwell
Franklin
Richland*
Tensas
Union
West Carroll

* Initially Richland Parish was a Phase One parish but was moved to Phase Two and replaced in Phase One by East Carroll parish.

Progress Towards Objectives

Objective 1.1
Increase the number of individuals receiving behavioral health services by 10%



"Moving the needle" in terms of increasing the number of people receiving behavioral health services is an ambitious goal for a project of this scope and timeframe. Changes in help-seeking behavior may not necessarily immediately follow public education and information campaigns.

While measurable change was not possible nor expected within the six-month period of this report, NEDHSA has information systems in place to monitor behavioral health service utilization trends over time. The data summarized here were provided for the period of April-June 2021 and the following quarter, July-September 2021. Since this project started effective July 1, 2021, these data can serve as a baseline for future examinations of behavioral health service utilization in these parishes.

Over these two quarters, gender and race composition of the client population remained consistent.

There is an expression in the social sciences, "correlation does not imply causality." If behavioral health service utilization in the Northeast Delta region does increase, it cannot be proved that the Rise Above Stigma campaign is necessarily responsible for the increase. Still, if more Northeast Delta residents do access behavioral health services, it will be a good outcome regardless of the cause.

Data provided by Dependra Bhatta, PhD, Director, Department of Behavioral and Primary Health Analytics, Nov. 23, 2021.

Objective 1.2
Develop Stigma Reduction Plan (SRP) with each parish (1 of 2)

A process was initiated to create Parish Implementation Teams in six of the targeted parishes. In collaboration with NEDHSA, SheRay's developed and released a Request for Applications for community- and faith-based organizations in Louisiana Region 8. Organizations applied to perform the duties of the Parish Implementation Team in their parish. Organizations with successful applications were awarded $5,000 to support their work.

The Parish Implementation Teams met frequently with SheRay's and NEDHSA staff to plan the Town Hall meetings for each respective parish.

The Town Hall meetings were intended to provide the basis for identifying issues, needs, and priorities for each parish's customized Stigma Reduction Plan.

Parish Implementation Team Leadership

Parish	Organization(s)
Jackson	Hand Up Ministries*
Lincoln	First choice Counseling*
Madison	Pre-K 12 and Beyond*
Morehouse	Northeast Counseling First Choice Counseling Good Shepard Personal Care Services
Ouachita	Faith & Hope Behavioral Health* Korporate Kouture* Go Care Community Health* SOAR Transitional Home* ULM Speech and Pathology Northeast Delta CIT True Worker Compensation* Guidance Behavioral Health*
Richland	Bayou Family Care Yancey's Pharmacy

* Funded Parish Implementation Team

Objective 1.2
Develop Stigma Reduction Plan (SRP) with each parish (2 of 2)

In support of this objective, Town Hall meetings were held in Jackson Parish and Madison Parish during the reporting period.

The information that emerged from the Town Hall meetings was intended to form the basis for developing a Stigma Reduction Plan for each Parish in the second half of project period.

The Town Hall meetings in Jackson and Madison Parishes were lively and well-attended.

Participants identified local definitions of stigma, factors affecting access to behavioral health services in their parish, and possible solutions to help reduce barriers to getting needed help.

Analysis of the data collected from these Town Hall meetings is reported later in this report.

Objective 1.3
Provide Implicit Bias and Trauma Informed Care Training

Providing training to parish members on topics such as implicit bias and trauma informed care was an activity planned as an important outcome of the Stigma Reduction Plan for each Parish. Issues and needs identified through the development of the Stigma Reduction Plan were intended to inform the implementation of these trainings.

These trainings were not planned for the first six months of the project.

Objective 2.1
Reach 10,000 people in the targeted population with messaging regarding culturally competent, linguistically appropriate evidence-based, and strength-based behavioral health services

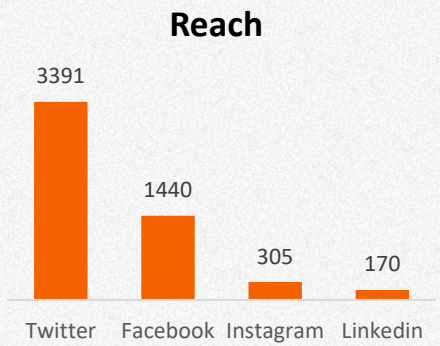
Data provided by DeRon Talley, MBA, Communications Director for NEDHSA, shows that based on newspaper circulation and billboard impressions data alone, NEDHSA has already reached more than 10,000 people in the region with messaging promoting the Rise Above Stigma initiative. Specific analysis of various media channels is given on the next page.

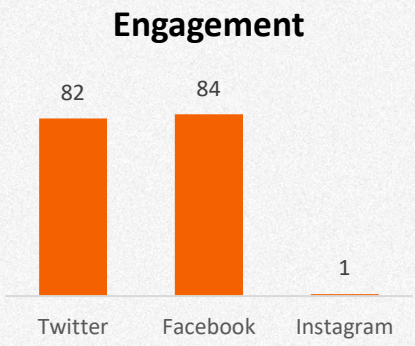
NEDHSA's media campaign is an important part of the Rise Against Stigma initiative. It is complementary to the use of media messages as outlined in the BAMM BH model. In that model, messaging is developed with members of the community, utilizing data from the Town Hall meetings and other relevant data gathered during the process. Community input from the Town Hall meetings that were collected during this period may be useful for informing future NEDHSA media messaging.

Rise Above Stigma Marketing Analytics

Twitter's reach overperformance

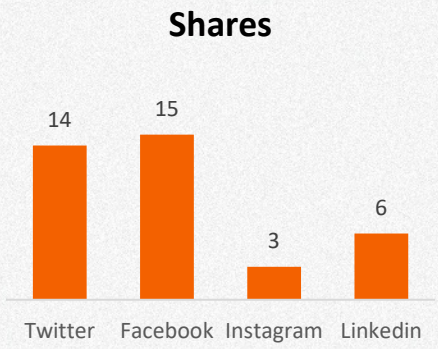
During the marketing campaign Twitter was ahead of the other platforms by a large margin in terms of reach per post. Twitter accrued an average of 283 reach per post with its most popular posts being DeRon Talley's "Public Information Director DeRon Talley joins Cory Crowe to talk about the #RiseAboveStigma initiative!" and "RiseAboveStigma project was featured in a half-page ad in @OuachitaCitizen!" together totaling near 2000 reach.

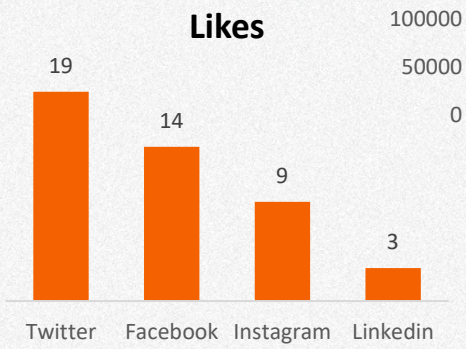


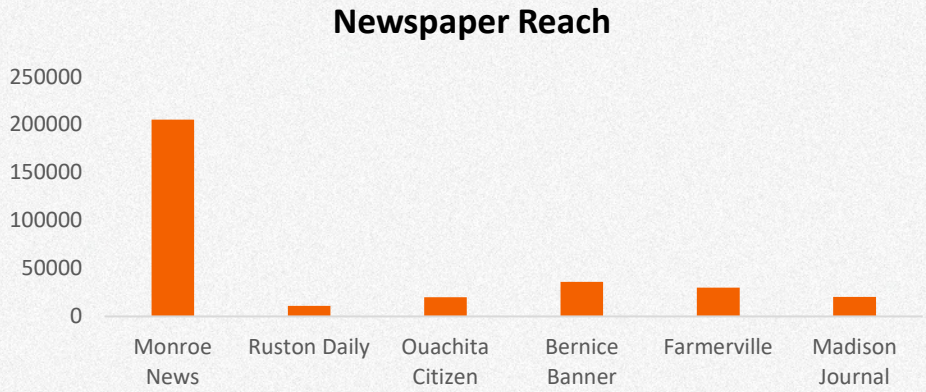


Facebook's engagement overtakes Twitter

Despite Twitter's performance on reach, Twitter and Facebook had a similar engagement score. Both platforms had the same number of posts at 12 with an average engagement of 7 per post.

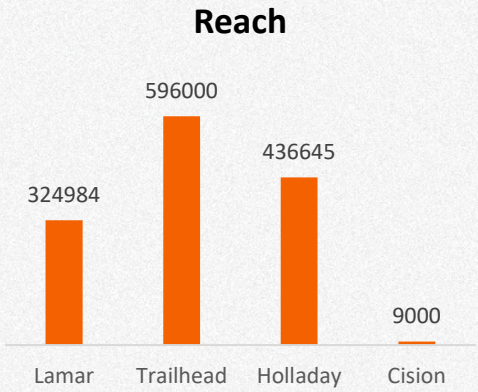






Billboards averaged nearly 11,000 impressions daily

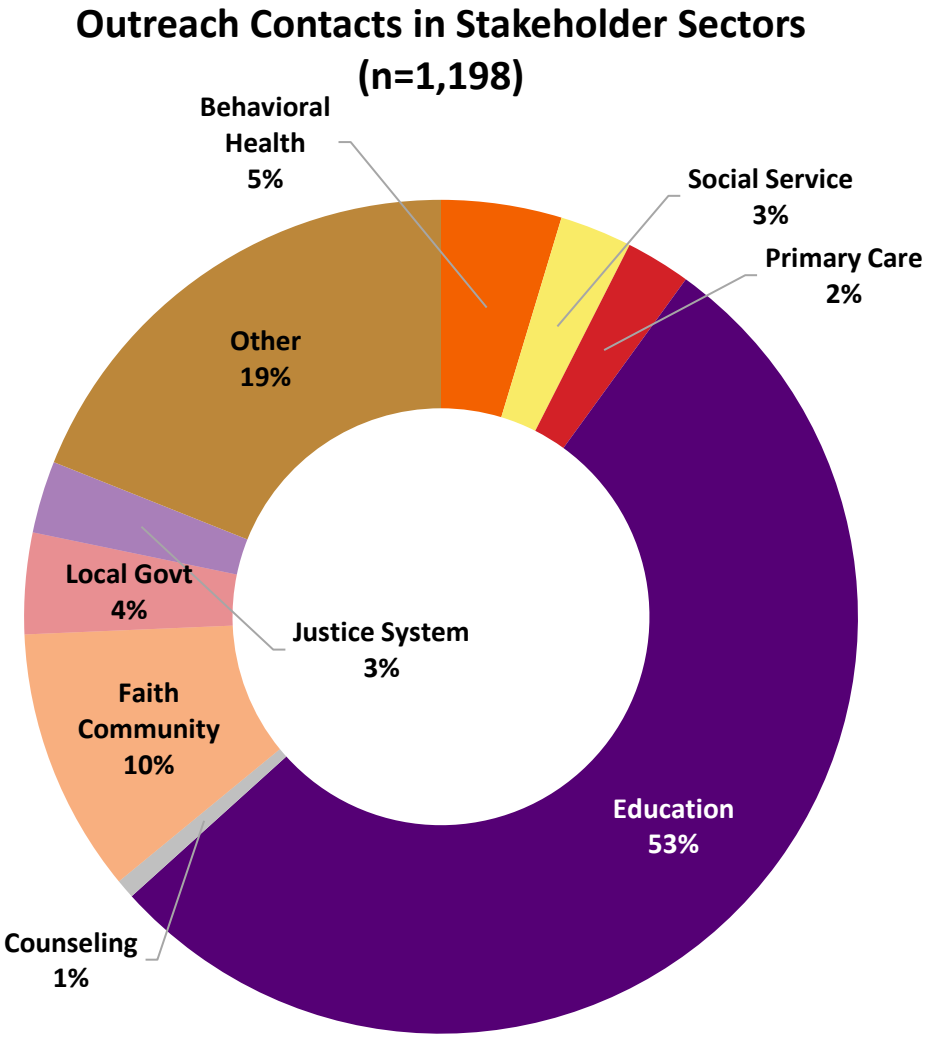
The Holladay Company had a total reach of 436,645 throughout its Digital Placement Advertising campaign starting on 8/1/2021 and ending on 10/15/2021. During the period of 08/01/2021-12/01/2021 Lamar Company's Billboard had a reach of 324,984 per month, totaling a reach of 1,299,936 over its duration. The Trailhead Company's Billboard campaign extended from 08/01/2021-12/31/2021 and had a reach of 596,000 each month, totaling 2,980,000 reach. The Press Release Distribution using the Cision platform reached 7,000 individuals over three different press releases with the highest reach stemming from the Initial Rise Above Stigma Press Release at 3,000 reach.



Objective 2.2
Establish relationships with Human Services, Treatment Providers, etc. in each of the twelve (12) parishes

SheRay's, through its outreach efforts in the six parishes of focus between July-December 2021, documented more than 1,000 contacts with people and organizations representing various stakeholder groups.

These contacts resulted in invitations to apply for the RFA to work on the Parish Implementation Teams, as well as invitations to participate in development of Parish Stigma Reduction Plans.



Objective 2.3
Provide information of services for family members of persons with addiction

SheRay's has created a service directory that can be made available for family members of persons with substance use disorder, as well as others looking for addiction service resources.

For each service provider in the directory, information includes the organization name, location, contact information, and services available.

Objective 3.1
Develop a strategy utilizing the regional plans to recruit clients for services

Development of strategies for recruiting potential clients to behavioral health services was planned for the second half of the project period.

In the first six months, the focus was on outreach to community members through various strategies – including Town Hall meetings – in order to develop responsive Stigma Reduction Plans for each Parish.

Development of strategies to recruit clients for services would have been part of the implementation of the Stigma Reduction Plans.

Some possible solutions for addressing stigma associated with seeking help for behavioral health issues were raised during the Town Hall meetings held thus far (for Jackson and Madison Parishes). These possible solutions may provide a foundation for future strategies to increase engagement and retention in behavioral health services in those communities as well as others in the Northeast Delta region.

Objective 3.2
Identify, develop, and provide culturally competent information on stigma best practices and resources for individuals, families, and treatment providers

The work accomplished through the Parish Implementation Teams and the Town Hall meetings that were held during this period started to identify practices that addressed cultural competence with respect to behavioral health services in the Northeast Delta region.

Further identification of best practices and resources for consumers and providers would have been a focus of the latter part of the project.

Objective 3.3
Referral to treatment, complete the GPRA for each of the 12 communities and provide a 6-month follow-up with providers

Referral of individuals to behavioral health treatment was not a focus during the first six months of the project; this would have been emphasized in the second half of the year, as parish members worked on implementing their Stigma Reduction Plans and focused on encouraging those seeking help to access care.

The GPRA refers to a set of questionnaires used by treatment providers that receive funding from the Substance Abuse and Mental Health Service Administration (SAMHSA). It is designed to be administered when the client enters treatment, at 6-month follow-up, and at program discharge. Collecting these data in the future would allow monitoring in the aggregate of client characteristics, presenting issues, and outcomes at the individual, program, and systems levels. When these data are reported to SAMHSA, they are included in SAMHSA's report to Congress as part of the Government Performance and Results Act (GPRA).

In general, having systems for collecting client-level measures of demographic and clinical characteristics, social determinants of health, and tracking measurable outcomes over time may be considered a best practice in behavioral health services.

Objective 4.1
Evaluation of the project

This document serves as the evaluation report for the project period from July 1, 2021 through December 31, 2021.

The evaluation used a mixed methods approach to use both quantitative (numeric) and qualitative (descriptive) data to document the extent to which the project met its objectives, and to document the processes and outcomes of the implementation of the stigma reduction project.

The evaluation was guided by the logic model on the next page.

Note: Objective 4.2 was to submit a final evaluation report including policy recommendations. This is not a deliverable for the first six months of the project.

NEDHSA Rise Above Stigma: Logic Model

Resources	Activities/Deliverables	Objectives	Outcomes	Long-Term Goals
• Stigma Reduction Framework • 12 parish communities • Key stakeholders & community members • Recovery Act funding • NEDHSA leadership & staff • SheRay's & Associates (project management) • The Measurement Group (external evaluation) • Parish Implementation Teams • Online meeting platform • Physical meeting spaces • Social media, website, flyers • List of faith-based organizations & community (parish) based organizations • Work to date by NEDHSA	Implement BAMM BH • Town Hall meetings • Develop stigma reduction plan • Implement culturally appropriate media campaigns • Develop Parish Implementation Teams to assist in development of recruitment plans, strategies, & SRP • Establish relationships with providers in 12 parishes • Develop provider directory for families/consumers • Provide mental health awareness & other culturally & linguistically appropriate trainings for 12 parish communities	• 1.1. Increase # of individuals receiving behavioral health (BH) service by 10% • 1.2. Develop stigma reduction plans with each parish • 1.3. Provide Implicit Bias & Trauma Informed Care Training • 2.1. Reach 10,000 people in targeted population with messaging re: BH services • 2.2. Establish relationships with local providers in the 12 parishes • 2.3. Service info for family members of persons with addiction • 3.1. Develop strategy with regional plans to recruit clients for services • 3.2. Culturally competent info on stigma best practices & resources • 3.3. Treatment referrals-12 parishes • 4.1. Project Evaluation • 4.2. Final report	• Identify & understand stigmas, barriers & challenges that prevent people from accessing services • Articulate the Stigma Reduction Strategy (SRS) for possible replication • Reach & engage communities in the 12 parishes around behavioral health stigma reduction via media campaigns • Increase provider capacity to address stigma in the 12 parishes • Increase knowledge, anti-stigma attitudes, & behaviors via culturally & linguistically appropriate trainings	• Reduce BH stigma • Increase access to BH support services • Engage marginalized populations in accessing recovery into paraprofessional workforce • Ensure safety & wellbeing of individuals in each parish

Project Outcomes: What Did We Achieve So Far? (1 of 2)

After six months, progress towards the outcomes outlined in the logic model had just begun. Here, we take a brief look at what the project accomplished as well as the related successes and challenges during this six-month period.

Outcome: Identify & understand stigmas, barriers & challenges that prevent people from accessing services

The two Town Hall meetings held thus far started conversations about stigmas, barriers, and challenges in the parishes where those meetings occurred. Much more work remains to identify and understand these issues in the ten parishes that did not yet have a Town Hall meeting. Furthermore, the conversation can greatly benefit from the participation of a broader group of stakeholders in the process.

Outcome: Articulate the Stigma Reduction Strategy (SRS) for possible replication

This outcome was a target for the end of the year-long project. Articulating the Stigma Reduction Strategy for possible replication was not an intended or possible outcome within the first six months of the project.

Project Outcomes: What Did We Achieve So Far? (2 of 2)

Outcome: Reach & engage communities in the 12 parishes around behavioral health stigma reduction via media campaigns

NEDHSA has engaged in a media campaign that has reached communities across the region with stigma reduction messages. NEDHSA should seek ways to build on this messaging to further engage communities around behavioral health stigma reduction.

Outcome: Increase provider capacity to address stigma in the 12 parishes

During the first six months, Parish Implementation Teams were trained on the Strategic Prevention Framework/Capacity Building. They were also trained about the Stigma Reduction Planning process.

Additional training and education for local service providers to increase provider capacity to address stigma was a focus in the second half of the project year. The groundwork for doing so was starting to be created from the work initiated by the Parish Implementation Teams and SheRay's.

Outcome: Increase knowledge, anti-stigma attitudes, & behaviors via culturally & linguistically appropriate trainings

The trainings aimed at increasing knowledge, anti-stigma attitudes, and behaviors were planned for the second half of the project period. Challenges were faced in the implementation of planned baseline data collection of knowledge and anti-stigma attitudes, as the sampling strategy did not gain traction in the parishes.

Supporting Evaluation Data: Outreach

SheRay's and Parish Implementation Teams

An Outreach Partnership Model

Outreach to parish communities was accomplished via collaboration between an Outreach Specialist employed by SheRay's and community- and faith-based organizations in each early phase parish. This section of the report summarizes the outreach and related activities documented by both the SheRay's Outreach Specialist and the Parish Implementation Teams.

Outreach Summary

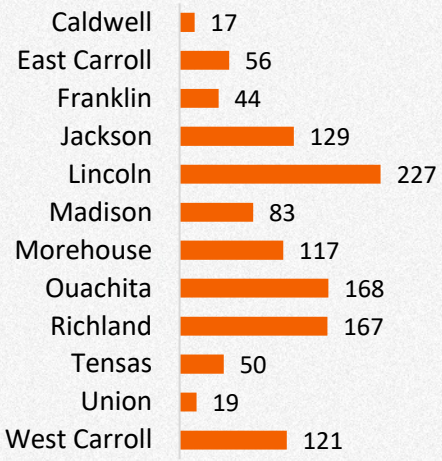
To help develop and implement parish Stigma Reduction Plans, SheRay's had an Outreach Specialist working to engage community stakeholders. This role was filled by primarily one person. The Outreach Specialist worked and resided in the Northeast Delta region and had experience working with many stakeholder groups relevant to behavioral health services.

The Outreach Specialist documented 1,198 outreach contacts during this six month period. Initially, outreach was documented in a narrative format. As evaluation procedures were subsequently implemented to collect more detailed data, contacts were documented via a Google Form which collected information including the number of people reached, topics addressed, and other aspects of the outreach activities*.

Based on the more detailed information about the purpose of the outreach activities (n=38 activities), most were focused on developing Parish Implementation Teams (95%). Relevant items were distributed, including invitations to Town Hall meetings (71%). People and organizations from various disciplines were reached, including mental health and substance use service providers, social service providers, case managers, primary care providers, workers from law enforcement/justice system counselors, teachers, faith leaders, and city leaders. Outreach occurred with people of diverse demographic backgrounds.

Relationships were built from the ground up, often starting with cold calls. COVID-19 proved to be a challenge to outreach; face-to-face contacts were often not possible early in the process due to public health concerns. Most early outreach was conducted by phone (76%) and email (61%). When COVID-related restrictions were eased, outreach specialists went to some organizations in person to talk about the program, based on the public health guidelines in place for that parish.

Outreach Contacts by Parish



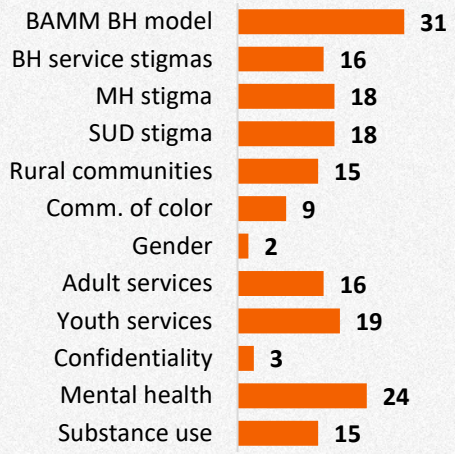
*The more detailed outreach data collection started in November 2021.

Activity Summary: Parish Implementation Teams

From October to December 2021, the Parish Implementation Teams (described on page 11) documented 32 community activities: 15 in Madison Parish, 12 in Jackson Parish, and 5 in Ouachita Parish. These activities reached at least 1,400 individuals. Participants came from diverse backgrounds in terms of age and role in the community. Informational materials were provided including program information and Town Hall flyers.

Activity Purpose (n=32)

Topics Addressed (n=32)



Glossary: MH = Mental Health; SUD = Substance Use Disorder; Connex=connections; PIT = Parish Implementation Team; Comm. = Communities

Qualitative Data: Parish Implementation Team Successes

At the end of each month, Parish Implementation Teams completed a Feedback Form (via Google Form) to report on the successes, challenges, and lessons learned in their work with their respective parishes.

Overall, the Parish Implementation Teams started to gain momentum in their community engagement work during this period. **80% of the reports indicated that new relationships had been established in the past 30 days.**

Theme	Mentions	Selected Examples
Networking, engagement, & collaboration	5	"I have been able (to) reach out to several businesses and they are willing to be a part in this movement to address the stigmas in our area."
Linking consumers to behavioral health services	3	"We have been successful in reaching 3 new community members and getting them started with mental health services."
Identifying resources, barriers & gaps	2	"We have talk(ed) with people in the community that have drug and mental issues about getting help."

In addition to the data summarized in the table, one mention each was given to Town Hall meeting and data collection

Qualitative Data: Parish Implementation Team Challenges

In addition to the information in the table to the right, one mention each was given of the following challenges:

Meeting logistics
Lack of treatment facilities in communities of color
People not taking the problem seriously
Hard for people to discuss behavioral health issues
Challenges with sustained participation in the Stigma Reduction Plan process
Challenges related to insurance coverage for behavioral health

Theme	Mentions	Selected Examples
Availability and uptake of local behavioral health services	5	"In addressing the stigmas that prevent access to Behavioral Health Services. I have encountered a lack of treatment facilities in the communities that were predominately African American."
COVID-19	3	"Of course, I am having to do more phone contacts instead of face to face due to Covid."

Qualitative Data: Parish Implementation Team

Key Activities for Success

In response to the question, "What was most the important or key activity in your work?" Parish Implementation Team members identified the themes shown in the table at right.

Theme	Mentions	Selected Examples
Community engagement/ outreach	6	"When outreaching the community I can really see and understand the needs of those who need assistance." "The most important activity this month was the outreach meeting at the community center. We reached a different audience at this meeting, mostly youth."
Broadening collaboration	3	"I was able to have a brief phone encounter with someone in the probation and parole office to be help in this movement. Working with and through this organization we will be able to reach out those that normally would not get this information." "The most important activity this month was to develop relationships with key people in the community to address the Mental Health needs."
Educating clients	2	"Educating clients has been the most important activity…because this allowed for clients to have a better understanding of their own mental heal and how mental health counseling services will benefit their mental well-being."
Action steps to prepare for the Town Hall	2	"Getting a speaker locked in for the Townhall meeting."
Advertising on social media & email for recruitment	1	"…This was a key activity to support the project as well as generating more members to the implementation team…"

Supporting Evaluation Data: Town Hall Meetings

About the Town Hall Meetings

Two Town Hall meetings were held in December 2021. Due to COVID-19 precautions, both Town Hall meetings were held online using an interactive webinar format.

Three additional Town Halls were scheduled but not yet held during this six-month reporting period (Lincoln, Morehouse, and Ouachita parishes).

Jackson Parish Town Hall

Held December 2, 2021
22 participants*

Madison Parish Town Hall

Held December 7, 2021
10 participants*

Each Town Hall meeting was recorded. The evaluation team transcribed these recordings and coded the contents for qualitative themes. Qualitative data were coded and analyzed using NVivo software.

The following pages summarize the major themes that were discussed. Findings are organized in terms of questions addressed and how they relate to individual, community, and systems-level issues.

*excluding those from SheRay's and the evaluation team

Town Hall Themes

What is stigma? (1 of 3)

The findings shown here illustrate what Town Hall participants disclosed in terms of their views and definitions of stigma as it relates to behavioral health and behavioral health services

Coding of these themes was guided by the Health Stigma and Discrimination Framework. This first summary focuses on themes related to the individual's experience of stigma.

Stigma Experiences	Mentions	Selected Examples
Anticipated Stigma	16	"I find it when individuals come in that are experiencing problems with substance abuse or mental illness, they feel alienated. First of all, they've experienced it because they're hopeless anyway. And when people tend to be judgmental and, as one person said earlier, 'label' them, that makes them feel worse and they want to go back into hiding because they feel like no one cares and no one wants to help them."
Experienced Stigma	7	"I think it's a trust factor. People don't really know who to trust. People have been hurt and harmed by so many systems. When I say systems, I mean systematically."
Internalized Stigma (Self-Stigma)	10	"A lot of people are ashamed to come and ask, they don't know who to go to without someone going around talking about them and telling them something about it." "With the embarrassment, people who have mental illness, they're ashamed to go out and talk to other people about their issues."
Perceived Stigma (Public)	12	"I think they're afraid about how others may perceive them, how their families or communities might think about them if they reach out for help. And those are things that I think we can fight against as clinicians."

Town Hall Themes

What is stigma? (2 of 3)

The findings shown here illustrate what Town Hall participants disclosed in terms of their views and definitions of stigma as it relates to behavioral health services

The summary in the table at right focuses on themes related to stigma practices in the community.

Stigma Practices	Mentions	Selected Examples
Discrimination	5	"That's something we got to work with is being diverse and being able to work with – getting past that bias. Getting past that discrimination. Being able to work with that person because you genuinely want to help that individual be successful in their lives."
Perceived Stigma (Public)	9	"Again, the stigma is judgment. Judgement by appearance, first of all. We size them up, 'Oh they look, oh they're acting all crazy' and that is the greatest stigma, just judging people without giving them the opportunity to reveal to you what their issues are..."
Stereotypes	4	"The thing I've noticed is the word 'mental'…when we had our very first meeting, when people say "mental," the first thing that pops in the head is like 'I am not crazy.' …I had a gentleman ask me a question a couple days ago, I think he's a substance user. And I told him, I said 'No, I'm not doing that program, but I deal with mental health.' And he said 'Oh, nah, nah, nah, I don't want to do it because I'm not crazy.' That's the first thing, when you mention stigma, is that in African American communities, the first thing you say when you say 'mental,' the person immediately jumps to that word that 'I am not crazy.' To me, that part of mental health is really the hurdle that we faced for a very long time."
Prejudice	5	"When we talk about it and when we're sittin' and trying to identify what those issues are, it's viewed as a 'that's their problem' or 'that's what goes on on that side of town.' I can remember growing up that if we saw someone of a certain race on our side of town, we automatically said they were over there to buy drugs."

Town Hall Themes

What is stigma? (3 of 3)

The summary in the table at right continues the previous page with a focus on themes related to stigma practices.

Stigma Practices	Mentions	Selected Examples
Private Stigma	2	"And a lot of the times we ourselves have experienced some of the same things they're going through whether it be substance abuse or mental illnesses or even just trials and tribulations, but we don't want to be reminded that we are like that - that we are substandard."
Public Stigma	27	"We as a society have to come to the grips that we keep people on a certain level and if they don't meet those guidelines or they don't measure up to where we think they should, then we have a tendency to judge them."
Secondary Stigma (Associated Stigma)	5	"I think oftentimes because people feel stigmatized, they are already fighting that battle of do I talk to anyone about what's going on with my mental health? Do I trust anyone that I can talk to about what's happening? And then the other issues may layer may add another layer of concern for them, Can I talk to anyone about the fact that I am struggling with my sexuality? Can I talk to anyone about that fact I don't feel comfortable in my own skin? All of those things happening, I think it adds layer upon layer of the stigma they're already feeling."
Stigma Associated with Seeking Help	13	"And it's also, to me, it's the fear of unknown. What would happen if I go? What would happen if I ask for help? You know, are they going to judge me? Discriminate against me? It's just a lot of factors why people just don't."

Town Hall Themes

What are some reasons for stigma related to behavioral health services?

The findings summarized here show what Town Hall participants identified as issues related to stigma related to behavioral health service use. Overall, there were 37 mentions of reasons for behavioral health service-related stigma.

We further examined these responses in terms the level of analysis they represent: Individual (12 mentions), community (28 mentions), and systems (8 mentions).

The most frequent categories mentioned were related to social norms, societal attitudes, social judgment, and lack of awareness.

Theme	Mentions	Selected Examples
Social Norms	21	"Not being willing to address and say that these are issues that we are having in the community. Like I said, a lot of times when I go and I do the Narcan trainings, and I try to explain not just what Narcan is but the purpose and benefits for the community, I can't tell you how many times people say, 'Well that's not an issue people are having in our area.' and I'll say, 'It isn't?' And I have access to the data, I see and I know….You see what goes on and you hear about things through friends and family and social media and you do know that it is an issue that's going on in the community so denial is another part of it."
Societal Attitudes	21	"So, I think that's a lot of it in our society, instead of a 'take care of them mentality,' it's all about me, my, and I. So, if you don't enhance me or if I can't get in and benefit from you, then pretty much then we leave them, outcast them. Pretty much to me, it's all about people looking at them and judging them and their perspective."
Social Judgment	16	"First of all, they've experienced it because they're hopeless anyway. And when people tend to be judgmental and, as one person said earlier, 'label' them, that makes them feel worse and they want to go back into hiding because they feel like no one cares and no one wants to help them."
Lack of Awareness	10	"We just don't know how many people are out there, we suspect there's so many. And I think most of us can see the visibility as people walk up and down the road, and whatever their illness is, talking to themselves, whether its drugs, or whatever."

Town Hall Themes

What keeps people from using behavioral health services?

The findings summarized here show what Town Hall participants disclosed in terms of their views about what keeps people in their parish from using behavioral health services.

The most frequently mentioned topics were classified as having to do with stigma, logistical/financial barriers, and lack of access.

Theme	Mentions	Selected Examples
Stigma	31	"…they are already feeling hopeless, like nobody cares and then when they get into a program to try to get those resources, we don't always be pleasurable, we don't always make it easy we don't always give them the information that they need. A lot of is education. We are afraid of the unknown."
Logistical/ financial barriers	15	"And I think another issue that we don't always realize is that many people in our community are not aware of how to access services and that can be for a variety of reasons: socioeconomic reasons, limited transportation, even educational levels."
Lack of access	11	"Like you said, lack of service, and that's one of the biggest problems that we need. One thing is, poverty. The financial situations here in the parish. And lack of knowledge. There's not a lot of information here. A lot of people living in poverty don't have television, they don't watch television. They don't even know what kind of help is available. It's a lot of being in a poor area where people don't have access to many things and knowledge."

Town Hall Themes

What are some possible ways to increase access to behavioral health services in your parish?

The findings summarized here show what Town Hall participants disclosed in terms of their views about what might facilitate people in their parish to benefit from using behavioral health services.

Potential solutions were identified at the individual, community, and systems levels. The most frequently mentioned themes brought up involved education, community collaborations, and the faith community.

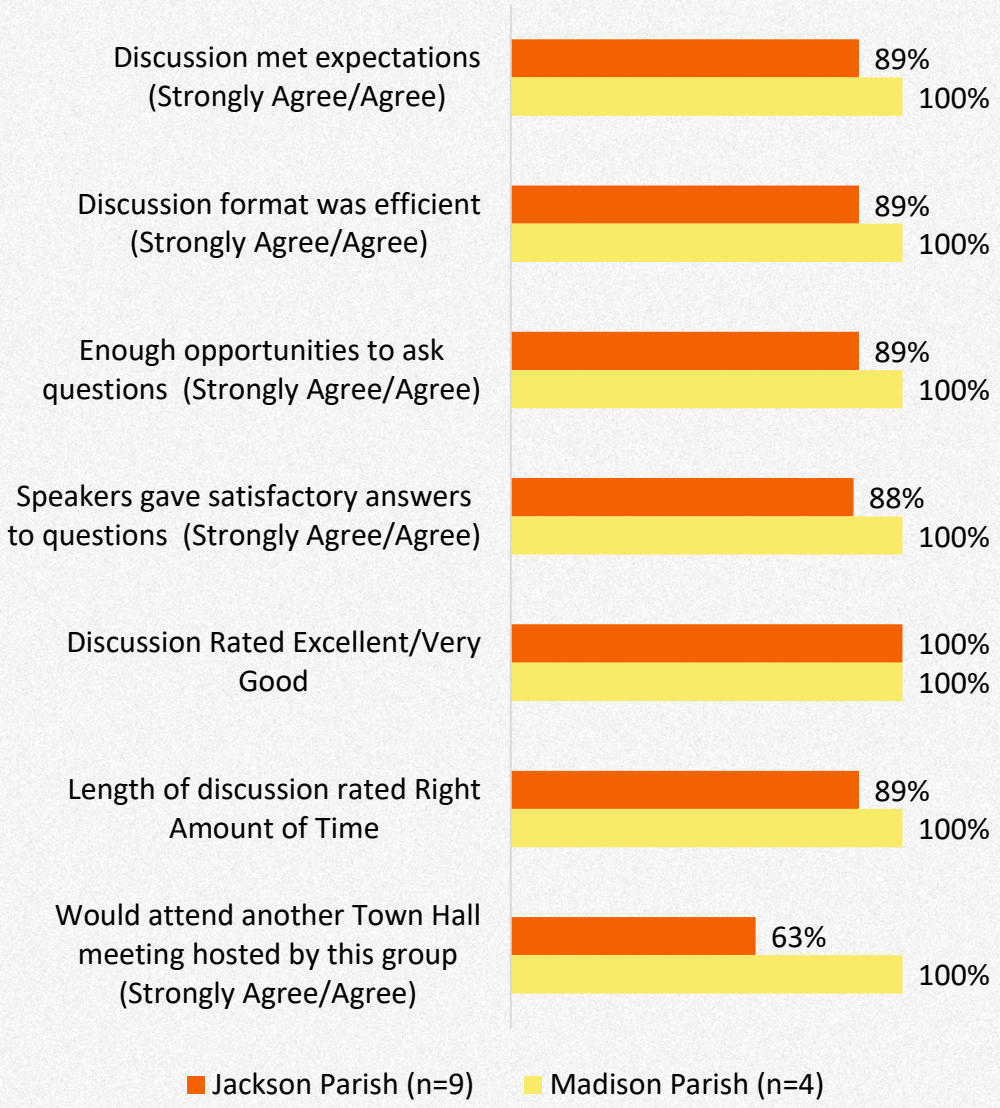
Theme	Mentions	Selected Examples
Education	19	"We need leaders. We need people that are committed, that are dedicated to making this work, to seeing this through. But I think this still starts with education. I think we need to educate the parents, the children, everyone."
Community Collaborations	14	"What we need as a community action standpoint, we need someone to help us and mediate because we are not equipped to deal with mentally ill people. We need more forums like this where we can come together and know exactly where the services are."
Church/Faith-Based	7	"And faith plays a part when faith gives you the direction of what's right and what's wrong. Who's in and who's out. It gives people a choice. And when you have a choice to do whatever it is that's your desire, that pleases you. Then these are the things that we do run into. Self-satisfying things that we run into. And faith plays a big part in that because our faith tells us that that it's not about us. It has to be about people in our communities. How we can effect change and be the change."

Town Hall Participant Feedback

Each Town Hall meeting included a link to a voluntary participant evaluation survey.

Those who replied to the Town Hall evaluation survey generally had positive feedback about the event.

For the Jackson Parish Town Hall, 9 out of 22 participants completed the evaluation. For Madison Parish, evaluation surveys were received from 4 out of 10 participants.



Parish Data Profiles

Parish Data Profiles

Although not originally part of the scope of work or evaluation design, this report includes a general data profile for each of the 12 parishes in the Northeast Delta region to provide some context for possible issues related the use of and potential stigma associated with behavioral health services.

These data were obtained via internet searches by the evaluation team primarily during the first three months of the project (July – September 2021).

These data are by no means exhaustive. We have included the information here to help inform the discussion about what issues may affect behavioral health service needs in each of the 12 parishes. Other information that may help illustrate local behavioral health needs may be found in sources such as NEDHSA's COVID-19 Social Health Impact Assessment (2020).

The parish profiles are presented in the following pages in alphabetical order.

Caldwell Parish

About the Parish

The population of Caldwell Parish is 9,992 (Data USA, 2019). The largest ethnic populations include White/Caucasians, Black/African Americans, and Hispanics making up 79.2%, 16.4%, and 2.5% of the parish population, respectively.

Mental Health-Related Data

As of 2018, an average of 5.7 poor mental health days were reported as well as 5.3 poor physical health days among residents in Caldwell Parish. Caldwell Parish has up to three psychiatric providers for every 100,000 individuals in the parish, and one general mental health provider for every 710 individuals in the parish.

According to US News, Caldwell Parish reported 42 deaths due to suicide, alcohol-related diseases, or drug overdoses per 100,000 people for the period of 2012 to 2018. This is the highest number of deaths by suicide for the entire Region 8. About 19.1 % of adults reported their mental health was not good during fourteen or more days in a thirty-day period in 2018.

Health Equity Issues Identified

Approximately 25.1% of the population of Caldwell Parish lived below the federal poverty line in 2019 as compared to the national poverty rate of 13.4%. The largest demographic living in poverty in the parish are females below the ages of five years old. Approximately 1,713 White/Caucasians reside in Caldwell Parish, and this is the largest ethnic population living below the federal poverty line. According to US News, Caldwell's Gini Index* Score is 0.54, which reflects a severe income gap within the parish.

Substance Use-Related Data

The rate of excessive drinking in 2018 and alcohol-impaired deaths in 2019 was reported to be 19% and 30%, respectively. About 21.8% of the parish population identify as smokers as of 2019.

*The Gini Index is a measure of income inequality ranging from 0, which indicates perfect equality, to 1, which indicated perfect inequality.

East Carroll Parish

About the Parish

According to Data USA, the population of East Carroll Parish as of 2019 is 7,096. The largest ethnic populations include Black/African Americans, White/Caucasians, and individuals who come from multiracial backgrounds making up 69.37%, 29%, and 0.6% of the parish population, respectively.

Mental Health-Related Data

As of 2018, an average of 6.2 poor mental health days were reported as well as 6.7 poor physical health days among residents in East Carroll Parish. East Carroll Parish has up to three psychiatric providers for every 100,000 individuals in the parish, and one general mental health provider for every two hundred individuals in the parish. According to US News, about 22.1% of adults reported their mental health was not good during fourteen or more days in a thirty-day period in 2018.

Health Equity Issues Identified

Approximately 44.6% of the population of East Carroll Parish lived below the federal poverty line in 2019 as compared to the national poverty rate of 13.4%. The largest demographic living in poverty in the parish are females below the ages of five years old. Approximately 1,601 Black/African Americans reside in East Carroll, and this is the largest ethnic population living below the federal poverty line. According to US News, East Carroll's Gini Index* Score is 0.71, which reflects a severe income gap within the parish. According to this measure, East Carroll has the highest income inequality in Region 8.

Substance Use-Related Data

The rate of excessive drinking in 2018 was reported to be 14%. About 34.3% of the parish population identify as smokers as of 2019.

*The Gini Index is a measure of income inequality ranging from 0, which indicates perfect equality, to 1, which indicated perfect inequality.

Franklin Parish

About the Parish

According to Data USA, the population of Franklin Parish as of 2019 is 20,238. The largest ethnic populations include White/Caucasians, Black/African Americans, and individuals who come from multiracial backgrounds making up 65.1%, 33.8%, and 0.5% of the parish population, respectively.

Mental Health-Related Data

As of 2018, an average of 5.6 poor mental health days were reported as well as 5.4 poor physical health days among residents in Franklin Parish. Franklin Parish has up to three psychiatric providers for every 100,000 individuals in the parish, and one general mental health provider for every 670 individuals in the parish.

According to US News, Franklin Parish reported 31.7 deaths due to suicide, alcohol-related diseases, or drug overdoses per 100,000 people for the period of 2012 to 2018. About 19.1% of adults reported their mental health was not good during fourteen or more days in a thirty-day period in 2018.

Health Equity Issues Identified

Approximately 29% of the population of Franklin Parish lived below the federal poverty line in 2019 as compared to the national poverty rate of 13.4%. The largest demographic living in poverty in the parish are females below the ages of five years old. Approximately 2,883 White/Caucasians reside in Franklin, and this is the largest ethnic population living below the federal poverty line. According to US News, Franklin's Gini Index* Score is 0.49, which reflects a big income gap within the parish.

Substance Use-Related Data

The rate of excessive drinking in 2018 and alcohol-impaired deaths in 2019 was reported to be 17% and 38%, respectively. About 24.2% of the parish population identify as smokers as of 2019.

*The Gini Index is a measure of income inequality ranging from 0, which indicates perfect equality, to 1, which indicated perfect inequality.

Jackson Parish

About the Parish

According to Data USA (2019), the population of Jackson Parish is 15,876, spread over 580 square miles. The largest ethnic populations include White/Caucasians, Black/African Americans, and Hispanics making up 67.3%, 29.7%, and 0.9% of the parish population, respectively.

Mental Health-Related Data

As of 2018, an average of 5.5 poor mental health days were reported as well as 5.1 poor physical health days among residents in Jackson Parish. Jackson Parish has up to seven psychiatric providers for every 100,000 individuals in the parish, and one general mental health provider for every 930 individuals in the parish. According to US News, Jackson Parish reported 26.8 deaths due to suicide, alcohol-related diseases, or drug overdoses per 100,000 people from 2012 to 2018. About 18.4% of adults reported their mental health was not good during fourteen or more days in a thirty-day period in 2018.

Health Equity Issues Identified

Approximately 22.8% of the population of Jackson Parish lived below the federal poverty line in 2019 as compared to the national poverty rate of 13.4%. The largest demographic living in poverty in the parish are females between the ages of 25 and 34. Approximately 1,601 Black/African Americans reside in Jackson, and this is the largest ethnic population living below the federal poverty line. According to US News, Jackson's Gini Index* Score is 0.48, which reflects a large income gap within the parish.

Substance Use-Related Data

The rate of excessive drinking in 2018 and alcohol-impaired deaths in 2019 was reported to be 16% and 23%, respectively. About 30% of the parish population identify as smokers as of 2019.

*The Gini Index is a measure of income inequality ranging from 0, which indicates perfect equality, to 1, which indicated perfect inequality.

Lincoln Parish

About the Parish

Lincoln parish has the second largest population in the region with 47,246 residents (Data USA, 2019). The largest ethnic populations include White/Caucasians, Black/African Americans, and Asian making up 53.3%, 40.6%, and 1.66% of the parish population, respectively.

Mental Health-Related Data

As of 2018, an average of five poor mental health days were reported as well as 4.5 poor physical health days among residents in Lincoln Parish. Lincoln Parish has up to eleven psychiatric providers for every 100,000 individuals in the parish, and one general mental health provider for every 250 individuals in the parish. According to US News, Lincoln Parish reported 24.9 deaths due to suicide, alcohol-related diseases, or drug overdoses per 100,000 people for the period of 2012 to 2018. About 16.4% of adults reported their mental health was not good during fourteen or more days in a thirty-day period in 2018.

Health Equity Issues Identified

Approximately 30.3% of the population of Lincoln Parish lived below the federal poverty line in 2019 as compared to the national poverty rate of 13.4%. The largest demographic living in poverty in the parish are females between the ages of 18 and 24. Approximately 7,571 Black/African Americans reside in Lincoln, and this is the largest ethnic population living below the federal poverty line. According to US News, Lincoln's Gini Index* Score is 0.54, which reflects a severe income gap within the parish.

Substance Use-Related Data

The rate of excessive drinking in 2018 and alcohol-impaired deaths in 2019 was reported to be 17% and 24%, respectively. About 22% of the parish population identify as smokers as of 2019.

*The Gini Index is a measure of income inequality ranging from 0, which indicates perfect equality, to 1, which indicated perfect inequality.

Madison Parish

About the Parish

According to Data USA, the population of Madison Parish as of 2019 is 11,306. The largest ethnic populations include Black/African Americans, White/Caucasians, and Hispanics making up 63.5%, 33.8%, and 0.4% of the parish population, respectively.

Mental Health-Related Data

As of 2018, an average of six poor mental health days were reported as well as six poor physical health days among residents in Madison Parish. Madison Parish has up to three psychiatric providers for every 100,000 individuals in the parish. As of 2019, Madison has the largest number of mental health providers in the Northeast Delta region with approximately 1,086 providers within the parish.

According to US News, Madison Parish reported 26.8 deaths due to suicide, alcohol-related diseases, or drug overdoses per 100,000 people for the period of 2012 to 2018. About 20.5% of adults reported their mental health was not good during fourteen or more days in a thirty-day period in 2018.

Health Equity Issues Identified

Approximately 36.4% of the population of Madison Parish lived below the federal poverty line in 2019 as compared to the national poverty rate of 13.4%. The largest demographic living in poverty in the parish are females between the ages of 25 and 34. Approximately 2,919 Black/African Americans reside in Madison, and this is the largest ethnic population living below the federal poverty line. According to US News, Madison's Gini Index* Score is 0.52, which reflects a severe income gap within the parish.

Substance Use-Related Data

The rate of excessive drinking in 2018 and alcohol-impaired deaths in 2019 was reported to be 16% and 23%, respectively. About 30% of the parish population identify as smokers as of 2019.

*The Gini Index is a measure of income inequality ranging from 0, which indicates perfect equality, to 1, which indicated perfect inequality.

Morehouse Parish

About the Parish

According to Data USA, the population of Morehouse Parish as of 2019 is 25,610. The largest ethnic populations include White/Caucasians, Black/African Americans, and Asians making up 49.3%, 49.1%, and 0.5% of the parish population, respectively.

Mental Health-Related Data

As of 2018, an average of 5.6 poor mental health days were reported as well as 5.3 poor physical health days among residents in Morehouse Parish. Morehouse Parish has up to three psychiatric providers for every 100,000 individuals in the parish, and one general mental health provider for every 280 individuals in the parish. According to US News, Morehouse Parish reported 31.9 deaths due to suicide, alcohol-related diseases, or drug overdoses per 100,000 people for the period of 2012 to 2018. About 18.7% of adults reported their mental health was not good during fourteen or more days in a thirty-day period in 2018.

Health Equity Issues Identified

Approximately 28.3% of the population of Morehouse Parish lived below the federal poverty line in 2019 as compared to the national poverty rate of 13.4%. The largest demographic living in poverty in the parish are females between the ages of 25 and 34. Approximately 5,082 Black/African Americans reside in Morehouse, and this is the largest ethnic population living below the federal poverty line. According to US News, Morehouse's Gini Index* Score is 0.48, which reflects a big income gap within the parish.

Substance Use-Related Data

The rate of excessive drinking in 2018 and alcohol-impaired deaths in 2019 was reported to be 17% and 46.43%, respectively. About 23.2% of the parish population identify as smokers as of 2019. In 2018, there was an outbreak of Hepatitis A that was believed to be due to illicit intravenous drug use.

*The Gini Index is a measure of income inequality ranging from 0, which indicates perfect equality, to 1, which indicated perfect inequality.

Ouachita Parish

About the Parish

Ouachita Parish is by far the largest population-wise in Region 8. The parish seat is Monroe, its most populous city. According to Data USA (2019), the population of Ouachita Parish is 4,648,794. The largest ethnic populations include White/Caucasians, Black/African Americans, and individuals who come from multiracial backgrounds making up 57.8%, 37.3%, and 11.4% of the parish population, respectively.

Mental Health-Related Data

As of 2018, an average of 5.2 poor mental health days were reported as well as 4.7 poor physical health days among residents in Ouachita Parish . About 17.1% of adults reported their mental health was not good during fourteen or more days in a thirty-day period in 2018 . Caucasian males are the largest demographic affected by suicide, with approximately thirty-five males committing suicide in 2018 alone.

Despite the mental health and substance abuse rates reported, there may be a lack of providers to adequately address these issues. Ouachita Parish has 12 to 14 psychiatric providers for every 100,000 individuals in the parish, and one general mental health provider for every 200 individuals in the parish. According to US News, Ouachita Parish reported 36.3 deaths due to suicide, alcohol-related diseases, or drug overdoses per 100,000 people from 2012 to 2018.

Health Equity Issues Identified

Approximately 24.7% of the population of Ouachita Parish lived below the federal poverty line in 2019 as compared to the national poverty rate of 13.4%. The largest demographic living in poverty in the parish are females between the ages of 25 and 34. Approximately 58,000 Black/African Americans reside in Ouachita, and this is the largest ethnic population living below the federal poverty line. According to US News, Ouachita's Gini Index Score is 0.52, which reflects a severe income gap within the parish.

Substance Use-Related Data

The rate of excessive drinking in 2018 and alcohol-impaired deaths in 2019 was reported to be 19% and 31.58%, respectively. About 22.96% of the parish population identify as smokers. According to the Ouachita Special Crimes Apprehension Team, deputies confiscated large amounts of illegal narcotics from the Ouachita Parish including 52.25 grams of cocaine, 1325 grams of methamphetamine, and 24.5 grams of heroin, 2,600 ecstasy tabs, and 5.2 grams fentanyl.

*The Gini Index is a measure of income inequality ranging from 0, which indicates perfect equality, to 1, which indicated perfect inequality.

Richland Parish

About the Parish

According to Data USA, the population of Richland Parish as of 2019 is 20,350. The largest ethnic populations include White/Caucasians, Black/African Americans, and Hispanics making up 60.6%, 35.8%, and 1.37% of the parish population, respectively.

Mental Health-Related Data

As of 2018, an average of 5.6 poor mental health days were reported as well as 5.2 poor physical health days among residents in Richland Parish. Richland Parish has up to seven psychiatric providers for every 100,000 individuals in the parish, and one general mental health provider for every 210 individuals in the parish. According to US News, Richland Parish reported 25.2 deaths due to suicide, alcohol-related diseases, or drug overdoses per 100,000 people for the period of 2012 to 2018. About 19% of adults reported their mental health was not good during fourteen or more days in a thirty-day period in 2018.

Health Equity Issues Identified

Approximately 30.5% of the population of Richland Parish lived below the federal poverty line in 2019 as compared to the national poverty rate of 13.4%. The largest demographic group living in poverty in the parish is females below the ages of five years old . Approximately 2,971 Black/African Americans reside in Richland, and this is the largest ethnic population living below the federal poverty line. According to US News, Richland's Gini Index* Score is 0.49, which reflects a large income gap within the parish.

Substance Use-Related Data

The rate of excessive drinking in 2018 and alcohol-impaired deaths in 2019 was reported to be 17% and 20%, respectively. About 22% of the parish population identify as smokers as of 2019.

*The Gini Index is a measure of income inequality ranging from 0, which indicates perfect equality, to 1, which indicated perfect inequality.

Union Parish

About the Parish

As of 2019, the population of Union Parish is 22,353. The largest ethnic populations include White/Caucasians, Black/African Americans, and Hispanics making up 68.9%, 24.8%, and 2.36% of the parish population, respectively.

Mental Health-Related Data

As of 2018, an average of 5.1 poor mental health days were reported as well as 4.7 poor physical health days among residents in Union Parish. Union Parish has up to three psychiatric providers for every 100,000 individuals in the parish, and one general mental health provider for every 920 individuals in the parish.

According to US News, Union Parish reported 33.3 deaths due to suicide, alcohol-related diseases, or drug overdoses per 100,000 people for the period of 2012 to 2018. About 17.1% of adults reported their mental health was not good during fourteen or more days in a thirty-day period in 2018.

Health Equity Issues Identified

Approximately 17.3% of the population of Union Parish lived below the federal poverty line in 2019 as compared to the national poverty rate of 13.4%. The largest demographic living in poverty in the parish are females below the ages of five years old. Approximately 1,842 White/Caucasians reside in Union, and this is the largest ethnic population living below the federal poverty line. According to US News, Union's Gini Index* Score is 0.49, which reflects a large income gap within the parish.

Substance Use-Related Data

The rate of excessive drinking in 2018 and alcohol-impaired deaths in 2019 was reported to be 20% and 25%, respectively. About 19.35% of the parish population identify as smokers as of 2019.

*The Gini Index is a measure of income inequality ranging from 0, which indicates perfect equality, to 1, which indicated perfect inequality.

Tensas Parish

About the Parish

Tensas Parish has a population of 4,561 (Data USA, 2019), making it the most rural parish in Region 8. The largest ethnic populations include Black/African Americans, White/Caucasians, and Hispanics making up 55.4%, 42.2%, and 1.14% of the parish population, respectively. Tensas Parish is 100% rural and has the second lowest population density in Louisiana. The parish lost 21% of its residents in 2020 due to the lack of high wage jobs in the parish.

Mental Health-Related Data

As of 2018, an average of 6.2 poor mental health days were reported as well as 6.3 poor physical health days among residents in Tensas Parish. Tensas Parish has up to three psychiatric providers for every 100,000 individuals in the parish, and one general mental health provider for every 870 individuals in the parish. According to US News, about 20.5% of adults reported their mental health was not good during fourteen or more days in a thirty-day period in 2018.

Health Equity Issues Identified

Approximately 34.7% of the population of Tensas Parish lived below the federal poverty line in 2019 as compared to the national poverty rate of 13.4%. The largest demographic living in poverty in the parish are females below the ages of five years old. Approximately 1,199 Black/African Americans reside in Tensas Parish, and this is the largest ethnic population living below the federal poverty line. According to US News, Tensas's Gini Index* Score is 0.48, which reflects a big income gap within the parish.

Substance Use-Related Data

The rate of excessive drinking in 2018 and alcohol-impaired deaths in 2019 was reported to be 15% and 33%, respectively. About 27.69% of the parish population identify as smokers as of 2019.

*The Gini Index is a measure of income inequality ranging from 0, which indicates perfect equality, to 1, which indicated perfect inequality.

West Carroll Parish

About the Parish

According to Data USA, the population of West Carroll Parish as of 2019 is 11,041. The largest ethnic populations include White/Caucasians, Black/African Americans, and Hispanics making up 78.8%, 16.1%, and 2% of the parish population, respectively.

Mental Health-Related Data

As of 2018, an average of 5.6 poor mental health days were reported as well as 5.2 poor physical health days among residents in West Carroll Parish. West Carroll Parish has up to three psychiatric providers for every 100,000 individuals in the parish, and one general mental health provider for every 2,710 individuals in the parish.

According to US News, West Carroll Parish reported 40.1 deaths due to suicide, alcohol-related diseases, or drug overdoses per 100,000 people for the period of 2012 to 2018. About 18.7% of adults reported their mental health was not good during fourteen or more days in a thirty-day period in 2018.

Health Equity Issues Identified

Approximately 21.9% of the population of West Carroll Parish lived below the federal poverty line in 2019 as compared to the national poverty rate of 13.4%. The largest demographic living in poverty in the parish are females below the ages of five years old. Approximately 1,393 White/Caucasians reside in West Carroll, and this is the largest ethnic population living below the federal poverty line. According to US News, West Carroll's Gini Index* Score is 0.49, which reflects a big income gap within the parish.

Substance Use-Related Data

The rate of excessive drinking in 2018 and alcohol-impaired deaths in 2019 was reported to be 20% and 13%, respectively. About 20.8% of the parish population identify as smokers as of 2019.

*The Gini Index is a measure of income inequality ranging from 0, which indicates perfect equality, to 1, which indicated perfect inequality.

Evaluator Conclusions and Recommendations

The Rise Above Stigma/BAMM BH project had extremely ambitious goals, especially given a timeframe of just 12 months. In the first six months, outcomes were just starting to be achieved. Stigma and related attitudes can be deeply entrenched; effecting change in long-held beliefs is not easy. In addition, the project encountered challenges due to the COVID-19 pandemic and other factors which affected timely implementation. Yet despite these obstacles, **the beginnings of a mechanism for stigma reduction in the Northeast Delta region were accomplished. Anti-stigma messaging was shared widely across a range of platforms; budding community coalitions were created and energized via the Parish Implementation Teams.**

Town Hall meetings in Jackson and Madison parishes created forums for discussing issues and possible solutions for reducing behavioral health-related stigmas and increasing service access. Many ideas for potential solutions were shared, especially those addressing community- and systems-level factors.

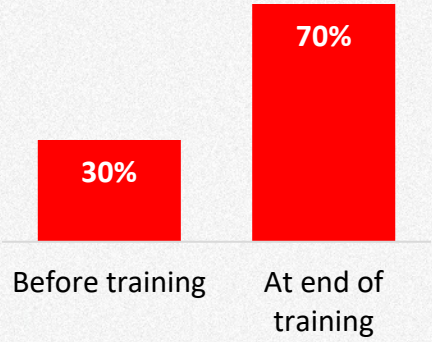
In a community process such as the one planned for the Stigma Reduction Plans in the 12 parishes, bringing together diverse stakeholders for capacity-building takes time. The Strategic Prevention Framework upon which this model was built typically includes a period of up to a year to assess local need, develop a strategic plan, build community capacity, and identify evidence-based practice(s) to address local behavioral health needs. While the outcomes identified for this project are critical for improving behavioral health service access, they may be more suitable as long-range goals. Future efforts might benefit from breaking down those longer-term outcomes into SMART objectives – those which are Specific, Measurable, Achievable, Realistic, and Time-Limited.

Appendix: Parish Implementation Team Capacity-Building Training Evaluation Data

Parish Implementation Team Training Evaluation

On October 25, 2021, members of the Parish Implementation Teams participated in a training which provided an overview of the Strategic Prevention Framework and community capacity building. Post-training surveys were received from 10 out of 19 participants (53%).

Increase in participant knowledge (% rated Very Good or Excellent)



When asked how they planned to use what they learned in the training, participants gave examples such as:

"Make sure decision makers are involved."

"Collaborating to fill a common goal."

"How to conduct an assessment of the community."

Increase in knowledge ratings significant at the $p < .05$ level.