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The Role of Anti-Racist Community-Partnered Praxis in Implementing Restorative Circles Within Marginalized Communities in Southern California During the COVID-19 Pandemic

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The COVID-19 pandemic has exacerbated the adverse influence of structural racism and discrimination experienced by historically marginalized communities (e.g., Black, Latino/a/x, Indigenous, and transgender people). Structural racism contributes to trauma-induced health behaviors, increasing exposure to COVID-19 and restricting access to testing and vaccination. This intersection of multiple disadvantages has a negative impact on the mental health of these communities, and interventions addressing collective healing are needed in general and in the context of the COVID-19 pandemic. The Share, Trust, Organize, and Partner COVID-19 California Alliance

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(STOP COVID-19 CA), a statewide collaborative of 11 universities and 75 community partners, includes several workgroups to address gaps in COVID-19 information, vaccine trial participation, and access. One of these workgroups, the Vaccine Hesitancy Workgroup, adopted an anti-racist community-partnered praxis to implement restorative circles in historically marginalized communities to facilitate collective healing due to structural racism and the COVID-19 pandemic. The project resulted in the development of a multilevel pre-intervention restorative process to build or strengthen community–institutional partnerships when procurement of funds has been sought prior to community partnership. This article discusses this workgroup's role in advancing health justice by providing a community-based mental health intervention to marginalized communities in Southern California while using an antiracist praxis tool to develop a successful community–institutional partnership and to live up to the vision of community-based participatory research.

Keywords: community-based; mental health; restorative; antiracism; CBPR; partnerships; community–academic partnerships; intervention planning

Community-based participatory research (CBPR) is an approach that facilitates conducting research and partnerships between academic research institutions and community-based organizations and entities (CBOEs). The aim of this approach is to develop and implement collaborative interventions that directly address the salient needs of communities (Israel et al., 1998; Schulz et al., 1998; Zimmerman, 2020), with emphasis on those affected by health disparities (National Institute on Minority Health and Health Disparities, 2018). Community–academic partnerships benefit both partners by increasing funding for CBOEs to implement innovative multisector programs that bring diversity and inclusion to academic research institutions. In academic research institutions, such diversity and inclusion help to make scientific research by those institutions more robust, offer students connections to community through service-learning programs that are grounded in real-world knowledge, and actively contribute to the improvement of local and national social conditions (Zimmerman, 2020).

Despite the clear principles of CBPR—community engagement, partnership, action, and change—there continue to be pitfalls in the implementation of this approach that further perpetuate structural and institutional racism (Adkins-Jackson et al., 2022). Structural racism is produced by systems of oppression that discriminate against racialized populations with the goal of maintaining white supremacy (Bailey et al., 2017; Gee & Hicken, 2021). Institutions, like academic research institutions, reproduce structural racism via discriminatory policies and procedures toward marginalized individuals and communities (Adkins-Jackson et al., 2021). Although CBPR, in its purest form, engages community and academic partners in shared decision making, resource allocation, and power distribution (Minkler & Wallerstein, 2008; Van de Sande & Schwartz, 2017), the application of this approach often falls short in addressing the inequitable distribution of power and resources among community–academic partnerships. Traditionally, power (e.g., decision-making) and resources (e.g., grant funds) are consolidated within academic research institutions—and other power-holding institutions (e.g., government)—as agencies often fund research projects where the principal investigator (PI) is from a scientific institution (Heaney et al., 2007). Although CBPR's approach calls for shared partnership, it does not prohibit the power hoarding that can occur when institutional partners are imbued with decision-making authority.

There are alternative university-managed research models like the Community-Owned and -Managed Research (COMR) Model that was developed by West End Revitalization Association, a CBOE, to address this specific issue (Heaney et al., 2007). The COMR model necessitates that the PI of an award be the community partner to facilitate the CBOE's authority on the project relating to decision-making, project management, and data ownership. The model also encourages long-term commitment to solving health justice issues, another implementation pitfall that reveals how structural and institutional racism assign power to institutional partners in ways that undermine CBPR approaches.

Despite the innovation of the dynamic COMR model and growing literature on CBPR, disproportionate distribution of power and resources between community–academic partners persists. CBOEs are often included in research late in the process such as once research questions and agendas have been established (Adkins-Jackson et al., 2022). Some academics using CBPR reproduce structural racism through emphasizing end products like scientific publications that do not directly benefit community partners. Most dangerously, structural racism is (re)produced when partnerships dissolve when funding for the institutional partners ends. While publishing in scientific journals can be fruitful for securing future funding for the partnership, these actions and end products do not readily provide benefit to the CBOE or community at-large. Moreover, academic

institutions reproduce institutional racism when they do not recognize nor establish institutional mechanisms to compensate community members from marginalized communities (e.g., undocumented, low-income, people from rural backgrounds).

Part of the allure of CBPR, COMR, and similar models is that such approaches are ideal to address health disparities in marginalized communities with limited resources. Given institutional partners are equipped with sources of funding, personnel, and access to research infrastructure, there is a strategic opportunity to assist disenfranchised community partners with large catchment areas, while addressing salient health concerns. Yet, too often, structural and institutional racism shapes the relationship by viewing community partners as objects rather than partners and investigators co-producing knowledge in research (Ahmed et al., 2004). It is clear that CBPR models like COMR can address inequitable distribution of power and resources throughout the research process. However, not all partnerships begin as COMR describes. The COMR model is ideal to implement before the research process has begun as it entails building partnerships with CBOEs in ways that result in pursuing a research project, collaborative intervention, and/or long-term commitment with CBOEs and the community at-large.

We, as community–academic partners, agree with the intentions of CBPR and the practice of COMR. Engagement of community throughout the research process, from development of research questions, study design, to proposal submissions to project implementation and dissemination, is fundamental. In this article, we put forth a model to engage when funding for a pre-existing project has already been procured. Our approach can be used with established collaborations or new partnerships that come out of a community need for collective healing. Our model tasked community–academic partnerships with: (a) working together toward equitable partnership and establishing (or restoring) trust by implementing a project together; and (b) implementing a community-based mental health intervention (CBMHIs; i.e., restorative circle) to provide a direct service to a historically marginalized community hard hit by structural racism and resulting syndemics during the COVID-19 pandemic (Gravlee, 2020; Mendenhall et al., 2021). These components subsequently encompass a multilevel pre-intervention restorative process.

The multilevel pre-intervention restorative process reduces the time from implementation of research to direct benefit to the community by centering community needs and emphasizing healing and restoration at multiple levels of injury. We engaged CBPR to implement this restorative program. To intervene on structural racism in COVID-19-related health disparities and to achieve CBPR's vision, we adopted an anti-racist praxis as a tool to engage in reflexive relational practices that named and addressed racist institutional actions that prohibited equitable partnership, ultimately facilitating shared decision making, resource sharing, and knowledge co-creation.

THEORETICAL FRAMEWORK: ANTIRACIST PRAXIS AS A TOOL

An antiracist praxis draws on a cross-section of theoretical concepts relating to structural racism (Bailey et al., 2017), institutional racism (Adkins-Jackson et al., 2021), and anti-racism (Came & Griffith, 2018). Structural racism is facilitated by an institution, like an academic research institution, claiming authority over decision-making regarding research with historically marginalized communities. Performing institutional racism, academic institutional partners force CBOEs to abide by their regulations regarding stipends, documentation needed for incentives, and other harmful approaches that result from an institutional partner housing the grant funds for a project (Adkins-Jackson et al., 2022).

Anti-racism is an advocacy-based approach rooted in acknowledging and intervening in structural and institutional racism by increasing inclusivity, representation, and dismantling power structures (Griffith et al., 2007; Legha & Miranda, 2020). Key to anti-racism framing is the position that racism is a modifiable social construct; thus, anti-racism is a practice and not a fixed goal. Came and Griffith (2018) outline five components of an anti-racism praxis: a reflexive relational practice, socio-political education, structural power analysis, systems change, and monitoring and evaluating.

A reflexive relational practice refers to active relationship building where accountability for those in power is vital to the success of the partnership. In a community–institutional partnership, this might take the form of decentering the research needs of the institutional partner and encouraging the community partner's preferences to be the deciding factor in an actionable step. Socio-political education involves a decolonization process of "unlearning and relearning conscientization" (Came & Griffith, 2018, p. 183), which is similar to how Legha and Miranda (2020) describe naming the racist legacies of institutions and their harmful impact on society. Through socio-political education, institutional partners can lessen the chance of repeating harm by unlearning the behaviors that have traditionally perpetuated structural and institutional racism in community partnerships; and relearning to critically analyze racism and inequities within their institution—while

learning new partnership approaches and collaborative skills (Came & Griffith, 2018; Legha et al., 2020; Legha & Miranda, 2020).

The remaining components of an anti-racism praxis are core to the implementation of our restorative program. A structural power analysis is a process where the pathways through which racism operates are identified and opportunities for anti-racist intervention are targeted (Came & Griffith, 2018). A structural power analysis of community–institutional partnerships reveals striking power imbalances like policies that place restrictions on subawards and position institutional partners as key decision-makers, and ultimately, the sole responsibility for knowledge creation and dissemination. System change is where an anti-racist intervention occurs as the knowledge gained through the structural analysis is brought together with socio-political education and reflexive practices. Thus, as inequitable policies and practices are identified, a system change necessitates that institutional partners develop advocacy-based systems to resist power imbalances by advocating for fair, equitable, and just payment. Monitoring and evaluating institutional change is the key to ensure the accountability of a practice of anti-racism over time.

Given the utility of the Came and Griffith (2018) anti-racism praxis, we used CBPR as our engagement framework and anti-racism praxis as a tool to develop our multilevel pre-intervention restorative process. As we show in this article, our approach and antiracist praxis addressed the inequitable distribution of power and resources between these community–academic partnerships. The following question guided our work: Can CBPR-informed community–academic partnerships that employ an anti-racist praxis, foremost intervene on the role of structural racism on the mental health of historically marginalized communities, and also build an equitable partnership that establishes trust among partners?

OUR APPROACH: MULTILEVEL PRE-INTERVENTION RESTORATIVE PROCESS

Setting

The Share, Trust, Organize, and Partner COVID-19 California Alliance (STOP COVID-19 CA), a statewide collaborative of 11 universities and over 75 community partners, carried out this study from Fall 2020 to Fall 2021. This alliance included several workgroups, including a vaccine hesitancy workgroup (VHW), to address salient COVID-19 concerns in historically marginalized communities in California. Community and institutional representatives across sites formed the VHW, under the leadership of the first author, Dr. Adkins-Jackson, to identify barriers and facilitators to vaccine trial participation and vaccine uptake for marginalized communities throughout California (Cheney et al., 2021).

Reflexive Relational Praxis

Within the VHW, the first two authors, Drs. Adkins-Jackson and Vazquez, developed the multilevel pre-intervention restorative process to address the dual need of building relationships between community and institutional partners, and providing a safe space and service to historically marginalized communities that have been hard hit by the COVID-19 pandemic. Drs. Adkins-Jackson and Vazquez were frustrated with the constant extraction of stories and data from historically marginalized communities without the acknowledgment from researchers for the need to protect the mental health and well-being of their communities, particularly their grief and need for healing. Discrimination and oppression among these communities were amplified during the pandemic for research purposes. At the time of the study, Drs, Adkins-Jackson and Vazquez, both members of historically marginalized communities, were postdoctoral scholars. Together they developed the multilevel pre-intervention restorative process as an evolved approach rooted in the core principles of CBPR and applied anti-racism praxis as a tool to engage in equitable community–institutional partnerships to improve health in historically marginalized communities. The STOP COVID-19 CA project created an opportunity to use this approach.

Restoring Health Within Communities

Marginalized communities experience structural racism, oppression, and discrimination that are reflected in stressed immune systems, trauma-induced health behaviors, and income dependence that further increase exposure to COVID-19 (Bailey et al., 2017; Geronimus et al., 2010; Glymour & Manly, 2008; Stuifbergen & Im, 2008; Webb Hooper et al., 2020). Intersecting forms of disadvantage (e.g., racism, sexism, transphobia, lack of health insurance, having an undocumented status, having limited proficiency in English, being a part of the essential labor workforce) place some marginalized communities at greater risk for COVID-19 exacerbating the physical, psychological, and emotional well-being of already marginalized communities (Carson et al., 2021; Gehlbach et al., 2021; Hill et al., 2021). Discourses about the pandemic origin, spread, and low vaccination rates stigmatize and blame marginalized groups contributing to depressive and post-traumatic stress symptoms, substance use, and diminished life satisfaction (Bor et al.,

TABLE 1
Examples of Culturally and Structurally Responsive Restorative Circles

Restorative circle	*Description*	*Citation*
Sister Circles	Provides culturally responsive mental health counseling, social support, and collective healing practices that meet the unique needs of Black women	(Sister Circle, 2021)
Umoja Circles	Provides a space to express experiences related to health inequities and anti-Black racism	(Makhay, 2021)
Safe Black Space	Combines African-centered healing strategies (e.g., libation, drumming, etc.) within practices of mindfulness and other self-care exercises to overcome the traumas associated with structural racism	(Safe Black Space, 2021)
Emotional Emancipation Circles	Provides a deep level of healing by focusing on Black circle participants identifying the traumas they experience that are rooted in anti-Black racism and learning essential emotional wellness skills to overcome them	(Community Healing Network, 2021)
Talking Healing Circle	The gathering resembles a group counseling session infused with Mexican ancestral traditions. The facilitator burns the incense, beat an elk-skin drum and sing in Nahuatl, a Mexican indigenous language, in preparation for a practice they call a talking healing circle.	(Plevin, 2019)

2018; Cokley et al., 2022; Garcini et al., 2021; Stoller, 2021; Cheney et al., 2021).

One way to address collective mental health is through CBMHIs that meet the specific needs of the whole community through structurally and culturally responsive approaches (i.e., addressing anti-Black racism and context-driven trauma; Safe Black Space, 2021). CBMHIs involve multi-sector partnerships and emphasize community members as the designers, providers, facilitators (e.g., local practitioners, community members, and activists, faith leaders, educators, etc.), and recipients of the intervention in community settings (Castillo et al., 2019). CBMHIs provide trauma-informed mental health support in safe community settings and studies have shown that community-led interventions provide more culturally responsive information that lead to successful adoption of the service and necessary changes in health (Corbin et al., 2015; Makhay, 2021; McNeish et al., 2019; Plevin, 2019).

A restorative circle is a healing circle conducted in a safe space for community members to discuss their concerns regarding health, health care, COVID-19, and other related topics. Inspired by the Truth and Reconciliation Commission in South Africa and Safe Black Space in Sacramento, California (Brahm, 2007; Safe Black Space, 2021), Dr. Adkins-Jackson proposed a combination of these approaches in a restorative circle that allowed community members space to discuss their feelings about structural racism, COVID-19, and related events, but placed an emphasis on the needs of the community and the conflicts pertinent for them to discuss. Similar, to talking circles, umoja circles, emancipation circles, and sister circles, (Community Healing Network, 2021; Makhay, 2021; Plevin, 2019; Safe Black Space, 2021; Sister Circle, 2021), restorative circles provide space for individuals to repair harm through a facilitated dialogue (Ortega et al., 2016). Table 1 provides a list of these structurally and culturally responsive circles that are traditionally used in marginalized communities as safe spaces for the discussion of trauma and healing and the cultivation of resilience (Cowan et al., 2022). Like other structurally and culturally responsive circles, restorative circles center on collective healing through prompts that encourage participants to share common experiences. Given the successful implementation of the aforementioned CBMHIs, Drs. Adkins-Jackson and Vazquez believed that these novel restorative circles would be an effective strategy to reduce mental health burden due to

TABLE 2
Restorative Circle Guidelines

Circle section	*Description*	*Example*
Setting (or introduction)	Encompasses the physical and psychoemotional environment of the circle including the ambiance of the in-person or virtual space and the mood of the facilitator.	During the setting, key components include land acknowledgments and the recognition of past and present abuses and discrimination inflicted upon the communities from which attendees descend. These acknowledgments establish solidarity within the circle.
Shared agreements	The facilitator, mental health provider, and attendees set agreements.	Attendees share best practices and approaches that promote safe spaces e.g., speaking one at a time, active listening, and confidentiality of information shared. These agreements affirms confidentiality and establish a safe space for everyone
Open discussion	Facilitator leads attendees in discussions about trauma, coping, grief, resilience, and related topics.	Storytelling can be used to inspire attendees to share their own experiences. Facilitators can also engaged attendees by setting a question e.g., "What food got you through this experience?" These strategies help attendees to reflect and share.
Takeaways	Reflections from attendees on the benefits gained from attending the restorative circle.	Attendees share one thing they are taking away from participating in the circle. This reflection helps attendees to be mindful of helpful resilience strategies.

structural racism and the COVID-19 pandemic, and thus, they were selected as the CBMHI. Although the multilevel pre-intervention restorative process was led by Drs. Adkins-Jackson and Vazquez as a part of the VHW, the restorative circles were organized by the community partners of the community–institutional partnerships of this study. This emic (insider) approach allows for self-agency among communities and yields ownership of a process where meaningful dialogue and connections could be made (Ortega et al., 2016).

Restorative Circles

The 11 sites across California were invited to implement restorative circles in their respective regions. Sites were required to collaborate with community partners. Institutional partners provided planning support resources such as venues for in-person events, meeting platforms suitable for virtual circles, and other community resources referenced by CBOE's as needed for their local community such as mental health professionals and informational pamphlets (e.g., on intimate partner violence). Drs. Adkins-Jackson and Vazquez provided 30-min training sessions to facilitators and mental health professionals to guide them on conducting restorative circles, which included four key components: setting the agenda, reviewing shared agreements, open discussion, and takeaways (described in Table 2).

As a core component of the multilevel pre-intervention restorative process, the restorative circles were to benefit historically marginalized communities directly. Therefore, the circles were not to be treated like a focus group where semi-structured questions guide responses and data is extracted from the discussion. Theremore, parameters to ensure the community was centered were set on the circles where minimal descriptive statistics were recorded (i.e., number of attendees), a pre- and post-test was not given, and institutional partners could not attend the circle.

In alignment with the CBPR and anti-racism praxis that we utilized (i.e., anti-racist community-partnered praxis), the community–institutional partnerships made decisions together regarding the characteristics, purpose, and styles of the restorative circles implemented within diverse communities. Thus, restorative circles varied by site, modality (virtual or in-person), time (anywhere from 90 to 120 min), and community characteristics. But all

TABLE 3
Restorative Circle Characteristics

Restorative circle	*Community*	*Ages*	*Number of attendees*	*Resources provided*	*Type of partnership*
Online	Latinx youth	16–25	12	How to cope with grief	Community organization and university
Online	Latinx Promotores	30–55	18	COVID-19 and children; Cognitive behavioral therapy	Community organization and university
In-person	Black Men	18–35	25	Coping with racial stress	Church and university
In-person	LGBTQ and allies	25–55	18	Coping with COVID-19-related stress	Church, academic health center, and university
In-person	LGBTQ and allies	25–55	13	Coping with COVID-19-related stress	Church, academic health center, and university
In-person	Transgender persons	17–26	5	Intimate partner violence; journals	Community organization, academic health center, and university

restorative circles were consistent in that they included facilitators and mental health professionals that reflected the community (e.g., Spanish speaking). In addition, the topics discussed varied per site as did the material shared with attendees at the conclusion of the restorative circles. For example, one site sought to engage adolescents and families preparing to return to in-person classrooms and the stress of this transition—participants were provided material on the signs and symptoms of anxiety among children and adolescents. During the sessions, the mental health professional helped facilitate the session and was available to provide one-on-one or group-level support, as needed, during the circle. Community partners were asked to set the monetary value for facilitators and mental health professionals to hold the circles.

Data Collection and Analysis

Data collection involved a group interview with community–institutional partners that implemented the restorative circles. In September and November 2021, Drs. Adkins-Jackson and Vasquez facilitated two group interviews with community partners, institutional partners, facilitators, and mental health professionals using a semi-structured interview guide with questions aimed to elicit information on characteristics of anti-racist community partnerships (shared decision-making, resource distribution, relational praxis, knowledge co-creation). These topics informed a deductive analysis of the group interview data in which analysts sought out examples of anti-racist praxis and examined the degree to which each partnership engaged in the four practices.

RESULTS

We evaluated five sites or community–institutional partnerships in Southern California that collectively conducted six restorative circles. As described in Table 3, community partners varied, including one large recreational program, two local community-based organizations, and two local churches. One of the partnership teams included an academic research institution, an academic health center, a community-based organization, and a local church. Other partnership teams included an academic research institution and a CBOE.

The six restorative circles were conducted between June and October 2021: Four planned among existing partnerships and two with new partnerships. Two circles were conducted virtually and held in Spanish; four were conducted in-person and held in English. The circles ranged from 90 to 120 min with an average of 17 attendees. Table 3 provides attendee characteristics per circle and a list of resources provided to attendees.

Establishing an Anti-Racist Community Partnership. These findings highlight the ways community–institutional partners engaged in anti-racist praxis, evidenced by shared decision-making, equitable distribution of resources, reflexive relational practices, and

knowledge co-creation, as well as how restorative circles offered a healing space for community members. These circles provided a safe space for discussing stress and sharing collective grief as attendees openly discussed their fears, concerns, and experiences during the COVID-19 pandemic.

Shared decision-making. Some CBOEs had specific ideas about how to organize and implement the restorative circles, whereas others would have liked more structure. For instance, one CBOE provided the institutional partner with a multi-page proposal of structured ideas for the circles. Whereas, another CBOE struggled with the lack of structure provided by the institutional partners and direction in determining the appropriate audience. This partnership required more follow-up meetings than other partnerships with their institutional partners and Drs. Adkins-Jackson and Vazquez for brainstorming and planning.

Equitable distribution of resources. Resources varied by partnerships. For instance, community partners serving as facilitators or mental health providers set the monetary value for their role in the restorative circles, thus their compensation varied. Community partners generally appreciated the opportunity to determine their compensation; however, this varied across partners as some institutional partners were concerned with the variation in pay across sites. One institutional partner argued for a set range to ensure pay equity across sites. Though this same institutional partner noted that this feature (i.e., setting their value) was important because community partners may work with institutions for free. This was evidenced by a community partner that responded positively: "I was shocked I was getting paid to do this." This quote highlights the immense free labor that members of these communities provide.

Community partners encouraged compensation to restorative circle attendees, which was viewed as a genuine approach to community health and collective healing. Although discussed, the partners decided not to incentivize participation because attendees were not participants in the research study—the focus of data collection was on the partnership, not the restorative circles. However, one community partner disagreed with this decision. During the evaluation circle, it was noted that payment to attendees would have been cumbersome given institutional policies requiring participant identification and completion of W-9s or remunerating with gift cards instead of cash, which can deter participation from undocumented individuals.

Reflexive relational praxis. A key component of antiracist praxis was transparent communication from the institutional partner. Both community and institutional partners described clear communication as critical to the success of implementing the restorative circles. Partners met a minimum of five times to plan and organize for the restorative circles. In addition to scheduled meetings, regular communication occurred via email and text message. Email exchanges with Dr. Adkins-Jackson and Vazquez facilitated payment procedures (e.g., invoicing, maneuvering the institutional payroll website, etc.) for facilitators and mental health professionals.

Both community and institutional partners described communication as transparent. During the group interview, one community partner described "loving" the institutional partners after working successfully with them. Transparent communication between partners was not observed by the community at-large. Only one of the restorative circles was hosted at an institutional partner's site and none directly introduced the institutional partner. One institutional partner described uncertainty as to whether the communities would know they (i.e., the institutional partners) were involved in the service provided.

Trust. The process of planning and organizing the restorative circles presented an opportunity for active relationships and building trust between partners. For the pre-established partnerships, planning the restorative circles strengthened their relationships. One institutional partner shared how the community partner had been "the boss of this project." Other institutional partners shared their appreciation for how the multilevel pre-intervention restorative process encouraged the community "to lead when working with a research institution." Another community partner said the "trust and confidence" built with their institutional partner was appreciated.

Knowledge co-creation. Although institutional partners did not attend the circles, they held conversations with community partners to debrief and plan for upcoming circles. Institutional partners commented on the depth of knowledge generated during the circles. An institutional partner commented how they felt they had been "guessing what was needed but hearing from the community partner directly helped." Both community and institutional partners described learning significant aspects about the community's needs during the pandemic through the restorative circles. These needs varied and included access to public health information about the COVID-19 vaccine and children, a subject of concern among many circle attendees, as well as "tips

and tools" to cope with racial stress induced by the pandemic. Community partners who attended the circles reported conversations from attendees shifting from discussions of depression, grief, and the COVID-19 vaccine for children to macro-level inequities, including racism, discrimination, and social injustices. In a restorative circle for Black men, attendees detailed lived experiences and traumas that affected their mental well-being stemming from injustices from local law enforcement agencies. These attendees recounted instances of police brutality, discrimination, and undiagnosed post-traumatic stress that negatively influenced their trust of government, health care, and public health more generally. In a restorative circle for self-identified transgender persons, discussion of domestic violence, trauma, and interpersonal violence occurred. Attendees also discussed violence and trauma as side effects of the pandemic not openly discussed or acknowledged elsewhere.

Benefits of community-led intervention. Community–institutional partners greatly appreciated and valued implementing restorative circles as a community-led intervention. For example, during the group interviews, community partners commented on how the process eased concerns about incorporating formal mental health services into the intervention. Community partners leading efforts for the Black male and Latinx/Hispanic restorative circles had been unsure about including a mental health professional given a history of distrust of health care systems in Black and Latinx communities. One community partner ultimately decided to have a pastor to facilitate the restorative circle for Black men in addition to a mental health provider from the same racialized group, city, and age group. For the circles held with the Indigenous Latin American community, a community mental health educator co-facilitated the circles. A deacon trained by Drs. Adkins-Jackson and Vazquez in psychoemotional support facilitated the LGBTQ and allies restorative circle.

DISCUSSION

This study explored the implementation of an anti-racist community-partnered praxis in Southern California. The process yielded a multilevel pre-intervention restorative process that can be used in existing and new partnerships to address the role of structural and institutional racism in CBPR partnerships when grants have already been procured.

Using a structural power analysis from Came and Griffith's (2018) anti-racism praxis, the community–institutional partners engaged in shared decision-making in which the voice of the community was centered. Through collaboratively planning the restorative circles (i.e., Level 1 of the multilevel pre-intervention restorative process), power was shifted from the institution to the community. Community partners shaped the restorative circle curriculum by making salient changes—not emphasizing the acknowledgments section because these were often addressed by circle attendees—and determining who facilitated the circle and what resources were provided to attendees.

However, despite community partners setting their value and the use of a third party to process payments (a university not conducting a partnership in this process), there was not sufficient system change to intervene on institutional inequities in the distribution of resources. Although this grant was received prospectively, institutional payment processes required retrospective reimbursement payments to CBOEs—meaning all community partners had to pay for their time and effort and wait for reimbursement. Some community partners struggled to fund their time upfront, delaying the implementation of their circles for months. Although this delayed the onset of implementation, the restorative circles still occurred due to the commitment of the community partners.

As described by Heaney and colleagues (2007), relationship building and trust between partnerships were strengthened when community partners led the collaboration. The partnerships were strengthened by transparent and continuous communication. Institutional partners openly shared the institutional restrictions they faced and community partners shared the impact of such restrictions on their ability to execute the circles. This transparency built trust between partners, allowing for a restorative collaboration (Cowan et al., 2022). However, the trustworthiness of specific individuals from an institution may not have translated to the institution's trustworthiness. Although the collaboration was an effective first step at establishing or strengthening the partnerships, continued partnership may be needed to restore institutional trustworthiness.

The co-created knowledge gained by both partners helped solidify the partnership, even after the end of funding. Community partners learned more about the needs of their community without sacrificing attendees' data. Institutional partners learned about concerns specific to these marginalized communities, and the role of restorative circles and mental health professionals in providing support. All partners gained knowledge about structuring CBMHIs to promote collective healing among marginalized communities (i.e., implementation of the CBMHI is Level 2 of the multilevel pre-intervention restorative process). With the exception of one

partnership, plans were made to continue partnerships and pursue further funding, which suggests this pre-intervention process facilitates the community-building component of CBPR that allow further collaborations, possibly using a COMR model, to flourish. With continued partnership, brings more opportunities to address community concerns, obtain social change, and evaluate that change over time to ensure it occurs (Came & Griffith, 2018)—all of which successfully employ CBPR as initially envisioned.

Limitations. We designed the restorative circles to be a research-free safe space focused on acknowledgment, listening, respect, and collective healing. As such, data were not collected from attendees of restorative circles. This created a space in which attendees could openly share their stress, fears, and collective grief. Community partners were present at each of the circles and attended the group interviews where they shared their insights and observations. Our analysis is, thus, limited to observational data and feedback from community partners and does not include input from restorative circle attendees.

IMPLICATIONS FOR PRACTICE AND POLICY

Our findings have implications for public health practice and institutional policy settings. First, there is a need for community-led interventions to address collective grief and trauma during the COVID-19 pandemic. Grief therapy and trauma-based counseling may provide safe spaces for therapeutic, innovative, and culturally responsive interventions that facilitate collective bereavement and healing that are needed, especially within historically marginalized communities. Interventions such as restorative circles may also assist communities in the management of collective trauma, stress, and inequities exacerbated by the pandemic. Many such communities bear the burden of limited access to COVID-19 testing, vaccination, and related health care services during the pandemic. Community-led interventions such as restorative circles, present structurally and culturally relevant ways to address existing and exacerbated unmet community mental health needs.

Second, by engaging in anti-racist practices—such as power sharing (i.e., shared decision-making and equitable distribution of resources)—community–institutional partnerships can begin to address the effects of structural racism on the community health of marginalized communities and foster deeper trust between these groups as seen in this work. Such praxis may prompt power-holding institutions like academic research institutions to consider ways to proactively integrate and operationalize anti-racist business, management operations, and policies as well as eliminate ongoing discriminatory policies and procedures in order to create equity between community and institutional partners. Our work shows the value of anti-racist praxis in the implementation of community-led interventions and advocates for funding research and programs led by community–institutional partnerships that embrace decolonizing methodologies and advocate for equity and social justice.

Despite a rich history of partnership, structural and institutional policy changes in the implementation of CBPR, COMR, and similar models are still needed to advance bidirectional partnerships among academics and CBOEs. As discussed, academic research institutions hold inequitable amounts of power over the resources often needed to build and sustain community–academic partnerships. Moreover, community–academic partnerships remain hard to implement in the traditional institutional workflows of many academic research centers (Nkimbeng et al., 2022; Strike et al., 2016). Thus, developing and mandating institutional guidelines and policies which fundamentally consider these partnerships and unequivocally reframe these as equitable is imperative if this work is to continue. As seen in our work, the multilevel pre-intervention restorative process with harmonized implementation between community–institutional partners working collaboratively on a project centering historically marginalized communities is possible. Therefore, reflecting this paradigm in institutional policy rhetoric and implementation may lead to greater trust between academic research institutions and historically marginalized communities as well as advance health equity in a manner previously unmatched in traditional research spaces.

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