MENTAL HEALTH FIRST AID IN A FAITH-BASED AFRICAN AMERICAN SETTING

Doctor of Nursing Practice Project
Presented to the Faculty of Sinclair School of Nursing
Graduate Studies
University of Missouri

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Nursing Practice
by
MONIQUE OSBORNE, MSN, RN

Nancy M. Birtley, DNP, APRN, PMHCNS-BC, PMHNP-BC, DNP Committee Chair
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Background and Significance

According to the World Health Organization (WHO, 2021a), depression is the world’s primary cause of disability and is estimated to affect 280 million people worldwide. Mental illnesses such as depression and anxiety have contributed to more than 700,000 suicidal deaths per year (WHO, 2021b). Racial/ethnic, gender, and sexual minorities are susceptible to poor mental health outcomes due to stigma, discrimination, religious beliefs, and challenges in accessing quality services (American Psychiatric Association [APA], 2023).

Mental illness is rapidly increasing in the African American population. Between 2015 and 2018, serious mental illnesses increased from 2.7% to 4.5% in Black young adults, aged 18-25 and 2.7% to 4.4% in the 26-49 age range. More specifically, major depressive episodes increased from 9.5% to 10.3% in Black youth ages 12-17, 6.1% to 9.4% in young adults 18-25, and 5.7% to 6.3% in the 26-49 age range (Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). According to SAMSHA (2018), approximately 56.7% of Black Americans reported some type of mental illness. Despite these statistics, the rate of seeking treatment remains low for the Black community. Of Black Americans with any mental illness, 69.4% received no treatment (SAMSHA, 2018). Regarding substance abuse, over 90% of Black and African Americans over 12 did not receive treatment (SAMSHA, 2018).

The evidence reveals the need for mental health treatment in the African American community. As the rates of mental health illnesses increase, this community must have access to appropriate and adequate resources. Research indicates that the Black Church plays a central role in mental health care. Wharton et al. (2018) reported that older, church-going African Americans often used formal care as a last resort, turning instead to the Church for support (Wharton et al., 2018). As of late, more agencies are now accepting as fact what has always been known in the Black community—public health advancements have the potential to be successful if it begins at the Black Church (Goldbum et al., 2021).

Purpose Statement/PICOT and Objectives

The purpose of this quality improvement (QI) project is to evaluate the efficacy of using the Mental Health First Aid (MHFA) program in an African American church-based setting. MHFA is an international training program that teaches individuals how to identify, understand, and respond to someone who is experiencing a mental health or substance use-related crisis (MHFA, 2023). This project is based on the following PICOT question: Among African American adult church attendees (P), does Mental Health First Aid (MHFA) training (I) compared to no training (C) improve mental health literacy, reduce stigma, and increase confidence in assisting someone with mental health concerns?

The objectives for this project are:

1. A minimum of 30 church members will attend MHFA training.
2. There will be a 10% improvement in mental health literacy.
3. There will be a 10% reduction in stigma related to mental illness.
4. There will be a 10% increase in confidence in assisting someone with mental health concerns.

Review of Literature

A literature search was performed to identify how various Mental Health First Aid (MHFA) interventions impact mental health outcomes. A total of 377 articles were found on the PubMed and APA PsycINFO databases, and ten articles included in the final review. This critical review of the literature identified the following themes: MHFA increased mental health
knowledge, reduced stigma about mental problems, and increased confidence to help someone with a mental health problem.

**Increased Mental Health Knowledge**

Throughout the literature, MHFA trainees consistently reported an increase in the awareness of signs, symptoms, and risk factors of mental illnesses. Banh et al. (2019) conducted a pre-post study design with members of the general population who participated in MHFA and found significant improvements in mental health knowledge from pre- ($M = 11.82, SD = 2.70$) to post-training ($M = 13.97, SD = 1.84$), $F(1, 111) = 56.39, p < .00, d = 0.931$. Improvements in mental health knowledge were also noted among ethnic groups (Crooks et al., 2018; Lee & Tokmic, 2019). Utilizing the 16-item true/false quiz in the MHFA manual, Reavley et al. (2021) found that MHFA had statistically significant positive outcomes in mental health knowledge from baseline to 2-year follow-up when comparing MHFA eLearning and blended MHFA groups to Psychological First Aid, $d = 0.50, 95\% CI[0.18, 0.81]$, $d = 0.98, 95\% CI[0.64, 1.31]$ and $d = 0.47, 95\% CI[0.16, 0.78]$, respectively.

**Reduced Stigma about Mental Health Problems**

When individuals perceive mental illness as a sign of weakness, it profoundly decreases the likelihood of sharing feelings and seeking treatment. A systematic review showed a reduction in stigma and avoidance after taking the MHFA course (Zeng et al., 2022). Positive changes in stigma were also observed among church participants, $t[26] = -2.948, p < .01$, with the post-mean score for stigma ($M = 16.48, SD = 2.47$) higher than that of the pretest ($M = 14.04, SD = 3.54$) (Costello et al., 2020). Stigma was measured using four items from the Social Distance Scale (SDS) with a higher score indicating decreased stigma attitudes (Costello et al., 2020). McCormack et al. (2018) utilized both the SDS and Attitudes to Mental Illness Questionnaire (AMIQ) and reported a decrease in stigma towards people with depression and schizophrenia after MHFA training with pharmacy students ($p < 0.05$).

**Increased Confidence in Helping Others**

A MHFA research study based in a Nepalese community in Australia reported significant changes in the ability to help someone who was going through a crisis (Nepal et al., 2022). There was a significant difference in ‘confidence to help’ from pre-training ($M = 2.88, SD = 0.81$) to post-training ($M = 3.58, SD = 0.60$), $p < 0.001, d = 0.83$. One survey of MHFA participants reported that the most significant number of respondents ($n = 70$) strongly agreed with the following statement: I am confident I can listen nonjudgmentally to someone experiencing a mental health crisis (Witry et al., 2021). Similarly, university students reported that the training helped them to respond more appropriately to the emotional challenges of friends (Rodgers et al., 2021). Rodgers et al. (2022) and Witry et al. (2021) measured confidence with established MHFA self-evaluation questions. The literature review showed that MHFA effectively increases confidence in helping people with mental health problems.

**Methods**

This QI project was designed to be a community-based outreach that utilized the Mental Health First Aid program to educate participants on how to identify and respond to persons experiencing a mental health crisis. To evaluate this program, pre- and post-intervention scores of the Mental Health First Aid Opinions Quiz (see Appendix F), the Personal Stigma Subscale (see Appendix G), and a single response based on a vignette were compared (See Appendix H).

**Intervention**

This project implemented a Mental Health First Aid (MHFA) program in an African-American church-based setting. MHFA is an international training program that teaches
MENTAL HEALTH FIRST AID

individuals how to identify, understand, and respond to someone who is experiencing a mental health or substance use-related crisis (MHFA, 2023). The cornerstone of the program is the MHFA Action Plan which provides five essential steps for helping others: “assess for risk of suicide or harm, listen nonjudgmentally, give reassurance and information, encourage appropriate professional help, and encourage self-help and other support strategies” (MHFA, 2023). The program was a single session, 8-hour long course consisting of lectures, hands-on activities and practice, and videos.

Measurement Tools and Data Analysis

Calculations for sample size were based on the recommendations from G Power 3.1. Using a $df = 1$, a power of 0.80, an effect size of 0.50, and a $p = 0.05$, the minimum sample size of 32 subjects were required. Participants completed questionnaires before and after the intervention. The primary outcomes variables were mental health literacy, stigmatizing attitudes, and confidence in helping someone with a mental illness. The MHFA Opinions Quiz was from the MHFA Instructor Manual and instructors are encouraged to use it after the course to assess knowledge of course material. No psychometric properties apart from face validity have been reported for this quiz (Morgan, 2018). The Personal Stigma Subscale is a subset of the larger Depression Stigma Scale and was used to measure changes in stigma attitudes (Griffiths et al., 2008). The Personal Stigma Subscale is both reliable and valid as indicated by a test-retest reliability coefficient, $r(435) = 0.71$, and convergent validity of $r(998) = 0.53$. For confidence in helping someone with a mental illness, a scenario developed by Kitchener and Jorm (2002) was be read, followed by a single response Likert-type question (see Appendix G).

Demographic information collected included: age, gender, race, church role, occupation, and level of education. Descriptive statistics were used to characterize and summarize the demographic data obtained from participants. The McNemar’s test for dependent samples was used to compare pre-and post-scores from the MHFA Opinions Quiz. Permission to use was granted with citations. Measures of significance, such as effect size and 95% confidence intervals were calculated. Statistical significance was defined as $p \leq .05$. The Wilcoxon signed-rank test was used to measure statistical significance for the Personal Stigma Subscale and confidence in helping someone with a mental illness. The Vargha and Delaney ($A$) effect size measures were utilized to determine the clinical significance of MHFA intervention, using values of small (0.56), medium (0.64), and large (0.71).

Results

Overall Demographics

A total of nine female subjects volunteered to participate in this QI project. The predominant age group was 45 and older (88.9%, $n = 8$), with one participant in the 25-44 age range (11.1%, $n = 1$). The ethnicity was predominately Black (100%, $n = 9$). For education, 44.1% ($n = 4$) of the subjects held a master’s degree, 44.1% ($n = 4$) held a bachelor’s degree, and 11.1% ($n = 1$) held a high school diploma. The predominant occupation was retired (33.3%, $n = 3$) and one each (11.1%) for the following occupations: director, nanny, program manager, nurse, claim specialist, and pastor. Church involvement included five leaders (55.6%), two clerks (22.2%), one not involved (11.1%), and one unknown (11.1%). A total of seven participants fully completed the MHFA Opinions Quiz, the Personal Stigma Scale, the confidence vignette, and the demographic survey.

Mental Health Literacy

While not statistically significant in any of the responses, there were some notable observations when comparing pre and post scores for the MHFA Opinions Quiz. For the
question, “Schizophrenia is one of the most common mental health problems,” more than half of the participants changed from an incorrect to a correct response. For the question, “It is not a good idea to ask someone if they are feeling suicidal in case you put the idea in their head,” 4 participants answered true (incorrect) compared to 1 participant at the post-assessment ($p = 0.250$).

**Stigmatizing Attitudes**

While not statistically significant, the Vargha and Delaney ($A$) revealed large decreases in stigma in each question. “People with depression could snap out of it if they wanted” ($p = .317, A = 1.3$), “Depression is a sign of personal weakness” ($p = .317, A = 1.3$), “Depression is not a real medical illness” ($p = .317, A = 1.3$), “People with depression are dangerous” ($p = .257, A = 1.5$), “It is best to avoid people with depression, so you don’t become depressed yourself” ($p = .317, A = 1.3$), “People with depression are unpredictable” ($p = 0.102, A = 2.0$), “If I had depression, I would not tell anyone” ($p = .066, A = 1.9$), “I would not employ someone if I knew they had been depressed” ($p = 0.705, A = 1.3$), and “I would not vote for a politician if I knew they had been depressed” ($p = 1.00, A = 1.1$). The findings are indicative of improvement in stigmatizing attitudes.

**Confidence in Helping Others**

When comparing the pre and post confidence levels of helping John in the vignette, the Wilcoxon Signed Rank Test revealed a statistically significant improvement in self-reported confidence with the following question: “How confident do you feel in helping someone at work with a problem like John?” ($p = .016$). The median score after the program was five compared to three before the program.

**Conclusions**

The purpose of the QI project was to evaluate the efficacy of using the MHFA program in an African American church-based setting. The project objective of a minimum of 30 church members was not met because nine church members attended. The project objective of a 10% increase in mental health literacy among participants was met with a 24% increase in correct responses. The objective of a 10% decrease in stigma related to mental illness was met with a 19% decrease in the group average stigma scores. The objective of a 10% increase in confidence with helping a person with a mental health illness was met with 75% increase in the group average confidence scores.

**Stakeholder Recommendations**

MHFA has shown promising results in improving the mental health literacy, confidence, and stigmatizing attitudes in the Black church setting. This project was a collaborative effort put on by the African American Pastoral Council. It is reasonable to offer MHFA to each individual church in the Charlottesville area as compared to the joint effort.

**Strengths and Limitations**

A strength of this QI project is meeting 75% of the objectives related to improvements in mental health literacy, confidence, and stigmatizing attitudes. The confidence objective demonstrated both statistical and clinical significance. Decreases in stigmatizing attitudes were also clinically significant. The use of a convenience sample, as well as prevarication and responses shift biases are noted limitations. In summary, this QI project contributes to the growing literature that supports the use of MHFA in various settings and populations to improve mental health knowledge, reduce stigma, and increase confidence in helping others with a mental health illness. More studies are needed to measure the real time impact of this course in the participants’ sphere of influence.
References


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Appendix A: D1 DNP Committee Form

DNP Residential Project Committee Appointment Request

Student’s Name: Monique A. Osborne

Student’s Number: 14344622

Date Submitted: June 5, 2023

I request that the faculty members listed below be appointed to serve as my Residential Project committee.

Nancy M. Birtley
Name of Chair*

Gina Oliver

Carolyn Mitchell Dillard
Member*

Monique A. Osborne
Member*

Signature of Director of DNP Program, School of Nursing

To be completed during the semester enrolled in:

N9080 Section 1 DNP Residency Project
Appendix B: DNP Residency Project Proposal/IRB Protocol

DNP D-3 Form

Approval of DNP Residency Project Proposal and the Institutional Review Board Protocol

Candidate's name: Osborne, Monique  
Mizzou ID number: 14344622

Project Title: Mental Health First Aid In a Faith-Based African American Setting

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The clinical project is:              | 0 | 0 |

The Program Committee has explained the decision regarding the acceptability of my project proposal.

Monique Osborne  
11/17/2023

Student Signature: Miriam D. Butler, DNP, NP-C, FNP-BC  
Digitally signed by Miriam D. Butler, DNP, NP-C, FNP-BC Date: 2023.11.21 14:45:42 -06'00'

Director, DNP Program in Nursing  
Date

SON Approved 7/2010  
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