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Utilizing Wellness Champions as a Faith-Based Initiative for Mental Health Promotion

Tracy M. Webster Cooley
University of Missouri-St. Louis, tmcp77@umsystem.edu

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Tracy M. Webster Cooley, MSN, RN

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Advisory Committee

Dr. Susan Dean-Baar, Ph.D, RN, FAAN
Chairperson

Dr. Sheila Grigsby, PhD, MPH, RN

Tamela Strayhorn, MS

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Abstract

Purpose: This program evaluation project evaluated the effectiveness of mental health training and support provided to wellness champions affiliated with a behavioral health organization. This project sought to gain a better understanding of how clergy and laypersons acting as wellness champions in predominately African-American faith-based organizations perceive they create an atmosphere to decrease stigma and increase mental health promotion and wellness when receiving education and training on mental health.

Methods: A descriptive project using a program evaluation design to evaluate the effectiveness of the training of 122 wellness champions from faith-based organizations received from a behavioral health organization from 2015-2019. Data was collected using an anonymous, online survey distributed to 122 wellness champions affiliated with a behavioral health organization. Eighteen participated in the survey, a follow-up interview was conducted with 8 wellness champions.

Results: Overall respondents evaluated the mental health training very positively with 8 of the 9 items being rated somewhat or strongly agree by 72.2-84.3% of the participants. Of the 9 knowledge, attitude and skills questions on the survey, seven had means ranging from 4.11-4.50. Two items had means below 4.0. The items below 4.0 focused on ability to identify congregants with substance additions and that the training changed perceptions that mental health problems are due to a lack of trust in God and a lack of strong faith. 82% of respondents had made a referral to a community connector since their training. The results from the study indicate that congregates trained in mental health increased their knowledge of behavioral health symptoms, confidence to connect

with community connectors, and ability to enable referrals for access to care and treatment.

Implications for Practice: This program evaluation study reveals that the education and training provided by the behavioral health organization increased mental health literacy and was effective in preparing congregates to be effective in their role as a wellness champion. Future training should consider strengthening focus on substance addictions and exploring the beliefs about the role of trust in God and strong faith in contributing to mental health problems in the African-American faith based organizations.

Keywords: African American, church-based, faith-based organization, clergy, laypersons, faith leaders, mental health, wellness champions

Mental illness continues to be a significant challenge in the African American community. African Americans are identified as having a greater severity of untreated mental health disorders than any other racial groups (Dempsey, Butler, & Gaither, 2016). According to the National Alliance of Mental Illness (NAMI) (2019), report that African Americans are 10% more likely to report experiencing serious psychological distress. These individuals are more likely to experience socioeconomic disparities and other barriers such as stigma, lack of knowledge of mental health disorders, and distrust of the healthcare system. NAMI (2019) reports, African Americans being reluctant to discuss mental health issues due to stigma, shame, and guilt, which can lead to individuals not to receiving treatment or delay seeking treatment. Dempsey et al. (2015) suggest a history of racism, misdiagnosis, and a lack of culturally sensitive services has caused this population to seek support from clergy in African American churches rather than professional health services.

Social stigma is a primary factor that leads to reluctance to seek treatment or discourages individuals from discussing their mental health problems (Hatzenbuehler, Phelan, & Link, 2013). According to NAMI (2019) the African American community, family, and spiritual beliefs can be a source of strength and support for those suffering from mental illness when combined with other mental health services. Many African Americans that are faith-based don't believe in accessing mental health services for reasons of being criticized that their faith isn't strong enough. One's faith can play a huge role in how individuals perceive their mental illness and the understanding of the disease. Faith can be a stigma that can keep individuals from seeking treatment or receiving the support that they need from others in the faith-based communities. African

American churches have played an immense role in communities as a resource for managing mental and emotional problems and have been a resource for African Americans to rely on for assistance when experiencing mental health problems when unable to access formal mental health services. Churches also can play a role in decreasing stigma and the negative effects that African Americans face when experiencing mental disorders or mental problems.

Recognized as pillars in the community, churches offer many services to support individuals in their communities that may need food, clothing, monetary donations, and social support (Brand, 2017). Several studies suggest that African Americans discuss their emotional and psychological problems with clergy. According to Anthony, Johnson, and Schafer (2015), 40% of African Americans use faith-based organizations as a resource for meeting their mental health needs and are more likely to seek help from faith leaders or clergy, which can be an avenue for assistance with their psychological needs. Many congregates feel comfortable sharing their problems and psychological issues with their pastors or other ministerial staff because they feel they will not be judged negatively. Anthony et al. (2015) also report religious organizations offer healthcare education and support for chronic health conditions in diverse communities. Faith-based communities historically have been a place to serve communities by providing social support, education on common healthcare conditions, and providing food to those in need.

Significance of Problem

Numerous studies suggest lack of mental health promotion in African American communities continues to be an issue caused by stigma and health disparities. African

Americans experience health disparities and also experience disadvantages accessing mental healthcare services. Hankerson and Weissman (2012) discussed that African Americans are less likely to access traditional mental health services as compared to whites. Haynes et al. (2017), states that there are three main barriers to accessing mental health services; limited knowledge about mental health, community stigma, and mental health system-level barriers. During psychological crises, many African Americans tend first to seek support from informal social networks such as the church, faith leaders, and clergy or pastors due to these existing barriers (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000).

A behavioral health organization in a Midwestern city, has implemented a community initiative designed to build pathways to appropriate mental health care within African American communities. This organization has implemented a program to support the behavioral health treatment and recovery of individuals within faith-based organizations and other community members that experience behavioral health disorders. The program educates faith leaders and church volunteers to act as wellness champions within their church. The wellness champions complete at least 19 hours of training and make a commitment to assist in reducing the stigma of seeking treatment and provide support and referral resources to those experiencing mental illness [Behavioral Health Network, (BHN) 2014]. This program intends to improve collaboration with key partners in the city, such as hospitals, behavioral health leaders, advocacy groups, and faith leaders, to form a multidisciplinary team of individuals to improve mental health promotion and wellness in diverse communities.

Health ministries initiated within faith-based organizations or churches are becoming more common and proactive in improving health promotion by addressing mental health and substance abuse (Brewer & Williams, 2019; Hankerson & Weissman, 2019). These authors suggest that forming partnerships between mental health services and the African American church could be a way of eliminating stigma and negative beliefs regarding mental illness. Educating laypersons to implement faith-based ministry programs into their organizations allows churches to be an avenue for influencing health promotion, disease prevention, and can decrease stigma regarding mental illness in diverse populations. Laypersons and clergy operating as community health wellness champions is an intervention that is becoming a conducive method to address these issues (Woodall, White, & South, 2013).

Purpose of the project

The purpose of this project was to evaluate the training and support provided to wellness champions in a behavioral health organization that has implemented a program to decrease stigma and promote mental health awareness in African American communities. This project sought to seek a better understanding of how clergy and laypersons acting as wellness champions in faith-based organizations perceive they create an atmosphere to decrease stigma and increase mental health promotion and wellness when receiving education and training on mental health.

Project Outcomes

The specific question guiding this project is how do the wellness champions perceive the education that they received in preparing them for their role? The rationale for this project was to provide insight on how wellness champions perceive their

knowledge through being educated on mental health and supporting improved access to care for individuals needing mental health services.

The outcomes were the perceived effectiveness of trainings of the faith leaders and church volunteers, identified as wellness champions, on knowledge of behavioral health symptoms, confidence to connect with community connectors to enable referrals for access to care and treatment, and the ability of participants to make effective referrals to appropriate services, and their confidence in assisting those seeking support with mental health issues.

Review of the Literature

A systemic search of the literature from 2000 to 2019 in PUBMED, CINAHL, Public Health, and Psych databases was completed. African American, church-based, faith-based organization, clergy, laypersons, faith leaders, mental health, wellness champions were the search terms used either separately or in combination. The search yielded 34 full text, peer-reviewed, and scholarly journal articles. Twenty-three articles met the criteria for this project (See Appendix A). Inclusion criteria for this review were as follows: articles published in English from any country discussing health ministries implemented in faith-based organizations on mental illness or mental health, and African Americans as the target population. Exclusion criteria were any articles discussing physical health ministry programs.

Stigma in Mental Illness

Many African Americans suffer in silence because they don’t want to be stigmatized or experience embarrassment. Mental illness stigma derives from fear, rejection, discrimination, and avoidance of individuals with mental illness which is a

cluster of negative attitudes and beliefs that influences the behavior (as cited in Mathews, Corrigan, Smith, & Aranda, 2006). Unfortunately, negative beliefs and attitudes influences an individual with mental health needs not to seek treatment. Choudhry, Mani, Ming, and Khan (2016) state that lay individual's attitudes and beliefs about mental illness are shaped through personal knowledge about mental illness, knowing and interacting with someone living with mental illness, and cultural stereotypes. Education on mental illness could influence individuals to change their perception and attitude toward individuals with mental health issues.

The Role of the Church

African American churches are trusted organizations that are accessed easily and are well-known organizations within African American communities (Williams, Gorman, & Hankerson, 2014). Taylor et al. (2000) reports African Americans attend church at higher rates and participate often in private devotional practices such as prayer and reading religious materials. According to Campbell and Littleton, (2018, as stated in Bell-Tolliver and Wilkerson, 2011) "African Americans report higher rates of religiosity and use of religious coping strategies compared to other ethnic groups" (p. 1). African Americans have identified the church and spirituality as a coping mechanism utilizing the act of prayer, praise and worship, singing, and seeking counsel from clergy and other church members as therapeutic outlets (Ward et al., 2009, as cited in Dempsey et al., 2015). The role of the church has expanded to addressing beyond the spiritual needs of congregates but could be identified as a holistic organization. African American churches have been successful in promoting positive health behaviors by developing health ministries that implement interventions that influence communities to make positive

behavioral health challenges (Brewer & Williams, 2019). Community-based interventions require individuals to collaborate with community-based agencies to change individual behaviors by educating individuals within their community setting (Williams et al., 2014). Faith-Based Health Promotion (FBHP) interventions are a great tool to implement culturally sensitive and community-based health programs (Campbell & Littleton, 2018). Although these program's objectives are to improve mental health promotion to community members through education, screening, and treatment, they lack frequent evaluation of such interventions and programs (DeHaven, Hunter, Wilder, Walton, & Berry, 2004). Developing partnerships between the African American Church and behavioral health providers and organizations may help increase the number of individuals seeking mental health care amongst African Americans by decreasing stigma within their communities (Hankerson & Weissman, 2012).

Faith Leaders and Lay Persons as Wellness Champions

The literature clearly articulates clergy are involved in all aspects of their congregates lives, and especially their mental health (Anthony et al., 2015). African American clergy have been known to provide services such as counseling for bereavement, marital issues, pregnancy, employment, violence/abuse, drug abuse, and legal problems (Taylor et al., 2000). African American clergy have been very instrumental in playing a major role in influencing the health beliefs and behaviors of their congregants (Anthony et al., 2015). Taylor et al. (2000), discuss the role of clergy as agents that can influence behavioral or social change. In the study conducted by Mantovani, Pizzolati, & Gillard (2017), the researchers found that community well-being champions (CWBCs) shared ideas about mental health and well-being by focusing on the

things that that they were concerned about and able to change within that community to encourage change. The authors report that wellness champions are in a unique position to reach individuals often over looked within diverse communities (Mantovani et al., 2017). They found that the study participants only met resistance from the people they were engaging in services because of a lack of knowledge and stigma of mental health.

Many African Americans use clergy as their main support to help manage their depression, unfortunately there is a small number of clergy trained in counseling (Anthony et al., 2015). Mental health first aid (MHFA) is a training program that has been designed to educate members of the public to identify symptoms of psychological issues and how to provide support to someone who may be at risk for developing a mental illness, or someone experiencing a mental health crisis (Morawska et al., 2013). Anthony et al. (2015), found that some African American clergy struggle with difficulty identifying symptoms of depression and frequently find themselves assisting congregants with depression symptoms. Several research studies suggest that clergy have not obtained adequate training to manage symptoms of depression, substance abuse, domestic violence, and psychotic disorders (Brewer & Williams, 2019). In the study by Mantovani et al. (2017), the authors found that well-trained wellness champions enhance awareness about mental health problems in their communities and have the ability to engage with leaders in the community to adapt interventions that improve mental wellness.

Health Ministry Training

Galiatsatos and Hale (2016), state that religious organizations are constantly in contact with individuals who are in need of education and support about physical health issues. Lay health educators promote health initiatives and increase access to resources in

communities by being a link between religious organizations and healthcare organizations (Galiatsatos & Hale, 2016). Educating lay persons to serve in underserved communities can be beneficial in promoting physical and mental health initiatives to improve access to resources that can improve community health.

Haynes et al. (2017) suggest that mental health education programs, such as MHFA, have been shown to have a positive impact on increasing knowledge about mental illness, decreasing stigma, and changes the attitudes of congregates about mental illness. Morawska et al. (2013), indicate that MHFA training is an important program that would benefit anyone individuals that are working with diverse populations. Hadlaczky, Hökby, Mkrtchian, Carli, and Wasserman (2014) report that MHFA increases mental health literacy of the general population.

There are gaps in the literature regarding the effectiveness of health ministry programs and there is limited research that evaluates mental health training programs as well as the mental health wellness champions. Hankerson and Weissman (2012) found that most studies focused on substance abuse disorders and physical health issues. In the survey conducted by DeHaven et al. (2004) the authors found that faith-based health programs can increase knowledge of diseases, improve health seeking behaviors, and the risk associated with disease and disease symptoms, there is limited research that evaluates the effectiveness of these programs. Although several health ministry programs focus on physical diseases, there are limited studies that have evaluated the role of clergy and other laypersons within those programs. Stewart (2014), examined the role of clergy and lay leaders within HIV Ministries and the barriers that they faced within health ministries and found that further evaluation is needed to assess the effectiveness of those

programs. Leavey, Loewenthal, & King (2007), suggest that exploring the impact of mental health training needs is imperative since there is lack of information on the type of support faith leaders are able and willing to give. Although there is a variety of research that suggest that church-based programs are successful in addressing disparities for numerous medical conditions, the African American Church is not used enough as an avenue for mental health resource (Hankerson & Weissman, 2012). They also feel that African American churches should be equipped to provide mental health screening, treatment, education, and other services for African Americans.

Theoretical Framework

A program evaluation framework developed by the Center for Disease Control (CDC, 2017) was used to guide this project. According to Lavinghouze and Snyder (2013) an evaluation plan is needed to assess the processes and outcomes of a program. Developing an evaluation plan will guide the researcher on what direction to take to evaluate the objective outcomes of the research study. The CDC Program framework list 6 steps: 1 Engaging the Stakeholders, 2. Describing the Program in the Evaluation Plan, 3. Focusing Your Evaluation Plan and Your ESW, 4. Gathering Credible Evidence, 5. Planning for Conclusions, and 6. Planning for Dissemination and Sharing of Lessons Learned (Lavinghouze & Snyder, 2013). Each of these steps is highlighted in this paper (noted by italics).

Engaging Stakeholders

The investigator met with stakeholders and discussed their Bridges to Care and Recovery (BCR) program's training and outcomes. The key stakeholders involved with the BCR program are the program managers, pastors of the churches, and wellness

champions. The stakeholders meet monthly to discuss how the program is functioning and any program needs that should be addressed. The investigator has attended several monthly meetings and trainings provided by the organization and also participated in the mental health first aid training course offered to the wellness champions.

The behavioral health organization was interested in evaluating the effectiveness of the training provided to the wellness champions and how the wellness champions view their role as key individuals in the mental health program at their churches.

Program Description

The behavioral health organization that was evaluated implemented their BCR program in 2015 to increase mental health literacy and build pathways to appropriate care for African Americans within disadvantaged communities. The program requires the wellness champions to participate in 19 hours of training. The training consists of the following: MHFA training, Companionship Training/How to Build a Mental Health Ministry, Trauma training, Opioid crisis management, Crisis services/suicide prevention, and Recovery resources. The BCR program offers monthly meetings to implement the training. Wellness champions are required to renew their MHFA certification every 3 years.

Focus of Evaluation Plan

The behavioral health organization has evaluated knowledge, beliefs, and attitude of the wellness champions immediately after all training was completed. Further evaluation is needed to assess the overall effectiveness of the programs training curriculum in preparing the wellness champions to be effective in their role overtime. Utilizing a program evaluation framework will allow the researcher to evaluate the

effectiveness of the training that the wellness champions have received and if they feel confident in their role as a wellness champion.

The plan for the remaining steps of the program evaluation framework are described in the method section.

Method

Design

This was a descriptive project using a program evaluation design to evaluate the perceptions of wellness champions in the effectiveness of their training in a mental health ministry program. The program evaluation framework is an effective way to improve and make recommendations for change. The program evaluation project is expected to identify additional educational needs and recommendations to improve the behavioral health ministry program.

Setting

The study was implemented at a large Midwestern metropolitan behavioral health organization that has implemented a program called Bridges to Care and Recovery servicing 65 African American congregations served by the behavioral health organization.

Sample

A convenience sample of 122 wellness champions from 65 churches served by the mental health organization was recruited for this study. The anticipated recruitment process initially was for the investigator to attend the monthly meetings held by the behavioral health organization staff for the wellness champions to solicit participants for the study. Due to COVID-19 the recruitment process was transitioned to soliciting

participants virtually through email. Inclusion criteria included the following: (1) Completed the BCR training and (2) are considered an active wellness champion in the BCR program.

Approval Processes

Approval of this program evaluation project was obtained from the University of Missouri St. Louis Institutional Review Board.

Procedures

Gathering Credible Evidence

Wellness champions that were considered active participants in the BCR program since 2015 were recruited for the project. Initially the investigator planned to recruit participants by attending the monthly meetings held by the behavioral health organization. As participants enter the meeting location the investigator would provide the participants with a recruitment letter that explains the purpose of the project study (See Appendix B). The first 30 minutes of the meeting was to present the wellness champions with a presentation about the project, answer questions about the project, and have the participants to fill out the paper survey (See Appendix C). Attached to the survey was an additional form to be completed by participants who were willing to participate in a 1 on 1 interview with the investigator (See Appendix D). The investigator expected to have at least 20 participants agree to be interviewed. Eight wellness champions out of the eighteen participants agreed to participate in the interview. Interviews lasted from twenty minutes to one hour. The investigator initially planned to collect surveys and place them in an envelope and keep in a locked cabinet until the investigator began data analyses. The data collection process was transitioned to sending

out a link to an online anonymous Qualtrics survey inviting all wellness champions affiliated with the behavioral organization from 2015 to 2019 to participate in the study. The investigator contacted the wellness champions that expressed willingness to participate in a phone interview.

The investigator met with the stakeholders to discuss the data collection instruments that were used to evaluate the health ministry program and evaluate if the instruments achieved its purpose for evaluating their program. Revisions were made based on the feedback received. The investigator provided continuous feedback to stakeholders throughout the data collection process informing them of any problems that occurred during data collection.

Data Collection and Analysis

Planning for Conclusion

Data was collected utilizing qualitative and quantitative methods which consisted of an online Qualtrics survey and phone interviews. A 20-question survey, using a Likert scale (Appendix C), and seven interview questions (See Appendix E), designed by the investigator, was used to collect the data for this study. Demographic data included age, gender, race, education, role in the church, religious affiliation, years in ministry. Descriptive statistics was used to analyze wellness champion's characteristics and attitude, knowledge, and perceptions of their training from the survey. The data collection process had to be modified due to COVID-19 and the project was transitioned from face to face to utilizing online technology due to the state's mandate to "shelter at home". The survey was sent out by the behavioral health organization on behalf of the investigator the first week of March via email to 122 wellness champions that were affiliated with their

BCR program from 2015-2019. The data collection process took place from the month of March 2020 to the end of May 2020. The behavioral health organization sent out repeat emails to the wellness champions which included two follow-up reminders being sent out over three weeks to encourage completion of the survey. The organization also made announcements at the beginning of their monthly virtual meetings to remind the wellness champions to fill out the survey and consider participating in an interview with the investigator. Text messaging was another form of communication that was used to communicate with the wellness champions to participate in the study. Eighteen wellness champions responded to the survey and eight out of the eighteen agreed to participate in a phone interview with the investigator. Data was stored on a password protected computer owned by the primary investigator. Survey data was analyzed using Excel and Intellectus Statistics (2019). Interview data was analyzed by listening to recorded interviews and identifying common themes and answers to specific questions, and then summarizing the data.

Results

Study Participants

Eighteen out of 122 wellness champions participated in the study. To gain a better understanding of the personal characteristics of the wellness champions demographic questions were asked that included their sex, age, race, education, religious denomination, years at church, and training year. Other additional data characterized the participants role in their congregation, referrals made to community connectors, other health ministries within their church and if they assisted or developed a behavioral health ministry or event. Demographic data and other additional characteristics are recorded in Table 1.

The majority of the respondents were female (n=18, 88.8%) and two respondents were male. The majority of the wellness champions were African American (94.4%), and 1 respondent identified themselves as multi-racial (n=1, 5.5%). Half of the respondents were between the ages of 65-80 (n= 9, 50.0%), followed by 50-64 (n=6, 33.3%) and 30-49 (n=3, 16.6 %). Overall, the wellness champions were well educated with 77.77% having a college degree. Half of the respondents possessed Bachelors (33.33%) and/or Masters (22.22%) degrees. The remaining wellness champions had doctorates (11.11%), associate degrees, (11.11%), some college (16.67%) and 1 respondent had a high School diploma or GED. The wellness champions identified their religious denomination as Baptist (27.8%), Christian denomination (16.7%), Methodist C.M.E (16.7%)., Non-Denominational (22.2%), and Pentecostal Church of God (16.7%). Half of the respondents had been members at their church for 21-30 years (50%), 6 respondents 5-10 years (33.3%), and 3 respondents 11-20 years (16.7%). The wellness champions who responded to the study were trained between 2015 and 2019. There were 4 respondents trained in 2015 (22.2%), one respondent trained in 2016 (5.5%), three respondents trained in 2017 (16.6%), six respondents trained in 2018 (33.3%), and 4 trained in 2019 (22.2%) responded to the survey (Table 1).

Additional Characteristics of Wellness Champions

Other additional data characterized the wellness champion's connection to community services. Thirteen (72.2%) out of eighteen wellness champions indicated that they had made a referral to a community connector. The wellness champions indicated that they had made referrals to community health agencies, mental health counseling, and primary care services. Other services that fell within the three categories were substance

use, spiritual care, and peer support groups. Six (33%) of the wellness champions identified themselves as being a congregate of their faith organization. There were seven respondents (38%) that identified themselves as having other roles in their church such as associate pastor, chair of health ministry, minister, pastor assistant, teacher, trustee and Sunday school teacher. Five respondents (27.8%) identified themselves as pastors of their congregation. Half of the respondents indicated that their church has a health ministry. The wellness champions that identified their church organization having a health ministry listed the following: Breakfast club for breast cancer survivors, health care ministry, health ministry, health unit, mission ministry, nurse ministry/health unit, nurses guide and grief support group. One respondent identified their organization as having a doctor and nurse on duty, and another respondent indicated that their organization is working on an addiction program and food pantry. Frequencies and percentages of these additional characteristics are presented in Table 1.

The survey measured the respondents' attitude, knowledge, and perceptions of their training which is presented in Table 2. Overall the majority of the wellness champions perceived that the training that they received prepared them to be confident in their role as a wellness champions. Questions 1 through 6, and questions 8 and 9 rated strongly or somewhat agreed by 72.22% - 84.33%. Question 7 rated lower at 38.89%.

Table 3 show the summary of mean and standard deviation from the wellness champions responses to the survey questions. The mean for seven out of the nine questions ranged from 4.11-4.50 and 2 questions ranged from 3.39-3.78.

Table 4 illustrates the distribution of question means by year of. Wellness champions trained in 2015-2016 show a mean of 4.00 or above for eight out of the nine

questions. Wellness champions trained in 2017 and 2019 show a mean of 4.00 or above for seven out of the nine questions. Wellness champions trained in 2018 show a mean average of 4.0 or above for six out of the nine questions. Six of the nine questions had a mean below 4.0 in at least one of the years. Only the question on training changing perceptions that mental health problems are due to a lack of trust in God and a lack of strong faith had means below 4.0 in three of the five years.

The qualitative component of this project consisted of conducting interviews with the wellness champions to explore their personal experience in their role. Eight out of eighteen wellness champions participated in an interview with the investigator. The wellness champions were asked seven questions. The summary of the responses is shown in Table 5. The common themes from the interviews consisted of the wellness champions expressing how the training was sufficient and increased their knowledge and awareness about mental illness and what resources are available in the community. Also, the wellness champions identified that the training helped them recognize congregates that are suffering from some type of mental health challenges. Although all of the wellness champions stated that the training was sufficient they also suggested some additional topics or activities that could be added to the training curriculum (See Table 5). Another theme was that the training has made them aware of the factors that may cause congregates not to seek services such as not knowing about services in the community, not feeling comfortable discussing their problems. Another theme identified was how their faith allows them to love everybody and to be compassionate and sensitive to the needs of other congregates. Another theme from the interviews identified changes in the attitudes of the pastors about mental illness and how mental illness and disorders are

discussed more intelligently over the pulpit. Another theme was how congregates are grateful for the assistance but some congregates don't follow through with the referral process. Experiencing shame and not wanting to follow the processes required by the community agencies or organizations were some of the reasons that some congregates didn't proceed with the referrals. Several of the wellness champions also commented about their belief that prayer can have a positive change on an individual's mental status. Although several of the wellness champions stated that praying alone will not fully eliminate the mental health issues that the congregates are experiencing they also need to seek out other resources to help manage their symptoms that they are experiencing.

The wellness champions were asked to share a story about their experience as a wellness champion. The common themes from this question was that the congregates that they assisted were grateful and thankful for the help. The congregates that received help experienced improved mental health which resulted in them experiencing positive changes in their overall lives.

Discussion

The study suggests that when sufficient training on mental health is provided to laypersons that their knowledge, attitude and perception about mental health is increased. The training that the wellness champions received increased their knowledge about barriers that could prevent access to mental health services such as stigma and increased their knowledge about mental illness and resources in the community. The study illustrates that more than half of the wellness champions have agreed that the training they received prepared them for their role and made them confident to perform in their role as a wellness champion. Haynes et al. (2017) discussed that mental health education

programs have been shown to have a positive impact on increasing knowledge about mental illness, decreasing stigma, and changes the attitudes of congregates about mental illness. Fifteen out of the eighteen wellness champions agreed that the training had changed how mental illness is viewed and or discussed across the pulpit.

Seven out of eighteen wellness champions agreed that the training changed their view that mental health problems are due to a lack of trust in God and a lack of a strong faith and seven were neutral on this question. The remaining wellness champions strongly or somewhat agreed that their perception didn't change. One's faith and belief in God could play a role on how an individual respond to someone experiencing mental health problems or can affect how someone evaluates their mental health issues and if they will or will not seek treatment. It is possible that this question was rated lower than the other questions because the wording may have been confusing. Wellness champions who entered the training with a good understanding that a lack of trust if God and a lack of a strong faith are not contributors to mental health problems are likely to not have had changes in their view or perceptions.

Although the majority of the wellness champions strongly or somewhat agreed that the training helped them identify congregates who are addicted to substances five of the eighteen either were neutral or somewhat or strongly disagreed. This may be an area of training to assess for what could be included to improve laypersons ability to identify substance addiction problems.

The study also illustrates that thirteen out of eighteen wellness champions made a referral to a community connector since they were trained as a wellness champions which is an objective of the behavioral health organization to increase partnerships within the

community. Galiatsatos and Hale (2016) report that lay health educators can increase access to resources in communities by being a link between religious organizations and healthcare organizations. This project supports that changing attitudes and beliefs about mental illness in faith-based communities can also let congregations see that the church has a role in mental health promotion and highlight their role as an advocate for addressing health disparities and the need to develop partnerships with behavioral health organizations. Hankerson and Weissman (2012) suggested that developing partnerships can increase the number of individuals seeking mental health care and decrease stigma in African American communities.

Although the majority of the wellness champions stated that the training was efficient they also suggested that some additional topics or activities should be included in the training such as role play scenarios, self-care, care giver support, suicide and grieving, refresher courses, and additional information on agency fees and hours of operation as well as free community services. Leavey, Loewenthal, and King (2007) state that it is important to explore what other training is needed for faith leaders and what additional support are they needing. Meeting the educational needs of wellness champions can better help them serve their congregation. Hankerson and Weissman (2012) feel that African American churches should be equipped to provide mental health screening, treatment, education, and other services. The project has shown that effective training can significantly increase knowledge of behavioral health symptoms, confidence to connect with community connectors and ability to make effective referrals to appropriate services, and their confidence in assisting those seeking support with mental health issues.

Planning for Dissemination

The investigator will meet with the stakeholders and share the results of the project with the stakeholders. Included in the presentation the investigator will provide illustrations and graphics to show the findings and discuss strengths and limitations identified from the data analysis. The investigator will discuss recommendations with the stakeholders that could be implemented into their mental health ministry program. The investigator has identified that the facility stakeholders should further explore how one's beliefs, faith, and trust in God impacts mental health. Also, the facility should explore the impact of their training in identifying substance & addiction and what information should be included in the training to help identify individuals with substance addiction problems.

Limitations

This project showed that congregates in faith-based organizations trained in mental health education can improve access to mental health care in African American communities through referral and support of behavioral health ministries and events. However, some limitations are noted such as the homogeneity of the population sample may not yield the same results in the general population. One of the greatest obstacles that the investigator encountered was transitioning the project to an online study which yielded a lower response rate from the wellness champions. Less than 20% of the wellness champions responded to the survey. The restrictions resulting from COVID-19 eliminated the ability to meet personally with the wellness champions to explain the project and therefore could have caused unwillingness to take out time to fill out the survey and reluctance to participate in a phone interview. The group that did respond may not have represented the large group of 122 wellness champions and the sample may not

have proportionally reflected the male population of wellness champions to evaluate their impact in this role. Recommendations for future projects would to increase the sample size and recruiting more male participants to assess gender differences in future studies.

Implications for Practice

The results of this study have great implications for faith-based organizations to implement mental health ministries into their organizations. Pastors, clergy, and congregates trained in mental health literacy can be on the frontlines to promote mental health wellness in African American communities. The study shows that wellness champions have the potential to play a central role in decreasing stigma and increasing access to mental health services when they have the knowledge and confidence to create a positive impact in these communities. Sufficient training of wellness champions or other lay persons can decrease stigma and promote mental health wellness in African American communities.

Recommendations for Further Investigation

Although this study had a small sample size, there should be study replication of evaluating the training and education provided to laypersons involved with community programs that focus on mental health promotion and wellness in other African American faith-based communities. There are several things that need to be furthered explored from this study. One item is to explore how an individual's beliefs on how one's faith and trust in God impacts how they respond to individuals with mental health problems and how an individual experiencing mental health challenges respond to their problem or if they will seek treatment. Another recommendation would be to explore what support is needed for churches to establish health ministries in the church and how it impacts mental health and physical health of individuals. Future studies should also explore how wellness

champions impact or improve mental health outcomes in their communities. Findings also suggest that further exploration of what additional training may be needed to help identify individuals with substance addiction problems in the African-American faith-based organizations. In addition, future research should be broadened to the population within the community and comparing the effectiveness of implementing behavioral health ministries in faith-based communities with general community-based initiatives.

Conclusion

This project has highlighted that lay persons trained as wellness champions have a special way of creating change in the African American communities when it comes to mental health seeking behaviors. Behavioral health education programs delivered within faith-based communities may be effective in improving mental health literacy therefore creating an environment that decreases stigma and other barriers preventing individuals from seeking help. It is important for community programs to evaluate the training and education that they provide to leaders and laypersons in faith-based organizations to assess the effectiveness of their program in meeting their objectives. Effective program evaluations will identify additional educational needs that can be implemented into their curriculum that can improve the outcomes of their program and improve the behavioral health ministry programs in faith-based organizations. Church leaders trained on mental health literacy helps them to understand the importance of having mentally healthy congregates as well as physically healthy congregates which can benefit the communities that their organization resides in. Effective education and training allow faith-based communities to be a pillar in the community to support mental health promotion in a compassionate manner and create partnerships with healthcare agencies.

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Table 1: Characteristics of Wellness Champions

Variables	***Wellness Champions n=18***	***Percentages %***
Gender		
Female	16	88.89
Male	2	11.11
Race		
Black/African American	17	94.44
Multi-Racial	1	5.56
Age		
30 – 49 yrs.	3	16.67
50 – 64 yrs.	6	33.33
65 – 80 yrs.	9	50.00
Education		
High School diploma or GED	1	5.56
Some college	3	16.67
Associate's degree	2	11.11
BA, BS	6	33.33
MA, MS	4	22.22
PhD, MD, JD	2	11.11
Religious Denomination		
Baptist	5	27.78
Christian	3	16.67
Methodist C.M. E	3	16.67
Non-Denominational	4	22.22
Pentecostal Church of God	3	16.67
Years of Church Membership		
11 – 20 yrs.	3	16.67
21 – 30 yrs.	9	50.00
5 – 10 yrs.	6	33.33
Year of Training		
2015	4	22.22
2016	1	5.56
2017	3	16.67
2018	6	33.33
2019	4	22.22

Table 1 continued

Variables	*Wellness Champions n=18*	*Percentages %*
Have you made a referral to a community connector since you have been a wellness champion?		
No	5	27.78
Yes	13	72.22
Who did you make a referral to?		
Community Mental Health	2	11.11
Mental Health (Counseling)	9	50.00
Primary Care	2	11.11
Missing	5	27.78
What is your role in your congregation?		
Congregant	6	33.33
Other	7	38.89
Pastor	5	27.78
Does your congregation have other health ministries?		
No	9	50.00
Yes	9	50.00
Have you helped establish a Behavioral Health Ministry or Event?		
No	11	61.11
Yes	7	38.89

Due to rounding errors, percentages may not equal 100%.

Table 2 Distribution for Survey Responses of the wellness Champions

Survey Questions	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
Q1. The mental health training has prepared me to be confident in my role as a wellness champion	11.11	0	5.56	22.22	61.11
Q2. The mental health training has changed my attitude or beliefs about mental illness	0	5.56	11.11	27.78	55.56
Q3. The mental health training has helped me identify stigma and shame associated with mental illness	11.11	0	16.67	11.11	61.11
Q4. The mental health training helps me identify if congregates are experiencing mental health challenges	0	11.11	5.56	33.33	50.00
Q5. I believe that the overall training provided was sufficient to prepare me for my role as a wellness champion.	11.11	0	5.56	27.78	55.56
Q6. I believe that pastors and congregates trained on mental Illness will increase the number of congregates seeking help for their mental problems	5.56	0	11.11	27.78	44.44
Q7. The mental health training has changed my view or perception that mental health problems are due to a lack of trust in God and a lack of a strong faith	16.67	5.56	38.89	0	38.89
Q8. The mental health training helps me identify congregates who are addicted to substances	5.56	11.11	11.11	44.44	27.78
Q9. The mental health training has changed how mental illness is discussed over the pulpit	11.11	0	5.56	22.22	61.11

Table 3: Summary of Mean and SD Survey Questions

Survey Questions	M (n=18)	SD
Q1. The mental health training has prepared me to be confident in my role as a wellness champion	4.22	1.31
Q2. The mental health training has changed my attitude or beliefs about mental illness	4.50	1.10
Q3. The mental health training has helped me identify stigma and shame associated with mental illness	4.11	1.37
Q4. The mental health training helps me identify if congregates are experiencing mental health challenges	4.11	1.28
Q5. I believe that the overall training provided was sufficient to prepare me for my role as a wellness champion	4.17	1.29
Q6. I believe that pastors and congregates trained on mental Illness will increase the number of congregates seeking help for their mental problems	4.17	1.04
Q7. The mental health training has changed my view or perception that mental health problems are due to a lack of trust in God and a lack of a strong faith	3.39	1.50
Q8. The mental health training helps me identify congregates who are addicted to substances	3.78	1.17
Q9. The mental health training has changed how mental illness is discussed over the pulpit	4.22	1.31

Table 4: Distribution of Mean for Year of Training and Response to Survey Questions

Survey Questions	2015 (n=4)	2016 (n=1)	2017 (n=3)	2018 (n=6)	2019 (n=4)	Total mean by 2015-2019
Q1. The mental health training has prepared me to be confident in my role as a wellness champion	4.75	4.00	4.33	4.67	4.0	4.22
Q2. The mental health training has changed my attitude or beliefs about mental illness	4.25	5.0	4.67	4.17	4.0	4.50
Q3. The mental health training has helped me identify stigma and shame associated with mental illness	4.50	5.0	4.33	3.67	4.0	4.11
Q4. The mental health training helps me identify if congregates are experiencing mental health challenges	4.75	4.0	4.67	3.67	3.75	4.11
Q5. I believe that the overall training provided was sufficient to prepare me for my role as a wellness champion	5.00	4.0	3.67	4.83	3.75	4.17
Q6. I believe that pastors and congregates trained on mental Illness will increase the number of congregates seeking help for their mental problems	4.50	3.0	4.00	4.33	4.0	4.17
Q7. The mental health training has changed my view or perception that mental health problems are due to a lack of trust in God and a lack of a strong faith	3.0	5.0	3.67	3.17	4.50	3.39
Q8. The mental health training helps me identify congregates who are addicted to substances	4.00	4.0	4.33	4.17	4.0	3.78
Q9. The mental health training has changed how mental illness is discussed over the pulpit	4.75	4.0	3.33	4.17	4.0	4.22
Mean of year total	4.38	4.22	4.11	4.09	3.67	

Table 5: Wellness Champion Interviews (n=8)

How has the training you received helped you feel comfortable exploring the causes of congregates mental problems such as depression?
➢ Increased knowledge and awareness about mental illness ➢ Helped me recognize someone with mental health problems ➢ Increased knowledge of community resources
How has the training you received helped you identify barriers that may hinder congregates from seeking mental health services or seeking social support from you as a wellness champion?
➢ The training has helped me identify: • Stigma • Congregates not knowing about resources • Congregates not feeling comfortable discussing their problems
How do you think that the training has changed the way Pastors or clergy talk about mental illness across the pulpit? What changes have you noticed?
➢ Changes in attitudes about mental illness ➢ Pastor discussing mental illness in sermons and identifying disorders ➢ Pastors discussing mental illness more intelligently
How does your faith affect your role in helping congregates ability to deal with their mental health issues?
➢ My faith teaches us to love everybody ➢ My faith teaches me too be more compassionate and understanding
What additional types of training or resources do you believe would be helpful to increasing your capacity as a wellness champion or to improve the program?
• The training is sufficient but the following topics should be implemented into the training: • Role playing scenarios • Training for wellness champions to stay healthy • Caregiver support groups • Training on suicide and grieving • Information on agency fees, free services, and hours of operation of agencies • Yearly refresher courses
What was your experience providing a behavioral health referral to any of the congregants?
➢ Congregates not following the referral process ➢ Congregates are grateful for the assistance
Tell me a story about what your experience has been as a wellness champion?
➢ I helped a family that had no idea about available services in the community that they could have utilized to help their son who was experiencing mental challenges. The family had been dealing with their son's mental health problems without support. The family was so thankful and grateful for my assistance. ➢ I assisted a young man that was having difficulties and was homeless. The young man had been off of his medication and was in college. I assisted him getting back on his medication and assisted him to reach out to housing office at his college. The young man was able to get help with his medication and help with housing. The young man will graduate this Spring and is doing well. ➢ I assisted a young lady to seek out services 5 times before she decided to follow through with the process, once she did follow through with the referral process her entire life changed.

Appendix A

CITATION	**PURPOSE / BACKGROUND**	**PARTICIPANTS / SETTING** Sample & Setting	**METHODS / DESIGN** Study Design & Interventions	**RESULTS / LIMITATIONS / RECOMMENDATIONS**
Anthony, J. S., Johnson, A., & Schafer, J. (2015). African American Clergy and Depression: What they know; What they want to know. *Journal of Cultural Diversity*, *22*(4), 118–126. Retrieved from http://search.ebscohost.com.libproxy.siue.edu/login.aspx?direct=true&db=rzh&AN=111918001&site=ehost-live&scope=site	The association between African American clergy's ability to recognize depression symptoms Does depression counseling differ from spiritual counseling? AA clergy identify as their resource and training needs in order to develop skills in recognizing and managing depression in congregants	Purposive sampling was used to recruit participants for this study. Sixty-five clergy completed and returned the Mental Health Counseling Survey and Personal Profile Questionnaire.	Descriptive, quantitative research study was approved by the University of Cincinnati Institutional The Mental Health Counseling Survey (MHCS) eleven item questionnaire designed to identify the knowledge, beliefs and counseling experiences of African American clergy	Disparities in mental health status exist can lead to feelings of unhappiness and dissatisfaction Limitation small group of African American clergy Research should focus specifically on the training needs of clergy
Behavioral Health Network of Greater St Louis. (2014) Bridges to Care and Recovery Retrieved from http://www.bhnstl.org/wpcontent/uploads/2016/08/BHN-Community-Report-Letter-Size_vFINAL.pdf	Reduce the stigma of mental illness in faith-based communities Strengthen partnerships between service providers Improved access through Community Connectors, remove barriers and fill the gap between services. Enhance and extend the impact of the current safety-net system Divert from health emergency and criminal justice systems through early intervention	65 churches, 221 participants trained	Training laypersons and clergy as wellness champions MHFA courses Pre-& Post evaluations surveys	Wellness Champions increased their knowledge, demonstrated fewer stigmatizing attitudes towards mental illness, and were more likely to engage in behavior to foster mental health.
Brand, D. J. (2017). The African American Church: A Change Agent for Health. *ABNF Journal*, *28*(4), 109–113. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=125885624&site=ehost-live&scope=site	Evaluating churches as a change agent	AA churches	Systematic review of church-based interventions	Health professionals still face obstacles in improving health outcomes among AA. There's a need for a non-traditional approach that is trusted, culturally sensitive and able to reach hard-to-reach populations
Brewer, L. C., & Williams, D. R. (2019). We've Come This Far by Faith: The Role of the Black Church in Public Health. *American Journal of Public Health*, *109*(3), 385–386. https://doi-org.libproxy.siue.edu/10.2105/AJPH.2018.304939	Study examines 3 articles highlighting the role of faith-based organizations (FBOs) as re-sources for tackling major health challenges and improving population health. Partnering with the Black Church will help reduce and eliminate health disparities.	3 Faith-based organizations.	Systematic review of 3 articles discussing community engagement, cultural relevance, health initiatives along with religious contexts.	Recommendations of a lack of formal training, limited mental health resources, or theological biases. Clergy and members of African American churches to reduce mental illness stigma and create a comfortable climate to advance mental health wellness and recovery.

CITATION	**PURPOSE / BACKGROUND**	**PARTICIPANTS / SETTING** Sample & Setting	**METHODS / DESIGN** Study Design & Interventions	**RESULTS / LIMITATIONS / RECOMMENDATIONS**
Campbell, R. D., & Littleton, T. (2018). Mental health counselling in the Black American Church: reflections and recommendations from counsellors serving in a counselling ministry. *Mental Health, Religion & Culture* https://doi-org.libproxy.siue.edu/10.1080/13674676.2018.1494704	The goal of this study was to examine the relationship between "The Black Church", the mental health needs of its members, and addressing those needs from the perspective of counsellors within the church. Churches is the go-to place for many African Americans in times of trouble and struggle Church should fill the gap in quality mental health services Church should work to address the stigma that exists in Black communities.	Study was conducted at African American-serving church in the Midwest in the US. The four study participants worked with the church's counselling ministry in both volunteer and paid capacities of at least a year and a half.	Three-phase research study consisted of a "Needs assessment", to assess the mental health needs of the congregation from three perspectives: that of the current counsellors at that time, the pastoral and ministerial staff, and the congregants themselves. First phase of the study included conducting qualitative interviews with the four counsellors of the counselling department The second phase was a focus group with the church's lead pastor and ministers The third and final phase was the administration of an online survey of church members around their mental health needs.	The results indicated that the church has the potential to increase the number of persons receiving mental health care but also improve the cultural appropriateness of such services, thereby reducing early service termination and improving mental health outcomes for Black Americans.
Choudhry, F. R., Mani, V., Ming, L. C., & Khan, T. M. (2016). Beliefs and perception about mental health issues: a meta-synthesis. *Neuropsychiatric disease and treatment*, *12*, 2807–2818. doi:10.2147/NDT.S111543	Aim to study to belief systems and perception regarding mental health problems.	Fifteen relevant published qualitative and mixed-method studies, regarding the concept of mental health, were identified for meta-synthesis.	The methodology involved a systematic review and the meta-synthesis method, which includes synthesizing published qualitative studies on mental health perception and beliefs.	Attitudes and beliefs about mental illness are shaped by personal knowledge, knowing and interacting with someone living with mental illness, cultural stereotypes about mental illness, media stories
DeHaven, M. J., Hunter, I. B., Wilder, L., Walton, J. W., & Berry, J. (2004). Health programs in faith-based organizations: are they effective? American journal of public health, 94(6), 1030–1036. doi:10.2105/ajph.94.6.1030	Examined the published literature on health programs in faith-based organizations to determine the effectiveness of these programs.	386 articles met search criteria.	Systematic literature review of articles describing faith-based health activities.	Most programs focused on primary prevention, general health maintenance, cardiovascular health, or cancer. Significant effects reported included reductions in cholesterol and blood pressure levels, weight, and disease symptoms and increases in the use of mammography and breast self-examination. Faith-based programs can improve health outcomes. Means are needed for increasing the frequency of the programs being evaluated.

CITATION	**PURPOSE / BACKGROUND**	**PARTICIPANTS / SETTING** Sample & Setting	**METHODS / DESIGN** Study Design & Interventions	**RESULTS / LIMITATIONS / RECOMMENDATIONS**
Dempsey, K., Butler, S.K., & Gaither, L. (2016). Black Churches and Mental Health Professionals. *Journal of Black Studies*, 47, 73 - 87. 10.1177/0021934715613588.	This article explores how clergy of Black churches and leaders in mental health agencies may collaborate to provide culturally sensitive services for African Americans.	Forty-one pastors of black churches.	Semi-structured interviews to explore mental health needs.	African Americans are more likely to rely on the elders of their churches and their own spiritual beliefs, rather than seek support from mental health professionals. Due to past and present experiences with institutionalized racism in America.
Galiatsatos, P., & Hale, W. (2016). Promoting Health and Wellness in Congregations Through Lay Health Educators: A Case Study of Two Churches. *Journal of Religion & Health*, *55*(1), 288–295. https://doi-org.libproxy.siue.edu/10.1007/s10943-015-0069-7	Evaluate the impact of trained lay health com-munity congregation members in two faith communities Establishing trust with the community, the training of lay health educators, and the implementation strategies and outcomes of health initiatives for those communities.	Urban setting. African-American Methodist church and in a Latino Spanish-speaking Catholic church.	Prospective observational report involving two churches.	The Lay Health Educator Program impact the medical community. Further studies should address the long-term role of lay health educators, religious organizations, and their impact on the overall health of a community.
Hankerson, S. H., & Weissman, M. M. (2012). Church-based health programs for mental disorders among African Americans: a review. *Psychiatric services (Washington, D.C.)*, *63*(3), 243–249. doi:10.1176/appi.ps.201100216	Explore studies involving church-based health promotion programs for mental disorders among African Americans to assess the feasibility of utilizing such programs to address racial disparities in mental health care. African Americans, com-pared with white Americans, under-utilize traditional mental health services.	Of 1,451 studies identified, only eight met inclusion criteria.	Systematic review A literature review of MEDLINE, PsycINFO, CINAHL, and ATLA Religion databases was conducted to identify articles published be-tween January 1, 1980, and December 31, 2009.	Church-based health promotion programs have been successful in addressing racial disparities for several chronic medical conditions, the literature on such programs for mental disorders is extremely limited.
Hadlaczky, G., Hökby, S., Mkrtchian, A., Carli, V., & Wasserman, D. (2014). Mental Health First Aid is an effective public health intervention for improving knowledge, attitudes, and behaviour: A meta-analysis. *International Review of Psychiatry*, *26*(4), 467–475. https://doi.org/10.3109/09540261.2014.924910	The aim of this study is to explore the effects of a MHFA program.	599 papers were identified, 45 met the inclusion criteria on the first round.	Meta-analysis conducted in PubMed, PsycINFO, Cochrane Library, and Google Scholar were searched for peer-reviewed articles related to MHFA interventions carried out at any point before March 2014.	MHFA increases mental health literacy of the general population.
Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a Fundamental Cause of Population Health Inequalities. American Journal of Public Health, 103(5), 813–821. https://doi-org.libproxy.siue.edu/10.2105/AJPH.2012.301069	This study explored the evidence on the health consequences of stigma and present a conceptual framework describing the psychological and structural pathways through which stigma influences health.	Data Sets for Examining the Role of Stigma in Population Health.	Review of the literature on Stigma.	Stigma (1) influences physical and mental health outcomes (2) disrupts access to resource (3) enables the creation of new mechanisms that ensure the reproduction of health inequalities among diverse populations.

CITATION	**PURPOSE / BACKGROUND**	**PARTICIPANTS / SETTING** Sample & Setting	**METHODS / DESIGN** Study Design & Interventions	**RESULTS / LIMITATIONS / RECOMMENDATIONS**
Haynes, T. F., Cheney, A. M., Sullivan, J. G., Bryant, K., Curran, G. M., Olson, M., … Reaves, C. (2017). Addressing Mental Health Needs: Perspectives of African Americans Living in the Rural South. *Psychiatric Services*, *68*(6), 573–578. https://doi-org.libproxy.siue.edu/10.1176/appi.ps.201600208	Study aimed to understand mental health, mental health treatment, and barriers to treatment from the perspective of rural African-American residents and other stakeholders in order to devise culturally acceptable treatment approaches.	50 participants, Study was conducted in Jefferson County, located in the Arkansas Delta. African Americans living in the Arkansas Delta experience negative health outcomes and marked health disparities.	Snowball recruitment technique A semi-structured interview.	Stressful living environments, religious beliefs, and stigma impact perceptions of mental health and contributed to barriers to help seeking. Community strategies are needed to improve emotional wellness in rural African-American communities, and social support, mental health literacy, and promoting emotional wellness.
Leavey G, Loewenthal K, & King M. (2007). Challenges to sanctuary: the clergy as a resource for mental health care in the community. *Social Science & Medicine*, *65*(3), 548–559. Retrieved from http://search.ebscohost.com.libproxy.siue.edu/login.aspx?direct=true&db=rzh&AN=106019465&site=ehost-live&scope=site	This study examined barriers and dilemmas for clergy in caring for people with mental illness. Clergy across the faith spectrum provide support and comfort to people at times of crisis or loss; bereavement and separation and counselling for emotionally or 'spiritually 'distressed people.	Purposive sampling or theoretical strategy sample that contained 19 Christian ministers, six rabbis and seven imams.	Qualitative study Intervention strategy Thirty-two interviews were completed.	Clergy play and important role in FBO's but often confused role in the care of people with mental health problems. This may go unrecognized in organizations that train clergy in mental illness. More research is needed on the mental health training needs, explanatory models and type of pastoral care that clergy are able and willing to give. More research on how trainers should engage clergy from different faith communities and accommodate spiritual conceptualizations of illness.
Mantovani, N., Pizzolati, M., & Gillard, S. (2017). Engaging communities to improve mental health in African and African Caribbean groups: a qualitative study evaluating the role of community well-being champions. *Health & Social Care In The Community*	This study examines the impact of the relationship between the intervention (education) and the community through the participants' engagement in the outreach project Community well-being champions were instrumental in bringing people together and initiating community change while contributing to social capital. They helped to form and strengthen existing social networks within communities.	13 participants (seven men and six women). The age ranged from 24 to 75 years (mean age 49). Recruited from African and African Caribbean communities (seven male and six female).	A qualitative stud, Semi-structured, one-to-one interviews were carried out with 13 community and well-being champions (CWBC) taking place over 15 months. with CMHC Intervention was education.	Limitations, budget and time. longitudinal effects, engagement strategies within this population could not be measured. CWBC's lacked the skills to speak with recipients about sensitive issues which evaluating CWBC's as healthy change agents was hindered The study suggests that further research is needed that adopts measures and designs that capture the transformative changes within community engagement.
Mathews AK, Corrigan PW, Smith BM, & Aranda F. (2006). A qualitative exploration of African-Americans' attitudes toward mental illness and mental illness treatment seeking. *Rehabilitation Education*, *20*(4), 253–268. Retrieved from http://search.ebscohost.	Outcomes measured, cultural factors, social norms, mental illness stigma, attitudes and behaviors.	70 African Americans from low-income community.	Qualitative study, focus groups	Understanding cultural variations in attitudes, behaviors about mental illness can guide interventions to decrease stigma.

CITATION	PURPOSE / BACKGROUND	PARTICIPANTS / SETTING Sample & Setting	METHODS / DESIGN Study Design & Interventions	RESULTS / LIMITATIONS / RECOMMENDATIONS
Morawska, A., Fletcher, R., Pope, S., Heathwood, E., Anderson, E., & Mcauliffe, C. (2013). Evaluation of mental health first aid training in a diverse community setting. *International Journal of Mental Health Nursing*, *22*(1), 85–92. https://doi.org/10.1111/j.1447-0349.2012.00844.x	The aim of the study was to examine the effectiveness of MHFA for a workforce involved with culturally-diverse populations. Attitudes, and opinions regarding a depression and schizophrenia vignette, the Kessler Psychological Distress (K-10) Scale, and the Personal and Perceived Stigma Scale, was given to all participants to complete at the beginning and end of the course.	A total of 458 participants were trained in MHFA.	An evaluation questionnaire, A structured follow-up interview was conducted 6 months after the participants had completed the program.	Study indicate that MHFA training is an important program for individuals working with diverse populations and would benefit workers to take the course.
National Alliance on Mental Health. (2019). African American mental Health Retrieved from https://www.nami.org/find-support/diverse-communities/african-americans	Resources and material for mental health			
Stewart, J. (2014). Pastor and Lay Leader Perceptions of Barriers and Supports to HIV Ministry Maintenance in an African American Church. *Journal of Religion & Health*, *53*(2), 317–325. https://doi-org.libproxy.siue.edu/10.1007/s10943-012-9627-4	The purpose of this study is to examine the role, barriers and supports clergy and lay leaders experienced in the development of a long-standing HIV ministry in an African American church. Clergy and lay leaders have a pivotal role in the development and maintenance of HIV Ministries within the African American church.	The sample consisted of 5 clergy and lay leaders of the HIV Ministry. Participants were clergy and lay leaders from a church located in a Midwest urban com-munity. This particular church was selected because it had a HIV ministry that had been inexistence for nearly 20 years.	Semi-structured interview guide developed by the author. Interview consisted of open-ended questions The interviews lasted approximately 30 min to 2 hours.	little is known about the roles, barriers that the champions face and the supports they have found in the development and maintenance of an HIV Ministry. Few studies have examined the role of clergy and lay leaders in the development and maintenance of existing HIV Ministries, the barriers they faced or the supports that made the ministry possible. This information could prove to be invaluable in developing a framework with which to better understand this process.
Taylor RJ, Ellison CG, Chatters LM, Levin JS, & Lincoln KD. (2000). Mental health services in faith communities: the role of clergy in Black churches. *Social Work*, *45*(1), 73–87. https://doi-org.libproxy.siue.edu/sw/45.1.73	To examine the research, highlighting available information with regard to the process by which mental health needs are identified and addressed by faith communities.	635 AA congregations surveyed.	Descriptive study consisting of surveys Descriptive Review of the literature on mental health services delivered in black churches.	Limitations of research supports that programs are not being evaluated and if clergy are knowledgeable of the resources to give referrals.

CITATION	**PURPOSE / BACKGROUND**	**PARTICIPANTS / SETTING** Sample & Setting	**METHODS / DESIGN** Study Design & Interventions	**RESULTS / LIMITATIONS / RECOMMENDATIONS**
Williams, L., Gorman, R., & Hankerson, S. (2014). Implementing a mental health ministry committee in faith-based organizations: the promoting emotional wellness and spirituality program. Social work in health care, 53(4), 414–434. doi:10.1080/00981389.2014.880391	Program goals are to educate clergy, reduce stigma, and promote treatment seeking for depression. Key lessons learned are to initially form partnerships with church staff if there is not a pre-existing relationship with the lead pastor.	400 participants attended the two PEWS Conferences. Promoting Emotional Wellness and Spirituality (PEWS) Program with funding from a pilot grant from the State of New Jersey's Department of Mental Health Services.	Empirical research The PEWS Program offers a four-day, 10-hour training curriculum for churches. The training program consists of 1) a pre-test 2) video vignettes, 3) an overview of signs, symptoms, and treatment options for depression and other common mental disorders; 4) an introduction to effective communication techniques; 5) basic crisis intervention skills; 6) technical assistance to link congregants to higher levels of care; and 7) a post-test to assess participants' retention of the training material.	Lack of quantitative data from either the pre- and post-test assessments or the conference evaluations. Lacked ability to measure the effects of the PEWS Program training on participant knowledge of mental disorders, treatment seeking for depression, and referrals from clergy to mental health professionals. Future studies should evaluate how implementation varies in different geographic regions of the country.
Woodall, J., White, J., & South, J. (2013). Improving health and well-being through community health champions: a thematic evaluation of a program *Perspectives in Public Health*, https://doi.org/10.1177/1757913912453669	Examined the role of lay workers (referred to as 'community health champions') involved in community projects delivered by Altogether Better across Yorkshire and Humber. The aim of the paper is to describe key features of the community health champion approach and to examine the evidence that this type of intervention can have an impact on health.	30 champions, inter-views were conducted face to face, using a semi-structured interview schedule designed to address the aims and objectives of the evaluation. A form of snowball sampling (or chain sampling).	A qualitative approach evaluation of interviews conducted with seven different projects to gather the views of community health champions with Interviews with project staff and partners and within Participatory workshops to gather the views of champions. Data collection was conducted over a three-month period.	Engaging lay people in health needs to be more common, limited information on how this program effects mental health and FBO's .

Appendix B

Wellness Champions Recruitment letter

Dear Wellness Champion,

I hope this letter finds you well. My name is Tracy Cooley, I am a registered nurse and currently completing my capstone project in my Doctorate of Nursing Practice (DNP) program at the University of Missouri- St. Louis. My project entitled, Utilizing Wellness Champions as a Faith-Based Initiative for Mental Health Promotion, is currently seeking participants, to evaluate the effectiveness of the training for this mental health ministry program. I am seeking participants that have been trained as wellness champions in the Bridges to Care and Recovery since 2015. Participation in the study will include filling out a 20-question survey. Individuals who complete the survey will be asked if they are interested in participating in a 1 on 1 interview with the researcher discussing your role as a wellness champion. Approximately twenty individuals who volunteer will be randomly selected for an interview. The interview will last 30 minutes to an hour. Participation in the interview will provide participants the opportunity to discuss your experience as a wellness champion in your church and ways to improve the current training program. Participation in the study in general will contribute to understanding the education of wellness champions in the faith-based communities involved in mental-health wellness programs to decrease barriers that hinder African Americans from seeking mental health services. Participation will be completely confidential. There will be no attachment to participant names or congregation affiliation. The survey will be confidential. Please consider participating in this study. If you have any questions or would like more information please email me at tmcooley3@yahoo.com or you can contact Rose Jackson-Beavers from the Bridges to Care and Recovery Program @ rbeavers@bhnstl.org.

Thank you for your time and assistance.

Tracy M. Cooley MSN, RN

Appendix C

Mental Health Ministry Program Evaluation Survey

Thank you so much for agreeing to participate in this study. These questions should take no more than 15 - 30 minutes to complete. The primary purpose of this study is to gain a better understanding of your role as a wellness champion within your organization. Please be as honest as possible, knowing that your opinions are very important and will be kept strictly confidential.

1) What is your gender?

□ Male □ Female

2) What is your primary ethnic or racial heritage? (choose one)

□ Asian □ Black/African American □ Hispanic □ Native American

□ White/Caucasian □ Multi-racial □ Other □ No answer

3) How old are you?

□ 18 – 29 yrs □ 30 – 49 yrs □ 50 – 64 yrs □ 65 – 80 yrs

4) What level of education have you completed?

□ Some high school □ High School diploma or GED □ Some college □ Associate's degree

□ BA, BS □ MA, MS □ MDiv

□ PhD, MD, JD □ None □ Other _____

5) What is your religious denomination? (e.g. Baptist, Non -denominational, A.M.E., Church of God, etc.)

_____

6) How many years have you been a member at your church?

□ less than 5 yrs □ 5 – 10 yrs □ 11 – 20 yrs □ 21 – 30 yrs

7) What year did you complete the wellness champion training?

□ 2015 □ 2016 □ 2017 □ 2018 □ 2019

8) Have you made a referral to a community connector since you have been a wellness champion?

□ Yes □ No

If yes, who did you make your referral to?

□ Community Mental Health Clinic □ Primary Care (Behavioral Health)

□ Mental Health (Counseling) □ Spiritual Care

□ Substance Use □ Peer Support Groups

□ Domestic Violence/IPV □ Other-
_____

9) What is your role in your congregation besides being a wellness champion?

□ Pastor

□ Clergy

□ Congregant

□ Other (please specify): _____

10) Does your congregation have other health ministries? □ Yes □ No

If so, what? _____

11) Have you helped establish a Behavioral Health Ministry or event? □ Yes □ No

If so, what? _____

Directions: Mark the choice for each question that best describes your feelings since you have been trained as a wellness champion:

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
The mental health training has prepared me to be confident in my role as a wellness champion					
The mental health training has changed my attitude or beliefs about mental illness					
The mental health training has helped me identify stigma and shame associated with mental illness					
The mental health training helps me identify if congregates are experiencing mental health challenges					
I believe that the overall training provided was sufficient to prepare me for my role as a wellness champion.					
I believe that pastors and congregates trained on mental Illness will increase the number of congregates seeking help for their mental problems					

The mental health training has changed my view or perception that mental health problems are due to a lack of trust in God and a lack of a strong faith					
The mental health training helps me identify congregates who are addicted to substances					
The mental health training has changed how mental illness is discussed over the pulpit					

If you would be willing to participate in a Face-to Face interview to further discuss your role as a wellness champion please complete the attached sheet?

Thank you for your assistance in completing this survey. Any information that you provide will be kept strictly confidential. All data will be analyzed and reported as group data.

Mental Health Ministry Program Evaluation Study

Are you willing to participate in a Face-to-Face interview to further discuss your education and role as a wellness champion?

□ Yes □ No

If yes please provide your contact information:

_____

What year did you complete training? _____

I have read (or have been read) the recruitment letter regarding this project conducted by Tracy Cooley. I am interested in participating in a 1 on 1 interview session with the researcher.

. _____ (Printed Name)

_____ (Signature)

_____ Contact # or Email

Best time to contact you: Days_____ Evenings_____

Appendix D

Mental Health Ministry Program Evaluation Study

I have read (or have been read) the recruitment letter regarding this project conducted by Tracy Cooley. I am interested in participating in a 1 on 1 interview session with the researcher.

. _____ (Printed Name)

_____ (Signature)

_____ Contact # or Email

Best time to contact you: Days_____ Evenings_____

Appendix E

Interview questions:

1. How has the training you received helped you feel comfortable exploring the causes of congregates mental problems such as depression?

2. How has the training you received helped you identify barriers that may hinder congregates from seeking mental health services or seeking social support from you as a wellness champion?

3. How do you think that the training has changed the way Pastors or clergy talk about mental illness across the pulpit? What changes have you noticed?

4. How does your faith affect your role in helping congregates ability to deal with their mental health issues?

5. What additional types of training or resources do you believe would be helpful to increasing your capacity as a wellness champion or to improve the program?

6. What was your experience providing a behavioral health referral to any of the congregants?

7. Tell me a story about what your experience has been as a wellness champion.