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Breaking Cultural Stigma Associated with Mental Health Among Black Immigrants

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Abstract

Problem: Immigrants are the fastest growing segment of the United States population with 10% identifying as black and are widely affected by mental illness, especially during the immigration process. The lack of health insurance impacts access to health and mental health care. The study aims to decrease perceptions of mental health stigma in the black immigrant population after an educational program.

Methods: The project used a descriptive, observational pre-post-test design with an educational program. It collected quantitative data in the pre-post-survey via paper and pencil, and used coded data to maintain participant anonymity.

Results: The study used the Community Attitudes toward Mental Illness (CAMI) self-reported scale to measure participants' attitudes towards mental illness. The results showed a statistically significant decrease in mental health stigma across three of the four subscales after the educational program. There was a statistically significant mean increase for the Authoritarian, Benevolence, and Community Mental Health Ideology Sub-Scale scores with an increase of 5.81 points, $t(15) = 4.169$, $p < .001$, 3.25 points, $t(15) = 1.910$, $p = .038$, and 3.94 points, $t(15) = 2.753$, $p = .007$, respectively. No statistically significant increase in the mean for the Social Restrictiveness Sub-Scale was found with an increase of 0.313 points, $t(15) = 0.180$, $p = .430$.

Implications for Practice: An educational program is an effective way to reduce stigma surrounding mental illness and should be implemented with the black immigrant population in the U.S. to improve mental health outcomes.

Breaking Cultural Stigma Associated with Mental Health Among Black Immigrants

Immigrants are the fastest growing segment of the United States (U.S.) population. However, the population is widely affected by mental illness, especially depression and especially during the immigration process (Ikonte et al., 2020). The risk of severe psychological distress (SPD) significantly impacts their health and well-being and increases the risk of depression (Ikonte et al., 2020).

Black immigrants are one of the fastest growing segments of the population in the past decades with 10% of all immigrants identifying as black. For example, Nigerian born immigrants increased between 2010 and 2019 by 79% (Esterline & Batalova, 2022; Pederson et al., 2022). One-in-ten black people in the U.S. are immigrants (Tamir & Anderson, 2022). According to the 2021 Census results, St. Louis City had a population of 293,310 people of whom, 6.9% were foreign born individuals or approximately 20,238 immigrants in this medium sized Midwestern city (United States Census Bureau, n.d.)

Immigrants in the U.S. also experience significant health disparities. About 58% of immigrants in the U.S. in 2019 had private health insurance, 30% had public health insurance, and 20% lacked health insurance (Esterline & Batalova, 2022). This is in comparison to their U.S. born counterparts of whom 69% had private health insurance in 2019, 36% had public health insurance and only 8% lacked health insurance entirely (Esterline & Batalova, 2022). Based on census data in 2019, this equates to approximately 8.98 million immigrants in the U.S. who do not have health insurance, and

this lack of health insurance greatly impacts access to health care including access to mental health care.

Mental Health

Immigrant mental health and well-being are often overlooked by the healthcare system (Pederson et al., 2021). The status of being immigrants causes them to experience significant barriers such as financial strain, racism, discrimination, stigma, language barriers, lack of information, and feeling isolated (Tulli et al., 2020). Cultural stigma and discrimination are major issues for mental health patients and families. Stigma entails an attitude and belief towards someone, viewing them in a negative way because they have distinguishing characteristics (Tulli et al., 2020). The immigrant population frequently experiences stigma, a social process negatively impacting access to mental health and access to care and services (Douglass et al., 2022). The stigma of mental illness results in unmet needs for the immigrant population negatively impacting their mental wellbeing and overall wellness. The underutilization of mental health services in the U.S. by this population remains one of the most troubling and persistent health disparities, especially for depression in minority groups such as immigrants (Douglass et al., 2022).

Mental Health Factors for Immigrants

The immigration process, consisting of the migration process and the after-events such as settling into the new nation, can negatively impact the immigrant's mental health and well-being. For example, immigration-related stressors can increase suicidal ideation and risk because of the distress associated with cultural stress (Rodriguez et al., 2021). Additionally, immigrants and minority individuals experience significant stigmatization caused by underlying drivers, such as institutions, citizenship status, and ethnicity, which

are crucial factors to mental health (Douglass et al., 2022). Bamgbose et al. (2022) acknowledged that the intersection of factors, such as race, gender, and migration, plays a significant role in female immigrants experiencing disparities such as those regarding mental health and associated disorders.

Understanding the different perspectives of the immigrant population on mental health and wellness concerns and associated stigma is integral to implementing evidence-based approaches to promote positive mental health outcomes. Mental health and wellness amongst the immigrant population must be addressed. Rodriguez et al. (2021) highlight that most immigrants in the U.S. have no access to mental health services compared to the non-immigrant population.

The purpose of this project was to educate black immigrants and improve knowledge pertaining to mental health and associated stigma in the black immigrant population. The aim of this project was to decrease perceptions of mental health stigma by 5% in the black immigrant population ages 20 to 65 years old being provided services at a Midwestern, urban community organization after a mental health educational training with clients over the course of one month. The primary outcome measure was the level of mental health stigma as assessed using the Community Attitudes toward Mental Illness (CAMI) scale. The study question for this project was: In black immigrants aged 20-65 years old being served by an urban, Midwestern community organization, what is the change (if any) in the level of mental health stigma after an educational program?

Literature Review

A literature search was conducted using CINAHL, PubMed, and EBSCO databases. The keywords utilized for the search included *immigrant population*, *standardized screening, mental health education*, *stigma*, *access to mental care*, *mental health education*, and *mental health awareness* with Boolean search operators AND and OR. A search in each of these databases yielded more than 1,450 publications. Inclusion criteria included articles published between 2017 to 2022, in English language, were peer-reviewed and scholarly, and included immigrants 20 years and older. Exclusion criteria included articles published before 2017, immigrants under the age of 20, and nonimmigrants. After reviewing the articles, 14 publications were retained for use in this literature review.

Mental Health and Immigration Process

Access to mental health services is critical as a proactive approach to strengthening an individual's mental, social, emotional, and psychological needs. Despite the resiliency of immigrants, they are not immune to the impact of mental illnesses as they are at higher risks of depression and other illnesses due to the difficulties of the migration process. The migration process includes myriad stressors, such as limited support and lack of access to care. A qualitative study by Rousseau and Frounfelker (2019) pointed out some of the mentioned barriers that need addressing, which included language and cultural barriers and the issues related to the larger social environment affecting an individual's psychosocial functioning Additionally, health care providers must be sensitive to cultural factors and beliefs when diagnosing and providing mental healthcare services to the immigrant population. Providers should aim to integrate best

practices such as screening migrants and providing services for suspected mental illnesses while remaining sensitive to their psychosocial conditions. Similarly, a quantitative study by Ikonte et al. (2020) looked at the trends in the prevalence of depression and psychosocial distress in the U.S. immigrant compared with the non-immigrant population. It was identified that mental illnesses are highly prevalent in the U.S. immigrant population, impacting approximately 18% of U.S. immigrants.

Moreover, several factors in the migration process significantly impact health outcomes. When compared to natives, immigrants who are beginning the immigration process recorded a lower prevalence of depression. However, over time after immigrating, this population are more likely to develop serious psychological distress and rates of depression surpasses those of natives (Ikonte et al., 2020). Healthcare providers addressing mental health and related services should consider the underlying mental health conditions and their impact on the long-term health and well-being of the immigrant population. Furthermore, evidence supports establishing a community-based mental health services program and supports increasing the availability of resources to support such programs and best practices (Ikonte et al., 2020).

Factors Affecting Mental Health

Factors such as gender, race, and immigrant statuses negatively impact the determinants of health, and specifically black female immigrants experience significant mental health disparities. Results from a quantitative study by Pederson et al. (2021) revealed several important themes that included confidentiality, spirituality and religion as a support system, migration, acculturative influence as a source of emotional distress, the management of mental illness, and addressing stigma. Penderson et al. (2022)

indicated that cultural and religious beliefs underpin the concept of mental illness and the associated stigma among immigrant populations. The authors note that cultural beliefs and the biopsychosocial models can coexist positively and influence mental healthcare positively. Mental health programs should integrate factors, such as stigma, acculturation, and spirituality to effectively address the mental healthcare needs of black immigrant women. This study sheds light on the factors that can help mental healthcare providers understand mental health stigma in the studied population, which includes cultural and religious factors. The study informs the need to build stigma-oriented interventions that reduce mental health stigma amongst the immigrant and marginalized populations in the U.S. (Pederson et al., 2021).

A qualitative study by Tulli et al. (2020) evaluated immigrant mothers' perspectives regarding the barriers and facilitators in accessing mental healthcare for their children. Barriers to mental health care for immigrants include lack of information, language barriers, racism, discrimination, feeling unheard by the services providers, isolation, and financial strain (Tulli et al., 2020). The highlighted facilitators to obtain services include personal and educational levels, schools offering services, and the availability of free services. Healthcare providers could improve access to mental health services for immigrants and refugees by addressing issues related to racism in the health system. They can achieve that by creating awareness concerning mental health and providing trained interpreters to help bridge the communication gap (Tulli et al., 2020). Language barriers make immigrants feel isolated, anti-social, and hopeless leading to depression. Struggling with comprehension makes it hard for them to seek help, especially with mental health-related issues.

Stigma is widely associated with depression in the immigrant population. A qualitative study by Douglass et al. (2022) explored the stigma associated with mental health conditions, alcohol, and other drug use amongst individuals from migrant and ethnic minority populations. The authors recognize stigma as a social process that affects individuals' access to mental health support and care. Moreso, the authors recognize that other factors are enablers and further intersect with the stigmatization process in this population, including ethnicity, citizenship status, and gender. The comprehensive review provided an understanding of mental health conditions, associated stigma, and related interventions (Douglass et al., 2022). The framework for health stigma and discrimination from this study as well as other conclusions can guide culturally sensitive initiatives meant to lessen stigmatization's detrimental effects. A quantitative study by Livingston et al. (2018) examines the stigma associated with mental illnesses targeting a population of Asian men in Vancouver, Canada. The authors mention factors such as racism, acculturation pressures, patriarchal social relations, and xenophobic nationalism (Livingston et al.,2018). Mental illness in the immigrant and minority populations continues to be met with stigma.

Mental Health Stigma Assessment Tools

The Community Attitudes toward Mental Illness (CAMI) self-reported scale created by Taylor, Dear and Hall (1979) and Taylor and Dear (1981) is a validated tool to assess level of stigma in a population. The tool is derived from the Opinions About Mental Illness (OMI) scale developed in the early 1960's by Cohen and Struening (1962) and Struening and Cohen (1963) as its conceptual basis. The tool addresses the issue of deinstitutionalization and community-centered treatment. The scale boasts of its

reliability and construct validity. The level of validity is α = 0.87 while the level of

reliability for every element includes Authoritarianism, r = 0.68; Benevolence, r = 0.76;

Social restrictiveness, r = 0.80; and Community Mental Health Ideology, r = 0.88 (Yang

& Link, 2015). The significant strength of the CAMI is its development of attitudes

towards community mental health treatment facilities representing new development in

the caring of individual with mental illness (Yang & Link, 2015). Unfortunately, most

stigma screening tools were either developed in the Western countries or were derived

from Western tools and, as of yet, there are no tools specific to the immigrant population

or that have been studied specifically with this population.

Education

Mental health literacy education positively impacts mental health attitudes and the

need to access mental health services. A qualitative study by Fernández-Gutiérrez et al.

(2018) emphasized health literacy interventions for the immigrant populations. The

authors note that health literacy is a significant social health determinant that influences

improvement in health, empowers patients, and reduces inequalities. Vulnerable groups,

such as immigrants, lack health literacy programs, and healthcare providers lack

familiarity with the important concepts for such initiatives. A literature review identified

few results on the availability of specific health literacy programs for immigrants

(Fernández-Gutiérrez et al., 2018). However, a positive change is associated with health

literacy amongst the group, especially in functional health literacy, which facilitates a

critical analysis of information and arriving at informed decisions. Different strategies

exist to improve health literacy. In a recent qualitative study by Baumeister et al. (2019),

the authors look at interventions for improving health literacy. Some suggested initiatives

include group-based education programs on mental health and wellness, telephone interventions to improve patients' engagement, telemedicine in rural environments, and teach-back training (Baumeister et al., 2019).

Gaps in the Literature

Despite reviewing the existing literature addressing the relationship between stigma and mental health among immigrants, numerous gaps exist. Evidence about stigma and mental health issues in urban Midwestern communities is missing. Additionally, there is not enough research outlining the short-and-long term changes in the level or perception of mental health stigma after the implementation of an educational program, specifically in an immigrant population. Additionally, the lack of appropriate stigma assessment tool specific to immigrants or non-western cultures is a noted gap. Lastly, there is minimal research on stigma and mental illnesses focusing on West African immigrants.

Framework

The selected framework to guide this project was the Johns Hopkins Nursing Evidence Based Practice Model. The model guided research from the problem-solving approach using the three-step process of practice question, evidence, and translation (PET) (Johns Hopkins University, 2020). It facilitated access to the latest research findings and evidence-based practices on immigrant, stigma and mental health using the PET process. The framework formulated the research questions, searched for evidence, and appropriately integrated them into patient care. This project completed the first step of this framework by identifying clear practice questions. Additionally, the second step of this framework was completed through the literature review process. The last step of this

model translated the evidence identified in the literature review into practice through the implementation of an educational program about mental illness, stigma and depression with an immigrant population being served by a community organization in a medium sized, Midwestern city. This implementation was evaluated for efficacy.

Methodology

Design

This project used a descriptive, observational pre- post-test design with an educational program. Quantitative data was collected in the pre- post-survey via paper using coded data to maintain participant anonymity.

Setting

The project took place in a non-profit religious organization serving predominately immigrants located in an urban, Midwestern area. The organization serves approximately 50 members and is part of a larger religious organization that provides support and religious practice for immigrants living in the community. The organization consists of pastors, religious leaders, and the congregation.

Sample

The project used convenience sampling technique to identify participants who have immigration status including legal, illegal, or asylum seekers without permanent residency being served in this community organization. The inclusion criteria for the sample included participants identified as non-permanent residents, immigrant status, aged 20-65 years old, living in this urban, Midwestern community and served at this community organization. The exclusion criteria included people younger than 20 years old or older than 65 years, U.S.-born, with permanent residency, living outside of this

urban, Midwestern community and not served by this community organization. The goal was to obtain sample sizes of approximately 15-30 participants.

Approvals

Formal, written approval was obtained from the participating non-profit organization on September 22, 2022, and was signed by the senior pastor stating the church did not have an Institutional Review Board (IRB). The project was also approved as an exempt study by the University of Missouri- St. Louis (UMSL) IRB prior to implementation.

Procedures and Intervention

The Primary Investigator (PI) met with organizational stakeholders to develop the project and obtain approval. The project first identified immigrants from the congregants using a convenience sampling approach. Participants were asked to complete a pre-survey of the form of the CAMI tool (see Appendix A) with several demographic questions added. Each survey had a unique identifier created by participants by naming their favorite color and favorite number. Participants then participated in a live synchronous educational program about mental illness developed from evidence-best practice information and provided by the PI. Additionally, participants were provided with resource information to access local mental health services. One month after the educational intervention, participants were asked to complete the post-test, again using their same unique participant identifier so pre- and post-tests could be paired. Data was collected and analyzed, and the results disseminated to key stakeholders with recommendations for future practice.

Data Collection

The primary data collection tool was a pre- and post-survey. Participants that met the inclusion criteria took the pre-survey on mental health using the CAMI assessment tool (see appendix A) as well as demographic questions. Participants attended a mental health educational program, and one month later, a post-survey was administered to again assess stigma.

The CAMI is a self-report scale designed to measure the negative and positive attitudes toward mental illness and mentally ill patients. The scale includes 40 items with the following four dimensions:

1. Authoritarianism: corresponds to a view of the mentally ill person as someone Inferior who requires coercive handling.

2. Benevolence: refers to a paternalistic and sympathetic view of the mentally ill

3. Social Restrictiveness: concerns the belief that the mentally ill are a threat to society and should be avoided.

4. Community Mental Health Ideology: refers to the acceptance of mental health services and mentally ill patients in the community.

Each dimension has ten questions: five positives and five negatives. Each question is scored using a Likert scale where response categories range from 1 (strongly disagree) to 5 (strongly agree). (Browne, 2010, p. 21).

Statistical Analysis

Descriptive statistics were used to analyze the demographic data collected. The data were analyzed using IBM SPSS Statistics Version 28. Additionally, a paired *t*-test was used to identify any statistically significant differences between the mean scores of the pre- and post-surveys.

Results

Descriptive Statistics

A total of 16 participants engaged in this project, and surveys were collected from the identified participants who predominantly identified as female ($n = 9$, 56%) with only seven male participants (44%) (see Figure 1). The participants varied in age from 20-65 (see Figure 2). The participants came from different African countries including Nigeria ($n = 10$), Kenya ($n = 2$), Ghana ($n = 3$), and Congo ($n = 1$) (see Figure 3). The participants had different insurance status which included the insured ($n = 6$) and the uninsured ($n = 10$) (see Figure 4). The study used the Community Attitudes toward Mental Illness (CAMI) self-reported scale to measure the attitudes of the participants towards mental illness (see Figure 5). A detailed reporting of the mean scores for both the pre- and post-tests for each CAMI subscale score is found below.

Inferential Statistics

Paired *t*-tests were utilized in the analysis to compare the studied variables, and all assumptions for the paired *t*-test were met by using appropriate statistical tests and measures (see Table 1). Assumption one was met as the data was found to be normally distributed, and assumption two was met as variances between groups was found to be equal. While assessing for assumption three, four outliers were detected that were more than 1.5 box-lengths from the edge of the box in a box plot. Inspection of their values

revealed one of these to be extreme outliers while the other three were not and those three were kept in the analysis. While assessing for normality of distribution to ensure assumption four was met, the difference scores for the pre-Authoritarian and post-Authoritarian subscales were normally distributed, as assessed by Shapiro-Wilk's test (p = .77); the difference scores for the pre-Benevolence and post-Benevolence subscales were normally distributed, as assessed by Shapiro-Wilk's test (p = .572); the difference scores for the pre-Social Restrictiveness and post-Social Restrictiveness subscales were normally distributed, as assessed by Shapiro-Wilk's test (p = .095); the difference scores for the pre-Community Mental Health Ideology and post-Community Mental Health Ideology subscales were normally distributed, as assessed by Shapiro-Wilk's test (p = .423) (see Table 1). Having met all assumptions for the paired samples t-test, this data set was found to be appropriate for this statistical analysis.

When the surveys were completed, two adjustments were made to simplify the process of data analysis. The Cami had both positive and negative questions, and the negative questions were reverse coded so that an accurate mean could be found. All negative questions were reverse coded, and the means were calculated independently for each subscale.

Authoritarian Subscale

After the educational program, participants' negative perspective that people with mental illness are inferior to those without mental illness decreased from M = 29.94 (SD = 4.19) to M = 24.13 (SD = 4.46) (see Figure 3). The educational program elicited a statistically significant decrease in the mean for the Authoritarian Sub-Scale score with a

decrease of 5.81 points, a 19.41% decrease in negative perspectives about the mentally

ill, $t(15) = 4.169$, $p < .001$, 95% CI [2.84, 8.78]. This analysis showed a large effect size,

Cohen's $d = 1.042$. The statistically significant mean decrease between pre- and post-

scores indicates that post educational training, participants' perception about individuals

with mental illness changed to increasingly believe that those with mental illness should

not be viewed as inferior and should not be handled with coerciveness.

Benevolence Subscale

Based on the result, the data showed that after the educational program,

participants' paternalistic and sympathetic view of mentally ill individuals decreased

from $M = 28.31$ ($SD = 3.68$) to $M = 25.06$ ($SD = 4.76$) (see Figure 3). The educational

program elicited a statistically significant decrease in the mean for the Benevolence Sub-

Scale score with a decrease of 3.25 points, a 11.48% decrease in paternalistic views of the

mentally ill, $t(15) = 1.910$, $p = .038$, 95% CI [- .377, 6.88]. This analysis showed a

medium effect size, Cohen's $d = 0.477$. The statistically significant mean decrease

between pre- and post-scores indicates that post educational training, participants' view

about individuals with mental illness reduced in perceptions of mental health stigma and

were somewhat sympathetic towards mentally ill individuals.

Social Restrictiveness Subscale

Results after the educational program shows that there were no significant

differences across the participants in terms of social restrictiveness that entails negative

belief that individuals with mental illness are a threat to society and should be avoided.

As can be seen from $M = 26.38$ ($SD = 5.16$) to $M = 26.06$ ($SD = 3.77$) (see Figure 3). The

educational program did not elicit a statistically significant decrease in the mean for the

Social Restrictiveness Subscale score with a small decrease of 0.313 points, a 1.19%

decrease in negative beliefs that the mentally ill are a threat to society and should be

avoided, $t(15) = 0.180$, $p = .430$, 95% CI [-3.39, 4.02]. This analysis showed a small

effect size, Cohen's $d = 0.45$. The were no statistically significant mean differences

between pre- and post-scores. This indicates that post educational training, participants'

perception about individuals with mental illness did not change the negative belief that

individuals with mental health ill are a threat to society and should be avoided.

Community Mental Health Ideology Subscale

The result after the educational program shows that there were statistically

significant differences among the participants in terms of the acceptance of mental health

services and mentally ill patients in the community. This subscale decreased from $M =$

27.38 ($SD = 3.79$) to $M = 23.44$ ($SD = 5.62$) (see Figure 3). The educational program

elicited a statistically significant decrease in the mean for the Community Mental Health

Ideology Subscale score with an decrease of 3.94 points, a 14.39% decrease in negative

social acceptance, $t(15) = 2.753$, $p = .007$, 95% CI [0.89, 6.99]. This analysis showed a

medium effect size, Cohen's $d = 0.688$. The statistically significant mean decrease

between pre- and post-scores indicates that post educational training, participants have a

greater sense of social acceptance of those with mental illness.

Discussion

The purpose of this study was to educate black immigrants about mental illness in

an effort to impact the associated stigma and aimed to decrease perceptions of mental

health stigma by 5% in the black immigrant population ages 20 to 65 years old being

provided services at a Midwestern, urban community organization after a mental health

educational training with clients over the course of four months. The primary outcome measure was the level of stigma. The findings showed a statistically significant decrease in mental health stigma across three of the four subscales after the educational program, with decreases of 19.41% for the Authoritarian Subscale, 11.48% for the Benevolence Subscale, and 14.39% for the Community Mental Health Ideology Subscale, which greatly exceeded the decrease in mental health stigma by the 5% goal of this project. These results provide valuable insights into the effectiveness of mental health education programs in improving the mental health outcomes of the black immigrant population in Midwestern communities.

The study revealed that after the educational program, there was a significant decrease in short term beliefs on the Authoritarian and the Benevolence Subscale scores, which suggests that participants' perception about individuals with mental illness changed to increasingly believe that those with mental illness should not be viewed as inferior and should not be handled with coerciveness. Additionally, the mental health educational program was able to elicit a statistically significant decrease in short term beliefs in the mean for the Community Mental Health Ideology Sub-Scale score suggesting that educational training about mental health and stigma can lead to a greater sense of social acceptance of those with mental illness among the black immigrant population.

Culturally Sensitive Programs

The study emphasizes the need to develop and implement culturally sensitive programs that address the unique challenges faced by the black immigrant population regarding mental health and stigma. The immigration process and the experiences of settling into a new country can have a negative impact on immigrants' mental health and

well-being. Understanding the perspectives of this population and their specific mental health concerns is crucial to design effective interventions.

The educational program led to significant changes in their attitudes and beliefs. These results indicate that culturally sensitive programs that address the unique experiences and challenges faced by the black immigrant population can effectively promote positive mental health outcomes and reduce stigma. By providing education and information tailored to the needs and cultural backgrounds of black immigrants, these programs can help to bridge the gap in mental health services and support for this population.

Limitations

One limitation to this project was the small sample size, which may limit the generalizability of the findings to other black immigrant populations. Another limitation is the use of self-reported data, which may be subject to social desirability bias. Additionally, the study was conducted in a non-profit religious organization, which may not be representative of all black immigrant communities. Furthermore, the study did not assess the long-term effects of the educational program on mental health stigma and retention of knowledge of mental illness. Finally, another limitation includes the lack of a standardized screening tool and assessment specific for this population and cultural-and-gender specific interventions to treat immigrants diagnosed with mental illness such as depression. Despite these limitations, the study provides valuable insights into the effectiveness of educational programs in breaking cultural stigma associated with mental health among black immigrants. In the black immigrant population, one significant health disparity is the underutilization of mental health services.

Strengths

One strength of this project was the use of a pre-post-test design, which allowed for the comparison of mental health stigma and knowledge of mental illness before and after the educational program. Another strength is the use of quantitative data collection methods, which allowed for the analysis of the data using appropriate statistical methods. The study was conducted in a non-profit religious organization, which provided a unique setting for the study and allowed for the inclusion of a hard-to-reach population. The study also contributes to the understanding of mental health issues among black immigrants and provides insights into effective strategies for addressing these issues.

Recommendations for Future Study

Based on the findings of this study, several recommendations can be made for future research in the area of mental health literacy and stigma reduction in the black immigrant population. Despite the prevalence of mental illness in this group, they lack the knowledge and resources to access treatment. Gaps in the studies include the lack of a standardized screening tool and assessment for the group and cultural-and-gender specific interventions to treat immigrants diagnosed with depression. As a result, future studies should focus on researching and improving mental health screening tools and educational care programs that put into context the gender, culture, sexual orientation, and ethnicity of the immigrant population.

Future studies should aim to measure the long-term effects of mental health education programs on the attitudes and behaviors of black immigrant populations towards mental health. While the study showed reductions in stigma, it is important to

understand the long-term effects of the educational program and if it translates into significant improvements in mental health outcomes.

Furthermore, future studies should explore the specific barriers and obstacles that black immigrants face when trying to access mental health services. This will enable the development of more effective and targeted interventions to address these barriers and improve access to mental health services for this population. Future studies should explore the impact of cultural factors such as religion, spirituality, and traditional healing practices on mental health literacy. By better understanding the role of cultural factors in mental health outcomes, interventions can be designed that are more effective in addressing mental health needs of this community.

Lastly, future research should focus on the use of technology to improve mental health outcomes for black immigrant populations. This could include the development of digital mental health tools in different languages that cater to the specific needs of this population. Additionally, social media campaigns and online support groups could be utilized to provide culturally specific mental health resources and support to black immigrants. By exploring the use of technology to improve mental health outcomes in this population, we can expand the reach of mental health interventions and promote further awareness on mental health stigma.

Implications for Practice

The findings of this project have significant implications for mental health practice in working with black immigrant populations. Mental health providers need to recognize the unique barriers to accessing mental health services that face this community and tailor their services to meet their specific needs. The study highlights the

potential of mental health education programs to improve mental health literacy and reduce stigma among black immigrants. Mental health professionals should consider incorporating these types of programs as part of their treatment plans when working with black immigrant populations. Additionally, mental health providers must recognize the influence of cultural factors on attitudes and behaviors towards mental health within this community. A culturally competent approach, which involves understanding and addressing cultural differences and biases, can be employed to ensure that mental health services align with the cultural values and beliefs of black immigrant clients. Ultimately, by providing effective and culturally appropriate mental health services, we can improve the overall mental health outcomes of black immigrant populations, reduce stigma surrounding mental health, and promote overall wellbeing.

Conclusion

Immigrants are the fastest growing segment of the United States population with 10% identifying as black and all are widely affected by mental illness especially, during the immigration process. This project has shown that mental health education programs can be effective at reducing stigma among black immigrants. The findings highlight the importance of increasing awareness about mental health and reducing stigma in the black immigrant population, as they often face significant barriers to accessing mental health services. Additionally, the study demonstrates the potential for mental health education programs to promote positive attitudes and behaviors towards mental health in this community. However, further research is needed to establish the long-term impact of such programs and to identify specific cultural factors that may influence attitudes and

behaviors towards mental health among black immigrants. By addressing the mental

health stigma among the black immigrant communities, we can ensure that they receive

appropriate support and care, and ultimately improve their mental health outcomes.

Overall, the study contributes to the growing body of evidence that highlights the

importance of mental health education programs in reducing stigma and improving

mental health literacy among diverse populations.

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Appendix A

Community Attitudes Towards Mental Illness

The following statements express various opinions about mental illness and the mentally ill. The mentally ill refers to people needing treatment for mental disorders but who are capable of independent living outside a hospital. Please circle the response which most accurately describes your reaction to each statement. It's your first reaction which is important. Don't be concerned if some statements seem similar to ones you have previously answered. Please be sure to answer all statements.

a. As soon as a person shows signs of mental disturbance, he should be hospitalized.

SA   A   N   D   SD

b. More tax money should be spent on the care and treatment of the mentally ill.

SA   A   N   D   SD

c. The mentally ill should be isolated from the rest of the community.

SA   A   N   D   SD

d. The best therapy for many mental patients is to be part of a normal community.

SA   A   N   D   SD

e. Mental illness is an illness like any other.

SA   A   N   D   SD

f. The mentally ill are a burden on society.

SA   A   N   D   SD

g. The mentally ill are far less of a danger than most people suppose.

SA   A   N   D   SD

h. Locating mental health facilities in a residential area downgrades the neighbourhood.

SA   A   N   D   SD

i. There is something about the mentally ill that makes it easy to tell them from normal people.

SA   A   N   D   SD

j. The mentally ill have for too long been the subject of ridicule.

SA   A   N   D   SD

k. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.

SA   A   N   D   SD

l. As far as possible mental health services should be provided through community-based facilities.

SA   A   N   D   SD

m. Less emphasis should be placed on protecting the public from the mentally ill.

SA   A   N   D   SD

n. Increased spending on mental health services is a waste of tax dollars.

SA   A   N   D   SD

o. No one has the right to exclude the mentally ill from their neighbourhood.

SA   A   N   D   SD

p. Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great.

SA   A   N   D   SD

q. Mental patients need the same kind of control and discipline as a young child.

SA   A   N   D   SD

r. We need to adopt a far more tolerant attitude toward the mentally ill in our society.

SA   A   N   D   SD

s. I would not want to live next door to someone who has been mentally ill.

SA   A   N   D   SD

t. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.

SA   A   N   D   SD

u. The mentally ill should not be treated as outcasts of society.

SA   A   N   D   SD

v. There are sufficient existing services for the mentally ill.

SA   A   N   D   SD

w. Mental patients should be encouraged to assume the responsibilities of normal life.

SA   A   N   D   SD

x. Local residents have good reason to resist the location of mental health services in their neighbourhood.

SA   A   N   D   SD

y. The best way to handle the mentally ill is to keep them behind locked doors.

SA   A   N   D   SD

z. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.

SA   A   N   D   SD

| SA=Strongly Agree | A=Agree | =Neutral | D=Disagree | SD=Strongly Disagree |

| SA=Strongly Agree | A=Agree | N=Neutral | D=Disagree | SD=Strongly Disagree |

Appendix A (continued)

Community Attitudes Towards Mental Illness—continued

aa. Anyone with a history of mental problems should be excluded from taking public office.

SA A N D SD

bb. Locating mental health services in residential neighbourhoods does not endanger local residents.

SA A N D SD

cc. Mental hospitals are an outdated means of treating the mentally ill.

SA A N D SD

dd. The mentally ill do not deserve our sympathy.

SA A N D SD

ee. The mentally ill should not be denied their individual rights.

SA A N D SD

ff. Mental health facilities should be kept out of residential neighbourhoods.

SA A N D SD

gg. One of the main causes of mental illness is a lack of self-discipline and will power.

SA A N D SD

hh. We have the responsibility to provide the best possible care for the mentally ill.

SA A N D SD

ii. The mentally ill should not be given any responsibility.

SA A N D SD

jj. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.

SA A N D SD

kk. Virtually anyone can become mentally ill.

SA A N D SD

ll. It is best to avoid anyone who has mental problems.

SA A N D SD

mm. Most women who were once patients in a mental hospital can be trusted as baby sitters.

SA A N D SD

nn. It is frightening to think of people with mental problems living in residential neighbourhoods.

SA A N D SD

COMMUNITY ATTITUDES TOWARDS THE MENTALLY ILL
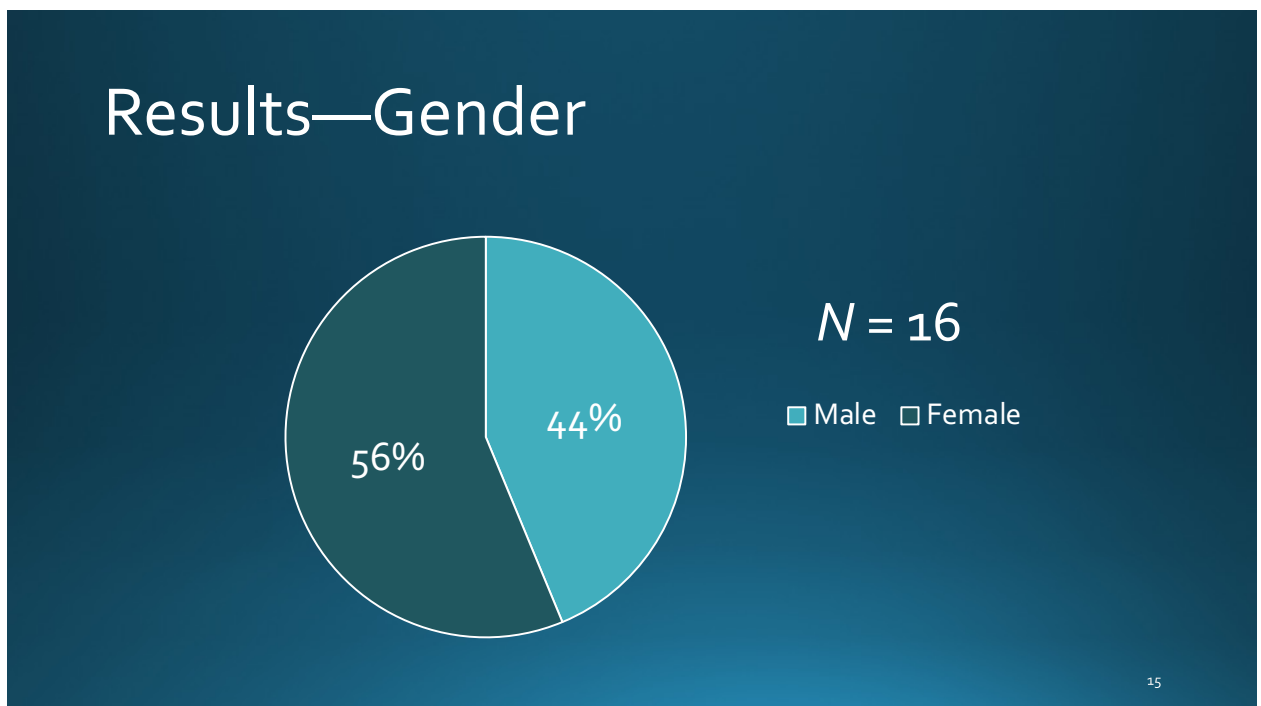
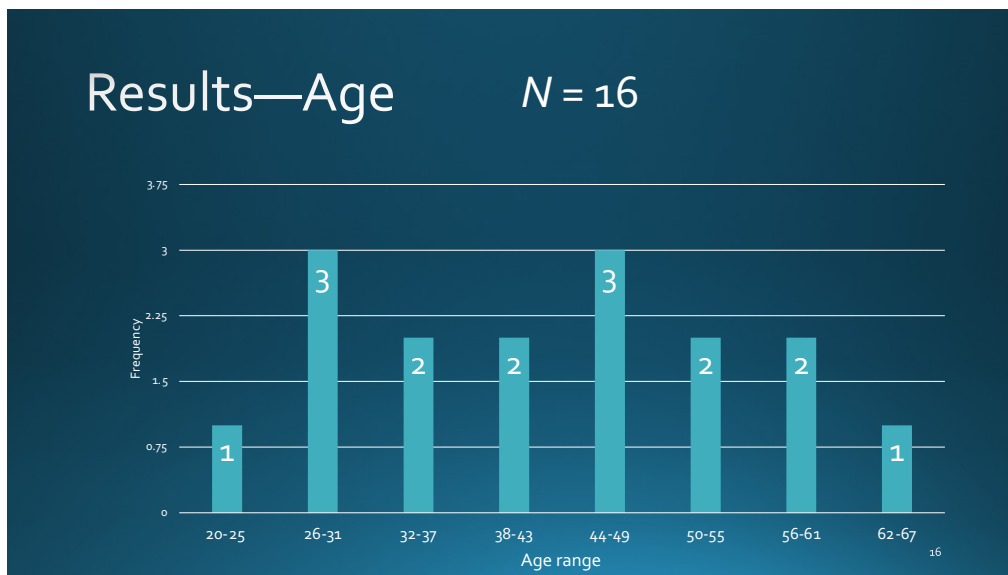| SA=Strongly Agree A=Agree N=Neutral D=Disagree SD=Strongly Disagree |
| --- |

Appendix B

Demographic of Participants

Figure 1

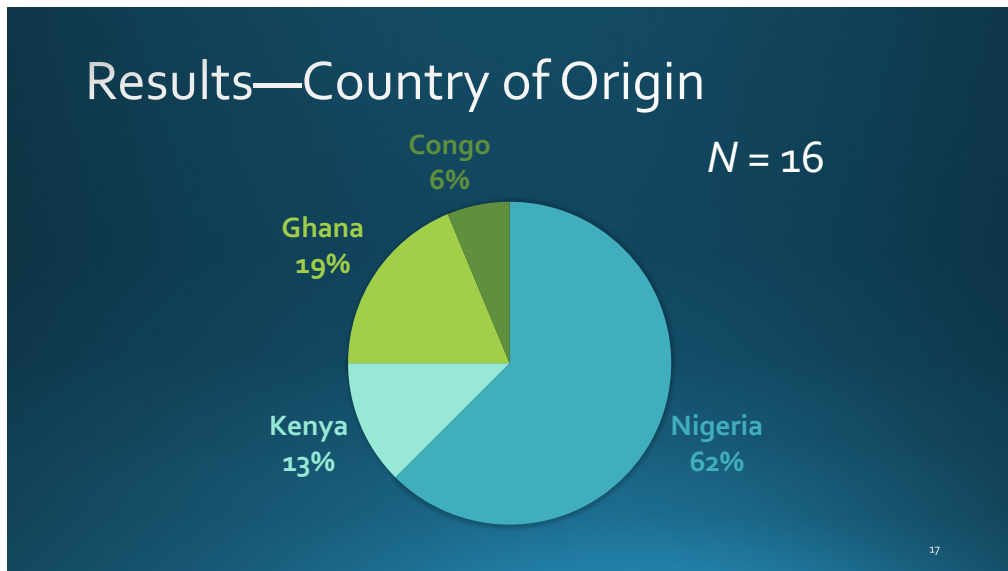*Note.* Total number of participants; $N = 16$ (females $n = 9$, males $n = 7$).

Appendix B (continued)

Demographic of Participants

Figure 2

Note. Age demographic of participants; *N* = 16 (25 – 65) years old.
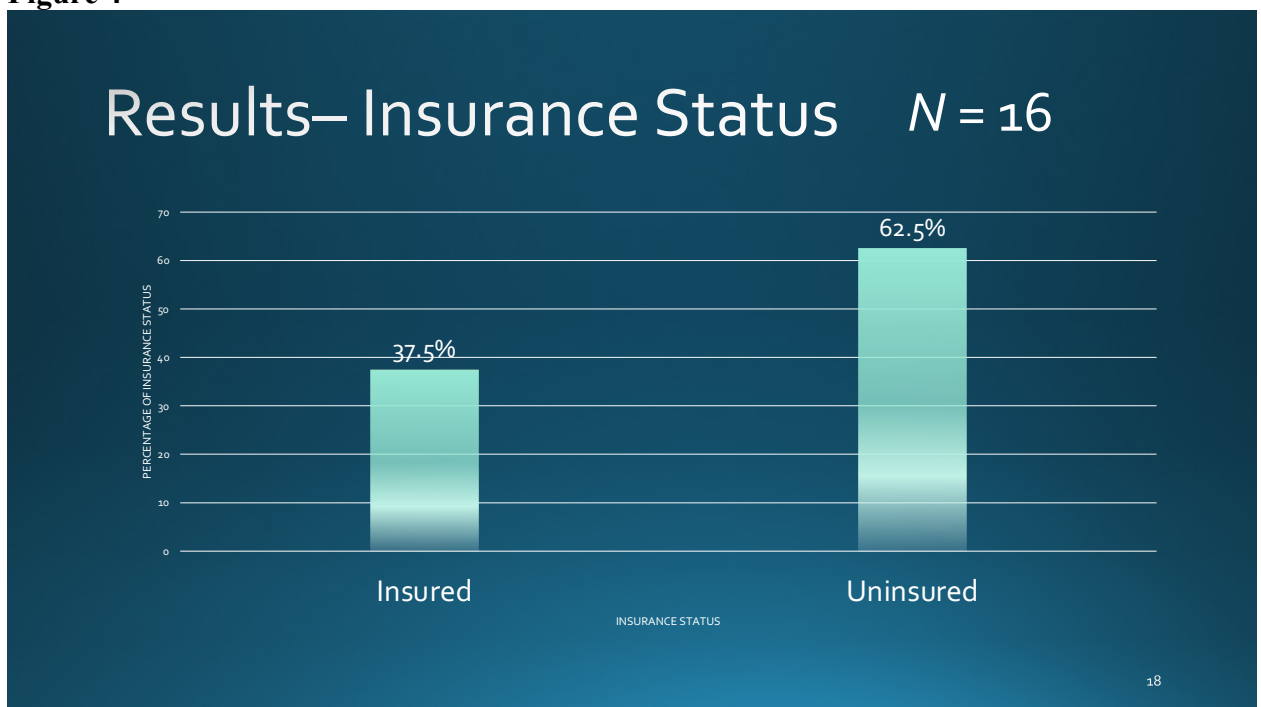
Figure 3

Note. Country of Origin of participants; *N* = 16.

Appendix B (continued)

Demographic of Participants

Figure 4

Note. Insurance Status of participants (*N* = 16)

Appendix C

Figure 5

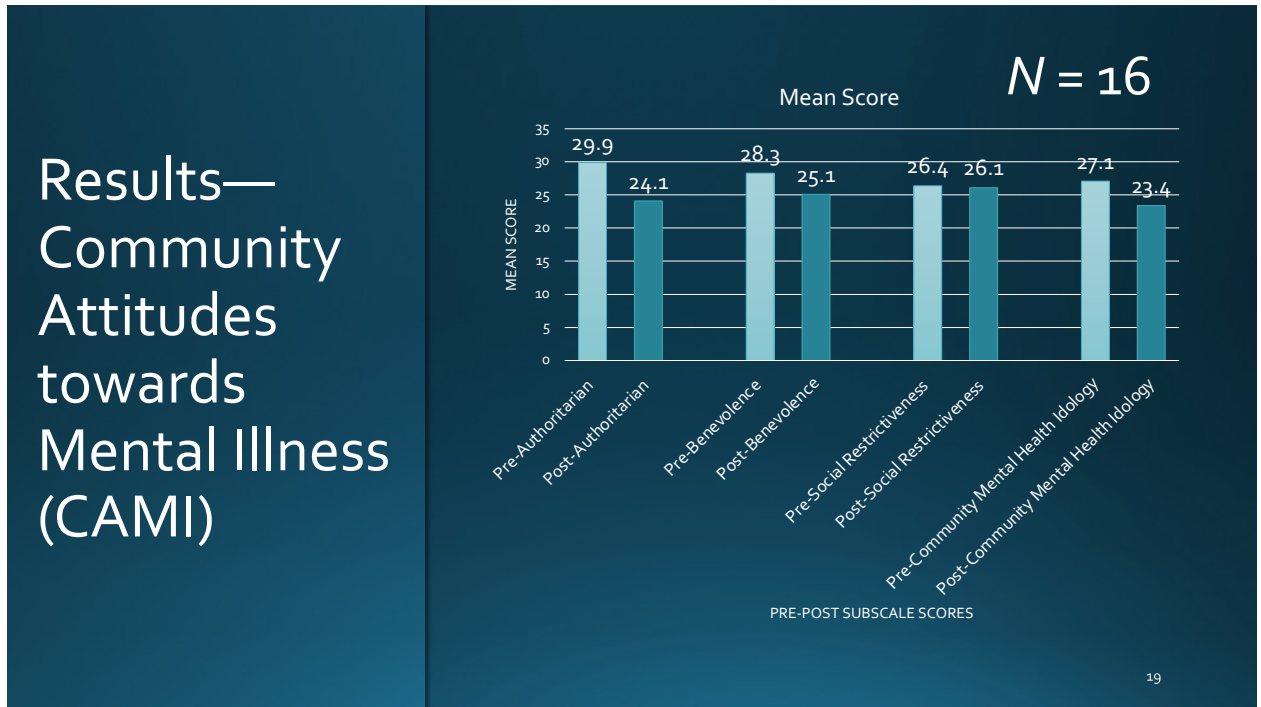***Community Attitudes Toward Mental Illness (CAMI)* Pre-post *Subscale Scores***

Figure 6

Paired *t*-test

Pre-Post Authoritarian Subscale

Negative perceptive that people with mental illness are inferior decreased

Statistically significant mean decrease $t(15) = 4.169$, $p < .001$

Pre-Post Benevolence Subscale

Paternalistic and sympathetic view of the mentally ill increased

Statistically significant mean increase $t(15) = 0.038$, $p = .038$

Pre-Post Social Restrictiveness Subscale

Minimal decrease in negative belief that the mentally ill are a threat to society and should be avoided

No statistically significant mean decrease $t(15) = 0.180$, $p = .430$

Pre-Post Community Mental Health Ideology Subscale

Increased acceptance of mental health services and mentally ill patients in the community

Statistically significant mean increase $t(15) = 2.753$, $p = .007$

Results—Paired *t*-test

20

Appendix C

Table 1
The *p*-value for the paired t-test

Pre-Post Authoritarian Subscale	• Negative perceptive that people with mental illness are inferior decreased. • Statistically significant mean decrease ($p < .001$)
Pre-Post Benevolence Subscale	• Paternalistic and sympathetic view of the mentally ill increased • Statistically significant mean increase ($p = .038$)
Pre-Post Social Restrictiveness Subscale	• Minimal decrease in negative belief that the mentally ill are a threat to society and should be avoided. • No statistically significant mean decrease ($p = .430$)
Pre-Post Community Mental Health Ideology Subscale	• Increased acceptance of mental health services and mentally ill patients in the community • Statistically significant mean increase ($p = .007$)