Examining Perceived Stigma, Barriers, and Mental Health Access among African American Women

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Abstract

African American women are heavily burdened by unmet mental health needs and yet underuse mental health services. The purpose of this study was to evaluate outcomes of a faith-based intervention program among participants drawn from five black churches located in Southern California. We sought to understand mental health access among different ages and examine changes in perceived stigma about mental illness among program participants. This study used a one-group pretest posttest design. The participants (n = 142) included female church and community members of five black churches located in Southern California. The data sample includes 126 pretest and 107 posttests responses, and for analysis purposes, pretests and posttests were matched for a total of 90 matched pairs. A paired sample *t-test* was performed to determine if there was a decrease in perceived mental health stigma among program participants. A statistically significant difference ($t(89) = -3.52$, $p = .001$) was found between mean pre-test and post-test scores for perceived mental health stigma. A Pearson's Correlation was performed to examine the relationship between age and mental health access among program participants at posttest, no relationship between age and mental health access was found. This intervention was successful in decreasing perceived mental health stigma among participants. Efforts should be made by public health departments to promote church partnerships with outside organizations to address mental health disparities.

Keywords: mental health access, perceived stigma, African American women, healthcare barriers.

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Introduction

Mental illness, also known as mental health disorders, include conditions that affects a person's thinking, feeling or mood. These conditions can be associated with distress or impaired functioning. (National Alliance on Mental Illness [NAMI], 2019). Mental health disorders can lead to significant distress and disability that undermines quality of life. Major depression is one of the most common mental health problems in the United States affecting approximately 14.8 million adults (Substance Abuse and Mental Health Service Administration [SAMHSA], 2009). When compared by gender and age, women ages 18 to 45 years old account for the largest proportion of functional impairment of the depressed adults in the US. African American women are heavily burdened by unmet mental health needs and yet underuse mental health services. Recent studies have documented the underuse of mental health services among African American women. According to data reported by SAMHSA (2012), in 2011 approximately 7.5 % of African American women sought treatment for depression compared to 13.6 % of the general population. Moreover, African Americans have a higher risk of persistence and disability from mental health disorders than their white counterparts (Primm et al., 2010). A study published by Lesser et al. (2011) found that among people suffering from major depressive disorder (MDD), chronic MDD was about 61% for African Americans versus 50% for white Americans. Experiencing severe forms of mental health disorders is particularly debilitating as it often leads to higher levels of comorbidity (Borba et al., 2012).

Overview of Literature

Mental Illness among African American Women

African American women carry an increased stress in daily life related to experiences of gendered racism, stereotyping, oppression, and economic strain which researchers have found

are associated with poorer mental health outcomes (Noonan et al., 2016). Stressors that play a significant role in mental disorders such as racism, discrimination, gendered sexism, and poverty are likely to occur more frequently among African American women than among their white female counter parts (Perry, Harp, & Oser, 2013).

African American women experience a unique form of oppression that is specific to their race-gender subgroup. For example, African American women experience both race and gender wage gaps. Women on average earn lower wages than their male counterparts and African American women earn less than their white female counterparts (Bureau of Labor Statistics [BLS], 2020). Gendered racism has been related to higher levels of psychological distress (Lewis & Neville, 2015), greater depressive symptoms (Carr et al, 2014), and more post-traumatic stress symptom (Woods, Buchanan, & Settles, 2009). Experiencing reoccurring stressors can induce psychological distress, which in turn can lead to prolonged and severe forms of mental disorders (Jacob, 2013). Despite these stressors, African American women are less likely to seek help for mental health issues (Holden et al., 2012).

Mental Health Access

Defining Mental Health Access

The severity of mental health disorders can be further exacerbated by the lack of access to healthcare services (Greiner, 2015). Greiner (2015) explained that the lack of access to timely and appropriate mental healthcare services can result in higher prevalence of chronic mental illness, disability, and mortality. Researchers have defined health care access as the ability to obtain or receive services to meet health needs adequately (Levesque et al., 2013). Healthy People 2020 stated that access to health care requires three steps: gaining entry to the health care system; accessing a location where needed services are provided, and finding a provider with

whom the patient can communicate and trust (U.S Department of Health and Human Services, 2014).

Barriers to Mental Health Access

There are several barriers to healthcare access that individuals face. The extent to which a population gains access to services can depend on financial, organizational, social, and cultural barriers (Copeland & Snyder, 2011). Research suggested that African Americans are less likely to seek mental health care than their Caucasian American counterparts, are more likely to leave treatment prematurely, and are more likely to seek initial treatment in primary care settings as opposed to specialty settings (Holden et al., 2012). These help-seeking trends have been linked to a history of mistrust of medical professionals as well as cultural stigma surrounding mental health issues (Holden & Xanthos, 2009).

Further, when African Americans decide to seek treatment or mental health services, they are often exposed to inequalities in care (Alegria et al., 2010). For example, African Americans are under-diagnosed and under-treated for affective disorders (Gara et al., 2018) and over-diagnosed and over-treated for psychotic disorders (Schwartz & Blankenship, 2014). In addition, African Americans are less likely to receive newer and more comprehensive treatment modalities (Cook et al., 2014). These inequalities have been attributed to a lack of cultural competency and bias in service delivery on the part of mental health professionals (Shim et al., 2013).

Disparities in geographic availability of mental health care professionals can obstruct access to mental health services. Research suggested that communities with high proportions of African American residents are four times more likely than whites to have a shortage of specialists (Gaskin et al., 2012). Studies suggested that individuals are less likely to access

mental health services if they live in regions with low number of mental health providers (Wielen et al., 2015), and where services are distant (Dinwiddie et al., 2013).

Insurance coverage is one component of access to care, and those at greater risk for experiencing barriers to access include those with low income, members of ethnic minority groups, the uninsured, and those with public insurance (Allen et al., 2017). African Americans are overrepresented among low income groups; they often have less access to health insurance and have a greater reliance on public mental health systems (Rowan et al., 2013). Research suggested African Americans are over-represented in inpatient treatment, under-represented in outpatient treatment (Primm et al., 2010), and more likely to use emergency rooms to treat mental health disorders than their white counter parts (American Psychiatric Association [APA], 2017). Barriers to mental health access can be logically grouped into three categories: systemic, sociocultural, and individual.

Systemic Barriers

Disparities in mental health outcomes may result from interactions between systems and patients and clinicians and patients (Wasserman et al., 2019). Systemic barriers, as defined by Jackson et al. (2014), are factors such as availability, acceptability, and accessibility of services that affect the accuracy of the assessment and appropriateness of treatment provided to individuals seeking care. Many African American women have trouble with obtaining culturally competent mental health treatment services. Copeland and Snyder (2011) conducted a study on barriers to Mental Health Treatment Services for low-income African American women whose children received behavioral health services. The authors found that visible barriers to mental health treatment services often included the lack of community resources, transportation, childcare, convenient hours, and financial resources for services. Furthermore, invisible barriers

included individual perceptions of mental health treatment and services rooted in life experiences, low knowledge of available services, and inadequate support to seek such services.

Similarly, a study conducted by Roberts (2012) suggested that African American women with white physicians are often not educated as well about preventive care, are not screened as effectively, or are not as often referred to state-of-the-art treatments as white women with white physicians. Furthermore, Snipes et al., (2011) conducted a study of physicians' attitudes about the role of race in treatment decision-making. The author found that all African American physician participants viewed race as important when making decisions about their patients' treatment, while only four white physicians considered race medically relevant. In addition, the same researchers found that African American physicians linked race to the hypothetical patient's social determinants of health such as socioeconomic status, as well as their own ability to deliver culturally appropriate care.

Access and Availability. Accessibility refers to the ease and convenience of accessing services. (Brondeel et al., 2014). Availability refers to the quantity and competency of services offered to individuals (Olawande et al., 2018). Factors such as the referral process, waiting period for an initial appointment, and waiting times can become barriers to healthcare access (Kaplan et al., 2015). African Americans report greater difficulty than whites in obtaining medical care at a consistent location (Agency for Healthcare Research and Quality [AHRQ], 2010). Moreover, African American women are less likely to undergo screening for mental disorders and access mental health services compared to their white counterparts (Hahm et al., 2015). Among African American women, perceived barriers to care were associated with not having insurance coverage (29%), treatment cost (21%), and waiting times for an appointment (9%) (Pullen, Perry, & Older, 2014). African Americans have a higher prevalence of barriers

(7.9%) than whites (6.6%), relating to not getting an appointment soon enough, and not finding a doctor of choice (Kullgren et al., 2011). Moreover, Ward and colleagues (2009) reported three barriers to treatment seeking among African American women in the Midwest; access issues with providers, culturally incompetent clinicians, and lack of services offered in proximity.

Moreover, African Americans are significantly more likely than other Americans to live in high-poverty neighborhoods and have limited access to healthcare services (Firebaugh & Acciai, 2016). The availability of clinicians and limited access to them can affect how quickly patients receive the care they need (Sharma et al., 2017). Delay and failure in treatment seeking after first onset of mental disorders can exacerbate psychiatric comorbidity (Cheung et al., 2017).

Acceptability. Acceptability is a multi-faceted construct that reflects the extent to which people delivering or receiving a healthcare intervention consider it to be appropriate (Sekhon et al., 2017). Acceptability of services can include social or cultural concerns (Saurman, 2015). Cultural competence and implicit bias are concerns that impact issues in assessment, diagnosis, and treatment in clinical practice (Carpenter-Song et al., 2011). Physicians' interpretation of symptomology can affect the assignment of psychiatric diagnosis and subsequently the appropriate and correct treatment for patients (Holden & Xanthos, 2009).

Gara et al. (2012) found that African Americans are more likely to be diagnosed with significantly higher rates of schizophrenia than non-Latino whites. Mistrust of provider diagnosis has been identified as a factor influencing African American women's under use of mental health services (Woods-Giscombe et al., 2016). Fear of treatment and fear of being hospitalized are major reasons for underutilization of mental-health services among African Americans (Williams et al, 2012). In addition, lack of trust in providers was the most reported barrier in a study of perceptions of mental health services among low-income, perinatal African American women

(Leis, Mendelson, Perry, & Tandon, 2011). In a qualitive study examining depressed African American women living in Portland, Nicolaidis and colleagues (2010) found that a common barrier to seeking care for depression was mistrust of the healthcare system. In that same study participants perceived the healthcare system as a racially biased system.

Practitioners and clinicians play an important role in providing adequate and culturally appropriate mental health services. Currently few mental health professionals reflect the cultural and ethnic characteristics of racial and ethnic minority groups in need of mental health services (Smith, 2015). In 2015 whites constituted almost 84% of the psychologist workforce compared to Hispanics (16.1%), and African Americans (4.9 %) (U.S. Department of Health and Human Services [DHHS], 2017). These percentages are inadequate given that African Americans make up 13% of the U.S population (United States Census Bureau, 2019) and over 16% reported having a mental illness in the past year ([SAMHSA], 2018). Meyer and Zane (2013) found that racial match among African Americans is found to be a strong predictor of the service experience across access and quality of care. Accordingly, the small number of clinicians of color in the mental health care system makes it less likely that an African American client can request or be assigned an African American clinician (Glover, 2012). Consequently, the fear of being misdiagnosed, stereotyped, or pathologized keeps many African American women from seeking mental health services (Awosan et al., 2011).

Socio-Cultural Barriers

An additional set of barriers are more deeply rooted in the racial and cultural experience of African Americans as a community. Socio-cultural barriers are man-made constructs originating from social norms and cultural values (Savolainen, 2016). Cultural beliefs are determining factors of whether people seek help in the first place, what types of help they seek,

and what coping styles are acceptable (Villatoro & Aneshensel, 2014). For example, among African Americans there is the idea of the "Super Black Women" (SBW) schema. The SBW is a combination of beliefs and cultural expectations of incessant resilience, independence, and strength behavior related to Black womanhood (Abrams et al., 2014). As a result, many African American women have mastered the art of portraying strength while concealing trauma (Abrams, Hill, & Maxwell, 2009). Adherence to the SBW can become a barrier to mental health access when it becomes a maladaptive coping strategy ultimately resulting in delayed care (James, 2015).

Within African American communities, faith and religion often play a significant role in individuals' beliefs, practices, experiences, and daily activities (Debnam et al, 2011). The use of informal support for mental disorders such as family, friends, and ministries, is common among African Americans (Chatters et al., 2011). One study indicated that approximately 40% of African Americans use clergy members as their primary resource for mental health treatment (Anthony, Johnson, & Schafer, 2015). That same study also revealed that African Americans are 2.5 times more likely to seek help from a clergy member than a mental health professional. In fact, among African American women living with mental health disorders, 23% use informal support only, while 14% use professional services, and 60% do not seek any help (Sosulski & Woodward, 2013).

In another study Lukachko et al. (2015) found that among African American women high church attendance was marginally associated with lower odds of using professional mental health services. High levels of religiosity among African Americans may lend to a greater reliance on religious counseling and coping when facing a mental health problem. The tendency of African

Americans to use clergy for health care services that might otherwise be provided by the mental health care system can act as a barrier to mental health access (Harris, 2018).

Stigma. Mental illness in African American communities are frequently associated with shame and embarrassment (Masuda, Anderson & Edmonds, 2012). Common stigma beliefs include that those with mental illness are dangerous, will not recover, and that their mental illness is their own fault (Watson & Shaun, 2011). Mental health stigma occurs when people have negative thoughts and beliefs regarding those with mental health illness. Stigma has been identified as an important influence on use of mental healthcare services and a prevalent barrier to seeking help among African American women (Woods-Giscombe et al., 2016).

Given African American women's double minority status, the stigma associated with seeking help may create an additional unwanted burden (Williams, 2014). For example, African American women reported that using professional psychological services would confirm society's negative perceptions of African American womanhood (Watson & Hunter, 2015). In one study Ward et al., (2013) found that among African Americans, internalized stigma had a direct relationship with help seeking attitudes, thus acting as a barrier to mental healthcare. Stigma can deter individuals from seeking help in fear of being perceived as crazy or weak, hence contributing to the reluctance of discussing problems with professionals (James, 2015). The threat or perception of social rejection due to mental illness discourages many from seeking care (Perry et al., 2013), and this is especially true among African Americans, as they already suffer from other types of discrimination.

Individual Barriers

Individual barriers to mental health access include the characteristics of a person that makes them more or less likely to seek help from a mental health provider (Andrade et al., 2014).

Decisions to seek care for mental health are largely determined by individual attitudes, knowledge, and beliefs about mental health (Mackenzie et al., 2014). If a person is unaware about the existence of effective treatments and location of services, then they are less likely to seek care (Coles & Coleman, 2010). Absence of knowledge implies that many do not know the signs of mental illness and thus, are unable to recognize when they need help (Briggs et al, 2014). Low mental health literacy is also correlated with lower rates of help seeking (Wang et al., 2019). Among a group of African American residents in an urban community Roberts et al. (2008) found that mental illness was recognized only when severe symptoms were observed, and that mild symptoms were thought to be normal coping.

Moreover, people are unlikely to seek care for mental illness if their attitudes and beliefs about them are negative. In a representative sample of 250 depressed older adults, African American women had more negative attitudes toward seeking mental health treatment than their white counterparts (Conner et al., 2010). Furthermore, these negative attitudes were strongly and negatively correlated with service utilization. Conner et al. (2010) also found that lack of confidence in treatment and mistrust of mental health service providers had an impact on participants' attitudes about seeking mental health treatment and ultimately became a barrier to help seeking.

Age. Findings regarding the relationship between age and access to mental health services among African Americans are inconsistent. While some studies reported that younger women are more likely to seek care and have more positive attitudes toward seeking psychological help (Have et al., 2010; Andrade et al., 2014) others reported that older women have a higher prevalence of seeking care (Wong et al., 2017). A possible explanation to inconsistent findings is that age groups are not comparable across studies, making it difficult to

draw definitive conclusions regarding age. Differences in outcomes may also be due to cofounding variables such as socioeconomic status and race/ethnicity. For example, loss of insurance rates is high among minorities in their twenties, which may be a financial barrier to access care (Sohn, 2017). However, coverage increases in later adulthood as many individuals qualify for Medicare at age 65 (Sohn, 2017). Further research is warranted on the subject.

Summary

Despite efforts to expand access to mental health services around the nation, differences in access and help seeking patterns persist, specifically for minorities. Moreover, African Americans are disproportionately affected by mental health disorders. Many African American women are heavily burdened by unmet mental health needs and yet underuse mental health services. Gaps in current research limit opportunities to develop culture, gender, and age-specific interventions to reduce stigma and increase treatment-seeking behaviors among African American women (Ward, Clark, & Heidrich, 2009). Recognition of the inadequate mental health care afforded to minorities has led many to advocate for a new treatment approach that delivers services according to cultural preferences and appropriateness (Snowden, 2012).

Purpose of the Study

The Broken Crayon Still Color Project (BCSCP) is a community-defined evidence-based program that provides education, information dissemination, outreach, and advocacy to reduce mental health disparities among African American women in the Riverside and San Bernardino Counties. The purpose of this study is to evaluate outcomes of a faith-based intervention program among program participants. We sought to understand mental health access among different ages and examine changes in perceived stigma about mental illness among program participants.

Research Questions

This study answered two questions:

1. Do participants in the BCSCP report a decrease in perceived stigma associated with mental health illness following the intervention?
2. Is there a relationship between age and mental health access among program participants?

Hypotheses

Relevant to the first question, it was hypothesized that perceived stigma towards mental illness would be shown to decrease among participants following completion of the program. It was further hypothesized that there would be a relationship between age and mental health access

Method

Research Design

This study used a one-group pretest-posttest design. Secondary data from a community-based mental health program in Southern California was used. Data was collected between January 2018 and November 2019. The Institutional Review Board (IRB) at California Baptist University approved this study under exempt status on December 20, 2017 (Appendix A). Consent was obtained from participants prior to participation in the mental health program (Appendix B).

Intervention

The Broken Crayon Still Color Project (BCSCP) was an eight-week mental health intervention. During the period under study, the program was implemented in five churches as part of a five-year program implementation plan. The target population included African American women ages 18 years and older. Program sessions were facilitated by a licensed clinical psychologist and were held for two hours each week over an eight-week period. The program content included modules on core mental health issues (depression, anxiety, PTSD, and substance abuse) and provided participants with the tools to better understand what constitutes good mental health. The other components of the program were designed to help eliminate the stigma associated with mental health illness and increased awareness of mental health services and resources

Procedure

Members of the evaluation team, which consisted of two program evaluators and a trained research assistant, collected the program data. The evaluation team collected the signed consent forms prior to the distribution of the pretest (Appendix B). The evaluators informed each

participant about their rights by orally informing the participants about the project and the purpose of data collection. Pre and post surveys were administered during Week 1 and Week 8, respectively, using a paper and pencil survey. The pretest included 58 questions, and consisted of three sections: demographics, program specific questions, and state mandated questions. The posttest included 59 questions and consisted of specific questions and state mandated questions; demographic questions were not asked on the posttest. Participants, on average, took 30 minutes to complete the pretest and posttest surveys. Survey data were entered into the Statistical Package for Social Sciences (SPSS) version 26.

Participants

The participants (n = 142) in this study include female church and community members of five black churches located in Southern California. The data sample included 126 pretest and 107 posttests, and for analysis purposes, pretests and posttests were matched for a total of 90 matched pairs.

Independent Variables

The independent variables in this study were age and perceived stigma. Age was measured at the continuous level and calculated using the date of birth provided by the participants. Perceived stigma was measured at the ordinal level using a Likert scale. Perceived stigma was assessed using six different questions: “How willing would you be to move next door to someone with a mental illness,” “How willing would you be to spend an evening socializing with someone with a mental illness,” “How willing would you be to make friends with someone with a mental illness,” “How willing would you be to have someone with a mental illness start working closely with you on a job,” “How willing would you be to have someone with a mental illness marry into your family,” and “How willing would you be to employ someone if you knew

they had a mental illness." Response options for each question included: 0 (definitely unwilling), 1 (probably unwilling), 2 (neither willing nor unwilling), 3 (probably willing), or 4 (definitely willing). Questions were scored using a Likert-type scale and summed to produce a final score. Final scores ranged from a low of 0 to a high of 24. It is important to note that a higher score is equivalent to a low perception of stigma.

Dependent Variables

The dependent variable in this study included mental health access. Mental health access was measured at the continuous level and was produced using the sum scores of two ordinal variables. Mental health access was assessed using two different questions; "I am confident that I know where to seek information about mental illness" and "I am confident I have access to resources (doctor, Internet, friends) that I can use to seek information about mental illness". Response options included: 0 (strongly disagree), 1 (disagree), 2 (neither agree nor disagree), 3 (agree), and 4 (strongly agree). Questions were scored using a Likert-type scale and then summed to produce a final score. Final scores ranged from a low of 0 to a high of 8. Higher scores were indicative of greater confidence seeking access to mental health services and resources

Data Analysis

A paired samples *t*-test was used to answer the first research question, (*Do BCSCP participants report a decrease in perceived stigma associated with mental health illness?*). A Pearson's correlation was used to answer the second research question, (*Is there a relationship between age and mental health access among program participants?*)

Using G*Power Software, Version 3.1.9.2, a medium effect size of .3, an alpha level of .05, and a power of .80 was selected to estimate the minimum required sample size of 88 for the

first question and 84 for the second question. The sample size used for the first research question included 90 matched pairs, which exceeds the required minimum sample size. The second question used pre-test data only and included a sample size of 124.

Results

Demographics

There were 142 participants in this study. One hundred twenty-six completed the pre-test measures and 107 completed the post-test measures. A total of 90 participants completed both pretests and posttests, resulting in matched pairs. The demographic characteristics of the participants are shown in Table 1. All program participants (100%) were female. During the pre-test, participants provided demographic information by answering six questions. The average age for participants was 54.4 years with a range of 19 to 93 years. Most (90.0%) of the intervention participants classified themselves as Black or African American. Additionally, most participants reported their marital status as married or living together (43.7%) followed by divorced or separated (25.4%). When asked to state their level of education most participants (84.2%) reported completing some college, holding an Associate's degree, or being college graduate. The number of persons per household ranged from one to eleven, with a median of three persons per household. Of the participants sampled, 56.8% had an annual income of $54,999 or below.

Table 1

Demographic Details of Program Participants (n = 142)

Variable		n	%	*M*	*SD*
Gender					
	Female	142	100		
Age					
				54.4	15.4
Education					
	9-11 Grade	1	.8		
	High School graduate or GED	8	15.0		
	Some College or Associates Degree	63	52.5		
	College Graduate or Above	38	31.7		
Ethnicity					

	American Indian or Alaskan Native	2	1.7		
	Black or African American	108	90.0		
	Latino, Hispanic or Spanish	3	2.5		
	White	2	1.7		
	Multi-racial	3	2.5		
	Other	2	1.7		
Marital Status					
	Married or Living Together	55	43.7		
	Widowed	13	10.3		
	Divorced or Separated	32	25.4		
	Never Married	26	20.6		
Number of Persons in Household					
				3.3	2.0
Household Income					
	Low < $54,999	65	56.8		
	High > $54,999	49	42.9		

Note. *n* = sample size, % = percentage, *M* = Mean, *SD* = Standard Deviation.

Major Findings

Perceived Stigma

A paired sample *t*-test was performed to determine if there was a decrease in perceived mental health stigma among participants after the eight-week BCSCP. A statistically significant difference ($t(89) = -3.52$, $p = .001$) was found between mean pre-test and post-test scores for perceived mental health stigma. The mean pre-test scores for perceived mental health stigma ($M = 16.36$, $sd = 3.75$) were significantly lower than the participants' mean post-test scores ($M = 17.74$, $sd = 4.20$). It is important to note that an increased score was indicative of the decline in participants' perceived stigma. It is evident that after the intervention, the program participants were more willing to socialize, live, and work with someone who has a mental health illness.

Mental Health Access

A Pearson's' correlation was performed to examine the relationship between age and mental health access among program participants at posttest (Table 2). A weak and non-significant correlation was found ($r(120) = .706$, $p = .403$). Results of the Pearson's correlation indicate that there is no relationship between age and mental health access among participants.

Table 2

Pearson's Correlation results between age and mental health access among program participants (n=124)

Measure	Age	Mental Health Access
Age	—	.07
Mental Health Access	.07	—

Note. Correlation is not significant (2-tailed). *P>.05*

Discussion

Summary of Major Findings

Mental health services are largely underutilized by African Americans women, despite this population having a higher risk of persistence and disability from mental health disorders compared to their white counterparts (Perry et al., 2013). Existing literature noted that among African American women, stigma is a major barrier in seeking mental health services (Woods-Giscombe et al., 2016; Ward et al., 2013). Furthermore, stigma about mental health disorders can result in treatment avoidance and delay seeking mental health services (Ward et al., 2009). The first research question in this study investigated outcomes of a church-based intervention program on perceived mental health stigma. The findings resulting from a paired samples *t*-test, revealed that the intervention was successful in decreasing mental health stigma among program participants. These findings indicated that participants are more willing to socialize, live, and work with someone who has a mental health illness among completion of the intervention.

The second research question focused on the relationship between age and mental health access. Using a Pearson's correlation our findings revealed a weak negative relationship between age and mental health access. There findings are inconsistent with findings in the literature with regards to age and mental health access. Some studies reported that younger women are more likely to seek care and have more positive attitudes toward seeking psychological help (Have et al., 2010; Andrade et al., 2014), while others reported that older women have a higher prevalence of seeking care (Wong et al., 2017). This study reports no significant finding in any direction, and therefore is inconsistent with current body of literature.

This study focused on mental health access using two subjective survey questions. The survey questions focused on participant perception of access to mental healthcare. The information provided by participants could have been misinterpreted or answered in a bias way

that skewed results. For example, participants may have different definitions or interpretations of what access to mental health care is. Participants could have potentially dismissed resources they would otherwise have considered access to mental healthcare. A Pearson's correlation test does not account for covariates, which may affect the study outcome. It is possible that covariates, such as income, health insurance status, and educational attainment could influence the relationship between age and mental health access (Farr et al., 2010; Sohn, 2017).

Study Limitations

This study has several limitations. This study employed a one-group pre-test/post-test quasi experimental design. This design is methodologically a weaker design as it lacks a comparison group. The chance of selection bias could serve as a limitation because a non-random convenience sample was used. The intervention was not offered to every church-based organization in Riverside and San Bernardino Counties, and only five African American churches were selected to participate in the intervention. Therefore, the results of this study cannot be generalized to the overall population within these two counties.

Another limitation may have been the manner in which the survey was administered. The survey administrators were present at the time surveys were disseminated, which may have resulted in self-reporting bias. Because the intervention took place in a church setting, participants may have felt pressured to answer the self-administered survey in a way that would have positive results on what they interpreted as the clergies' or their fellow church goers' desired response.

Implications for Public Health Practice

This study evaluated outcomes of a faith-based mental health intervention program. Literature revealed that faith and religion frequently plays a significant role in the beliefs,

practices, experiences, and daily activities among African American communities (Debnam et al, 2011). In addition, the use of informal support for mental disorders (such as family, friends, and ministries) is common among African Americans (Chatters et al., 2011). This intervention was tailored to its target audience and included a culturally competent facilitator who shared the racial/ethnic identity of its program participants. This study indicates that an intervention designed to be culturally competent can decrease perceived stigma among African American women in Riverside and San Bernardino Counties.

African American clergy have a long tradition of providing care for community members who encounter emotional distress (Williams, Gorman & Hankerson, 2014). Introducing public health practices to such clergy members can help build a strong foundation to create competent and effective interventions designed to increase mental health service use among African Americans. To reverse the historical mistrust and cultural incompetence in healthcare experienced by African Americans, interventions that are acceptable and appropriate must be developed for the target population (Debnam et al, 2011). It will take collaborative efforts from clinicians, public health, and faith-based entities to educate the African American community about mental health and decrease disparities in this area.

Efforts should be made to engage African American clergy and religious communities in framing and formulating strategies for the delivery of mental health services. For example, the Promoting Emotional Wellness and Spirituality Program (PEWS) is a program that called for the creation of a Mental Health Ministry Committee in African American churches in New Jersey. The program goal was to educate clergy, reduce stigma, and promote treatment seeking for depression (William et al., 2014). The PEWS program promoted partnerships with church staff to advocate for promote mental health treatment seeking and reduce stigma among participants.

Future research should investigate how to identify ways in which professional mental health services might complement the concrete and intangible benefits associated with religiosity. In addition, efforts should be made to promote church partnerships with outside organizations to address mental health disparities.

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Appendix A: IRB Approval

Dear Dr. Penny,

Thank you for submitting this amendment for IRB #n015-1718 to add a research assistant, Linzey Ledesma; it has been **approved**.

Please remember:
In the case of an unforeseen risk/adverse experience, please report this to the IRB immediately using the appropriate forms. Requests for a change to protocol must be submitted for IRB review and approved prior to implementation. At the completion of the project, you are to submit a Research Closure Form. As the researcher, you are responsible for ensuring that the research is conducted in the manner outlined in
the IRB application and that all reporting requirements are met. Please refer to your original approval and to the IRB handbook for more information.

Date:
March 30, 2020

On behalf of the IRB,

Elizabeth Morris

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Appendix B: Consent Form

BROKEN CRAYONS STILL COLOR PROJECT PROGRAM EVALUATION & RESEARCH STUDY EXPLANATION

Dear *Broken Crayons Still Color* Participant:

PURPOSE: The purpose of this study is to evaluate the *Broken Crayons Still Color* Project (BCSCP), an 8-week (eight sessions) mental health program. The study will measure knowledge of core mental health issues, (including depression, anxiety, PTSD, and substance abuse), perceived stigma associated with mental illness, comfortability in discussing mental illness and stigma, and awareness of mental health resources. You were selected as a possible participant in this study because of your involvement in the BCSCP project.

This project is a part of the California Department of Public Health (CDPH) Office of Health Equity's (OHE) effort to reduce mental health disparities through the funding of 34 projects across the state to evaluate community-defined evidence practice (CDEP). The findings will be used to support changes in statewide and local mental health delivery systems and policies that will reduce mental health disparities among unserved, underserved and inappropriately served populations.

We are co-principal evaluators for the project. We are independent consultants for Health Healthy Movement (HHM), which is a Riverside-based organization that provides service to the community. We are also professors at California Baptist University (CBU) in Riverside, California. Our job is to gather information that will help determine how effectively the program meets its intended outcomes.

PROCEDURES: As a participant, you will complete a pretest survey during session 1 of the program and a posttest survey during session 8 of the program. You will also participate in a focus group activity during session 5 of the program.

VOLUNTARY PARTICIPATION: Participation in this study is voluntary. Anyone who does not wish to participate can be excused from the program.

POTENTIAL RISKS AND BENEFITS: The potential benefits of this study include the positive effects of participating in a mental health awareness program. The benefits to the field of public health include developing a greater understanding of the impact of such programs in the community. The risks are minimal and include the potential for participants to experience fatigue during the class or during completion of the surveys, as the classes are 2½ hours long and the pretest and posttest surveys each contain a minimum of 50 questions. To minimize these risks participants are allowed to take short breaks during their program participation and will be assisted by a facilitator with completing the surveys.

CONFIDENTIALITY: The information will be kept confidential. Although the participants' names will be collected, to create identification codes to match the surveys with the correct participants, the participant's identity will not be disclosed or used for any purposes. The data

collected will be provided to the California Department of Public Health's Office of Health Equity for analysis and dissemination. The data will be examined in group format and without regard to any individuals. All information collected will be stored in locked cabinets and in a secured electronic data system. Only a few selected individuals will have access to the information for the purpose of processing and analyzing. The focus group activity will be audio recorded and later professionally transcribed. We will not be able to match any voices on the recording with individual participants.

QUESTIONS: If you have any questions or concerns regarding this research study, please contact the principal investigators of this study, Dr. Marshare Penny (909.552.8535 or mpenny@calbaptist.edu) or Dr. Jessica Miller (951.552.8535 or jemiller@calbaptist.edu). If you have questions regarding your rights as a research subject, please contact the Office of Institutional Research (IRB@calbaptist.edu).

Your signature indicates that you have read and understand the information provided above, that you are willingly agree to participate, that you may withdraw your consent at any time and discontinue participation without penalty, that you will receive a copy of this form, and that you are not waiving any legal rights or future claims.

Thank you for your consideration.

Dr. Marshare Penny
California Baptist University

Dr. Jessica Miller
California Baptist University

CONSENT TO PARTICIPATE IN STUDY

TITLE: BROKEN CRAYONS STILL COLOR PROJECT PROGRAM EVALUATION & RESEARCH STUDY

I have reviewed the explanation of the Broken Crayons Still Color Project and the corresponding evaluation activities.

I understand the potential benefits and risks of participating in this project. All of my questions regarding this project have been answered.

I agree to participate; I am at least **18** years old; I understand that I can choose to not participate at any time.

Participant Name (print):
_____Date_____

Participant Signature:
_____Date_____

Evaluator Signature:
_____Date_____