Implementing a Depression Screening and Referral Program in an African American Church Community

Mary S. Garner

Jacksonville University

Presented to

DNP Chair: Dorcas E. Kunkel, DNP, RN, PHNA-BC, LHITHP

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Abstract

**Purpose:** The purpose of this quality improvement project was to launch a depression screening and stigma reduction program in a nondenominational church that serves mainly African Americans. Potential links between stigma, such as beliefs related to mental illness, and how education can influence help-seeking and health literacy among ministerial leaders were identified.

**Methods:** From March to June 2019, 28 African American ministerial leaders participated in this depression/suicidality educational awareness program. Three instruments were selected for this study: a demographic questionnaire, a Mental Health Knowledge pre/posttest, and a Community Attitudes Towards Mental Illness pre/post survey. Paired sample t-tests were used to determine pre- and post-education mental health knowledge and the presence of stigmatizing attitudes among ministerial leaders.

**Results:** There was an increase in the mental health knowledge which was retained for a period of at least 3 months, $t(25) = 9.74; p < .001$. Two of the four Community Attitudes Towards the Mentally Ill subscales showed significant reductions in negative attitudes on both the Authoritarianism and Social Restrictiveness scales, $t(25) = -9.05, p < .001; t(25) = -7.65, p < .001$, respectively.

**Recommendations:** Many Americans do not have their depression needs assessed. African Americans are one of the populations that are most likely to be missed. Additional efforts, such as collaboration with community mental health providers, seem to be promising steps towards optimizing diagnosis, treatment, follow up, and sustainability of faith-based programs.

**Key terms:** African Americans, depression, church, suicidality, minister, clergy, congregant, depression screening tools, stigma.
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Chapter 1

Introduction

Mental illness is a complex personal and social problem. According to the most recent data from the National Institute of Mental Health (NIMH, 2018), one in six adults in the United States lives with some form of mental illness. Mental illness has a major effect on the individuals’ quality of life and affects their family members. Most people will not have a psychiatric illness that masquerades as a medical disease; however, there is always a possibility. Many mental illnesses share the same symptoms as a physical illness and could make the diagnoses very difficult. Medical mimics, or “an underlying medical condition masquerading as a psychiatric disorder”, can be challenging for physicians and mental health providers; therefore, a correct diagnosis is vital because it leads to a more effective treatment plan (McKee & Brahm, 2016, p. 289).

Depression, also known as clinical depression or major depressive disorder, is one of the most common forms of mental illness, and the fourth leading cause of disability in the United States (World Health Organization [WHO], 2017). An estimated 16 million American adults, that is, 7% of adults in the United States aged 18 and older, have experienced at least one major depressive episode in their lives (NIMH, 2018; National Alliance on Mental Illness [NAMI], 2018). The American Psychological Association (APA, 2017) has estimated that approximately 13 to 16% of adults will experience depressive symptoms in their lifetime, and 4 to 8% may experience depression annually.

Depression does not discriminate. It affects anyone regardless of one’s age, gender, income, social status, race/ethnicity, religion/spirituality, or sexual orientation NAMI (2018). Depression can be potentially serious because it affects how a person thinks, feels, and acts.
Although treatable, depression has no single cause, and due to its complexity, a full understanding of depression has been elusive (Meaney, 2015). Recent study findings of the WHO (2018) indicated that stress, genetics, nutrition, perinatal infections, and exposure to environmental hazards are some of the contributing factors that increase the overall incidence of depression and associated mental disorders.

Depression is not only a healthcare issue but a growing economic burden as well. Left untreated, depression is as costly as heart disease or AIDS to the U.S. economy with an estimated annual price tag of over $51 billion in absenteeism from work and lost productivity, and $26 billion annually in direct treatment costs (Mental Health America [MHA], 2019). The total economic burden of depression has now been estimated to be $210.5 billion per year (Greenberg, Fournier, Sisitsky, & Pike, 2015). These findings have reinforced a growing concern about economic impact and costs associated with mental illness to our society.

**Background and Significance**

The risk of depression increases as children transition to adolescence (Mojtabai, Olafson, & Han, 2016). Depression often begins in late adolescence or in the early 30s. It will often persist, recur, and sometimes continue into adulthood if left untreated NIMH (2018). Statistics have suggested that the lifetime prevalence of depression is 20-26% for women and 8-12% for men; women reportedly experience depression at twice the rate of men regardless of racial or ethnic background (Depression and Bipolar Alliance [DBSA], 2018).

Depression has a high rate of morbidity and mortality. It is often undiagnosed and is the leading cause of disability for Americans 15 to 44 years of age. Each year in the United States, an estimated 30,000 suicides that occur annually are attributed to depression (Iliades & Bass, 2014). Men are four times more likely than women to take their own lives. Ahmedani, Belville,
Robertson, Hirsch, and Jurayi’s (2016) research findings revealed that an estimated 6-15% of patients in the United States who are diagnosed with mood disorders such as depression committed suicide annually. Projections about depression have generated concern on both domestic and global levels because of its impact on health outcomes and quality of life. The United States Preventative Task Force (USPTF, 2016) advised primary care health care practitioners to initiate and assess depression using screening tools including the Patient Health Questionnaire PHQ-9 (Spitzer, Williams, & Kroenke, 1999; Spitzer, Williams, Kroenke, Hornyak, & McMurray, 2000).

Clarke and Yarbrough’s (2013) research noted that technology-based mental health services for patients who reside in rural areas have been recognized as very beneficial for both medical providers and their patients who suffer from anxiety and/or depression; however, the treatment has been considered as inadequate due to the scarce number of providers and limited access to these specialty services. Some of these modern forms of technology, such as face-to-face chats, have positively contributed to both patient and family outcomes, as well as enhanced practitioner capacity (Boydell, Hodgkins, Pignatiello, Teshima, Edwards, & Willis, 2014). However, statistics have revealed that only an estimated 43% of individuals with mental illness receive treatment and counseling (Substance Abuse and Mental Health Services Association [SAMHSA], 2016).

Depression rates differ by ethnic groups and health behaviors (Olafson, Blanco, & Marcus, 2016), and the disorder affects people in different ways NIMH (2018). Similarities in the prevalence of depression have been documented for all racial and ethnic groups; however, racial minorities are noted to bear a disproportionately high burden of disability that results from mental disorders. A study that Budhwanl, Hearld and Chavez-Venter performed (2017)
concluded that although rates of depression were lower in Blacks (24.6%) and Hispanics (19.6%) than in Whites (34.7%), depression in Blacks and Hispanics is likely to be more persistent. Lack of health care providers’ cultural understanding was the primary factor that researchers surmised may contribute to under diagnosis and misdiagnosis of mental illness in people from racially/ethnically diverse populations, which hence delays identification and treatment for these groups.

Depressive symptoms are known to vary in all race/ethnicities depending on the stage of illness. Common signs of depression include sadness, worthlessness, guilt, frustration, irritability, difficulty sleeping, loss of interest in activities that formerly offered pleasure, high levels of anxiety, eating disorders, and substance abuse NIMH (2018). Studies on marginalized groups such as African Americans revealed that the course and trajectory of mental illness may be more chronic for this ethnic group than non-Hispanic Asian adults, compared with non-Hispanic White adults. Bailey, Mokonogho, and Kumar (2019) noted that depressive episodes in African Americans were more severe and disabling compared to Whites and resulted in less favorable outcomes, which were attributed to the following issues: racial disparities, poor family engagement, lack of access and retention in mental health programs, over prescription of antipsychotic medications, and underutilization of psychiatric services (Office of Ethnic Minority and National Affairs [OEMA], 2010). Additional issues noted were over diagnosis of mental disorders such as schizophrenia and other psychotic illnesses (Moran, 2014).

In the African American community, the cultural stigma concerning mental illness often discourages this ethnic group from seeking the help they need. African Americans are more likely to rely on religious coping strategies such as prayer and/or informal sources of support that include the senior pastor, members of the ministerial team, family members, and a limited
number of friends. Research specifically on African Americans indicated that social status and many other factors often pattern religious coping (Chatters, Taylor, Woodard, & Nicklett, 2015). As a result, people have their own perspectives and preferences regarding the appropriate use of religious strategies to use when life’s challenges occur (McAuley, Pecchoni, & Grant, 2000). Those dealing with a serious personal problem, poor health, and bereavement in this ethnic group have utilized prayer as one of the most frequent coping strategies (Chatters, Taylor, Jackson, & Lincoln, 2008; Dunn & Horgas, 2000).

Impact on Society

McLaughlin (2011, para. 1) described depression as “a consequential public health problem in the United States.” Studies have examined the relationship between ethnicity and depression and have found that overall, African Americans suffer from depression for extended periods of time and are less likely to receive the appropriate diagnosis and culturally competent care. When African Americans are diagnosed with major depressive disorder, it tends to be more chronic and severe (Williams et al., 2007). Behavioral problems, poor school performance, substance abuse, teen pregnancy, impaired social relationships, and dysfunctional family relationships are some of the many challenges for those with depression (Cheung, Kozloff, & Sacks, 2013). The limited research available has suggested that community social support can be beneficial to overall health and assist with well-being.

Suicide has been identified as one of the most adverse outcomes of depression. It affects all age groups, including children, and is the 10th leading cause of death in the United States (Centers for Disease Control [CDC], 2018). The Substance Abuse and Mental Health Services Administration (SAMHSA) defined suicide as “a serious public health problem that exceeds the
rate of death from homicide and AIDS for a combined death toll of nearly 40,000 annually, that is, *approximately one person every 12 minutes*” (2019, p. 10).
**Problem Statement**

Over the past year, a total of nine church members in this faith-based institution have either died by suicide, attempted a suicide, or have been admitted to an area hospital for inpatient psychiatric treatment for mood disorders such as depression (personal conversation with senior pastor, 2018). Although depression is a mental illness that is widely known, it is often hidden in the church due to negative societal responses to people with mental illness (Simpson, 2018). It is believed that African American clergy (the senior pastor and the lay pastors, who are also known as the ministerial team) are unaware of the challenges that depression poses due to lack of education. The research of Hankerson, Watson, Lukachio, Fullilove, and Weissman (2013) found that more studies designed to increase public knowledge on mental health issues is necessary.

**Purpose of DNP Quality Improvement Project**

The purpose of this Doctor of Nursing Practice (DNP) quality improvement (QI) project is to synthesize the knowledge learned from the literature review and translate it by launching a self-reported depression screening and stigma reduction program in a nondenominational church that serves mainly African Americans. This QI project was an attempt to elaborate on and clarify the link between stigma, such as beliefs related to mental illness, and how education can influence help-seeking and literacy among ministerial leaders. A Mental Health Knowledge test (MHKT), the Community Attitudes Towards Mental Illness Scale (CAMI), and a post education survey were used to evaluate this DNP project’s effectiveness in enhancing general mental health knowledge and changing negative attitudes towards mental illness to reduce the stigma associated among ministerial leaders.
The primary aim is engagement and education of stakeholders (e.g. senior pastor and ministerial leadership team) on the importance and processes of screening, referral and follow-up of congregants who could potentially be at risk for depression/suicidality.

The secondary aim is integration of mental health stigma reduction as a part of this training to improve the perspectives of the leadership team about persons suffering from depression and suicidality. This change may subsequently prevent mental health disorders from going undiagnosed and untreated in this congregation.
Significance of Project

The primary focus of this project is to both engage and educate stakeholders: the senior pastor, the ministerial staff, and designated leaders in this faith-based institution on the importance of screening congregants who these individuals identify as potentially at risk for depression and/or suicide and to emphasize the importance of collaboration and referral to the mental health community and assuring follow-up after treatment.

This DNP project promoted positive social change through education of the ministerial staff and leaders on the topic of depression, suicidality and cultural stigma that often accompanies mental health illnesses. Depression manifests differently in adults and children NIMH (2018). Early identification of those at risk for depression/suicidality, accurate diagnosis, appropriate treatment, and follow-up has been recognized by the United States Department of Health and Human Services (USDHHS) (2018) as factors that resulted in positive outcomes for those who sought help (Mental Health America, 2018). The results of this project are aimed at increasing awareness in the African American community who seek help. It can also serve as a template for similar programs.

Definition of Terms and Variables

The purpose of this section is to introduce and define the key terms and variables that are specific to this project. The defining of terms and variables is very important to help understand the context of this study.

General Terms

- **African American**: African Americans are an ethnic group of people, descendants from Africa, who are now residents of the United States. The United States Census (July 17, 2017) reported that African Americans compose 13.4% of
the U.S. population. Alternate terms include Black Americans or Afro Americans.

- **Clergy**: An individual or group of individuals whom the church has duly ordained or a religious body constituting a church denomination has licensed. Clergy are given authority to administer ordinances, consult religious worship, perform marriages, and preside at funeral services in accordance with doctrines of their faith-based organization (Church of All Worlds, 2018).

- **Congregant**: A member of the congregation (Episcopal Church, 2018).

- **Depression**: Depression is often referred to as a major disorder or clinical depression. Although it is very common, it has been identified as a serious mood disorder. No two people are affected the same way. Symptoms that affect how one feels, thinks, and handles daily activities, such as sleeping, eating, or working, characterize depression. To be diagnosed with depression, the symptoms must be present for at least 2 weeks NIMH (2018).

- **Depression screening**: Depression screening is defined as a test that healthcare providers use to confirm a preliminary diagnosis of depression. These tests may provide some insight to the providers about the patient’s mood so that they can diagnose the patient with more certainty (WebMD, 2018).

- **Depression screening tools**: These are tools that health care providers frequently used to detect self-reported symptoms of depression. There are a variety of tools available such as PHQ-2, PHQ-9, Beck’s Depression Inventory, and the McArthur Foundation Depression Tool kit that the USDHHS and the Centers for Medicare and Medicaid (CMS) use.
• **Major depressive disorder**: This is a mental condition with symptoms that vary from person to person in type and severity. They include: loss of interest in things one likes to do, feeling sad or empty, feeling irritable, being unable to enjoy things that were once pleasurable activities, feeling hopeless, loss of self-esteem, physical complaints or changes in sleep such as waking up early or sleeping too much, lack of energy, loss or increase in appetite, weight loss or gain, headaches or backaches, stomach pain or change in bowel habits, and suicidal thoughts or actions. Professional treatment is necessary for all types of depression (ICD10data, 2018).

• **Mental Illness**: A disease noted to have more than 200 classified forms, but the common characteristic among all is the inability to cope with life’s daily demands or routines with a notable change in attitude and/or behavior, which may range from mild to severe. Several common types of depression, known as depressive disorder, include major depression, bipolar disorder, schizophrenia, seasonal affective disorder, dementia, and some anxiety disorders. Social withdrawal or personality changes (behavior and attitude) may indicate a mental health disorder MHA (2018).

• **Minister**: This term is derived from the Latin word that means “servant to a higher good.” These individuals are licensed through an application process. Requirements are prior experience and training, reasons for wanting to be licensed, and letters of recommendation. Ministers can perform marriages, prison and hospital visitations, chaplaincies, and legal sacraments CAW (2018).
• **Stigma**: A negative view of someone generally based on a personal trait or other characteristic that some people believed to be a disadvantage (or negative attribute) by some people. Many people diagnosed with mental illness are often challenged by members of society who harbor these attitudes and beliefs (Mayo Clinic, 2018). The CAMI is a valid reliable tool to capture this stigma.

• **Suicidal Ideation**: When individuals want to take their own life or are thinking about taking their life. There are two types: active and passive. Those who experience passive suicidal ideations usually do not have any definitive plans to die, although they often make statements indicating that they wish they were dead or could die. Those who are experiencing active suicidal ideation, however, are not only thinking about committing suicide but often have an active suicidal ideation, which is a common symptom in major depression and bipolar disorder (Purse, 2018).

**Instruments/Tools**

• **CAMI Scale**: Authors Taylor and Dear (1981) explicitly designed this 40-item scale to measure community attitudes toward the mentally ill. The scale represents dimensions included in previous instruments: authoritarianism, benevolence, social restrictiveness, and community mental health ideology. Internal consistency alphas have satisfactory values; authoritarianism ($\alpha = .68$), benevolence ($\alpha = .76$), social restrictiveness ($\alpha = .80$), and CMHI ($\alpha = .88$). The terms used on this scale emphasize community contact with the mentally ill and mental health facilities (https://camiscale.com).
- **Patient Health Questionnaire-9 (PHQ-9):** A validated screening tool that is described as “a multi-purpose instrument used for the diagnosis, screening, monitoring, and measuring the severity of depression. The PHQ-9 is a self-reported tool that incorporates the DSM-V depression diagnostic criteria along with other leading major depressive symptoms. This tool rates the frequency of the symptoms, which factors into the scoring severity index. Question nine (9) on the PHQ-9 screens for the presence or absence of suicidal ideation. A follow-up non scored question on the PHQ-9 screens and assigns weight to the degree to which depressive problems have affected the patient’s level of function” (Kroenke, Spitzer, & Williams, 2002, p. 62).

**Variables**

Several variables were included in this QI project to identify the characteristics of participants and to establish the success of the planned intervention.

- **The independent variable:** Education/curriculum on depression/suicidality and mental health illness stigma. This intervention included training on mental health and illness awareness, utilization and purpose of the PHQ-9 tool, and provision of an evidence-based resource package for screening/referral/follow up.

- **Dependent variables** included the CAMI Scale, MHKT scores, and Post Education Survey PES. In addition, the frequency of PHQ-9 tool usage and the ministerial team’s frequency of referrals and follow up of congregants were calculated.

- **Categorical variables** included ethnic/racial characteristics including White, Black or African American, American Indian, or Alaska Native, Asian, Native Hawaiian, or other Pacific Islander; age, gender, socioeconomic status, education, and leadership position.
Questions Addressed in this DNP Project

Research studies have shown that African Americans are often more hesitant to seek help for mood disorders such as depression or anxiety than some other ethnic groups. As a result, many African Americans with depression continue to suffer in silence (Brown & McCreary, 2014). This DNP QI project will answer the following background needs assessment questions prior to project planning, implementation, and intervention.

Question 1: Did viewing and discussing the video, “Shadow Voices: Finding Hope in Mental Illness,” and the introduction/use of the PHQ-9 by the leaders result in improved mental health literacy over a 3-month period?

Question 2: Did viewing and discussing the video, “Shadow Voices: Finding Hope in Mental Illness, and/or administering the PHQ-9 during counseling, and reviewing the CAMI scale results, reveal an increase or decrease in negative attitudes (stigma) in this group over a 3-month period?

Chapter 2

Literature Review
A comprehensive review of the literature was performed using several databases: PubMed, Cumulative Index of Nursing and Allied Health (CINAHL), Psych Info, GALE, SAGE Journals, OVID, Google Scholar, The National Guidelines Clearinghouse, and EBSCO Host. The focus was on research articles published in peer-reviewed journals within the last 10 years; however, the search was not limited to research studies. This author also reviewed textbooks and a plethora of online databases. All abstracts and full text manuscripts were reviewed for additional relevant publications to include in the review.

This detailed electronic search for relevant information on African Americans and depression utilized the following keywords and combinations of search terms: African Americans and depression, African American clergy and depression, depression in the African American church, African Americans and suicide, suicide, depression, health care disparities, and African Americans and stigma. In addition, this researcher performed hand searches through reference lists to identify relevant studies.

The review of literature included a search for authors who had published research studies, articles, and books on African Americans and mental illness, depression, and faith-based mental health interventions. The key words for this search were: depression, depression screening, stigma, congregants, PHQ-9, non-pharmacologic treatment of African Americans with mental illness, ministers, clergy, pastoral counseling, and suicidal ideation.

The literature review focused specifically on the prevalence of depression in the African American community, barriers to treatment, risk factors, depression screening tools, treatment-seeking behavior, the role of the African American church, and the importance of a collaborative partnership between the African American church and community mental health providers.

The following inclusion and exclusion criteria were used to refine the search.
Inclusion Criteria: The participants were 18 years of age or older and English speaking. The study and intervention were conducted in the United States and published in English. Sources included peer-reviewed journals published between 2000-2018. These criteria provided an initial search of 1933 studies (Jacksonville University Library). The literature search revealed a total of 152 studies on African American clergy and counseling; 921 studies on African Americans, stigma, and mental illness; 43 studies on African Americans and the use of tools to diagnose depression; and 66 studies on the African American church and faith-based depression intervention (Jacksonville University Library).

Exclusion Criteria: Exclusion criteria were applied to reduce these results to those that would just inform the DNP project. Studies were excluded if they did not provide information on both the ethnic composition and racial groups that comprised the study sample. Studies were excluded if they did not address mental health awareness progress (e.g., implementation, interventions, and/or discussion on a variety of treatments that reduced the symptoms of mental illness and/or improved the behaviors or the skillset of those diagnosed with mental illness).

Also excluded were studies that did not include African American clergy and/or congregants who presented for counseling and were at risk for a mood disorder, suicide, etc., or studies that did not emphasize and/or discuss the collaborative efforts of the community mental health professionals with the African American population.

Lastly, also excluded were studies that only included African Americans of a specific age or population, those primarily focused on inpatient treatment, individuals with chronic comorbidities in addition to their diagnosed mental illness, and those individuals treated
for substance abuse. A total of 47 articles were included in the literature review for this DNP project.

Over the last several years, only a modest amount of research has been performed on depression in African Americans. These authors described this population as “underserved, understudied, and misdiagnosed as a group” (Sohail, Bailey, & Richie, 2014, para. 5).

This DNP project leader noted four very important factors that impact African Americans and depression: 1) the African American church, 2) African American clergy, 3) mental health awareness, and 4) barriers to care.

**The African American Church**

History has purported that many scholars have been interested in research on the nature, patterns, and functions of religion in the lives of African Americans due to the pervasiveness and persistence of the religious context in the lives of individuals, families, and communities for this population group (Chatters et al., 2015). The African American church has historically been the central institution in this community for both economic stability, counseling, and political involvement (Barber, 2015). Pastors, ministers, and other clergy are often referenced as “gatekeepers” or “first responders” simply because they play a vital role in meeting the physical, emotional, and spiritual needs of the congregation (Chatters, Taylor, Woodard, & Nicklett, 2015).

Religion is support for many African Americans, and on any given day, these faith leaders may encounter individuals with a wide variety of challenges that must be addressed. People often seek the sanctity of the church because it is both free and familiar; however, the subject of mental illness remains a taboo one in most African American churches, which
prevents those in distress from confiding in others or reaching out to the clergy members for help.

The first published study of depression screenings conducted in an African American church was in 2015. The purpose of this study was “to assess the feasibility of using the validated instrument, the PHQ-9, in the faith-based setting” (Hankerson, Lee, Brawley, Braswell, Wickramaratne, & Weissman, 2015). The initial analyses were conducted in 2013 and subsequent analyses in 2014. These research findings supported the fact that churches were an important setting to screen for depression using the PHQ-9.

Although research focused on African Americans with mental illness in the church has increased, there were no published studies that examined African American beliefs about stigma and mental illness using the validated instrument; CAMI. The only extant studies involved community-dwelling African Americans using the Common-Sense Model (CSM) which postulated that experience, cultural education, family, and friends form a person’s beliefs and attitudes (Ward & Heldrich, 2009; Ward, Wilshire, Detry, & Brown, 2013).

The NIMH (2016) estimated that almost one in five U.S. adults were living with mental illnesses such as anxiety disorders, major depression, and schizophrenia. African Americans were 10 percent more likely to report having serious psychological distress than non-Hispanic Whites, in part because they wait to seek help.

The National Survey of Black Americans (NBSA) published data regarding the role of the church versus that of the family on depressive symptoms. Issues explored were the impact of religion on the individual’s mental and physical being, as well as social support and functions of religion in coping (Chatters et al., 2015). Study findings revealed that negative interactions among church members appear to foster or exacerbate psychological distress and depressive
symptoms despite the degree of protective factors such as social or emotional support.
Additional research is necessary to elucidate the link between depressive symptoms, the
influence of church, and family-based support. These studies, although suggestive, have not
assessed the determinants of utilization of mental health services. Only persons who have
utilized these services have been included, and the convenience samples limited generalizability
(Villatoro & Aneshensel, 2014).

**African American Clergy: Multiple Roles, Internal and External Expectations**

The senior pastor’s perspective on pastoral care, has not been well researched, and there
is yet much confusion regarding the pastor’s actual role (Stansbury, Harley, Kung, Nelson, &
Speight, 2012). Generally, the bylaws of the church outline the duties and responsibilities of the
senior pastor. One of the core duties of the pastor is to lead the Sunday morning worship
services. Additional duties include: church operations, band provide counseling or support to the
members of the congregation, and ministerial leadership team (Kokemuller, 2019). In this role,
the senior pastor can dispel misunderstandings, reduce stigma associated with mental illness and
treatment, and facilitate access to treatment for those in need.

The clergy members’ knowledge about mental health disorders, their ability to recognize
symptoms of mental illness in their congregants, and their decision to refer these members to
community mental health providers are factors crucial for prompt treatment and positive
outcomes of those with mental illnesses (Anthony, Johnson, & Schoefer, 2015). Although
findings from the literature are scarce; the clergy’s attitude toward mental illness may perpetuate
stigma and as a result lead to the underuse of mental health services among members of the
congregation.

**Mental Health Awareness: Stigma, Early Identification, and Education**
Stigma, both public (general population’s reaction to people with mental illness) and self-stigma (prejudices that people with mental illness turn against themselves) may inhibit an individual with mental illness from seeking assistance from a mental health provider (Stansbury et al., 2012). These stigmatizing attitudes may create feelings of diminished self-esteem/self-efficacy, helplessness, indifference, and hopelessness, which may worsen depression. Although faith is a defining feature in the African American church and serves as a catalyst for creating political, systemic, and individual change in the Black community, when stigma is present, the true etiology of depression is not sought, and the congregant’s symptoms are attributed to a lack of faith, or one who is battling demons.

Race, ethnicity, and culture are embedded in these clergy/congregant relationships, and as such, they play a huge role in shaping everyone’s attitudes, beliefs, and behaviors (Cobb, Perry, & Dougherty, 2015). Many people still believe that emotional problems, mental health problems, and psychiatric disorders are a sign of moral weakness or failure. During these challenging times, access to a mental health professional is necessary to mitigate feelings of suicide and other forms of self-harm.
Barriers to Care

The Affordable Care Health Act [ACA], which expanded Mental Health Parity, and the Addiction Act of 2008 helped to tighten the gap between the insured and uninsured. After the introduction of the Addiction Act of 2008, many members of the lower income class and the poor were eligible for both substance abuse and mental health insurance. However, fear, mistrust of healthcare providers due to historical persecution of minorities, racism, misdiagnosis, inappropriate care, and the involuntary medical exploitation of Blacks were some factors that discouraged this population from seeking mental health care.

In “Black Americans Don’t Trust Our Healthcare System—Here’s Why,” Dr. Corey Williams (2017) discussed the horrible history of medical exploitation and abuse of Black people. The author pointed out how research has shown that Blacks are less likely to report trust in their healthcare providers and hospitals; therefore, they are less likely to seek treatment. Further research is clearly necessary to examine how faith-based organizations can increase partnerships between traditional health care services and community agencies, which will be important in forming collaborative partnerships.

Despite the ACA’s benefits, African Americans have continued to face challenges due to delays in obtaining medical care or prescription medication. Racial discrimination, in the form of both “old fashioned” and subtle microaggressions, was noted to hamper the therapeutic relationships between the client and the therapist (Terwillinger, Bach, Bryan, & Williams, 2013, p. 97).

It was interesting to note that although racial discrimination was prevalent in some areas, other therapists reportedly adopted a “colorblind ideology,” which these authors described as a
form of racism that provides an excuse for therapists to remain ignorant of the cultures and norms of nonWhite patients (Terwilliger et al., 2013, p.98).

Williams (2013) found in his article that often therapists unknowingly perpetuate racism during the counseling process with African American clients. Below are Williams’ examples of some statements from a licensed mental health provider to an African American client:

- “I don’t see you as Black. I just see you as a regular person” (para. 4).
- “I’m not sure we need to focus on race or culture to understand your depression” (para. 5).
- “If Black people just worked harder, they could be successful like other people” (para. 6).
- “Don’t be too sensitive about racial stuff. I didn’t mean anything bad/offensive” (para. 7).

These statements are examples of microaggressions and are believed to be the largest predictor of client dissatisfaction with some mental health therapists. Education and cultural competency are necessary to promote positive outcomes; however, in many instances, the therapist will excuse this dysfunctional behavior as “normative” and, as a result, the client often makes the decision no longer to participate in this type of patient/client relationship (Williams, 2013).

The constructs and perspectives of both ministerial leaders and mental health providers must be examined to facilitate the provision of culturally appropriate care (Dune, Caputi, & Walker, 2018). Appropriate care is crucial to accurate diagnosis. Culturally competent mental health specialists are limited; therefore, society must learn how to educate existing providers on the importance of cultural competence in mental health care to mitigate health care disparities.
The Patient Health Questionnaire-9 PHQ-9

The PHQ-9 is a validated tool that has been used to assist clinicians with making criteria-based diagnoses for depression and monitoring treatment response. The PHQ-9 functions as a screening tool and aids in the diagnosis. Health care providers used it as a symptom tracking tool to help track the members’ overall depression severity and the improvements of specific symptoms with treatment APA (2018). The researchers who developed this tool utilized the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) as their guide.

The PHQ-9 has been used in a variety of settings with individuals aged 12 and older. Pfizer developed and owns the PHQ-2 and PHQ-9; however, it is free to users, available in English and 30 other languages, and quick and easy to administer APA (2018). The PHQ-9 can be used, reproduced, and distributed without permission. Many primary care offices have the templates for the PHQ-2 and PHQ-9 as a part of their electronic health records. The staff are trained to administer both tests.

No strict guidelines exist as to how often the tool should be administered; however, a common recommendation for monitoring and adjusting treatment is 4 to 6 weeks. (Kroenke et al., 2001) defined a positive depression screen as follows:

A score > or =5 on the PHQ-9. This includes scores in the mild (5-9), moderate (10-14), moderately severe (15-19), and severe (20-27) ranges. Scores in the mild range were deemed important because persistent symptoms, regardless of severity, conveyed an increased risk for later development of major depression and suicidal behavior. A score of greater than or equal to one on item 9 of the PHQ-9 questionnaire was considered indicative of suicidal ideation and considered a positive depression screen regardless of total PHQ-9 score (p. 609).
When the results of the screening indicated that depression was present, a licensed mental health professional was contacted, and a referral was initiated. Depression symptoms that did not meet the DSM-V criterion according to Kroenke et al. (2001) were attributed to additional psychological syndromes such as dysthymic disorder, cyclothymic disorder, substance abuse, bereavement, and bipolar disorder; therefore, it was important to refer the congregant to a mental health professional for evaluation.

The reliability and validity of the PHQ-9 has indicated that it has sound psychometric properties and very high scores for internal consistency (New York State Office of Mental Health, 2016). Kroenke et al. (2001) used the PHQ-9 in a study that involved two different populations. These studies revealed that a mental health professional was between 7 to 13.6 times more likely to diagnose individuals who scored high (>10) on the PHQ-9 with depression; however, individuals who scored low (≤ 4) on the PHQ-9 had less than 1 in 25 chances of having depression according to Cronbach alphas of 0.86 and test-retest reliability of 0.89. (para. 2).

**Community Attitudes towards Mental Illness Scale**

The second instrument used in this project was the validated questionnaire, CAMI Scale, that Taylor and Dear (1981) developed. The instrument is a modified version of the Opinion About Mental Illness Scale that Gilbert and Levinson developed in the 1960s (Madianos, Economou, Peppou, Kallergis, Rogakou, & Alevizopoulos, 2012). The purpose of this scale was to measure the attitudes of the ministerial team towards the mentally ill before and after educational awareness intervention, noting any stigma towards those with mental illness.

According to Taylor and Dear (1981) initially, only scales that measured the professional’s attitudes towards the mentally ill were available, and very little effort was made to
develop a scale that assessed community attitudes. These researchers combined two of what they believed were the most comprehensive and validated scales, the Opinions about Mental Illness (OMI) and Community Mental Health Ideology (CMHI) scales and adapted them to form the CAMI scale.

This scale consists of 40 items (statements) and four subscales that include: Community Health Ideology, Benevolence, Authoritarianism, and Social Restrictiveness (Krameddine, DeMarco, Hassel, & Silverstone, 2013). Taylor and Dear (1981) freely granted permission for the use of the CAMI scale (see Appendix D for statement to that effect); however, users are required to acknowledge the CAMI source and to document in detail any changes they made to the original instrument. The primary focus is on how stigma may impact mental illness (Wei, McGrath, Hayden, & Kutcher, 2015).

Krameddine et al. (2013) described the four subscales as follows: (a) CAMI-A or Authoritarianism, designed to measure stigma; (b) CAMI-B or Benevolence, one of which measures a fear of mental illness; (c) CAMI-SR or Social Restrictiveness, designed to indicate one’s acceptance of the mentally ill in the community and/or workplace; and (d) CAMI-CMHI, or Community Mental Health Ideology, which measures the individual’s commitment to a community mental health ideology, that is, total community involvement working with a variety of community resources to assist patients. Scoring of the four subscales was based on the use of a five-point Likert scale. Consistent with previous studies, higher scores on the CMHI Ideology and Benevolence subscales indicate a greater acceptance of the mentally ill, whereas high scores on the Social Restrictiveness and Authoritarianism subscale indicate greater amounts of cultural stigma.
To assess for reliability and validity of statements and scales, Taylor and Dear (1981) conducted two separate pretests. The initial findings revealed alpha coefficients for all four scales above 0.50 which, though modest, were considered satisfactory. However, when some of the statements were replaced (e.g., two statements replaced on the social restrictiveness scale to eliminate unnecessary repetition), all the alpha coefficients were higher in all categories except for the Benevolence subscale. The results are as follows: CMHI=0.88, SR=0.80, Benevolence=0.76, and Authoritarianism = 0.68, though lower, but still satisfactory.

In addition, construct validity was assessed by using factor analysis to test their empirical reproducibility. A high degree of intercorrelation was found (e.g., the lowest correlation was -.63 between authoritarianism and benevolence, and the highest was -.77 between social restrictiveness and CMHI. Although the researchers concluded that these results were higher on the second pretest, they attributed the differences to the revisions they made (Taylor & Dear, 1981).

Wei et al. (2015) reviewed 9 studies which utilized some of the most widely used stigma measures based on the number of studies in which the measures were applied. The stigma measures included were: The Social Distance Scale (SD), Opinions about Mental Health Illness (OMI), Devaluation-Discrimination (DD), Depression-Stigma Scale (DSS), also called Personal and Perceived Stigma of Mental Illness, Attribution Questionnaire (AQ), Internalized Stigma of Mental Illness (ISMI) and Perceived Dangerousness (PD). Future research is needed on how to apply the existing tools to develop programs, interventions, and policies. The goal is to determine which model provides a better prediction of the presence or absence of stigma/negative attitudes towards the mentally ill.
Chapter 3

Theoretical Framework

Two models were selected to support and guide this change project. The theoretical framework selected to frame this quality improvement project was Dr. Nola Pender’s Health Promotion Model (HPM, 1982). The second model that was selected to assist the health care staff in the process of making a change was Dr. William Edwards Deming’s Plan-Do-Study-Act model, sometimes called PDSA, the “Deming Cycle,” or “Deming Wheel” (1950).

Pender’s Health Promotion Model

Pender described this model as one that was constructed from Fishbein’s expectancy theory-value theory (1970s) and Bandura’s Social Cognitive theory (1977), using a nursing perspective (McEwen & Willis, 2014). Pender’s Model HPM can be used a guide to understand the factors that motivate people to engage in certain behaviors, and as a framework for research aimed at predicting health-promoting lifestyle choices. These choices help people achieve higher levels of well-being, which mitigates the health problems that behaviors that are largely preventable cause (Joseph, 2016). The HPM that Nola Pender devised (1982, 1996) defined health as “not merely the absence of disease, but a positive dynamic state” (Nursing Theorist, 2011, para 1).

Health care professionals can use Pender’s HPM to develop and execute health promotion interventions for individuals, families, and groups in almost every setting. The HPM model, if used effectively, can empower individuals to make healthy lifestyle choices that result in positive outcomes. This model is often used in project planning/program management to understand and explain health behavior, which in turn enables the researcher to identify, develop, and subsequently implement interventions to overcome the negative aspects of patients’ behavior
(Rural Health Information Hub, 2018). Recent studies that Khodaveisi, Omidi, Farokhi, and Soltanian conducted (2017) provided detailed examples of how Pender’s HPM could be used to design or revise an existing health promotion and/or health prevention program.

Murdaugh, Parson, and Pender (2018) described the HPM as a “competence or approach-oriented model” (p. 40). The authors defined positive self-efficacy or self-confidence and increased self-awareness as beliefs about oneself that are achieved by teaching individuals how to overcome negative aspects of their behavior. In other words, a better understanding of ourselves as unique and separate individuals empowers us to make changes that are built on our strengths instead of our weaknesses.

It has been suggested that interventions that improve an individual’s self-efficacy are desperately needed to maximize management of depression and other mental health disorders. The construct of self-efficacy, which is one of the most important predictors of health behavior, is very important in developing an external locus of control. Individuals with low self-efficacy, anxiety, and/or depression may feel inefficient and unable to control themselves, whereas those with a high level of self-efficacy may judge the perceived threat as controllable. Thus, by reducing their negative thoughts and concerns about potential threats, these individuals deal directly with the problems they face, which helps improve their mental health (Kurnat-Thoma, ElBanna, Oakcrum, & Tyroler, 2017).

**Evidence of Empirical Testing**

Nursing scholars and researchers have widely used Pender’s HPM to both explain and predict health behaviors. This model is easy to understand and is highly generalizable to all populations (Alligood, 2014). Pender’s conceptual framework integrated nursing behavioral sciences and the factors that influence health (Murdaugh, Parsons, & Pender, 2018). This model
integrated constructs from the social cognitive theory and the expectancy-value theory within a holistic nursing perspective that is applicable to any health behavior in which threat is not the source of motivation.

In the revised HPM model, Pender incorporated three new concepts: activity-related effect, commitment to a plan of action, and immediate competing demands and preferences (Murdaugh et al., 2018). Pender explored some of the individual characteristics and experiences and how they impact behavior.

- Personal factors: Some of the concepts reviewed were personal factors that were categorized as biological, psychological, and sociocultural. Biological factors reviewed include age, body mass index, aerobic capacity, or strength; psychological factors include self-esteem, self-motivation, and perceived health status; and sociocultural factors include race, ethnicity, acculturation, and socioeconomic status (Murdaugh et al., 2018). Pender suggested that the personal factors should only be those that are theoretically relevant to predict or explain a target behavior.

- Prior related behavior was also believed to indirectly influence health-promoting behavior or outcome expectations. In other words, if either long- or short-term benefits are experienced during initial implementation of a behavior change, the behavior is more likely to be repeated.

**Behavior-Specific Cognitions and Effect**

Pender described behavior-specific cognitions and effects as variables that intervention could modify. After an intervention was performed, these variables were examined when evaluating change. Murdaugh et al. (2018) listed the variables as self-efficacy, activity-related
effect, interpersonal influences, perceived benefits and barriers, interpersonal influences, and situational influences. These authors described the variables as follows:

- **Perceived Benefits of Action**: Intrinsic or extrinsic benefits used directly and indirectly to motivate behavior.
- **Perceived Barriers to Action**: Mental blocks, hurdles, or perceived costs of acting. If the desire or motivation was high, then the action was likely to occur or vice versa.
- **Perceived Self-efficacy**: The individuals’ competence and perceptions of their ability to accomplish the task will often motivate them to engage in the behavior.
- **Activity-related Affect**: The emotional response that the individual feels after the behavior takes place will often determine whether the person will repeat the behavior. There are three (3) components: arousal to the act itself (act-related), self-acting (self-related), and the type of environment (context) where the behavior was performed. Was the experience positive or negative?
- **Interpersonal Influences**: These are cognitions (thoughts) that may impact the behaviors, beliefs, or attitudes of others. These thoughts or perceptions may or may not reflect reality. All of us often accept or reject social norms. The HPM proposes that our interpersonal influences may play a positive or negative role in whether we adopt or reject a behavior change.
- **Situational Influences**: The individuals’ social environment as well as their personal perceptions or thoughts may facilitate or impede their behavior. Studies have shown that a person’s perceptions of options available and the environment in which a given behavior takes place indirectly and directly influence the behavior (Murdaugh et al., 2018).
In the faith-based environment, health care professionals can use Pender’s HPM to promote a sense of well-being and harmony to those who may be challenged with a mood disorder or are contemplating suicide (Peterson & Bredow, 2009). Pender’s model includes measures that individuals take to achieve optimum health; therefore, an individual’s thoughts, behaviors, and environment interact to achieve a desired outcome. A positive self-efficacy will lead to a greater likelihood that the behavior will be performed, and the goal will be accomplished (Pender, 1996).

Assumptions

The HPM model’s success is based on the following assumptions that individuals play an active role in their behavior (Alligood, 2014). Pender’s assumptions are listed below:

a) Individuals will often seek what they may consider adequate living conditions through which they can attain optimal health.

b) A greater knowledge of self-awareness and self-efficacy can impact learning as well as the individuals’ ability to assess their strengths and weaknesses.

c) An individual’s ability to remain stable despite challenging times and/or changes leads to growth.

d) Persons who make a commitment to a plan of action will often regulate their behavior to achieve a certain goal.

e) Interpersonal influences such as family, peers, work, and social environment shape an individual’s attitudes and beliefs. These factors can either facilitate or impede negative or positive behavior.
f) Nurses and other health care professionals are primary sources of interpersonal influences and are very important in the health promotion process to individuals and families.

g) People can change their behavior as necessary.

The primary focus of Dr. Nola Pender’s HPM was the individual; however, further research should be performed to ascertain if the model is effective with communities and families. Although studies have continued to support HPM concepts, the researcher must remember that the individual must be committed to a plan of action, review any immediate competing demands, and identify a specific strategy that can be utilized to initiate, perform, and reinforce the behavior desired. Individuals who have a stronger belief in their self-efficacy or personal capability to execute a positive health-promoting behavior or change are quicker to discard faulty strategies and will ultimately achieve the desired behavior change (Murdaugh et al., 2018).
Pender’s Health Promotion Model is comprised of four assumptions: (a) individuals seek self-control; (b) self-improvement and environment are important factors; (c) one’s interpersonal environment, which includes healthcare practitioners, may impact behavior; and (d) positive self-efficacy generates changes in individuals, their environment, and behavior (Nursing Theory, 2011).

For patients who suffer with depression, the best approach towards managing the condition is to ensure that the individuals take the necessary steps to seek medical help and
follow up with a specific treatment plan from a mental health provider/clinician (Kroenke, Spitzer, & Williams, 2001).

**Application of Pender’s HPM**

People of all ages, gender, and ethnicities can benefit from health-promoting behavior. Researchers around the world can utilize Pender’s HPM to intervene in many different venues to influence health promotion related to education, research, and policy (McEwen & Willis, 2014). Pender’s HPM is often referenced as one that “describes the interaction between the nurse and the consumer while considering the role of the environment in health promotion” (Alligood, 2014, p. 405).

Behavioral studies indicate that changes in the individuals’ behavior are highly influenced by their will to change, but certain prior experiences may affect their progress (Halverson & Bienenfield, 2018). For patients who suffer with depression, Kroenke et al. (2001) argued that the best approach toward eradicating the condition is to ensure that the individuals take the necessary steps to seek medical help and follow up with a specific treatment from a mental health provider.

Peterson and Bredow (2009) described health education as one strategy that researchers utilize for the implementation and management of health promotion and disease prevention. Pender’s HPM can be very useful to the health care professional simply because it has allowed the focus to transition from prevention of disease to that of health promotion. This collaborative model allows the nurse and the patient to be agents of change and work together toward optimum health care goals, which include the health benefits and threats they face.
Plan-Do-Study-Act Model

The Plan-Do-Study-Act (PDSA) method, a four-step management model used in business and other venues for carrying out change (Institute for Health Improvement [IHI], 2018) was the model that was selected for this QI project. Additional names for this model are the “Deming Wheel,” “Deming Cycle,” or “Shewhart Cycle” (see Figure 2).

![Figure 2. PDSA. Reprinted from the Institute for Healthcare Improvement (2018). Retrieved on July 7, 2018 from http://www.ihi.org. Reprinted with permission.]

This model consists of two parts: three (3) questions that comprise the “thinking part,” and the “doing part” of the PDSA cycle (IHI, 2018). The goals selected for this project were specific, measurable, attainable, realistic, and time limited (SMART). Changes to existing processes, the initiation of new processes, and implementation of new tools are some of the benefits of this quality improvement model that were relevant to this project.
This QI project utilized data analyses that used quantitative measures to determine whether an education awareness program that included depression/suicidality screening using the validated instrument, the PHQ-9, would result in early identification of self-reported depressive symptoms, prompt referrals to community mental health providers for treatment, and the ministerial leaders’ follow up within a 2-week period.

The IHI (2018) recommended the following four steps that the researcher or project leader should review prior to initiating change:

- The collection of baseline data for the area you wish to improve.
- Define the target population and location for the change(s).
- Establish a clear aim (e.g., reduce stigma and increase referrals to community mental health agencies).
- The selection of project or change leaders and their team who will develop and implement the desired change.

This model is very simple but was a very powerful way to approach the challenges of this faith-based institution.

**Goals and Expected Outcomes**

The goal of this QI project was educating the ministerial leaders on the importance of depression screening, referral, treatment, and follow up in the hope that suicide attempts in this faith-based organization would be decreased. An educational awareness and stigma reduction program was implemented to provide the ministerial team participants with evidence-based tools that could be utilized during the counseling process. The validated tool selected for the ministerial leaders’ use during their no-fee counseling sessions was the PHQ-9.
The primary aim of this project was engagement and education of stakeholders (e.g., the senior pastor and the ministerial leadership team) on the importance of screening, referral, and follow up of congregants who have been identified as at risk for depression/suicidality. First, the leadership team reviewed and discussed the Public Broadcasting System (PBS) video, “Shadow Voices: Finding Hope in Mental Illness” as a part of this educational awareness program. Next, the ministerial leaders were introduced to the validated instrument: PHQ-9, that mental health professionals use widely for depression screening programs in the United States.

The secondary aim was integration of mental health stigma reduction as a part of this training, which may subsequently prevent mental health disorders from going undiagnosed and untreated. The CAMI survey will be used to assess the ministerial leaders’ attitudes towards people with mental illness.

After implementation of this doctoral project, this project leader completed an analysis of the data comparing the baseline results of the MHKT pre/posttest scores, the pre/post intervention CAMI scores, and the surveys received: both the Demographic and PES. In addition, the project leader was given data which indicated the number of PHQ-9s performed, referrals, follow up, and dispositions recorded for a 3-month period.

According to the literature review, the congregants and their families may receive benefits through a decrease in suicide attempts (Ahmedani et al., 2016; Hankerson et al., 2013; Brown & McCreary 2014; Chatters et al., 2015) and heightened awareness of the symptoms of depression; those who suffer from depression receive help in connecting to a mental health provider MHA (2019).

Outcome Objectives
At the completion of this quality improvement project, specific outcome objectives included the following:

- The post intervention MHKT test scores would reflect a retention of knowledge attained over the 3-month period (March–June).
- The post intervention CAMI scale scores would reflect a decrease in the Authoritarianism and Social Restrictiveness subscales and an increase in the scores for the Benevolence and Community Mental Health Ideology after a 3-month period (March–June).
- Over the 3-month (90–day) period, screenings will occur with appropriate referral as indicated.
- The PES results will reflect the ministerial leaders’ increase in perceived knowledge.
- A community mental health resource binder was be compiled and presented to the senior pastor for official use only.

**Process Objective Description**

- Development of a depression awareness and referral program, which includes stigma reduction, to increase awareness of the importance of recognizing depression screening/suicidality in the church community and congregants (members).
- Develop stigma reduction materials and education for the ministerial team.
- Leaders will understand PHQ-9, its purpose, and the website where it can be accessed. They will receive paper copies with a score sheet and learn how each leader can work in collaboration with the pastor to screen congregants who are scheduled for counseling.
• CAMI scale will be one of the validated instruments used as a pretest for this DNP project.

Process Objective Measurement

• Project manager will achieve “buy-in” from the senior pastor, the Board of Directors, and the ministerial leadership team prior to implementation of this project.

• A facility needs assessment will be discussed with the senior pastor after IRB approval has been granted. All members of the leadership team will review and acknowledge the importance of confidentiality of program information and anonymity of congregants at the designated monthly meeting prior to project implementation.

Objective Baseline

• This facility has limited religious education programs for the ministerial leadership team. There are currently two programs provided for ministerial leaders in the church as follows:

(a) Ministerial Development Class for those who desire to become a licensed minister; this class is 2 years in length.

(b) Deacon training for those who desire to become an ordained deacon; those classes are 6 months in length. Seminary-prepared licensed ministers teach all the classes.

• No member of the ministerial leadership team has ever taken the CAMI scale survey.

• The senior pastor or any member of the ministerial team have referred no congregants in the past 90 days for mental health services.

• No members of the ministerial leadership team have ever used a PHQ-9 in their practice.
Objective Time Frame for Completion: 3 months

Outcome Objective Description

- The ministerial team will accurately describe and demonstrate the use of the PHQ-9. Confidentiality will always be maintained. A PHQ-9 score of >10 will be referred to the senior pastor for additional counseling and referral to the community.

- The senior pastor, the leader that has administered the PHQ-9, and the member will be the only persons aware of the member’s identity and score. The pastor will disseminate the PHQ-9 scores to the project leader on the Document Analysis Form weekly.

- The pastor will assign a number to each member counseled and tested. No personal identifiers will be used on the Document Analysis Form.

- Prior to implementation of the project, all ministers will receive a pretest from the major instruments: CAMI scale, designed to assess the presence of stigma toward the mentally ill, and MHKT to get a baseline on the leader’s mental health knowledge. There will not be any personal identifiers on the packets or the forms.

- After intervention (3 months later), the leaders received posttests, which were the same: MHKT, CAMI scale survey, and a program survey form for completion.

- No identifiers will be used. Each leader will place his original packet number in the upper right-hand corner of the post education survey form.

- All packets will be placed in a designated box near the door as each leader exits the room.

Objective Measurement
• MHKT Pre/Posttest scores of all ministerial leaders will be evaluated after intervention to ascertain if there were changes in mental health knowledge over the 3-month period.

• CAMI Pre/Post scores will also be evaluated after intervention to ascertain if there were changes in attitudes (stigma) towards mental illness.

• PHQ-9: Some questions for evaluation after intervention: Was this validated tool used? How many patients were screened, referred? Did someone follow up with those members referred within 2 weeks?

• The senior pastor informed the ministerial leaders to use the PHQ-9 form as a part of the Monday counseling sessions if the leader felt that the member was at risk for depression/suicidality. The leaders were informed to try this PHQ-9 form if needed for 3 months following the March 2019 project launch date. The leaders were instructed to observe the following guidelines
- All counseling sessions are confidential.
- The member will complete the PHQ-9, and the leader will score it.
- If the PHQ-9 score is >10, the member is referred to the senior pastor. If the senior pastor believes that the member’s mental/emotional condition warrants a referral, he will initiate a referral to one of the community mental health agencies near the patient’s home residence.
- The pastor or his designee will record all information on the Document Analysis form. All information will be deidentified before it is recorded on the Document Analysis form, and the Project Leader will review it. Neither the names of the members counseled, nor the names of the leaders will be annotated on this form.
- Each leader that has referred a member for counseling will follow up with the member in 1 week.

**Objective Time Frame: 3 months (90 days)**
Chapter 4

Methods

Chapter Four represents the procedures and methods that were used when conducting this QI project. This chapter describes the following: research design, recruitment of participants, settings and resources, organizational analysis of project site, instrumentation, quality improvement, the project implementation process, and ethical considerations and risks.

Research Design

A QI implementation design was used for this quality improvement project.

Setting and Resources

The facility chosen for this project was a nondenominational faith-based institution located in Okaloosa County, Florida. This faith-based institution has 681 members, of which approximately 30 hold leadership positions. The city in which this project took place has a population of approximately 21,000 people (U.S. Census Bureau, 2017). The population demographics (ethnic considerations) are as follows: White 77%, Black or African American 11.2%, American Indian 0.2%, Asian 3.4%, Native American or Pacific Islander 0.5%, Hispanic or Latino 9.2%, and two or more races, 3.9%.

Two primary mental health facilities in this city treat individuals who have been diagnosed with mental illness and alcohol or substance abuse. The larger facility is a 48-bed inpatient facility for adults age 18 and older. All patients who are admitted receive a comprehensive evaluation and plan of care. The overall objective(s) at Fort Walton Beach Medical Center Inpatient Psychiatric center are stabilization, functional improvement, and a successful transition to the next level of care.
The outpatient facility is designed for individuals who seek treatment for mental health and patients who are on a regular medication regime and wish to resume those medications. The primary candidates for this group home are those who participate in alcohol and drug rehabilitation programs. Those individuals who are not admitted to the group home return to their private residence at night. The individuals are eligible for group home, often referred to as aftercare, after they have completed a required 3-day inpatient stay at the local hospital (Fort Walton Beach Medical Center, 2018).

**Organizational Analysis of Project Site**

This faith-based institution was selected because the leadership team does not screen members for depression during their counselling sessions. There is no comprehensive list of community mental health providers or agencies for congregants with mental health issues. Currently, this facility is the largest African-American faith-based institution in this county. The leadership is heavily involved in many different community programs. Some of the onsite services provided are adult, teen, and children’s ministries, dance ministries, Academic Challenge League, Leadership in Okaloosa County, Ministerial Development Training, Nursing Home and Prison/Jail Ministries, and Feeding the Homeless on Thursdays. The site is a USDA Food Distribution Center for low-income families in need.

**Recruitment**

Recruitment procedures included an email invitation with a requested RSVP response from the ministerial leaders to the senior pastor two weeks prior to the launch date. This educational awareness program was substituted for the regularly scheduled monthly leadership meeting. Approximately one week prior to launch, a second email was sent by the senior pastor’s secretary to the ministerial leadership team as a reminder. The sample selection was not
random but purposeful and included only the leaders who were members of this faith-based organization. A minimum of 30 leaders were recruited.

The leadership were assured that participation was voluntary, confidentiality was maintained, and the data was reported as aggregate with no identifiers used. The congregants were counseled and screened on Mondays in the facility’s private conference room. Only the senior pastor, the counselee, and the leader were aware of the individual’s identification and whether the individual was referred to the community. The members who were counselled were scheduled for follow up in one week, and then approximately two weeks later. All member information was kept in a password-protected file on the pastor’s secure server.

**Instrumentation**

The project outcomes were evaluated by using the following four instruments: a demographic questionnaire, a pre/posttest on MHKT, a pre/post CAMI scale, and a post education survey completion form. The project leader received the deidentified summary form of PHQ9 results, referrals, and follow ups each week until completion of the project: 90 days.

1. **Demographic Questionnaire**

   The demographic information was collected from the participants at the initiation of the project. It included: age, gender, marital status, education, church attendance, mental health utilization of the participant/leader, and their family. The demographic questionnaire was one of the forms included in the packet of all participants(leaders). The packets were easily accessible on the main table in the education room. At the end of the presentation, the packets containing all forms were placed in a designated box on the main table for the project leader to collect.

2. **Mental Health Knowledge Test**
The purpose of this pre/posttest was to gain an understanding of each participant’s level of knowledge, experience, and perception of mental illness. This test was administered before educational intervention and 3 months after intervention to assess the retention of knowledge of participants involved in this study.

3. **Community Attitudes towards Mental Illness Scale**

The second instrument used in this project was the validated questionnaire, CAMI scale, that Taylor and Dear (1981) developed. The instrument is a modified version of the Opinion About Mental Illness Scale that Gilbert and Levinson developed in the 1960s (Madianos, Economou, Peppou, Kallergis, Rogakou, & Alevizopoulos, 2012). The purpose for using this scale was to measure the attitudes of the ministerial team towards the mentally ill pre and post educational awareness intervention, noting any stigma towards those with mental illness and then later having that discussion with the senior pastor and the ministerial team when the project results were available. Taylor and Dear (1981), freely granted permission for the use of the CAMI scale (see Appendix D). Users are required to acknowledge the CAMI source and to document in detail any changes made to the original instrument.

4. **Shadow Voices: Finding Help in Mental Illness**

This video was the primary educational intervention. It provided an inside look at what it was like to live with mental illness and how individuals and their families dealt with medical, governmental, societal and spiritual issues to hope. Ten people with mental illness told their stories, and many experts and advocates in the field added helpful perspectives. The DVD also included bonus material with more personal stories and historical background, advice and recommendations for churches in relating to mental illness, support of family members, self-care, and more.
5. **Post Education Survey**

The PES was created by the project leader to assess the leader’s perceptions of changes in their knowledge regarding mental health and their attitudes towards those with mental illness. The post education survey was given to each participant post-intervention with a reminder that the information obtained in the survey as well as its author would remain anonymous.

6. **Summary of de-identified PHQ-9 referrals and follow ups** were provided to project leader each week until completion of the project. These forms show the frequency when ministerial team applied the information and tools from the interventions to their ministerial practice with congregants.

**Project Study Procedure/Process**

On the day of project implementation, each participant gave informed consent prior to starting the program. The participants were asked to complete several surveys:

- Demographic survey.
- MHK pre/posttest (pretest at the initiation of the study and a posttest after 90 days).
- CAMI pre/post survey (pretest at the initiation of the study, and a posttest after 90 days).
- All participants and the project leader observed confidentiality. All answers on the surveys were kept strictly confidential with no collection of identifiable data. The time allotted for completion of the questionnaires/surveys was 1 1/2 hours. Answers on all surveys were kept strictly confidential with no collection of identifiable data.
- The ministerial leaders and the project leader viewed the DVD, Shadow Voices: Finding Hope in Mental Illness during the educational session. An open discussion forum followed completion of forms. The leaders were introduced to the PHQ-9, the
validated tool that was used to screen the congregants for depression. The participants were given the option of accessing the PHQ-9 via computers that were readily available in the facility computer lab or to use paper copies when they counselled the members.

- The participants were introduced to the community resource binder compiled by the project leader which lists all community behavioral resource agencies/providers who reside within a 200-mile radius that provide services to those with commercial insurance as well as to those that were not insured. *The disclaimer indicating that Jacksonville University did not endorse any of the information nor the facilities/agencies listed was on page one of this booklet.*

- From the launching of the project on March 10, 2019 until completion after the 90-day period, the project leader was always available in person on Wednesday nights from 6-9pm and available by cell for any questions/concerns from the leadership team.

- At 90 days post implementation, the participants were asked to complete a second CAMI, and MHKT.

- **NOTE:** At no time did the project leader administer the PHQ-9 to any of the participants, the congregants or have access to PHQ-9 test results that were administered to any congregants by the ministerial team/participants. Only the senior pastor had access to the data obtained from the PHQ-9’s conducted during this three-month period.

**Community Resource Tool**
The doctoral student project leader created a list of community resources located within a 200-mile radius for the behavioral health population that the senior pastor can access by the senior pastor via community resource manual, and a quick card reference version which lists the community mental health providers in Okaloosa County. This was a gift from the DNP project leader to the organization.

Purpose: To generate an updated list of community resources that could be used by the leaders to effectively link the members to all the services that were available. The resource manual consisted of:

- outpatient crisis intervention and mental health centers
- inpatient mental health services
- substance abuse inpatient and outpatient treatment centers
- transitional living
- out-of-state abuse resources
- support groups
- transportation
- veteran services
- prescription assistance
- hotlines and important phone numbers to know.

The following disclaimer will be annotated in the community resource manual and on the quick page reference: “Neither the doctoral student nor Jacksonville University is endorsing the following agencies or resources.” The information provided was solely for information purposes.

Ethical Considerations
This proposal for this DNP project was submitted to the Internal Review Board on December 20, 2018. On February 11, 2019, the project leader was granted a memorandum of approval JU IRB # 2018-077, indicating that this project was exempt from oversight. The participants were informed of their rights to participate, say no, or withdraw from the study prior to implementation of the project. Each participant was informed of their right to choose not to answer specific questions, or to stop participating at any time. The participants were also informed that they would receive no reimbursement or payment for their time.

**Risks**

The overall risks were considered minimal because this was an educational depression screening awareness, referral, follow up, and stigma reduction program. The risks were minimal for the project leader and ministerial leaders, who were all active church members. The project leader did not administer the PHQ-9 to the ministerial leadership team or the congregants. Only the ministerial leaders whom the senior pastor designated administered the test.

All information was deidentified and kept strictly confidential. The ministerial leaders and/or senior pastor counselled the congregants (members) on Mondays by appointment only, and the senior pastor initiated all referrals to community mental health agencies. In the event of an emergency, the senior pastor was called directly via private cell. The assistant pastor first screened all emergency calls for the senior pastor. If it was determined that the congregant was in imminent danger, the assistant pastor immediately notified the local authorities.

Only the senior pastor had access to all the data obtained from the PHQ-9s conducted during this 3-month period. This deidentified information was stored in the senior pastor’s office on his private share drive that is secure, and password protected.
Chapter 5

Data Analysis

Data were checked for completeness and then analyzed using SPSS 25 (IBM Corporation). All pre/post survey data were summarized separately using descriptive statistics and/or frequency tables. Continuous variables were summarized using n, mean, standard deviation, median, and range. Categorical variables were summarized using frequency and percentage of participants within each category. The alpha level for all analyses was set at \( p < 0.05 \). The outcomes to be evaluated included:

- Change in the leader’s mental health knowledge
- Change in the leader’s attitudes towards persons with mental illness
- Post completion of the Educational awareness program

Effect size was calculated to measure the magnitude of the differences or change in the attitudes of the leaders as evidenced by pre/post intervention CAMI scores.

The CAMI survey and MHKT were administered to 28 ministerial team participants pre/post educational intervention. There are currently 34 ministerial team leaders who serve at this facility; however, the other six were deployed in the military. The post-intervention collection of CAMI and MHKT was after a period of three months to ascertain if there was an increase in positive attitudes (reduction in stigma towards the mentally ill) as indicated by the scores on the mental health knowledge test. The paired samples t-test was also used to measure the participants’ scores for pre/post analyses of both instruments. Graphs and/or charts were used to illustrate this data (Figure 3) and (Figure 4). A histogram was used to display the frequency or proportion of tests that fell within the defined intervals.

Mental Health Knowledge Test
Measures of change in the pre/post MHKT scores were evaluated using paired samples t-tests and effect size to assess baseline knowledge and retention of knowledge after intervention. Effect size was completed to determine the size of the difference. A larger effect size provides that a difference is noteworthy. Effect size was calculated independent of participant number (sample size). The effect size showed the magnitude of change from the beginning of the project (pre-test) to the post test and the value of that change.

**CAMI**

The paired samples t-test was also used to evaluate CAMI scores from participants’ scores pre and post intervention to establish if there was a difference in attitudes towards the mentally ill.

**Post Education Survey**

The purpose of this PES was to evaluate the impact of the educational intervention, determine whether the program met the expectations of the ministerial leaders and senior leadership (pastor and associate pastor), and to assess the leaders’ perceptions of changes in their knowledge and skills or the impact on their future behavior (Jones, 2019).

The CAMI, MHKT, and PES are all outcome measures in this quality improvement project. They all reflect the impact of the educational intervention on both the retention of mental health knowledge after a 3-month period and any change in the ministerial leaders’ attitudes toward the mentally ill (e.g., an increase or decrease in stigma). These outcome measures all assess the progress in the outcomes that this educational program addressed and are important in collectively determining effectiveness.
Cost Benefit Analysis

African American faith leaders have found that they can raise awareness and connect people to resources by implementing mental health programs into their current educational curriculum (Hankerson et al., 2013). Research findings have suggested that church-based health promotion programs focused on education and treatment of chronic diseases have been very effective in decreasing their incidence and prevalence, thus improving outcomes. An example would be specially designed programs such as Mental Health First Aid. This 8-hour course, which has been taught in church basements, community centers, and behavioral centers, has seen exponential growth in the past 10 years (Mental Health First Aid, 2019). Faith-based organizations privately fund this program and similar ones; in addition, grants and/or congregants support them. Lack of funding for church-based programs could be a factor that may delay the implementation of programs of this nature.

After speaking with the senior pastor, it was determined that cost effectiveness, or cost benefit analysis for this facility, could not be fully conducted because counseling to congregants is performed as a ministerial-no-cost-service as part of the established mission of this organization. This collaborative, coordinated approach between the church and the mental health community, though scarcely studied, may have the potential to increase mental health utilization among the African American population. As with any program, funding is necessary to support these activities.

Below is a diagram (Table 1.0) that depicts the costs of this doctoral project for this author. As stated earlier, cost effectiveness, or cost benefit analysis for this facility could not be fully conducted because counseling to congregants is performed as a ministerial no-cost-service as part of the established mission of this organization (personal communication with senior
pastor). Congregants are instructed to schedule their counseling sessions with the ministerial team on Mondays, unless there is an emergency. If there is an emergency, the senior pastor is called directly. There was no cost per session to members, and no salaries were paid to counselors, who are members of the ministerial leadership team.

Table 1.0

Table 1.0

Project Budget

<table>
<thead>
<tr>
<th>DIRECT COSTS</th>
<th>AMOUNT SPENT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor (270 hours)</td>
<td>$38.00 hourly</td>
<td>$10,260 (in kind)</td>
</tr>
<tr>
<td>Materials: Depression DVD</td>
<td>$20.00</td>
<td>$20.00</td>
</tr>
<tr>
<td>DNP Project Travel</td>
<td>Gasoline: $3.15 gallon</td>
<td>112 miles x 12 weeks = $4,233.60</td>
</tr>
</tbody>
</table>

56 miles (2x/weekly)

44 miles (1x/weekly) 44 miles x 12 weeks = $1,663

TOTAL DIRECT COSTS $16,176.00

Meals: Lunch (provided)

Breakfast $135.00

Paper/Printing Supplies $300.00

Typing paper/Ink/Staples

TOTAL INDIRECT COSTS $435.00

COSTS

TOTAL COSTS $16,611.60 (in kind)
Chapter 6

Descriptive Summary

This sample included twenty-eight ministerial team participants who completed the demographic survey pre-intervention and returned 90 days later. Tables 2-4 summarize the demographic characteristics. As shown, the sample was well balanced in terms of gender and age; significantly more men than women had an undergraduate degree (26% vs. 21%), and as expected, over 80% attended church twice weekly. Tables 5 and 6 depict mental health utilization. Half the sample reported having utilized mental health services, and over 60% reported that a family member had utilized them. More women reported personal mental health utilization (18% vs. 10%), with men reporting higher mental health utilization for families (13% vs. 7%).

Demographic Survey Results (Detailed)

Table 2

<table>
<thead>
<tr>
<th>Gender of Participants Completing Surveys</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>14</td>
<td>50.0</td>
<td>50.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Male</td>
<td>14</td>
<td>50.0</td>
<td>50.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
### Relationship Status of Participants

<table>
<thead>
<tr>
<th>Relationship Status</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorced</td>
<td>2</td>
<td>7.1</td>
<td>7.1</td>
<td>7.1</td>
</tr>
<tr>
<td>Married</td>
<td>22</td>
<td>78.6</td>
<td>78.6</td>
<td>85.7</td>
</tr>
<tr>
<td>Single</td>
<td>3</td>
<td>10.7</td>
<td>10.7</td>
<td>96.4</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>3.6</td>
<td>3.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

### Table 4

#### Age of Participants

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-39</td>
<td>4</td>
<td>14.3</td>
<td>14.3</td>
<td>14.3</td>
</tr>
<tr>
<td>40-49</td>
<td>6</td>
<td>21.4</td>
<td>21.4</td>
<td>35.7</td>
</tr>
<tr>
<td>50-59</td>
<td>7</td>
<td>25.0</td>
<td>25.0</td>
<td>60.7</td>
</tr>
<tr>
<td>60 and above</td>
<td>11</td>
<td>39.3</td>
<td>39.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Table 5

*Church Attendance of Participants*

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once weekly</td>
<td>7</td>
<td>25.0</td>
<td>25.0</td>
</tr>
<tr>
<td>Twice weekly</td>
<td>21</td>
<td>75.0</td>
<td>75.0</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

• NOTE: Attendance is usually Wednesdays (Bible study) and Sundays.

Table 6

*Mental Health Utilization of Participants (Family)*

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>11</td>
<td>39.3</td>
<td>39.3</td>
</tr>
<tr>
<td>YES</td>
<td>17</td>
<td>60.7</td>
<td>60.7</td>
</tr>
</tbody>
</table>

Table 7

*Mental Health Utilization of Ministerial Participants*

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>39.3</th>
<th>39.3</th>
<th>39.3</th>
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<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>60.7</td>
<td>60.7</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 8

*Education Level of Participants*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Percent</td>
</tr>
<tr>
<td>Associates</td>
<td>7</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
</tr>
<tr>
<td>Bachelors or &gt;</td>
<td>13</td>
<td>46.4</td>
<td>46.4</td>
<td>71.4</td>
</tr>
<tr>
<td>High School</td>
<td>4</td>
<td>14.3</td>
<td>14.3</td>
<td>85.7</td>
</tr>
<tr>
<td>Some College</td>
<td>4</td>
<td>14.3</td>
<td>14.3</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

**DNP Project Aims**

Aim 1: To establish if the primary aim was met, a paired samples t-test was performed, and the effect size was calculated to determine the size of the difference. According to Cohen’s criteria, an effect size of .20 in a two-group mean difference is considered small, .50 is medium, and .80 is large (Salkind, 2009). The MHKT scores increased substantially from pre- to post intervention. Values were sufficient. There was a significant increase in the mental health knowledge that was retained for a period of at least 3 months, \( t(25) = 9.74; p < .001 \).
**Paired T-Tests on Mental Health Knowledge**

<table>
<thead>
<tr>
<th></th>
<th>Pre intervention</th>
<th>Post intervention</th>
<th>Pre/Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>T-Test</td>
<td>T-Test</td>
<td>Diff</td>
<td></td>
</tr>
<tr>
<td>Mental Health Knowledge</td>
<td>N</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>28</td>
<td>72.74</td>
<td>14.50</td>
<td>91.41</td>
</tr>
</tbody>
</table>

**Notes:** The pre-intervention mean reflects the ministerial leadership team scores from the pre-MHKT, and the post-intervention MHKT scores were the ministerial leaders MHKT scores after 90 days.

**Aim 2:** To establish if this aim was met, paired t-tests and effect size were also calculated (see Table 10). After a period of 3 months, two of the four CAMI subscales showed significant reductions in negative attitudes toward persons with mental illness; scores on both the Authoritarianism and Social Restrictiveness scales decreased significantly, $t(25) = -9.05, p < .001; t(25) = -7.65, p < .001$, respectively.

The scores on the two CAMI subscales that reflected positive attitudes toward mental health did not increase significantly, but this result was likely because the participants scored relatively high on the scales at pretest, so there was little room for improvement.

The effect sizes were negative because the post intervention means were larger; thus, the educational intervention had a significant impact on the attitudes of the leaders towards mental illness. In this project, all scales moved in the desired direction, that is, Authoritarianism and
Social Restrictiveness decreased, Benevolence and Community Mental Health Ideology increased.

Table 10

*Paired t-tests on CAMI subscales*

<table>
<thead>
<tr>
<th>CAMI</th>
<th>Pre-intervention Mean</th>
<th>SD</th>
<th>Post-intervention Mean</th>
<th>SD</th>
<th>Pre-Post Difference Mean</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authoritarianism</td>
<td>2.30</td>
<td>0.40</td>
<td>1.82</td>
<td>0.45</td>
<td>-0.48</td>
<td>0.27</td>
<td>-9.05</td>
<td>25</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Benevolence</td>
<td>4.06</td>
<td>0.60</td>
<td>4.17</td>
<td>0.47</td>
<td>0.11</td>
<td>0.31</td>
<td>1.84</td>
<td>25</td>
<td>0.078</td>
</tr>
<tr>
<td>Social Restrictiveness</td>
<td>2.25</td>
<td>0.51</td>
<td>1.77</td>
<td>0.51</td>
<td>-0.48</td>
<td>0.32</td>
<td>-7.65</td>
<td>25</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Community Mental Health Ideology</td>
<td>3.67</td>
<td>0.54</td>
<td>3.74</td>
<td>0.61</td>
<td>0.07</td>
<td>0.52</td>
<td>0.68</td>
<td>25</td>
<td>0.500</td>
</tr>
</tbody>
</table>

**Frequencies of the Ministerial Team’s Utilization of PHQ-9 Surveys**

Ministerial leaders administered a total of nine PHQ-9 tests during the period of March through June 2019. Figure 3 reveals that most of the PHQ-9 tests were administered in April at an average of one per week.
Figure 3. Frequency and Dates PHQ-9s were administered by leaders.

Ministerial Team Scoring of the PHQ-9 Surveys

The average PHQ-9 score conducted by the ministerial team conducted was 5.56 (see Figure 4). A score of 10 or more was indicative of depression; however, scores on the lower end tend to reflect less impairment in the individual, so less motivation to fix the issue (Kroenke, Lowe, & Herzog, 2004). Referrals to the appropriate providers were initiated per ministerial leaders.
Figure 4. Ministerial Team scoring of PHQ-9 Surveys.

A total of three members and one entire family were referred to community mental health agencies between the months of March through June 2019. A two-week follow-up call from the senior pastor and ministerial leader who counselled the member revealed that one member was placed on the antidepressant Zoloft, and all were actively participating in both individual and family counseling with one of the community mental health providers.

During the 3-month period, ministerial leaders screened nine congregants for depression by using the PHQ-9. All congregants and their family members who were referred to the community mental health providers for evaluation were contacted within 2 weeks.

Post Education Survey

The responses from the PES were very positive. All 28 participants were unanimous in their response that they all found value with the event, and it was worth their investment of time. They all agreed to participate in any health-related event that would be offered in the future. Because of this program, the men’s group was scheduled for a meeting on June 15, 2019.
Discussion

There was substantial improvement in mental health knowledge and attitudes towards the mentally ill from the beginning to the end of this QI project. An analysis of the MHKT and the CAMI Survey supports that Aims 1 and 2 were met. The independent variable(s) of MHKT scores and CAMI Survey scores were manipulated with an educational intervention (dependent variable) and reevaluated after three months. There was a significant effect of education on the mean scores of the MHKT as well as on the CAMI Survey scale.

The Education Survey was completed by 26 of the 28 ministerial team participants present. Survey findings revealed that all 26 participants enjoyed the presentation and either wanted additional information or similar presentations. All agreed that the presentation was informative.

Mental health awareness is an important issue in the African American community. The views of its leaders are crucial because they are the first line of defense. Most individuals do not seek help until adulthood, often unaware that 14 is the average age of early signs of mental illness NAMI (2018). Faith leaders are in a unique position to educate their congregations about mental health to help mitigate the adverse consequences of stigma, shame, and suicidal ideation that are often associated with mental illness. The lead pastor involved as primary stakeholder in this DNP project decided to refer several congregants and/or their families to community clinical professionals although the PHQ-9 scores were not >9. These congregants were referred if they exhibited a sense of hopelessness or were determined to pose an immediate danger to themselves or others. This was an important consideration because mental health clinicians and providers must work collaboratively with the church for early detection, prompt referral, evaluation, treatment, and follow up of those members identified as at risk.
Limitations

This project leader recognized all African American leaders were not differentiated by country of origin and background; therefore, they may not be congruent in their cultural understanding of mental illness and its associated stigma in the African American community. The largest limitation to this project was the project participant size (n = 28), which, although informative, was too small to yield any statistically significant conclusions due to its limited strength and depth. This QI project was conducted for the benefit of one population in one setting only; therefore, generalizability of findings to the general population is limited. Some of the barriers for recruitment were the fact that only ministerial team participants who were members of this church were recruited to participate in this study. An additional barrier was the fact that many of the leaders are active duty military members, and at least six ministerial team participants were deployed overseas.

Application to DNP

This DNP-prepared nurse will be equipped to lead the process of translating research into practice. Findings from previous studies, although limited, have suggested that gender, racial, and religious differences and preferences must be considered when counseling one suspected of mental illness to create a safe environment that would help reduce and eliminate the stigma associated with it. The DNP-prepared nurse can apply a bio-psycho-social-spiritual model such as Pender’s HPM for understanding that mental illness and substance use are not spiritual weaknesses, but they are illnesses for which treatment is available MHA, (2018).
Chapter 7

Conclusions and Recommendations

This doctoral scholarly project was a QI project designed to implement a depression/suicidality screening and awareness program in an African American church community, and it became evident that this was highly feasible. The African American church is in a unique position to improve the overall health and well-being of its congregants. Early identification, referral, prompt treatment, and follow up are believed to be very effective in overcoming the stigma and shame often associated with mental illness and viewing it with understanding and acceptance.

This project leader would recommend this topic for any faith-based institution to develop implementation strategies that are specific to their organization, and then to determine which were successful and not successful. Research has shown that collaborative partnerships between faith-based institutions and community health organizations are powerful tools for social, economic, and political change (Hankerson et al., 2013). Faith leaders are often official leaders of religious congregations whose primary responsibility is to provide for the spiritual development and care of their congregants MHA (2018). These leaders should be provided with ways to recognize signs of developing mental health problems, and there should be educational opportunities to promote the awareness and management of mental health crisis, including the risk of suicide or self-harm. When we empower these ministerial leaders with knowledge and encourage effective collaboration with community mental health providers, the congregants will be able to get the help they need.

Transferability of Project Findings
This project included one of 34 African American churches in one county in Northwest, Florida; therefore, the findings are not generalizable to all congregants in similar congregations in this county. A recommendation for the future QI projects of this nature would be for inclusion of all leaders in the church, not just those tasked to the ministerial staff, and for stakeholders and/or project leaders to reach out into the mental health community to request assistance in the implementation process. This action would enhance collaboration with those agencies, and perhaps the mental health providers could give information to the ministerial leaders during the implementation phase.

**Dissemination Plan**

The findings of the project will be presented in a public presentation at the university where the DNP project leader is enrolled. It is expected that the DNP project leader will report the findings to the senior pastor and associate pastor in a closed meeting after completion of the project. The senior pastor will collaborate with both the ministerial team participants and the Board of Directors to create a date and time to report these findings.

External submission of the doctoral project proposal to the Sigma Theta Tau Zeta Gamma Chapter resulted in the DNP project leader being selected as the 2019 STTI Graduate Research Grant Recipient. In accepting the award, the DNP project leader agreed to submit a final report to the STTI Zeta Gamma Chapter in the form of a manuscript suitable for publication in *Issues of Mental Health* as outlined in the agreement.

The community resource binder created by the DNP Project leader was compiled and presented to this faith-based institution as a gift for the senior and ministerial team as a tool for all the ministerial team participants to use when they counsel members of the congregation. The senior pastor emphasized the importance of individual and family privacy, and all in attendance signed written agreements to acknowledge receipt of that documentation.
References


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doi:10.1177/0021934715613588


doi:10.1177/089801010001800405


doi:10.1007/s11606-008-0539-7


Appendices
IMPLEMENTING A DEPRESSION SCREENING AND REFERRAL PROGRAM IN AN AFRICAN AMERICAN CHURCH COMMUNITY

COMMUNITY RESOURCE GUIDE
SUMMER 2019

“Neither Jacksonville University nor this doctoral student endorse any of these agencies or support groups listed in this resource guide.”
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Outpatient Crisis Intervention/Mental Health

Bridgeway Center Inc.
Main Office: Fort Walton Beach
137 Hospital Drive FWB, Florida 32548
Hours: Monday–Friday (9:00 a.m.–5:00 p.m.)

Fort Walton Beach
Outpatient Counseling Services
- Children and Family Services (850) 833-7400
- Assessment and Therapy Services (850) 833-7500
- Psychiatric Services (850) 833-7599

Addictions and Substance Abuse Services
Outpatient Services (850) 833-9191
Children/Adolescent Substance Abuse Treatment (850) 833-9191

Emerald Coast Behavioral Health
2004 Lewis Turner Blvd., FWB (850) 226-7893
Okaloosa Outpatient Center for Adults

Mental Health Association of Okaloosa and Walton Counties
571 Mooney Rd, FWB
Hours: Monday–Friday (9:00 a.m.–4:00 p.m.) (850) 244-1040
Family Support Center for Military Families

Eglin AFB (Building 205)

Mon–Friday (9:00 a.m.–4:00 p.m.)

Hurlburt Field

220 Lukasik Avenue Bldg. 90213

Hours: Monday–Friday (7:30 a.m.–4:30 p.m.)

Defuniak Springs

COPE Center

3686 US Highway 331 South, Defuniak Springs, FL

(850) 892-8045

Individual and Outpatient Therapy services as well as residential programs for persons with mental illness.

Inpatient Mental Health Services

Crestview

Exodus Rehabilitation Ministry

(850) 758-1788

Men only

Pensacola

Baptist Behavioral Health Hospital

(850) 469-5811

1101 West Moreno St., Pensacola

(850) 434-4866

Adults and Adolescent Inpatient Treatment

Lakeview Center

1221 West Lakeview Ave., Pensacola

(Main Line, Behavioral Health Services) (850) 432-1222
IMPLEMENTING A DEPRESSION SCREENING AND REFERRAL PROGRAM

(Behavioral Medicine Center, Inpatient Services)  (850) 434-4808

Offers over 60 treatment and vocational programs for children, adolescents, adults, and seniors. Provides inpatient and outpatient behavioral health services as well as alcohol and drug treatment programs.

Panama City

Emerald Coast Behavioral Health
1940 Harrison Ave., Panama City

Adults and Adolescents Inpatient Treatment  (850) 763-0017

Life Management Center
525 E 15th Street, Panama City  (850) 769-9481

Adults and Adolescent Inpatient Treatment

Substance Abuse Resource
Inpatient Treatment Center

Veteran Affairs
All patients are evaluated prior to admission. Evaluations are conducted Monday through Friday, and appointments can be made by calling 727-398-6661 or 1-888-820-0230, extension 15618 or 14676.

For additional information on the substance abuse treatment programs, please contact 727-398-6661 or 1-888-820-0230, extension 15898.

Fort Walton Beach

Jada Ministries (Men Only)  (850) 244-5357

Project Hope (Men Only)  (877) 491-3816

Destin

Blu By the Sea Gulf Coast (Men and Women)  (850) 547-6428

Destin Recovery Addiction Treatment Center  (850) 637-8787
IMPLEMENTING A DEPRESSION SCREENING AND REFERRAL PROGRAM

Gulf Breeze
The Friary of Lakeview (850) 392-3975

Navarre
Twelve Oaks Recovery Center (877) 875-9283

Panama City
CARE (Chemical Addictions Recovery Effort)
*Women Only* (850) 769-6156

Pensacola
Bradford Health Services
*Teens 13–18, Men and Women* (850) 308-7720

Fort Walton Beach
Bridgeway Outpatient Services (850) 833-7599

Shalimar
Path Way Opiate Treatment Center (850) 609-1040
(850) 609-1004
Methadone Clinic (850) 609-1040

Defuniak Springs
COPE Center (850) 892-8045
**Treatment Center of Panama City**
(850) 769-5695
2110 West 23rd Street Panama City, Fla.
*Drug and alcohol addiction detox facility, methadone maintenance, all clients in opioid treatment programs, SAMHSA-certified opioid treatment program. Adults and young adults.*

**Cantonment**

Metro Treatment of Florida LP/DBA/Pensacola Metro Treatment
(850) 968-3565
2420 S. Hwy 29, Cantonment, Florida 32533
*Drug and alcohol addiction detox facility, methadone maintenance, methadone drug and alcohol detox center, all clients in opioid treatment programs. Adults and young adults.*

**Tallahassee**

Tallahassee Memorial Hospital
(850) 431-5150
1616 Physicians Dr. Tallahassee, FL 32308
*Drug and alcohol detox facility.*
*Veterans, active duty military, military families, seniors, pregnant/postpartum women, persons with HIV or AIDS, trauma and sexual abuse victims.*

**Alabama**

Bradford Health Services
(334) 671-1677
114 Adris Place Dothan, AL, 36303
*Drug and alcohol addiction detox facility, Naltrexone (oral), Vivtrol (injectable Naltrexone)*
*Children, adolescents, young adults and adults.*

**Transitional Living**

**Fort Walton Beach**

Harbor House Recover Homes
(850) 473-9603
*Men Only*
Charis House  (850) 475-1116

Valparaiso

Genesis House  (850) 797-9677
Men’s Group Home

Destin

St. Andrew’s by the Sea Episcopal Church  (850) 650-2737
307 Harbor Blvd Destin, Florida 32541
Provides free showers, food pantry, sack lunches, and bicycles for those who need transportation to work and appointments.

Pensacola

Red Shield Lodge: Salvation Army Lodge
1310 North South St. Pensacola, Florida 32505
Accepts both men and women, and provides emergency and transitional shelter. The shelter is not equipped to serve those with disabilities. Requires a picture ID and a drug and alcohol test.

Santa Rosa Beach

Haven House  (850) 622-3774
Men Only

Path of Grace  (850) 974-4573
Women Only

Out-of-State Abuse Resources

American Addiction Center  (888) 986-6157
Will inform you of the following: insurance accepted, medical detox, residential detox, residential treatment, partial hospitalization programs, and intensive outpatient programs.

Birmingham, Alabama

Alethia House (Men)  (205) 324-6502
Alethia House (*Women*)

Inpatient and outpatient treatment for adults only. Group, individual, and family therapy, life skills coaching, employment and housing assistance, childcare, and transportation assistance.

**Olivia House**

Inpatient and outpatient programs, medical screening, individual, group, and family therapy, 12-step programs, and psychological assistance.

**Mobile, Alabama**

**Home of Grace for Women**

24/7 phone answered, inpatient setting, Christian-based program, 12-week program, housing and employment assistance, $4,225 with a $1056 deposit.

**The Bridge, Inc.**

Adolescents 12–18, gender-specific programs, located in Mobile County and Etowah County, inpatient and outpatient programs.

**Valdosta, Georgia**

**Greenleaf**

$3,600 deposit and $600/day. Chemical dependency for adults and adolescents, group, individual, and family therapy, psychiatric assistance, drug and alcohol detox.

**Support Groups**

**Fort Walton Beach**

**Alcoholics Anonymous**

Destin/Fort Walton Beach Area Meetings  
(850) 244-2421

**Al-Anon/Alateen**  
(850) 426-2666 or (850) 244-2009
Depression and Bipolar Support Alliance
Lakeview Center (850) 455-3385

Mental Health Association of Okaloosa and Walton Counties (850) 244-1040
571 Mooney Road NE FWB, Florida

Psychiatric treatment referrals, support groups, peer specialists’ services.
Also, financial assistance with psychiatric medicine.

Peer to peer support group every Monday at
First Christian Church 201 St. May Avenue FWB, Fla. 32548 (850) 244-1040

Narcotics Anonymous Hotlines and Locations
Fort Walton Beach Hotline (850) 496-1673
Pensacola Hotline (850) 723-4813

Hugs Not Drugs Group
First United Methodist Church
103 First Street SE FWB, Florida 32548 (Tuesdays and Fridays 8–9:00 pm)

Progress Not Perfection Group
First United Methodist Church
Chandler Center
210 Partin Dr. Niceville, Florida (Mon. and Tues. 7–8:00 p.m.)
(Saturday 6–7:00 p.m.)

Out of the Darkness Group
First United Methodist Church (Room 212)
599 8th Avenue Crestview, Florida 32536 Monday and Thurs. (7–8:00 p.m.)
TRANSPORTATION

Okaloosa County Transit

Fort Walton Beach (850) 833-9168
Crestview (850) 689-7809

For routes and schedules, please visit www.rideOCT@co.okaloosa.fl.us

TLT Transport (850) 955-9300

Non-emergency medical transportation service based primarily out of Santa Rosa and Escambia County, Florida, providing local and long-distance medical transportation to a wide range of handicapped individuals along the Gulf Coast. Hours of Operation: 24/7. Online scheduling at: http://www.tlttransport.com

Tri-County Community Council (Defuniak Springs) (850) 892-2422

Transportation for local non-emergency medical treatment, nutrition, shopping, education, recreation, employment/training, and other daily needs. 24-hour advanced notice required.

VETERANS’ SERVICES

90 Works (850) 619-5899

VA-funded program will pay all deposits and first month’s rent (850) 776-7672

Career Source/Veterans Service Org Networking Mtg.

13 Iowa Drive, Fort Walton Beach, Florida (850) 833-7587 ext. 217

Hours: Mon–Fri 9:00 a.m. to 4:00 p.m., veterans only

Eglin VA Community-Based Outpatient Clinic–CBOC

100 Veterans Way Eglin AFB, FL 32542

Outpatient Clinic (866) 520-7359

Mental Health Clinic (850) 606-2600
Substance Abuse  (850) 609-2630
Claims Assistance Examiner  (850) 609-2740
Hours: Monday–Friday (8:00 a.m.–4:30 p.m.)
Medical/Primary Care, RX Assistance veteran only

**Prescription Assistance**

Sharing and Caring
Provides $50/month medication vouchers
[http://www.sharing-n-caring.org](http://www.sharing-n-caring.org)

**Fort Walton Beach**
126 Beal Parkway SW FWB, Fla. 32548  (850) 244-0778
Hours: Monday–Friday (9-2). Closed at 11:00 a.m. on the 3rd Monday of every month.

**Niceville**
104 Bullock Boulevard Niceville, Florida 32548  (850) 678-8459
(Niceville & Valparaiso residents only)
Hours: Monday–Thursday (9–2) and Friday (9–12)
*Rent, utilities, food, medications*

**Crestview**
208 Martin Luther King, Jr. Avenue, Crestview Florida  (850) 682-1907
Hours: Monday–Thursday (9–12)

**GoodRx Inc. (discount prescription website)**
[www.goodrx.com](http://www.goodrx.com)
Walmart/Sam’s Club Pharmacies

$4.00 medication list, special discounts with Sharing and Caring and Mental Health Association. $24 Walmart Brand Relion Insulin (3 types) N, R, and 70/30.

Winn-Dixie Pharmacies

Will match Walmart/Sam’s Club $4.00 medications

Publix Pharmacies

Free Metformin (must first join free Diabetes management System), free Lisinopril (with no additive). Discounts on diabetes management system and direct care program, and the following antibiotics free: CIPRO, AMOXICILLIN, BACTRIM, AMPICILLIN and PENICILLIN VK.

Catholic Charities

11 First Street SE FWB, Florida 32548 (850) 244-2825

Prescription assistance

Seagrove Beach Medical Clinic

5399 E County Highway 30A

Santa Rosa Beach, Fla. 32549 (850) 231-6200

Pfizer Friends

http://www.pfizerrxpathways.com/see-how-we-help

Discount card program with participating pharmacies (e.g., Publix, Sam’s Club, Winn-Dixie, CVS). No membership fees; the only requirement is that the client has NO prescription coverage.
**Hotlines and Phone Numbers to Know**

- **Warm Line** 1-800-945-1355. This clear warm line is for individuals with a mental illness who want to talk with someone. Peer operations will take your call from 4:00 p.m. to 7:00 p.m., 7 days per week.
- **National Suicide Prevention Lifeline** 1-800-273-8255
- **Suicide Crisis**: Text CONNECT to 741741 from anywhere in the USA, anytime, about any type of crisis. A live, trained Crisis Counselor receives the text and lets you know that they are here to listen. Services are available 24/7.
- **Reach Out Hotline** 24 Hour Crisis Hotline: 716-834-3131. Anyone of any age who is experiencing a personal, emotional, or mental health crisis can call 24 hours a day. When you call Crisis Services, you will always speak with a professional counselor or trained paraprofessional volunteer.
- National Domestic Violence Hotline – Call 800-799-SAFE (7233)
- **The Military Crisis Line**, text-messaging service, and online chat provide free VA support for all Service members including members of the National Guard and Reserve, and all Veterans, even if they are not registered with VA or enrolled in VA health care. TEXT: 838255
  PHONE: 1-800-273-8255 press 1

**Reputable HOTLINES for Mental Health**

- **National Alliance on Mental Illness (NAMI)** 1-800-950-6264. Monday–Friday from 10 a.m. to 6 p.m. EST. Operators provide information about mental illness and refer callers to area treatment, support groups, family support, and legal support if needed.
- **Substance Abuse and Mental Health Services Administration (SAMHSA)**: (800) 662-4357. SAMHSA runs a 24-hour mental health hotline that provides education, support, and connections to treatment. It also offers an online Behavioral Health Treatment Locator to help you find suitable behavioral health treatment programs.
- **National Institute of Mental Health (NIMH)**: (866) 615-6464. This organization has a variety of methods for you to communicate with knowledgeable people about mental health issues. In addition to the phone line, there is a live online chat option. These resources are available Monday–Friday, 8:30 a.m. to 5 p.m. EST.
Appendix B

Permission to Use Plan-Do-Study-Act Illustration

Copyright Clearance Center

Book: The Improvement Guide: A Practical Approach to Enhancing Organizational Performance, 2nd Edition

Author: Gerald J. Langley, Lloyd P. Provost

Publisher: John Wiley and Sons

Date: Apr 1, 2009

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Appendix C

Community Attitudes Towards Mental Illness Scale (CAMI)

Conditions of Usage, Questionnaire, and Key

https://camiscale.com/cami-questionnaire

**Conditions of Usage**

Permission is freely granted to use the CAMI scale for research, educational, academic, and professional purposes, subject to two conditions: [1] the user makes appropriate attribution of the CAMI source; and [2] in order to avoid confusion or ambiguity, the user must clearly identify and record any modification(s) to the original scales in all reports and documentation pertaining to the user’s project.

To access the CAMI Scale survey questionnaire and key, please fill in the form and check the permission agreement box.
Appendix D

Community Attitudes towards the Mentally Ill

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.

INSTRUCTIONS:
Please circle or select ONE 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 like ones you have previously answered. Please be sure to answer all statements.

KEY: SA=Strongly Agree A=Agree N=Neutral D=Disagree SD=Strongly Disagree

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 neighborhood.
   SA A N D SD
KEY: SA=Strongly Agree A=Agree N=Neutral D=Disagree SD=Strongly Disagree

a. There is something about the mentally ill that makes it easy to tell them from normal people.
   SA A N D SD

b. The mentally ill have for too long been the subject of ridicule.
   SA A N D SD

c. 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

d. As far as possible, mental health services should be provided through community-based facilities.
   SA A N D SD

e. Less emphasis should be placed on protecting the public from the mentally ill.
   SA A N D SD

f. Increased spending on mental health services is a waste of tax dollars.
   SA A N D SD

g. No one has the right to exclude the mentally ill from their neighborhood.
   SA A N D SD

h. Having mental patients living within residential neighborhoods might be good therapy, but the risks to residents are too great.
   SA A N D SD

i. Mental patients need the same kind of control and discipline as a young child.
   SA A N D SD

j. We need to adopt a far more tolerant attitude toward the mentally ill in our society.
   SA A N D SD
KEY: SA=Strongly Agree A=Agree N=Neutral D=Disagree SD=Strongly Disagree

a. I would not want to live next door to someone who has been mentally ill.
   SA   A   N   D   SD

b. Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community.
   SA   A   N   D   SD

c. The mentally ill should not be treated as outcasts of society.
   SA   A   N   D   SD

d. There are enough existing services for the mentally ill.
   SA   A   N   D   SD

e. Mental patients should be encouraged to assume the responsibilities of normal life.
   SA   A   N   D   SD

f. Residents have good reason to resist the location of mental health services in their neighborhood.
   SA   A   N   D   SD

g. The best way to handle the mentally ill is to keep them behind locked doors.
   SA   A   N   D   SD

h. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.
   SA   A   N   D   SD

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 neighborhoods does not endanger residents.
cc. Mental hospitals are an outdated means of treating the mentally ill.

dd. The mentally ill do not deserve our sympathy.

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

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

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

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

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

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

kk. Virtually anyone can become mentally ill.
II. It is best to avoid anyone who has mental problems.

SA  A  N  D  SD

mm. Most women who were once patients at a mental hospital can be trusted as babysitters.

SA  A  N  D  SD

KEY: SA = Strongly Agree
     A = Agree
     N = Neutral
     D = Disagree
     SD = Strongly Disagree
Appendix E

Community Attitudes towards the Mentally Ill

Scoring Convention

1. Each of the 40 items on the CAMI requires a response of agreement/disagreement based on a 5-point Likert scale ranging from “strongly disagree” (scored as 1) to “strongly agree” (scored as 5).
2. Each subscale has 10 questions each (e.g., Authoritarianism, Benevolence, Social Restrictiveness, and Community Health Ideology).
3. After ALL subscales are calculated, you will have a total of (4) scores. Evaluate the subscales as follows:
4. A higher score on the Community Health Ideology and Benevolence indicates a greater acceptance of the mentally ill, whereas high scores on the Social Restrictiveness subscale indicates greater amounts of cultural stigma (Telles-Correia et al., 2013).

Reference


Appendix F

Informed Consent

JACKSONVILLE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
Informed Consent Document to Participate in IRB Exempt Research

1. EXPLANATION OF THE RESEARCH and WHAT YOU WILL DO:
   • You are being asked to participate in a research study that is designed to launch a
     self-reported depression screening and stigma reduction awareness program in a
     nondenominational church that serves mainly African Americans. You must be 18
     years of age and a member of the ministerial leadership team to participate in this
     research.
   • This study will be conducted for a period of 3 months. The overall purpose(s):
     The primary aim is engagement and education of stakeholders (ministerial leaders of
     a faith-based facility) on the importance of screening, referral, and follow up of
     congregants who are at risk for depression/suicidality.
     The secondary aim is integration of mental health stigma reduction as a part of this
     training, which may subsequently prevent mental health disorders from going
     undiagnosed and untreated.

PROCEDURES

• Informed Consent will be obtained from each participant prior to starting this
  program.
• You will be asked to complete several surveys:
  1) a Demographic Survey
  2) a pre- and postintervention Mental Health Knowledge Test (at the initiation of
     the study and after 90 days)
  3) a pre- and postintervention Community Attitudes Towards Mental Illness
     Survey (at the initiation of the study and after 90 days).
• All your answers on the surveys will be strictly confidential with no collection of
  identifiable data.
• Participants will view the DVD, “Shadow Voices: Finding Hope in Mental
  Illness.”
• Participants will be introduced to a resource packet that has a list of all community
  behavioral resource agencies/providers who reside within a 200-mile radius and
  provide services to those with commercial insurance as well as those who are not
  insured.
• Participants will be introduced to the Patient Health Questionnaire (PHQ-9), a
  validated tool that can be used for screening depression, its website, and how to
  administer the test. Its website is https://www.mdcalc.com/phq-9-patient-health-
  questionnaire-9
• At no time will the project leader administer the PHQ-9 to any of the ministerial team leaders or the congregants, nor will the project leader have access to the results of any tests that are administered at this faith-based institution.
• Ministerial leaders who use the PHQ-9 can access the tool via the deidentified web-based self-scorer.
• The MD Calc website provides the following disclaimer from Dr. K. Kroenke, the creator of this tool.

The disclaimer for the use of this tool per Dr. K. Kroenke is as follows, “Calculations must be rechecked and should not be used alone, for patient care, nor should they substitute for clinical judgment. These tools do not give professional advice; physicians and other health care professionals who use these tools or databases should exercise their own clinical judgment as to the information they provide. Consumers (nonmedical professionals) who use these tools or databases do so at their own risk. Individuals with any type of medical condition are specifically cautioned to seek professional medical advice before beginning any sort of health treatment. For medical concerns, including decisions about medications and other treatments, nonmedical users should always consult their physician or other qualified health professional as well. While information on this site has been obtained from sources believed to be reliable, neither we nor our content providers warrant the accuracy of the information contained on this site” (Last revised 17 October 2017).

• If the member has a PHQ-9 score of >10, he/she will receive additional counseling from senior pastor and/or referral to one of the community mental health agencies. The member will also receive a copy of his/her PHQ-9 score (results), with follow up scheduled with the ministerial staff within 2 weeks.
• Only the senior pastor will have access to all data obtained from the PHQ-9s conducted during this 3-month period. This information will be stored on the senior pastor’s private professional share drive in his office that is secure, and password protected.
• As noted per church by-laws, all information that ministerial team leaders obtain from congregational members will remain confidential. An example of exception to confidentiality is when the counselee indicates an intention to harm him or herself or someone else. In this case, the senior pastor will be notified immediately.

2. YOUR RIGHTS TO PARTICIPATE, SAY NO, OR WITHDRAW:
   Participation in this research project is completely voluntary. You have the right to say no. You may change your mind at any time and withdraw. You may choose not to answer specific questions or to stop participating at any time. Whether you choose to participate or not will have no effect on your grade or evaluation.

3. COSTS AND COMPENSATION FOR BEING IN THE STUDY:
   This study is completely voluntary; there will be no reimbursement or payment for time.
4. CONTACT INFORMATION FOR QUESTIONS:
If you have concerns or questions about this study or to report an injury, please contact the researcher:
Mary S. Garner MSN, RN, Co-Investigator and Project Lead
Email: mgarner@jacksonville.edu, Phone: 850-398-8119.
Dorcas Kunkel, DNP, RN, Principal Investigator
Email: dkunkel@ju.edu, Phone: 904-256-7986

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study, you may contact, anonymously if you wish, the Jacksonville University Office of Research Compliance, (904) 256-7151 or juirb@ju.edu.

Your signature below means that you voluntarily agree to participate in this research study.

________________________________________  ___________________________
Signature                                      Date

________________________________________  ___________________________
Person Obtaining this Consent                  Date
Appendix G

IMPLEMENTING A DEPRESSION SCREENING AND REFERRAL PROGRAM IN AN AFRICAN AMERICAN COMMUNITY

Mental Health Educational Awareness, Screening, and Stigma Reduction Pre- and Posttest

Please complete this form by answering the following questions. The information that you provide will be strictly confidential and will not be used to evaluate your performance or the qualifications for the leadership position that you now fill. It is solely for academic purposes only. Read each question carefully and check the appropriate response.

1. Among conditions that account for the most disability days taken per year, how does depression rank?
   a. First ☐
   b. Second ☐
   c. Third ☐
   d. Fourth ☐

2. It has been recommended that anyone over age 12 be screened for depression in clinical practices that have an integrated management system.
   a. True ☐
   b. False ☐

3. One of the most widely used depression screening tools is the Patient Health Questionnaire-9 (PHQ-9)
a. True ☐

b. False ☐

4. The PHQ-9 monitors for symptoms of depression that has been present for:

   a. 1 month ☐
   b. 1 week ☐
   c. 2 months ☐
   d. 2 weeks ☐

5. When a participant completes the PHQ-9, when is a referral indicated?

   a. When the total PHQ-9 score is > 10 ☐
   b. When the PHQ-9 score is > 15 ☐

6. Have you ever used the PHQ-9 tool? Do you have a referral process in your facility?
   (faith-based or community agency)

   a. Yes/Yes ☐
   b. Yes/ No ☐
   c. No /No ☐
   d. No / Yes ☐
   e. None of the above ☐
7. Most adults in the general population are not very familiar with depression and do not view depression with as much concern compared to other health conditions such as: hypertension, diabetes, and cardiovascular problems.

   a. True ☐
   b. False ☐

8. Scenario: You are in the congregation hall and observe someone that you feel might be at risk for depression. You decide to go over and speak to this person. Circle the response with the signs or symptoms that you might observe or statements that the congregant may voice that may indicate that the person is at risk for depression and/or suicide:

   a. ☐ (Signs/symptoms) Excessive sadness, moodiness or unexpected rage, recent weight loss or weight gain, and an increase in somatic complaints (unexplained back and stomachaches, lack of energy, indigestion).

   b. ☐ (Changes in Behavior) Reckless behavior such as spending sprees, fast driving, substance abuse (alcohol, drugs [including prescription meds], or tobacco), withdrawing from activities, isolating themselves from family or friends, sleeping too much or too little.

   c. ☐ (Changes in Talk) It the person talks about feeling hopeless, having no reason to live, being a burden to others, feeling trapped, or if the person speaks of “setting their affairs in order.”

   d. ☐ All of the above.
9. Depression is usually treated with a combination of medication and/or therapies. Two forms of counseling are Interpersonal Counseling and Cognitive Behavioral Therapy.
   a. True ☐
   b. False ☐

10. When a person has been referred to the community for a behavioral services consultation, when would you reassess this person to see how well he/she adapted to this therapy and/or community agency referral?
   a. 2 weeks ☐
   b. 1 month ☐

11. Medications called “mood stabilizers” are often prescribed for individuals diagnosed with bipolar depression.
   a. True ☐
   b. False ☐

12. Exercises such as walking, yoga, meditation, running, and cardiovascular exercise can help ease some of the symptoms of anxiety and depression.
   a. True ☐
   b. False ☐
Appendix H

IMPLEMENTING A DEPRESSION SCREENING AND REFERRAL PROGRAM IN AN AFRICAN AMERICAN COMMUNITY

Post education Survey

Thank you for your attending this Mental Health Educational Awareness, Screening, and Stigma Reduction Program. Please rate your overall experience by checking the appropriate box.

1. The program in its entirety:
   a. Very satisfied □
   b. Satisfied □
   c. Neutral □
   d. Unsatisfied □

2. Would you attend future educational programs?
   a. Yes □
   b. No □

3. What did you like MOST about the event?

4. What did you like LEAST about the event?
5. Do you have any suggestions for future programs?

Thank you! 😊
Appendix I

IMPLEMENTING A DEPRESSION SCREENING AND REFERRAL PROGRAM IN AN AFRICAN AMERICAN COMMUNITY

Demographic Survey

Please answer each question as accurately as possible by completely darkening the square in its entirety that is next to your selection. As a reminder, all information obtained from this questionnaire is confidential and is for academic purposes only. Thank you for taking the time to complete this questionnaire!

1. **GENDER**

   Female ☐
   Male ☐

2. **RELATIONSHIP STATUS**

   Single ☐
   Married ☐
   Separated ☐
   Divorced ☐

3. **AGE**

   25-29 ☐
   30-39 ☐
   40-49 ☐
   50-59 ☐
   60 and above ☐

4. **EDUCATION**

   High school ☐
   Some college ☐
   Associate Degree ☐
   Bachelor’s degree or higher ☐
5. **CHURCH ATTENDANCE** (in the last 12 months)

   - Once weekly □
   - Twice Weekly □
   - Online Services only □
   - None of the above □

6. **MENTAL HEALTH UTILIZATION**: Have you ever seen a mental health provider (e.g., licensed mental health therapist, psychologist, psychiatrist)?

   - Yes □
   - No □

7. **MENTAL HEALTH UTILIZATION**: Has any member of your family ever seen a mental health provider such as a licensed mental health therapist, a psychologist or a psychiatrist?

   - Yes □
   - No □
Appendix J

IMPLEMENTING A DEPRESSION SCREENING AND REFERRAL PROGRAM IN AN AFRICAN AMERICAN COMMUNITY

Permission to Use Health Promotion Figure

P E A R S O N

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8001 South Africa
USAPermissions@pearson.com

Jan 4, 2019

PE Ref # 207522

MARY GARNER 565 Wingspan Way, Crestview, FL 32536

Dear Mary,

You have our permission to include content from our text, HEALTH PROMOTION IN NURSING PRACTICE, 8th Ed. by MURDAUGH, CAROLYN L.; PARSONS, MARY ANN; PENDER, NOLA J., in your dissertation or master’s thesis at Jacksonville University.

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Sincerely,

Michael Prince,
Permissions Granting Analyst
**Patient Health Questionnaire (PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things?</td>
<td>Not at all, Several days, More than half the days, Nearly every day</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless?</td>
<td>Not at all, Several days, More than half the days, Nearly every day</td>
</tr>
<tr>
<td>Trouble falling or staying asleep, or sleeping too much?</td>
<td>Not at all, Several days, More than half the days, Nearly every day</td>
</tr>
<tr>
<td>Feeling tired or having little energy?</td>
<td>Not at all, Several days, More than half the days, Nearly every day</td>
</tr>
<tr>
<td>Poor appetite or overeating?</td>
<td>Not at all, Several days, More than half the days, Nearly every day</td>
</tr>
<tr>
<td>Feeling bad about yourself—or that you are a failure or have let yourself or your family down?</td>
<td>Not at all, Several days, More than half the days, Nearly every day</td>
</tr>
<tr>
<td>Trouble concentrating on things, such as reading the newspaper or watching television?</td>
<td>Not at all, Several days, More than half the days, Nearly every day</td>
</tr>
<tr>
<td>Question</td>
<td>Not at all</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Moving or speaking so slowly that other people could have noticed?</td>
<td></td>
</tr>
<tr>
<td>Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?</td>
<td></td>
</tr>
<tr>
<td>Thoughts that you would be better off dead, or of hurting yourself in some way?</td>
<td></td>
</tr>
</tbody>
</table>
| Total = \[
\]

\[
/27
\]

Depression Severity: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20-27 severe.

Validity has been assessed against an independent structured mental health professional (MHP) interview. PHQ-9 score ≥10 had a sensitivity of 88% and a specificity of 88% for major depression. It can even be used over the telephone.
