

A Program Plan: Project FRAMME

Forming Religious Alliances for Mental and Medical Education

*“Creating a Link between the Black Church and Formal Systems of Care to Improve
Depression Management in African American Females*

By

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Optimizing Depression Management for African American Women

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Abstract

Depression continues to serve as a clinical source of morbidity and mortality nationwide. Although there has been minimal data collected to suggest that this disease affects individuals disproportionately across races, it is becoming increasingly evident that a disparate phenomena exists in regards to treatment, access to care, and diagnosis among marginalized populations. African American females are a unique subset of this marginalized population as barriers to care exceed superficial realities such as transportation and socioeconomic status and extend to less transparent impediments shaped by spirituality, stigma, and racism. This paper will serve to analyze the obstacles that lead to disparate depression management among African American Females and will offer an alternate method of intervention via the black church. This paper will include a Program Plan to define and describe Project FRAMME as well as a two-dimensional literature review to examine past interventions modeled using the black church and an analysis of the use of Mental Health services mediated by the church.

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Introduction and Rationale

Depression in the United States

Depression is one of the leading causes of disability in developed nations according to a 1996 report done by Harvard School of Public Health along with the World Health Organization¹. This report examined the global burden of disease and illnesses, assessing both mortality and disability. It found that when it comes to disability, major depression ranked first on the top ten list illnesses causing the highest number of years lived with disability in terms of Disability Adjusted Life Years (DALYs) measurements¹.

As a mental illness characterized and diagnosed by a combination of clinical inferences and patient presentation, depression is in itself difficult to quantify and qualify across populations simply by statistical methods. Recent studies suggest that approximately 17 million Americans were affected by depression in 2008, making it the leading cause of disability in the US for people ages 15-44².

There is a 15-30% lifetime prevalence for US adults to experience at least one episode of depression from various reports. Like most chronic conditions, depression presents a daily burden for people who suffer from it. However, unlike other chronic conditions, depression by its very nature involves loss of interest in usual activities and decreased ability to experience pleasure. In order to complete certain activities of daily living, a person must not only have the physical ability but they must also have intrinsic motivation to complete the activity. People who suffer from untreated depression lack the latter and though physically able are otherwise disabled to some extent when it comes to completing the tasks that make them an independent and productive member of society.

Depression costs employers \$51 billion annually in absenteeism and lost productivity. This is in addition to money spent on prescription medicines and other direct costs that total \$12.4 billion ¹.

Depression in North Carolina

The 2005 National Survey on Drug Use and Health reports that within North Carolina, 7.7% of the population is likely to experience a major depressive disorder in their lifetime. Moreover despite a growing population, North Carolina has experienced a significant decline in psychiatric illness providers over the past decade³. Ironically enough, the most acute decline has occurred in the rural setting where the need for mental health is most dire. In these areas, neighbors, friends, and more importantly clergy, serve as alternative, non-traditional sources of counseling³.

Depression in African Americans

Specific data involving the distribution of depression amongst African Americans and more specifically African American females is limited and contradictory⁴. However, there is a general consensus that African American women are least likely to present to a primary care setting for mental health services despite data from recent surveys suggesting that African American women (along with latinos) have a higher rate of depressive symptoms in conjunction with psychological distress⁴.

Depression is a common clinical phenomenon about which scientific research has devoted itself to the efforts of improving treatment guidelines and enhancing the efficacy of pharmacological therapy. Despite these efforts employed by health policy makers and interventionists in reference to depression care, race and ethnicity continue to serve as sources of disparity across mental health management. African Americans are especially

vulnerable to being under treated for depression with treatment rates averaging less than half of those of Caucasians⁵. The role of the African American female in society has been shaped by slavery and years of racism. Furthermore, this role is multi-faceted and involves equal emphasis on financial and family responsibilities in the household. This allows little room for dedication to individual mental health and creates a structure in which psychological comfort is not a priority. This rich history of slavery and racism has helped to define a social identity shaped by psychological and cultural realities that often minimizes one's emotional responsiveness to society⁶. By minimizing responsiveness to society, one is able to repress emotional difficulties. As a result, the individual is able to target energies towards more immediate issues such as poverty, unemployment, and lack of access to health-care⁶. This phenomenon is further complicated in reference to the recognition of depression in the African American female as they present with clinical symptoms different from white women.

Although African Americans comprise one of the largest minority group in the US, minimal effort has been focused on obtaining data specific to the prevalence of depression among this population. African American females are at an increased risk for developing depression as they are part of a society that has historically devalued their gender, ethnicity, and culture. Thus, it is not a surprise that this population reports a higher rate of depressive symptoms⁷. Little data exists that confirms the specific prevalence of depression among African American women, however a general consensus among researchers substantiates that this population is the least likely to both initiate and continue adequate treatment for therapy. Prior studies hypothesized that environmental and genetic differences in the metabolizing anti-depressants explain disparities among

minorities in relation to treatment outcomes⁸. These studies fail to account for the poor association between biological traits and the definition of race. In addition, current scientific methods employ minimal focus on the relationship between culture and mental health service utilization. This is extremely important in the African American population where individual-interpersonal relationships and coping styles are highly influenced by religion, spirituality, and social support of the surrounding community, producing a stigma towards receiving medical treatment for depression⁹. Thus, a holistic approach to exploring the disparities in depression therapy among African American women should include an in-depth analysis of the complex inter-networking between community perceptions of disease, religious impressions of suffering, and mental and other barriers to care.

Current Depression Management

Recent trends suggest that most of the diagnosis and management of depression happens in primary care settings. Rates of diagnosis of depression in African Americans in primary care settings, in the last decade, have approached the rates of diagnosis in white populations in those settings¹⁰. This demonstrates increasing emphasis in primary care on identifying mental illness and certainly indicates progress. However, the phenomenon of psychiatric services being provided increasingly through primary care settings instead of through trained psychiatrists impacts African Americans negatively, in particular.

The majority of African Americans treated for depression are diagnosed in primary care clinics¹¹. In primary care settings pharmacotherapy is generally the primary means of treatment, while African Americans have been shown to have lower

acceptability of antidepressant medication and greater preference for mental health counseling and even more interest in counseling from clergy¹¹.

Also, in the United States the history of sexism and racism is interwoven into social experience of every person in some way or form, and is surely most pervasive in the lives and psyches of African American women. Because primary care physicians are not trained to be culturally competent counselors and because African Americans are less likely to take psychotropic drugs, the primary care setting often offers sub-optimal care for African American women⁵.

Barriers to Care

The barriers that African American women face in regards to depression treatment exist within the social consciousness created by a history of slavery as well as the socioeconomic divide caused by years of racism. Previous studies have solidified the notion that there is a need for depression treatment in the African American women. Despite the availability of effective treatments, the utilization rates are low⁹. Racial identity has been shown to be closely associated with establishing a positive therapeutic relationship¹⁰. Additional researchers have suggested that there is a deep-rooted cultural ideation imposed by African Americans that they are unable to achieve a trustful relationship with an individual of Caucasian decent. Thus, suggesting that cultural responsiveness may be responsible for a difference in help-seeking, diagnosis, and treatment duration. Bender reports that “Blacks are more tolerant of psychological distress, less likely to initiate treatment, more likely to receive diagnoses of schizophrenia and psychosis, and more likely to terminate treatment prematurely than White counterparts”¹⁰. In addition, they are more likely to minimize symptoms due to a fear

and mistrust of the hospital system, causing them to present in more emergent situations. These findings are particularly relevant to the barrier between African American women and depression care, as studies have shown that they are more likely to engage in repressive coping than white women⁹. In addition, the prospect of seeking professional assistance is further complicated by the geographic and economic barriers⁹.

Faith Based Prevention Strategies

A potential place for intervention is within the Black church. The Black church has traditionally served a vital social role in its community by providing treatment and prevention programs dedicated to mental and physical health. These services include substance abuse counseling, individual and marriage counseling, as well as health screenings and education⁶. In rural areas particularly in the south, the church serves as one of the most important sources of social and emotional support in the African American Community.

- Need For An Intervention: Why Community Based Participatory Design

Community Based Participatory Research (CPBR) serves to actively engage subjects, researchers, and community lay people in an interactive research study that promotes a trusting environment and serves to reduce anxiety in regards to research participation⁹. As it relates to the African American community, several studies published to date use this method design to assess intervention roles of the church on community health status^{9,12}. Because the church has traditionally served a vital role in social change and community perception, this method appears to be most feasible in encouraging research participation in a population that has traditionally held a sense of distrust and fear for organized clinical research and/or trials.

Thus CBPR is particularly important in African American communities where members suffer from disproportionately high rates of chronic disease, but where clinical trials and intervention studies have failed to reach this priority population effectively¹⁰.

Literature Review

To examine the feasibility of the successful implementation of a Program such as Project FRAMME preliminary efforts must be made to obtain information about current, past, and future research attempts related to this intervention strategy. Thus a literature review was performed to provide further education about the design of the infrastructure of Project FRAMME. This literature review will cover the following topics: 1) an assessment of current/past intervention programs mediated by the Church and 2) an assessment of current Mental Health Services provided by the church.

Guidelines/Implementation Section

The US Preventive Services Task Force recommends screening adults for depression in primary care settings based on the rationale that a screening decreases clinical morbidity associated with depression. However, the task force only recommends that screening be done in clinical practices that have “the systems in place to assure accurate diagnosis, effective treatment, and follow up”. These recommendations do not, however, specify how best to implement screening and the appropriate follow up that is recommended. Particularly these guidelines make no distinction about special considerations for more vulnerable populations. Given the vulnerability of African American women as a population, it is necessary to have more specific screening recommendations. It was difficult to find data that characterized the burden of suffering

explicitly in African American women, so more research should be done to further characterize this burden of suffering.

Assessment of Current/Past Intervention Programs Mediated by the Church

In order to foreshadow the feasibility and efficacy of Project FRAMME, an evaluation of community-based interventions mediated via the church were researched and analyzed. Given the limitations in regards to literature involving the Church and mental health services exclusively, I performed a literature review of programs featuring community medicine based preventative care instituted in the Black church. My search strategy included a Pub Med exploration using the search terms: church and intervention and medicine and program. My search was limited to free-text full articles. This resulted in 10 articles. I further specified my search to exclude articles not published in the United States and also excluded programs that did not feature the church as its prime intervention site. I also chose to review literature related only to the black population and excluded articles that featured other minorities or majority populations as its target group. A final total of 4 articles were yielded by this search.

A pilot project implemented by Davis-Smith et al, was performed to address the feasibility of a Diabetes Prevention Program (DPP) in the rural African American Church. This study utilized the NIH DPP model to guide its program structure and action plan. The design of this program included a 13 step procedure for its implementation process²⁰. The setting was identified as a church in rural Georgia based on the following selection criteria: a Sunday attendance of approximately 150 members (church's roster included a membership of 407 members with a 3:1 women: male ratio), an existing relationship with the pastor, and high levels of interest in the project. Participants

included adult members identified as high risk for diabetes based upon a screening questionnaire with a follow-up fasting serum glucose(fsg). Individuals recognized as pre-diabetic (fsg =100-125mg/dL) were enrolled in a six-session church DPP while diabetics (fsg>125 mg/dL) were referred to a primary care physician for management. Those with fsg <100mg/dL were counseled on lifestyle changes and behavior modifications. Out of 99 adults screened for diabetes, 11 individuals qualified for the DPP group, with a total of 10 subject participants²⁰. With a 78% attendance rate, a mean 7.9lb weight-loss after intervention, and 10.6 lbs of weight loss were observed after at 12-month follow-up. Additional unexpected outcomes included the promotion of healthy lifestyle behaviors in other church-sponsored programs such as a “well-person” report at morning service and a church-cooking ministry dedicated to making healthy foods.

A new D.A.W.N (Diabetes Awareness and Wellness Network), a randomized controlled trial conducted by Samuel-Hodge et al, describes a church-based diabetes self-management intervention. This program incorporated a community based model with the objectives of promoting behavioral changes to improve metabolic control, enhance physician-directed outpatient care, and increase community awareness and education of diabetes. An overall goal of this program was to provide intervention with a culturally sensitive approach¹². A total of 201 participants recruited from 24 different churches were randomized (as a church unit) into a special intervention group or a minimal intervention group. The special intervention group received individual counseling, twelve group sessions, and as well as follow-up from a physician and diabetes advisor. Resources provided for community-related interventions included a workshop and distribution of educational materials by trained church members. Subjects recruited in

minimal intervention group received 2 Adult Diabetes Association (ADA) pamphlets and bi-monthly readings about general health information and study updates. Although this study is not complete in the analysis of its results, the intent is that it will provide valuable and useful information in regards to randomized control intervention designs in the African American Church community¹².

Project Joy, conducted by Yanek et al, employed a faith-based approach to cardiovascular health in African American women. 529 women from 16 churches in the area of Baltimore were randomized to a standard behavioral intervention (SB), spiritual intervention (SI), or a self-help (SH-control) intervention. Subjects enrolled in the SB group underwent 20 weekly sessions on nutrition and physical behavior mediated by African American educators and church lay-helpers²¹. Those involved in the SI participated in similar activities supplemented by faith-based components. The SH group received pamphlets from the American Heart Association. Observed results included a significant reduction in associated cardiovascular disease related risk factors in the intervention group. These variables included improvements in body weight, waist circumference, systolic blood pressure, dietary energy, dietary intake, and sodium intake. There was no significant improvement noted in the self-help group. The researchers concluded that the church is an appropriate tool for cardiovascular intervention strategies in the African American community²¹.

A study performed by Mitchel-Beren et al attempted to improve colorectal screening measures in African Americans by using the church as its primary prevention site. Twenty Midwestern Black Churches were employed in educational, screening, and evaluation components of the cancer prevention program. The support of the Concerned

Pastors for Social Action, and the Michigan Black Nurses Association contributed to the educational component and further strengthened the community network needed to promote the program's success. Education about diagnosis, symptoms, and risk factors for colorectal cancer was provided to 1,488 church members. Of this group, only 17.8% of subjects participated in the screening process. This was mostly secondary to non-compliance with diet changes required for the screening kit. A follow-up evaluation suggested that most of the participants instituted dietary and life-style changes based upon colorectal cancer education received. No subjects were noted to be positive for cancer during the screening process. The low response did not however, negatively affect the educational benefits reported by participants in this study²².

Study Limitations/Barriers to Efficacy:

Several limitations in these 4 studies may be acknowledged and addressed in regards to study design and implementation strategy. The study composed by Davis-Smith et al was comprised of a small study population recruited from one church. This poses some threat to the generalizability of this program to the African American population as a whole. In addition, the absence of a comparison group fails to account for confounding factors that may have influenced the overall results. Thus it is possible that the overall efficacy of the program may have been overestimated. Although the DAWN study performed by Samuel-Hodges et al, made a valid attempt to address psycho-social and cultural barriers to health management and health seeking behaviors, it was unclear whether it was able to incorporate economical barriers such as income and/or the lack of neighborhood food stores with healthy food choices into the program infrastructure. They also failed to highlight the apparent stigma in African American

culture related to research participation and medical system use. Project Joy faced similar short-comings as dietary changes were necessary to observe the effect proposed by the intervention, yet monetary influences on nutrition were not addressed. Furthermore, Project Joy did not include an overall community component to its execution plan. This may have restricted the overall sustainability of the intervention as community involvement and investment have been shown to strengthen this program factor. This program also faced some challenges in regards to cultural competency as its initial (non-spiritual) intervention group model was originally composed without the inclusion of spiritual practices. This was not well accepted by participants and may have introduced a feeling of lack of sensitivity to faith and spirituality. Difficulties with trust and stigma related to research was poorly addressed as Pastor's were mistrustful of the randomization process. Finally, Project Joy did not indicate in its implementation strategy an approach to gaining support from participating Clergy. This may have affected the overall interest and retention rate of participants and eligible subjects. The study performed by Mitchell-Beren et al only made a weak attempt at creating a culturally competent program. Although the study elicited support from local pastors and nurses there was no defined relationship between these volunteers and participants. There also was reduced continuity of follow-up after the education materials were distributed and reviewed. This study also failed to foreshadow possible barriers related to culture, stigma, education, and socio-economic status by conducting a focus group. As a result education materials and instructions may not have been interpreted correctly and a full understanding of the commitment of the study may have been compromised.

Strengths/ Indicators of Efficacy

There were several notable strengths appreciated in these studies which seem to strengthen the efficacy of church-based interventions. The use of community volunteers and church congregation members to promote the intended intervention is a feature common to Projects DPP, DAWN, and Joy. Involving community members as well as congregation appeared to improve the susceptibility of the program. Also the support of the Pastor proved to be an important factor in compliance and interest in the program. Education about the disease target is also important and a key substituent of all 4 programs discussed. The use of a focus group to help guide the implementation strategy was employed by the 3 aforementioned programs. This served to promote a sense of personal investment in the intervention and also helped to balance the relationship amongst investigators and subject participants. It also appears that the use of group-structured sessions in addition to an individual component drives the support for self-efficacy and the zeal for behavioral change. Finally, Project Joy and Project DAWN addressed the potential educational barriers that may have resulted in misinterpretation educational materials and of investigator intent. A carefully planned focus group to aide in the design of materials appropriate for varying levels of education helped to improve participant understanding and interaction in group teaching sessions.

Assessment of Mental Health Services Provided by the Black Church

Few studies have been able to quantify the level of services provided to African Americans by the clergy as well as the efficiency and cost-effectiveness of counseling received. A completed literature search of research designs that focused on the

amenability of receiving mental health services via the church as well as the level of formal linkages to the health care system obtained by the church was obtained. A literature search with the MESH terms Church, Mental Health, and Black yielded 2 respectable papers in regards to the analysis of mental health services through the church in African American Communities. I did not limit my literature search by study design as I hypothesized that there would be minimal current research published about current preventative measures in this population. I finally chose the two papers by Young et al and Blank et al because of the applicability to my target population. Due to the limitations presented by the lack of current research evaluating depression in African American women, my goal was to find information that could be externally valid to my population. The 2 papers reviewed in this paper address this issue as they include a study population with demographics similar to my target population. A study performed by Young et al concluded that black clergy participated in an average of six hours of counseling work weekly and often addressed serious problems similar to those seen by secular mental health professionals, with whom they reported readily exchanging referrals¹⁷. This study included a cross-sectional design that addressed how African American clergy conceptualize, experience, and structure mental health counseling. Many of the respondents reported having and maintaining specialized education for their counseling work, which they described as including both spiritual and psychological dimensions¹⁷. This analysis was based on a cross-sectional study that included an interview of 121 African American pastors. Interviews were given to 82% of a population chosen out of the New Haven clergy registry. Interview sessions lasted

between 45 and 90 minutes and included demographic information as well as information about time spent doing pastoral counseling.

Statistical analysis comparing budget and mental services provided showed pastors with a church budget of more than \$60,000 per year (34 pastors) were involved with counseling for an average of 7.5 hours per week, but those with an annual budget of less than \$60,000 (51 pastors) averaged 5.2. hours per week, however this difference represents a trend and was not statistically significant. Thus, the majority of churches reported a wide-use of mental health services. In addition, most of the pastors reported that they observe and address severe mental illness and substance abuse in their congregations and they also counsel individuals outside their own denominations. More importantly, studies suggest that mental health services provided by the church are equally as effective as those provided by professionals⁶.

This notion applies specifically to the black female population, as their ideas of racial identity and stigmas of mental disorders challenge the acceptance of therapeutic counseling from an individual that is not culturally competent⁴. As a result, these women rely on alternative routes of social support such as distant relatives and most importantly clergy⁹. The social support provided by natural helpers in rural Black communities is motivated by shared beliefs about mental illness and the health care system. Even more important religious counseling is financially affordable. An additional study by Blank et al included a telephone interview by 269 pastors in the rural south⁹. Results reported that blacks were more likely to receive mental health services from the church than whites. A multivariate analysis comparing church budgets revealed the main effect for racial composition of churches was significant, with Black churches offering significantly more

services to their congregations than White churches. The interaction between the racial composition of the churches and their urban or rural location was non-significant. However, black churches had fewer links to formal systems of care, reporting very few referrals and a weak linkage with formal systems of care⁹. Both of these studies addressed the importance of black churches in mental health services as well as the dedication of the black church in providing these services.

Limitations/Strengths

Although both studies were able to quantify the utilization of services, neither study was able to validate the over-all cost-effectiveness of utilizing churches for mental health. Individual analysis of church budgets and percentage used on counseling services showed an inverse relationship between the two, however, not significant. Thus, it can at-least be concluded that churches on average are including mental health counseling as a significant part of their budget. The internal validity of both studies was significant. Although Yang concentrated on the black church as a whole, blank focused on the role of the black southern church. However, both studies methodologically included samples from a varied population within these subgroups, improving the application of the each study to the African American population. On the other hand, I believe that additional studies involving a larger subset of the African American population is needed in order to fully assess mental health services in African American communities. Few studies have evaluated the efficacy of a program that creates a liaison between the black church and professional mental health services. Based upon the combined information received the aforementioned studies, it is possible that religious involvement may support behavior that is more conducive to health. In addition, indirect health benefits may accrue from

involvement in church and community¹⁷. I propose an intervention that would address the cultural barrier of African American women to depression care as well as the socioeconomic barriers.

The analysis done by Young et al and Blank et al suggest that clergy do indeed play a vital counseling role with the African American community. Data also suggests that the majority of churches financially support these services as apart of the annual budget. In addition, previous research explains the possibility of a culture barrier influencing the communication of depressive symptoms by African American women. Furthermore, these studies hypothesize that this barrier may potentially be removed if this population is able to communicate with one that is culturally sensitive. Thus a counseling program promoting service via a “semi-professional” pastor seems practical. However, these studies fail to qualify the effectiveness of counseling services performed by clergy. Further research is implicated to finalize the costs created to educate the clergy as well as to staff individuals to serve as links between the church and the healthcare system. In addition, data regarding the ability of clergy to diagnose major psychiatric disorders failed to be presented. Moreover, both studies presented data confirming the lack of networking to professional systems by the African American churches. This is most concerning as a firm relationship with trained psychiatrists and hospital systems is necessary in order to provide proper referral services. Thus, although current studies solidify the close association between counseling services and the African American church, little research has confirmed the overall cost-effectiveness on the health system as a whole as well as the target population. In addition, the impact of a legislative bond

between the Black church and the health system on its members and leaders has failed to be hypothesized.

Finally, the Young et al, reports a 14 average years of education, while Blank et al. does not address education levels of the pastors at all. Thus a baseline education status for service providers must also be established to confirm that appropriate mental health services are being provided. It is obvious that continual research is needed in order to truly evaluate the effectiveness of this prevention program.

Conclusion/Feasibility of Church-Based Programs

Although current research involved in the prevention strategy presented is elementary in its efforts, I believe that the data is sufficient enough to suggest continued research efforts towards this program. Holistically, depression has served as a significant source of morbidity in the African American female population, necessitating the implementation of resources that will improve health access and management for this disease. The aforementioned church-based programs suggest that the use of the church as a tool for intervention is both feasible and efficacious. They also propose a design that improves the sustainability and acceptability of an intervention within a community that has traditionally exhibited a mistrust of the research community⁹.

Based upon the combined information received the aforementioned studies, it is possible that religious involvement may support behavior that is more conducive to health. In addition, indirect health benefits may accrue from involvement in church and community¹⁷.

A Program Plan: Project FRAMME(Forming Religious Alliances for Mental and Medical Education

Project FRAAME is a local initiative with the primary goal to improve screening measures as well as proposed depression management among marginalized populations, specifically African American women in the rural south. The method of intervention employed by Project FRAMME involves the construction of a formal link between the Black Church and formal systems of care. Formal systems of care are defined by Primary Care Systems as well as Specialized Care Systems (psychiatrists, multi-disciplinary organizations, etc) including but not limited to state-funded or privately funded local providers of mental health services. The over-all preface of this program is the utilization of an alternative resource for identifying, targeting, and providing mental health services for a population that is often overlooked due to several social, economical, and cultural limitations that are poorly addressed by our current National Mental Health System's service initiatives. There are few existing programs on both a state and national level that serve to improve screening and depression management in the African American female population within the rural community. In addition, few of these programs have attempted to use an integrative approach by valuing cultural, racial, and spiritual factors equally with socioeconomic barriers in considering the overall implementation strategy of the program¹³. Although the Black church has traditionally been a locus for community medicine, particularly throughout the south, it has been only a minimal focus until recent in regards to research derived intervention strategies for the black population¹⁴. This is particularly true in regards to mental health as the Black Church has been known to spend a substantial amount of its budget on counseling

services⁹. Project FRAMME will reduce the error in the under diagnoses and mal-management of depression in African American women by creating a linkage between the Black Church and Formal Systems of Care. With a community based participatory approach, it will incorporate the consideration of cultural risk factors such as stigma and mistrust that have been limitations to the efficacy of prior programs. This intervention will target the African American female ages (21-45) within the Grace Baptist Church in Durham County, Durham NC. This paper serves the purpose of describing a program plan which will guide my implementation strategy for Project FRAMME.

Program Content

Individuals participating in the development and implementation of Project FRAMME recognize the complexity involved in identifying the multiple factors that contribute to disparate mental health care among the African American population. With the recognition that physical barriers such as lack of transportation and adequate treatment sites within rural areas alone further complicate this target group's access to mental health care, it is necessary to consider more non-traditional methods of intervention to reach this group that is often overlooked. These methods employ the use of the local community along with support from central leaders of that community such as the clergy and local stakeholders. There is a growing awareness of the disparity that exists in conjunction with a recent movement towards the advancement of psychiatric care that makes for a ripe political environment in regards to support for a program such as this. In addition, there is a national push to educate the general population as well as the target group alike about mental illness and the nature of Psychiatry further suggests a positive environment for Project FRAMME. Furthermore, these efforts are strengthened

by the support of grass root organizations such as the National Alliance on Mental Illness (NAMI) that are represented on a state and local level.

Political Context: A new and innovative approach to improve the state of Mental Health Care in the African American Female (AAF) population, particularly in the South will be confronted by little resistance. The idea of using the church as a model for introducing Prevention strategies on both the health and educational level is increasing amongst public health workers and policy makers¹⁴. Although no formal infrastructure currently exist that create links between the Black Church and Primary Care Centers, there is a national recognition of the strong foundation that exists within the AAF population in regards to the delivery of counseling services by the clergy. The disproportion of the use of psychiatric services across racial lines is acknowledged by programs such as The NC Mental Health Association (NCMH) and the National Institute of Mental Health (NIMH)¹⁵. National and State funded initiatives such as these support the use of research and program tools to lessen this widening gap for the management of psychiatric illnesses such as depression as well as the utility of services.

National Priorities: A 1999 Mental Health Report of the Surgeon General highlights the vulnerability of the African American population in relation to mental health. This document suggests that the majority of this population resides in the rural south and provides a multi-variable analysis of the social limitations, physical barriers, cultural beliefs and historical context that contribute to the disenfranchisement of this group¹³. This report also concedes that is necessary to introduce cultural specific innovative

strategies to improve diagnosis and assessment of mental illness as well as access to treatment. Healthy People 2010, describes an effort “to increase the quality and years of healthy life and to eliminate health disparities”. This document that qualifies the nation’s priorities as it relates to the state of health-care, reports mental health as one of its leading health indicators. One of the primary goals of this collaboration is to increase the proportion of adults with mental disorders who receive treatment¹⁴. In addition, a future objective is to increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses cultural competence.

State and Local Priorities: North Carolina recognizes the improvement of the delivery of mental health services as a statewide priority. One of the goals of “Healthy Carolinians” is to increase the amount of adults that receive services for psychiatric illnesses. As of 1999, 141,068 NC citizens took advantage of treatment services from the Division of Mental Health Services/Disabilities/Substance Abuse Services¹⁵. The target goal for 2010 is that 162,228 individuals will achieve therapy. Within this state-wide initiative, there is a focus on depression and its associated co-morbidities. In addition, NC acknowledges the disparities across gender and socio-economic ties that lead to inadequate delivery, management, and diagnosis of depression. One of the primary objectives of this initiative is to eliminate health disparities while improving health care access in high risk populations.

According to the 2007 NC County Health Profile, Durham County houses a population of 247,612 individuals. The 2000 NC Census Bureau estimated that 40% of this population is of African American descent¹⁶. The median family income averages at

54,608, while 9.9% of families are living below the poverty level. 40% of the population has achieved a bachelor's degree or higher level of education.

Acceptability : The acceptability of this program is complex as it involves consideration of a multi-layered team consisting of involved clergy, outside providers, participants and supporting congregation and community. As a faith-based intervention, acceptability of this program is imperative to its success. Moreover, in regards to the participants and supporting community, it will be highly contingent of the careful construction of a program that is instituted in respect to cultural competency, stigma, racial differences, and socio-economic status¹⁷. To better insure acceptability from participants and supporting community, a focus group should be conducted to explore their needs, fears, and concerns as well as ideas on how to create a comfortable and trusting environment. It will be important to develop a trusting relationship with clergy, while it may also enhance the comfort level of the participants with the proposed intervention. The employment of a licensed clinical social worker within and with the help of the community will help to close the physical and social barriers throughout the infrastructure of the program. Allowing the health systems to utilize resources and service structure already in place will improve acceptability from the health provider perspective. With the increase of education about the diagnosis of depression within the AAF population, as well as the recent push to find innovative strategies to address depression in this population it can be speculated that program will be accepted across all levels.

Funding: Funding for this program will be sought from both state and local agencies such as the NIMH and the NC Mental Health Association. In addition, this program will seek alternative funding from local community agencies invested in this initiative. Support from local community centers and volunteer committees will also be enlisted.

Stakeholders: Stakeholders involved in the planning, implementation, and evaluation of Project FRAMME will include the clergy, the congregation of Grace Baptist Church, and community leaders. A Community Advisory Board will be constructed that will consist of health providers involved in the project, local community leaders, respected business owners and investors, additional community clergy, participants and appointed members of the congregation. Additional stakeholders will be officials of the NC Mental Health association, licensed clinical social workers, and community educators. Finally, Project FRAMME would benefit from the input of local counselors and members from the NC Health Dept.

Challenges: There are several challenges that must be met in order to ensure the efficacy and sustainability of Project FRAMME. One of the difficulties faced will be the incorporation of a non-spiritual based intervention within a faith-based community. A non-spiritual intervention will focus on individual accountability for disease with the use of healing through traditional medical treatments. These interventions are in opposition to spiritual based interventions such as prayer, meditation, and faith. Clergy may be reluctant to deviate from spirituality based counseling for what may be perceived as a more secular approach to treatment. This fear or misunderstanding may also overlap into

the congregation and participants, creating a sense of disrespect or lack of understanding of spiritual beliefs¹⁸. In addition, there is a stigma in regards to mental health and treatment options within the AA community that must be addressed¹⁹. This stigma may be related to the Black individual's tendency to rely on social support rather than formal systems services and may also be associated with the act of minimizing symptoms for fear of hospitalization⁹. African Americans are less likely to present with typical symptoms of depression, thus the inclusion of a culturally sensitive provider staff will be essential for maximizing the ability to diagnose these individuals⁴.

Additional challenges lie in the ability to effectively communicate the definition of depression, its management, and treatment options to participants and clergy. Participants may vary by educational level and exposure to the field of mental illness. Furthermore, clergy may also be confronted by barriers to education and may feel that their knowledge is inadequate for making referrals. The introduction of a diverse and carefully constructed Community Advisory Board will help to alleviate these challenges. The use of community educators will help to address the discrepancies related to teaching challenges. The support of a licensed clinical social worker will help to promote strong ties between the community and formal systems of care. Finally, specialized educators, participant providers, and Licensed Clinical Social Worker (LCSW) will be active devising an effective teaching tool to educate clergy about the diagnostics of depression.

Application of Program Theory

Factors that influence AAF to seek mental health services are multiple and complex. Particularly in the target population, physical barriers such as the scarcity of primary care and psychiatric physicians may contribute to a sense of perceived isolation. Cultural

beliefs, social stigma, and race all contribute to the disparity in regards to help-seeking behaviors in this minority population. Thus, the implementation strategy of Project FRAMME will involve the incorporation of several theories that hypothesize that individual, social, and community level factors all influence the likelihood of an AAF to seek mental health treatment in the rural south.

Individual Level: Project FRAMME utilizes the Health Belief model on an individual level which recognizes that an individual's personal characteristics, perceived susceptibility, perceived benefits, and perceived barriers all serve to influence the utilization of formal depression treatment services by AAFs. Perceived barriers may include stigma, deficiency in providers, and monetary constraints. Subjects may also fail to consider themselves as being susceptible to being affected by depression. Perceived benefits may include continuity of care, a sense of support, a sense of personal accountability, as well as a sense of hope for recovery. An individual's perceived needs may be influenced by their personal sense of susceptibility, education or knowledge of the disease, and knowledge of treatment outcomes. Health seeking behavior in this target population may also be manipulated by its social networks. The social learning theory will be applied to explain this disparity on an interpersonal level. This theory explains that people exist within environments where other's thoughts, advice, and support influence their behavior in regards to health. In alignment with the social learning concept, reciprocal determinism will be demonstrated by the intended increase in the awareness of depression within the community through educational techniques. Materials, resources, and seminars to help dispel stigma within the community would create an environment for reciprocal determinism to transpire. Clergy/Pastors will also

undergo targeted educational seminars to improve self-efficacy in diagnosing or recognizing depression. A multi-disciplinary network will help to reinforce a sense of community and trust which may be a perceived reward.

Community Level: This model hypothesizes that community level factors such as socio-economic status, rural location as well community acceptance help to explain the necessity for an intervention such as Project FRAMME. The preference for the utilization of social networks such as family, friends, and more importantly clergy also influences social resource availability. The community organizational model suggests that empowerment, community competency, and active participation all serve to improve the efficacy and sustainability of an intervention. The application of a CBPR approach with the use of a carefully appointed CAB will lead to a sense of self-reliance and personal investment.

Goals and Objectives

The overall goal of Project FRAMME is to improve the screening process of depression and increase access to healthcare for AAF living in the rural south by using the church as a model for a referral basis. A secondary goal of Project FRAMME involves educating clergy about depression and how to recognize its presenting symptoms. It will be necessary to train supporting staff as well while establishing

Short Term Objectives:

Overall Goal#1:Successful Implementation of Project FRAMME

- By month one Project FRAMME will have distributed advertisement about depression in the AAF community and the goals and objectives of Project FRAMME.
- By month one the Project team including volunteers and support staff will be created
- By month one information packet will be sent to surrounding Primary Care Physicians, Counselors, and Psychiatrists for Program Recruitment
- By month three Project FRAMME will have developed its CAB and created working relationships with the clergy and support staff
- By month three recruitment of participating Mental Health Specialists will be complete
- By month three Project FRAMME and its CAB will have established a good working relationship with the clergy
- By month four congregation and surrounding community have been introduced to Project FRAMME and its initiatives
- By year one at least referral from clergy is made to primary care physician or participating psychiatrist

Secondary Short-term Goal-Education of the Clergy

- By month one Teacher Educator of Clergy will have developed education materials for training
- By month one Clergy will be introduced to Teacher Educator and aware of education goals

- By month one Clergy will have working relationship with LCSW
- By month one staff will be trained by Program Coordinator about required duties such as development of education materials, distribution of materials, and recruitment
- By month one staff including Clergy will have completed 1 week seminar about definition, diagnosis, and disparities associated with depression
- By month 4 Clergy will have completed 4 month weekend course on diagnosis and management of depression

Long Term Objectives: Improvement in Depression Screening with increase in utilization rates of Treatment Services

- By year five 50 % of depression diagnosed participants will have been referred to outside psychiatrists for formal services
- By year five 75% of individuals receiving counseling services at Grace Baptist Church with depression symptoms will receive a formal diagnosis and offered formal treatment services
- By year five 75% of the church community will report familiarity with an outside psychiatrist or service provider for mental health
- By year six there will be an extension of this program to similar surrounding community churches
- By year five mental health physician investors will report an increase in the utilization of services from the target population

Implementation

The implementation of Project FRAMME will begin with the hiring of a Project manager and the selection of a Program Coordinator and 2 support staff. These support staff along with the Project manager will then utilize information from previously performed focus groups to devise a CAB. Support staff will be responsible for managing participant recruitment and marketing. They will also be beneficial in training volunteers for distribution of materials, making phone-calls for recruitment, and aiding with correspondence with participant Mental Health Agencies. Focus group participants will have been recruited from neighborhood participant volunteers as well as congregation members from Grace Baptist Church. Additional educational staff will also be selected and participant psychiatrists and physicians will be identified.

The CAB will meet to help decide the proper way to distribute educational materials about depression within the church and surrounding community. Educational staff will work alongside medical professionals to design a skills packet and education plan for participating clergy. All volunteers will also undergo specialized training mediated by hired Staff. Clergy will undergo a 4 month training commitment on how to recognize depression and will be educated on how to recognize and address challenges faced when referring identified subjects for formal services. Clergy will be responsible for identifying eligible participants with depressive symptoms. They will also work along-side a LCSW to provide demographic and economic and insurance history to target eligible Mental Health Services.

The LCSW will have a primary meeting with each identified target and introduce viable options for depression management. Furthermore, they will act as a liaison

between Program Staff and Mental Health Service providers to introduce participants for formal care. They will also communicate with Support Staff to target specific treatment goals for each patient and address additional barriers such as education status, transportation, or fears. Support staff will meet with and introduce each eligible participant to the goals of Project FRAMME, provide additional educational materials about depression, and address concerns or fears.

Participants will be offered professional treatment at a participant site of their choice. Services offered to each participant will include medical treatment by trained psychiatrists, therapy treatment by a psychologist, and counseling by a licensed therapist. Program participants of Project FRAMME must undergo formal mental health assessment by a trained physician before entering either of the treatment modalities. A primary diagnosis of depression must be confirmed. Recommendations for the appropriate treatment measure will be made and discussed formally with each participant before they are asked to make a decision about preferred services. Each participant will be asked to make a 1 year commitment to treatment modality of choice. The primary group will include participants that elect to utilize treatment services from a trained Psychiatrist. These group members may opt to also receive adjunctive counseling services from a therapist or psychologist of your choice. A secondary group of participants will include those that opt to utilize counseling services without treatment from trained Psychiatrists. Participants will also receive monthly check-ins with Program staff and will remain apart of depression education support group that meets monthly for one year. The education support group will be a disclosed meeting held monthly lead by Program support staff. It will create an opportunity for participants to share struggles and

fears with one another, ask questions, and learn about healthy alternatives for stress management.

Eligible subjects that refuse formal treatment may also opt to participate in the depression education group. At no point will participants be encouraged to discontinue their counseling relationship with Clergy. Each subject will complete an initial depression screening form and will also complete one at 6 months and 1 year. Providers will be expected to track demographic records during this period to analyze utilization trends by this community.

Conclusion

There is a growing national recognition that disenfranchised populations suffer from disparate mental health care. It has been reported that these populations are at an increased risk for encountering psychological distress and may be particularly vulnerable to depression. Along with this recognition lies the inertia to develop creative research strategies to explore associated factors and create effective and sustainable interventions. The black church has long been celebrated for its role as a resource for education and healing services throughout its community. Considering the most evident barriers (transportation, money, resources) facing AAF in the rural south it seems almost an innate idea to use the church as an alternative method for improving delivery of formal depression treatment services. Project FRAMME aims to improve screening measures and increase access to care by addressing physical barriers and attacking social stigmas that may influence healthy behaviors.

I propose an intervention that would address the cultural barrier of African American women to depression care as well as the socioeconomic barriers. Although little evidence about the efficacy of such a program exists, one can hypothesize that by better equipping the ministry staff to handle mental disorders such as depression as well as providing linkages for referrals for greater care, the cultural barrier between African American women and depression care will be made smaller. The accessibility of the church in the African American female population could potentially close the disparate gap amongst this population in regards to depression management. Moreover, shared beliefs and culture may modify stigma associated with mental health care and support positive help-seeking behavior. Thus, potentially reducing the morbidity suffered by this population due to long-term undiagnosed depression. In addition, a prevention strategy improving diagnostic procedures in the primary care setting would also further improve diagnosis and management in this population.

Programs focused on improving knowledge of depression in the black female population as well as education provided about support services should be distributed by individuals of the church. In addition, resources to train black clergy about mental health counseling could possibly make existing therapy more effective. Without the access barrier, more African American Women would be able to receive depression care without the worry of stigma and insurance costs. In addition, this could potentially reduce the number of African American women presenting with depression in an emergent situation. Further research is implicated to finalize the costs created to educate the clergy as well analyze the cost incurred to staff individuals to serve as links between the church and the healthcare system.

Resources/Inputs	Activities	Outputs	Short and Long-term Outcomes	Impact
The following materials will be utilized to implement Project FRAMME	The following activities must be performed in order to employ Project FRAMME	The proposed outputs will be expected after completion of activities	The following changes will be observed during the execution of Project FRAMME	The following changes are targeted by the initiation of Project FRAMME
<ul style="list-style-type: none"> -Distribution and marketing materials to inform community about Project FRAMME -Recruitment materials to be distributed to potential providers -Orientation packet for support staff including LCSW and Clergy Educator -Educational materials for Clergy -Registration materials for participants -Depression screening intake and assessment form for participants -Seminar materials for program participants -Cooperation from local mental health department -Cooperation from local stakeholder/community leaders -Support from church congregation and associates -National/State funding 	<ul style="list-style-type: none"> -Program Coordinator will formally train support staff -Support staff will train volunteers -Volunteers and support staff will distribute marketing materials conduct recruitment interviews -Clergy will undergo formal depression management training -Clergy will administer depression screening survey for suspected participants -Participants will meet with LCSW -Participants will complete in-take assessment -LCSW will communicate with treatment providers -Participants will take part in at least 1 year of preferred treatment + management group -Participants will complete depression survey at intake, 1 month, and 6 months 	<ul style="list-style-type: none"> -The local community will be informed about Project FRAMME -Local psychiatrists, therapists, and psychologists will be recruited as service providers -Community members and congregation will be recruited as participants in Project FRAMME -Clergy will initiate first screening process for depressed subjects -Each participant will have established care for Mental Health Services for at-least 1 year -Each participant will receive follow-up from Program team to evaluate progress 	<p>Short-term:</p> <ul style="list-style-type: none"> -Program participants will have appropriate treatment plan for depression -Clergy will be appropriate in diagnosis and referral for depressive symptoms -Participants will express a greater understanding of depression -Participants and community will be aware of available treatment measures for depression -Established link for formal services with Black Church <p>Long-term</p> <ul style="list-style-type: none"> -Treatment utilization rates for depression will increase in target population -Target population will report feeling more comfortable receiving formal treatment for depression -Target population will report a decrease in stigma associated with mental health 	<ul style="list-style-type: none"> -Improvement in screening process for depression in AAF -Decrease in morbidity/mortality associated with depression in AAF -Increase in utilization of Church for intervention strategies

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