MENTAL HEALTH DISPARITIES IN VULNERABLE COMMUNITIES: IMPLEMENTATION OF AN EVIDENCE-BASED PRACTICE MENTAL HEALTH DEPRESSION EDUCATION PROGRAM – A PILOT STUDY

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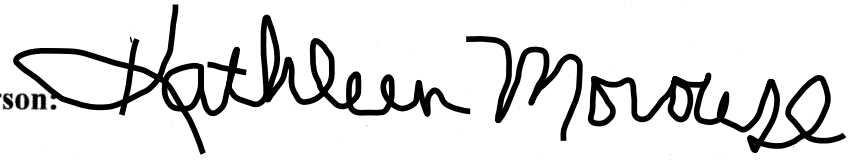
Committee Chairperson: 

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Dedication

To my family, who endured all the neglectful nights, days, weeks, months, and years it took for me to get to this point, the light at the end of the tunnel. I appreciate all your support.

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I want to thank the nursing faculty at Pennsylvania Western University's DNP program. I cannot express enough gratitude and appreciation to my committee chair Dr. Kathleen Morouse, committee members Dr. Timothy Wilson and Dr. Kenneth Ogali, whose guidance and encouragement kept me motivated. To Dr. Valera Hascup, thank you for your astute critique which facilitated in getting this project completed.

Abstract

The purpose of this evidence-based practice project is to evaluate the effectiveness of a pilot mental health knowledge questionnaire tool used to assess for change in knowledge. Currently, there are limited tools being used to assess mental health and depression knowledge in vulnerable communities. This study's objective and goal is to improve the current practice for community mental health education in vulnerable communities with the intent to increase awareness and dispel cultural misconception of mental health. A self-reported pre-test was administered to assess baseline knowledge of mental health and depression followed by the educational program on mental health and depression. The data was analyzed utilizing the Statistical Package for the Social Sciences (SPSS) 23 for descriptive and inferential statistics. The scores from a paired t-test were compared to determine the effectiveness of the educational intervention. This study sought participants aged 18 and older, fluent in speaking, reading, and understanding English. The findings reflect a positive improvement in knowledge recorded on the post-test responses. Results also showed an increase in correct responses on the post-test after the implementation of the mental health depression educational program. Finally, the promotion of educational programs on mental health and depression in vulnerable communities are beneficial in bring awareness of mental illness.

Keywords: African Americans, Community-based mental health programs, discrimination, explicit bias, implicit bias, LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual, questioning community), depression, mental health disparity, mental health education, mental health knowledge awareness, mental health promotion, vulnerable communities, and vulnerable populations.

Table of Contents

List of Tables

Table **Page**

List of Figures

Figure **Page**

Chapter 1: Introduction and Background of the Problem

Current research has identified mental health disparities in vulnerable communities as a critical problem resulting in negative mental health outcomes. Data from minority communities report greater disparities in medical and mental health services for vulnerable populations (Centers for Disease Control [CDC], 2019). The COVID-19 pandemic exacerbated mental health disorders resulting in alarming incidences of anxiety and depression (CDC, 2019). The purpose of this evidence-based practice project is to evaluate the effectiveness of a pilot mental health knowledge questionnaire tool used to assess for change in knowledge.

Mental health disparity is a crisis affecting millions of households across America. These disparities reflect a long history of systemic and structural inequities rooted in discrimination (Ndugga & Artiga, 2023). Discrimination is systemically woven in policies that affect vulnerable individuals. These unjust policies affect racial and ethnic minorities, socio-economically disadvantaged, the unhoused, disabled, elderly, refugees, lesbian, gay, bisexual, transgender, queer, intersex, asexual (LGBTQIA+), and the chronically ill (Mezzina et al., 2022).

Mental Health and Depression

Mental health disorders left untreated steadily lead to chronic disabilities and even suicide (Hsieh & Qin, 2017). Depression significantly affects an individual's mental health with feelings of sadness, loss of interest that could even lead to death. Worldwide, an estimated 300 million people have experienced depression affecting their quality of life (Herrman et al., 2018). Vulnerable populations have adverse mental health outcomes reporting increase depression, anxiety, post-traumatic stress disorder (PTSD) with limited treatment and access to services (Diaz et al., 2021).

Literature on similar topics noted discriminatory policies in healthcare negatively impacting vulnerable individuals compared to health outcomes of individuals in more affluent areas (D'Anna et al., 2018). These practices require a change to improve dignity and decency in the treatment of all human beings. Social factors of inept mental health and structural biases increase rates of serious mental illness in vulnerable populations created by mistrust, fear, and cultural differences. (Codjoe et al., 2021). Additional studies are necessary to identify and dismantle biases in healthcare for meaningful change to occur in practices and policies. Multiple study outcomes reveal a negative relationship between disparity and the availability of relevant resources in disadvantaged communities. (Codjoe et al., 2021). This evidence-based practice (EBP) project contributes to the increased need of mental health education as a practice model for the promotion of educational awareness in vulnerable communities.

Statement of the Problem

Mental health disparities along with discriminatory practices foster biases that continue to impact the overall quality of life for vulnerable populations (Commonwealth Care Alliance [CCA], 2022). These practices lead to inefficient and inequitable assistance affecting mental health in vulnerable populations (CCA, 2022). Black, Hispanic, and Asian adults were 39% less likely to receive mental health services than 52% of White adults (Singh, 2023). Research findings discovered disparities are experienced by minorities, every day of their life, from birth to death. Minorities experience discrimination economically, environmentally, educationally, and socially (Williams, 2016). Racial discrimination adversely affects vulnerable populations mental and physical wellbeing (Berger & Sarnyai, 2015).

Every human being will experience mental health challenges in their lifetime. According to the Williams (2016), one in five adults in the United States live with mental illness. Mental

health is an individual's ability to manage daily stressors, remain functional and engage positively with his family and the community (WHO, 2023). Experiencing positive mental health is important at every stage of life, from childhood to adulthood (CDC, 2019).

Mental health challenges are amplified by biases which create stress, deteriorate health, and produce psychological distress. These stresses manifest as mental health disorders, substance abuse and suicide (Lei et al., 2021) identified significant evidence suggesting reduced accessibility of daily necessities were contributing factors that deprivation can exacerbate mental health inequities. Limited availability of affordable housing, employment and health coverage increases the stress of life, compound that with scare resources deepens mental health distress.

Racism, discrimination, and biases are harmful in healthcare and the population (Hui et al., 2020). These inequities delay the establishment of adequate, available, culturally affirming resources and providers. Research results report marginalized patients have a difficult time locating services (Hui et al., 2020). Mental health inequities result in significant financial costs in the US health system. The total cost of racial/ethnic disparities in 2009 was $82 billion — $60 billion in excess health care costs and $22 billion in lost productivity (Gaskin, Dinwiddie et al., 2012). The lack of resources impedes services needed for preventive and chronic care treatment to maintain a healthy way of life.

Vulnerable populations are disproportionally impacted by the inequities in healthcare. This population represented individuals that include indigenous groups, gender, race, sexual orientation, class structure, ethnicity, religion, low-waged, uninsured, elderly, homeless, pregnant women, disability, human immunodeficiency virus infection and acquired immunodeficiency syndrome (HIV/AIDS), severe mental illness, displaced individuals, and rural residents (Tangcharoensathien et al., 2018). The U.S. Census Bureau statistics identified in 2005

that African Americans were 7.3 times more likely to live in low socioeconomic communities with limited or no access to mental or behavioral health services (Denton & Anderson, 2005).

After the adaptation of the Affordable Care Act (ACA), African Americans continue to remain uninsured due to unemployment, expensive insurance premium, extensive program requirements, shortage of culturally diverse healthcare providers and limited healthcare facilities within their communities (Gaskin et al., 2012). Multiple psychological research have shown a disproportionate amount of African Americans continue to be over-diagnosed with schizophrenia, bipolar disorder and post-traumatic stress disorder. These studies continue to report consistent findings, revealing African Americans are 78% more likely to be diagnosed with a psychotic disorder than Euro-Americans (Schwartz & Blankenship, 2014).

LGBTQIA+ population encounter social disadvantages and mental health disparities exacerbated by social isolation during the COVID-19 global pandemic (Salerno et al., 2020). Social disparities compound the individual's mental health thrusting them into a downward spiral of depression and mental illness. Mental health burden in the LGBTQIA+ individual is made worse by social inequities (Galea et al., 2020).

It is estimated that about one-sixth of LGBTQIA+ patients experience discrimination in healthcare and avoid care due to this fear (Powell, 2018). Discrimination does affect an individual's mental and physical health. Fear of seeking care leads to declined physical health. LGBTQIA+ person of color is at a greater risk for mental health disparities. They experience mounting mental health challenges created by PTSD, anxiety, depression, and suicidality stemming from ongoing systemic racial discrimination (Galea et al., 2020).

Healthcare inequities are supported by facility operations with policies, regulations and discriminatory biases manifested in omission of care, inadequate treatment, along with disregard

of cultural awareness (Baumann & Cabassa, 2020). These inequities are rooted in historical political injustices present in all areas of care throughout the world largely based on race and socioeconomic status (Baumann & Cabassa, 2020).

Background and Significance of the Problem

The ethical implications and medical ramifications of implicit and explicit bias in healthcare to underserved and underrepresented vulnerable populations are concerning as reflected in the current mental health crisis reported by the WHO (2022). There is a need to identify and address implicit and explicit racist behaviors in healthcare which is directly related to the health and wellness of the population. FitzGerald and Hurst (2017), identified in their study that healthcare professionals display similar levels of implicit bias as the rest of the public.

Healthcare professionals are entrusted to care for individuals, they took an oath to DO NO HARM. To care for the sick and vulnerable. Implicit associations about a group, be it prejudice or stereotype, influence the behavior of healthcare providers resulting in negative evaluations clouded in bias (Holroyd et al., 2016). Whether it is conscious, negligence, intentional, premeditated, bias in healthcare is a willful attempt to allow harm to befall a vulnerable human being. The data proves that African Americans, LGBTQIA+, pregnant women, refugees and other vulnerable populations are in danger in the healthcare system. We are all now implicit in allowing this practice to continue and do nothing except read it on paper. Evidence remains consistent in studies showing bias between patient-provider interactions are linked to discriminatory care (Cooper et al., 2012).

Mental health disparity hinders awareness, knowledge, and the ability to live a healthy quality of life. This EBP project's intent is to implement a mental health depression education program in a vulnerable community to increase awareness, dispel cultural stigmas and normalize

mental health care. The disparity of financial and transportation burden is eliminated from this project by conducting this project in the community, making it accessible for the residents to attend.

The student's interest was in mental health disparity in vulnerable communities and identifying the critical need for culturally sensitive resources. As a result, the student investigator conducted a pilot study to evaluate the effectiveness of a mental health knowledge questionnaire to assess for change in knowledge to develop and promote mental health and depression education in a selected vulnerable population in central New Jersey. This interest became the impetus for this doctoral project. Researchers use the population, intervention, comparison, and outcome (PICO) framework to conduct a focused literature review on the topic (Eldawlatly et al., 2018)

The critical need for medical and mental health services in underserved minority communities is unsettling. These limitations hinder optimal health and mental wellness for the population, contributing to disparities. The profession of nursing can contribute programs to decrease disparities in mental health in underserved communities and promote access and engagement to these services. Advance practice nurses would allow for detection of community specific needs, steering nursing research to discover and implement culturally relevant interventions to improve outcomes and quality of life for the community (Grando, 2005; O'Connor, 2015).

This doctor of nursing practice EBP project will contribute to the gap in programs needed to reduce mental health disparities in underserved, under-represented groups and other individuals that have been historically linked to discrimination and exclusion. This program promotes normalizing mental health care by providing information to allow the individual to

adapt new self-care habits and understanding (Hartweg & Metcalfe, 2021). The WHO (2022) recommends the promotion of mental health programs by health providers and collaborators to contribute to the reduction of disparity to enable a transformation towards better mental health for all.

Impact of Innovation Technology on Vulnerable Populations

With the progressive innovation of technology, vulnerable individuals' lives are still facing alarming risks. There is evidence demonstrating digital divides with the introduction of health information technology in healthcare with patterns differing by race, ethnicity, and other socioeconomic characteristics (Saeed & Masters, 2021). Healthcare systems are progressing forward and relying significantly more on technology. Vulnerable populations will be negatively impacted by this, as current broadband, artificial intelligence, technologies and bio-metric devices have limited input for cultural recognition. Inadequate and limited internet access hinders quality video conferencing required for diagnostic evaluation (Bakhtiar et al., 2020).

The beneficial outcome from eliminating mental health disparity is healthier individuals, decrease healthcare cost and improved quality of life. Collectively, every citizen will benefit from the elimination of mental health disparities. The cost of prolonged treatment results in higher taxes and insurance premiums for everyone. Increasing health access, services, and resources to eliminate mental health disparities has a potential of saving over $1billion US dollars (Cook et al., 2015).

Community-based programs are needed to serve as assessment centers, resources, and preventive facilities in empowering individuals to embrace self-care (Hartweg & Metcalfe, 2021). Collaboration between health professionals and community stakeholders can develop a shared goal to implement policies to recognize mental health needs among individuals who

utilize their services (Brown et al., 2019). Culturally relevant information is important to address stigma, misinformation, and cultural indifference in vulnerable populations (Cook et al., 2015).

Assumptions

Implementing an evidence-based mental health depression education program will improve understanding and awareness of mental illness, normalize care, clarifying cultural stigmas and increase utilization of services (WHO, 2021). Clarity of cultural misconception and stigmas. Promoting a self-help mental health model encourages individuals to use tools to decrease mental distress (Vaughn & Jacquez, 2020). Providers that are culturally representative of the community will increase resident engagement and trust. Representation is important as it builds therapeutic trust and relationships.

Purpose and Objectives

The purpose of this evidence-based practice (EBP) change educational project was to evaluate the effectiveness of a mental health knowledge questionnaire to assess mental health and depression before and after a mental health and depression educational program. The study aimed to implement a pre and post-test questionnaire to identify changes in awareness of mental health and depression symptoms. Currently, there are limited tools being used to assess awareness of mental health and depressive symptoms in vulnerable communities. The goal was to improve current practice of increasing mental health and depression awareness in vulnerable communities to promote and normalize the use of mental health resources.

PICO Research Question

The starting point for evidence-based practice was to develop that crucial clinical question to facilitate the search for evidence (Polit & Beck, 2022) using a PICO format. The acronyms represent:

Population – Vulnerable community (African Americans, Hispanics, LGBTQIA, religious)

Intervention – Depression education program

Comparison – Community awareness with no education on mental health and depression

Outcome – Improved knowledge about mental health, depression, available resources and how to access them

The PICO Question - Does implementing a mental health depression education program in a vulnerable community (African Americans, Hispanics and LGBTQIA+), improve knowledge, and attitude towards mental health care services as compared to the current community level of awareness with no depression education?

Definitions

The following key terms are defined to help the reader understand the context of each term in this study. These key terms are:

Depression is an extended period of sadness and despair lasting several days. It interferes with how you think, feel and care for our daily activities. This results in pain, change in sleeping pattern, lack of energy and recurrent thoughts of not wanting to be alive (American Psychology Association, 2017).

Health inequity denotes differences in health outcomes that are systematic, avoidable, and unjust (He, 2022).

Implicit bias involves unconscious intent or reaction that leads to a negative influence in the evaluation of a person based on unknown situational cues or characteristics such as race or gender (FitzGerald & Hurst, 2017).

Explicit bias implies conscious awareness and express negative preferences, beliefs and attitudes in the evaluation of a person that are endorsed, identified and communicated (Vela et al., 2022).

Mental health, according to the WHO (2022) mental health is a state of well-being where an individual realizes their own potential, able to cope with normal stresses of life, able to work effectively and successfully, and contributes to their community.

Mental health disparity refers to gaps in health, health outcomes, quality of care, and access to programs towards various populations (He, 2022).

Mental health prevention is intervening to minimize determinants of mental health before they become problems (WHO, 2010).

Mental health promotion is any attempt to encourage behaviors that can help prevent and reduce factors that can lead to mental disorders (WHO, 2010).

Social exclusion, also referred to as social isolation, is used to identify the marginalized participation or exclusion of certain people from economic, social, cultural, and political involvement according to the United Nations Commission for Europe Task Force on the Measurement of Social Exclusion (2022).

Vulnerable community: According to the American Hospital Association (2016), vulnerable communities include groups that may encounter limited access to health services; scant economical resources; inadequate insurance coverage; cultural challenges; health illiteracy; and unsafe environmental surroundings.

Vulnerable populations: The National Collaborating Center for Determinants of Health (2022) define vulnerable populations as group and communities subjected to higher risk for poor health outcomes related to barriers and exclusions to social, economic, political, and environmental resources.

Feasibility Assessment

This study was conducted in a hotel banquet hall in an urban community in New Jersey. There were no barriers to implementing this study. The study did not require external assistance or deployment of sophisticated technology or resources to affect it. The study is also justifiable on medical grounds and the results of this study may influence future decision making for mental health education in the community to decrease disparities by improving community awareness and mental health outcomes.

Budget

For this EBP, a hotel banquet hall was used to support the presentation, the cost for this location was $175 dollars. The cost for paper was $120 dollars, which was covered by Therapy Confidential & Consulting, LLC, a private mental health practice. The total project cost was rounded to $450 dollars. The student project investigator paid all other additional costs for this study. The mental health knowledge questionnaire is a reliable tool to screen for change in knowledge. This tool is intended to be used, distributed, and reproduced in any medium, provided the original work is properly cited (Yu, et al., (2015).

Limitations

A possible limitation when using any self-reported questionnaire could be related to the participant's unwillingness to report truthfully their psychological experience or distress, thus affecting the result of the project. Time may play a factor in providing a comprehensive program that is not overwhelming but easily understood and memorable. This will be limited to one community, no random sampling, and therefore findings may not be representative or generalizable to other larger similar communities.

Chapter 2: Review and Critique of the Literature

A comprehensive search of the literature on the phenomena of interest was conducted using databases that included EBSCO, the Cumulative Index of Nursing and Allied Health Literature (CINAHL), Elsevier, World Health Organization (WHO), APA PsycNet, The Centers for Disease Control and Prevention (CDC), Google Scholar, PubMed, Wiley.

The keywords discussed in this project are, African Americans, Community-based mental health programs, discrimination, explicit bias, implicit bias, LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual, questioning community), depression, mental health disparity, mental health education, mental health knowledge awareness, mental health promotion, vulnerable communities, and vulnerable populations. The articles and studies focused on the relationship between mental health disparities and mental health awareness, depression and utilization of resources and the impact on vulnerable communities. This information was relevant in establishing the realities of mental health disparities in vulnerable communities.

Procedures Used to Critique the Literature

The articles were evaluated to determine the hierarchy of the evidence as established by (Polit & Beck, 2022). Approximately eighteen articles were selected and evaluated for this literature review. Research reveals, poor utilization of services and policies limiting resources, access to mental health services and lack of professional trained providers in mental health remains contributing factors for inequitable mental health services and care in vulnerable communities (Kaur et al., 2023). Structural racism and discrimination continue to support inequitable distribution of resources in disadvantaged areas (Egede & Walker, 2020).

An analysis of vulnerable community conducted by the New Jersey Policy Perspective, found that mental health staff for white and Asian students increased over the decade, while

mental health staffing in predominantly Black and minority districts drastically decline over the same period (Weber, 2022). Programs are needed to directly address social and cultural intervention to increase sustainability to decrease behavioral decline in vulnerable populations (Egede & Walker, 2020).

While conducting the search for mental health resources in local vulnerable communities in central New Jersey, it was revealed the number of facilities needed to meet the need of the total population living in those neighborhoods was inadequate. The lack of resources is a microcosm of a substantial problem affecting the entire country patterned in disparity (Burns, 2022). Contributing to increasing resources, knowledge and education is the main reasons for conducting this doctoral nursing project. The goal is to promote mental health and depression education improving quality of life at home and the community. Public health messaging with social intervention is an effective technique for the promotion of positive mental health awareness for vulnerable population (Latha et al., 2020).

Reducing health disparities improves health outcome, structural living conditions are critical determinants of health disparities in minority populations faced with multiple structural disadvantages (Brown et al, 2019). Mental health disparities in minority communities have been identified by the WHO (2022), as a human rights violation against individuals with mental health illness. This behavior is widespread across systems everywhere. Suicide is still criminalized in several countries and the most disadvantaged remain the poorest, most at risk and least likely to receive adequate care (WHO, 2022).

Scientific literature appears to focus on mental health of Blacks, however, Asians, Hispanics, LGBTQIA+, and other vulnerable minority groups have also been significantly impacted by declining mental health as evident by the rise in anxiety, depression, PTSD, and

suicides (Lee & Waters, 2020). LGBTQIA+ patients continue to report negative mental health outcomes compounded with discrimination and lack of understanding of their specific concerns (Liu et al., 2022).

The researcher reviewed multiple peer reviewed articles highlighting and identifying disparities affecting vulnerable minorities, deprivation of resources, and clinically trained mental health providers are in demand to address these crisis (Townsend et al., 2023). One researcher reported that mental health inequities and lack of access is a public health concern festered by socioeconomic struggles, discrimination, and cultural stigmas, destroying lives, families and those living within the community (Coombs et al., 2021). Studies on cognitive behavioral skills development in vulnerable community settings are scarce. Increased evidence-based practice community programs are needed in mental health services that incorporate cultural relevant interventions and recommendations to foster an upstream approach to breakdown disparities (McMorrow et al., 2021).

Culturally competent relevant mental wellness resources and programs specific to African Americans are minimal, this is an example of inequities pertaining to the overall available of services within the identified community (McMorrow et al., 2021). To counter this current system the role of cultural competence is imperative in combating discriminatory practices. Community integration, cultural awareness of the local community, available infrastructure and direct service support are characteristics that are supportive of an inclusive mental health program (Chu et al., 2022).

Addressing vulnerable populations will require cultural awareness and sensitivity. Cultural competence is the standard of value in the profession of psychology outline in practice guidelines set forth by the American Psychological Association (APA, 2017). The APA

developed a framework guiding the practice of administering multiculturally competent service. This guideline outlines 10 strengths-based approaches when engaging with disadvantaged vulnerable communities (Clauss-Ehlers et al., 2019).

The evidence in the literature suggests public education on mental health reduces psychiatric morbidity when focused on the individual, and their environment (Sakiz, 2021). The introduction of an effective protocol to assist with the treatment of depression, one of the most common mental health illnesses affecting minority communities, may demonstrate efficiency in mental wellness (Vargas et al., 2019). This critique will attempt to determine if implementing a culturally competent mental health promotion program to increase depression awareness contribute to the reduction in mental health disparities in African American and minority communities.

Several studies utilized different methodologies for data collection. A cross-sectional design study with data collected from the National Health Interview Survey between 2017 and 2018 (Coombs et al., 2021). A mixed method process containing the development of a pre and post-test assessment tools along with the development of a semi-constructed interview as part of the process evaluation approved by an institutional review board from one of the author's institutions (McMorrow et al., 2021).

Vargas (2019) conducted a randomized comparative effectiveness study design approached with the use of the resilience against depression disparities (RADD) study design to assess interventions and engagements of the participants with depressive symptoms for LGBTQ participants (Vargas, 2019). Descriptive statistics were used to explore the relationship between mental health challenges and the usual source of care (Coombs et al., 2021). Qualitative data

were reviewed for themes and triangulated to heighten validity of results (McMorrow et al., 2021).

One result revealed that mental health challenges alone were not drastically affected in multivariable education programs, but a statistically significant change was detected when two or more barriers to care were present. Results verified resources in rural areas facing environmental burden due to large acreage of land in which to provide service coverage (Coombs et al., 2021). Results indicated improvement in depressive symptoms and overall mental wellness in participants enrolled in evidenced-based treatment, such as cognitive behavioral therapy as indicated in score changes on the participants pre and post assessments conducted (Vargas et al., 2019).

Within the discussion section, the authors focused on variables of mental health promotion, education, and cultural inclusion in African American, minority and LGBTQ communities where mental health facilities promote services (McMorrow et al., 2021). It was also discussed that additional information is needed when addressing depression as this was identified as a significant scientific gap in promoting depression outcome in racial, ethnic, and gender conscious minorities (Vargas et al., 2019).

Reviewing the limitations expressed in the study, the researchers were faced with multiple challenges to overcome. Homogeneity, low completion, rate, and lack of a comparison group affected the statistical power of the data collected limiting the valuation of the findings impeding the overall generalization of the population (McMorrow et al., 2021). The anticipation when conducting research and the need to rely on randomly chosen subjects, is their willingness to be forthright and honest when providing self-reported measures or subjective data. In this

case, access and utilization of mental health services has demonstrated validity in self-reported use of health services (Vargas et al., 2019).

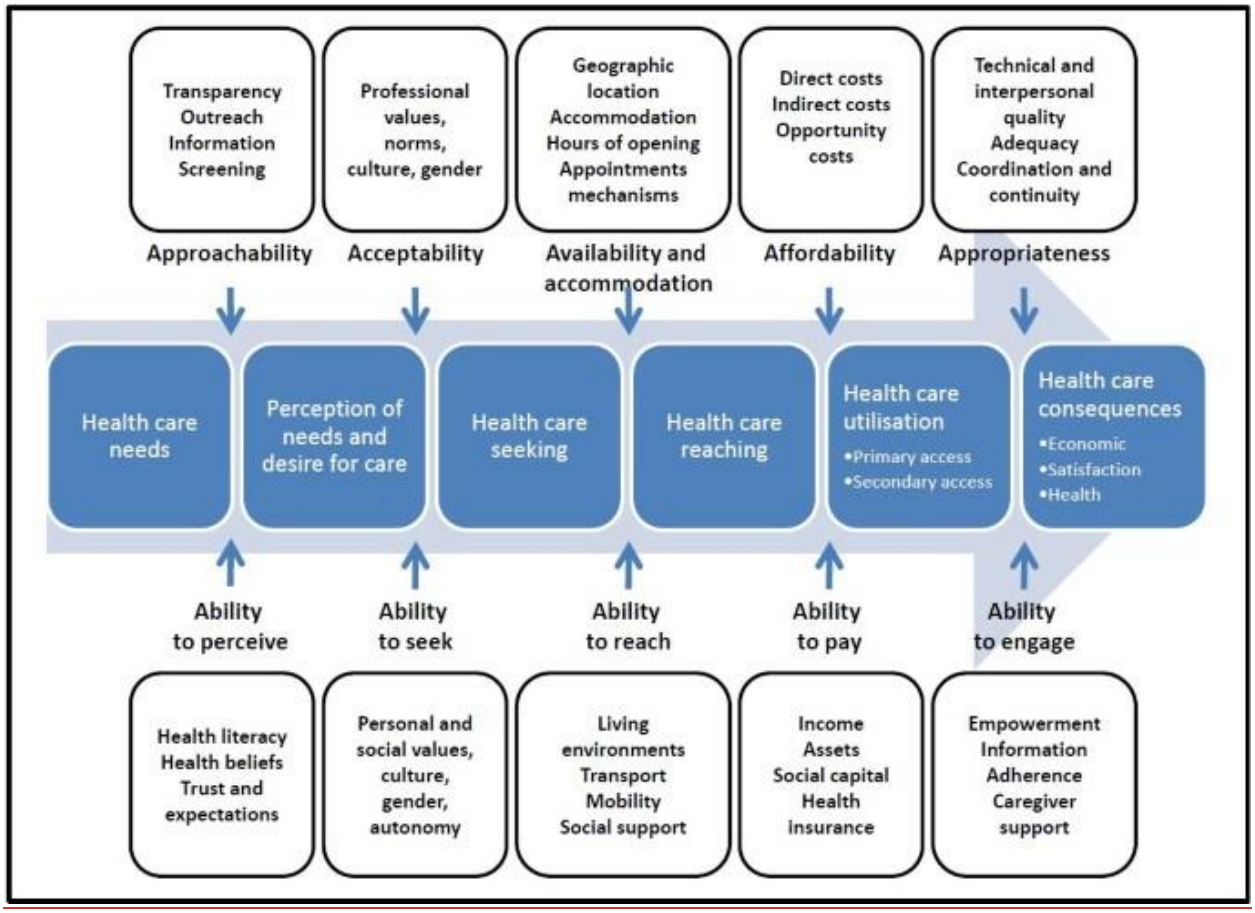
Conceptual Framework

The Levesque's Framework for Access to Health will provide the philosophical foundation for this study and the conceptual framework guiding this evidence-based practice project (Levesque et al., 2013). This framework suggests healthcare access should be approachable, acceptable, accommodating, affordable, and relevant (Cu et al., 2021). Levesque's framework identifies obstacles in the individual's ability to recognize, seek, reach, pay or engage in treatment and as well as the failures of the health system (Cu et al., 2021).

Levesque's framework is unique in its consideration of both the provider and the patient's view of their role, request, and ability in meeting those expectations during the interaction. The framework has proven successful in measuring access to healthcare from local to international settings allowing for a comprehensive review of the healthcare process (Corscadden et al., 2018). Levesque's Conceptual Framework of Access to Healthcare (figure 1) allows for a complete review of complicated processes in health facilities and the population (Levesque et al., 2013).

Figure 1

Conceptual Framework of Access to Healthcare



From: Patient-centred access to health care: conceptualising access at the interface of health systems and populations

Implication for Practice

The implication for nursing practice was the identification of a significant need for the promotion of culturally relevant mental health services to decrease disparities in the African American and minority communities and the role of the doctor prepared nurse leaders in addressing these issues (Vargas et al., 2019). Recommendation for continued qualitative or mixed research to acquire supplementary comprehensive initiatives to address mental health challenges and the barriers in accessing healthcare services is needed to understand the burdens on vulnerable populations to the reduction of inequities (Coombs et al., 2021).

Summary of Literature Review

In conclusion, cost remains one of the most significant barriers to access to mental health services along with the lack of health insurance, lack of culturally appropriate health education, lack of knowledge, availability of resources to vulnerable communities, lack of health facilities proximity and lack of representation (Coombs et al., 2021). These articles relate to topic of interest by emphasizing the need for an approach in addressing real-life social issues such as racial injustice of African Americans and minorities in the United States. Inequities in healthcare are manifested as implicit and explicit biases in interactions in how we treat the communities we serve. These issues must be rectified to eradicate disparities, inequalities, and inequities to mobilize the integration of equality distributed mental health service in all vulnerable communities including the LGBTQ communities (McMorrow et al., 2021).

Chapter 3: Methodology and Implementation

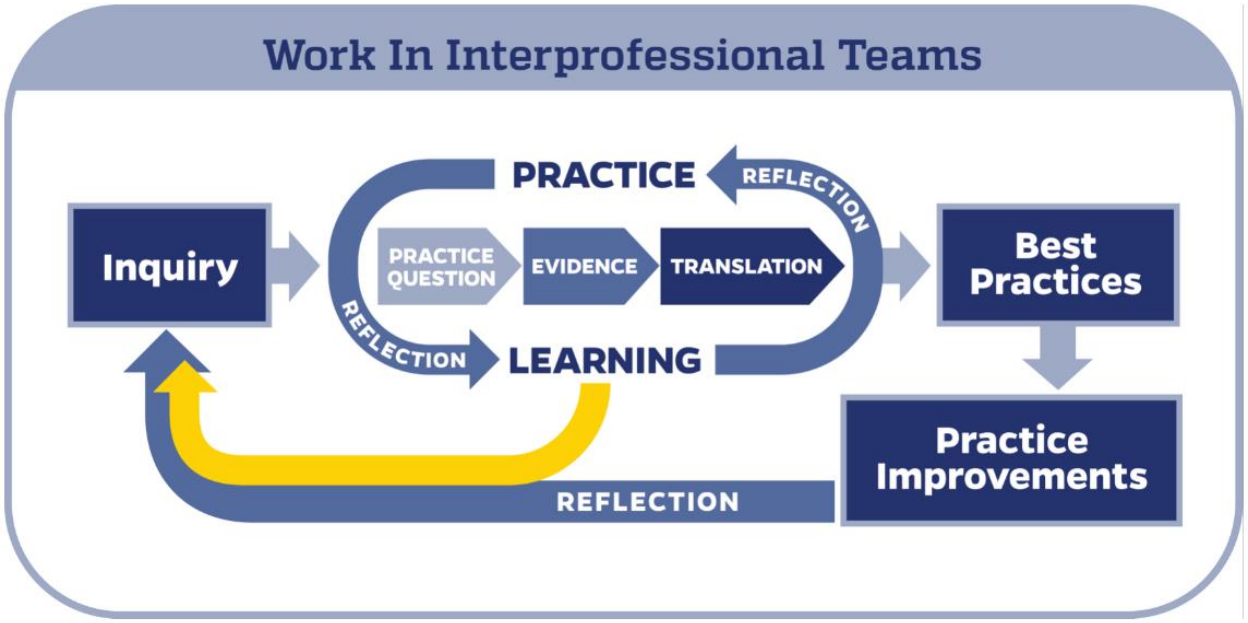
The purpose of this chapter was to introduce the methodology for this evidence-based practice (EBP) project regarding methods to decrease mental health disparities in vulnerable communities. The purpose of this evidence-based practice project is to evaluate the effectiveness of a pilot mental health knowledge questionnaire tool used to assess for change in knowledge. The aim was to decrease mental health stigma, misinformation, increase awareness and encourage the practice of mental health care. The intent was to utilize a revised version of the Mental Health Knowledge Questionnaire (MHKQ; Appendix A) to assess the participant's awareness of mental health and depression. This data was used for comparison of the mean test scores of the pre-test and post-test questionnaire to determine the effectiveness of the educational intervention on participants' knowledge of mental health, depression, and resources available to them. The questionnaire was free to share and adapt providing full credit, link, and any indication of changes (Appendix B). A PowerPoint covering information on mental health and depression to assess for change in knowledge was presented to the attendees.

Framework of the Study

The Johns Hopkins Nursing Evidence-Based Practice Model (Figure 2) was the EBP framework utilized for this project. Permission to use this model has been obtained (Appendix C). This model utilizes a problem-solving strategy to clinical decision making developed by the Johns Hopkins Hospital. The model has user-friendly tools to guide the user (Dang et al., 2022). This model was designed for practicing nurses with a three-step guide called PET: practice question, evidence, and translation. This ensures for a study to practice patient care without implementation delay.

Figure 2

The Johns Hopkins Evidence Based Practice Model



(Dang et al., 2022)

Research Design

This EBP project study design was a quasi-experimental pre-test-post-test cross-sectional design utilizing the MHKQ. In addition, participants were asked to complete a demographic questionnaire (Appendix D) for gender, age, working years, education, marital status, family status and residence. A letter of introduction explaining the study and the notice of implied consent (Appendix E) was given to all participants by the investigator. Implementing this project in a vulnerable community served as an intervention promoting educating the community about mental health, depression, and available resources to enhance the advancement of mental health and decrease mental health disparity. This project attempted to foster a safe space to allow for authentic self-reporting response from the participants (Gershon et al., 2020).

Setting and Sample

The participants for this project were recruited via a convenience sampling from the current residents of the community. Flyers were hand delivered to the businesses and residential buildings within the surrounding area of the project site two weeks prior. The program was conducted in an urban community in New Jersey with a large population of vulnerable groups, which includes African Americans, Hispanics, Native Americans, racial/ethnic minorities, lesbian and gay communities, religious groups, the unhoused, the uninsured, and refugees. Institutional Review Board (IRB; Appendix F) approval from Pennsylvania Western University was obtained prior to the start of the program.

A written agreement with the management company where the project was conducted was obtained (Appendix G). The facility manager's main role was coordinating and supervising the operations of the hotel as well as resolving any issues that may arise. The hotel manager is aware of all hotel guests but is not responsible for their activities or whereabouts. The hotel offers laundry service, vending machines, and hall rental as additional in-house services available for guests and patrons. The hotel is in a vulnerable community, providing short and extended stays for regular guests and for individuals in the process of being unhoused. Governor Phil Murphy, of New Jersey in 2020, extended the Lockout Protections To People Living in Hotels, this program attempted to resolve the housing shortage and protect families in New Jersey from homelessness (Yi, 2020).

Participants were screened prior to the beginning of the educational presentation to check for inclusion criteria. Participants included in this project were limited to 18 years of age and older, have the language proficiency to speak, read and understand English, be a member of a vulnerable population/group or live in a vulnerable community. Individuals who did not meet

these inclusion criteria were excluded from the study. After consenting to participate in the study and meeting the inclusion criteria's, participants were instructed to complete the demographic and pre-posttest questionnaire. The forms consisted of the demographic sheet, and the mental health knowledge pre and post-test questionnaire. The data collection forms were numbered, no names were used, and were randomly given to attendants, no identifying information was collected that could link data to any one individual participant. A program flyer (Appendix H) was placed at the entrance of the hotel and on all seven floors of the hotel to advertise the project. The participants were provided with a depression education handout A and B (Appendix I) and a local resource brochure (Appendix J).

Measurements

This project consisted of two questionnaires, a socio-economic demographic questionnaire and the researcher revised MHKQ questionnaire. The socio-economic demographic questionnaire collected participants' age, ethnicity, marital status, employment, income, and level of education. The MHKQ is a standardized multifaceted 20-item self-reported questionnaire that was revised by the student investigator for the purpose of assessing mental health depression knowledge and awareness of the participants in a vulnerable community. This questionnaire consisted of a twenty-item questionnaire which has been revised to assess mental health literacy. The first 16 questions are statements referencing mental health prompting the participants to choose either "true" or "false" as their response. The accurate responses for this tool are coded as "true" for the following questions 1, 3, 5, 7, 8, 12, 15, and16. The incorrect responses are coded as "false" for the following questions 2, 4, 6, 9, 10, 11, 13, and 14. Each correct response gets a score of 1 and incorrect responses are given a score of 0. Questions 17 to 20 inquired about the participants awareness of four promotional mental health days celebrated

in the United States. The answers for these four additional questions were given a 1 for “yes” and a 0 for “no” responses. The original questionnaire scale reported an internal consistency of Cronbach’s α coefficient of 0.61 (Yu et al., 2015). A Cronbach’s alpha was conducted on the revised form to obtain the reliability analysis of 0.56. The MHKQ assesses three areas of the populations understanding of mental health that include knowledge of mental health disorders (items 1, 2, 3, 5, 7, 8, 11, 15, & 16), causes of mental disorder (items 4, 6, 9, 10, 13, & 14) and an inquiry of the participants awareness of mental health promotional activities (items 17 to 20).

Procedure for Data Collection

A convenient sample of approximately 15 – 20 participants were sought for this study. No power analysis is needed with a convenience sample. The participants who attended this doctoral nursing evidence-based practice educational program received a letter of introduction, statement of consent, a demographic form, the pre and post-test mental health knowledge questionnaire, a brochure of resources and educational handouts relating to mental health and depression.

The project’s presentation was free of cost to all participants. The student investigator verbally described the study purpose to the participants and provided a letter of introduction that described the purpose of the doctoral nursing EBP project. Attendees were notified, the completion of the forms is their implied consent to participate in the project. The participants were asked to complete the demographic, and the MHKQ before the presentation and instructed to complete the post-mental health knowledge education questionnaire after the presentation. To capture all attendants as they entered the hall, the student investigator handed each person a packet containing the following documents, the introduction letter, consent statement, demographic questionnaire, pre-questionnaire, post-questionnaire, two educational handouts, and

a resource brochure. The participants were asked to place their completed forms back into the envelope they were provided. The data collection forms were gathered from each participant before they exited the hall at the end of the program.

Program Presentation and Time Schedule

The program was scheduled and presented on August 11, 2023. The program was scheduled at 1 PM at the Ramada Hotel banquet hall located in a vulnerable community in New Jersey. The presentation lasted for sixty minutes with additional time provided at the end of the program for questions. The program concluded after the ending of the educational presentation and the collection of all demographic forms and questionnaires.

No participants chose to disclose their mental health status or verbalize self-harm intentions, in the event someone presented with symptoms, they would have been provided with a consent and the Patient Health Questionnaire-9 (PHQ-9) assessment tool. The PHQ-9 is a nine-item questionnaire used to assess depression-related symptoms. This is a quick and efficient tool used by providers to diagnose and monitor patients (Pfizer, 2021).

Ethical Considerations

Approval was obtained from the Institutional Review Board (IRB) from Pennsylvania Western University and the community center director manager to conduct the program. Participation was voluntary and participants were able to withdraw at any time without penalty. Each participant received information regarding the EBP project with an implied consent before inclusion in the program. To provide confidentiality of the participant, no names were used, and a number was randomly assigned to each participant. All the program findings are reported in aggregate, and no individual participant can be identified or connected to the findings. No one will have access to the data except the student. All written data will be kept in a locked file

cabinet accessed only by the student. Any computer data is maintained on a password protected computer accessed only by the student. Data will be maintained for the required number of three years per the IRB protocol.

Chapter 4: Results and Findings

The intervention implemented for this doctoral nursing evidence-based practice project was a mental health depression education program, utilizing a modified mental health knowledge questionnaire with a pre-test post-test design. This design allows for the evaluation of the effectiveness of the program's information provided to the participants by assessing their response before and immediately after the educational program is presented.

Analysis of the Results

The data was analyzed using Dell SPSS Statistics software V.29.0. Sociodemographic characteristics of the sample were examined using descriptive statistics to compare the mental health knowledge (MHK) score of respondents. Age, gender, ethnicity, marriage, education, sexuality, employment, religion, and income were characteristics of the respondents assessed for the level of current mental health knowledge. The MHKQ characteristics of the participants responses to the educational program were examined using descriptive statistics, to compare the mental health knowledge questionnaire pre and post-test results, to assess for measurable level of change in knowledge before and after the mental health depression education program was presented.

Sample Characteristics

A total of 16 participants attended the mental health depression educational program. 13 participants completed the questionnaires with a response rate of 81.3%. The median age of the participants was 39 years with an age range of 18-60+. The majority of the participants were aged 40-60+. There were more female participants at 61.5% than male at 38.5%. The majority of the participants were single at 46.2%, with 23.1% being married, 15.4% divorced and widowed respectively. Most of the participants identified as heterosexual at 84.6%, one person identified

as bisexual at 7.7% and another identified as being gay at 7.7%. The majority of the attendants were African American at 84.6%, while 7.7% represented one Mixed race and one Caucasian individual. These participants acknowledged having a religion as Christian (84.6%), Islam (7.7%) and one other person stated they had no religion (7.7%).

The educational background of the participants was almost evenly divided except for one individual who had some college credits 7.7%. 46.2% of the participants were high school graduates or had taken a General Educational Development test, and 46.2% were college graduates. 53.9% of the attendants were employed full-time, 23.1% were retired, and 7.7% were students, unemployed or preferred not to say. Their income level fell in all ranges assessed. One-half of the participants, 46.2% made more than forty-five thousand dollars or more; one-third made between $20,000 to $30,000 and the others, 7.7%, either made less than $5,000 or preferred not to say. A more detailed description of the participants is displayed in Table 1.

Table 1

Demographic Questionnaire

Description of the participant (n=13)			
	Characteristic	**n**	**%**
Age:	25-39	3	23.1
	40-59	5	38.5
	60+	5	38.5
Gender:	Male	5	38.5
	Female	8	61.5
Ethnicity:	Black/African American	11	84.6
	Mixed race	1	7.7
	White/Caucasian	1	7.7
Marital status:	Single	6	46.2
	Married	3	23.1
	Divorced	2	15.4
	Widowed	2	15.4
Education:	High school graduate/GED	6	46.2
	Some college	1	7.7
	College graduate	6	46.2
Sexuality:	Heterosexual	11	84.6
	Bisexual	1	7.7
	Gay	1	7.7

Employment:	Full-time	7	53.9
	Retired	3	23.1
	Student	1	7.7
	Unemployed	1	7.7
	Prefer not to say	1	7.7
Religion:	Christianity	11	84.6
	Islam	1	7.7
	No religion	1	7.7
Income:	Less than $5,000	1	7.7
	$5,000-$10,000	1	7.7
	$10,000-$20,000	1	7.7
	$20,000-$30,000	3	23.1
	$45,000+	6	46.2
	Prefer not to say	1	7.7

MHKQ Pre/Post-Test Response Results

The computed paired sample statistics performed for the pre-test questionnaire had a mean score of 8.6, with a standard deviation of 2.39. The results for the post-test had a mean score of 11.6 with a standard deviation of 1.85. The paired difference before and after the educational program had a mean score of -2.85, with a standard deviation of 2.33 and a significance of 0.001. The findings represent an improvement in knowledge after the presentation evident by the 55 points difference between the pre and post-test results, a change of 21.1% increase in the results. The results show a statistically significant difference between the pre and post-test knowledge validating the statement that promoting mental health depression education in a vulnerable community does increase knowledge and awareness of mental health and depression. Details of these results can be found in Table 2.

Table 2

Paired Sample t-Test

	Mean	*n*	*SD*	*Range*	*Variance*
Pre-test	*8.9*	*20*	*2.4*	*9*	*5.7*
Post-Test	*11.6*	*20*	*1.8*	*7*	*3.4*

Pre - Post	*2.85*	*-2.33*	
Significance P≤0.001			

The four promotional mental health days awareness ranged from 38.5% to 69.2%, with the Suicide and Crisis Lifeline being the most widely recognized mental health promotional day 69.2% followed by the International Suicide Prevention Day as the second most recognized day 61.5%. Half of the respondents had heard about World Mental Health Day 53.85% and less than one-third of the respondents had any prior awareness of the International Day of Happiness 38.5%. Every participant had changes in their responses to almost every question on the questionnaire except for two questions.

The participant's response for Question # 1 and 10 remained the same on the pre-test as on the post-test, making them the only two questions that did not have a change in response after the program, all other questions showed changes in responses from all the participants. Both questions had an accuracy of 100% on the pre-test and the post-test. Question #1 states: "Mental health is a part of your health," the answer was true. Question # 10 states: "Even for severe mental disorders (such as, schizophrenia), medications should be taken for a short time only; there is no need to take them for a long time," the answer for this question was false. It is important to note that treatment and medication compliance is a precursor to positive health outcomes resulting in improved health and decreased healthcare cost (Aremu et al., 2022). The participants awareness of the importance of taking medication for an extended period is affirming that promotion is effective in getting information to the public increasing their knowledge and awareness of the subject being promoted.

The pre-test and post-test response rate for each question is displayed in table 3.

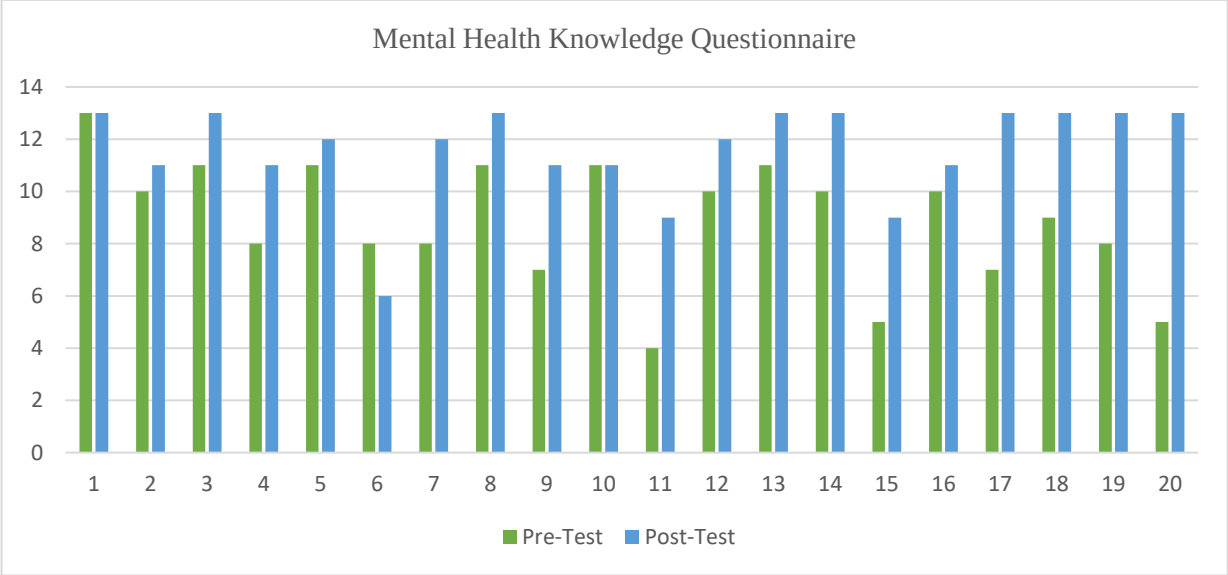
Table 3

MHKQ Pre/Post Questionnaire Response

			T/F	Pre/Post
1.	Mental health is a part of health.		T	13/13
2.	Mental disorders are caused by negative thinking.		F	10/11
3.	Many people have mental problems but do not realize it.		T	11/13
4.	All mental disorders are caused by external stressors.		F	8/11
5.	Elements of mental health include normal intelligence, stable mood, a positive attitude, quality social relationship and adaptability.		T	11/12
6.	Most mental disorders cannot be cured.		F	8/6
7.	Mental health problems are common health problems.		T	8/12
8.	Psychological problems can occur at any age.		T	11/13
9.	Mental disorders and psychological problems cannot be prevented.		F	7/11
10.	Even for severe mental disorders (e.g., schizophrenia), medications should be taken for a given time only; there is no need to take them for a long time.		F	11/11
11.	People with mental illness are more violent than the general population.		F	4/9
12.	Individuals with a family history of mental disorders are at a higher risk for psychological problems and metal disorders.		T	10/12
13.	Psychological problems in adolescents do not influence academic grades.		F	11/13
14.	Middle-aged or elderly individuals are unlikely to develop psychological problems and mental disorders.		F	10/13
15.	Individuals with a bad temperament are more likely to have mental problems.		T	5/9
16.	Mental problems or disorders may occur when an individual is under psychological stress facing major life events (e.g., death of family members).		T	10/11
			Y/N	
17.	Have you heard about World Mental Health Day?	October 10th	Y	7/13
18.	Have you heard about the Suicide and Crisis Lifeline?	9-8-8	Y	9/13
19.	Have you heard about the International Suicide Prevention Day?	Sept 10th	Y	8/13
20.	Have you heard about International Day of Happiness?	March 20th	Y	5/13

The pre and post-test graphic representation of the changes in response are displayed in table 4.

Table 4
Pre and Post-Test Response Graphic Representation



The first 16 questions referenced knowledge of mental health and depression. Question #11, "People with mental illness are more violent than the general population," had a five-point increase in responses, the most significant change for all the questions. An inference can be made that the population perceive people with mental illness to be more violent than the general population. Four participants answered the question correctly on the pre-test and nine participants responded with the correct answer on the post-test. The responses in the post-test represented a 38% increase in accuracy.

Questions # 7, 9 and 15 followed next with a four-point increase in positive responses. Question # 7, "Mental health problems are common health problems," had eight correct responses on the pre-test compared to 12 correct responses on the post-test, the second most

improved response with a 31% change in response. Question # 9, “Mental disorders and psychological problems cannot be prevented,” seven responded correctly on the pre-test which increased to 11 correct on the post-test, a 30.97% increase. Question # 15, “Individuals with a bad temperament are more likely to have mental problems.” The pre-test had five responses while the post-test had nine responses representing a 37.8% increase in accuracy.

Question # 4 and 14 had a 3-point increase in their accuracy response, a 23.1% positive change for both questions, respectively. Question # 4, “All mental disorders are caused by outside stressors,” eight responded correctly on the pre-test and this number increased to 11 on the post-test. Question # 14, “Middle-aged or elderly individuals are unlikely to develop psychological problems and mental disorders,” there were 10 correct responses on the pre-test, this number was increased to 13 correct responses.

Questions #2, 5 and 16 had the least change with only a one-point change in difference for accuracy with a change of 7.7% change in accuracy for each question. It can be inferred that the participants were confident and accurate in their knowledge of the questions posed. Question # 2 states, “Mental disorders are caused by negative thinking.” Question # 5 states, “Parts of mental health include normal intelligence, stable mood, a positive attitude, quality social relationship and adaptability.” Question # 16, “Mental problems or disorders may occur when an individual is under psychological stress facing major life events (such as a death).”

There were one other significant change resulting in a decline in responses from the questionnaire, question # 11, “People with mental illness are more violent than the normal population.” This question had a two-point decline in response from the pre and post-test. Eight participants initially responded correctly to this question, after the educational program the responses went down to six correct responses, a 15.4% decline in accuracy. This question will

require further investigation to understand the negative outcome of this result. We can infer from the results that the participants may have been influenced by the education provided which caused the participants to change their response.

Chapter 5: Summary of the Findings

The purpose of this evidence-based practice (EBP)project was to evaluate the effectiveness of a mental health depression educational program, utilizing a revised questionnaire, in a vulnerable community to promote mental health awareness to reduce mental health disparities in vulnerable populations. This chapter includes a discussion of major findings from the project and related literature on mental health disparities in vulnerable communities. The programs and projects for the elimination of mental health disparities are not popular topics available for review, more research is needed to effectively increase the number of programs for minority health. Promotional projects were identified to be effective vulnerable communities (Brown et al., 2019).

The effectiveness of this EBP mental health depression education program was observed within the quantitative findings as noted in the difference in responses between the pre-test questionnaire and the post-test questionnaire data. The results of the findings represent an increase in accurate responses for almost every question except for two which were unchanged by the presentation. From the findings we can deduce that knowledge was increased for all participants involved in the program as evident by the positive results. The need for mental health promotional educational intervention is essential in vulnerable communities to enhance mental health awareness (Zingg et al., 2016).

This EBP project focused on mental health disparities in vulnerable communities and the application of an educational program to improve mental health outcomes in the community. The outcome from this project supports the hypothesis that implementing a mental health depression education program in vulnerable communities, improve knowledge, and attitude towards mental health care services as compared to the current community level of awareness with no depression

education. A common theme and statement from the participants were, not knowing about the two weeks' time period needed for continuation of symptoms prior seeking mental health assistance from a provider.

Mental health symptoms exhibited nearly every day during a two-week period meet criteria to make the determination of a mental health disorder (Uher et al., 2014).

Compared to the 69.2% awareness rate of the Suicide and Crisis Lifeline, the awareness rates of the World Mental Health Day, International Suicide Prevention Day and International Day of Happiness were much lower. The reasoning may be due to the emphasis placed on suicide prevention resulting from a significant increase in suicide rates of 37%, over the past twenty years (Saunders & Panchal, 2023). The other three days also require The program defined disparities, mental health and depression, the participants were provided information on how to identifying mental illness the symptoms, treatments, and the impact mental health disorder have on the community. Majority of the participants verbalized learning something new from the information provided during the presentation. A review of the post results showed a significant increase in correct responses in most areas on the post-test questionnaire compared to their original responses on the pre-test questionnaire. Comparable promotion to foster public health awareness to decrease suicidal rate is also needed.

Mental health disparities in vulnerable communities are significant problems resulting in negative financial and overall health outcomes. The reports all indicate widespread disparities in medical and mental health resources for vulnerable populations exacerbating incidences of mental illness such as anxiety and depression (Center for Disease Control, 2022). This project was specifically targeted towards vulnerable populations that have endured systemic

discrimination culminating in the inequitable distribution of resources from policies enforcing biases in practice.

Organization discriminatory practices influence health outcomes and the ability to participate in preventive, supportive treatment services to prioritize and enhance quality of care for vulnerable communities (Brown et al., 2019). Minority communities have fewer social and financial opportunities exposing them to severe negative risks impacting food, housing, safety, and transportation. The data also support establishing collaboration in the community to increase buy-in, motivation and commitment to the initiatives, to increase sustainability and create trusting relationships between minority population and mental health providers (Egede & Walker, 2020).

Limitations

The mental health knowledge questionnaire (MHKQ) utilized for this evidence-based practice project was modified adjusting questions to the population being presented from the original used in China. The original questionnaire had an internal consistency and Cronbach α coefficient of 0.61. The MHKQ Cronbach scale is used to evaluate the reliability of the tool being used to capture data. The original scale of 0.61 indicates an acceptable but low internal consistency with a weak reliability relating to possible question correlation and uniformity (Yu et al., 2015). The intent of this project was not to validate the properties of the mental health knowledge questionnaire, but to assess the level of change in knowledge before and after an evidence-based practice educational programs in a vulnerable community. The scale of the psychometric properties for the mental health knowledge questionnaire is comparable in different studies and was not made a leading focus in this project (Yu et al., 2015).

The lack of comparison between the MHKQ and other tools used to measure mental health knowledge is another limitation of this project. The original version of the MHKQ was conducted in Chinese, the translated English version has been proven effective but not in comparison to other tools to evaluate interventional outcome. Additional studies may benefit from implementing both the English version of the MHKQ and another scale to analyze its feasibility and psychometric properties in comparison to other tools (Yu et al., 2015).

A notable limitation of this study was the location where the project was presented. This program was only conducted in one vulnerable community, significantly impacting the generalization of the findings. The findings, though significantly positive, are absent of supportive data to generalize the training to other communities. This program will require replication in additional communities to analyze the findings from those studies. A recommendation for future studies to improve the mental health awareness to reduce stigma in vulnerable communities is much needed (Codjoe et al., 2021).

Implications for Nursing

This study emphasizes the need for evidence-based practice mental health promotional programs to combat disparities and improve awareness of mental health in vulnerable communities. Mental health disparities in vulnerable communities highlight opportunities for doctoral prepared nurses to implement evidence-based practice education programs in partnership with community members towards developing, implementing, and improving challenges for minority populations (Morales et al., 2020). The World Health Organization (WHO, 2022) recommends the promotion of mental health programs by health providers and collaborators to contribute to the reduction of disparity to enable a transformation towards better mental health for all.

The data on successful sustainable and replicable interventions are lacking requiring additional studies reproducing studies with reportable outcomes. This doctor of nursing practice EBP project will contribute to the limited programs available to reduce mental health disparities in underserved, under-represented groups and other marginalized individuals that have been historically discriminated and excluded. This program promotes the normalization of mental health care through dissemination of information allowing the individual to adapt new self-care habits and understanding while incorporating Levesque's conceptual framework for independent access to healthcare (Levesque et al., 2013).

Recommendation for Future Research

Future directed programs may be beneficial in educating the public on accurate detection and causes of mental illness. To extend the impact of these studies, the level of influence must address structural discriminations, risks and factors that affect vulnerable communities (Morales et al., 2020). Further, this program emphasizes the importance of integrating effective community engagement approaches to develop close partnerships with community leaders to address healthcare inequalities for minority populations (Codjoe et al., 2021). Active involvement of medical personnels, community leaders, policy makers and media organizations are needed to eradicate inequities, disparities and stigmas related to mental health and mental illness (Kaur et al., 2023).

Conclusion

Financial insecurity, systemic discrimination, inadequate access to healthy food, clean drinking water, safe living environment, deprived educational system, poor employment prospects, and limited outdoor activity spaces, are some of the numerous factors contributing to

disparities in vulnerable communities (Brown, 2019). Influencing change within the community requires multiple-system interventions to effectively decrease mental health disparities.

Programs such as this may provide a framework on implementing evidence-based practice mental health depression education by healthcare providers transforming science into practice (Varges et al., 2019). Teaching and learning have a fundamental part to play in encouraging the process of promoting mental, emotional, and social health in schools (Macklem,2014)

Interventions, such as this doctoral nursing evidence-based practice mental health depression educational program, are needed to decrease mental health disparities and promote awareness in vulnerable population regarding the correct characteristics of mental disorders. This project has demonstrated to be an effective tool to positively increase awareness impacting the outcome of physical, mental, and social health (Yu et al., 2015). This framework provides a useful structure to guide study designs that can address the complexities of delivering vulnerable population mental health care and identify mechanism underlying disparity and how best to remedy them (Morales et al., 2020)

This project adds to the evidence of promotional education supporting sustained improvements for vulnerable populations mental health and reduce disparities that can help individuals and their communities gain the highest level of health. Significant contributions of successful educational programs are critical in dispelling stigmas, improving awareness, gaining understanding, and normalizing mental health care. (Brown et al., 2019).

The successful development of evidence-based practice projects requires dissemination and constant engagement to sustain effective practices by community leaders and healthcare professionals. Community involvement is a significant partnership for integrating science,

practice, and policies to counter factors that contribute to mental health disparities in vulnerable population and communities (Brown et al., 2019). Mental health in vulnerable communities is in crisis in the United States and the world. The rise in violence and uncertainty will continue to exacerbate the increase of mental distress. As demonstrated by this pilot study, mental health and depression promotion educational programs are successful in increasing knowledge in vulnerable communities. This improved knowledge can be used in nursing practice to improve self-care practices in patients seeking mental health services.

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Appendix A

(Participants will get two copies, a pre-test, and a post-test later in the program)

Study ID #: _____
Date: _____

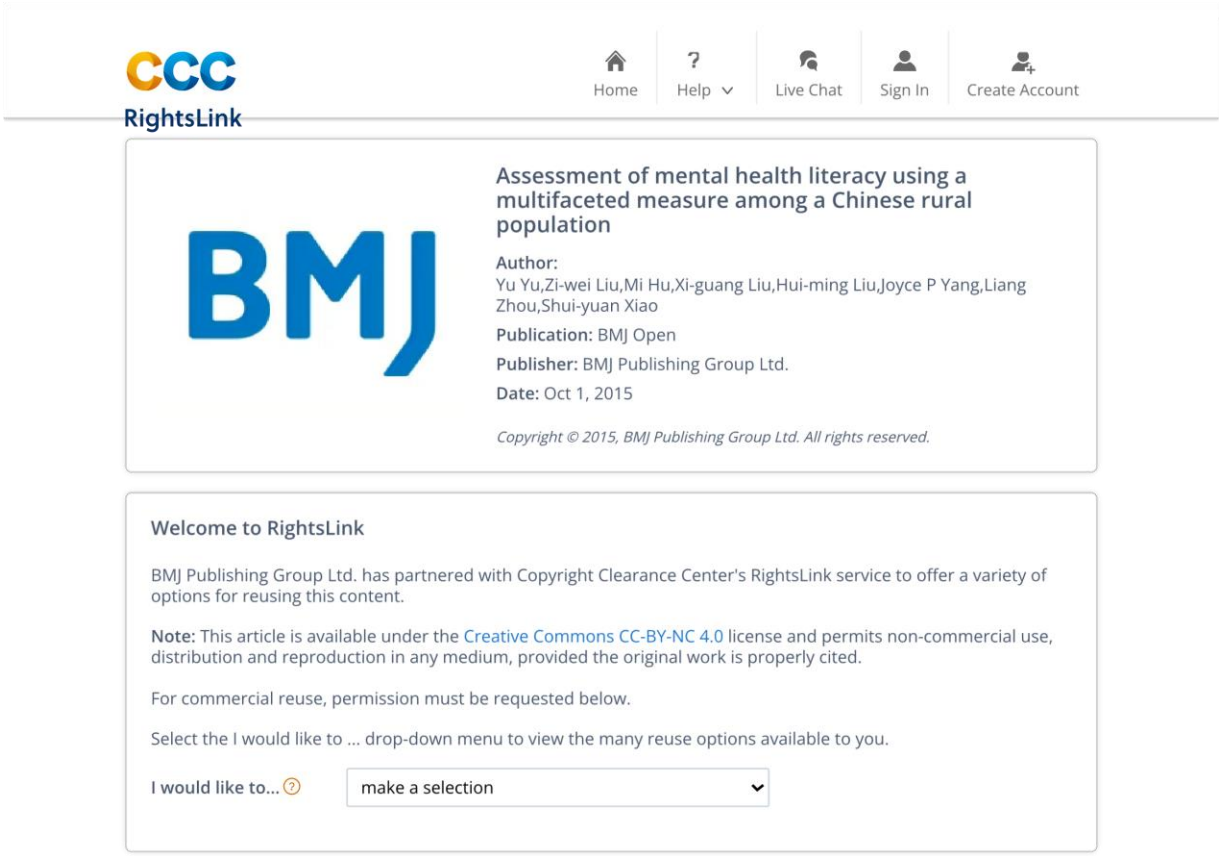
MENTAL HEALTH KNOWLEDGE QUESTIONNAIRE
Pre - Test

STUDY PARTICIPANT, please answer the questions to the best of your ability. Your answers to the following questions will be used for research purposes only and will be kept strictly confidential.

		True	False
1.	Mental health is a part of your health.		
2.	Mental disorders are caused by negative thinking.		
3.	Many people have mental health problems but do not realize it.		
4.	All mental disorders are caused by outside stressors.		
5.	Parts of mental health include normal intelligence, stable mood, a positive attitude, quality social relationship and adaptability.		
6.	Most mental health disorders cannot be cured.		
7.	Mental health problems are common health problems.		
8.	Mental health problems can occur at any age.		
9.	Mental disorders and psychological problems cannot be prevented.		
10.	Even for severe mental disorders (such as, Schizophrenia), medications should be taken for a short time only; there is no need to take them for a long time.		
11.	People with mental illness are more violent than the general population.		
12.	Individuals with a family history of mental disorders are at a higher risk for psychological problems and mental disorders.		
13.	Psychological problems in adolescents do not influence academic grades.		
14.	Middle-aged or elderly individuals are unlikely to develop psychological problems and mental disorders.		
15.	Individuals with a bad temperament are more likely to have mental problems.		
16.	Mental problems or disorders may occur when an individual is under psychological stress facing major life events (such as, death).		
		Yes	**No**
17.	Have you heard about World Mental Health Day? Oct. 10th		
18.	Have you heard about the Suicide and Crisis Lifeline? 9-8-8		
19.	Have you heard about the International Suicide Prevention Day? Sept. 10th		
20.	Have you heard about International Day of Happiness? March 20th		

Appendix B

Mental Health Knowledge Questionnaire – Permission to Use

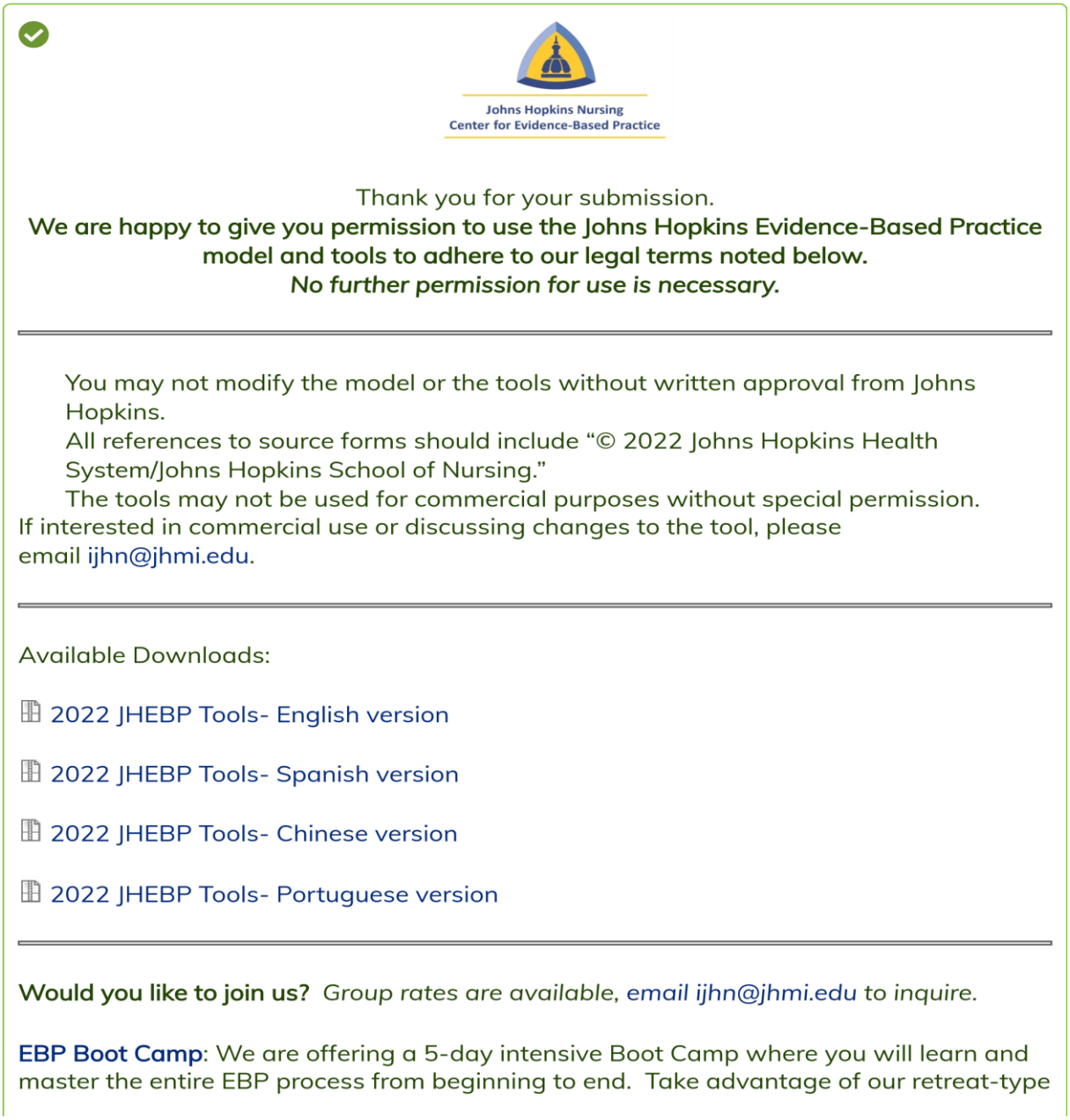


Yu et al., (2015) with changes. https://creativecommons.org/licenses/by-nc/4.0/

6/7/23, 10:27 PM Rightslink® by Copyright Clearance Center

Appendix C

JOHNS HOPKINS EBP MODEL AND TOOLS- PERMISSION



Johns Hopkins Nursing
Center for Evidence-Based Practice

Thank you for your submission.
We are happy to give you permission to use the Johns Hopkins Evidence-Based Practice model and tools to adhere to our legal terms noted below.
No further permission for use is necessary.

You may not modify the model or the tools without written approval from Johns Hopkins.
All references to source forms should include "© 2022 Johns Hopkins Health System/Johns Hopkins School of Nursing."
The tools may not be used for commercial purposes without special permission.
If interested in commercial use or discussing changes to the tool, please email ijhn@jhmi.edu.

Available Downloads:

2022 JHEBP Tools- English version

2022 JHEBP Tools- Spanish version

2022 JHEBP Tools- Chinese version

2022 JHEBP Tools- Portuguese version

Would you like to join us? *Group rates are available, email ijhn@jhmi.edu to inquire.*

EBP Boot Camp: We are offering a 5-day intensive Boot Camp where you will learn and master the entire EBP process from beginning to end. Take advantage of our retreat-type setting to focus on your project, collaborate with peers, and get expertise and assistance from our faculty. *COMING in 2024!*

Appendix D

Study ID: _____
Date: _____

DEMOGRAPHIC QUESTIONNAIRE

Fill in the following information about the PARTICIPANT. Your answers will be used for education only

Section A: Obtaining Information

Who is completing this form?

☐ The study participant ☐ A parent/guardian of study participant
☐ Spouse of study participant ☐ Other: _____

ANSWER THE FOLLOWING QUESTIONS AS THEY RELATE TO YOU – THE **PARTICIPANT**

Section B: Participants Information

1. Which is your age?

☐ 18 to 24 ☐ 25 to 39
☐ 40 to 59 ☐ 60 plus
☐ Prefer not to say ☐ _____

2. Which gender do you identify with?

☐ Male ☐ Female
☐ Transgender ☐ Other…
☐ Prefer not to say

3. Which race/ethnicity do you identify with?

☐ Hispanic/Latino ☐ Asian or Pacific Islander
☐ White/Caucasian ☐ Black/African American
☐ Mixed race ☐ Other…
☐ Prefer not to say

4. What is your marital status?

☐ Single ☐ Married
☐ Divorced ☐ Widowed
☐ Separated ☐ Never married
☐ Other ☐ Prefer not to say

5. What is your level of education?

☐ No schooling ☐ Some schooling
☐ Elementary to 8th grade ☐ Some college
☐ High school grad or GED ☐ College graduate
☐ Technical school ☐ Other…
☐ Prefer not to say

6. What is your sexual identification?

☐ Heterosexual ☐ Homosexual
☐ Bisexual ☐ Pansexual
☐ Asexual ☐ Lesbian
☐ Gay ☐ Other…
☐ Prefer not to say

7. What is your employment status?

☐ Employed – Full time ☐ Unemployed
☐ Employed – Part time ☐ Student
☐ Retired
☐ Prefer not to say

8. What is your religion?

☐ Christianity ☐ Islam
☐ Judaism ☐ Hinduism
☐ Buddhism ☐ No religion
☐ Prefer not to say

9. What is your total monthly household income?

☐ Less than $5,000 ☐ $20,000 to $30,000
☐ $5,000 to $10,000 ☐ $30,000 to $40,000
☐ $10,000 to $20,000 ☐ $45,000 +
☐ Prefer not to say

Appendix E

LETTER OF INTRODUCTION

University Affiliation: Pennsylvania Western University of PA Administrative Office

108 Carrier Administration Building

Clarion, PA 16214

814-393-2337

Project Title: MENTAL HEALTH DISPARITIES IN VULNERABLE COMMUNITIES: IMPLEMENTATION OF AN EVIDENCE-BASED PRACTICE MENTAL HEALTH DEPRESSION EDUCATION PROGRAM

Principal Investigator: Claudette L. Blake-Tonge, APRN
s_clblake@pennwest.edu
973-704-3756

You are invited to take part in a DNP program study being conducted through Pennsylvania Western University. We ask that you read this form and ask any questions you may have before you decide whether you want to take part in the study. The University requires that you give your signed agreement if you choose to take part.

Purpose of the Study:

- The purpose of this evidence-based practice project is to evaluate the effectiveness of a pilot mental health knowledge questionnaire tool used to assess for change in knowledge. Currently, there are limited tools being used to assess mental health and depression knowledge in vulnerable communities. This study's objective and goal is to improve the

current practice for community mental health education in vulnerable communities with the intent to increase awareness and dispel cultural misconception of mental health.

Procedures:

Completing the questionnaires is your implied consent to participate in this study. You will be asked to do the following:

- Complete an anonymous demographic information form. (This form will ask for information such as age, education, race).
- If you consent to participate, you will be in an educational program with other participants. You may know other participants as clients of The New Essecare of NJ or residents of the community.
- **Program location**:
  - Ramada Hotel 120 Evergreen Place, East Orange, NJ 07018, 973-677-3100
- The program will be conducted on July 8th, 2023, at 1pm. The program will be completed in one day lasting sixty minutes.
- There is no direct cost associated with participation. Indirect costs include your time.
- **YOU SHOULD NOT PARTICIPATE IN THIS PROJECT…**

  If you are UNDER 18 years old.

Risks of Being in the Study:

- There are no foreseeable or potential risks associated with taking part in this project.
- Claudette L. Blake-Tonge (Investigator) has successfully completed the Collaborative Institutional Training Initiative (CITI).
  - This program focuses on ethical principles, informed consent, privacy, confidentiality, and Pennsylvania Western University's standards of research.
- This project has been reviewed and approved by the Pennsylvania Western University Institutional Review Board to ensure the participants have minimal risk.

The Benefits to Participation are…

- There is no guarantee that you will get any benefit from taking part in this program.
- However, you may gain more understanding of mental health and depression.
- Your willingness to take part in this project may help you save someone's life.

Compensation:

- There will be no compensation of any kind for taking part in this project.

Confidentiality:

- To protect your identity, the data collection forms will not ask for any identifying information such as your name, address, email, phone number, or social security number.
- Please complete all the forms and place them in the unmarked envelope provided. Hand-deliver the envelope to the investigator.
- The demographic data information will be entered into a password protected spreadsheet.
- Your consent and all data collection forms will be kept with the principal investigator in a secured cabinet for the next three years.
- No video recording will be done of this program.

What else do I need to know?

You should know that Therapy Confidential & Consulting, LLC, a privately owned psychiatric mental health practice, will supply financial and/or material support for this study. Additionally, The Ramada Hotel is providing support for the project by supplying the facility to conduct this DNP project.

Right to Refuse or End Participation:

Understand that you may refuse to take part in this study or withdraw at any time.

Understand also, you can be excused from the study at any time by the investigator.

Complaints or Concerns: Please contact the Committee Chair: __Dr. Kathleen Morouse, DNP at morouse@pennwest.edu_ and/ or The Institutional Review Board at Pennsylvania Western University of Pennsylvania.

Pennsylvania Western University of PA Administrative Office

108 Carrier Administration Building

Clarion, PA 16214

814-393-2337

Statement of Consent:

By completing the questionnaires, you are giving your consent to participate in this project, and you are certifying that you are 18 years of age or older. You acknowledge that you have read the information described above and have received a copy of this information. You have asked any questions that you had regarding the project and have received answers to your satisfaction.

_____

Signature of Investigator

IRB Research Approval #: **Proposal #PW23-002**

Thank you for your participation.

Appendix F

Institutional Review Board Pennsylvania Western University IRB Approval Letter

Institutional Review Board
250 University Avenue
California, PA 15419
instreviewboard@calu.edu
Melissa Sovak, Ph.D.

Dear Claudette Blake,

Please consider this email as official notification that your proposal titled "Mental Health Disparities in Vulnerable Communities: Implementation of an Evidence-Based Practice Mental Health Depression Education Program" (Proposal #PW23-002) has been approved by the Pennsylvania Western University Institutional Review Board as submitted.

The effective date of approval is 07/20/2023 and the expiration date is 07/19/2024. These dates must appear on the consent form.

Please note that Federal Policy requires that you notify the IRB promptly regarding any of the following:

(1) Any additions or changes in procedures you might wish for your study (additions or changes must be approved by the IRB before they are implemented)

(2) Any events that affect the safety or well-being of subjects

(3) Any modifications of your study or other responses that are necessitated by any events reported in (2).

(4) To continue your research beyond the approval expiration date of 07/19/2024, you must file additional information to be considered for continuing review. Please contact instreviewboard@calu.edu

Please notify the Board when data collection is complete.

Regards,

Melissa Sovak, PhD.
Chair, Institutional Review Board

Appendix G

Facility Agreement

6 Round table 1 long table

Contract No : _____ Date _____

RAMADA
120 Evergreen Place East Orange NJ 07018
973 677 3100

Name: Claudette Blake Party Date : 6/24 Time From 1p To 3p

Organization: DNP Presentation : Mental Health & Depression

Address: 890 Terrill Rd. Plainfield NJ.

Telephone: 973 704 3756

Occasion: Mental Health Depression Education

Number of Guests 20-30 Security Deposit: $ _____ (Cash / cashier's check _____)

Hall Rental $ _____ 50% Deposit $ _____ Will be paid on _____

Balance $ _____ Will be paid on _____

TERMS AND CONDITIONS

1. A **Refundable security deposit of $250.00** with a completed signed BANQUET HALL AGREENMENT is required to secure the date. Without a deposit or a written agreement the date will not be secured. Any cancellation 0f your event will result in forfeiture of your deposit. The deposit will serve as a security deposit during your event and will be returned provided all policies and procedures are followed.

   An **additional deposit of 50%** of the total estimated cost must be paid 30 days prior to your function date. Payment are to be made in cash or cashier's check. **Balance due 2 weeks prior to your function date**. A Sales Tax (7%) and surcharge (10%) will be applied to the total cost of each function. Any additional charges due to changes up to your function date will be due on or before your function.

2. All displays, Exhibits or flyers, is any must conform to city code and fire ordinance rules. No posters & flyers on public property. No Smoke machine any fines imposed, transfers to customer.

3. **It is strictly forbidden to bring any Alcoholic/ Non – Alcoholic beverages onto premises for Sale.**

4. **Any Violations of item (3) the operations rules will result in customer and parties having to pay immediately the equivalent retail value and management will reserve the right to terminate the function based on the severity of the violation.**

5. Outside food and Non-Alcoholic beverages are permitted in to the banquet hall. A hold Harmless Agreement and Liability Insurance are required if food or beverage products not purchase and served by the Banquet all staff, are brought in for consumption by you.

6. Customer shall take good care of premises and redeem for any damages. Any Damage will be deducted from security deposit.

7 It is expressly agreed and understood by and between customer and parties to this agreement the proprietor(s) shall not be liable for any damage or injury to persons.
8. The music has to be at a moderate volume level (not loud) so as not to disturb the hotel guest.
9 The music has to be turn off at 11.00 pm. Strictly
10 Customer will permitted in to the banquet hall one hour prior to event

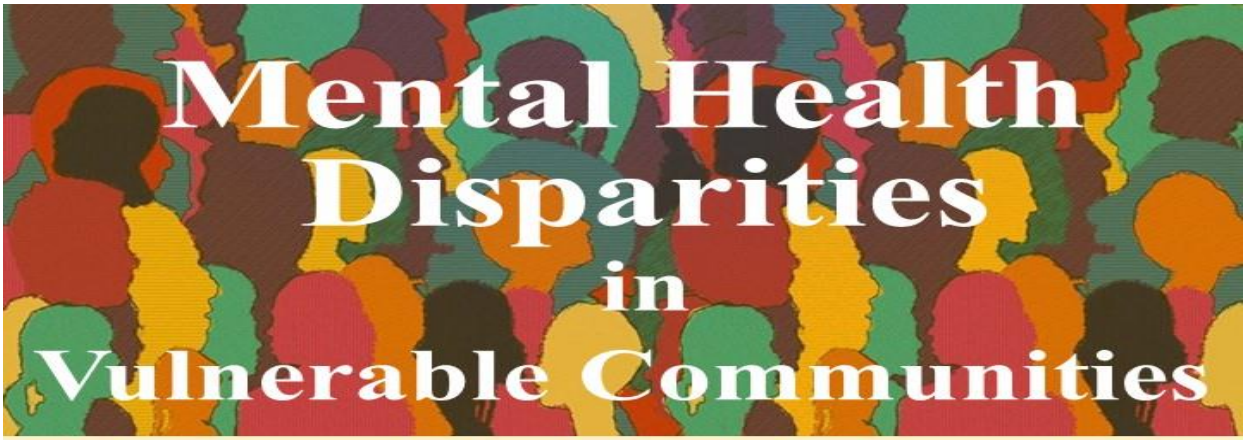
You are agreeing to comply with all applicable federal, State and local laws including health and safety code. You assume full responsibility for the conduct of all persons in attendance at your event and for any damage done to any part of our premises during the time of your event.

By signing this agreement we agree to abide by the terms and conditions.

6/13/22

Appendix H

Presentation Flyer



Mental Health and Depression Awareness

Friday August 11th, 2023
1pm – 2pm

Location: Ramada Hotel
120 Evergreen Place
East Orange, NJ 07018

Light refreshments will be served

Presented by:
Claudette L. Blake-Tonge, APRN, PMHNP-BC
Psychiatric Mental Health Nurse Practitioner-Board Certified

Mental health disparity is a healthcare crisis in vulnerable communities that include, racial/ethnic minorities, financially disadvantaged, uninsured, unhoused, LGBTQIA+, and the chronically ill (WHO, 2022). This program will discuss and define mental health and depression, assist in understanding depression, its causes, symptoms, treatment management and helpful resources. The goal is to promote mental health awareness to empower mental health self-care.

This program is FREE to the community.
Participants should be able to speak, read, and understand English.

A Doctor of Nursing Practice evidence-base project for Pennsylvania Western University, Clarion, Pennsylvania

Appendix I

Presentation Educational Handout A

Presentation Educational Handout B

Appendix J

Presentation Resource Brochure

Are you Depressed?

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: 0 + ____ + ____ + ____ = Total Score: ____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Total Score	Depression Severity
1 – 4	Minimal depression
5 – 9	Mild depression
10 – 14	Moderate depression
15 – 19	Moderately severe depression
20 – 27	Severe depression

If your score is 4 or greater, please consult a mental health professional. Resources listed.

Central/Northern New Jersey Mental Health Resources

Essex County Crisis Screening Center
973-926-7444

Mental Health Association of Essex and Morris Counties
973-509-9777

Essex County Hospital Center
973-571-2800

RWJ University Hospital-Rahway
732-381-4200

Rutgers Robert Wood Johnson Medical School
(Naloxon Nasal Spray Kits)
732-235-4341

Suicide and Crisis Lifeline
9-8-8

Community Emergency
Dial 2-1-1

Emergency Services
9-1-1

Integrity House.....973-623-0600
Family Service Bureau.....973-412-2056
The New Essecare of NJ.....973-414-0091
Youth Advocate Program (YAP).....973-624-1520
Therapy Confidential & Consulting.....908-228-5100

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MENTAL HEALTH DISPARITIES IN VULNERABLE COMMUNITIES:

Implementation of an Evidence-based Practice Mental Health Depression Education Program

What is Depression?

Depression is a common illness that affects how you feel, think and act.

Depression may feel like:

- You lost interest in doing things liked
- You stay home most days in the dark
- You have little or no energy
- You have trouble sleeping
- Your appetite has changed
- You have unplanned weight changes
- You have body aches over your body
- You get angry or irritable
- It takes a long time to make decisions
- You feel lost with no life direction
- You have thoughts of death
- These feelings last more than two weeks and has affected your life

(Psychiatry.org, 2022)

What causes Depression?

Depression can be caused by many different environmental, societal or medical factors.

Genetics, brain chemical imbalances, and hormonal changes are factors.

Poor nutrition, drugs and stress can also cause depression.

Risk Factors

Traumatic life experiences
Stress at home and work
Relationship changes
Social environments

Terminal illness
Loss and grief
Violence
Poverty

#1 leading cause of disability

50 Million American adults experienced mental illness in 2019

1 in 6 people will experience depression

15% of youth experienced a major depressive episode in the past year

(Psychiatry.org, 2022)

Mental Health Providers:

Psychiatrist, Psychiatric Nurse Practitioner, Psychologist, Therapist, or a Licensed Clinical Social Worker

ANYONE AT ANY AGE CAN HAVE DEPRESSION

Treatments for Depression

Psychotherapy
Techniques used by mental health professionals to help change negative thinking

Medications
Depression is treated with antidepressant, mood stabilizers or antipsychotics

Brain Stimulation
Electroconvulsive Therapy (ECT), used for treatment resistant depression

Mind-Body Medicine
Lifestyle modification such as exercise, meditation and yoga help with depression

Devash, 2021

Limitations in Treatment

What is Depression (2022). American Psychiatric Association. Psychiatry.org. https://psychiatry.org/patients-families/depression/what-is-depression

Devash, M. (2021). Let's Talk about Depression. HealthCentral.com. https://www.healthcentral.com/condition/depression