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The west side community outreach pilot project: A mental health outreach initiative in urban communities of color

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ABSTRACT

In 2017, The Kennedy Forum Illinois partnered with the City of Chicago and community partners to launch the West Side Community Outreach Pilot Project, an initiative designed to bring free mental health trainings to underserved communities on Chicago's west side. Participants self-selected from one of two broad training categories: an eight-hour Mental Health First Aid (MHFA) training or a shorter Mental Health Awareness (MHA) training. Trainings were enhanced with a Crisis Intervention Team (CIT) awareness component, which aimed to inform the public of the availability of specially trained law enforcement officers. A combined total of 488 training participants consented to evaluation at baseline (MHA $n = 316$; MHFA $n = 172$). For those who reported race and ethnicity, 64% ($n = 275$) identified as African American, while nearly 20% ($n = 92$) identified their ethnicity as Latinx. Analyses revealed significant within-subjects improvements for each group in reducing mental health stigma and increasing CIT knowledge. MHFA participants also demonstrated significant improvements in mental health knowledge, self-confidence, and decreased perceptions of difficulties providing aid. These findings highlight the initiative's ability to engage participants from targeted communities and the potential effectiveness of mental health trainings with racially diverse participants.

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Mental health stigma; urban populations; mental health first aid; Crisis Intervention Team (CIT)

Introduction

In 2015, Chicago police were dispatched to the home of Quintonio LeGrier, a young African American man experiencing a mental health crisis. During the response, an officer fatally shot LeGrier and his neighbor, Bettie Jones (Shoichet, 2015). The two deaths were among approximately 1,000 officer-involved fatalities across the nation that year, more than one-quarter of which involved victims with mental illness (Washington Post, 2018). In response to public recognition of the need for systemic change, a group of stakeholders worked in conjunction with the Office of the Mayor in Chicago to establish the Mayor's Citywide Mental Health Response Steering Committee (City of Chicago, 2016). The committee focused on strategies to improve police and other city agency responses to persons

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experiencing mental health crises and to improve the broader mental health system. It also recognized the need to improve community members' mental health literacy and knowledge about accessing mental health resources. Moreover, the committee aimed to reduce the likelihood of crises requiring police response by raising awareness and promoting the use of community mental health resources.

A key aspect of the committee's work was to develop a community-based mental health outreach initiative. Target areas were selected based on data provided by the City of Chicago and the Illinois Department of Public Health that revealed disproportionately high rates of behavioral health related hospitalizations in the last five years (Cohen, Prachand, Bocksay, Sayer, & Schuh, 2016). In collaboration with community leaders, a menu of six training options was developed and provided over an eight-month period. Training options included two variants of an eight-hour Mental Health First Aid (MHFA), standard and youth, and four versions of a two-hour Mental Health Awareness (MHA) training developed by the National Alliance on Mental Illness (NAMI) Chicago and Sinai Health Systems: standard MHA, Bridges of Hope for the faith community, and Under the Rainbow and trauma-informed MHA focused on youth mental health.

While the two-hour MHA trainings have not previously been evaluated, there is a growing body of research to suggest MHFA's effectiveness at improving participants' mental health knowledge, mental health stigma, self-confidence in providing help, and perceptions of difficulty performing MHFA-related actions (Hadlaczky, Hökby, Mkrtchian, Carli, & Wasserman, 2014; Jorm & Kitchener, 2011; Morgan, Ross, & Reavley, 2018; Rose, Leitch, Collins, Frey, & Osteen, 2018). The program's effectiveness and adaptability to specific cultural contexts has contributed to its expansion to nearly 25 countries (MHFA Australia, 2017a). However, research in the U.S. has been limited by its overreliance on white participants (Gryglewicz, Childs, & Soderstrom, 2018; Lipson, Speer, Brunwasser, Hahn, & Eisenberg, 2014; Rose et al., 2018). Therefore, it remains unclear whether MHFA or other brief mental health education programs are effective for African American and Latinx participants in urban settings.

Literature review

Behavioral health issues are common in contemporary society. According to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA; 2017a), nearly 20% of adults in the U.S. have a mental health disorder and 10% have a substance use disorder. Despite the availability of numerous evidence-based treatments, only 43% of the 45 million adults with any mental health issue in 2016 received treatment in the previous year (SAMHSA, 2017b). While structural barriers such as affordability of mental health care remain, intrinsic factors

including low perceptions of need and negative attitudes are more common reasons for avoiding treatment (Andrade et al., 2014; Mojtabai et al., 2011; Rowan, McAlpine, & Blewett, 2013). By extension, stigma surrounding mental illness continues to impede individual help-seeking decisions (Corrigan, 2004).

Although access barriers exist for many individuals with mental health care needs, low-income, racial, and ethnic groups continue to have the lowest rates of access to health care in the U.S. (Agency for Healthcare Research and Quality, 2016). This disparity is particularly evident among African Americans, who have the lowest median incomes and are overrepresented among persons living in poverty among all racial and ethnic groups (Fontenot, Semega, & Kollar, 2018). Rates of any mental illness among African Americans are comparable to the general population (Center for Behavioral Health Statistics and Quality, 2015). However, non-Hispanic African American adults (3.4%) are more likely than non-Hispanic white adults (3.2%) to report serious psychological distress (National Center for Health Statistics, 2016). Moreover, African Americans are about half as likely as whites to receive any mental health treatment (Wang et al., 2005). An estimated 8.6% of African American adults compared to 16.6% of white adults received any treatment in 2014 (SAMHSA, 2015). Previous studies have suggested that, in addition to factors such as income, insurance, and access barriers, internalized stigma from longstanding public discrimination and maltreatment may affect African Americans' attitudes and influence their mental health help-seeking decisions (Conner, Koeske, & Brown, 2009; Gaston, Earl, Nisanci, & Glomb, 2016; Ward, Wiltshire, Detry, & Brown, 2013).

Untreated or inadequately treated mental illness increases the risk for numerous adverse outcomes; including poorer physical health (Colton & Manderscheid, 2006), homelessness (U.S. Department of Housing and Urban Development, 2017) and suicide (Centers for Disease Control & Prevention, 2018). Likewise, greater exposure to adverse childhood events (ACES) and trauma increases the risk for mental health and substance use disorders, poorer physical health, and contributes to morbidity and mortality over the life course (Mersky, Topitzes, & Reynolds, 2013). Lack of access to adequate treatment in the community may result in overutilization of hospital and emergency room services (Samnaliev, McGovern, & Clark, 2009). Additionally, law enforcement officers are often the only available first responders when mental health crises occur, putting individuals at risk for becoming involved with the criminal justice system. The available data suggest that six percent of all police calls involve persons with mental illness and police contact accounts for nearly 30% of individuals' entries into mental health care (Livingston, 2016).

One approach to promoting appropriate mental health treatment has been to focus on the frequent interactions between law enforcement officers and persons with mental illness. City police departments across the nation have adopted the Crisis Intervention Team (CIT) model or are implementing CIT programs. First developed in Memphis, Tennessee, in the late 1980s, CIT is

a model of cross-system collaboration to improve safety in police interactions with individuals experiencing mental health crises, divert individuals with mental illnesses from the criminal justice system (and to mental health treatment) when appropriate, and to develop more responsive community mental health systems (Dupont, Cochran, & Pilsbury, 2007). It is a model that includes specialized training for a select group of officers that become CIT officers, collaboration with other system and community partners, and the identification of designated mental health-receiving facilities for officers to bring people in need of emergency psychiatric evaluation. CIT training is a 40-hour training that includes content on signs and symptoms of mental illnesses, available mental health services and crisis de-escalation skills; interactions with persons with mental illnesses, their families and service providers; and role play scenarios that allow officers to practice their new skills. Research on the CIT model, some of which has been conducted in Chicago, indicates CIT improves officer knowledge, attitudes and skills; decreases use of force with more resistant individuals; and increases linkages to psychiatric care (Watson, Compton, & Draine, 2017).

While CIT has focused on educating and training select law enforcement personnel, another approach has focused on informing the public. Mental health advocates have long worked for public health initiatives to address the general population's understanding of mental illness, stigmatizing beliefs and attitudes, and skills for early prevention and crisis intervention (Jorm, 2012). In recent decades, MHFA has emerged as a viable option for community-based mental health education. MHFA was developed in Australia in 2000 after two national surveys demonstrated the nation's need for an educational intervention to address the public's low mental health literacy, defined broadly as the "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm et al., 1997, p. 182). To address this problem, Anthony Jorm and Betty Kitchener created a nine-hour training program modeled after traditional First Aid. MHFA is designed to provide the public with the basic skills necessary for early prevention and crisis intervention for persons with mental health disorders (Jorm & Kitchener, 2011).

Initial Australian evaluations of MHFA suggested promising outcomes consistent with the program's primary goals. Analysis of data from the pilot evaluation of the first 210 MHFA participants revealed significant improvements through the six-month study period for recognition of mental disorders, self-confidence in providing MHFA, beliefs about treatment, and stigmatizing views of mental illness (Kitchener & Jorm, 2002). Subsequent randomized controlled trials conducted by MHFA developers supported these findings (Jorm, Kitchener, O'Kearney, & Dear, 2004; Kitchener & Jorm, 2004). Numerous studies have since revealed parallel findings for improvements in MHFA participants' mental health knowledge, self-confidence in providing aid, and reduction of stigma (Hadlaczky et al., 2014; Morgan et al., 2018).

Due to favorable results in the international context, MHFA launched in the U.S. in 2007 as an eight-hour training and quickly gained in popularity (MHFA Australia, 2017b). Between 2010 and 2012, the National Council for Behavioral Health and Georgetown University's National Technical Assistance Center for Children's Mental Health partnered to develop and implement a youth version (YMHFA; Georgetown University, 2018). A wide array of funding opportunities accelerated the program's expansion following President Barack Obama's *Now is the Time* initiative (White House, 2013). The President's plan to reduce gun violence contained a section calling for the establishment of Project AWARE, which included \$15 million in funding to provide MHFA training to teachers and \$40 million for school districts to build mental health service networks. This funding was authorized by legislation such as the Mental Health First Aid Act of 2015 (S. 711/H.R. 1877) and its subsequent iterations. Eligibility for financial support has since broadened from the initial focus on school-settings and nearly \$60 million in funding is available for mental health-related training through SAMHSA's Mental Health Awareness Training Grants and Project AWARE State Education Agency Grants (SAMHSA, 2018a, 2018b). These opportunities have enabled more than one million participants to receive MHFA training in the U.S. (National Council for Behavioral Health, 2018).

In contrast to the robust body of international research on MHFA, there have been relatively few evaluations of its effectiveness in the U.S. Results from initial U.S. evaluations have largely mirrored findings from international studies. For example, a large multisite randomized controlled trial of MHFA with resident advisors ($n = 553$) and residents ($n = 1,990$) in college and university campuses across 19 states found significant improvements in participants' self-confidence, mental health knowledge, and recognition of mental health disorders when compared to a treatment-as-usual condition (Lipson et al., 2014). Additionally, studies have found similar results for the youth-focused version, YMHFA (Gryglewicz et al., 2018; Rose et al., 2018).

Despite generally positive findings, MHFA evaluations have been limited by their lack of racial-ethnic diversity. In one exception, Subedi et al.'s (2015) pre-test/post-test evaluation of MHFA with Bhutanese refugees ($N = 58$) found immediate improvements in participants' recognition of mental health disorders, self-confidence providing help, and attitudes toward appropriate mental health treatments, but found no significant improvements in participants' negative attitudes toward persons with mental illness. Another study surveyed a primarily African American sample of social service employees immediately before and after YMHFA training in urban Maryland (Aakre, Lucksted, & Browning-McNee, 2016). Although the study found significant improvements in recognition of mental illness and likelihood of providing help overall, the investigators were unable to link data at the individual level. Moreover, mental health knowledge – a central feature of MHFA – was only measured at post-test.

While much of the literature on standardized mental health education programs for mental health literacy and stigma have focused on MHFA evaluations, there is some evidence to suggest that other brief educational interventions can be equally effective. For example, Corrigan, Morris, Michaels, Rafacz, and Rusch (2012) conducted a meta-analysis of 72 studies on anti-stigma interventions of three types: protest, education, or interpersonal contact with persons living with mental illness. The study found no significant changes resulting from protest campaigns, but revealed small-to-moderate reductions in stigma for programs that featured education or contact. Programs featuring interpersonal contact with persons with mental illness were most effective at improving attitudes and behavioral intentions among adults, while education programs had largest effect on adolescents (Corrigan et al., 2012). Other scholars have found similar results for brief educational programs, but have debated whether these positive changes are sustainable over time (Gronholm, Henderson, Deb, & Thornicroft, 2017). Taken collectively, the literature on the apparent benefits of brief anti-stigma and MHFA programs has fallen short of addressing the appropriateness of such public health interventions for racially diverse participants in urban contexts.

The present study contributes to the literature by presenting findings from a pilot evaluation of two CIT-enhanced public mental health training options conducted in racially diverse communities on Chicago's west side. Although these programs were not directly compared or tested against each other, findings from each program are presented together herein for descriptive purposes. To this end, this study addresses two research questions:

- (1) Does participation in brief MHA training relate to significant improvements in racially diverse participants' mental health stigma and perceptions of the CIT program (knowledge, comfort, expectations, and beliefs)?
- (2) Do participants in eight-hour MHFA trainings experience significant improvements in knowledge, self-confidence, and perceptions of difficulty in aiding people with mental illness in addition to improvements in stigma and perceptions of the CIT program?

Methods

Procedure

In 2017, The Kennedy Forum Illinois, NAMI Chicago, and partner organizations launched the West Side Community Outreach Pilot Project to increase mental health awareness in four underserved Chicago neighborhoods (The Kennedy Forum, 2018). Chicago is a diverse city with 2.7 million residents of which an estimated 49% are white alone, 31% African American alone, 6% Asian alone, and 29% of individuals from any racial background are

ethnically Latinx (U.S. Census Bureau, 2016). However, greater concentrations of African Americans reside in the four west side neighborhoods represented in this study. In 2015, African Americans accounted for approximately 83% of the population in Austin, 89% in North Lawndale, 91% in East Garfield Park, and 96% in West Garfield Park (Chicago Metropolitan Agency for Planning, 2017). Median annual incomes for these neighborhoods ranged from an estimated \$22,000 to \$31,000 – far lower than the citywide median annual income of nearly \$50,000. Moreover, these neighborhoods are among those with the highest rates of behavioral health hospitalizations in Chicago (Cohen et al., 2016). At the time of the West Side Community Outreach Pilot Project's launching, Chicago's CIT program had been in existence for more than a decade and approximately 2,300 out of 13,000 sworn officers were CIT-trained.

The initiative formed an advisory committee of leaders from Chicago's west side neighborhoods of Austin, North Lawndale, and East and West Garfield Park and asked for their support and guidance to deliver free mental health training to the community. The advisory committee met regularly to discuss target populations and outreach efforts, and recommended targeting those who worked or volunteered in schools, churches, and community-based organizations. These target groups were selected due to their position within the community as trusted messengers, their presumed higher likelihood of coming into contact with someone experiencing mental health distress, and their ability to intervene before the situation becomes a crisis. Further, the advisory committee created a list of behavioral health resources available in the community for distribution throughout the initiative. In addition to forming the advisory committee, the initiative recruited a group of mental health providers already working in the targeted neighborhoods to deliver MHFA and MHA trainings. MHFA trainers were all certified and MHA trainers were provided by the developing organizations. All trainers received training in CIT content and were provided with slides and training materials. Through various outreach efforts, Chicago's west side was blanketed with information advising community members how to register to attend a free mental health training. In total, free mental health trainings were provided to 583 participants on Chicago's west side.

Evaluation participants were recruited from a convenience sample of training attendees, most of whom lived, worked, or lived and worked on Chicago's west side. Approximately 84% ($n = 488$) of trainees agreed to participate in the evaluation. This included a total of 172 MHFA participants and 316 MHA participants at baseline (see Table 1). At the beginning of each training session, a research team member addressed the group, described the evaluation and invited those interested to participate. Trainees were reminded that they were free to decline to participate in the research evaluation and still participate in the training. To be included in the evaluation, participants were required to be 18 years of age or older and fluent and literate in English. Participants were

Table 1. Number of participants by training group at baseline.

Training Group	Version	n	(%)
MHFA (<i>N</i> = 172)	Y-MHFA	123	71.51
	MHFA	49	28.49
MHA (<i>N</i> = 316)	MHA	191	60.44
	Bridges of Hope	70	22.15
	Under the Rainbow	47	14.87
	MHA Youth-Trauma	8	2.53

Note. Y-MHFA = Youth-Mental Health First Aid. MHFA = Mental Health First Aid. MHA = Mental Health Awareness.

provided with a study information sheet that included standard consent form language. A waiver of documentation of consent was obtained following the first training when several participants stated that they would complete the survey and provide an email address for follow-up, but did not want to sign anything. Evaluation was conducted following Institutional Review Board approval from the principal investigator's home institution. Funding for this study was provided by The Kennedy Forum Illinois.

Training options

Participants were offered a menu of six training options from which to choose (see [Table 2](#)). Two versions of MHFA and four versions of MHA trainings were available, all of which were enhanced with a CIT Awareness component. For the purposes of evaluation, these six types of training were grouped into two broad categories based on similarity of content: MHA or MHFA. A total of 25 training sessions ($n = 10$ MHFA, $n = 15$ MHA) were provided at community locations on Chicago's west side from January to August 2017.

The two MHFA training types included standard MHFA or the youth-focused YMHFA. Both options were based on the eight-hour, standardized versions of MHFA. These trainings provided information on recognizing the signs and symptoms of mental illness and centered on the five-part ALGEE action plan, which teaches participants to assess, listen, give reassurance, and encourage appropriate professional and self-help (Kitchener & Jorm, 2008). The main difference between the two MHFA variants was that the standard version's content focused on adults, whereas YMHFA content focused on youth experiencing mental health crises. All MHFA trainings were enhanced with a section on accessing CIT-trained officers in the event of a mental health crisis requiring a police response. Of the 10 MHA trainings, there were three standard MHFA and seven YMHFA training sessions provided.

Alternatively, participants could choose from one of four shorter MHA training options developed by NAMI Chicago and Sinai Health System (NAMI Chicago, 2018; Sinai Health System, 2018). These four versions lasted

Table 2. West Side community outreach pilot project training contents.

Program	Focus	Content	Duration
MHFA USA, National Council for Behavioral Health	Adults with mental illness	Prevalence, signs, & symptoms of mental illness & substance use disorders; MHFA action plans (ALGEE) for anxiety, depression, psychosis, and substance use disorders; CIT awareness and access.	8.0 hours
Youth MHFA USA, National Council for Behavioral Health	Youth with mental illness	Prevalence, signs, & symptoms of mental illness & substance use disorders; MHFA action plans (ALGEE) for anxiety, depression, psychosis, substance use disorders, behavioral, & eating disorders; CIT awareness and access.	8.0 hours
Mental Health Awareness, NAMI-Chicago	Adults with mental illness	Prevalence, signs, & symptoms of mental illness; causes of mental illness (biology & environment); Trauma; Treatment & recovery; Barriers to care; Stigma; Responding to mental health crises; CIT awareness & access.	2.0 hours
Bridges of Hope, NAMI-Chicago	Adults with mental illness, faith-based	Prevalence, signs, & symptoms of mental illness; Role of spirituality and faith in supporting persons with mental illness; Responding to mental health crises; CIT awareness & access.	2.0 hours
Under the Rainbow, Sinai Health System	Youth with mental illness	Prevalence, signs, & symptoms of mental illness; Causes of mental illness; Safety planning for low & high-risk situations; Identifying agencies & supports; CIT awareness & access.	2.5 hours
MHA Youth-Trauma, Sinai Health System	Youth with mental illness, trauma	Prevalence, signs, & symptoms of mental illness; Safety planning for low & high-risk situations; identifying agencies & supports; impact of trauma (cognitive, emotional, behavioral, social); CIT awareness & access.	2.5 hours

approximately two hours each and included the standard MHA version with content focused on adults experiencing mental health crises; Bridges of Hope, which applied content from the standard version to the faith community; Under the Rainbow, with content focused on youth mental health; and an additional youth-focused version that was MHA youth/trauma-informed. All MHA training options were similar in scope and included content on recognizing the signs and symptoms of mental illness, options for making mental health referrals, as well as accessing CIT-trained officers. Of the 15 total MHA sessions provided, eight were standard MHA, three each of Bridges of Hope and Under the Rainbow, and one MHA youth/trauma-informed session.

Data collection

All evaluation data were collected between January 2017 and March 2018. Separate surveys were developed for MHFA and MHA participants. Respondents from both groups completed surveys at pre-test, post-test, three months, and six months. Hard copy surveys were administered in-person immediately before and after trainings, while follow-ups were conducted online

via Qualtrics software at three and six months after the trainings. Given low response rates for the online follow-up surveys, we report only on data from the pre- and post-tests.

Measures

MHFA and MHA programs were evaluated separately. However, common measures related to demographics, mental health stigma, and CIT awareness were used for both questionnaires. The key difference between surveys for the two groups was that the longer MHFA survey contained additional MHFA-specific measures adapted from five impact scales developed by the Georgetown University Center for Child and Human Development (GUCCHD; Anthony & Banh, 2014). While the developers are conducting pilot research on the measures, psychometric properties of the instrument have not been published to date. Preliminary findings suggested acceptable reliability for all but the stigma subscale ($\alpha < 0.55$; Anthony & Banh, 2014). For this reason, the GUCCHD stigma subscale was replaced with the Attribution Questionnaire (AQ9), which has established reliability (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003).

Demographics

Background and demographic characteristics were collected at baseline for both groups. Participants self-reported age, gender, race/ethnicity, education, whether they lived or worked on Chicago's west side, if they had ever experienced mental health problems in themselves, family, and/or friends, and familiarity with the CIT program.

Mental health stigma

Mental health stigma was assessed for both groups at all timepoints using summed scores from the nine-item Attribution Questionnaire (AQ-9; Corrigan et al., 2003). Participants' attitudes about mental illness were scored on a scale of one (none at all) to nine (very much). Two items were reverse coded so that higher scores reflected more negative perceptions of mental illness. The AQ-9's internal consistency was within the lower bounds of acceptability for the MHFA evaluation ($\alpha = 0.69$), but it demonstrated higher reliability for the MHA group ($\alpha = .79$).

CIT knowledge

CIT knowledge was measured for both groups at all timepoints through a five-item test developed for this study. Respondents indicated whether each statement regarding CIT was true or false (e.g. All officers are equally trained to manage a mental health crisis when responding to a 911 call). CIT knowledge scores represented the total number of correct responses.

CIT comfort, expectations, and beliefs

Participants from both programs were asked to rate three items on a Likert-type scale ranging from one (not at all) to five (very much): comfort requesting a CIT officer, expectations that a CIT officer would be dispatched, and beliefs that CIT officer-involvement would lead to a better outcome. These measures were assessed at all observation periods.

Mental health knowledge

Mental health knowledge was assessed for MHFA participants at all time-points using a 15-item test developed by the GUCCDH (Anthony & Banh, 2014). Participants were asked to rate agreement with each statement regarding mental health (agree, disagree, or don't know). The Mental Health Knowledge score represented the total number of correct responses.

Self-confidence performing mental health actions

Self-confidence performing mental health actions was measured at all time-points for MHFA participants using nine items developed by the GUCCDH. Each item consisted of a five-point, Likert-type, scale ranging from one (not comfortable at all) to five (very comfortable). A self-confidence summed score was calculated by dividing the total score by nine. Internal consistency of scaled items was highly reliable ($\alpha = 0.89$).

Difficulty performing mental health actions

Perceived difficulty in performing mental health actions was assessed at all timepoints for MHFA participants using five-items developed by the GUCCDH. Each item consisted of a five-point, Likert-type scale ranging from one (not difficult at all) to five (extremely difficult). A summed score was calculated by dividing the total score by five. The measure's internal consistency was acceptable ($\alpha = 0.77$).

Data analysis

Demographic and background variables were analyzed using descriptive statistics. Prior to analysis of repeated measures, scaled items were assessed for internal consistency by calculating unstandardized alphas (Cronbach, 1951). Although data were collected at four timepoints, only pre-test and post-test changes are reported herein due to low response rates at the three and six-month follow-ups. Of the 176 MHFA study participants, 98% ($n = 172$) completed the pre-test, 89% ($n = 156$) completed the post-test, 31% ($n = 54$) completed the three-month follow-up, and 19% ($n = 34$) completed the six-month follow-up. For the 329 MHA participants, completion rates were 96% ($n = 316$) at pre-test, 92% ($n = 303$) at post-test, 21% ($n = 68$) at three months, and 17% ($n = 57$) at six months.

Paired sample *t*-tests were run separately for MHA and MHFA participants to assess mean within-subjects differences in outcomes from pre-test to post-test. Results from these separate evaluations are presented herein for descriptive rather than comparative purposes. Effect sizes were calculated using Cohen's *d* (i.e., the difference in means divided by the standard deviation of difference in means). Interpretations followed Cohen's (1988) recommendations for small ($d = 0.2$), medium, ($d = 0.5$), and large ($d = 0.8$) effects. Results were interpreted as significant based on a two-tailed test of significance ($\alpha \leq 0.05$). All data were analyzed in Stata version 15.0 (StataCorp, 2017).

Results

Sample characteristics

Demographic characteristics are presented in Table 3. The majority of MHFA participants identified as African American ($n = 83$, 56%) and approximately 22% ($n = 35$) of participants reported being of Latinx ethnicity. Similarly, the majority of MHA participants also identified as African American ($n = 192$; 68%), while 19% ($n = 57$) of all participants identified their ethnicity as Latinx.

Mental health stigma

Paired sample *t*-test results for MHFA and MHA evaluations are presented in Tables 4–5. MHFA participants' mean mental health stigma scores decreased by 0.23 points at post-test ($M = -0.23$, $SD = 0.83$). Decreases were statistically significant though small ($t_{(130)} = -3.215$, $p < .01$, $d = -0.28$). Conversely, MHA participants experienced a slightly larger reduction in

Table 3. Baseline demographic characteristics of MHFA & MHA participants.

Characteristic	MHFA		MHA	
	n	(%)	n	(%)
Age: <i>M</i> (<i>SD</i>)	40.30	(13.05)	45.58	(14.18)
Female	102	(61.08)	247	(78.91)
Black/African American	83	(56.08)	192	(68.09)
White	47	(31.76)	61	(21.63)
Other	18	(12.16)	29	(10.28)
Latinx	35	(21.60)	57	(18.94)
< Associate's Degree	41	(24.55)	59	(18.91)
= Associate's Degree	13	(7.78)	55	(17.63)
= Bachelor's Degree	46	(27.54)	68	(21.79)
> Bachelor's Degree	67	(40.12)	130	(41.67)
Live West Side	56	(33.73)	92	(30.16)
Work West Side	112	(67.07)	213	(71.24)
Live/Work West Side	44	(25.00)	75	(22.80)

Note. Latinx reflects ethnicity and crosses racial categories.

Table 4. Paired sample t-test results for MHFA participants.

Variable	N	Pre-test		Post-test		Changes from Pre-test to Post-test			
		M ₁	SD ₁	M ₂	SD ₂	t	df	Cohen's d	
Mental Health Stigma	131	3.15	0.97	2.91	0.97	-3.22	**	130	-0.28
CIT Knowledge	146	4.04	1.00	4.34	0.90	3.45	*	145	0.29
CIT Comfort	137	3.77	1.21	4.26	1.11	4.81	*	136	0.41
CIT Expectations	138	3.20	1.29	3.73	1.15	4.81	*	137	0.41
CIT Beliefs	136	3.60	1.19	3.94	1.14	3.76	*	135	0.32
Mental Health Knowledge	150	10.03	2.80	11.87	2.66	7.76	*	149	0.63
Self-Confidence Performing MHFA	140	3.74	0.74	4.21	0.84	6.66	*	139	0.56
Difficulty Performing MHFA	131	2.14	0.79	1.68	0.60	-8.34	*	130	-0.73

* $p < 0.001$. ** $p < 0.01$.

Table 5. Paired sample t-test results for MHA participants.

Variable	N	Pre-test		Post-test		Changes from Pre-test to Post-test			
		M ₁	SD ₁	M ₂	SD ₂	t	df	Cohen's d	
Mental Health Stigma	256	3.34	1.10	2.95	1.22	-7.56	*	255	-0.47
CIT Knowledge	279	3.82	1.02	4.10	0.84	4.32	*	278	0.26
CIT Comfort	281	3.55	1.28	4.45	0.84	12.42	*	280	0.74
CIT Expectations	279	3.24	1.20	3.97	1.00	10.63	*	278	0.64
CIT Beliefs	270	3.64	1.18	4.33	0.89	10.29	*	269	0.63

* $p < 0.001$.

mean stigma scores at post-test ($M = -0.39$, $SD = 0.83$), that was statistically significant with a medium effect size ($t_{(255)} = -7.560$, $p < .001$, $d = -0.47$).

CIT knowledge

Improvements in CIT knowledge test scores were very similar for both programs. MHFA participants had 0.29 more correct responses at post-test ($M = 0.29$, $SD = 1.03$). Improvements were statistically significant with small effect ($t_{(145)} = 3.449$, $p < .001$, $d = 0.29$). MHA respondents' scores also increased by 0.29 points at post-test ($M = 0.29$, $SD = 1.11$), which was also significant with small effect ($t_{(278)} = 4.324$, $p < .001$, $d = 0.26$).

CIT comfort

Post-test increases in scores for comfort requesting a CIT officer were slightly smaller for MHFA ($M = 0.49$, $SD = 1.19$) than for the MHA group ($M = 0.90$, $SD = 1.21$). Increases for MHFA participants were significant with small effect ($t_{(136)} = 4.814$, $p < .001$, $d = 0.41$). In contrast, significant increases in comfort mean scores for the MHA group suggested moderate effect ($t_{(280)} = 12.424$, $p < .001$, $d = 0.74$).

CIT expectations

Similar findings occurred for participants' expectations that a CIT officer would be dispatched upon request. MHFA participants' mean change scores were slightly lower ($M = 0.53$, $SD = 1.29$) than MHA program participants ($M = 0.72$, $SD = 1.14$). Results suggested MHFA had small effect ($t_{(137)} = 4.813$, $p < .001$, $d = 0.41$), whereas MHA had medium effect ($t_{(278)} = 10.631$, $p < .001$, $d = 0.64$).

CIT beliefs

There were significant post-test improvements in beliefs that CIT officer-involvement would result in a better outcome for both the MHFA group ($M = 0.35$, $SD = 1.07$) and for MHA participants ($M = 0.68$, $SD = 1.09$). Again, the effect size was smaller for the MHFA group ($t_{(135)} = 3.764$, $p < .001$, $d = 0.32$) than for the MHA group ($t_{(269)} = 10.289$, $p < .001$, $d = 0.63$).

Mental health knowledge

Analyses suggested significant improvements with moderate effect for MHFA participants' mental health knowledge ($t_{(149)} = 7.761$, $p < .001$, $d = 0.63$). On average, participants' mean scores increased by nearly two more correct answers at post-test ($M = 1.84$, $SD = 2.90$).

Self-confidence performing MHFA

Likewise, there were significant improvements in MHFA participants' self-confidence in performing MHFA-related actions ($t_{(139)} = 6.659$, $p < .001$, $d = 0.56$). Participants' self-confidence increased by nearly one-half point at post-test ($M = 0.47$, $SD = 0.84$).

Difficulty performing MHFA

Finally, MHFA participants' perceptions of difficulty in performing MHFA-related actions decreased significantly ($t_{(130)} = -8.337$, $p < .001$, $d = -0.73$). On average, perceptions of difficulty in performing MHFA-related actions decreased by nearly one-half point at post-test ($M = -0.46$, $SD = 0.63$).

Discussion

Findings from the West Side Community Outreach Pilot Project evaluation indicated that the initiative was successful in its primary aim of engaging people who live and/or work in targeted communities. As such, these results provide initial support for this approach as a viable public health outreach strategy for reducing stigma and improving mental health knowledge in urban, African American, communities.

A notable finding from this evaluation is that the shorter trainings appeared to reduce mental health stigma and increase knowledge and awareness of the CIT program as well or better than the eight-hour MHFA trainings. This finding must be interpreted with caution because participants self-selected into the trainings rather than being randomly assigned. Thus, direct comparisons of these likely non-equivalent groups are not appropriate. Moreover, while all the trainings shared the core elements of recognizing the signs and symptoms of mental illness, treatment options, and CIT awareness, only the MHA trainings specifically addressed stigma as a topic. Still, this finding provides tentative evidence that brief trainings can have positive impact. Additionally, the shorter training might be appealing for community members who are unable or unwilling to attend an eight-hour MHFA training. Future research utilizing a randomized controlled design would be needed to determine how the two-hour trainings compare to MHFA for the outcomes of interest.

MHFA-specific outcomes largely mirrored results from previous studies with primarily white participants. The program's small-to-medium effects on mental health literacy, self-confidence performing MHFA actions, and decreases in mental health stigma and perceptions of difficulty in performing MHFA-related actions are all consistent with the MHFA literature. Thus, these results provide support for the feasibility of MHFA in a racially diverse setting.

Unfortunately, low completion rates for the three- and six-month follow-ups impeded the ability to assess the initiative's effects over time. Future research might consider providing incentives to increase the completion of follow-up tests. Additionally, participants might be retained through ongoing community engagement, as well as through disseminating reminders and refresher materials via post or email periodically.

Limitations

Results related to the effectiveness of the trainings should be interpreted with caution due to several methodological limitations. First, the six trainings were grouped into broader MHFA and MHA categories for analysis based on duration and shared characteristics. However, it should be noted that the

trainings varied slightly in terms of content. Additionally, participants were not randomized to training conditions and there was no control group. Comparisons of findings between training types were presented for descriptive purposes only. By extension, female participants with an associate degree or higher were overrepresented in this study. Results might vary in a more representative sample of persons living in west side communities. There were also challenges in terms of the measures used for evaluation. MHFA measures are still being evaluated and psychometric properties remain largely absent from the literature. Given the lack of actual behavioral measures, we can only theorize that improvements in knowledge, attitudes, and comfort will translate into changes in behavior related to recognizing mental health distress, assisting others in accessing care (or accessing care for oneself), and requesting a CIT officer when police assistance with a mental health crisis is needed. Finally, low response rates during the three- and six-month follow-up periods limited the ability to analyze the durability of longer-term impacts of these trainings.

Conclusion

Despite its limitations, this project demonstrated that it is possible to engage members of targeted urban communities in mental health trainings. Additionally, it provided initial data to suggest that shorter trainings can influence mental health stigma and knowledge on accessing CIT officers. These findings also indicated positive impacts for MHFA with an urban, predominantly African American sample, which has not previously been the primary focus of much MHFA research. Findings from this study support the need for more rigorous research to accurately assess each program's effectiveness with African Americans and other historically underrepresented groups in urban settings, as well as the need for an examination of the longer-term impacts on service access and well-being associated with public health interventions designed to improve mental health literacy and stigma.

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