Needs Assessment Battery

Design Overview

We will conduct 10 to 15 focus groups consisting of 8 to 10 persons each during which participants will complete the relevant program measures and conclude with a 90-minute *discussion*. We will also invite participants to complete individual interviews if they would feel more comfortable providing the information this way.

Measures

The following surveys will assess a) patient and stakeholder knowledge of PCOR and CER as well as perceptions of individuals with mental illness and mental illness treatment. All measures will be administered by the Co-Leads and Program Manager (all of whom with have completed Human Subjects training). To minimize assessment burden on our stakeholders while maximizing information gathering aligned with our objectives, only brief self-report measures are included. Almost all measures have been used with our proposed set of stakeholders via The AAKOMA Project and our joint university faith community (CTSA) award. Additionally, members of the First United Methodist Church of Hyattsville, Maryland's Health and Wellness Ministry served as expert community evaluators of the measures by completing the full assessment battery and providing feedback on a) the time to completion, b) sensitivity and readability of the questions, and c) feedback they felt relevant for community members. Our proposed set of written measures was selected to limit stakeholder burden while allowing the program team to examine mental illness literacy (IDLS) awareness (IDLS, LOF) and stigma (SSRPH, FQ).

Participating stakeholders will complete a brief demographic questionnaire including age, gender, years of completed education, zip code, homeownership status, number of years leadership experience, professional training, church attendance and estimated annual family income. Youth participants will complete demographic questions including career aspirations, college choices, estimated grade point averages, current grade and frequency of church attendance. As well, we will add two items to assess knowledge of Patient Centered Outcomes Research and Comparative Effectiveness Research. Many of the proposed demographic questions are already included on one of the program measures (the ILDS). Therefore, to reduce study participant burden, we will add the few items of interest to the research team to the ILDS.

We will use the 5-item Stigma Scale for Receiving Psychological Help (SSRPH) (Pyne et al., 2004). The SSRPH has good reliability (coefficient alpha = .77 - .78) and has been used with diverse samples of young adults and adults (Elhai, Schweinle, & Anderson, 2008). Higher scores reflect more stigma associated with treatment seeking (Komiya, Good, & Sherrod, 2000). Additional stigma measures include the 12-item Family Questionnaire (FQ); a 3-sentence stimulus vignette to "assess public stereotypes about family members of people with mental illness in 12 domains" including blame and pity and the Level of Familiarity measure (LOF), an 11-item survey with questions varying, "in terms of how familiar the person is with mental illness" to generate an overall familiarity score indicating individual knowledge of mental illness.

We have included the International Depression Awareness Literacy Survey (IDLS) (Hickie AM et al., 2007), a measure developed specifically to examine depression stigma, knowledge, attitudes toward treatment and beliefs about need for treatment in diverse populations. While this measure targets adults, it is written at an approximately 7th grade reading level. This measure includes a Literacy subsection, which allows researchers to identify the proportion of people who correctly identify the signs and symptoms of depression. The IDLS has been tested in diverse international populations (Hickie AM, et al., 2007).

Discussions

We will conclude with a 90-minute *discussion* in a focus group format. Our discussion questions will be derived from some tested stem questions from The AAKOMA Project, new questions from our AAKOMA Community Advisory Board (est. 2007), items developed by the funded partnership between Dr. Breland-Noble and Dr, Carter-Williams from their 2013 partnership grant and lessons learned from the governance team. We will audio record the discussion to facilitate data analysis. Specific to patient-centered outcomes research and comparative effectiveness research, our University Lead, Dr. Breland-Noble, will build on her postdoctoral training in Mental Health Services Research, where she received training in comparative effectiveness research and collaboration with other university stakeholders with expertise in patient-centered outcomes research (e.g., Dr. Kristi Graves, Georgetown University professor, PCORI Principal Investigator and patient-centered outcomes research trainer for Dr. Breland-Noble and Rev. Chase-Sands' Pipeline to Proposal Award). Specifically, we will build into this Engagement Award the training provided by Dr. Graves from the Pipeline Award to develop questions related to PCOR and CER so that we can assess our stakeholders' level of knowledge in this area.

Our qualitative focus group question guide was derived from tested stem questions from Dr. Breland-Noble's K award AAKOMA Project and new questions based on the feedback of our AAKOMA Community Advisory Board (est. 2007) and the FUMC Health and Wellness committee including their pastor Rev. Joan Carter-Rimbach and members of the FUMC Health and Wellness Ministry. At the conclusion of each focus group, the program team will carefully collect all de-identified surveys and will debrief with participants about their experience. Throughout each focus group, the program team will also collect notes on group process.

Additional Individual Interviews

Our data collection activities also involve additional individual interviews and participant responses with a subset of 35 adult faith leaders and 15 youth utilizing the **Individual and Institutional Health Promotion Capacity Checklists (IHPCC)**. The Checklists are comprised of 62 Likert-scaled items and will be relatively straightforward to complete. The process for data collection for this aim will progress as follows. As of April 29, 2016, the program team has generated a list of participant churches and individual adult participants (faith leaders and stakeholders) based on our use of the Alvarez Strategic Recruitment framework and tracking system. From this tracking system, our team will compile a list of specific participants to complete

the IHPCC. Respondents selected for this phase of the work will also be asked to help us to expand our pool of engaged stakeholders who contribute to our overall set of tasks for the award.