Partnering for Progress: Enhancing Mental Health Crisis Response in Rural North Carolina through Faith-Based Training

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ABSTRACT

Background: Mental health concerns affect millions of Americans annually; further exacerbated by the Covid-19 pandemic. Rural areas face unique challenges due to limited access to mental health care, augmented by social disparities and cultural stigma.

Methods: Leveraging partnerships with local organizations, this project implemented the Empower training program to equip community members with skills and resources to identify and respond to mental health crises.

Outcomes and Lessons Learned: Post-intervention survey results showed improved knowledge and confidence among participants in mental health crisis intervention. Lessons learned included the importance of involving trusted community members in marketing and program design, the value of partnerships in bringing mental health training into community spaces, and the use of low-cost, pre-existing resources to support sustainability.

Conclusions: Programs that train community members to recognize and respond to mental health crises and promote mental health resources can help address limited mental health resources in rural communities.

KEYWORDS: Nursing, Community health partnerships, Community-Based Participatory Research, Health promotion, Mental Health Services, Rural Health Services, Mental Health, Public Health, Faith-Based Intervention

Mental health concerns impact nearly 50 million Americans each year, and the COVID-19 pandemic led to an increase in mental illness exacerbation nationwide. Although the prevalence of mental illness is similar in rural and urban areas, lack of access to mental health care in rural communities is a major contributor to underdiagnosis and undertreatment.[1] Evidence suggests that rural health disparities are driven by inequitable social circumstances including environmental factors, higher poverty rates, and lack of providers and services.[1] Individuals experiencing mental health crises in rural areas deemed Mental Health Professional Shortage Areas (MHPS) have limited access to timely services.[2] Although rural America is not homogenous, cultural stigma around mental health is not uncommon in rural communities; therefore, rural residents may avoid help-seeking behaviors or seek treatment only when symptoms are severe enough to merit hospitalization.[2]

The combination of limited mental health care access and cultural stigma often leads individuals in rural communities to rely on family, friends, or faith-based organizations rather than on professional preventative or acute mental health services.[1] Rural faith-based communities are often consulted for mental health assistance due to ease of access, cultural sensitivity, low cost, and established trusting relationships. However, most clergy, congregation members, and laypersons within these communities often lack formal training, leaving them feeling unprepared to respond effectively in a mental health crisis.[1] This paper describes a quality improvement (QI) project designed to promote awareness of mental health needs, resources, and response to mental health crises within faith-based communities in a single county in North Carolina. Aspects of existing partnerships that supported this project as well as lessons learned will be discussed.

History of Faith Community Nursing

Originally termed "parish nursing," faith community nursing (FCN) is designed to promote holistic well-being of the body, mind, and spirit. The work of Rev. Dr. Westburg, a Lutheran pastor who idealized the use of nurses to support interprofessional collaboration between religious and healthcare providers, was pivotal to the modern conception of FCN, which is inclusive of all religions. The American Nurses Association recognized FCN as a nursing specialty in 1997 and approved *Faith Community Nursing: Scope and Standards of Practice* in 2005.[3]

The integration of parish nursing into healthcare systems in North Carolina has played a significant role in linking faith communities with healthcare resources, especially in addressing mental health challenges. This model has been particularly evident since the 1990s, with key programs such as those at Presbyterian Hospital and the establishment of Duke University's Master of Science in Nursing in parish nursing in 1999. These initiatives demonstrated the value of faith-based nursing in fostering community support for individuals experiencing mental health crises.[4]

Cone Health Congregational and Community Nurse Program

In 1998, Cone Health (formerly Moses Cone Hospital) hired a new chief nursing officer (CNO) previously employed by a Midwestern hospital system that had a parish nursing program. Through the advocacy of the Director of Chaplaincy Services and the new CNO, Cone Health approved the Congregational Nurse Program as a new community outreach program. Since 1998, the program has expanded an initial placement of six nurses in churches to its current relationships with 67 congregations and faith-based organizations. In 2022, the Congregational

Nurse Program was renamed the Congregational & Community Nurse Program (CCNP) to be inclusive of community partners.[5]

The CCNP addresses health equity by bridging gaps in healthcare. Congregational & Community Nurses (CCNs) serve beyond hospitals or clinics, promoting health and wellness of mind, body and spirit through engagement with individuals in places of worship (including all denominations) and at community/agency sites.[5]A faith community needs assessment identifies health ministry priorities and defines the faith community nurse's role. To partner with CCNP, faith-based organizations apply based on need, and an assessment determines required resources.[5]

Nurses in the CCNP either volunteer to serve at their place of worship or are paid through Cone Health, grant funding, or community gifts. Paid nurses work as guests at community locations that serve populations needing assistance, such as the unhoused, migrants/immigrants, and those who are food insecure. Both volunteer and paid nurses address health inequities by assisting with navigation of the healthcare system and making referrals. Additionally, CCNs deliver holistic, community-based care by providing free health promotion interventions such as health education, health screenings, immunizations, and personal health counseling.[5] Currently, the CCNP does not offer specific mental health services, although the CCNs occasionally provide in-service training on mental health interventions.

LOT 2540

LOT 2540, a salvage and recycling ministry, was created in 2011 in response to a lack of local resources for Rockingham County residents living below the federal poverty line. Its

mission is to "promote spiritual, emotional and physical restoration for families and individuals of our community".[6] The salvage storefront receives furniture, houseware, and other donations that it sells to the public; all profits support the organization's mission through community programs, including The Well, a kitchen through which they provide approximately 1200 hot meals monthly, and a mobile food market that provides approximately 500 boxes of food to local residents monthly. The organization also hosts weekly "lunch and learns" focused on spiritual, mental, and physical wellness and growth. In 2017, a CCN was assigned to Lot 2540 to address healthcare access gaps by offering weekly services such as wellness checks, individual health counseling, and health education.[6]

Mt. Sinai Missionary Baptist Church

Mt. Sinai Missionary Baptist Church, a historically Black church with approximately 120 active members and a strong community presence since 1888, joined 12 historically Black churches in Rockingham County to form an alliance called the Eden Ministers Alliance. In 2021, a CCN was assigned to Mt. Sinai, playing a key role in connecting congregants to local healthcare resources and enhancing health literacy around health promotion and maintenance. Recognizing the impact of the CCN's role, Mt. Sinai has designated every fifth Sunday for the CCN to address wellness topics like hydration, nutrition, and other health initiatives with the congregation.[7]

Identifying a Community Need

Rockingham County, a rural area in northwest North Carolina with a population of approximately 91,000, faces escalating mental health needs. The 2019/2020 Rockingham County

Community Health Assessment (CHA), a collaborative effort between the Rockingham County Division of Public Health, Cone Health Annie Penn Hospital, UNC Rockingham Health Care, and the United Way of Rockingham County, found that up to 50% of Rockingham County residents reported having personal experience with or knowing someone affected by mental health.[7] Data highlighted Rockingham County residents experienced more poor mental health days and frequent mental distress as well as a higher rate of suicide among residents compared to the state average for these measures.[8] See Table 1 for detailed demographic and mental health data for Rockingham County compared to the state of North Carolina.

For many, the COVID-19 pandemic exacerbated pre-existing mental health issues. Research has found that fear related to the pandemic led to an increase in psychiatric illness including depression, anxiety, and post-traumatic stress disorder.[9] Loss of jobs, fear of getting sick, and increased exposure to misleading information via the news and social media led to increasing levels of anxiety, particularly among individuals who were marginalized or lacked resources.[9,10] It is unsurprising, therefore, that during an in-depth community assessment performed by the project coordinator in the fall of 2021, CCNs and formal and informal leaders in Rockingham County identified mental health as a priority need exacerbated by the COVID-19 pandemic.

Mental health services and resources are limited in Rockingham County. In 2021, the county had only one freestanding behavioral health clinic, despite the growing need for mental health services and a significant shortage of mental health providers. Data indicate an upward trend of unduplicated client visits at this clinic (from 14,657 in 2016 to nearly 20,000 in 2018).[8] Rockingham County has a 760:1 resident-to-mental health provider ratio; the national average is

380:1, and the state average is 390:1.[8,11] Limited access to mental health services leave many residents dependent on community and faith-based networks for support, as formal resources remain inadequate. It is clear that multiple compounding factors exist in Rockingham County which validate the need for additional mental health support and resources.

Program Selection

The overall program goal was to improve the informal mental health support network in Rockingham County to better meet the mental health needs of the community in which there is are limited formal mental health resources. Mental health first aid is defined as "the help offered to a person developing or experiencing a mental health crisis until professional help is received or the crisis resolves". [12] Training community members in mental health first aid can reduce stigma and significantly expand mental health support .[13] Faith-based programs are well-documented for their positive impact on well-being, including mental health support, and are often used as venues for health education interventions. [14] Together, these approaches contribute to building more informed, supportive communities that are better equipped to address mental health challenges.

Three potential programs were reviewed by the project team: Mental Health First Aid, Johns Hopkins University Lay Health Educator program, and Gateway to Hope University (GTHU) Empower program. After careful discussion with team members and community partners, the Empower program was selected over other program options due to its unique advantages. Initially, it provided both synchronous and asynchronous learning modes, offering exceptional flexibility and accessibility for participants with diverse schedules. Currently, the program is available only as a self-paced, asynchronous option. Tailored specifically for faith-

based communities, the Empower program is also offered at no cost, making it a practical and sustainable choice for resource-limited faith-based organizations.[15]All partners agreed that these qualities including the ease of use, alignment with the values of the faith community, and affordability made the Empower program the ideal choice for this initiative.

Gateway to Hope University is the training organization of the Hope and Healing Center & Institute in Houston, Texas, an agency dedicated to decreasing barriers to mental health and reducing stigma.[15] The Empower training program is designed to teach laypersons the fundamentals of identifying mental illness, developing safe and effective situational responses, and building a network to quickly connect those in distress with professional care.[15] The faith-based component can be excluded to adapt Empower for Schools and Empower for Workplaces, making it suitable for implementation in public schools and organizations of any size.[15]

The two-hour Empower training comprises 30 minutes on each of the following topics: Recognize, Refer, Relate, and Restore.[15] Recognize defines mental health and common chronic mental health conditions. Refer identifies need to refer through assessment of the severity of perceived danger; specifically, the speaker presents assessment of suicidal ideation using the QPR (Question, Persuade, Refer) method.[16] Relate shares how to relate to someone who is experiencing a mental health crisis. Restore focuses on building restorative programs that faith communities can put in place with community group support and further training.[15] Although there is no existing data on the Empower program's outcomes, it has received national recognition from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the White House Mental Health Summit. These endorsements highlight its potential as a progressive model for reforming the mental health system in the United States.[15]

Program Implementation

The program was targeted toward faith-based agencies in Rockingham County that have a contractual relationship with the Cone Health CCNP. Initially, CCNs in Rockingham County were surveyed to determine interest in implementation within their faith-based agency. CCNs from two agencies (Lot 2540 and Mt. Sinai Baptist Church) expressed interest. An established relationship between the project coordinator and the CCNs within these two agencies was integral to their willingness to support the intervention and market it within their agency. The project coordinator spent approximately six months prior to the intervention fostering relationships with Lot 2540, delivering educational sessions alongside the CCN. The project coordinator had developed a relationship with the CCN at Mt. Sinai through their mutual involvement in the CCNP and work as faculty in local universities. This personal approach allowed the project coordinator to connect with CCNs, community partners, and community members.

Three training dates were selected, and participants signed up via an online link. The participants at Lot 2540 were community members, program participants, and employees. At Mt. Sinai, they were clergy and congregation members. The training was led by the Community Education Coordinator who was employed by Gateway to Hope University.

Marketing efforts included (a) sending information to CCNs and clergy within the faith communities for distribution in church bulletins, (b) attending an Eden Ministers Alliance monthly meeting, and (c) posting training information on Lot 2540's social media.

The intervention was offered either as an asynchronous, self-paced two-hour online training, or as a live, synchronous hybrid training held in-person and via Zoom with a Gateway to Hope University educational staff member. The live synchronous training was offered twice at Lot 2540 and once at Mt. Sinai Baptist Church.

Partner Involvement

Essential community partners, including the Assistant Director of the CCNP, the Executive Director of Lot 2540, and the CCN at Lot 2540, gathered to demonstrate their support for the Empower training initiative. Lot 2540, with its facilities featuring tables, chairs, and a kitchen setup, was offered by the Executive Director as the Zoom training location. Both the CNP and Lot 2540 ensured the availability of the necessary technology to support the training sessions.

Support from Mt. Sinai was also secured by presenting data from the population and community assessment during the Eden Ministers Alliance, a collaborative group that brings together clergy members, including pastors and associate ministers, within the Eden area, monthly meeting. The pastor and CCN at Mt. Sinai, along with other members of the Eden Ministers Alliance, played a crucial role in the success of the Empower program. Their efforts in marketing, promoting, and endorsing the program within their congregations significantly contributed to creating an environment of acceptance. This support ensured that an external presenter discussing the topic was welcomed and valued by the community, enhancing the program's impact and reach.

Data Collection and Analysis

Quantitative and qualitative methods were used to evaluate this quality improvement (QI) project. The project was reviewed and acknowledged as a QI project by Cone Health Nursing

Research and Innovation and Office of Research Support as well as by Rush University's Office of Research Affairs. A post-intervention survey was used to obtain feedback from participants. The survey consisted of eight questions, six knowledge-related fill-in-the-blank items, one Likert scale confidence-focused question, and one question inviting the participants to share any feedback about how the program could be improved (see Figure 1 for post-survey questions). On the post-intervention survey, participants were asked to identify warning signs that someone is experiencing a mental health crisis. Along with analyzing data from the post-intervention survey, lessons learned were identified based on qualitative feedback from participants provided on the post-intervention survey and discussion among the partners post-implementation.

Results and Lessons Learned

Results

A total of 66 individuals attended the program. Eleven participants attended one of the two sessions at Lot 2540, and 55 participants attended the session at Mt. Sinai Baptist Church. Demographic data was not collected via the post-intervention survey; however, all participants were at least 18 years old and had a connection to the partner organizations prior to program implementation.

Post-intervention survey results

Of the 66 participants who completed the training, 62% (n = 41) completed the post-intervention survey. Of those completing the survey, 71% percent (n = 29) were able to identify two or more warning signs that someone is experiencing a mental health crisis. The most common warning signs identified included changes in behavior (n = 12), misuse/overuse of alcohol or drugs (n = 5), and suicidal ideation (n = 5). When asked to correctly identify the next three steps to take after identifying warning signs that someone is experiencing a mental health

crisis, 48% (n = 21) of participants identified two next steps, and 11% (n = 5) identified one step they could take after recognizing warning signs. Additionally, 30% (n = 13) of participants were able to correctly identify how to respond to clients who report suicidal ideation with a plan.

Regarding identification of potential referral sources, 59% (n = 24) of participants were able to correctly identify at least one referral source, and 27% (n = 12) correctly identified three referral sources. The most common referral sources listed by participants included 911/EMS (n = 7), the Houston Hope Line (n = 7), and a counselor/public health department (n = 5). Further, after completing the training, 83% (n = 34) of participants *agreed* (n = 27) or *strongly agreed* (n = 7) that they felt better-prepared to refer someone in mental distress for community, peer, or professional help.

Participants were informed about opportunities to continue this free training and were provided with details on how to register for these courses. They could opt to provide their contact information on the survey if they wished to complete one or more additional trainings offered by Gateway to Hope University: *Mental Health Coach Training, Mental Health Companion Training,* or specialized training focusing on *Substance Abuse and Addiction, Adolescent or Elder Mental Health,* and *Trauma.* Forty-nine percent (n = 20) of participants expressed interest in pursuing additional training.

Lesson Learned

Involving Trusted Community Members in Program Marketing

Attendance at the three program sessions varied widely despite marketing efforts in multiple faith-based agencies. Low attendance at Lot 2540 sessions might have been influenced by timing (Friday and Saturday afternoons), community apprehension toward discussing mental illness, or unfamiliarity with the project coordinator. Recruiting trusted members of Lot 2540 to market and coordinate future programs could improve participation.

In contrast, turnout at Mt. Sinai Baptist Church was high, likely due to the strong relationship between the CCN and program coordinator. This highlights the importance of trust in vulnerable populations for effective outreach and health delivery. Collaborating with trusted community figures, such as faith leaders or influential laypersons, can vouch for the program's value, reduce skepticism, and address stigma.

Aligning session timing with community preferences, such as integrating sessions into Bible studies or lunch programs, could increase accessibility. Leveraging existing events fosters familiarity and reduces participation barriers [16]. Marketing efforts through social media, community newsletters, word-of-mouth campaigns, or co-hosting events with local organizations like food pantries could also expand reach.

Incorporating Community Member Input into Program Design

Another lesson learned was the importance of involving members of faith-based communities in program planning, not just CCNs and partner organization staff. Based on participant feedback on the post-surveys, closed captioning for the synchronous, online intervention sessions would have been helpful. Captioning is not only beneficial for deaf or hard-of-hearing participants but improves all participants' comprehension and memory of concepts.[19] The feedback highlighted a desire for role-play opportunities to practice skills and debrief during

sessions. Role-play, a proven learner-centered strategy, enhances confidence and skill application. Vizeshfar, Zare, and Keshtkaran demonstrated its effectiveness in improving communication and active listening among community health volunteers—key skills for mental health crisis intervention. Incorporating role-play into the program can better prepare participants to navigate sensitive conversations, such as those involving mental health crises or suicidal ideation.[20]

The program was adapted to a live synchronous Zoom format to accommodate out-of-state facilitators, which worked well at Lot 2540. At Mt. Sinai, delivering the program via a large monitor in the sanctuary. This setup, recommended by the pastor and CCN, aligned with participants' usual practices, promoting comfort and familiarity. Despite these adjustments, post-survey feedback highlighted areas for improvement to better meet participants' needs.

Conducting a pre-intervention assessment to understand participants' learning needs, styles, literacy levels, and cultural preferences would further enhance program planning and implementation efforts and address participant feedback prior to implementation. This process would ensure that teaching methods—such as visual aids, storytelling, or peer-led discussions—are appropriately tailored during the planning phase to resonate with participants. Furthermore, pre-assessments can guide program coordinators in making necessary adjustments to pre-designed interventions, ensuring they align with the unique needs of each community.

Adapting the Evaluation Methods

Pre-intervention assessments can also play an important role in program evaluation by establishing a baseline for comparison, which enhances the credibility of post-survey results and demonstrates changes directly attributable to the intervention. While pre-intervention

assessments are a powerful tool, research suggests they are not the only way to confirm learning outcomes. Retrospective post-assessments, for instance, can yield valid insights into participants' progress by addressing biases associated with initial knowledge gaps. [18] However, in this case, a pre-intervention assessment was not conducted due to time constraints, limiting the ability to measure baseline knowledge accurately. Despite this limitation, participants demonstrated enthusiasm and expressed a willingness to continue learning, indicating promising engagement. Future implementations should incorporate pre-intervention assessments when feasible to establish a clearer understanding of knowledge gained and to strengthen the overall evaluation process.

Additionally, some participants left several "fill in the blank" questions on the post-survey unanswered. It was unclear whether this was due to a lack of knowledge about the correct answers or because they did not complete the entire survey. Including focus groups or interviews as part of the evaluation process could provide further qualitative insights that complement quantitative data, capturing a more comprehensive picture of program outcomes. Including formative evaluation strategies, or assessing participant feedback during the program rather than solely post-training, can allow for real-time adjustments, ensuring the program remains responsive to participant needs. Tailored evaluation tools, such as using visual scales, can further enhance accessibility and data quality.

Refining future iterations of the program by integrating participant feedback, role-play opportunities, and real-time evaluation tools can enhance its effectiveness. These adjustments ensure alignment with participant needs and community-specific contexts, promoting greater confidence, engagement, and sustainability in mental health crisis interventions.

Using Low-Cost Pre-Existing Resources to Support Sustainability

This community-based program is low-cost and requires limited resources, making it easy to replicate, implement, and sustain. It can be (a) easily implemented into a variety of settings as participants need not be community experts or have completed pre-existing training, (b) offered in multiple formats (synchronous or asynchronous), and (c) easily duplicated and offered multiple times a year. Remote and virtual group interventions may be beneficial as an increase in telehealth services over the past five years has improved access to care, particularly for behavioral health services, in rural populations.[21]

Value of Partnerships in Bringing Mental Health Training into Community Spaces

Collaborating with faith-based organizations equipped with established CCNs presents a valuable avenue for introducing mental health training into community settings. These partnerships leverage existing platforms where health-related conversations are commonplace, fostering an environment conducive to destigmatizing mental health discussions. Reducing stigma surrounding mental health is paramount, necessitating avenues for increased education, dialogue, and support. Through these partnerships, barriers to discussing mental health are broken down, empowering community members to engage openly without fear or judgment. The significance of these partnerships and the implementation of this program cannot be overstated. As a result, an increasing number of individuals within the Rockingham County community are now better prepared to recognize mental health warning signs, knowledgeable about available support resources, and possess enhanced confidence in providing mental health support within their communities.

Conclusion

Recognition of the unique mental health needs and challenges of rural communities is essential to improving mental health outcomes. Faith-based organizations are well-positioned to

provide support and resources to individuals experiencing a mental health crisis, especially in rural areas where mental health resources are scarce; however, training and resources are needed to ensure that faith-based leaders and members are able to respond to mental health needs within the community.

The identification and implementation of the Empower training program in rural faith-based agencies highlighted the importance of (a) identifying evidence-based approaches, and (b) collaborating with community partners to bring mental health programming into the community. Such programs can help address limited mental health resources in rural communities by engaging community members in outreach efforts to promote mental health resources and respond to mental health needs in the community. This project garnered significant support from local faith-based agencies: There are now 66 trusted members of the faith-based communities in Rockingham County who are trained in mental health crisis intervention, providing a powerful catalyst for building a strong mental health support network.

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Table 1. 2021 Data for Rockingham County compared to North Carolina

	Rockingham County	North Carolina
Race		
White alone	77.5%	70.6%
Black or African American alone	19.0%	22.2%
American Indian and Alaska Native alone	0.6%	1.6%
Asian alone	0.7%	3.2%
Native Hawaiian and Other Pacific Islander alone	0.1%	0.1%
Two or More Races	2.1%	2.3%
Hispanic or Latino	6.3%	9.8%
White alone, not Hispanic or Latino	72.1%	62.6%
Income and Poverty		
Median household income (in 2019 in	$43,579	$54,602
Per capita income in the past 12 months	$24,209	$30,783
Persons living in poverty	18.4%	13.6%
Access to Care Indicators		
Uninsured Adults	16%	16%
Mental Health Providers	760:1	390:1
Quality of Life Indicators		
Poor Mental Health Days (per month)	5.0	4.1
Frequent Mental Distress	16%	13%
Excessive Drinking	17%	18%
Social and Economic Indicators		
Suicides (per 100,000)	16	13

County Health Rankings, 2021[2] *US Census Bureau, n.d*[22]

Figure 1. Post-Intervention Survey Questions

1) Identify four warning signs that someone experiencing mental health crisis may have:

2) After identifying warning signs of someone experiencing mental health crisis, what are next steps you can take to support this individual?

3) After completing this program, I feel better prepared to ask someone if they are thinking of killing themselves.
    a. Strongly agree
    b. Agree
    c. Neither agree or disagree
    d. Disagree
    e. Strongly disagree

4) If someone has a plan to kill themselves, what steps will you take next?

5) Identify three referral sources you will use for clients experiencing mental health crisis:

6) If you are interested in completing the next two levels of the program, which include how to create mental health support groups and becoming a one-on-one coach, please provide your contact information below.

7) Please share a brief example of how you will apply the skills you learned or what you will do differently as a result of taking this training.

8) How can we improve this course for future learners?