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Training Spanish-Speaking Latinx Adults in Mental Health First Aid: A Pilot Feasibility Trial

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ABSTRACT. The dispersion of the Latinx population across the United States has resulted in mental health service gaps in communities that are experiencing rapid growth. We formed a community-academic partnership to assess the feasibility of training Latinx residents in an evidence-based mental health intervention and to pilot outcome measures. Spanish-speaking Latinx adults were trained in Mental Health First Aid (MHFA), a program that provides participants with skills and knowledge about mental health issues. The MHFA training was well-received as evidenced by participants' reported satisfaction with the training and their engagement in the 2 days of training. Twenty-three participants attended the first day of training, and 20 participants attended the second day of training (including two participants who did not attend on Day 1). Results of a paired *t* test indicated significant mean differences in mental health knowledge and help-seeking self-efficacy after training ($d = 0.51$ and 0.75, respectively). Focus group ($n = 13$) results provide further support that the training increased participants' mental health literacy and help-seeking behaviors. Focus group participants also discussed cultural stressors faced by their community that negatively affect mental health and agreed that offering more trainings such as MHFA could help promote mental health in the Latinx community. Training Latinx residents in mental health interventions is feasible and may help address mental health access barriers.

Keywords: mental health literacy, help-seeking behaviors, community partnership, Latinx

Latinxs are the largest and one of the fastest growing ethnic minority groups in the United States (Noe-Bustamante, et al., 2020). In 2019, there were 60.6 million Latinxs living in the United States or the District of Columbia (including Puerto Ricans living on the island), representing 18% of the U.S. population (Noe-Bustamante et al., 2020). The number of Latinxs living in the United States is projected to represent 28% of the U.S. population by 2060 (U.S. Census Bureau, 2018a). The dispersion of the Latinx population across the United States has resulted in rapid growth in the number of Latinxs living in southern and northeastern states that had previously not had many Latinx residents (Stepler & Lopez, 2016). For example, between 2007 and 2014, the Latinx population in southern states increased by 43% (Stepler & Lopez, 2016). In Virginia, the Latinx population nearly doubled between 2000 and 2010 (Sturtevant, 2011–2012) and, more recently, makes up 9.4% of the state population (U.S. Census Bureau, 2018b). This rapid growth has created a

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Latinx "emerging community" (i.e., communities where the Latinx population was initially small but is growing rapidly; Wainer, 2004) in some Virginia areas.

Latinx individuals in emerging communities experience discrimination and other cultural stressors (e.g., acculturative stress, social isolation; Corona et al., 2009; Gonzalez et al., 2013; Perreira et al., 2010), which can negatively affect mental health (Cobb et al., 2017; Corona et al., 2017). Although experiencing these stressors is not unique to living in an emerging Latinx community, individuals in emerging communities often have less access to bilingual mental health services and other bilingual resources that can help individuals cope with these stressors (Bridges et al., 2010; Cameron & Hansen, 2005). A potential solution is to train Latinx residents as community health workers (*promotores*) so that they can better recognize mental health symptoms, combat mental health stigma, and connect community members to mental health services (Barnett, Lau, et al., 2018; Hoeft et al., 2018).

Empowering the Community to Help Itself

Despite experiencing high rates of mental health problems such as depression and anxiety (Alegría et al., 2007), Latinxs, particularly those who are more connected to their ethnic group and/or speak Spanish, are less likely than those who are less connected to their ethnic group and/or speak English to utilize formal mental health care services (Alegría et al., 2008; Keyes et al., 2012). Structural barriers such as lack of culturally and linguistically appropriate services, transportation, insurance, and high treatment costs are associated with decreased or delayed service utilization (Bridges et al., 2010; Parra-Cardona & DeAndrea, 2016). Cultural (e.g., religiosity, gender role expectations) and individual (e.g., mental health stigma, low help-seeking efficacy) factors are also associated with the under-utilization of mental health services (Barrera & Longoria, 2018; Moreno & Cardemil, 2013).

These types of barriers may be exacerbated in emerging communities that have experienced rapid growth in the Latinx population. For instance, community members in emerging communities may experience social isolation and have fewer family and friends who can provide social support, guidance, and other resources during times of stress (Documėt et al., 2015). Moreover, in some Latinx emerging communities, community members are often unaware of the few bilingual mental health services available (Corona et al., 2009). Accordingly, interventions that teach community members how to identify mental health symptoms in others, combat mental health stigma, and connect community members to mental health services may address mental health barriers in emerging Latinx communities.

The roles of community health workers in mental health lay interventions vary greatly from serving as a patient navigator who helps someone access services to implementation of mental health interventions (Barnett, Gonzalez, et al., 2018; Weaver & Lapidos, 2018). Lay health interventions implemented by community health workers can help reduce mental health disparities by reducing access barriers and increasing mental health intervention implementation in areas with limited bilingual mental health providers (Barnett, Lau, et al., 2018; Hoeft et al., 2018). These interventions may also be faster to implement than waiting for organizations to hire enough bilingual mental health providers to address mental health problems in areas experiencing rapid growth.

In the United States, early lay health interventions were focused on addressing physical health issues such as diabetes and obesity, and the behaviors that contribute to these negative health outcomes, such as low rates of physical activity (Ayala et al., 2010; Costa et al., 2015; Spencer et al., 2011). Research has demonstrated that implementing lay health interventions to address physical health disparities is feasible and can positively affect community members' physical health (Ayala et al., 2010; Costa et al., 2015; Spencer et al., 2011). Given this success, attention turned to implementing lay health interventions to address mental health disparities. Recent systematic reviews found that mental health lay interventions are also feasible and show promise in symptom reduction (Barnett, Gonzalez, et al., 2018; Weaver & Lapidos, 2018) and connecting community members to services (Ayala et al., 2010). In sum, prior literature supports the use of mental health lay health interventions in low-resourced areas.

Mental Health First Aid

Mental Health First Aid (MHFA; Kitchener & Jorm, 2002) is an intervention-training program that provides adults with skills and knowledge about mental health. Participants learn how to combat stigmatizing attitudes toward mental health, recognize acute mental health crises in others, and connect peers with helpful resources. MHFA is implemented by

a trained, certified instructor during an 8-hour interactive course delivered in one 8-hour session or two 4-hour sessions. After the training, participants take an examination; those who successfully pass are certified for three years as a Mental Health First Aider. Training Latinx community members in MHFA has the potential to increase MHFA trainees' mental health literacy (i.e., mental health knowledge, help-seeking self-efficacy, mental health attitudes); thereby, empowering them to promote mental health in their community (Jorm, 2012; Kutcher et al., 2016).

Mental Health First Aid has been implemented globally and in the United States with prior studies demonstrating the effectiveness of MHFA training (Banh et al., 2019; Mendenhall et al., 2013; Morrissey et al., 2017). Three systematic reviews, which included studies using a pre-post design, found that training in MHFA improves mental health knowledge, recognition of mental health problems, and decreases mental health stigma (Hadlaczky et al., 2014; Maslowski et al., 2019; Morgan et al., 2018). MHFA has also been shown to improve trainee's mental health help-seeking behaviors and self-efficacy (Bahn et al., 2019; Mendenhall et al., 2013).

Although most of the studies included in the three meta-analyses were conducted in Australia, two reviews (Maslowski et al., 2019; Morgan et al., 2018) included two studies conducted in the United States with adults, which further support the program's effectiveness (Lipson et al., 2004; Mohatt et al., 2017). Other studies in the U.S. further demonstrate the trainings' effectiveness. For instance, using secondary data on MHFA feedback forms obtained from the National Council for Behavioral Health's Database, Crisanti et al. (2016) reported increases in confidence and skills related to mental health literacy in adults trainings' in MHFA. They also found that American Indian/Alaskan Native participants reported lower mental health literacy confidence scores than Latinx, African American, and European American participants. Using a mixed-method design (i.e., pre-post and qualitative methods), Lee and Tokmic (2019) implemented MHFA in a U.S. community that had seen a significant increase in the Latinx and Asian immigrant population. The authors trained primarily White (45%) and African American (38%), English-speaking community-based workers, who were focused on promoting health in an immigrant community. As in other studies, Lee and Tokmic (2019) reported increases in mental health knowledge, and decreases in negative attitudes toward individuals with mental health problems. Other MHFA studies conducted in the United States have focused on members of the Army National Guard and community first responders (Mohatt et al., 2017), university students (Lipson et al., 2014), secondary data analysis of national trainings of MHFA (Bahn et al., 2019), and a primarily European American sample of adults from a rural community (Mendenhall et al., 2013). Although there is a Spanish version of MHFA, this is the first study, to our knowledge, conducted with Spanish-speaking adults living in the United States.

The Present Study

We formed a community-academic partnership, which included mental health professionals from three units at a local university (psychology, social work, medicine), a student advisory team (undergraduates and doctoral students), and two community partner organizations (a nonprofit organization that provides services such as adult education, English literacy classes, citizenship classes, and a nonprofit health clinic). The idea for the present study developed from a roundtable organized by one of the community partners who then invited the first author to facilitate the roundtable. During the roundtable, it became evident that barriers to mental health care for Latinxs in the local community continued to exist despite having identified these barriers nearly a decade prior (Corona et al., 2009). Community members identified MHFA as a potential solution for addressing some of these barriers. After the roundtable, the community-engaged team was formed. Together, the team collaboratively wrote and was successful in obtaining funding to implement the MHFA training (e.g., to pay for the MHFA facilitators) and to support the research (e.g., staff time, participant incentives, community partner honorarium). Accordingly, the team implemented an evidence-based intervention that was not already offered in the community and conducted a mixed-method study to assess the feasibility of this intervention and to pilot the outcomes in a pre-post design.

We conducted a mixed-method study to assess the feasibility of training Latinx adults in an evidence-based mental health intervention and to pilot outcome measures in a pre-post trial. This approach was taken to prepare for a larger randomized controlled trial (Blatch-Jones et al., 2018; Eldridge et al., 2016). Latinx residents were trained in MHFA and completed a short survey pre- and posttraining. To assess feasibility, we collected information on

participant attendance, their satisfaction with the training, and their self-report on their help-seeking self-efficacy and MHFA mental health knowledge. This study also provided us with the opportunity to pilot the outcome measures that were translated into Spanish. We hypothesized that participants' help-seeking self-efficacy and MHFA knowledge (using measures used in prior MHFA evaluations) would increase from pre- to postintervention. Six months postintervention, we conducted focus groups with a subsample of participants. The focus groups provided us with an opportunity to obtain participant perspectives at a longer-term follow-up and in areas measured by the surveys. Specifically, we obtained participants' perspectives of what they learned in the training, and whether they shared this knowledge with others in the community.

Method

Participants

Twenty-five Latinx adults participated in at least one day of the MHFA training. Participants' ages ranged from 18 to 63 ($M = 46.72$, $SD = 12.30$) and slightly over three-fourths identified as women (76%) and less than one-fourth (24%) identified as men. Most (92%) had immigrated to the United States from Latin American countries (e.g., Mexico, El Salvador, Dominican Republic). Participants' educational backgrounds were diverse: 4.2% reported less than a high school degree; 16.7% were high school graduates; 20.8% had attended some college; 29.2% had a college degree; and 29.2% had attended some graduate program and/or had a graduate degree. Participant characteristics are provided in Table 1.

Procedures

Participants were recruited from community partner organizations and were eligible to participate if they (a) self-identified as Latinx, (b) were 18 years and older, and (c) would be able to participate in the MHFA training conducted in Spanish. Flyers were provided to community partners and also posted in their organizations. Flyers provided potential participants with information about the study and also a phone number to call to learn more. Community partners also made announcements about the study and MHFA training to groups in their organization (e.g., a *promotores* group trained for physical health; ESL classes). The Institutional Review Board at Virginia Commonwealth University approved the protocol.

Participants attended two half-day MHFA trainings conducted in Spanish. The first training was held November 5, 2016, and the second training was held November 12, 2016. MHFA trainings took place at a community partner site and were led by certified MHFA trainers who spoke Spanish and English and who were not part

TABLE 1

Participant Characteristics

Characteristics	n	%
Sex		
Women	19	76
Men	6	24
Country of Origin		
Colombia	5	20
Mexico	5	20
Peru	3	12
El Salvaador	2	8
Guatemala	2	8
Honduras	2	8
United States	2	8
Venezuela	2	8
Dominican Republic	1	4
Ecuador	1	4
Education		
Less Than High School	1	4.2
High School Graduate	4	16.7
Some College	5	20.8
College Degree	7	29.2
Some Graduate or Graduate Degree	7	29.2
Language Spoken at Home		
Only Spanish	5	22
More Spanish Than English	13	57
Both Equally	3	13
More English Than Spanish	1	4
Only English	1	4
Language Usually Think		
Only Spanish	7	28
More Spanish Than English	10	40
Both Equally	6	24
More English Than Spanish	1	4
Only English	1	4
Language Spoken With Friends		
Only Spanish	7	28
More Spanish Than English	8	32
Both Equally	8	32
More English Than Spanish	1	4
Only English	1	4

of the research team. Participants were given a MHFA workbook, breakfast and lunch, and small raffle prizes for attending the MHFA sessions. Twenty-three participants attended the first day of training, and 20 participants attended the second day of training (including two participants who did not attend on Day 1). Prior to and immediately after the trainings, participants completed a short questionnaire that assessed MHFA knowledge and help-seeking self-efficacy. Six months postintervention, 13 trainees participated in a focus group that lasted approximately two hours and was held at a community partner site. Focus group participants were provided with lunch and $40 for their time and effort.

Measures

All study materials were available in Spanish and English. Whenever possible, we used existing Spanish translations of measures (i.e., MHFA satisfaction measure, MHFA workbook). All other questionnaires and study material (i.e., consent forms, focus group questions) were translated from English into Spanish using a combination of the translation by committee and back-translation approaches (Knight et al. 2009; Marin & Marin, 1991; Sireci et al., 2006). Study material was first translated into Spanish by a bilingual project coordinator. Next, two different bilingual project coordinators back-translated the study material into English and discrepancies were discussed with a fourth translator and a final determination was made. Our community partner reviewed and provided feedback regarding Spanish translations to ensure all measures were culturally and linguistically relevant to the local community.

Sample Characteristics

Participants were asked to report their birthdate; sex; race and ethnic background; where they were born; the highest grade in school they had completed; and their language use when speaking at home, with friends, and that they usually think in.

Quantitative Data: Outcome Measures

MHFA Knowledge. Participants (see Table 1) answered 17 true or false questions based on the content of the MHFA training (Bond et al., 2015). Example items include, "It is best not to try to reason with a person having delusions" and "People with mental illnesses are much more likely to be smokers." Items were summed and higher scores indicated greater MFHA knowledge. Scores can range from 0 to 17.

Help-Seeking Self-Efficacy. Participants answered four items used in prior MHFA evaluations to assess their help-seeking self-efficacy (Bond et al., 2015; O'Connor & Casey, 2015). Sample items include, "I feel knowledgeable about mental illness resources" and "I feel comfortable talking about mental health issues with my family." Items were rated on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Items were summed so that higher scores represent greater help-seeking self-efficacy (α = .92 at pre- and .78 at postasseessment). Scores can range from 0 to 20.

Mental Health Literacy (MHL) Confidence. After the second day of training, participants answered nine items assessing their perceived confidence in applying the skills and knowledge taught in the course. Ratings were made using a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Sample items include, "As a result of this training, I feel more confident that I could ask someone if they are considering suicide." Items were averaged with higher scores representing greater MHL confidence (range of scores = 0 to 45; α = .91).

Course Satisfaction. After the second day of training, participants answered four items assessing their satisfaction with the MHFA course content, and three items assessing the competency of each facilitator. Ratings were made using a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Sample items include "Course content was practical and easy to understand" (satisfaction with course content) and "The instructor demonstrated knowledge of the material presented" (perceived facilitator competence). Items were averaged with higher scores representing greater satisfaction regarding course content (range of scores = 0 to 20), and perceived facilitator competence (range of scores = 0 to 15). Open-ended questions were also asked to assess the strengths and weaknesses of the program and how it could be improved.

Qualitative Data: Focus Groups

Semistructured Interview. Participants were asked to share (a) what they learned from the MHFA training; (b) how they shared what they learned about MHFA with others in their community; and (c) whether they think other Latinx residents would participate in a mental health intervention program that is led by community residents and what the barriers and supports would be to that participation.

Data Analysis Plan

Participants who completed both preintervention and postintervention surveys were included in the current analysis ($N = 20$). Two particpants had one missing data point at pretest; two additional particpants had one missing data point at posttest. These were determined to be missing at random, and values were imputed via simple mean substitution using the mean value of knowledge and help-seeking self-efficacy, respectively, at pre- and postintervention. Within-group differences in help-seeking self-efficacy and MHFA knowledge before and after the intervention were calculated using paired-sample *t* tests. Statistical analyses were performed using SPSS (IBM Corp., 2017); *p*s less than .05 were considered statistically significant.

Focus group data were coded using a thematic analysis approach (Braun & Clark, 2006). First, the coders became familiar with the data by reading and rereading the transcript and writing down notes and impressions. In the second step, the coders developed general initial codes from the data using open-coding, which allowed the coders to generate new codes as they reviewed the transcript and to modify existing codes. In Step 3, coders examined the initial codes, identified themes, and then searched for themes. Next (Step 4), coders reviewed the themes to ensure that they captured the data/initial codes and, in Step 5, the coders further defined themes and created a thematic map. Step 6 was to write up the findings. Two team members participated in this coding process (the first and eleventh author). Both team members have extenssive experience conducting qualitative studies and coding qualitative data, are bilingual (English-Spanish), and Latinx. Trustworthiness in the qualitative process was achieved through team member triangulation, documentation of thoughts and notes, use of a coding framework, and team consensus (Nowell et al., 2017).

Results

Quantitative Findings

Overall, participants in this sample were engaged in the MHFA training as evidenced by the fact that 80% attended both days of training. We found no significant demographic differences (i.e., age, sex, education, language preference, country of origin) between those who completed both sessions and those who only attended one session. Among those who completed both sessions, participants' satisfaction with the course content ($M = 4.65$, $SD = 0.50$, range = 3 to 5), perceived competence of the instructor ($M = 4.89$, $SD = 0.30$, range = 4 to 5), and MHL confidence ($M = 4.61$, $SD = 0.43$, range = 3 to 5) were high. In responding to open-ended questions about the training, participants shared that it was "excellent," that they "learned a lot," and several participants noted that having a bilingual facilitator was very important. The one area participants highlighted as a potential area for improvement was the amount of time with numerous participants noting that the "training time was too short."

Regarding help-seeking self-efficacy, results of a paired *t* test indicated significant mean differences in help-seeking self-efficacy preintervention ($M = 13.78$, $SD = 4.72$, range = 4 to 20) and postintervention ($M = 16.94$, $SD = 2.54$, range = 12 to 20), $t(19) = -3.24$, $p = .005$ ($d = 0.75$). However, 10% of the sample reported lower self-efficacy postintervention than at Time 1, and 10% had no change in self-efficacy following the intervention. Pretest surveys indicated that participants, on average, answered 9.19 out of 17 mental health knowledge questions ($SD = 1.93$, range 5 to 14) correctly. Following the intervention, the average number of correct items was 10.50 ($SD = 1.7$, range 6 to 15). Results of a paired *t* test indicated that this was a statistically significant increase in mean mental health knowledge from preintervention to postintervention, with participants increasing their knowledge on average by 1.31 points, $t(19) = -2.50$, $p = .003$ ($d = 0.51$). However, it should be noted that nearly 20% of our sample scored *lower* on mental health knowledge at postintervention than they did at baseline, 8% of the sample received the same score at preintervention and postintervention, and 72% improved their knowledge score.

To examine factors that distinguished between those who improved and did not improve following the intervention, a series of exploratory chi-square and independent-samples *t* tests were conducted to examine associations between sociodemographic factors (i.e., sex, language, birthplace, age when came to the United States) and postintervention change. A dichotomous variable was created to distinguish between those who did not increase help-seeking self-efficacy following the intervention (no or negative change = 0), and those who did (change = 1). The categories for the language preference variable included only Spanish, more Spanish than English, both equally, and only English (although the variable originally had 5 categories, no participants in the subsample indicated that they spoke more English than Spanish). Results indicated that only language most frequently spoken at home was

significantly associated with group membership. In particular, participants who reported speaking Spanish or mostly Spanish at home were more likely than expected to be in the "improved" (n=10) group than the no improvement group (n=0), $X^2(3) = 7.8$, $p = .01$. No significant associations were found for sociodemographic variables and improvement in mental health knowledge.

Qualitative Findings

Three themes emerged from the thematic analysis that further support the feasibility of training Latinx in MHFA. The themes include (a) cultural stressors, (b) improved mental health literacy (e.g., mental health knowledge, causal attributions), and (c) mental health help-seeking behaviors. Figure 1 depicts the three emergent themes, including how they are interrelated.

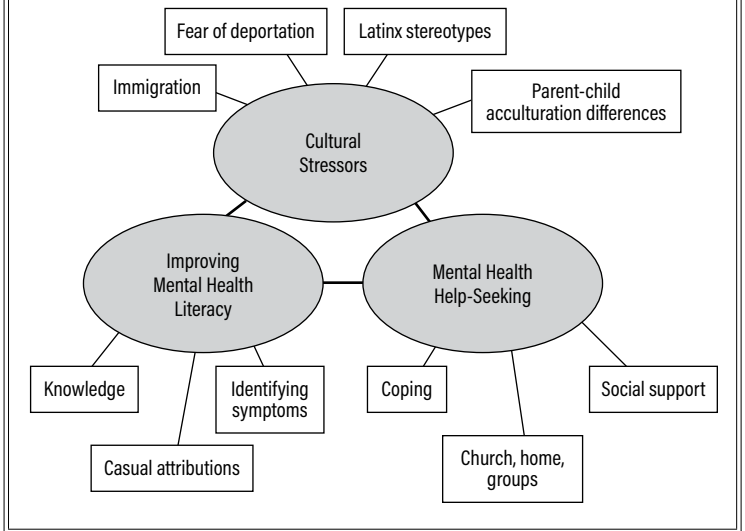
Cultural Stressors

Focus group participants pointed out that many individuals in their community were experiencing depression and stress, and they associated these mental health problems with cultural stressors. Specifically, participants talked about fear for themselves, their children, and community associated with being Latinx and/or an immigrant in the current political climate. For instance, one participant shared, "La comunidad Latina está viviendo miedo y estrés por inmigración, sin saber cómo manejar esa situación. Me he fijado que está constantemente viviendo en miedo y eso causa estrés y ese estrés causa otras enfermedades." [The Latinx community is experiencing fear and stress from immigration, without knowing how to handle this situation. I have noticed that it is constantly living in fear and that causes stress and that stress causes other illnesses]. One participant said:

> Y en la comunidad Latina yo creo que la situación de inmigración está afectando a muchas personas causando mucha nostalgia, y mucho estrés y está causando otras enfermedades de salud, ya sean mentales o si las expresamos en forma de enfermedad física. [And in the Latina community I think that the immigration situation is affecting a lot of people, causing a lot of nostalgia and stress, and it is causing other illnesses, whether they be mental health illnesses or whether we express them in the form of physical illnesses].

FIGURE 1

Thematic Analysis Map



Improving Mental Health Literacy

Participants overwhelmingly shared that they appreciated the MHFA training and that they learned new information about stress, depression, and identifying mental health symptoms. A participant shared, "Aprendí a distinguir las diferencias en desordenes y enfermedades mentales. Y que, aunque muchos tengan síntomas parecidos, no significa que tengan la misma enfermedad." [I learned to distinguish the differences between disorders and mental illness. And although many have similar symptoms, it does not mean they have the same disease]. Several participants further shared that what they learned was personally relevant to themselves or family members who may be struggling with mental health problems such as depression. For instance, a participant expressed

> Pero lo que yo aprendí fue sobre la depresión. O sea, yo estaba deprimida, pero yo no sabía que era depresión. Pero cuando yo aprendí lo que era, yo dije "guau." Y ahí reconocí que yo necesito aprender a hacer algunas cosas, para no tomar las cosas tan a la ligera porque por eso me deprimía. [But what I learned was about depression. I mean, I was depressed, but I didn't know it was depression. But when I learned what it was, I said "wow." I recognized that I need to learn to do some things, so as not to take things so lightly because that is why I was depressed].

Similarly, another participant expressed

> Yo también tengo mi experiencia con la depresión, este … yo la he vivido, ha sido difícil salir [de la depresión]. Creo que lo principal de que aprendí en el grupo es a buscar ayuda. Muchos lo reconocemos y no lo queremos aceptar. No queremos buscar la ayuda. [I also have my experience with depression, um ... I have lived with depression. It has been difficult to reduce it [the depression]. I think the main thing that I learned in the group is to seek help. Many of us recognize it and we do not want to accept it. We do not want to seek help].

Finally, participants also talked about gaining a better understanding of the factors that may affect an individuals' mental health (i.e., causal attributions about mental health disorders, mental health stigma). One participant shared, "Y por ultimo que hay un estigma muy fuerte con el tema de la depresión. Uno dice que alguien está deprimido y la gente te mira como una cosa rara." [And finally that there is a very strong stigma on the subject of depression. One says that someone is depressed and people look at it as a strange thing]. Other participants talked about how the cultural value of machismo may make it difficult for men to express feelings of depression. For instance, one participant said, "Entonces no podemos dejar afuera a los hombres porque también los hombres sufren mucho de depression… Ellos tienen mucha depresión, pero les cuesta hablar." [So we cannot leave men out because men also suffer a lot of depression… They have a lot of depression, but they find it difficult to speak.] Other participants agreed with this statement and mentioned it being related to the cultural value of machismo (e.g., "It is for machismo" was said in response to the prior participant's statement).

Mental Health Help-Seeking

Focus group responses provide some insight into why mental health help-seeking may be low. Specifically, participants mentioned that people in the community are suffering from stress and depression, but that people do not know where to go for help or that they do not seek help because of stigma or fear related to the political climate. One participant shared

> Hay mucha gente en la comunidad de nosotros que no está informada. Ellos no están guiados. Están por tirar la toalla y devolverse a sus países por la depresión que tienen tan grande. No saben qué hacer. Buscan información, pero no hay un lugar donde puedan recibir ayuda e información. Tienen miedo de salir. Tienen miedo de hacer cosas que antes no lo tenían. Eso trae mucha depresión. Hay demasiado miedo. [There's a lot of people in our community who are not informed. They are not guided. They are about to throw the towel and return to their countries because of depression. They do not know what to do. They seek information, but there isn't a place where they can receive help and information. They are afraid to leave. They are afraid of doing things that they didn't have before. That brings a lot of depression. There is too much fear.]

However, participants noted that the training helped them increase their help-seeking self-efficacy and also that they used what they learned in the MHFA training to cope themselves or to help their family/friends. A participant shared "Aprendí a controlar las emociones de depresión " [I learned to control the emotions of depression]. Participants mentioned that, since the training, they used what they learned to help others at home, church, and groups they belong to, such as a group for parents who have children with disabilities.

Discussion

The goals of the present study were to determine the feasibility of training Spanish-speaking Latinx adults in MHFA and to pilot outcome measures (that were translated into Spanish) in a pre-post design. Most existing literature has examined the implementation of MHFA training in English, including some studies that included English speaking Latinx individuals (Banh et al., 2019; Hadlaczky et al., 2014; Lee & Tokmic, 2019; Mendenhall et al., 2013; Morgan et al., 2018). To our knowledge, this is the first study that evaluated the implementation of MHFA in a Spanish-speaking sample living in the United States and that piloted Spanish versions of the outcome measures.

Results from the present study demonstrate the feasibility of training Spanish-speaking Latinx community residents in MHFA. Specifically, the MHFA training was well-received as evidenced by participants' reported satisfaction with the

training and their engagement in the two days of training (80% attended both days of training). Consistent with previous research demonstrating the effectiveness of MHFA training (Banh et al., 2019; Mendenhall et al., 2013), the present study found that mean scores on help-seeking self-efficacy and MHFA knowledge increased between pre- and posttests, reflecting that Spanish-speaking participants reported being more comfortable with help-seeking behaviors, had a better understanding of available resources, and knowledge about MHFA after being trained. Indeed, research has demonstrated that interventions adapted to focus on specific cultural groups and those that are provided in an individual's native language are more effective than nonadapted interventions (Soto et al., 2018). Although no other adaptations were made to the MHFA intervention in the present study, it is possible that additional cultural adaptations (e.g., incorporating metaphors) could further enhance the interventions' effectiveness and trainee's satisfaction. In a meta-analysis of culturally adapted mental health interventions, Soto et al. (2018) found larger treatment effects in studies that had more cultural adaptations.

To obtain a better picture of whose help-seeking self-efficacy and MHFA knowledge scores improved, exploratory analyses were conducted. Specifically, we found that participants who reported speaking mostly Spanish in their households were more likely to be in the group whose help-seeking efficacy scores improved after the training, compared to the group whose scores did not improve. First, it is possible that participants differed in their language fluency in Spanish. Perhaps individuals who did not primarily speak Spanish at home (21% of participants) would have felt more comfortable engaging in the training and learned more in a group with peers who were speaking English. It is also possible that participants who primarily speak Spanish at home adhere more to Latinx cultural values (e.g., personalismo, familismo) that can affect treatment engagement and outcomes (see Bernal & Domenech Rodríguez, 2012).

A second goal of the present study was to pilot the outcome measures that were translated into Spanish. Although we piloted outcome measures that have been used in prior MHFA evaluations, not all item sets demonstrated adequate internal consistency, and our sample size does not permit us to make any practical conclusions about the psychometric properties of these brief item sets. For example, we attempted to measure participant's attitudes towards mental health, but those item sets had low reliability ($\alpha = .43$) and were therefore not included in analyses. Accordingly, more work is needed to determine the measure equivalence (Chávez & Canino, 2005) of existing MHFA measures when translated into different languages. This finding also highlights the benefit of conducting mixed-method research when culturally adapting interventions. The addition of qualitative data provides researchers with an additional data point when measures being piloted do not demonstrate cross-ethnic equivalence or when participants have mixed reactions to cultural adaptations (see Crooks et al., 2018, for results of a cultural adaptation of MHFA in First Nation contexts). Indeed, findings from the focus groups provide support that the training resulted in perceived increases in participants' mental health literacy including their knowledge of mental health symptoms, which is consistent with findings from quantitative studies (Banh et al., 2019; Morgan et al., 2018).

Three themes emerged from the focus groups that are consistent with prior quantitative findings regarding improvements in participants' mental health literacy after MHFA training. Specifically, focus group participants noted increases in their mental health literacy, and they also emphasized the role of cultural stressors in mental health. For instance, many participants mentioned that the Latinx community is experiencing cultural stressors such as deportations and the negative political climate surrounding Latinx individuals and immigrants, which in turn is negatively affecting their mental health. Additionally, participants reported that fears related to immigration were the main contributor to mental health symptoms in their community.

Given the timing of when this study was conducted, it is important to consider the impact of the 2016 election, as the anti-immigration and specifically anti-Latinx rhetoric has had an immense impact on the well-being of the Latinx community within the United States. Media reports have consistently documented a decline in mental health and emotional well-being of Latinx individuals after the 2016 election (Ritter & Tsabutashvili, 2017; Viser, 2017). Several studies have found that more severe exclusionary immigration policies are correlated with psychological distress and negative mental health outcomes, such as social isolation, fear of family separation, anxiety, and depression (Becerra et al., 2020; Bruzelius & Baum, 2019; Hatzenbuehler et al., 2016; Vargas et al., 2017).

In a qualitative study of a mental health support group for Latinx immigrants, Jalisi et al. (2018) found that, after the election, participants reported being reluctant to report crimes, avoiding public places, limiting family outings, and experiencing anxiety due to fears of deportation and family separation. Additionally, Krupenkin et al. (2019) found a statistically significant increase in online searchers of mental health related terms (such as "therapy," "depression," "suicide," or "anxiety") between May 2016 and December 2017 specifically among Spanish-speaking users; they did not find the same increase for English-speaking searchers. It is important to note that these negative outcomes are not only experienced by undocumented individuals; documented immigrants may experience fear by association and anxiety for friends and relatives that may be undocumented (Ayón & Becerra, 2013; Vargas et al., 2017). These studies not only provide a better understanding of the stressful climate for our research sample, but also highlight the need for a promising and feasible mental health intervention, such as MHFA, that can be implemented with this population.

Participants further shared how the knowledge they learned in the MHFA training helped them understand their own experiences. Using semi-structured interviews with undergraduate nursing students in Hong Kong, Hung et al. (2019) found that training in MHFA improved participants self-awareness of their own mental health status. Although MHFA is not designed as a mental health intervention that reduces trainee's symptoms, Kitchener and Jorm (2004) reported that training in MHFA improved Australian trainee's mental health. Together, these findings suggest the inclusion of mental health symptom measures in future MHFA evaluations to assess the impact of MHFA on trainee's own mental health.

Limitations and Implications for Future Research

Despite these promising results, the present study is not without limitations. First, the sample included 25 Latinx adults and, of those 25, only 20 participants completed both days of training. It is important to note that the second day of training occurred the weekend immediately following the 2016 election. Given the political climate surrounding Latinx immigrants during that election (Lopez et al., 2018), we actually expected fewer community members to attend. We believe retention was aided by the trust that has been established between the research team, community partners, and members of the community. It is also possible that the community's desire to learn and help one another in promoting mental health further contributed to their engagement in this project. In addition, the majority of participants in this sample had some college education so the findings may not generalize to Latinx individuals from more diverse educational backgrounds. Although we attempted to assess mental health knowledge using a measure that has been used in prior MHFA evaluations, this measure demonstrated poor reliability in this study. Additionally, the current study did not compare the effectiveness of the MHFA training program against a control or comparison group. Finally, although findings from the focus groups provide additional evidence of participants' perceived benefits of the MHFA training, we did not conduct member checking of the qualitative findings.

Results from the present study also highlight potential areas for future research. First, future studies should enroll a larger, more diverse sample, randomize participants into intervention and control groups, and include reliable and valid measures (in English and Spanish) of mental health knowledge, help-seeking behaviors, stigma, and mental health literacy. Using a longitudinal design would allow for an examination of how participants implemented what they learned in the training in their communities and whether improvements in outcomes are sustained. In a meta-analytic review, Morgan et al. (2018) identified only two studies that assessed outcomes beyond 6 months. Future studies could also assess the sustainability by exploring whether community members who were trained would be interested in being recertified as MHFA trainers. Further, more research is needed that includes the help-seeking behaviors and mental health outcomes of individuals who are the recipient of MHFA behaviors by trainees (Chowdhary et al., 2019; Maslowski et al., 2019; Morgan et al., 2018). Finally, this type of community-based intervention may be especially relevant given the disproportionate impact that the COVID-19 pandemic has had on the Latinx community. Latinxs are at high risk of contracting COVID-19 (Webb Hooper, Nápoles, & Pérez-Stable, 2020) and/or knowing someone who has the virus (Johnson, Ferno, & Keeter, 2020). Thus, it is not surprising that the fear and concern about contracting COVID-19 is more prevalent among vulnerable populations, including Latinx individuals, and that this fear is associated with increased mental health problems (Fitzpatrick, Harris, & Drawve, 2020).

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