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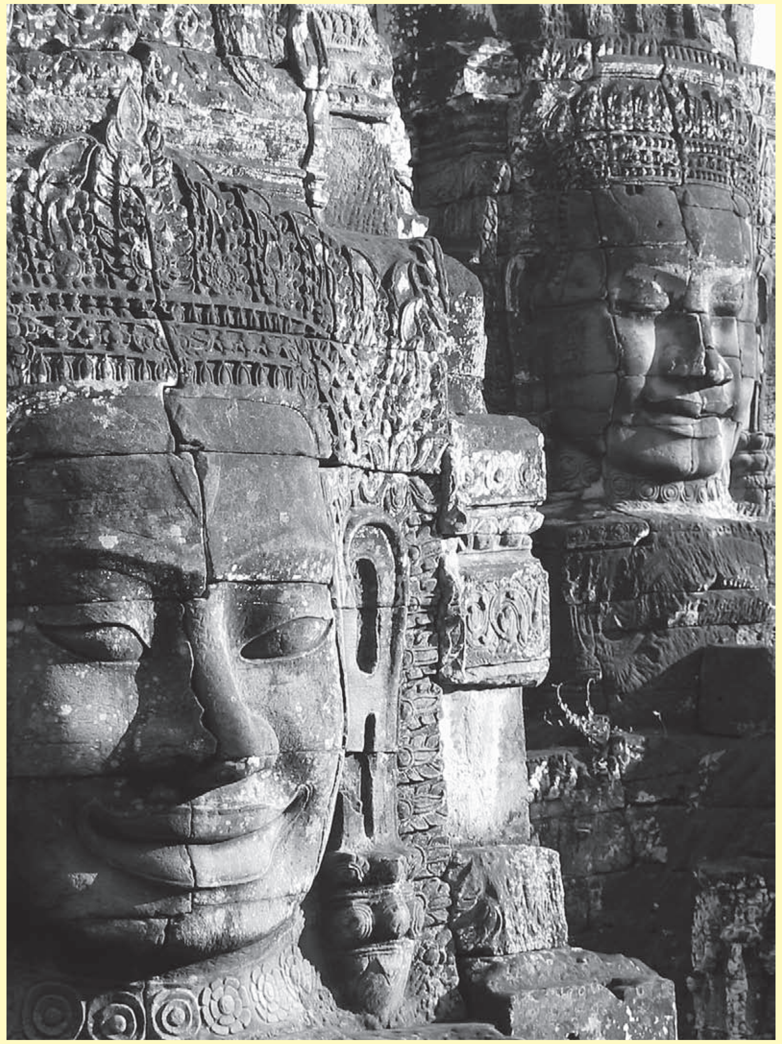

Ethnicity & Disease

Official Journal of ISHIB

Volume 21, Number 3
Supplement 1

Partnered Participatory Research to Build Community Capacity and Address Mental Health Disparities and Disasters

Ethnicity & Disease

Official Journal of ISHIB

Ethnicity & Disease is an international journal that exclusively publishes information on the causal relationships in the etiology of common illnesses through the study of ethnic patterns of disease. This peer-reviewed journal publishes original reports, reviews, editorials, special articles, commentaries, brief reports, book reviews, and letters on such topics as ethnic differentials in disease rates, the impact of migration on health status, social and ethnic factors related to healthcare access, and metabolic epidemiology. A major priority of the journal is to provide a forum for exchange between the United States and the developing countries of Europe, Africa, Asia, and Latin America.

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About ISHIB

ISHIB is a professional medical organization providing education, advocacy and research on high blood pressure and related risk factors in ethnic populations. ISHIB was founded in 1986 to respond to the problem of high blood pressure among ethnic groups. Today, its organizational scope includes diabetes, stroke, lipid disorders, renal disease, and other related cardiovascular risk factors. The objectives of the Society are:

- to promote public awareness of the harmful effects of hypertension and related risk factors, especially among ethnic minority populations;
- to develop health-related programs to improve the quality of life in ethnic populations worldwide;
- to educate the public on ways to prevent the complications of hypertension and other related cardiovascular diseases;
- to stimulate research and clinical investigation;
- to disseminate scientific findings to aid in the understanding of differences in hypertension and related risk factors among ethnic populations.

Accredited Professional Educational Programs

In cooperation with leading healthcare institutions, ISHIB develops and implements accredited educational programs for physicians, nurses, pharmacists, and other allied health professionals who care for ethnic patients with hypertension and other co-morbid cardiovascular diseases.

Patient and Community Education

To promote public awareness about the dangers of high blood pressure and related cardiovascular diseases, the Society conducts patient and community education programs throughout the year. Programs are designed to meet the needs of the community and have included a children's program to help young people reduce risk factors related to hypertension and adult programs to help adults take preventive approaches in maintaining healthy lifestyles. The ISHIB focus includes health promotion, disease prevention and treatment, as well as community-based research initiatives.

Research

The Society's research unit conducts clinical trials related to hypertension prevention, treatment and management as well as data gathering and analysis of current disease trends. ISHIB is highly regarded as a resource for protocol development, study management, and patient recruitment.

International Interdisciplinary Conference

The Society sponsors an annual international conference. Begun in 1985, the conference attracts recognized lecturers and an impressive audience of international health professionals who gather to learn from each other, debate the utility of current practices and theories, present never-before published research, and continue to build the solutions to eliminating the disproportionate rates of disease among ethnic populations.

Worship-Site Health Education Program

ISHIB coordinates this program that brings speakers to congregations to discuss hypertension and related cardiovascular diseases. On-site blood pressure screening and community information accompany the presentations.

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Partnered Participatory Research to Build Community Capacity and Address Mental Health Disparities and Disasters

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CONTENTS

VOLUME 21, NUMBER 3, SUPPLEMENT 1

FOREWORD: From the Editors

INTRODUCTION

MENTAL HEALTH INFRASTRUCTURE AND TRAINING PROJECT

FOREWORD

PARTNERED PARTICIPATORY RESEARCH TO BUILD COMMUNITY CAPACITY AND ADDRESS MENTAL HEALTH DISPARITIES AND DISASTER

Benjamin F. Springgate, MD, MPH; Kenneth B. Wells, MD, MPH

Key Words: Community-partnered Participatory Research, Community-based Participatory Research, Collaborative Care, Disaster, Mental Health

Community-partnered participatory research (CPPR), established in the paradigm of community-based participatory research, represents a relatively recent innovation in the field of mental health services research.[1] As part of a public health model, CPPR offers a potentially advantageous framework to address mental health needs in response to population-level emergencies and large-scale disasters.[2–3] During the last five years, we have documented the development of this field through a series of special issues of *Ethnicity* & *Disease*.[4–5] The first offered models that address disparities in mental health in pilot studies.[4] The second outlined a more generalizable model to frame CPPR initiatives.[5] In this issue, we present recommendations from several centers that are developing the CPPR field; we offer examples of application of CPPR for mental health services within a large services delivery demonstration following a major disaster; and we present several projects developed through a CPPR center, as well as two other related CPPR projects.

As co-editors of this volume, and as co-leaders along with multiple other academic and community partners represented in these pages, we would like to make a few comments from a more personal perspective about developing, participating in, and reflecting on the impact of CPPR mental health services projects. First, we generally have found that approaches that explicitly address enhancing community engagement and partnership in research are highly suited to address mental health issues. Stigma surrounding mental health, unaddressed disparities, and limited popular knowledge of opportunities for treatment and recovery make community engagement in research all the more important. From a community perspective, such trust-based engagement may play a critical role in increasing the value of academic partners as resources to solve issues of access and unmet need. For example, if engagement is aligned suitably with community traditions and strengths, it may help to increase awareness of proven and effective outreach, screening, education, or treatment strategies. Further, the introduction of research holds promise to increase evidence and improve planning and effectiveness of care in the long-run.

Second, we would like to comment on the importance in this work of having committed, knowledgeable community partners, who are able to foster the trust of the community and can help engage the community in sensitive topics such as mental health. This topic may require frank, longitudinal community-academic dialogues to begin to share, appreciate, and accommodate diverse perspectives. These dialogues may be supported by efforts to get to know community programs and leaders before engaging them in strategies for change or research. In our cases, we have had numerous partners who have been generous and applied their expertise across a range of services improvement and research efforts. Some of these partners are represented in this volume, but such work cannot be done without dozens and even hundreds of partners who contribute to various steps and activities, in the service of both research and two-way capacity building.

Third, we have learned that such work progresses incrementally, rather like a quality improvement or community learning paradigm, with stages of discovery, stages of change, and stages of evaluation and research. Thus, we have learned to value steps both large and small; and to value the potential of discovery in each step, including understanding how to conduct research while building capacity to address disparities in mental health. Partly for this reason, why we thought it would be important to acknowledge diverse projects and steps within the same issue, in order to stimulate thought and discussion about the larger lessons and opportunities.

What are those larger lessons? One is that mental health is an important topic for community-engaged research. Another is that mental health features centrally in the long-term recovery process from major disasters and a partnered

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approach makes it possible to develop and implement evidence-based approaches to recovery at scale. Yet another reason is that extending partnerships to new types of partners within the same community can raise important new issues and opportunities that broadens the overall approach and its effectiveness. We are in the early stages of observing both similar and unique issues in community engagement and partnered research that emerge across different communities and projects. At the same time, we have found it possible to share frameworks, lessons, protocols, and toolkits across communities and projects, and at times to share the experiences and contributions of partners across projects and communities. Some of these relationships are apparent in the authorship of articles in this issue, and some will become more apparent as later stages of these projects are published. Finally, we note that capacity building within vulnerable communities in the area of mental health is both effective and satisfying for academic and community investigators and participants, permitting both early- and longer-term impacts that complement and reinforce the value of the partnered research endeavor.

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INTRODUCTION: PARTNERED PARTICIPATORY RESEARCH TO BUILD COMMUNITY CAPACITY AND ADDRESS MENTAL HEALTH DISPARITIES AND DISASTERS

(*Ethn Dis.* 2011;21[Suppl 1]: S1-3–S1-4)

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During a February 21, 1998 radio address, then President Clinton announced the launching of a new Racial and Ethnic Health Disparities Initiative. ''By the year 2010, we must eliminate racial and ethnic disparities,'' he said. ''America has the best health care in the world… but we can't take full pride in that system until we know that every American has the best health care in the world,'' Clinton declared.

Americans are still struggling with how to make health, especially mental health, care treatment and delivery equitable for all groups. Despite ongoing efforts to eliminate health care disparities, they continue to exist. In fact, recent studies have found that mental health care disparities are increasing.[1,2] In this special supplement, the articles present unique and important new findings on efforts where researchers directly partnered with community leaders and members from underserved communities to improve mental health care. Their collaborative efforts built community capacity to eliminate mental health disparities and to address disasters that had occurred in these underserved communities.

Traditional research methods are likely inadequate to solve the longstanding problems with disparities in mental health care because they do not adequately take into account community context. Community partnered participatory research brings the best and latest research techniques to the major issues affecting community health by bridging community expertise and rigorous academic methods to develop community-appropriate interventions. The origins of disparities lie in individuals, physical and social environments, as well as health care and public policies. It is imperative that underserved communities participate equally in developing strategies that eliminate disparities. Herein, 13 articles provide cutting edge information on community partnered approaches toward improving mental health care.

Four articles focus on methodological issues essential for developing community partnered work. In *Community Based Partnered Research: New Directions in Mental Health Services Research*, we present findings from a national conference bringing together researchers and their community partners focused on eliminating mental health disparities. Second, *Partnered Evaluation of a Community Engagement Intervention: Use of a Kickoff Conference in a Randomized Trial for Depression Care Improvement in Underserved Communities* provides a leading edge perspective on bringing the community to the table to begin a community partnered randomized trial. In *The Partnered Research Center for Quality Care: Developing Infrastructure to Support Community-Partnered Participatory Research in Mental Health*, we describe a National Institute of Mental Health funded Center that supports diverse community partnered research efforts. Finally, in *Participatory and Social Media to Engage Youth: From the Obama Campaign to Public Health Practice* important new technologies for engaging communities are discussed.

Also in this special supplement, five articles focus on community partnered research conducted in post-Katrina New Orleans to aid recovery. In *Community Perspectives on Post-Katrina Mental Health Recovery in New Orleans*, community members describe the challenges and lessons they learned in helping rebuild mental wellness, resilience, and recovery in New Orleans following Katrina. In *Building Capacity for Cognitive Behavioral Therapy Delivery for Depression in Poor Disaster-Impacted Contexts*, work to implement a proven intervention for depression is described. In *Building Community Resilience through Mental Health Infrastructure and Training in Post-Katrina New Orleans*, a major program to improve the infrastructure to provide mental health services to the post-Katrina New Orleans community is described and evaluated. A large effort to provide collaborative care by integrating a novel role for community health workers into mental health teams is described in *Community-Based Participatory Development of Community Health Worker Mental Health Outreach Role to Extend Collaborative Care in Post-Katrina New Orleans*. Participants' experiences with this approach are described in *Opportunities and Challenges of Implementing Collaborative Mental Health Care in Post-Katrina New Orleans*.

Underserved communities have many strengths to build upon to improve mental health. Among these assets in many communities is spirituality. In two articles, researchers describe an exciting new, community-partnered venture to holistically address unmet mental health needs in the Los Angeles African American community by integrating spirituality. In the first, *Project Overview of the Restoration Center Los Angeles: Steps to Wholeness – Mind, Body and Spirit*, we view the recommendations of an active planning committee's effort to address depression in the African American community in Los Angeles. Authors address the unique challenges and facilitators that arise with diverse partners and perspectives working toward a similar goal in *Addressing Unmet Mental Health and Substance Abuse Needs: A Partnered Planning Effort Between Grassroots Community Agencies, Faith-based Organizations, Service Providers, and Academic Institutions*.

Finally, two studies focus on the important area of community partnered research to improve the mental health of youth. In the first, *Effects on School Outcomes of Low-Income Minority Youth: Preliminary Findings from a Community-Partnered Study of a School Trauma Intervention,* the authors provide data suggesting that treating trauma among youth improves academic performance. A second article, *Strengthening Families of Children with Developmental Concerns: Parent Perceptions of Developmental Screening and Services in Head Start*, addresses the important, yet controversial area of early child mental health screening, and provides important data on parent perceptions and concerns.

Together, these articles lay the groundwork for developing research necessary to truly eliminate mental health and mental health care disparities. Each article provides insights from both researchers and community members, a unique blend that moves beyond our current knowledge.

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THE MISSING PIECE MEETS THE BIG O: DISASTER MENTAL HEALTH RECOVERY AND COMMUNITY RESILIENCE

(*Ethn Dis*. 2011;21[Suppl 1]:S1-5–S1-7)

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Key Words: Mental Health, Disaster, Resilience

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Evolving concepts of disaster management place significant emphasis on the concept of resilience. In physics, resilience is the ability of an entity to resume its original form after it has been deformed or stressed. As applied to emergency preparedness and response, it means that a community should be able to handle a disaster and return to normal. The concept of resilience suggests that day-to-day, pre-event community practices, as well as what happens during the emergency response, have profound implications for quality of recovery, and hence, resilience. Resilience and recovery planning have traditionally focused primarily on rebuilding the physical infrastructure and ensuring the restoration of commerce. Making sure that individuals and families have a place to call home, and that medical care, grocery stores, schools and child care, and businesses bounce back quickly are of vital importance to the success of recovery from a disaster. Successful recovery is also dependent on how well-prepared a community is to cope with the disaster, (what it has planned for) and how well organized the acute response is. Both rest on a strong commitment to planning and on relationships between local, state and federal governments and agencies.

However, even when planning and response is well-executed on local, state and federal levels, and the physical infrastructure of a community is restored, we cannot assume that recovery will be complete. Equally important to successful recovery are the potentially devastating psycho-social effects disasters have on individuals and communities. In other words, restoring infrastructure is likely necessary, but not sufficient, for meeting the goal of resilience. Equal, if not greater attention and resources must be placed on ensuring that the health – including the emotional and behavioral health - of the people who live and work in these communities also return to a state that is at least as well off as it was before the disaster. The focus on emotional and behavioral health during recent disasters has helped to illustrate their importance as elements critical to successful recovery.

Since Hurricane Katrina swept through New Orleans in August 2005, much of the physical infrastructure has been rebuilt and residents have re-established themselves in communities. Yet, the emotional and social toll of the storm continues to deeply affect the everyday lives of the people who live there. One year after Katrina, 11.3% of the population reported suffering from serious mental illness; two years out the percentage suffering from PTSD had reached almost 21%. (http://www.adph.org/ALPHTN/assets/560handouts.pdf) Today, six years after the storm, children exposed to Katrina are still nearly five times as likely as other children to suffer from a serious emotional disturbance (SED).[1]

Residents are not the only population whose emotional well-being is dramatically affected by disasters; first responders are often the most affected. After the 2001 September 11th attacks on the World Trade Centers, 12.4% of rescue workers (or 1 out of 8) developed PTSD (http://www.adph.org/ALPHTN/assets/560handouts.pdf) Recognition of the mental health needs of emergency responders is critical to maintaining healthy, resilient communities.

Whether the term community is used to mean neighborhood, town or city, or to describe a group of people sharing a common interest or goal such as the responders during the World Trade Centers attacks, a strong community can contribute to creating both an environment that decreases the potential for members to develop mental, emotional and behavioral health disorders,[2] and one that provides a strong network of support to help speed up the healing process once an event has occurred. For instance, firefighters in New York City who responded to the 9/11 attacks were affected not only by their experiences as responders, but because they lived in firehouses three days out of the week also experienced the loss of 'family.' For many, the immediate impact of this two-fold trauma resulted in increased emotional and mental health issues, including PTSD, but over time because the community within each firehouse worked together and healed together, these issues were resolved more quickly.[3]

For both residents and responders, inadequate coping with an experience such as 9/11 or Hurricane Katrina may not only lead to PTSD and depression, but can also function as a kind of emotional priming, making those affected less able to cope with similar disasters in the future.[4] During the 2010 Deepwater Horizon oil spill that deeply impacted communities in five states along the Gulf of Mexico, the need for an immediate medical response was considered small. However, for many residents who depended on the water as the source of their livelihood, elevated levels of stress and anxiety resulted from the financial and emotional burdens created by the spill. As weeks passed and oil continued gushing into the Gulf, rates of domestic violence, drinking and drug abuse, along with signs and symptoms of mild and severe depression began to rise[5] – all indications of the declining emotional well-being of the communities affected by the spill. The suicide of a boat captain from one of the Gulf Coast fishing communities brought to the fore the urgency to address the mental and behavioral health needs of the affected communities.

When public health officials began noticing an uptick in the indicators of elevated levels of stress associated with the spill, the local, state and federal governments began developing resources to help residents cope, including a 24-hour oil spill distress help line. While these were appropriate measures for addressing the stress experienced by Gulf Coast residents, mental health providers in the New Orleans area also began receiving calls from some of their patients who had been treated for PTSD after Katrina. These patients were now experiencing similar kinds of stress and anxiety during the oil spill. Such higher-than-expected rates of stress, depression and PTSD resulting from repeated exposure to disasters highlights the need for better understanding of how to effectively treat patients who are exposed to repeated disasters, and how to develop effective preventative strategies for avoiding the onset of post-disaster mental illness.[6]

In an effort to build a more resilient nation, FEMA drafted the National Disaster Recovery Framework (NDRF) in conjunction with multiple federal agencies. This document provides a framework for enhancing long-term recovery and supporting state and local governments in their efforts, including the restoration of behavioral health services. The framework recognizes that post-disaster communities often suffer from unmet emotional health needs, and provides a structure for the federal government to assist states with ensuring continuity of care for affected individuals and continuity of essential health services (including behavioral health services).

The NDRF is a valuable document for bolstering long-term recovery efforts, but needs to be supplemented with evidence-based strategies to inform decision makers about the kinds of behavioral health services that can address the growing need for such services in communities affected by disasters. It is up to our nationwide community of researchers and clinicians to begin developing a research agenda to address disaster mental health prevention strategies, and to test these strategies through pilot programs in areas prone to frequent disasters. After all, if we are serious about resilience – serious about rebuilding communities after disasters to be better than they were before – we must invest in our human capital on an equal basis with the investment in our physical infrastructure.

While much is known about managing the psychological and emotional effects of disasters, there is still a lot of work to be done in terms of preventing long-term negative consequences. Although most people recover from disasters with time, not enough is known about how to effectively prevent individuals and communities from developing lasting emotional and behavioral health morbidity because of such events. Social science research specifically indicates that most individuals recover relatively quickly, but some recover at slower rates and others show long-term negative psychological effects. It is critical for us to have a better understanding of how to increase the number of people in the first group and decrease the number in the latter groups.

This issue of *Ethnicity & Disease* provides some examples of the type of research that has been done in this regard but highlights how much more we need to know. Our knowledge about prevention in this field remains remarkably limited. And, while we recognize that every disaster is different, the need for a set of evidence-based intervention strategies that can effectively shorten the period of distress, and prevent more people from developing DSM-IV disorders, will be relevant to a wide array of potential disasters.

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COMMUNITY-BASED PARTNERED RESEARCH: NEW DIRECTIONS IN MENTAL HEALTH SERVICES RESEARCH

Objective: Community-based participatory research has the potential to improve implementation of best practices to reduce disparities but has seldom been applied in mental health services research. This article presents the content and lessons learned from a national conference designed to stimulate such an application.

Design: Mental health program developers collaborated in hosting a two-day conference that included plenary and break-out sessions, sharing approaches to community-academic partnership development, and preliminary findings from partnered research studies. Sessions were audiotaped, transcribed and analyzed by teams of academic and community conference participants to identify themes about best practices, challenges faced in partnered research, and recommendations for development of the field. Themes were illustrated with selections from project descriptions at the conference.

Setting and Participants: Participants, representing 9 academic institutions and 12 community-based agencies from four US census regions, were academic and community partners from five research centers funded by the National Institute of Mental Health, and also included staff from federal and non-profit funding agencies.

Results: Five themes emerged: 1) Partnership Building; 2) Implementing and Supporting Partnered Research; 3) Developing Creative Dissemination Strategies; 4) Evaluating Impact; and 5) Training.

Conclusions: Emerging knowledge of the factors in the partnership process can enhance uptake of new interventions in mental health services. Conference proceedings suggested that further development of this field may hold promise for improved approaches to address the mental health services quality chasm and service disparities. (*Ethn Dis.* 2011;21[Suppl 1]:S1-8–S1-16)

Key Words: Community-Based Partnered Research, Mental Health, Disparities, Implementation, Dissemination

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INTRODUCTION

In the last decade, policymakers, providers, the public, and the research community have paid increasing attention to the quality chasm or gap between the advances in clinical research and the realities of real-world practice.[1] McGlynn and colleagues, for example, found that only 55% of persons with a chronic health condition received appropriate care; quality of care for depression was close to this average, while substance abuse was about 10%.[2] There has also been increasing attention to disparities in access to, quality of, and outcomes in psychiatric care for ethnic minorities and other vulnerable populations.[3–11] Because mental disorders exact a high toll on individuals and families,[12] efforts to address quality gaps and disparities have important clinical, social and policy implications.

It is widely known, however, that traditional information dissemination approaches to transport evidence-based interventions into practice have failed to substantially close the quality gap or reduce disparities.[13,14] Reasons cited for the limited impact of evidence-based interventions in vulnerable communities include: 1) they do not account for community and cultural context, such as the infrastructure realities of safety-net service systems or community cultural norms; 2) they focus on individuals without using community resources to support implementation; 3) research findings are primarily disseminated through scientific journals, not to communities; 4) the gold standard for clinical research, the randomized clinical trial, emphasizes internal validity over external validity or generalizability, and often excludes vulnerable populations.[15–17]

Because mental disorders exact a high toll on individuals and families,[12] efforts to address quality gaps and disparities have important clinical, social and policy implications.

Community-based participatory research (CBPR) is one approach to address such shortcomings of traditional research and information dissemination methods, by engaging diverse community stakeholders in developing and evaluating programs that are embedded and sustainable within the local community and cultural context.[18–27] CBPR has been recommended as a paradigm for increasing the relevance of clinical research through public participation and community engagement.[28–30] Experts in management sciences have recently emphasized action research[31,32] and en-

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gaged scholarship,[33] which follow some principles and methods that overlap with CBPR. In CBPR, key community stakeholders are full participants in research design, conduct of the research, analysis, interpretation, conclusions, and communication of results.[34] In this way, CBPR shifts authority for action to the community, and the community-academic partnership.[18,21,24]

Community-based participatory research holds promise as an approach to address the quality gap and service disparities for theoretical, practical, and ethical reasons. Populations more involved in research may be more likely to be committed to its use. Such involvement may increase attention to life circumstances and cultures of participants in intervention design, which could yield more acceptable interventions for that population. For example, consideration of how culture is expressed in local norms and interpersonal interactions has been proposed as critical to developing more respectful and effective community health interventions in mental health.[35] Further, research may be more feasible if community members are involved in its development. Active participation of the user population in research development and implementation increases autonomy, and inclusion of individuals from underserved populations as research leaders can increase social justice and equity in the research development process.[27,36,37]

Despite these potential advantages, the application of CBPR to mental health services research has been relatively recent. Wells and colleagues proposed a conceptual model to integrate mental health services and CBPR principles in intervention design[27] and Bruce et al[38] summarized relevant literature for affective disorders. Based on this model, pilot studies blending CBPR principles and mental health services research methods were developed,[18,39–42] and these experiences also informed the documentation of a variant of CBPR, community-partnered participatory research (CPPR) that emphasizes equal community and academic coleadership of research.[21,43] However, there is continuing uncertainty about whether interventions using CBPR principles lead to better health outcomes or sustainable community change, as relatively few CBPR studies are interventions or use strong randomized designs.[44] Despite the growth of community-based health intervention projects in the social and behavioral sciences, there is still no systematic, rigorous approach to assessing community capacity and systems change within a local cultural context.[45] Awareness of both these limitations and possibilities prompted leaders of several mental health services research centers to convene a joint conference. The goal of the conference was to explore the promise and challenges in developing the CBPR interface of fields and methods, as a follow-up to the proposed model of integration[27] and preliminary development of experiences with partnered research in these centers. This article describes the conference and the lessons learned.

CONFERENCE DESIGN

Planning

The executive planning committee for the conference included academic and community partners from four National Institute of Mental Health (NIMH) Centers: UCLA/RAND, Washington University in St. Louis, Cambridge Health Alliance (CHA)/Harvard Medical School, and Georgetown University. The executive committee planned the conference in phone calls and follow-up emails. Different centers took responsibility for sections, maintaining a balance in leadership among centers and between community and academic leaders. The executive committee developed a conference website and an evaluation design including digital recording of almost all sessions, transcriptions of recordings, and note-taker/recorders to provide immediate feedback. The committee invited other partnering research groups and also asked each center to nominate partnerships for participation as well as additional programs and centers for geographic balance. Costs of the conference were covered by discretionary funds of the participating centers; we did not use separate conference grants. Research procedures for the evaluation were approved by the IRB of the host institution (RAND).

Participating Research Partnerships

The executive committee also invited investigators from the research center at Cornell and research programs affiliated with the UCLA/RAND Center in southern United States (University of Arkansas, University of Mississippi, Tulane University, and Tugaloo College) so that participating partnerships were drawn from four census regions of the United States. Each center followed its own procedure to select partners and projects according to its CBPR goals and available budget. Participants included staff from NIMH and other National Institutes of Health (NIH), the Robert Wood Johnson Foundation, the Substance Abuse and Mental Health Services Administration (SAMSHA), and an expert consultant in CBPR (Dr. Nina Wallerstein). Community partner attendees represented an array of agencies, including nonprofit health organizations and community associations, for-profit health consulting and healthcare organizations and providers, schools, county and state health and human service departments, faith-based programs, and educational institutions (Table 1). Nearly 80 people attended over two days, with approximately 40% community partners and 60% academic partners participating.

Conference Structure

The two-day conference was held on July 24–25, 2006 at the RAND Corpo-

Table 1. Organizations, partnerships and projects represented

Organization	Partners	Projects
Cornell's Weill Community-Based Research Partnerships in Geriatric Mental Health	Westchester County Department of Senior Programs and Services Visiting Nurse Association of Hudson Valley	Research Network Development Core -integrates mental health into social, nutritional, and medical activities Home Healthcare Research Partnership -depression detection improvement, administration data for research -effectiveness & implementation studies for depression and home health care
Georgetown University's Center for Trauma and the Community	Primary Care Coalition of Montgomery County, Maryland Greater Baden Medical Services Inc Unity Health Care, Inc Prince George's Health Department, Maryland	Montgomery Cares Behavioral Health pilot (PCC and GTU Project) -culturally-sensitive behavioral health services for screening and treatment -evidence-based collaborative care services -evaluations of clinical, process, and economic outcomes
University of Arkansas	Mental Illness Research, Education, and Clinical Center	-depression intervention to assist ministers -community based outpatient clinics in partnership with other providers
UCLA's Health Services Research Center	United Behavioral Health (a health plan) Healthy African American Families RAND, Drew University Los Angeles Public School System	-provider incentives to improve depression care Witness for Wellness -workgroups to conduct research targeting depression in Los Angeles -school-partnered intervention for trauma
University of Mississippi/Tugaloo College	Historically Black Colleges and Universities Faculty Development Network	-new partnership with projects in the development phase
University of Southern California	County Emergency Department	-improving depression care for medically indigent -project for depression care targeting older minorities -patient centered depression care project featuring self-management of depression and medical illness
Washington University in Saint Louis	Missouri state agencies	-improving mental health care in social services through screening, assessment, referral, and care coordination -improving community long-term care response to late life depression
Cambridge Health Alliance/ Center for Multicultural Mental Health Research	The Right Question Project, Inc. Graham & Parks Alternative Public School	-pilot to empower and activate mental health patients in their health care -formulating questions and focusing on key decisions of their health care -school system intervention to maximize mental health promoting capabilities -multiple factors & system patterns leading to problem behaviors in poor immigrant children

ration in Arlington, Virginia. Day 1 of the conference opened with an introduction and overview. The structure of the conference included a series of plenary sessions and breakout groups centered on themes related to the CBPR experience (eg, Sharing a Vision, Building Relationships, Evaluating our Partnerships). Facilitators used mutually identified topics to guide discussion in each content area: challenges, strategies (successful and unsuccessful), community and academic research priorities, lessons learned, partner contributions to improving services and scientific advances.

All breakout groups were followed by summary sessions with report-backs from participants, and synthesis of information among all conference participants. Day 2 of the conference opened with comments from staff of NIMH (Dr. David Chambers) and SAMSHA (Dr. Crystal Blyler), concerning their priorities for partnered research and application of CBPR principles in services, respectively. The topics of the breakout groups for Day 2 were guided by feedback from the experiences of the participants during Day 1. One executive committee member (Wells) circulated among groups, summarized the feedback across groups at the final plenary discussion, and led a discussion of next steps and future directions. The executive committee issued an invitation for follow up planning efforts. Loretta Jones, from Healthy African American Families, closed the conference with a ceremony where each participant took a key and considered what doors (eg, partnerships, vulnerable populations) to open up in their communities.

ANALYSES

All audiotapes from the workshop breakout groups were transcribed for analysis. The executive committee for the conference including academic and community partners that volunteered to participate in follow-up efforts at the conference divided into workgroups,

Table 2. Partnership development challenges and recommendations

Challenge	Recommendation
Conflicting agendas among stakeholders; competing priorities (eg, financial interests, staff availability; timing).	Negotiate an initial written document detailing roles, time commitments, expectations, and goals, including ownership of data.
Community partners' needs and preferences differ from researcher's agenda; power dynamics shift over the different stages of the research.	Be flexible in expectations and rules for partnership development; recognize that conflicts may be unavoidable and effective partnership development takes time.
Ensuring long-term continuity as different stakeholders may have evolving work charges.	Make a shifting membership explicit; recognize that such shifts are not an indicator of failure.
Structural issues: institutional and funder policies conflict with partnership development; bureaucratic guidelines complicate exchange of financial resources, staff turnover, service system changes, and maintaining involvement of parties; physical distance and limited transportation deter participation.	Maintain researcher presence in community discussions both before and after the funded phase to build long-term trust despite structural constraints; work together to develop a sustainable infrastructure for the partnership and for the service initiatives launched through the partnership.
Resource and labor intensity of partnered research curtail participation in and documentation of the research.	Varied solutions based upon individual nature of partners and cultures; recognize time and resources to document the partnership process; build relationships before data collection; explore innovative means of capturing process and outcomes.

largely falling along lines of individual centers, with 2–4 community and academic members per group. Each work group analyzed the transcripts taking one to two breakout groups. A priori questions were used by the reporters of the breakout groups to synthesize the discussions of that day. They were also asked to develop themes, examples and an overall synthesis. Groups were given flexibility in how community partners participated (eg, full review, working in pairs with academics, reviewing academic comments and editing them). Issues raised in these sessions were summarized by note takers selected by the group.

Those notes and syntheses were used by the executive committee to further aggregate the qualitative data across breakout groups. Repeated themes, appropriate to the *a priori* questions that guided the conference and those that were generated within the discussion groups, were then extracted by the executive committee without use of software. Then, the first and second authors further distilled the themes by aggregating those themes that percolated in several breakouts so as to minimize repetition. Our approach followed a comprehensive synthesis around the identified themes to allow for details and examples that would elucidate the richness of the groups' discussions.

RESULTS

Themes were identified in five main areas: 1) partnership building; 2) implementing and supporting the work of community-based research partnerships; 3) developing creative dissemination; 4) evaluating the impact; and 5) training. Findings were also synthesized into recommendations for the field.

Partnership Building

Primary themes that emerged included the importance of transparency regarding incentives for different stakeholders to come together, partner priorities and the timeline of the project (Table 2). Creative examples were given by participants of ways in which they managed shifting priorities of participants over the course of the partnerships. For example, the Witness for Wellness project had a policy in which participants could get "on and off the bus" as they were able to participate, making a shifting membership explicit and recognizing that such shifts are not an indicator of failure. Developing a sustainable infrastructure for the partnership and for the service initiatives launched through the partnership was a major concern since funding for research was time-limited. The resources required and the labor intensity of partnered research was a constant theme, as these factors can curtail or enable participation. The data collected in evaluating partnered research are often qualitative, which is very labor intensive, and innovation is required to capture actual process and outcomes in a time sensitive way.

Implementing and Supporting the Work of Community-Based Research Partnerships to Improve Quality of Care

Beyond establishing the partnership, specific challenges in implementing and supporting the research were noted by participants (eg, improve the quality of mental health services). To be successful in the work, it is necessary to marshal community support, transform university and community agency policies, develop ongoing trust and commitment among members, and balance the professional demands of the work (Table 3). The implementation of partnered research can often affect the organization of how a partner does business. Examples were given in which organizational policy change was the primary goal of the research collabora-

Table 3. Implementation challenges and recommendations

Challenge	Recommendation
Difficult to marshal community support, and transform university and community agency policies, to facilitate work.	Explore projects where organizational and policy change are the primary goal of the research collaboration.
Difficult to sustain mutual trust between academic and community partners and with funders of services programs and research.	Utilize community expertise to identify and prioritize problems for quality improvement; utilize academic partners for expertise on available treatments and services.
Difficult to find sufficient time and effort for the partnership, given effort often not fully compensated by funding or available resources.	Help community members and researchers see importance of investing time; be respectful of the demands for time; develop awareness of time demands in community; academic and policy circles and among funders

tion, as in the School Systems Enhancement Project where CHA and the Graham and Parks Alternative Public School documented changing systems in a public school to improve the mental health and functioning of immigrant children. Another grant-funded partnership led to a broader, long-term commitment by a school of social work to forge agency partnerships for educational and service-improvement purposes.[46] Other examples were given in which change at the systems level were initially unintended, such as how planning for a partnered research pilot concerning depression services led to new contracts between the Los Angeles County Department of Mental Health and community-based organizations.[47]

Developing effective work to improve quality of care was viewed as requiring sufficient time and effort of the partnership, even when that effort was not fully compensated by funding or available resources. For community organizations, it was noted that this often meant participating in meetings and dissemination activities without a specific budget. For research staff, the time to build a strong partnership and develop a trusting relationship with community members was viewed as competing with other activities (eg, writing articles, teaching courses, submitting grant applications) that are, according to department chairs, more salient for career advancement.

Developing Creative Dissemination Strategies

A key theme was the importance of knowledge transfer in the development and implementation of a dissemination plan of the findings. Without a dissemination plan, research has little impact in the real world.

Innovation and development of new strategies to disseminate information on the partnership and partnership process was also emphasized. Dissemination of data on outcomes of interventions and partnered research efforts were viewed as essential to foster buy-in for community-partnered research (Table 4). Suggestions included using a partnered process that builds community capacity to analyze and publish findings.[48] Another level of dissemination discussed was efforts to create a manual with lessons learned from the research and community engagement process to standardize steps leading to partnered research and improved quality of care.[49]

Evaluating the Impact Including Evaluating the Partnerships

Improving the quality of science was noted as important so that the field of CBPR is improved and accepted, and interventions adopted and enhanced. Under the theme of evaluation, the concern was that the partnership itself often lacks an evaluation (Table 5). The groups recommended that partnership

Table 4. Dissemination challenges and recommendations

Challenge	Recommendation
Sharing products of partnered work with all stakeholders, particularly with those that will lead to uptake of information or intervention in the community.	Encourage mutual participation in academic and community meetings and open ''report backs'' to the community; share publications; encourage data dissemination by the funding source; make information available in blogs, web pages, radio programs or newspaper articles.
Difficult to develop innovative strategies to disseminate information on the partnership and partnership process.	Encourage community/academic projects: partnership CD, a bibliography of resources for website, journal dedicated to partnership in research, Power Point presentations for use in both venues.
Challenging to analyze and disseminate data on outcomes of interventions and partnered research efforts to encourage community buy-in.	Build community capacity to analyze and publish findings; create manual with lessons learned from process to standardize steps leading to partnered research and improved outcomes.
Lack of credit given to community participants and lack of input on projects from all partners.	Plan joint presentations and publications for recognition of community and agency support; ensure full co-ownership of data and results.

Table 5. Evaluation challenges and recommendations

Challenge	Recommendation
Vision of benefit to the community is lost given complex nature of the research and the bureaucratic systems in which it exists.	Document best CBPR practices thoroughly: What works? What does not work? How does CBPR improve uptake of study findings? What is the added value of having community partnerships?
Lack of an evaluation of the partnership itself.	Institutionalize partnership evaluation; fund development of a best practices model for evaluating partnerships.
Lack of clear communication between partners, not listening or incorporating partner points of view, and lack of respect for different types of experience.	Link variations in communication characteristics to positive/negative outcomes, including effectiveness of partnered work, eg, an effective intervention or building community capacity.

evaluation be institutionalized, and that funding go to the development of a best practices model for evaluating partnerships. Some major issues to evaluate were balance of power (in terms of who controls the money), lack of equality, lack of respect for community experience and capacity, shifts of power during the project that are appropriate to partner interests and strengths, and sharing leadership in grant submissions.

Training

An important theme was sufficient training in partnered research for community partners and young academic investigators (Table 6). Participants noted that such trainings would need to be offered from both perspectives: community to academic trainings, and academic to community trainings. By developing trainings and materials for partnered research, new partnerships could learn from the experience of older partnerships.

Recommendations for the Field

An end goal would be to make partnered research a mainstay approach across disciplines, if data existed to support the importance of this undertaking. This would involve creating buy-in for community engagement in research from the scientific community, community agencies, and funding agencies. Evaluation was viewed as still needed in order to be able to attribute outcomes of partnered research projects to the partnership process. Dissemination of findings once again weighed in as essential to impact the field. A shift towards conventionalizing partnered research was thought to require funding support for partnerships that were built into grant mechanisms, as well as including experienced CBPR researchers and community members as members of grant review panels.

Structuring the Partnership

The groups recommended forming partnerships as a win-win situation. Understanding and communicating the goals and needs of the community along with those of the investigators is vital not only as the partnership is getting structured, but also as it progresses. To achieve a shared vision of the partners, it is necessary to develop strategies to better understand each other's worlds, including engagement of community members in research activities to understand what research has to offer and for researchers to sit on community advisory boards to learn about what the community has to offer.

An end goal would be to make partnered research a mainstay approach across disciplines, if data existed to support the importance of this undertaking.

Setting Up the CBPR Project

One important component in the early stages of a CBPR project is to make expectations about the role of each group clear from the early phases of the project (pre-grant period), so that groups are not disappointed with the tasks and process as it unfolds. Simultaneously, the partners should outline the objectives from the very beginning in goals for community and for academic institutions. Becoming aware of the funding agency's agenda is critical to ensure success. Also relevant is to require a partnership evaluation, along with other evaluations relative to implementing the partnership and improving the quality of the science

Table 6. Training challenges and recommendations

Challenge	Recommendation
Lack of sufficient training in partnered research for community partners and young academic investigators.	Offer trainings from both community and academic perspectives; include trainings by funders; generate templates for agreements, eg, formal memoranda of understanding; less formal roles and responsibilities.

and dissemination. The groups also recommended paying attention to the end user to make sure that the generated information has relevance.

Developing Creative Dissemination

A crucial aspect of CBPR is the efficient dissemination of methods to evaluate program outcomes and partnership success. Effectual dissemination entails both breaking ideas and process into small pieces to identify what can be done on a daily basis to share lessons learned, and also put the pieces together to collaborate and disseminate the lessons learned. The groups also discussed the importance of assisting media in framing encounters that happen on a daily basis from a mental health perspective and from a social activism perspective so that mental health has a more prominent role in the media. Another recommendation was the development of a toolkit on how to adapt and disseminate evidence-based practices in the community to establish community validity.

Training

Different workshops should be provided to train young investigators in CBPR methods, including processing the data so that they are useful to the community groups and agencies.

DISCUSSION

The themes and topics identified in the meetings at this conference underscore the emerging knowledge regarding the process of CBPR and the factors that contribute to or limit its success in mental health services research. They demonstrate the components of the CBPR process that are critical to its success as well as those where continued work is needed to address inherent tensions in the partnership process, in the development of a standard evaluation process, and strategies to address institutional constraints. In addition, the conference themes suggest that community partnered research can contribute to improved interventions with greater contextual and cultural validity that may result in better quality of care for diverse populations. Throughout the conference themes a clear blueprint for enhancing the strategies that facilitate development and implementation of effective mental health interventions emerged. Some have recently argued that close attention and analysis of the process and implementation of an intervention should precede measurement of the actual health outcomes,[50] given that these factors may substantially improve chances that a new intervention might have an effect.[51] Evidence suggests that community involvement enhances intervention quality, and that the most rigorous research designs in community partnered research are also associated with the strongest health outcomes.[44] Continued attention to embed community partnered strategies as part of a rigorous intervention process could enhance efforts to uptake interventions and improve the quality of care.

Particularly when addressing issues of mental health disparities, attention to issues of research process and implementation as part of the intervention process appear to be closely tied to subsequent improvements in quality of care. For example, a community-based participatory project with Aboriginal people in Canada found that the partnered approach was critical to overcoming barriers to mental health service provision, and that local management and delivery of quality of mental health services improved dramatically.[52] Although this study did not track specific mental health outcomes, the barriers to delivery of care were effectively addressed through a participatory approach, making the next step of evaluation of mental health outcomes possible. Others have applied partnered research strategies to encourage uptake for physicians in administering evidence-based practices – another way in which community-based strategies that target process and implementation issues can lead to improvements in quality of mental health care.[53]

Community participatory strategies can also improve quality by assessing the specific components of partnered research that lead to sustained improvement in the community after the research has ended. In particular, efforts towards training and developing multidisciplinary partnerships within the community have the potential to build infrastructure to support sustainability of clinical research findings. The conference themes identified many training topics focused on increasing the capacity of participants (researchers and community) to learn to work from each other, deal with bureaucracy, manage institutional review boards, and learn best practices and cultural awareness.

Further, the emphasis on developing strategies for evaluation across themes provides the means for testing what components of partnered research can lead to sustainability, hence further informing the goals of long-term quality improvement in real-world settings. There is a need for standardized measures for process and evaluation outcomes for partnership, both qualitative and quantitative.[44] The conference themes suggest that development of these standardized practices and measures require innovation and creativity, as well as an understanding that measures should be flexible in adapting them for different cultures and languages.[52,54] In addition, there is a need for standardized measures to evaluate the link between partnered research and actual health outcomes. The development of such measures is in its infancy. Although there are good measures for evaluating dimensions of group dynamics within community-based participatory research,[55] there is less work identifying the constructs and measures of community-based participatory research that are linked to positive health outcomes. However, recent work is attempting to identify how CBPR can reduce disparities in depression outcomes by increasing implementation of quality improvements in underserved communities.[56] One major challenge of measuring the association between partnered research and health outcomes is the potential for lack of generalizability to other communities and settings, due to the fact that the work is often deeply embedded in specific contexts. To address this challenge, more research that includes multiple sites is needed to replicate findings across different communities using partnered research approaches.[57,58]

The conference was developed to explore how application of CBPR to mental health services research could address the research practice gap in mental health research. In that regard, the focus in the discussions on communication between researchers and community members, as well as the ideas generated for shared models of dissemination, hold potential to increase the visibility of research and the importance of dissemination in the community. By working in partnership from the beginning, CBPR methods avoid creating dynamics in the first place that lead to gaps between knowledge base and the realities of real-world practice that lead to service disparities. In particular, shared conversations about trust, power and access to research information may build a foundation for knowledge generation that is truly informed by the experiences of those the interventions are meant to affect. The promise of CBPR lies not only in its potential for improving community-based research per se, but also in its potential for improving the relevance and process of scientific investigations, dissemination and implementation of evidence-based practices in many areas. Although utilizing these principles may slow the research protocol at the front end, the expectation is that we can encourage the uptake of research findings and, subsequently, reduce mental health disparities and improve quality of care in the real world.

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COMMENTARY: REAPING THE BENEFITS OF RESEARCH PARTNERSHIPS: CHALLENGES AND OPPORTUNITIES

(*Ethn Dis.* 2011;21[suppl 1]:S1-17–S1-19)

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In 2006, the National Advisory Mental Health Council, which provides guidance to the National Institute of Mental Health (NIMH), produced *The Road Ahead: Research Partnerships to Transform Services*, a report of recommendations to advance services research and clinical epidemiology. As the report's name belies, the Council saw partnerships among individuals, organizations and communities as crucial to ensuring maximal public health benefit from research. The authors reported,

> ''collaborating strategically with stakeholders can help make the Institute's research available to a broader audience in more meaningful and tangible ways. NIMH's partners include persons living with mental illness and their families, advocates, payers, clinical practitioners, researchers, and research administrators. By learning more about the needs of these diverse partners and their perspectives, NIMH can channel research in directions that are responsive to partners' needs.''[1]

In response to the report, NIMH advanced a number of activities targeting the improvement of partnerships among multiple stakeholders. For state/research partnerships, NIMH supported a contract to the NASMHPD (National Association of State Mental Health Program Directors) Research Institute, facilitating advancement in infrastructure to support research on the impact of state policies on mental health outcomes, as well as *RFA-09-050: Use of Pooled State Administrative Data for Policy-Relevant Mental Health Services Research.*[2] For partnerships with health care settings, NIMH developed a Mental Health Research Network,[3] leveraging integrated health care delivery systems to improve the quality and efficiency of services and effectiveness research.[4] Each mechanism was designed to stimulate partnered research agendas to ensure the relevance of NIMH-supported studies.

More recently, the strategic plan of the NIMH[1] has articulated the importance of enhancing the public health impact of mental health research. This fourth strategic objective reaffirms the goal of extending research beyond academic centers, journals and bookshelves, to directly benefit people with mental disorders, their families, and the practitioners and systems that deliver mental health care. Inherent in this goal is the continued desire for NIMH and its funded researchers to connect to a myriad of stakeholders, desiring maximal benefit from research investments.

Related to the content of this special supplement to *Ethnicity & Disease*, NIMH has explored multiple methods for developing research partnerships within communities. Several funding opportunity announcements have been issued, both agency and institute-driven, on the use of community based participatory research approaches to conduct research studies.[5] NIMH also continued its support of the Interventions and Practice Research Infrastructure Support Program (IP-RISP), which offered up to five years of funding to partnerships of research institutions and practice settings, with the expectation that innovative and effective research would emerge that otherwise could not be developed.[6] In both cases, the research agendas are intended to drive the partnership process. Greater involvement of communities in research would ensure that the studies are designed to answer the most important questions within communities and services systems, and to pave the way for use of

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research findings to drive wide-scale improvements to mental health care.

In addition, NIMH-funded researchers are working to ensure the connection between research-tested interventions and the myriad of clinical and community settings where they can be used. This is by no means exclusive to mental health, but paramount for all of health research. The trans-NIH funding opportunity announcements in dissemination and implementation research include participation from 12 Institutes and Centers,[7] and the annual NIH meeting on the science of dissemination and implementation has grown dramatically in just a few years. NIMH currently funds approximately $45 million a year in this area, recognizing that the connection from development and testing to widespread use of effective interventions requires active partnerships.[8]

These initiatives, exemplified by the themes of the articles in this supplement, have shown both the importance of partnerships and the challenges associated with initiating them, supporting them, and enabling them to translate their efforts into full-borne research studies that affect mental health. We recognize the tremendous efforts spent by these fledgling partnerships, and their vulnerability to competing demands, limited resources, shifting timeframes and other barriers. From recent initiatives, several principles seem important for successful benefit from research partnerships.

EMPHASIS ON THE ULTIMATE IMPACT OF THE RESEARCH

Research-practice partnerships may struggle to maintain momentum toward the development and execution of a scientific agenda. As discussed previously, many competing demands for all participants can create obstacles for the work moving forward. The immense contributions from this work can then be lost. Scientific success may come from a keen focus on how the partnership can specifically advance the research field, while partners may require clear benefit to service delivery and substantial benefits on individual and system outcomes. Key questions include: How are the partners positioned to develop new knowledge? How can the research questions, designs, and findings result in tangible information that can significantly improve mental health?

STRATEGIC DEVELOPMENT OF NEW PARTNERSHIPS

A number of emerging areas could benefit from research partnerships. For example, advances in information technology give average individuals immense processing power at their fingertips and in their pockets. Determining how best these applications can be integrated within mental health care will likely require expertise from the technology sector, mental health researchers and a range of stakeholders in community and clinical practice. Similarly, efforts to scale-up and sustain a range of interventions require knowledge of policy, organizations, providers and those who can benefit from mental health care. Strategic partnerships in these and other areas with representation from relevant stakeholder groups could reap great rewards for the research enterprise and public mental health.

DEVELOPMENT OF A "CO-AGENDA"

Many opportunities exist for research partnerships, both in the development of research knowledge and the application of those findings to improve mental health. The pursuit of "win-win" themes for partnerships seems essential to ensure that return on the effort of all partners is achieved. One "win-win" example centers on implementation research and quality improvement (QI). Many researchers are studying how best to improve the implementation and ongoing use of effective interventions. Simultaneously, health and social systems around the country are working on a plethora of efforts aimed at improving the quality of their services. Unfortunately, the worlds of implementation research and QI are infrequently coupled. Quality improvement activities offer significant opportunities to continue gathering information about the implementation and sustained use of interventions within practice and could lead to optimization of those interventions. A partnership that merges QI and implementation research could be of value to all participants. Other "co-agendas" could be framed around large-scale efforts to reduce disparities, data standardization to allow quality measurement in local systems, the development and testing of local innovative mental health care practices, and assessing the impact of federal, state and local policies.

One current limitation of efforts to bridge research and practice lies in the assumption that these entities are by necessity distinct. Research knowledge must be translated to yield benefits, and practice communities may lie in wait for the next big thing. The themes in this issue challenge that assumption, recognizing the importance of partnerships with all stakeholders, including, I would argue, funding agencies like the NIMH. Indeed, as the "Road Ahead" report recommended and the strategic plan mapped out, NIMH's opportunities to maximize the benefit of research lie in its own partnership activities, ensuring that the Institute moves beyond the research world to connect directly with patients, providers, administrators and policymakers. The work summarized in this issue takes the concept of partnerships to a new level—partnerships can conduct research and practice activities within the same framework. Through partnerships like those described within this issue, the scientific and practice communities may have the largest public health impact.

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MENTAL HEALTH INFRASTRUCTURE AND TRAINING PROJECT

BUILDING COMMUNITY RESILIENCE THROUGH MENTAL HEALTH INFRASTRUCTURE AND TRAINING IN POST-KATRINA NEW ORLEANS

Objective: To describe a disaster recovery model focused on developing mental health services and capacity-building within a disparities-focused, community-academic participatory partnership framework.

Design: Community-based participatory, partnered training and services delivery intervention in a post-disaster setting.

Setting: Post-Katrina Greater New Orleans community.

Participants: More than 400 community providers from more than 70 health and social services agencies participated in the trainings.

Intervention: Partnered development of a training and services delivery program involving physicians, therapists, community health workers, and other clinical and non-clinical personnel to improve access and quality of care for mental health services in a post-disaster setting.

Main outcome measure: Services delivery (outreach, education, screening, referral, direct treatment); training delivery; satisfaction and feedback related to training; partnered development of training products.

Results: Clinical services in the form of outreach, education, screening, referral and treatment were provided in excess of 110,000 service units. More than 400 trainees participated in training, and provided feedback that led to evolution of training curricula and training products, to meet evolving community needs over time. Participant satisfaction with training generally scored very highly.

Conclusion: This paper describes a participatory, health-focused model of community recovery that began with addressing emerging, unmet mental health needs using a disparities-conscious partnership framework as one of the principle mechanisms for intervention. Population mental health needs were addressed by investment in infrastructure and services capacity among small and medium sized non-profit organizations working in disaster-impacted, low resource settings. (*Ethn Dis.* 2011;21[suppl 1]:S1-20–S1-29)

Key Words: Community-based Participatory Research, Collaborative Care, Disaster, Mental Health

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INTRODUCTION

The disasters of Hurricanes Katrina and Rita contributed to unmet need for mental health services among the affected population, approximately one third of whom experienced symptoms of depression, post traumatic stress or anxiety.[1–3] Mental health services responses in New Orleans were hampered by limited baseline services capacity prior to the disaster and stigma.[4] Displacement of specialty providers – only 22 psychiatrists practiced in the Greater New Orleans area nearly one year after the storms as well as infrastructure damage resulting in closure of health facilities, including New Orleans' only public hospital, further stymied community access to evidence-based mental health services.[5]

Community disaster recovery may be limited or slowed when significant proportions of the population are affected or disabled by cognitive impairment associated depression, anxiety, or post-traumatic stress disorder. Racial and ethnic minority communities may be at greatest risk of delayed recovery, given the higher burden of disaster impact experienced[6] and their lower likelihood of receiving appropriate mental health care.[7–10]

Community-academic partnered approaches in training, research, and services delivery may improve population mental health and resilience, and may offer certain advantages following a major disaster, particularly in low resource settings and among racial and ethnic minority groups.[4,11,12] In a partnered, community participatory approach, academicians may facilitate training and uptake of evidence-based models by community providers, while community members contribute invaluable insight into how to tailor these models to improve implementation based on their intimate understanding of community need, expectations, and contextual factors.[13–15] Together community members and academics may set the stage for impactful population-level

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Table 1. Project council partner agencies

Agency	Agency type	Areas of expertise	Role in project council
Common Ground Health Clinic commongroundclinic.org/	Community-based health care provider	Health care delivery Community outreach, engagement, organizing, and context	Supported proposal development Provided mental health services Co-led training sessions Provided feedback on training curricula
Episcopal Community Services (ECSLA) ecsla.org/	Community-based social service provider	Case management Community outreach, engagement, and context	Supported proposal development Provided mental health services Provided feedback on training curricula
Holy Cross Neighborhood Association helpholycross.org/	Community-based organization	Community outreach, engagement, and context	Supported proposal development Provided mental health outreach, education, screening, and referrals Co-led training sessions Co-developed training curricula Disseminated project results
RAND Health rand.org/health.html	Policy research institution	Project direction and development Evidence-based mental health care models	Supported proposal development Co-led training sessions Co-developed training curricula Supported project direction Provided model implementation support Disseminated project results
St. Anna's Medical Mission stannanola.org/samm.php	Community-based health care provider	Health care delivery Community outreach, engagement, and context	Supported proposal development Provided mental health services Co-led training sessions Co-developed training curricula Disseminated project results
St. Thomas Community Health Center and Wellness Center stthomaschc.org/	Community-based health care provider	Health care delivery Community outreach, engagement, and context	Community-based health care provider Provided mental health services Supported proposal development Provided feedback on training sessions
Tulane Community Health Center at Covenant House tuchc.org	Community-based health care provider	Health care delivery Community outreach, engagement, and context	Provided mental health services Supported proposal development Co-led training sessions Co-developed training curricula Disseminated project results
Tulane University School of Medicine tulane.edu/som/	Research institution	Project management	Project management Supported proposal development Co-led training sessions Co-developed training curricula Disseminated project results
UCLA Health Services Research Center hsrcenter.ucla.edu/	Research institution	Evidence-based mental health care models	Supported proposal development Co-led training sessions Co-developed training curricula Provided model implementation support Disseminated project results
University of Washington, Department of Psychiatry & Behavioral Sciences uwpsychiatry.org/	Research institution	Research institution Evidence-based mental health care models	Supported proposal development Co-led training sessions Co-developed training curricula Provided model implementation support Disseminated project results

interventions and innovative, equitable research agendas and information exchange.[8]

REACH NOLA is a 501c3 nonprofit organization based in New Orleans, the mission of which is to improve health equity, community health, and access to quality health care through partnered programs, services, and research.[16] REACH NOLA began in April 2006 as a novel, community-academic collaborative that organized to address post-Katrina health needs in New Orleans by uniting the unique strengths of community agencies and academic institutions. REACH NOLA partners applied an equity-focused framework drawing from principles and practices of community-based participatory research (CBPR)[12,17,18] to conduct a rapid community-participatory assessment of access to health care in post-Katrina New Orleans. The partners shared the findings from this assessment with community members, policymakers, and

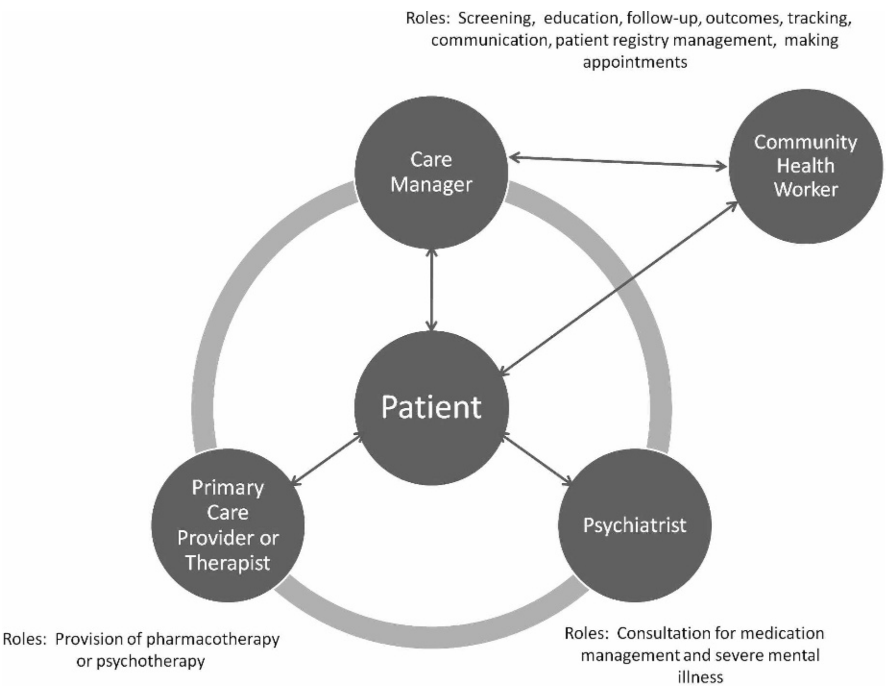

Fig 1. Elements of Collaborative Care

health agency leaders as a basis for planning partnered responses to the community health challenges that subsequently were identified.[4,19]

In recognition of the epidemic of unmet post-disaster mental health needs, REACH NOLA's lead community partners (St. Anna Medical Mission, Holy Cross Neighborhood Association, Common Ground Health Clinic, Episcopal Diocese of Louisiana, St. Thomas Community Health Center and others), as well as REACH NOLA's lead academic partners, (RAND Health, the UCLA Health Services Research Center, the Tulane University School of Medicine, Section of General Internal Medicine and Geriatrics) developed proposals to work together to meet post-disaster community mental health challenges. As recovery proceeded, community and academic partners agreed that there was a broader need to support competencies for mental health recovery, following community priorities, and relying to the extent feasible on evidence-based approaches, to support improved outcomes in mental health. The nascent REACH NOLA partnership garnered critical initial support from the Robert Wood Johnson Foundation, and later from the hurricane recovery program of the American Red Cross, to work to improve access to and quality of post-hurricane mental health services in the greater New Orleans region. Partner agencies developed two health and resilience centers featuring collaborative pilot programs through the St. Anna Episcopal Church Medical Mission and the Tulane Community Health Center at Covenant House. These centers and their partners together built capacity for high quality mental health services delivery, and provision of social services in accessible, neighborhood settings.[20]

This article describes the next phase of this trajectory of development; the REACH NOLA Mental Health Infrastructure and Training (MHIT) Project. It is, to our knowledge, the first peer-reviewed account of disaster recovery model specifically focused on developing mental health services and building capacity for agencies and providers within a disparities-focused, community-academic participatory partnership framework. This descriptive overview provides insight into development of MHIT's programmatic structures and products and their application in Greater New Orleans after Hurricanes Katrina and Rita to improve mental health.

METHODS

This narrative history of the REACH NOLA MHIT is drawn from project documents including meeting minutes, training agendas, participant surveys, project web pages, service reports, and recollections from key participants. Building on the initial progress of its health and resilience centers, beginning in 2008, REACH NOLA developed MHIT as a broader capacity-development initiative. The intent of MHIT was to support development of accessible, high-quality mental health services among health and social service agencies that work with underserved populations in Greater New Orleans, while supporting growth of community leadership to address disparities in mental health care and to advance disaster recovery. The mechanisms to accomplish this intent included: 1) using community-participatory methods to develop and deliver workforce training programs for evidence-based therapies for depression and trauma, based on versions of collaborative care and other models;[21–23] 2) providing financial support to agencies to hire needed staff; and 3) building novel linkages within and among clinical and non-clinical agencies and providers to integrate services into a wider range of neighborhood-based primary care and social services settings, particularly through community health workers, therapists, and primary care providers. [13–15,24]

Table 2. Course ratings and sample qualitative feedback of MHIT training participants*

Training seminar date	Overall course rating (1=poor, 5=excellent)	Comments
July 2008 (*n*=42)	4.9	This will be an ongoing and continuing process…together we can make this mental health approach to recovery work. The presenters worked very hard, and the effect, expertise and energy are appreciated. Nice flexibility to meet audience needs.
October 2008 (*n*=42)	4.7	I learned some useful skills and will apply them. I believe New Orleans could benefit from a second training. There should have been more information given by the presenters and less input from the attendees. I would love for this course to continue. We needed discussion of examples relevant to the city of New Orleans, a city rebuilding post disaster. Excellent training.
February 2009 (*n*=134)	4.73	(Presenters) were exceptional. They interacted with the audience, made examples applicable and were coherent and reflective. This is better than grad school! The materials are so very helpful to case managers. This was a fantastic introduction to CBT. The session on communicating effectively to optimize treatment was excellent. The sharing and networking was very fruitful. Self-care assessment worksheet was fabulous. Very organized. Excellent role-playing practice. The CBT info was presented very quickly. As a new comer, it was a bit difficult to keep up with the pace.
May 2009 (*n*=80)	4.56	I like the fact that we met together—both outreach and clinical. The communicating effectively piece was extremely important as a means of making more informed and ethical decisions. Could maybe spend more time on how to do PDSA cycles and evaluate them. Would like more opportunity to network. PTSD: More theory and less case study. We all know the cases. We need treatment techniques. Also more focus on resilience and protective factors. This CBT course allowed me to open my ideas, correct and refine them and enable me to rationally learn, step-by-step on how to do this work.
August 2009 (*n*=57)	4.69	I liked the idea you involved community members from New Orleans in the training. The serious mental illness was a big help to me. It helped me to understand what's really going on with certain clients. The presentations continue to be relevant and helpful to my work. Expected actual self-care session, not just a discussion- although it was a good discussion. More time set aside for networking. Loved the case studies and role playing.
December 2009 (*n*=70)	4.67	The role plays for suicide were very engaging and essential. CBT: Great training, great educators, great info. Training was very helpful. Loved the self care portion (not only for my own use, but for use with clients as well.) Very good program and useful because I find that generally no matter what the problem, depression is there and it immobilizes the person to act.
March 2010 (*n*=43)	4.54	What about asking a client or two to come and present? The interaction and information…related very much to what I do as an outreach worker. I was able to learn some new tools and put them into practice. Each session has offered additional useful information and reinforcement of previous learning. Professional presentation. Very helpful. Continue…doing presentations and activities combined. It's like a hands-on experience while you're learning.

* MHIT participants reported on several other measures including instructor knowledge, instruction materials, and applicability of knowledge and skills gained. Across all seven training seminars, mean scores for all measures were consistently between four and five on a five point Likert scale.

Use of community participatory methods has been advanced for its value in improving mental health services capacity to support public health, including after disasters.[11,12,25] The MHIT adhered to major tenets of community participatory work including shared power and financial resources, community and academic involvement in all aspects of the project, and mutual respect for all participants' contributions.[11] Project leaders established a project council to create a structure for equitable participation in project development and execution. Comprising multiple community and academic agency partners (Table 1) representing a range of relevant experiences and strengths,[26] the council used consensus decision making to guide the project. During

Table 3. Evolution of MHIT curricular content

	July 2008 participants: 82	October 2008 participants: 67	February 2009 participants: 113	May 2009 participants: 95	August 2009 participants: 76	December 2009 participants: 93	March 2010 participants: 57
All participants	- Collaborative care overview - Patient registry - Measuring and tracking symptoms	- Collaborative care overview - Patient registry - Measuring and tracking symptoms	Previous topics plus: - REACH NOLA partner presentations - Team building - PDSA quality improvement - Communicating effectively - Building clinical and community partnerships - Self-care	Previous topics plus: - PTSD symptoms and treatment approaches - Networking - Care management	- PTSD overview and case presentations - Improving communication - Self-care - Sustainability	- Collaborative care overview - Self-care - Networking	- Collaborative care overview - Implementing collaboration - Self-care - Social networking demonstration
Primary care providers	- Medication management - Working with a collaborative care team - Indications for psychiatric consultation	Previous topics plus: - Patient attitudes towards antidepressants - Coordinating care between providers	Previous topics	Previous topics	No sessions offered for primary care providers	No sessions offered for primary care providers	No sessions offered for primary care providers
CHWs and case managers	- Identifying depression and PTSD - Community education - Referrals and follow-up - Suicidal clients - Basic behavioral activation - Supporting treatment - Relapse prevention - Communicating with providers	Previous topics plus: - Role definition - Building trust - Defining PTSD and depression - Confidentiality - Handling emergencies - Use of PTSD and depression screeners - Other screening tools - Problem solving - Research and evaluation	Previous topics plus: - Tracking outcomes using services log and patient registry	- Previous topics plus: - Building teams - Cultural competency - Working with clients in denial - Medication overview - Serious mental illness - Discussion of challenges and successes - Self-care	- Review of CHW training program successes - Safety strategies - Serious mental illness - Screening and resources for substance abuse - Self-care	May 2009 topics plus: - Research and evaluation	Previous topics plus: - Review of current outreach practices and strategies for improvement - Addressing stigma

Table 3. Continued

	July 2008 participants: 82	**October 2008 participants: 67**	**February 2009 participants: 113**	**May 2009 participants: 95**	**August 2009 participants: 76**	**December 2009 participants: 93**	**March 2010 participants: 57**
Therapists	Overview of evidence-based therapy - Screening for substance abuse - Patient education - Coordinating treatment - Behavioral activation - Relapse prevention - Cognitive behavioral therapy (CBT) or problem solving treatment (PST)	Previous topics plus: - Patient registry	Previous topics plus: - Role of therapist in collaborative care model - Patient registry	CBT - Advanced CBT (for previous participants)	- Description of CBT training program successes - Review of CBT concepts - CBT case presentations - CBT sustainability discussion	- Description of CBT training program successes - CBT implementation discussion	Advanced CBT
Non-prescribing primary care staff (nurses, administrators, care managers)	- Identifying and tracking depression and PTSD - Substance abuse screening - Patient education - Coordinating treatment - Basic behavioral activation - Supporting medication therapy - Coordinating provider communication - Relapse prevention	- Care manager role - Confidentiality - Setting protocols for handling emergencies - Consulting with a psychiatrist - Using screening tools for PTSD, depression, and substance abuse - Behavioral activation	No sessions offered for non-prescribing primary care staff	No sessions offered for non-prescribing primary care staff	No sessions offered for non-prescribing primary care staff	- Topics for care managers - Communicating with psychiatrists and PCPs - Tracking outcomes - Strategies for implementation - Topics for administrators - History of project - Rationale for using collaborative care - Opportunities and challenges of collaborative care implementation	Topics for administrators - Resources and opportunities for collaboration - Creating memoranda of understanding

weekly conference calls, as well as ad hoc and committee meetings, the council identified options for implementing programs using evidence-based services in community settings. Academic partners lent experience in collaborative care for depression[21,22] (Figure 1) and cognitive behavioral therapy.[27,28] Community partners lent substantial expertise in recovery leadership, and conducting community sensitive outreach, education, and referrals among disaster-impacted communities.

RESULTS

Workforce Training

The council developed training curricula and other products to support agencies, primary care physicians, therapists, social workers, care managers, case managers, and community health workers in implementing evidence-based practices. In the context of seven free, open-enrollment trainings offered between 2008 and 2010, community and academic co-leads taught to over 400 participants curricula involving small group discussion, skill practice sessions, and larger lectures. All attendees participated in collective seminars focused on developing organizational capacity to implement elements of collaborative care. Breakout sessions developed profession-specific skills. Curricular elements were modified by the project council over time to reflect trainee feedback (Table 2), community partner needs, and the transitioning landscape of community recovery. The project council added for all participants sessions on team building, networking, plan-do-study-act (PDSA) cycles, and communication to enhance care coordination. Community health workers and case managers received requested information on cultural competency, serious mental illness skills, and self-care. Training in cognitive behavioral therapy came to include an advanced track for previous attendees desirous of further skill development (Table 3).

Resource Support

The project provided financial support and offered more targeted technical assistance to eight community-based organizations to help build capacity for community mental health services as well. Approximately 80% of total project funding was allocated to community agencies, with such assistance primarily facilitating agency hires of clinical and para-clinical staff, including physicians, therapists, care managers, and community health workers. During the two-year project period these agencies collectively delivered over 110,000 mental health services including individual and group therapy, screenings, referrals, and outreach. Technical assistance included weekly support calls to assist teams from primary care clinics that were implementing elements of collaborative care, such as developing patient registries or systems of care management. Academic partners also offered community-based agencies support in implementing an evidence-based model of cognitive behavioral therapy.

Linkages

The project further sought to develop novel linkages among community agencies and providers by facilitating new partnerships, inter-agency communication, and understanding of how agencies and providers may rely on one another as resources. Trainings included round-robin information exchanges to permit providers and potential collaborators to meet, to share information about services at their respective agencies, to collect relevant contact numbers, and to identify opportunities to work together. Existing community resource guides were expanded, building on a longer standing collaboration of Common Ground Health Clinic and REACH NOLA, and updated guides were distributed widely in print and online versions.[29] Trainees in cognitive behavioral therapy developed regular provider meetings to discuss advancement of evidence-based psychotherapy in the broader community. Community health workers initiated monthly meetings to discuss opportunities and challenges in outreach, screening, education, referral, and peer support across their agencies. Efforts were piloted to enable community organizations to make referrals to one another using co-developed protocols. Multiple project products were co-developed and/or distributed for wider community use, some of which may have potential for utility in other post-disaster or low-resource settings (Table 4).

Although MHIT was a services- and capacity building-focused project, community and academic partners also collaborated on pilot data collection, interpretation, and dissemination efforts to document opportunities for advancement of understanding and processes of shared learning.[17] All pilot research efforts affiliated with the project were reviewed and either approved or found to be exempt by each of the RAND Corporation and Tulane University Institutional Review Boards. As examples, Bentham et al in this issue[13] describe the results of a community-academic partnered approach to implementing a model of collaborative care for depression in primary care safety net clinics. Wennerstrom et al[24] describe community-academic participatory development of a community health worker training program for post-disaster mental health needs. Ngo et al[15] describe implementation of a cognitive behavioral therapy training program to support local capacity for delivery of evidence-based therapy and training.

DISCUSSION/CONCLUSION

Post-disaster communities frequently struggle with a predictably complex web of simultaneous challenges – lim-

Table 4. MHIT products and contributions

Target audience	Product: website
Community members and community health workers	Depression can be treated information sheet: reachnola.org/pdfs/depressioncanbetreated.pdf
	PTSD Fact sheet from National Center for PTSD: reachnola.org/pdfs/howisptsdmeasured.pdf
	Self-care and self-help following disasters from National Center for PTSD: reachnola.org/pdfs/selfhelpfollowingdisasters.pdf
	About depression presentation: reachnola.org/pdfs/aboutdepressionpresentation.pdf
	Greater New Orleans Community Resource Guide: reachnola.org/pdfs/communityresourceguide_jan09.pdf
Community health workers and case managers	CHW training videos: reachnola.org/mhittrainingvideos.php
	Mental health safety and emergencies: reachnola.org/pdfs/mentalhealthsafetyandemergencies.pdf
	Problem solving skills presentation: reachnola.org/pdfs/problemsolvingskills_oct08.pdf
	Client services log: reachnola.org/pdfs/serviceslog.pdf
	REACH NOLA Mental Health Outreach Manual: reachnola.org/pdfs/reachnolamentalhealthoutreachmanual2009.pdf
	REACH NOLA Mental Health Outreach Trainers Manual: reachnola.org/pdfs/REACHNOLAMentalHealthOutreachTrainersGuide.pdf
	HIPPA and confidentiality rules: reachnola.org/pdfs/hipparules_jun2009.pdf
	Authorization for release of health information: reachnola.org/pdfs/healthinformationreleaseauthorizationform.pdf
	Client consent form: reachnola.org/pdfs/clientconsentform_template.pdf
	Confidentiality agreement: reachnola.org/pdfs/confidentialityagreement_template.pdf
	Referral form: reachnola.org/pdfs/referalform_template.pdf
Therapists	Psychological first aid (courtesy of National Center for PTSD): reachnola.org/pdfs/ptsdmanual.pdf
	Cognitive behavioral therapy introduction and application training videos: reachnola.org/mhittrainingvideos.php
	CBT Manuals (courtesy of UCLA Health Services Research Center): www.hsrcenter.ucla.edu/research/wecare/CBTmanuals.html
	Problem Solving Therapy (PST) Manual: reachnola.org/pdfs/pstmanual.pdf
	PST problem list: reachnola.org/pdfs/pstproblemlist.pdf
	Problem solving worksheet: reachnola.org/pdfs/pstworksheet.pdf
	Problem solving checklist: reachnola.org/pdfs/pstchecklist.pdf
Therapists and community health workers	Helping someone schedule activities: reachnola.org/pdfs/helpingsomeonescheduleactivities.pdf
	Scheduling activities: reachnola.org/pdfs/schedulingactivities.pdf
Primary care providers	Depression and PTSD screening, treatment, and medication management training videos: reachnola.org/mhittrainingvideos.php
	Collaborative care for treating depression- PCP presentation: reachnola.org/pdfs/CollaborativeCareforTreatingDepression.pdf
	Depression and anxiety- primary care providers presentation: reachnola.org/pdfs/DepressionandAnxietySlides.pdf
Primary care providers, health care administrators, therapists, psychiatrists, community health workers, case managers and care managers	Introduction to the collaborative care model presentation: reachnola.org/pdfs/introcollaborativecaremodel.pdf
	Implementing change presentation: reachnola.org/pdfs/ImplementingChange-PDSAQI.pdf
	Team building, networking, quality improvement, and communicating effectively presentation: reachnola.org/pdfs/TeamBuildingNetworkingQICommunication.pdf
	Care management key components: reachnola.org/pdfs/caremanagmentkeycomponents_jun09.pdf
	Patient path to wellness: Evidence-based treatment for depression and/or PTSD: reachnola.org/pdfs/patientpathtowellness.pdf
	Relapse prevention plan: reachnola.org/pdfs/relapsepreventionplan.pdf
	Team building process forms: reachnola.org/pdfs/teambuildingprocessforms.pdf
	Introduce the care team: reachnola.org/pdfs/introducecareteam.pdf
	Commonly prescribed psychotrophic medications: reachnola.org/pdfs/medicationcard.pdf
	PHQ-2 Depression Screener: reachnola.org/pdfs/phq2depressionscreener.pdf
	PHQ-9 Depression Screener (English): reachnola.org/pdfs/phq9depressionscreener_english.pdf
	PHQ-9 Depression Screener (Spanish): reachnola.org/pdfs/phq9depressionscreener_spanish.pdf
	Primary Care PTSD Screener: reachnola.org/pdfs/ptsdpcposttraumaticstressdisorderscreener.pdf
	Combined Primary Care PTSD Screener and PHQ-2: reachnola.org/pdfs/combindephq2andptsdpcscreener.pdf
	GAD 7 Anxiety Screener: reachnola.org/pdfs/gad7anxietyscreener.pdf
	AUDIT-CAGE Abuse and Dependence Screener: reachnola.org/pdfs/auditgageabusedependencescreener.pdf
	PTSD and seasonal anxiety presentation part 1: reachnola.org/pdfs/PTSDandSeasonalAnxiety-Part1.pdf
	PTSD and seasonal anxiety presentation part 2: reachnola.org/pdfs/PTSDandSeasonalAnxiety-Part2.pdf

ited basic infrastructure, governmental and nongovernmental disorganization and communication failures, decrements of health and social services capacity, exacerbated socioeconomic and racial disparities among disaster survivors, extraordinarily high levels of human need (including among service providers), heightened economic uncertainty and loss, and a pressing need to re-assess and address risk mitigation practices and capacities. In this context, a high prevalence of mental health problems and unmet mental health needs coincident with the disaster, when left unaddressed, may cripple or dramatically prolong individual, family, or community recovery.

This article describes a participatory, health-focused model of community recovery that began with addressing emerging, unmet mental health needs using a disparities-conscious partnership framework as one of the principle mechanisms for intervention. Mental health needs were addressed by: 1) investment in infrastructure and services capacity among small and medium sized non-profit organizations working in disaster-impacted, low resource settings; 2) developing networks and partnerships among health and social service providers that encourage recovery and resilience; 3) training for professionals and non-clinical staff, agency technical assistance, and quality improvement initiatives to improve availability of high quality mental health care for survivors; and 4) development of community resources to promote education, access, and appropriate utilization of services. These interventions promoted concurrent development of new community and academic partnered leadership for the disaster recovery.[14] This model of leadership development may continue to be impactful over time in these communities as sustained networks emerge that facilitate ongoing resource-sharing and knowledge transfer, foster further development of existing community strengths, and create new opportunities for community leadership of recovery efforts, including as trained community health workers.

This project has several limitations. The project was funded principally as a services and capacity building project, not as research, and this framework constrained the prospective design considerations as well as collection and analysis of data that would be necessary to more rigorously evaluate both processes and outcomes. While many elements of the project are likely to be generalizable to broader application and testing, it is possible that aspects of implementation of the project in the post-Katrina environment in New Orleans are in some ways unique. Project partners in many instances were impacted by the disaster themselves, a circumstance which may have uniquely influenced project development and implementation. Additional research is necessary to understand how elements of this model may be applied to impact individual and community recovery, build agency and provider capacity, or encourage resilience.

New Orleans, as with many disaster-impacted communities, faces the risk of recurrent and even seasonal disaster that can exacerbate existing socioeconomic and health disparities. Development of a better understanding of means to expedite mental health and community recovery, and to encourage resilience is important not only to New Orleans but to any disaster-prone community. New and timely research to test evidence-informed models of recovery, and interventions that may promote mental health or resilience, may prove to be of lasting value to diverse populations and communities, domestically and abroad. The costs of research to test evidence-informed models of recovery, and interventions that may promote individual and community resilience, may prove to be not only cost-effective for governments, philanthropy, and service providers, but capable of mitigating substantial human suffering.

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OPPORTUNITIES AND CHALLENGES OF IMPLEMENTING COLLABORATIVE MENTAL HEALTH CARE IN POST-KATRINA NEW ORLEANS

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Objectives: To describe participants' experiences with training on, and implementation of, a collaborative care mental health approach for treating depression and anxiety in post-disaster New Orleans.

Design: Healthcare providers from three organizations that participated in the Mental Health Infrastructure and Training (MHIT) program underwent semi-structured interviews.

Setting: The MHIT program provided training and clinical support to community-based agencies.

Participants: Social workers, care/case managers, primary care providers, and a psychiatrist that participated in trainings.

Intervention: The MHIT project consisted of a series of trainings and clinical support designed in collaboration with specialists from Tulane University, RAND/UCLA, the University of Washington, and local community organizations with the goal of creating local resources to provide screening, diagnosis, triage, and treatment for depression and anxiety.

Main Outcome Measures: Interview participants were asked to describe the impacts of training on the following areas: delivery of mental health services, ability to implement elements of the collaborative care model, care of clients/patients, and development of networks.

Results: Interview transcript analysis identified themes highlighting the opportunities and challenges of implementing a collaborative care model.

Conclusion: Implementation of a collaborative care model for treating depression and anxiety was possible in post-Katrina/Rita New Orleans and has potential for implementation in future post-disaster recovery settings. (*Ethn Dis.* 2011;21[Suppl 1]:S1-30–S1-37)

Key Words: Collaborative Care Model, Hurricane Katrina, Post-disaster, Implementation

Introduction

The prevalence of mental illness significantly increased in New Orleans and surrounding communities following hurricanes Katrina and Rita.[1–4] Existing mental health services were decreased due to provider displacement and damaged infrastructure.[5]

REACH NOLA was created in 2006 to leverage community, healthcare, and academic resources to address community-identified health concerns. Increased community need for mental health resources and a desire to provide high quality, evidence-based, cost-effective care prompted REACH NOLA to create the Mental Health Infrastructure and Training (MHIT) program, which provided a series of community-academic co-led trainings on collaborative mental health care and offered clinical support to local providers and community organizations to address mental health needs in the Greater New Orleans area.[6]

Collaborative care approaches to mental health treatment have been demonstrated effective in non-mental health care setting.[7] The successful implementation of collaborative care and the robustness of its impact across diverse primary care settings have been demonstrated.[8–13] Recent research has shown that collaborative care programs can be adapted for use in adults with chronic medical conditions such as diabetes,[14,15] osteoarthritis pain,[16] and cancer,[17] and successfully integrated within those specialty treatment settings.

Increased community need for mental health resources and a desire to provide high quality, evidence-based, cost-effective care prompted REACH NOLA to create the Mental Health Infrastructure and Training (MHIT) program.

Building on the evidence base of collaborative care models for depression, including Partners In Care (PIC) and Improving Mood Promoting Access to Collaborative Treatment (IMPACT),[18–19] REACH NOLA along with academic partners from UCLA, University of Washington, and RAND, engaged REACH NOLA constituents in a dialogue regarding a proposed series of trainings in collaborative care that ultimately resulted in the offering of seven multi-day seminars between July 2008 and March 2010. This dialogue, which occurred in a variety of venues, helped trainers to begin tailoring materials and goals to the local audience. Training topics included principles of collaborative mental health care, team building in collaborative care, psychotherapies for depression (problem-solv-

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ing treatment and cognitive behavior therapy[20]), fundamentals of medication management of depression and PTSD, opportunities for interagency networking, elements of self-care, quality improvement, and mental health outreach. Training participants included community health workers, counselors, social workers, case managers, primary care providers, administrators, psychiatrists, and psychologists employed by over 70 agencies in the greater New Orleans area. Training content evolved across the training period through feedback mechanisms that included site visits with participating agencies, telephone conference calls with participants, and participant representation on the executive committee.[6]

The REACH NOLA MHIT program is an extension of an overarching community-based participatory research (CBPR) approach to organizing community response to, and recovery from, the Katrina disaster.[5] This process of engaging partners in the development of training content helps ensure that the evidence-based interventions offered in these trainings are tailored to local community/organization resources, capabilities, and contextual factors,[6] and thus to improving the likelihood of longer term sustainability and positive outcomes. In this way, the CBPR approach was utilized as a method of diffusion of innovative, evidence-based models of collaborative mental health care in the Greater New Orleans area.

In this article, we report the experience of a subset of MHIT training participants who received technical/clinical support to implement a collaborative care approach to mental health services in their organizations for treating patients with depression and anxiety (stress and PTSD). Specifically, we present their perspectives on identifying how participation in the training program and implementation support for mental health impacted their experiences of access to mental health care, quality of care, and network development within and across their organizations.

To our knowledge, the REACH NOLA MHIT program is the first time that a collaborative-care-based quality improvement approach for mental health treatment has been applied in a post-disaster recovery setting.

Methods

MHIT Program Training

The MHIT program is described in detail in this issue.[6]

The Collaborative Care Model

Participants in the MHIT program received training in the collaborative care model for depression treatment in primary care based upon the IMPACT study.[19] This model supports the medication management of depression symptoms by primary care providers (PCPs) in the primary care setting. A care manager does initial screenings, coordinates and facilitates further diagnostic evaluation by the PCP, provides in-person or telephone follow-up with patients, tracks treatment response, and provides updated information to the PCP regarding patient care and outcomes between clinic visits. A psychiatrist provides consultative support to the care manager in making treatment recommendations to the PCP. Screening tools are used to track symptoms over the course of treatment, and recorded in an online registry.

Interview Participants

Participants in this study were drawn from a larger sample of training participants. Of the organizations that sent participants to the MHIT program trainings, three had integrated all of the core elements of the collaborative care model, including care manager consultation support by a psychiatrist. Members of these three organizations were chosen to be interviewees for this study. The three organizations include a primary care clinic staffed by clinicians and administrators from a local academic medical center, a faith based community center that provided some health care screening and treatment services with a mobile health unit, and a community healthcare center that offered traditional and alternative care approaches to medical and mental health conditions. Each of these organizations predominantly provides care to low income and uninsured, culturally diverse, with a predominance of African American, clients/patients. These organizations serve adult populations. Twelve healthcare workers from these three organizations (four PCPs, two social workers, two administrators, two care managers, one community health worker, and one psychiatrist) were interviewed for this study (Table 1). Ten participants were women, four were African American, two were Latino, seven were White, and one was Asian American.

Semi-structured qualitative interviews were conducted at participants' offices or by telephone. Topics of the interview included healthcare worker training and background, implementation of the collaborative care model at the participant's organization, perceived appeal of elements of the collaborative care model, challenges of implementing elements of the collaborative-care model in their organization, impact of the MHIT program training on care in their organizations, practice patterns, and their clients/patients (Appendix A).

A REACH NOLA employee who was unaffiliated with the MHIT project conducted all interviews. Interviews were audio recorded and transcribed.

Interview Instrument Development and Analysis

The interview guide (Appendix A) for this study was modified from a guide developed for assessment of satisfaction with a collaborative-care program for treating depression and osteoarthritis pain in elderly patients.[16]

Table 1. Characteristics of participants interviewed

Age (y)	Sex	Training	Highest Degree	Current position*	Years at position†
41	F	Public health	Masters	Executive director	2+
33	F	Medicine	MD	Physician	1+
35	F	Medicine	MD	Physician	4
35	F	Medicine	MD	Physician	1+
65	M	Education/counseling	Masters	Program coordinator	1+
29	F	Sociology	BA	Social service support	1+
40	F	Social work	Masters	Social worker	2+
34	M	Medicine	MD	Physician	2+
51	F	Nursing	BA	Community wellness director	3.5
27	F	Behavioral psychology	BS	Care/case manager	10 months
40	F	Nursing	Masters	Director of clinical services	1.5
35	F	Social Work/public health	Masters	Social worker	1

* position at current organization at the time of interview
† number years at current position

Three of the authors (KB, WB, SV) independently reviewed blinded interview transcripts to identify comments that fit into the following areas: 1) access to mental health care, 2) quality of care, and 3) network development within and across organizations. From these comments the authors generated themes. Transcript comments that did not fit into the three above areas were not included for further analysis. The three authors then compared themes and came to consensus on a set of overarching themes that were labeled as opportunities and/or challenges of implementing a collaborative care model in these organizations in post-Katrina New Orleans.

Results

Themes from the interviews were organized into two broad categories: 1) opportunities- themes that represent participant perceptions of improvements in access, care delivery, community impact with the implementation of the collaborative care model and, 2) challenges- themes that represent participant perceptions of difficulties in implementation of the collaborative care model in their organizations. Themes and supporting quotes for each category are presented in Tables 2 and 3.

Opportunities

Improved Client/Patient Access to Mental Health Care

Two organization administrators reported that implementation of elements of the collaborative care model improved organizational capacity to offer mental health services on site. These participants also suggested that integrated mental health services reduced the stigma clients/patients can associate with requesting mental health support. Also, they reported that MHIT's community health worker training program was valuable for identifying individuals in need of care in the community, again decreasing stigma about seeking mental health care.

Team Approach to Care and Improved Communication between Providers

Primary care provider participants, whose clinic had an onsite psychiatrist, social workers, and a care manager, valued having access to the care manager who provided information between patient visits. They appreciated having the support of readily accessible mental health care providers. The social worker participants from this same primary care clinic reported that they appreciated having their expertise valued and having a venue to discuss client care with other providers.

Improved Screening

Overall, participants reported that regular screening for depression and anxiety improved mental healthcare processes. A care manager reported the symptom specific screening tools, PHQ-2 & PHQ9, facilitated non-stigmatizing dialogue with patients focusing on improving functioning and accessing services. Primary care provider, social worker, and care manager respondents also reported that screening tools facilitated tracking of, and team communication about, client/patient progress. Some organizations integrated screening tools into the workflows of community outreach workers.

Care Management and Coordination of Care

All participants reported that the care manager role was integral to the success of a collaborative care model. Participants identified the care manager not only as a role, but also as a set of functions that can be distributed across different members of a care team. Some participants reported distribution and modification of care manager functions to fit their organization's service structure and needs. Others reported identifying a dedicated person as a care manager.

Table 2. Themes that describe opportunities as a result of implementation of collaborative care model

Theme	Example quotation
Team approach to care	''My impression was that the patient care should be done by both the primary care and the mental health providers… as a true collaboration with the mental health provider and the primary care provider working hand-in-hand.'' [SW]
Care management and coordination of care	''Having the care manager coordinate mental health patients and implementing the screening on all our patients have been two biggest things that I've noticed that have helped improve our processes, and improve the flow of patients as well as hopefully the outcomes of patients.'' [ADM]
Improved screening	''The screening tools have been helpful… in trying to get people to see how what's been going on with them is affecting different areas of their lives.'' [CM]
Improved access to care	''Coming from a culture where mental health is almost like a taboo subject…we made it a little bit more acceptable to come in and request to see a social worker, or request that you would like to talk to someone about what's going on.'' [ADM-2]
Improved between visit follow-up	''Being able to discuss the patient's care with the care manager, informally, in between visits…because a lot of times they get different sides of the story.'' [PCP]
Improved communication between providers	''Helps to lessen the hierarchical kind of structure that often occurs in a primary care clinic between mental health people and the primary care physicians.'' [SW-2]
Improved focus on mental health issues	''The training has personally helped me grow in my knowledge of mental health issues. And therefore has helped me to get our program in a better shape than what it was before. And then by doing that, it's just helped the patients in the long run too.'' [ADM] ''I tend to use anti-depressants a lot more because the conversation comes up. I tend to refer a lot more for cognitive therapy than I ever did before. And also I'm always going to be following up relatively quickly.'' [PCP-2]

ADM= administrator; CM= care manager; PCP= primary care provider; SW= social worker

Improved Follow-Up between Clinic Visits

The structure for tracking clients/patients was one of the most appealing aspects of the collaborative care model, as reported by social worker, care manager, and PCP participants. These participants viewed the collaborative care model as a tool to prevent clients/patients from falling through the cracks. Participants reported patient tracking highlighted engagement issues sooner, creating opportunities for earlier intervention.

Improved Focus on Mental Health Issues

Comments by two PCPs, social worker, and director of clinical services participants highlighted that MHITs program training improved their knowledge and focus on mental health issues

Table 3. Themes that describe challenges with implementation of a collaborative care model

Theme	Quotation
Lack of onsite medical services	''The fact that we don't have everything under one roof is one of our biggest problems.'' [ADM]
Integration of care manager	''We've parachuted some roles into the clinic setting on top of people who already had other work to do. And it felt burdensome, particularly for the social workers who wanted to start doing care management tasks on top of the tasks that they're already responsible for.'' [PSY]
Provider and patient buy-in to use of model	''Asking primary care providers to be engaged in treatment and addressing mental health issues… requires a certain change in culture and outlook. And you have to have significant buy-in from the different members of the team.'' [SW] ''Our referral process and getting the patients to the services and just the steps that we have to follow. It seems to be ever changing.'' [PCP] ''There are some patients who say they agree to the care management, to the collaborative care model, and they really don't. They don't want anybody calling their house… you can't get in touch with them, for whatever reason.'' [CM]
Patient registry	''We looked into the online database type patient registry. Although it was good in and of itself, we were also at a point where we were trying to implement our electronic medical record system so we felt that it was necessary for us to put in our energies into establishing our own in-house system.'' [ADM-2]
Screening tools	''… the PHQ-9. In one sense it's appealing because it's objective and it's something that you can quickly look at as snapshot for progress. On the other hand I've noticed and we've had a lot of comments from those in our organization about it, feeling that it wasn't accurate.'' [PCP-2] ''I find the PHQ9 is not the best screening tool because sometimes the patients are confused by it… (they) have a hard time reading it and understanding what we're really asking.'' [PCP-3]

ADM= administrator; CM= care manager; PCP= primary care provider; PSY= psychiatrist; SW= social worker in their day-to-day work. The PCPs reported increased comfort in screening for depression and anxiety, use of antidepressants, and referral for specialty mental health services to the care manager or social worker.

Challenges

Lack of Onsite Services

Participants identified not having all service elements, particularly onsite PCP's, within their given organization as a barrier to implementation. Other participants reported that having few organization staff with multiple responsibilities, and part-time organization staff, as challenges to implementation of the collaborative care model as well.

Integration of Care Manager

Social worker, care manager, and psychiatrist participants reported that addition of care manager functions to existing responsibilities was difficult, creating a perception that the collaborative care model was too burdensome to implement and represented additional work on already strained resources. Some organizations resolved this by dedicating a staff member to care management or distributing care manager functions among different individuals.

Care manager participants also reported lack of infrastructure such as office space and protected time to meet with clients/patients as barriers to implementation of care management. One care manager reported that lack of a formalized process for introducing the care manager to a patient/client prior to follow-up telephone contacts made client/patient engagement difficult.

Initial Provider/Client Buy-in

Care manager and social worker participants reported that implementation required consistent buy-in and support from different levels within an organization as implementation necessitated change to existing organization structure and culture of care. Care manager participants reported experiencing these changes as frustrating because clinicians did not: consistently use protocols within the collaborative care model, use screening tools, or update the team about patient status as care progressed.

Primary care provider participants experienced difficulty with implementation because the mental health referral process seemed to be ever changing. Screening all patients for depression added an additional task that seemed to compete with other care objectives within a clinical visit. Social worker/care manager participants suggested that the collaborative care model may challenge a PCP's philosophy about what is, or is not, within scope of care and clinical responsibility.

Finally, social worker, care manager, and PCP participants identified the clients/patients as barriers to effective implementation of collaborative care. Some patients would express initial interest in addressing mental health needs, but did not appear for initial appointments with the care manager. Other patients began a collaborative care treatment plan, but did not keep follow-up appointments, or respond to between-visit telephone calls.

Web-based Patient Registry Implementation

None of the participants reported implementation of the web-based patient registry designed to support collaborative care. Barriers to implementation included perception that the registry was too difficult to use in a non-primary care setting and concern that it was redundant in an organization that already had an electronic medical record (EMR) system. One organization administrator reported that interest in using the web-based registry competed with scheduled updates and modifications to their EMR systems; and so it seemed simpler to use their existing EMR to do some of the registry functions rather than implement the registry itself.

Screening Tools

Some participants questioned whether screening tools accurately reflected patients' functioning as they reported that some patients found questions confusing or had difficulty completing the questionnaires, possibly due to limited literacy.

Discussion

This study attempted to gain impressions from program participants regarding the application of a collaborative care model to address depression and anxiety. The results suggest that participants in the REACH NOLA MHIT program were open to implementation of the collaborative care model of delivering mental health services, and valued the training and support provided by the MHIT program.

That participating organizations were able to integrate the core components of the collaborative care model suggests that the CBPR approach to organizing community response post-disaster is an effective method for diffusion of innovative, evidence-based mental health interventions. A critical

The results suggest that participants in the REACH NOLA MHIT program were open to implementation of the collaborative care model of delivering mental health services, and valued the training and support provided by the MHIT program.

step in the diffusion and dissemination of service delivery innovations is the engagement of key stakeholders, decision makers, change agents, and communicators.[21] The CBPR process in general, and the MHIT program in particular, accomplished this objective.

Collaborative care models of mental health treatment build upon the strengths of primary care and mental health approaches to care, and evidence-based approaches to chronic disease management.[22] These strengths appear to be the same elements that participants reported as appealing: the multidisciplinary approach to client/patient care, systematic screening, tracking of outcomes, and utilization of a specialized care manager.

The limited mental health resource environment of this implementation fostered creative implementation of the collaborative care model. Sharing of resources across organizations for care management and primary care occurred among some of the participating organizations. Within some organizations, the care manager tasks were distributed creatively to address client/patient needs. Probably the most novel incidence is the integration of outreach/community health workers into the collaborative care model. These individuals were trained to do screenings for depression and anxiety, trained in problem-solving therapy, and trained to foster connection of potential clients/patients to primary care and other healthcare centers in the community.[23]

Physician participants in this study indicated that having close follow-up by the care manager was a valuable component of the collaborative care model. This finding is similar to that of a survey of physicians who participated in the IMPACT trial, which demonstrated that given limited PCP time and resources (even in a non post-disaster setting), having a care manager whose responsibility it is to educate patients about mental illness and provide structured follow-up between clinical visits as the most helpful component of the collaborative care model.[24]

Participants report the advantage of tracking data on patient progress, yet found implementation of a web-based registry burdensome, particularly in those organizations that already had EMR systems in place. The function of a registry to support collaborative care is not only to be a repository of disorder specific data over the course of treatment, but to also present the data in a way that encourages its real-time use for clinical decision making. Integration of a web-based registry does require specialized local IT support, and access to this may have been a barrier to its implementation for organizations. The registry approach to managing data can be done manually in a pen and paper fashion. This approach has been successful in other low resource settings.[25] This option was not specifically highlighted in the trainings and might have been a more viable option for the care managers.

A number of respondents in this study commented that implementation of a collaborative care model in their organizations met with some resistance, and suggested that this was due to perceptions that treating mental health was not within scope of the PCPs' practice, that PCPs did not have enough training to participate, or that collaborative care tasks such as screening were too time consuming. Previous studies of provider satisfaction with a collaborative care model suggest that these attitudes change over time with continued organizational, administrative buy-in and support of the collaborative care model.[24] Previous studies have also shown that objective evidence of client/patient improvement was the single most important factor, and motivator, for participating providers to continue with the collaborative care model.[19,24,26]

Of special consideration, however, is the impact of post-disaster and recovery conditions on healthcare providers of all types in New Orleans. It is well documented that while providing care to the community in the context of often unpredictable and shifting priorities that can characterize recovery in a post-disaster setting, providers were also experiencing their own trauma and losses as a result of the disaster.[27,28]

This post-disaster impact is also relevant to patients/clients, many of whom were very focused on rebuilding their homes, which took priority over seeking mental health care.[27] The reality is that for many served by the organizations that participated in the MHIT program, stable housing, telephone or other methods of contact were still not in place. These two realities may well explain why some clients/patients, while expressing interest in addressing their mental health needs, were not able to consistently follow-up.[27,28]

This study was conducted in the context of a quality improvement effort without additional resources to do structured evaluation of the collaborative care model in this post-disaster setting and therefore this study has significant limitations. First, only a small fraction of those who participated in the MHITs program were interviewed, so perspectives offered here are not necessarily generalizable to the rest of the program participants. Second, there was no control group, or usual care group, for comparison, and so there is no way to identify what factors are most salient to successful implementation of a collaborative care model in this post-disaster setting. Third, the results reported here represent perspectives offered only after implementation of the MHIT program. Without pre-implementation data for comparison, we are unable to comment definitively on any changes in attitudes, motivations, or clinical practices. And finally, no client/patient outcomes data were gathered, and so any conclusions about the effectiveness of the collaborative care model in this setting are speculative at best.

In spite of these limitations, this study highlighted some interesting points that may serve as initial guidance for future implementations of collaborative-care models in a post-disaster setting: 1) by their nature, collaborative care models are flexible and allow for creative implementation, particularly with regard to screening and care manager functions; 2) it is feasible to integrate community health workers into screening and intervention components of the collaborative care model; 3) the role of the care manager is a fulltime task and in limited resource situations, sharing care manager tasks with dedicated support to do the tasks may be the best way to approach getting the tasks integrated; 4) screening tools can be very effective at decreasing community stigma about mental health issues by helping clients/patients focus on functional improvement; and 5) it is possible to obtain components of the collaborative care model by sharing resources across organizations.

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Appendix A. Interview guide

- How does collaborative care for depression work?
- Were there elements of the collaborative care program that were more appealing than others?
- What do you like most about the collaborative care program at your organization?
- What were some of the challenges for your organization to implement the collaborative care program?
- What have been the most important barriers to implementing the collaborative care program?
- Were there elements of the collaborative care program that were less appealing than others?
- What would you say you liked least about the collaborative care program and how it could be improved?
- What aspects of the program have been most helpful to your patients?
- What aspects of the program have been most helpful to you?
- Is there anything that could have been done differently to encourage uptake or use of the collaborative care model by your organization?

BUILDING CAPACITY FOR COGNITIVE BEHAVIORAL THERAPY DELIVERY FOR DEPRESSION IN DISASTER-IMPACTED CONTEXTS

Numerous challenges exist in implementing evidence-based practices, such as cognitive behavioral therapy, in resource poor, ethnic minority, and/or disaster-affected communities with disparities in mental health. Community-academic participatory partnerships are a promising approach to addressing disparities by implementing community-appropriate, evidence-based depression care. A community-academic collaborative was formed in New Orleans after Hurricane Katrina to expand resources for effective depression care, including cognitive behavioral therapy. In this article, we: 1) describe our model of building capacity to deliver cognitive behavioral therapy for depression in post-disaster community-based settings; 2) discuss the impact of this training program on therapist reported practice; and 3) share lessons learned regarding disseminating and sustaining evidence-based interventions in the context of a disaster impacted community. Using a mixed methods approach, we found that this model was feasible, acceptable, and disseminated knowledge about cognitive behavioral therapy in community settings. Over the course of two years, community providers demonstrated the feasibility of implementing evidence-based practice and potential for local community leadership. The lessons learned from this model of implementation may help address barriers to disseminating evidence-based interventions in other low-resource, disaster-impacted community settings. (*Ethn Dis.* 2011;21[suppl 1]:S1-38–S1-44)

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INTRODUCTION

Disasters such as Hurricanes Katrina and Rita are associated with psychological problems among survivors.[1] Approximately one-third of Gulf Coast residents affected by the 2005 storms experienced symptoms of psychosocial distress including depression.[2] In New Orleans, the increased need for mental health services, coupled with the closure of health care delivery sites and lack of psychosocial service providers left many residents without access to quality care.[3,4] As in other low-resource communities, evidence-based practices (EBPs) for depression treatment such as cognitive behavioral therapy (CBT),[5,6] were not widely available in a range of community-based agencies where people sought depression care such as community mental health agencies, psychiatric hospitals, primary care settings, faith-based counseling centers, substance abuse agencies, and private practices.

Little is known about how to effectively build capacity for the delivery, implementation, and sustainability of CBT and other EBPs in post-disaster settings.[7] Community-based agencies face complex challenges, including insufficient dissemination of research findings and practice guidelines to therapists, lack of staff training opportunities, insufficient funds and resources, therapist burnout, negative beliefs about EBPs, lack of motivation, and other organizational barriers to adopting new practices.[8–9] These issues are compounded and even more difficult in low-resource, ethnic minority, and post-disaster communities due to significant provider shortage in an already over-burdened mental health system.

Successful depression care quality improvement (QI) interventions in primary care settings involving a manualized CBT program show promise for use in community settings.[10–12] However, there is a critical gap in our understanding of the factors associated with successful implementation of CBT in community-based settings.[13,14] Research on CBT dissemination is particularly relevant for disaster-affected communities in which existing resource limitations are further weakened by infrastructure devastation, loss of human resources, as well as concurrent trauma recovery of mental health providers.[2,15]

Community-based participatory processes have been identified as a promising approach for disseminating EBPs for mental health problems in low-income ethnic minority communities,[16] and we believed this approach would be appropriate in a post-disaster setting. Central to this approach is the use of community engagement strategies to build equal, collaborative relationships among researchers and community members so that expertise from the field may guide the research process and increase the likelihood of producing sustainable programs.[17] The REACH NOLA Mental Health Infrastructure and Training Project, (MHIT)[18] described in detail in this issue, was a community-academic partnered effort aimed at rebuilding mental health infrastructure and strengthening the service network system following Hurricane Katrina. The initiative provided training and implementation support for a collaborative care model for depression, a team-based approach across a range of providers and service organizations to deliver depression care including care management, medication management, and CBT through a series of workshops and community planning meetings.

This effort provides an opportunity to examine CBT training and implementation in community-based practices, including psychiatric hospitals, mental health, faith-based, and primary care agencies recovering from disaster. This article describes a community-academic partnered approach to implementing CBT in a resource-poor disaster-impacted context, discusses the impact of this training program on therapist reported practice, and reports lessons learned regarding implementing and sustaining CBT in a post-disaster community setting.

METHODS

We first describe our community-partnered model for building capacity in CBT in community settings and the activities delivered through the REACH NOLA MHIT CBT Program. We will also discuss the mixed methods evaluation approach to document the implementation of CBT and examine the impact of our training program on community therapists. Specifically, three substudies will be described: 1) survey of CBT training and implementation, 2) workshop discussion on implementation of CBT program, and 3) focus group with CBT phone consultation participants.

REACH NOLA MHIT CBT Program

REACH NOLA is an umbrella non-profit organization that brought together academic and community partners to develop the Mental Health Infrastructure Training project that involved several depression care components, including psychoeducation, outreach, care management, medication management, and CBT. The MHIT CBT Program aimed to improve quality of mental health services through use of community engagement strategies and organizational outreach, training workshops on CBT for depression, ongoing support for implementation, and development of local leadership in the New Orleans community.

Community engagement and outreach are essential for uniting academic and community stakeholders and for successful dissemination of mental health interventions in ethnic minority community settings.[17,19] At the beginning of the REACH NOLA MHIT project, academic and community co-leaders met with a wide range of community-based agencies such as primary care clinics, mental health specialty agencies, non-profit organizations, and neighborhood associations to learn about community context, assess community needs, and develop partnerships. Individual follow-up phone calls were also made to REACH NOLA MHIT CBT workshop participants, administrators, and clinical directors to obtain feedback about the first workshop and suggestions to improve and tailor the training program to better meet the needs of community providers. The community-partnered approach allowed for the planning team, consisting of both community and academic partners to weigh the costs and benefits of various training approaches and training topics to cover, including the decision to focus formal therapy training on depression. Although the need for trauma treatment was evident, the complexity of training community clinicians on treatments for both depression and trauma disorders was not feasible. Agencies and clinicians wanted foundational training on evidence-based mental health treatments that could be relatively easy to train, reach a greater number of clients, and sustained in real world agencies. We therefore selected a manualized cognitive behavioral therapy for depression with demonstrated effectiveness in diverse community settings.[20] However, training on trauma awareness, trauma diagnoses and assessment, and information about trauma treatments were provided to help providers be more trauma-informed. In addition, self-care training to support providers also addressed issues related to trauma and secondary trauma exposure and promoting positive mental health for providers within our system.

In-person organizational outreach was conducted at four community mental health agencies that elected to participate in CBT implementation support to assess community and agency context and needs. These meetings were critical to obtain administrative buy-in of the EBPs, learn about community context, identify common goals for training, tailor programs to meet agency needs, and provide implementation support for the ongoing consultations.

Workshops

Over a year and a half (6/2008–12/2009), six CBT training workshops were provided to 132 therapists from 40 community agencies as part of the broader REACH NOLA MHIT training program. The workshops consisted of a 1- to 2-day overview of a manualized CBT for depression program,[21,22] which included three modules: 1) thoughts and mood, 2) activities and mood, and 3) people interaction and mood. Trainings focused on discussion of theoretical background of CBT, case conceptualization, cognitive restructuring, activity scheduling, thought logs, as well as strategies to address barriers to CBT implementation. The CBT program included options for group or individual therapy. The workshops consisted of didactic presentations, case study reviews, role plays, exercises, video review, and discussion about ways to balance delivery of evidence-based practice with ways to individualize the program to meet needs of various populations and issues. A CBT therapy toolkit, which included CBT provider manuals (both group and individual treatment), client workbooks, depression screener (eg, the Patient Health Questionnaire – 9),[22] and exercise worksheets, were provided.

Ongoing Consultations

Effective implementation of CBT requires extended consultation with a CBT expert.[7,23–24] Two types of phone consultations were offered: 1) one-hour weekly open group conference calls to provide technical assistance, such as session review or troubleshooting/feedback held on a drop-in basis, and 2) one-hour weekly individual phone consultations, involving review of audio-recorded sessions of the MHIT CBT for depression program. Consultations focused on providing feedback on fidelity to the treatment manual and core CBT skills as well as troubleshooting implementation barriers, discussing ways to tailor manual language and examples, engaging ethnic minority clients around depression care, and modifying the treatment to fit clients' socio-cultural needs and post-disaster contexts. All trainees that participated in the workshops were invited to participate on the group conference and/or individual phone consultation calls. Attendance was infrequent and inconsistent in the group conference calls, which were intended for providers unable to commit to the weekly individual support of one treatment case (12–15 weekly sessions). After several months, only trainees from agencies that received organizational outreach participated in both types of ongoing phone support. On average, five providers from three community mental health agencies attended the weekly group consultation. Thirteen therapists from the same three agencies participated in the intensive phone consultation, ten completed one case, and three had continued intensive phone consultation for a second case, including group therapy. Three therapists co-consulted and supported a new trainee at their respective agencies.

Leadership Development

A core group of three self-selected therapists received additional leadership support to train local therapists on the CBT for depression. The leadership development model included support for workshop presentations, weekly trainer/leaders meeting for strategic planning, including organization and outreach activities, identification of group needs, development of CBT peer network for local providers, and problem solving barriers to implementation. After approximately one year, the local training team participated in workshop planning and gradually assumed responsibility for workshop presentation to the local team, as well as sharing of phone consultation responsibilities. By December 2009, two members of the local CBT training received further CBT training and certification at the Beck Institute for Cognitive Therapy and Research. These individuals will continue to provide trainings to local agencies and therapists and organize a CBT professional support network to share resources and exchange peer consultation.

Table 1. Demographic characteristics of research participants (N=35)

Demographic Variables	*n* (%)
Age (mean, SD)	44.42 (13.80)
Female	26 (66.7%)
Ethnicity*	
African American	3 (8.8 %)
White American	29 (82.9%)
Latino American	3 (8.6%)
Other	1 (2.9%)
Educational Level	
College	4 (11.8%)
Masters	29 (82.9%)
PhD	1 (2.9%)
Other	1 (2.9%)

* Percentages do not add up to 100% because some respondents endorsed more than one group.

Study #1: Survey of CBT Training and Implementation

A 40-item survey of trainees at CBT training workshops five and six (August 2009 and December 2009) was conducted to assess effectiveness of training, use of resources and impact on clinical practice. Thirty participants attended the fifth workshop, and 18 (60%) completed the survey. Fifty-three people attended the sixth workshop, and 22 (42%) completed the survey. Of those, 5 previously completed the survey in August 2009. Only responses from their last survey (6th workshop) were analyzed. The respondents (N=35) were primarily female (68%), White American (83%), and had an average age of 44.82 (SD 13.80) (Table 1). Most respondents reported master's degree education (83%), worked in community mental health settings (66%), and identified themselves as a counselor/therapist (62%) or social worker (36%) (Table 2). On average, respondents had extensive experience in the field, reporting an average of 10.38 (SD 10.39) years of therapy experience, with 6.47 (SD 8.16) years of experience at their respective agencies. Therapists reported that they had an average of 14.40 (SD 7.89) patients per week.

Table 2. Participants' settings and positions

Settings*	*n* (%)
Community Mental Health	23 (65.7%)
Psychiatric Hospital	4 (11.4%)
Substance Abuse	4 (11.4%)
Private Practice	4 (11.4%)
Social Services	4 (11.4%)
Faith-based Organizations	7 (20%)
Positions*	
Social Workers	12 (36.4%)
Case Managers	5 (14.7%)
Counselors	21 (61.8%)
Administrators	4 (12.1%)

* Percentages do not add up to 100% because some respondents endorsed more than one group.

Survey

Single retrospective self-reported items were used to assess level of expertise and level of use of CBT before and after CBT training (eg, "please rate your level of expertise with CBT before the CBT training"; "please rate your level of use of CBT after the CBT training"). Participants were also asked to rate how helpful phone consultations, workshops, and materials were to learning CBT; how often they used CBT in their clinical

Table 3. Ratings of training helpfulness and utility

	Not at all (1)	A little (2)	Somewhat (3)	A lot (4)	Extremely (5)	Mean (SD)
Helpfulness						
Workshops			16.7%	50%	33.3%	4.17 (.70)
Materials	0%	3.8%	11.5%	50%	34.6%	4.15 (.78)
Consultation	10%	0%	30%	0%	60%	4.00 (1.41)
Usefulness						
CBT Training	3.4%	0%	10.3%	82.8%	3.4%	3.83 (.66)

practice; how often they used manualized evidenced-based treatments; and how often they used CBT in depression before and after the training. Self-ratings were on a 5-point Likert scale.

Study #2: Workshop Discussion on Implementation of CBT Program

An open-ended unstructured discussion session focused on CBT implementation was held at the final workshop in December 2009. The discussion lasted two hours and included all participants at that workshop (*N*=53). The discussion was facilitated by the four trainers of the workshop as part of a quality improvement process to better understand therapist perspectives about: 1) the needs of the community, 2) barriers in implementation, as well as 3) the successes in implementation and solutions for barriers. Extensive notes were taken during this discussion and reviewed for accuracy and elaboration of context by all trainers who participated in the discussion.

Study #3 Focus Group with CBT Phone Consultation Participants

All 13 therapists who participated in the phone consultation process were invited to participate in one semi-structured, two-hour focus group that covered: 1) experience in the individual phone consultation process; 2) experience implementing the CBT manual for depressed clients; and 3) plans and challenges in sustaining the program after the training period. Five therapists participated. The REACH NOLA MHIT project manager, who was not involved in the CBT training, facilitated the focus group.

Qualitative Analyses

Both the focus group notes and implementation discussion notes were thematically analyzed[25] independently by four members of the academic-community research team to understand the impact of the training experience, challenges to implementing CBT in New Orleans, as well as possible solutions. Each researcher reviewed notes independently and identified themes in the aforementioned areas. Themes were generally consistent, although formal inter-rater consistency was not assessed. We held two meetings following the independent thematic analyses to discuss themes, evaluate discrepancies, reach consensus regarding themes pertaining to benefits, barriers, and participant suggestions, and identify the most important lessons learned from these discussions.

The survey instrument, focus group interview guides, and procedures were approved by institutional review boards at RAND and Tulane University. No financial incentives were offered to study participants.

RESULTS

Study #1: Training Survey

Approximately half of the respondents (49%) attended only one workshop, 31% attended 2 or 3, and 20% attended 4 or more. Among respondents that had attended a previous MHIT CBT training (*n*=18), 50% indicated that they used the group therapy manual and 67% the individual therapy manual. Seventy-eight percent indicated that they used the PHQ-9 to assess depression symptoms; 67% reported use of the MHIT CBT manual worksheets and exercises; 44% reported use of the advanced training worksheets and 50% reported use of the exercises. Thirty-three percent reported utilization of phone consultation and 27% contacted CBT trainers for assistance regarding implementation. The workshops, materials, and phone consultations were rated highly, with mean scores on helpfulness 5-point scale ranging from 4.00–4.17. The overall usefulness of the CBT training had an average rating of 3.83 (SD .66) (Table 3).

Correlational analyses of number of CBT workshop training sessions attended and reported change (before and after training) in expertise and use of CBT show that the number of training workshops attended were positively associated with self-rated expertise in CBT ($r=.39$, $P<.05$) and marginal significance for general use of manualized treatment ($r=.37$, $P=.056$). No relationship, however, was found for increased use of CBT, suggesting that trainees perceived increased expertise/knowledge about CBT and manualized treatment, but that this did not necessarily translate into increased use of CBT treatment for patients. Six therapists (30%) indicated that they completed CBT treatment with one client and two therapists (10%) completed the CBT program for 4–6 patients. The majority of therapists (85%) reported that they used parts of the manual with an average of 9.89 patients, (10.82 SD) ranging from 1 to 30 patients.

Study #2: Workshop Discussion on Implementation of MHIT CBT PROGRAM

Themes related to benefits of the CBT program, barriers to implementation, and recommendations were identified in the workshop discussion. Workshop participants expressed interest in receiving additional CBT trainings, and participating in a peer group, group phone consultation, and/or an online forum, if they were developed. Thirty-five of 53 therapists in attendance at the CBT workshop discussion identified interest in support for CBT implementation, 22 indicated interest in future trainings, ten identified interest in both trainings and consultations, and one committed to becoming a trainer.

Benefits

Therapists relayed experiencing various benefits to participating in the REACH NOLA MHIT CBT training. Most notably, therapists reported gaining valuable clinical skills and observing positive changes in clients. For example, a therapist stated that the training "improved all of my skills. I'm now using it for more clients." The routine use of depression symptoms scales was seen as particularly helpful, as it not only provided data to clients regarding their progress, but also helped demonstrate the effectiveness of the program and increase agency buy-in, which facilitated the CBT implementation. In addition, the therapists commented on the flexibility of the CBT program, which allowed them to make it their own.

Barriers

Therapists noted several structural barriers to implementing the CBT program, with two main themes related to administrative buy-in and limited resources. Logistics and costs associated with printing and preparing CBT materials for therapists and patients were viewed as a barrier. Some therapists noted that organizational instability, such as program and role changes impeded CBT program implementation. Client barriers such as inconsistent session attendance, non-compliance with homework, and desire for more supportive therapy were reported as hindrances to implementing the CBT program. Therapists who received consultation reported that as they became more experienced with the intervention, clients became more consistent with attendance and homework compliance. Clients also showed greater improvements in PHQ-9 scores, and they reported a greater sense of support, confidence, and satisfaction with their current therapist than in past therapeutic relationships. Further, therapists reported that increased experience with the model led to greater transferability of concepts to a wider range of clients.

Participants' Suggestions

Although therapists noted some success with the CBT program, they voiced a need for more focused trauma treatment and requested adaptations for African American faith communities. Therapists discussed the need to develop outreach efforts in non-traditional settings such as churches, noting that even though the CBT program may be effective, stigma associated with seeking help for mental health services continues to be a significant barrier. One therapist working in a faith-based setting stated, "…I have kids who would rather go to jail than to a clinic" for help with mental health concerns.

Study #3: Focus Group with BRIGHT Phone Consultation Participants

Benefits

Therapists who received long-term phone consultation to support implementation of the REACH NOLA MHIT CBT for depression program identified several benefits to consultation participation including opportunities for professional development and collaboration with other therapists, and the potential to increase capacity to address post-Katrina demand for services that resulted in long wait lists at multiple agencies. They viewed participation in phone consultation as valuable to their practice, citing having a "higher level of competency because of this training," and increased self-efficacy and confidence in administering CBT. One participant noted that feedback received during consultation was "one of the most valuable" elements of the program and another said that even among competent therapists "trainers can always pick out some little thing they can improve on," suggesting that consultation may accommodate therapists from a wide range of skill levels. Therapists also believed consultation supported the modifications they made to the model and offered them practical suggestions for applying the program.

Participants who received consultation reported positive effects on clients including improved PHQ-9 scores. The program's homework assignments were viewed as valuable for their ease of use and for allowing clients to translate knowledge into practice. Several therapists believed the manual was helpful in treating difficult clients who claimed knowledge of the material or were hesitant to apply concepts. Participants reported that a facilitator of adoption was the evidence of benefits to clients. Therapists reported that they were motivated and inspired by client's ability to clearly define and monitor their own progress and decrease their time in therapy. Therapists noted decreased caseload due to implementation of the program.

Barriers

Therapists identified barriers to implementation including the time commitment required, difficulty of leaving work to attend training sessions, and uncertainty about employer support for participation. The CBT training, described as a "flooding model," with too much information presented at once, was viewed as overwhelming to therapists. They suggested a developmental model, where skills training would be systematically and incrementally increased with each workshop. Therapists identified a need for additional CBT trainers, including local staff to provide support and promote the project to new participants. Insufficient protected time to receive adequate consultation was a concern, as were delays due to technological problems with recording equipment.

Participant Suggestions

Participants offered several suggestions for expanding implementation of the program. They reported that training seminars would be improved by extending the length from one to two days; covering only one module of the manual per seminar, rather than all three in one workshop; allowing more practice using tools; using exercises on oneself to gain familiarity with materials; working in small groups facilitated by someone with advanced skills; and using teleconferencing to facilitate participation of new therapists.

Therapists also presented the following recommendations for improving the manual: adding an additional module on PTSD, as it is relevant in the post-disaster context and may result in violence and substance abuse; altering the language and drawings to be more culturally appropriate and accessible for populations with limited education; adding language specific to disaster recovery; and altering the manual to be appropriate for children, clients involved in the penal system, and members of faith communities. Participants reported they had already adapted the program in various ways to suit the needs of clients, such as administering the modules non-sequentially, scheduling two sessions for each one in the manual, and planning for sessions to run longer than usual.

Greater community participation in the overall project was recommended, with one therapist noting that the initiative needs to expand, and suggesting that the REACH NOLA MHIT project should engage additional local therapists and universities.

DISCUSSION

Our results are promising in that they suggest that community therapists may be receptive to CBT training generally and manualized treatment, in particular. We also found that our training approach was feasible, acceptable, and disseminated knowledge about CBT in community settings. Over the course of two years, community providers demonstrated the feasibility of disseminating CBT knowledge and local community leadership emerged from this process.

Although therapists reported that the program was useful and increased their expertise, only 30% of the therapists actually completed the program with one client. The majority of the therapists used only elements of the program with their clients. Only agencies that requested or accepted outreach/implementation support yielded therapists who participated in ongoing consultations, although many agencies were consistently represented at workshop trainings, highlighting the importance of administrative buy-in at the outset. In addition, only therapists who participated in the ongoing individual phone consultation adopted the program in their practice and applied it to non-training patients. Those who participated in the phone consultation also expressed benefits to their clinical practice (including increased skills, broadening of professional network, improved patient outcomes) suggesting that this longer-term approach to training may provide real world outcomes that may reinforce their personal use of CBT and increased agency buy-in and investment into supporting the program. Additionally, the development of local leadership also emerged from the relationship building of a long-term consultation process. As relationships formed over the training period, therapists themselves became more invested in the dissemination to the community and volunteered their own time to support such efforts. In addition, many therapists also attended the workshops to network with other providers, as they found the support and sense of community beneficial, and perhaps healing as they worked to rebuild damaged mental health infrastructure. Therefore, effective implementation and dissemination of CBT, particularly in a disaster-impacted, low-resource community, may require significant efforts at the outset to engage administrators and therapists in community agencies to support the implementation, protect therapist time to receive longer-term consultation, and build in extensive opportunities to be part of a service community aimed at supporting one another.

Therapist feedback also points to the need to scaffold training to optimize learning. The REACH NOLA MHIT planning team, which included academic and community partners, selected depression-focused, rather than trauma-focused CBT, which is known to be less complex, and therefore less difficult to teach to those new to using CBT. Given that many clinicians voiced concerns about "flooding of information," we focused on building a foundation for CBT for depression and integrated trauma education in the second year of training to help providers become more trauma informed in their delivery of depression treatment. Although trauma-focused CBT training was not offered formally and systematically in the CBT curriculum, phone consultations allowed for opportunities for trainers to address trauma issues at the individual provider level. Given that the groundwork for CBT has been laid in New Orleans, the next phase of the trainings should integrate CBT for trauma, adapt examples and language in the manual so that they are more culturally congruent with African American communities, and work in collaboration with faith-based organizations to increase the reach of the program.

Given that this evaluation was conducted in the context of a quality improvement effort without dedicated funds for evaluation, the data had several limitations inherent in real world evaluations of trainings. Due to resource constraints and concern for therapist burden, we did not collect pre- and post-training data, including measures of CBT competence, fidelity, attitudes, etc. Therefore, these findings are preliminary and their purpose is to describe our process of engaging therapists around a capacity building effort in implementing EBPs in a low-resource context, particularly therapists' perspectives on facilitators and barriers to adoption, rather than to test the effectiveness of our training model.

In conclusion, the community-partnered approach that the REACH NOLA MHIT team applied throughout the CBT training process seemed to be successful at engaging community agencies and providers, increasing perceived knowledge and skills in CBT, and increasing practice of CBT for those who participated in ongoing CBT support, because it empowered clinicians and administrators to contribute to a collaborative professional network, supported the needs of clinicians, evolved from the needs of the community, encouraged community leadership, and adapted the CBT training to work with the resource limitations and damaged infrastructure of a post-disaster context.

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COMMUNITY-BASED PARTICIPATORY DEVELOPMENT OF A COMMUNITY HEALTH WORKER MENTAL HEALTH OUTREACH ROLE TO EXTEND COLLABORATIVE CARE IN POST-KATRINA NEW ORLEANS

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Objectives: The REACH NOLA Mental Health Infrastructure and Training Project (MHIT) aimed to reduce disparities in access to and quality of services for depression and post-traumatic stress disorder (PTSD) in post-Katrina New Orleans by developing a mental health outreach role for community health workers (CHWs) and case managers as a complement to the collaborative care model for depression treatment.

Intervention: Community agency leaders, academics, healthcare organizations, and CHWs engaged in a community participatory process to develop a CHW training program.

Design: A review of qualitative data including semi-structured interviews, project team conference calls, email strings, and meeting minutes was conducted to document CHW input into training and responses to implementation.

Results: CHW contributions resulted in a training program focused on community engagement, depression screening, education, referral assistance, collaboration with clinical teams, and self-care. CHWs reported use of screening tools, early client successes in spite of challenges with client engagement, increase in networking and collaboration with other community agencies and providers, and ongoing community hurricane recovery issues.

Conclusions: This intervention development approach and model may be used to address post-disaster mental health disparities and as a complement to traditional implementation of collaborative care. (*Ethn Dis.* 2011;21[Suppl 1]:S1-45–S1-51)

Key Words: Community Health Workers, Community-Based Participatory Research, Collaborative Care, Disaster, Mental Health

INTRODUCTION

Underserved communities are at high risk for poor access to quality care for common mental disorders such as depression and posttraumatic stress disorder (PTSD),[1,2] particularly following exposure to disasters such as the 2005 Gulf storms.[3,4] Evidence-based quality improvement programs such as collaborative care approaches that integrate primary care providers, patient care managers, and mental health specialists into patient-focused teams increase access to services and improve health and employment outcomes for depressed and anxious primary care patients, including underserved groups.[5–8] However, such programs may be difficult to implement in public sector agencies and those damaged by disaster, owing to resource and infrastructure limitations.[9] Secular and faith-based social service organizations often have infrastructure for post-disaster outreach, case management, and medical care that could support quality improvement, but staff and administrators may lack adequate training to address mental health issues,[10] facilitate appropriate referrals for care, and help affected persons overcome mental health related stigma.

Health and social service agencies often utilize community health workers (CHWs) – personnel who provide fellow community members with health services including education and healthcare referrals – to fill unmet public health needs in underserved communities.[11] CHW engagement is a promising strategy to overcome disaster-resultant healthcare infrastructure limitations in contexts such as post-Katrina New Orleans,[12] where the shuttering of healthcare facilities and exodus of providers diminished local capacity to address well-documented unmet, ongoing mental health needs.[3,4,13] CHW facilitation of early entry into appropriate care for community members with mild to moderate symptoms of anxiety, depression, and trauma may prevent serious mental health sequelae and subsequent use of emergency health services. CHW provision of peer-to-peer support for fellow community members may fill gaps in availability of traditional counseling services, and their participation as members of collaborative mental health treatment teams could increase patient engagement, leading to increased efficacy of care delivery. Previous CHW participation in addressing community mental health needs has included application to homeless or severely mentally ill populations,[14,15] international settings,[16] and

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in one study, following a disaster,[17] but CHWs have not previously been documented in the scientific literature as serving as members of a mental health treatment team in a post-disaster environment.

In this article, we explore: 1) the process and viability of using a community-based participatory approach to develop a framework and model for CHW and case manager mental health outreach as a complement to quality improvement training in collaborative care for depression in post-Katrina New Orleans; and 2) the feasibility of the model itself, as well as early responses to a training curriculum that was developed to operationalize the model. While the need for developing a mental health outreach model was jointly recognized by academic and community participants in early stages of the project we describe, we were uncertain of whether the community-based participatory approach would lead to an implementable model within the short time period required by the urgency of the post-disaster situation. We were also uncertain whether CHWs receiving relatively little training in mental health issues would find the outreach model and training applicable to their work. We report on the process of model development and early experiences with implementing a training program to address these feasibility and potential effectiveness issues.

We report on the process of our mental health outreach model development and early experiences with implementing a training program to address these feasibility and potential effectiveness issues.

METHODS

Community-based participatory research (CBPR) approaches have been recommended to address health disparities,[18] particularly in groups with historical distrust in research and services.[19] This approach has been applied to mental health services research,[20,21] and was the basis for development of the participatory REACH NOLA partnership[22,23] that led the Mental Health Infrastructure and Training Project (MHIT).

Training Development

Initiated in May 2008, MHIT aimed to address limitations in access and quality of mental health care for New Orleans area hurricane survivors by providing staff and administrators at social service and safety-net agencies with multi-day training seminars and follow-up technical support in evidence-based practices for treatment of depression and psychological trauma. Approximately 400 therapists, psychiatrists, primary care providers, care managers, administrators, CHWs, and case managers employed by 70 participating institutions attended team-focused sessions on implementation of collaborative care for depression that included: overview of the collaborative care model; implementing system change through structured quality improvement methods; improving care coordination and communication between clinical providers; strategies for assembling a collaborative care team; networking with other community providers; and quality improvement methodology.

Profession-specific collaborative care competencies were developed through: instruction of medication management principles for primary care providers; therapist training in administration of evidenced-based therapy; and care manager sessions on coordination of depression treatment.

The addition of CHWs as members of the collaborative care team required the development of a CHW-specific training curriculum and resources. A work group of community and academic MHIT project co-leads, and New Orleans-based CHWs engaged in a participatory, iterative process with the goal of developing a sustainable, culturally competent CHW training program for mental health outreach. Work group collaborators sought to: 1) be responsive to community needs and acknowledge community strengths; 2) be consistent with key components of the collaborative care model of chronic disease management[24] such as promoting evidence-based treatments, care coordination, and patient participation; 3) build on existing CHW models that address health disparities;[25] and 4) support CHW-patient engagement in nonclinical settings to contribute to patient education that results in an increase in the utilization of evidence-based screening tools, and to contribute to the referral of patients into treatment, which may be critical to bringing underserved populations into appropriate care.[22]

Sixty-two CHWs and case managers attended the first three MHIT training seminars held between July 2008 and February 2009. Trainers used didactic instruction, role-playing and discussion at Training 1 to demonstrate the use of depression screening tools and teach principles of community engagement; at this time participants and trainers identified a need for additional instruction to address more adequately community concerns. All participants in Trainings 1 through 3 were invited to contribute to a revised CHW mental health outreach curriculum by providing insights on community context and feedback on training materials and resources. The project team altered training topics, techniques, and materials in response to CHWs' goals and concerns.

All information presented at trainings was documented in a written manual and distributed with a CD of resources and a client education DVD. CHWs received a book on depression education and treatment options, including collaborative care[26] and community resource guides describing low- or no-cost social services resources to address client needs.

Partnered Working Group Qualitative Assessment

We conducted a qualitative review of CHW input into training development and responses to training and implementation using a partnered working group approach.[27] Data sets were reviewed by two-member work group teams, with each member independently reviewing the source material. We analyzed blinded data from all sources of CHW feedback that included: minutes taken during 20 CHW-specific breakout sessions during Trainings 1, 2, and 3; 12 MHIT project team weekly conference calls among academic and community partners including CHWs; three CHW support calls, in which academic partners provided CHWs with post-seminar technical assistance for implementation of outreach techniques and use of screening tools; 31 email strings from project team members, including CHWs; and five semi-structured telephone interviews of CHWs who participated in the training seminars and support calls.

A structured form was developed to record themes and text examples based on the analysis questions. Then team members together reviewed all documents to identify common and uncommon themes and associated citations. Authors integrated these summaries to reduce redundancies and clarify distinct themes.[28]

No financial incentives were offered to participants. Research procedures were found to be exempt from review by IRBs at RAND, Tulane University, and the University of Washington.

RESULTS

Community input into training development is summarized in Table 1. CHWs revealed the following primary concerns: complex post-hurricane challenges; need for services for vulnerable populations; continuing stressors such as concern about future hurricanes; frustration with inability to satisfy clients' financial needs; difficulty responding to suicidal clients; and concern about existing community and agency capacity, resources, and infrastructure to support mental health services and referrals. CHWs and case managers reported strengths in the areas of trust-building with clients, knowledge of the community, and flexibility. Many CHWs described difficulty accommodating the stresses of being on the front line, facing personal recovery needs, and lacking time or resources to get help for personal recovery. CHWs requested instruction in self-care techniques to cope with personal and work-related stress.

Table 2 summarizes findings concerning CHW responses to the training. The CHWs generally offered positive feedback on the training content and valued both guided role playing and follow-up support calls. They reported using PHQ-2[29] and PHQ-9[30] screening questionnaires. To increase community acceptability, some rephrased screening questions to include colloquial language, or they incorporated screening questions into informal conversations. Although most CHWs were familiar with employers' existing privacy policies, some CHWs identified confidentiality/HIPAA training as useful – particularly role playing the application of policy and tools. Training in problem-solving skills and behavioral activation support was novel for most CHWs, and use of these techniques was noted in follow-up support calls. CHWs offered specific suggestions for improvement of training and materials such as inclusion of additional role-playing sessions, emphasizing cultural competence and networking, simplifying the case registry form, and integrating training for CHWs and therapists. CHWs identified a number of challenges to conducting outreach and client follow-up, including difficulty of reaching clients, stigma, lack of community infrastructure, job conditions, and barriers to collaboration. Training participants acknowledged five types of positive training impact: increased delivery of high-quality care, improved networking opportunities, increased respect for providers, assistance with continuing education requirements, and increased hope for community mental health recovery.

The final CHW training curriculum contained modules that covered: overview of depression and PTSD; techniques for building trust with clients; instruction in use of PHQ-2 and PHQ-9 depression screening tools; community resources for referring depressed patients; skills for problem-solving and behavioral activation, which were adapted from psychotherapy trainings in other collaborative care initiatives; self-care for community health workers; community education techniques; and tools for tracking client services and outcomes.

DISCUSSION

This project aimed to expand the implementation of collaborative care for depression through a community-partnered, participatory approach to developing and evaluating a culturally appropriate mental health training program for CHWs and case managers in post-Katrina New Orleans. The effort integrated principles of collaborative care, CHW models for other health conditions, and participatory planning. The result, a program presented in a

Table 1. Community input into development of community health worker training program

Themes	Quotations
What are the needs of New Orleans residents?	
Multiple problems	"Most people before the storm could handle their issues, but afterwards, it was difficult to deal with because all the problems were adding up."
Difficulty of housing	"It's always housing issues."
Vulnerable populations and mental health issues	"There are a lot of scary things being noticed in the community in terms of children without parents in homes by themselves, people not able to find jobs and not having any hope for dealing with rebuilding issues, elderly folks living alone on dark streets with no relatives checking on them, children in desperate need of mental health interventions."
Suicidal clients	"Just talking to them straight out. Are you having thoughts of killing yourself? They want someone to listen to them, and are relieved that I brought it out." "I met a woman in the doctor's office who wanted to die."
Fit with agency scope	"They say 'I need this fixed' rather than accepting assistance." "75% of clients are hard to get a follow-through because what you are offering is not direct enough."
Continuing stressors	"We are back from (evacuation due to hurricane) Gustav and seeing people in the community centers and counseling offices whose needs have only increased."
How is mental health outreach currently conducted?	
Lack of mental health outreach programs	"There is nothing out there in the community that addresses the needs of mental health outreach workers."
Knowledge of local needs	"History of serving low-income and/or African-American populations of post-disaster Greater New Orleans area."
Engage in client's story	"I want to hear your story, tell me what you're experiencing."
Support without enabling	"There is a thin line between empowering and enabling."
Faith-based support	"I had to go to the Bible." "I pray with them."
Build trust	"We deal with building the trust of community folks to work with them."
Flexible style	"Let people know that we are here for them and won't abandon them." "Need to be flexible in terms of meeting people on their own terms."
What do CHWs and community-based organizations need to address stress and depression in New Orleans?	
Resources/staff	"Get so many (clients) that you become overwhelmed." "Clients are responding, but would respond better if we weren't standing on someone's porch going door to door." "A place we can refer our clients—that's our big need as case management."
Funds for medication	"One of the major problems we have is funds for medication."
Self-care/personal treatment	"You need to treat yourself as a patient." "Discussion of having recently trained counselor run support group for outreach workers for mutual benefit."
Integrate into existing programs	"Work with other programs—nutrition for high school students, encourage exercise and healthy habits."
Agency capacity and accountability	"The vast majority of those agencies are not doing what they say they are doing; lack of direction; no enforcement mechanisms."

training manual[31] is itself an important addition to the public mental health field, building on prior documented approaches.[32] Early feedback suggests that CHW participation in post-disaster mental health outreach may bolster community resilience by increasing interagency collaboration, building trust, and alleviating mental health-associated stigma.

Data from the partnered evaluation of the program suggest that the two-way knowledge exchange between community and academic partners enabled the development of a community-relevant program informed by experts in local context. We were encouraged that a participatory model was effective in supporting program development in a short time period, and for a stigmatized issue in the context of a historically underserved community following a major disaster. Consistent with participatory research principles, it was possible to develop awareness of the many challenges for the population and environment post-disaster, while maintaining an asset-based approach that supported hope in participants.[21]

The data suggested a positive overall response to training and desire for additional information in problem-solving therapy and PTSD. Participants valued confidentiality training. Depression screening was implemented by many participants and was often report-

Table 2. Community health worker responses to training program

Themes	Quotations
What did CHWs think of the training and materials?	
Informative	‘‘Training was well done, well put together, very informative and educational for those who wouldn’t have as much knowledge on a particular subject.’’
	‘‘The role-playing on how to deal with difficult clients was very interesting.’’
What components are CHWs using?	
PHQ-2 and PHQ-9: Strategies for use of screening and referral resources	‘‘Several of our workers have used the PHQ-2.’’
	‘‘Paraphrasing (screening items), so we could understand each other.’’
	‘‘I suggest they go to a clinic because I don’t want them to say I said they have ‘such and such.’ When they come back I ask about the visit and then ask the questions and present the options.’’
Confidentiality tools	‘‘Confidentiality materials were helpful, especially HIPAA laws’’
Behavioral activation	‘‘Elderly man who develops a plan to get off bus one block early to return to exercise, feels better; then gets off 2 blocks early and runs into a friend.’’
How can CHW training and support materials be improved?	
Case registry	‘‘The form is too long, break it down. Some questions need to be eliminated.’’
Cultural competence	‘‘Spanish version or simplified version for folks with low education.’’
	‘‘Would like a more community-oriented approach and language.’’
More role playing	‘‘People need more practice and a practice session is very helpful.’’
More relationship building	‘‘Needs to be a greater effort to get them all to talk. Have everybody exchange phone numbers and have some conversations.’’
Therapy for CHWs	‘‘Having recently trained counselor run support group for outreach workers.’’
Integrate with counseling skills	‘‘You created an artificial distinction between counseling and outreach piece, that didn’t work (for our needs in mental health agency).’’
What are the challenges associated with implementing the CHW role?	
Community infrastructure	‘‘Reluctance to call police because of the way they handle it sometimes.’’
	‘‘Limited hospital services.’’
	‘‘Long wait for buses.’’
Client resistance and denial	‘‘We get the ‘I’m not crazy.’’’
	‘‘Denial issues.’’
	‘‘People don’t want to go to care.’’
	‘‘When we try to get people to accept some responsibility, people get upset with us and report us to the front office.’’
Hard-to-reach clients and clients with complex issues	‘‘‘Catch me if you can’ clients.’’
	‘‘When I called her the following week, have not been able to get through.’’
	‘‘Try to reach family to follow-up with elderly.’’
	‘‘Clients dealing with multiple issues—health is last.’’
	‘‘Problems on top of problems.’’
Job conditions	‘‘Work force too small, pay too little.’’
	‘‘Management is not on the same page.’’
Agency relationships and provider collaboration	‘‘Don’t have the interrelationships within and between agencies.’’
	‘‘Still trying to collaborate (to find a) place we can refer our clients.’’
	‘‘Outreach workers could work more closely with providers, churches.’’
What is the early impact?	
Hope	‘‘It gives us all hope…It’s good that you started that process.’’
Networking	‘‘The most important thing is that we stay in touch to make sure we are working on the same basis so we can all help each other.’’
	‘‘We increased ease of getting help for clients, working with other agencies.’’
	‘‘Do a resource network of mental health and rehabilitation providers. That would be a great service you could do.’’
Certification	‘‘Our agency pre-Katrina, failed Joint Commission because we did not do this. They will look to see if you have things like this in your program.’’
Improved quality and funding	‘‘Helps set our own standards, better opportunity to shine, clarify ourselves, and get more money.’’
Perception of providers	‘‘First time realized these providers want to do well.’’

ed as acceptable in the community. Some adapted screening tool questions to increase cultural appropriateness, but these informal adaptations were not validated for reliability. Some CHWs noted resistance and difficulties with follow-up for referrals among those clients who screened positive for depression. CHWs requested enhanced focus on cultural competence, which was implemented in a training session after the data collection period. Additional CHW suggestions included adding information on managing severely mentally ill clients and addressing workplace safety concerns, both addressed in subsequent seminars. We found that the program instilled hope, offered networking opportunities, helped with continuing education requirements, and supported CHWs' commitments to improving the quality of their services

We found many challenges to implementation of mental health outreach practices, especially limited community capacity for service delivery, inadequate funding for CHWs, and social stigma of mental illness. We failed to generate consistent use of both web- and paper-based case registry tools designed to track client interactions and depression scores, as these tools were perceived as burdensome. CHWs expressed a strong need for personal assistance with recovery stressors and anxiety about future hurricanes. The participatory nature of the project allowed us to implement modifications in response to many of these concerns. Some challenges, such as environmental factors, could not be directly addressed by the CHW intervention, but generating awareness of them improved the ability of CHWs to anticipate client needs.

We were somewhat surprised that the most innovative feature of the program, orientation to problem solving and behavioral activation, reportedly led to early client successes, with one CHW using behavioral activation to assist a client in implementing a physical activity regimen, leading to increased social interaction and improved mood.

This intervention may offer an important resource for underserved communities to address mental health disparities following major disasters, as a complement to implementation of collaborative care programs in healthcare settings.

In summary, we found that it was possible to use a community-partnered, participatory research approach to design, implement, and evaluate feasibility of a CHW mental health outreach training program built on evidence-based practices in post-disaster New Orleans. Preliminary data support the acceptability and feasibility of implementation of most components, including novel features such as behavioral activation. We recommend ongoing program development supported by community input, as well as a formal evaluation to determine effectiveness of the model. This intervention may offer an important resource for underserved communities to address mental health disparities following major disasters, as a complement to implementation of collaborative care programs in healthcare settings.

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COMMUNITY PERSPECTIVES ON POST-KATRINA MENTAL HEALTH RECOVERY IN NEW ORLEANS

Disaster-affected communities may face prolonged challenges to community-wide mental health recovery due to limitations in local resources, infrastructure, and leadership. REACH NOLA, an umbrella non-profit organization comprising academic institutions and community-based agencies, sought to promote community recovery, increase mental health service delivery capacity, and develop local leadership in post-Katrina New Orleans through its Mental Health Infrastructure and Training Project (MHIT). The project offered local health service providers training and follow-up support for implementing evidence-based and new approaches to mental health service delivery. This commentary shares the perspectives of three community leaders who co-directed MHIT. They describe the genesis of MHIT, the experience of each agency in adopting leadership roles in addressing post-disaster needs, challenges and growth opportunities, and then overarching lessons learned concerning leadership in a prolonged crisis. These lessons may be relevant to community agencies addressing hurricane recovery in other areas of the Gulf States as well as to inform long-term disaster recovery efforts elsewhere. (*Ethn Dis.* 2011;21[suppl 1]:S1-52–S1-57)

Key Words: Mental Health, Community-Based Participatory Research, Disaster, Hurricane Katrina

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Community leadership and capacity are essential for recovery from large-scale disasters such as Hurricanes Katrina and Rita. Six years after the 2005 storms, the New Orleans community still faces considerable challenges. Common disaster-related psychosocial problems such as depression and anxiety continue to affect individuals unable to access appropriate treatment.[1] Community-based organizations' attempts to serve clients' complex physical, emotional, and social needs may be hindered by lack of human and financial capital. Many communities still struggle to rebuild the physical infrastructure and social fabric of their neighborhoods. Individuals working within nonprofit, faith-based, health and social service agencies often experience these individual, organizational, and community-level stressors simultaneously, creating a substantial barrier to asserting leadership to advance disaster recovery.

Promising local capacity-development efforts include leveraging the resources of community-based organizations and academic institution through community-partnered projects.[2] Opportunities to develop community leadership in the areas of supporting mental wellness, resilience, and recovery since 2005 were afforded through the work of new organizations and expanded partnerships[3] among community-based agencies. REACH NOLA, a 501(c)3 nonprofit organization cofounded by community and academic partners to address unmet, locally-identified health concerns in post-disaster New Orleans, represents one clear example. The organization, recognized as an asset to disaster recovery efforts,[4] has since its inception employed community-participatory methods such as equitable sharing of power[2] to engage local agencies in designing and implementing health-focused programs, services, and research.

One of REACH NOLA's efforts, the Mental Health Infrastructure and Training Project (MHIT) is described in detail in this issue.[5] This 20-month community-wide effort to address post-disaster mental health, resilience and recovery involved more than 70 agencies and 400 providers and supported delivery of over 110,000 client services. Community-based organizations partnered with academic institutions to offer training and implementation support for evidence-based[6,7] and new[8] approaches to mental health service delivery. Descriptions of MHIT's collaborative care,[9] cognitive behavioral therapy,[10] and community health worker[8] training programs are detailed in this issue.

This commentary features perspectives of leaders from three community-based agencies that co-directed MHIT. They describe the genesis of MHIT, the experience of each agency in adopting leadership roles in addressing post-disaster needs, challenges and growth opportunities, and then overarching lessons learned concerning leadership in such a prolonged crisis. These lessons of overcoming obstacles, growth, and recovery may be relevant to community agencies addressing hurricane recovery in other areas of the Gulf States as well as to inform long-term disaster recovery efforts elsewhere.

BACKGROUND

New Orleans' health care infrastructure was largely destroyed by Hurricanes Katrina and Rita in 2005.

Community-based agencies responded by filling service gaps to the best of their abilities, drawing on their extensive knowledge of community assets and needs. In early 2006, several New Orleans-based social service agencies, health clinics, and faith-communities, as well as local and non-local academic institutions, began a collaborative effort to identify and build capacity to address community health concerns. Operating under the umbrella organization REACH NOLA, participating agencies agreed to abide by community-based participatory principles such as equitable sharing of power among organizations and community-academic co-leadership.[2]

REACH NOLA's first community health assessment revealed depression, stress, and anxiety as prominent and growing health concerns among New Orleanians.[3] While approximately one third of residents experienced symptoms of depression or PTSD,[11] people with fewer resources or more significant storm trauma were more likely to experience serious psychological impacts, and many people did not receive appropriate care.[12,13] The increase in mental health morbidity, coupled with the exodus of health providers and the shuttering of major service delivery facilities, underscored the need to develop mental health service delivery capacity in a way that drew on previously underutilized community strengths.[1]

With the generous support of the Robert Wood Johnson Foundation and the largest post-Katrina behavioral health grant issued by the American Red Cross, REACH NOLA partners began to address community stress and mental illness needs and started MHIT. The program was overseen by an executive council consisting of representatives from four academic/research institutions and four community-based organizations.[5] MHIT provided infrastructure support to six local services agencies to offer screening, referrals, education, outreach, and treatment for stress and depression. In addition, MHIT hosted training seminars, co-developed and presented by academic and community agencies, for health and social service professionals regarding evidence-based models of mental health care, quality improvement, community engagement, developing community networks of care, and other topics. More than 400 primary care providers, counselors, social workers, case managers, care managers, psychiatrists, psychologists, and community health workers (CHWs) from over 70 community agencies attended. All participants learned strategies for implementing collaborative models of care and team-based approaches to treatment, while specialized tracks were offered to develop skills specific to the various professions and paraprofessional groups. Community and academic partners developed a manualized mental health outreach training curriculum.[8] Post-seminar implementation support facilitated improvements in providers' and agencies' clinical practices and promoted project sustainability by fostering local leadership.[9,10]

CHARLES ALLEN, HOLY CROSS NEIGHBORHOOD ASSOCIATION

Developing Leadership

Shortly after Hurricane Katrina, the Holy Cross Neighborhood Association (HCNA), a trusted community-based organization in the Lower 9th Ward, resumed holding regular weekly meetings. Association president Charles Allen, along with other local leaders, aimed to provide a forum for returning residents to reconnect and discuss strategies for rebuilding the devastated community. In so doing, they also created a safe place for community members to express their emotions. Residents reported struggling to set priorities and follow through with tasks necessary for rebuilding, and they frequently had outbursts of anger and crying. Association leaders quickly realized that residents could not reconstruct the community without first addressing their primary recovery concern – mental health.

Mr. Allen's concern for human recovery prompted him to join other organizations in cofounding REACH NOLA, and later implementing MHIT, to engage in collective action to address unmet community health needs, particularly in the area of emotional recovery. Mr. Allen recognized that although HCNA leaders lacked capacity to provide clinical mental health services, the organization's trusted position in the community afforded it a unique opportunity to not only educate community members about depression and encourage residents to seek treatment when necessary, but to address stigma associated with mental disorders. MHIT provided HCNA infrastructure support for three CHWs to conduct mental health outreach under Mr. Allen's supervision.

The HCNA team served a central role implementing MHIT. Mr. Allen served on the project's executive council and contributed significantly to the development of a culturally relevant CHW training manual. Association CHWs delivered presentations during seven training seminars, offering insight and practical suggestions for engaging community members in discussions about depression and overcoming stigma. The association also led support meetings for CHWs where they shared referral resources with their peers from other agencies.

Benefits and Challenges of Participation

MHIT developed HCNA's capacity to colead and execute a community-based project focused on health, increasing the potential for the agency to receive support for future health improvement efforts. Lower 9th Ward residents who became CHWs appreciated not only the economic benefits of employment, but also the opportunity to discover a career path that they found rewarding and empowering.

Networking with other agencies and sharing of ideas during training seminars and follow up meetings provided valuable opportunities for sharing best practices, resolving problems, learning about community resources, locating points of referral for clients, and establishing relationships. Most important, HCNA staff successfully facilitated entry into care for many residents in need of counseling and additional disaster recovery support. As a result, the community as a whole appears to be more receptive to discussing mental health and getting counseling for this critical issue.

Association leaders have faced some challenges in working on community-based mental health, particularly pervasive stigma. Residents have feared being labeled as crazy or that acknowledgement of stress or trauma might result in being committed to an institution. Engaging clients in follow-up for care also has proved difficult at times. Sustainability of the community engagement and outreach is a significant concern in light of the periodicity of philanthropic grant support. Though community members are still in need of support for emotional recovery, HCNA has not yet acquired funding to maintain outreach efforts.

Overall, the benefits of MHIT have been profound. From providing access to quality mental health care, reducing the stigma of mental illness, to providing worthwhile job opportunities to residents, the MHIT project has served well to help address the need for quality mental health care in the Lower 9th Ward and throughout New Orleans.

DONISHA DUNN, TULANE UNIVERSITY COMMUNITY HEALTH CENTER

Developing Leadership

Donisha Dunn, a dually trained internist and psychiatrist, returned to her native New Orleans in 2008 after completing residency in psychiatry and internal medicine. She joined the staff at Tulane University Community Health Center (TUCHC), a National Center for Quality Assurance-recognized patient-centered medical home[14] established in the aftermath of hurricane Katrina, and a REACH NOLA partner organization. Seeking to promote team-based approaches to care and integration of behavioral health services into primary care clinics, Dr. Dunn became the director of mental health programming at TUCHC and joined the MHIT executive council.

MHIT supported Dr. Dunn's leadership in implementing a quality improvement initiative for treating depression through a collaborative care approach.[6,7] At MHIT training seminars, TUCHC primary care providers, social workers, and care manager learned components of this approach to treating depression including screening, education, medication management, outcomes tracking, use of a patient registry, and psychotherapy. A collaborative care expert from the MHIT executive council provided TUCHC with weekly consultations to review steps for model implementation and to troubleshoot problems.

The project's executive council participation offered an important route for leadership development. As part of the council, Dr. Dunn contributed to planning and implementing the project. During CHW training seminars, she translated medical information about mental illness and medication into language accessible to trainees with no clinical background. She cofacilitated monthly CHW support meetings, soliciting feedback from previous training participants that led to modifications such as adding crisis management and serious mental illness content to later training seminars. As the only local psychiatrist on the executive council, Dr. Dunn served a vital role in developing and delivering the training curriculum for physicians. Her insight into local context and physician culture led to adaptations in training structure to better accommodate doctors' needs.

Benefits and Challenges of MHIT Participation

Through participation in MHIT, TUCHC developed an evidence-driven and quality-focused program to manage patients using mental health services, and a systematic approach to improving care for depressed patients. The health center's new mental health programming resulted in an increased number of patients receiving counseling services, and clinically significant improvement in the increased proportion of patients who had follow up monitoring.[15] Primary care providers in the clinic became increasingly comfortable managing depressed patients and psychotropic medications. The addition of care management for depression enhanced treatment follow-up and adherence. Integration of behavioral health into TUCHC's programming contributed to its recognition as a tier three patient-centered medical home by NCQA.[14]

Broadening TUCHC's practices presented challenges. New responsibilities were added to some staff members' previous duties. Stigma associated with mental health hindered engagement for some patients, as well as some staff members' willingness to participate in collaborative care implementation. The health center faced limited capacity to deliver services for serious mental illness and substance abuse, and there were few specialty clinics to which patients could be referred.

Participating in the executive council facilitated the sharing of ideas and insights between local and distant leaders with various areas of knowledge such as psychotherapy or research, and from diverse settings such as neighborhood organizations, faith communities, and clinical organizations. These connections served as a reminder that TUCHC is part of a larger network of organizations working toward common goals, and they emphasized the need to enhance connections between health centers and community members.

Opportunities to share ideas during training conferences and follow-up meetings were instrumental in developing partnerships with other agencies. These collaborations provided a link to primary care for some patients, increased access to services and prevented unnecessary hospitalizations for mental health crises.

DIANA MEYERS, ST. ANNA'S MEDICAL MISSION

Developing Leadership

St. Anna Episcopal Church, largely undamaged by Katrina, assumed a leadership role in providing essential post-storm services to the working-class Tremé community. Church leaders discovered lack of access to basic health care services as a major concern among community members, and partnered with several non-local churches to establish St. Anna's Medical Mission, (SAMM) a mobile health outreach and screening program.

The mission began operating in 2006 under the direction of Diana Meyers, a parishioner and registered nurse. Although Ms. Meyers had significant background in providing clinical services, her limited experience in mental health made her apprehensive about directing a new program with limited staff. She found some support and gained leadership skills through her involvement in REACH NOLA and MHIT.

Ms. Meyers' participation in REACH NOLA's efforts to document health needs confirmed that SAMM patients were like many New Orleanians – they required clinical services for stress, depression, and trauma. She and other SAMM staff felt unprepared to help clients address mental health concerns, as they lacked formal training on the topic and resources for referral were limited. MHIT enabled SAMM to hire mental health staff including counselors, a part-time psychiatrist, and a care manager, and then provided previous and newly-hired team members with training in addressing depression, stress, anxiety, and PTSD. Upon gaining confidence in assisting clients in emotional distress, Ms. Meyers instituted changes to SAMM's clinical practice to include screening patients for depression during intake procedures and tracking patient progress. She also developed SAMM programming focused on promoting health and resilience, such as therapeutic drum circles, individual counseling, and stress management events.

Ms. Meyers' leadership in the MHIT executive council provided insight into community needs and practical suggestions for project implementation. With the support of fellow community-based and academic leaders, she undertook the significant task of developing a mental health outreach training curriculum for non-clinical providers such as CHWs and case managers with no prior mental health experience. Ms. Meyers co-facilitated some CHW training sessions. Her contributions, informed by personal experience of interacting with stressed and depressed SAMM patients with little training and no experience in how to do so, were invaluable in teaching others with neither medical nor mental health experience.

Benefits and Challenges of Participation

Participating in the MHIT project has been both challenging and rewarding. SAMM staff was initially concerned about working with non-local academic partners, fearing they would impose their ideas without considering community context, but all partners established trust and proved willing to listen and learn from one another. Academics were supportive when local community-based organizations suggested adaptations to training materials and curricula or pointed out when a proposed course of action would be inappropriate for the community. All participants demonstrated a true desire to make the project work for the people of New Orleans.

Misson staff sometimes felt conflicted and guilty about taking time away from clients to attend and facilitate MHIT training seminars. Participating in executive council meetings and preparing for and coleading training seminars required a significant investment of Ms. Meyers' time that would have been otherwise spent on other duties vital to SAMM's operations, but ultimately, the investment of staff time has increased SAMM's ability to provide quality services for clients.

Networking with over 70 other organizations participating in MHIT trainings connected SAMM staff to potential treatment resources and new mental health programming has enabled collaboration with other agencies. For example, social service organizations that lack on-site professional mental health care make referrals to SAMM, where patients receive screening and a care manager facilitates entry into treatment. Developing and maintaining collaborations with other organizations has been time intensive, as it requires ensuring that organizations meet one another's needs and that there is a manageable referral system. Staff still struggle to find adequate resources for the underserved and uninsured population.

Stigma associated with depression continues to be a significant barrier to accessing treatment, as does community members' tendency to prioritize basic survival needs over health. SAMM staff members are hopeful that community education about mental health will foster discussion among members of social support networks.

The Mental Health Infrastructure and Training Project supported Ms. Meyers' efforts in sharing newly adopted practices at local, regional, and national conferences. She has applied leadership and consensus building skills honed through this project in her role as cochair of a consortium comprising New Orleans-based mobile health units.

DISCUSSION

Lessons learned from REACH NOLA's efforts to promote leadership through MHIT may be relevant to other communities at risk of, or recovering from, disaster. Community-academic partnered public health efforts that intentionally work to advance community leadership and resources, while fostering implementation of scientifically-supported models of health services delivery, may develop enduring capacity to improve access to appropriate services, improve population health outcomes, and reduce outcomes disparities among vulnerable populations.

Early MHIT partners invested in developing an evidence-based mental health training program and altering their clinical practices because their participation in a community-academic needs assessment revealed that mental health was a significant problem. They experienced firsthand the need to treat depressed and traumatized patients. Community leaders provided input into the project design before program funding was requested, creating early buy-in and the opportunity to partner as equal decision-makers in implementation.

Leveraging existing personal and agency strengths was central to MHIT's success. The Holy Cross Neighborhood Association – adept at communicating with community members – took on an outreach role, while TUCHC expanded its strong clinical program to include mental health treatment. St. Anna's broadened clinical care management and services in partnership with other organizations. While these agencies' participation in MHIT expanded their ranges of services to some extent, the changes were complementary to their usual scope of work, and reflective of emerging community needs.

CONCLUSION

This article has attempted to explore how engagement in MHIT, a community-partnered participatory project, enabled local leaders and agencies to leverage their personal and institutional resources to drive recovery in post-disaster New Orleans. Community-partnered approaches are designed to enhance individual and institutional capacities through academic support. They develop interagency collaborative capacities toward a common response and recovery purpose, which in turn further support both community capacity and individual and agency leadership. Such community-academic co-led initiatives and models of implementing them, may be useful to consider as a catalyst for generating community-driven, and academic-supported, response capacities.

In learning from this effort, funders, academic partners, and community leaders interested in advancing post-disaster recovery should consider how to work with disaster-impacted community members to incorporate benchmarks and measurement into their efforts to build services capacity, promote community leadership, improve population health, and reduce health disparities. Communities at risk of recurrent seasonal disaster from hurricanes or other threats such as oil spills, as well as their partners in academia and granting agencies, must be encouraged to sustain the networks of leadership, support and information exchange that are developed post-disaster, and to improve agency and community resilience in the face of potential, subsequent threats. The gains in community leadership and capacity developed after a disaster should not represent quick fixes to a short term problem, but would be seen more appropriately as opportunities for long term community growth, population health, and change.

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THE PARTNERED RESEARCH CENTER FOR QUALITY CARE: DEVELOPING INFRASTRUCTURE TO SUPPORT COMMUNITY-PARTNERED PARTICIPATORY RESEARCH IN MENTAL HEALTH

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Evidence-based programs have been shown to improve functioning and mental health outcomes, especially for vulnerable populations. However, these populations face numerous barriers to accessing care including lack of resources and stigma surrounding mental health issues. In order to improve mental health outcomes and reduce health disparities, it is essential to identify methods for reaching such populations with unmet need. A promising strategy for reducing barriers and improving access to care is Community Partnered Participatory Research (CPPR). Given the power of this methodology to transform the impact of research in resource-poor communities, we developed an NIMH-funded Center, the Partnered Research Center for Quality Care, to support partnerships in developing, implementing, and evaluating mental health services research and programs. Guided by a CPPR framework, center investigators, both community and academic, collaborate in all phases of research with the goal of establishing trust, building capacity, increasing buy-in, and improving the sustainability of interventions and programs. We engage in two-way capacity-building, which affords the opportunity for practical problems to be raised and innovative solutions to be developed. This article discusses the development and design of the Partnered Research Center for Quality Care and provides examples of partnerships that have been formed and the work that has been conducted as a result. (*Ethn Dis.* 2011;21[suppl 1]:S1-58–S1-70)

Key Words: Community Based Participatory Research, Mental Health, Community-academic Partnership

INTRODUCTION

Community Partnered Participatory Research (CPPR) is a form of Community Based Participatory Research (CBPR) that engages community and academic investigators in all phases of research. It has the potential to transform the way that research is designed, conducted, and disseminated and the power to build capacity in resource-poor communities and among community and academic investigators. To stabilize and enable this form of research, groups conducting CBPR-related studies over time have developed sustainable and effective infrastructures based in academic and community partnerships.[1–3] In 2003, we developed an infrastructure in Los Angeles to support development of a CPPR-based research environment to address health disparities across several major chronic health conditions.[2] Through community engagement, that infrastructure supported pilot studies including the Witness for Wellness initiative to address depression in South Los Angeles,[4–8] pilots that expanded application of evidence-based approaches to child exposure to community violence from school-based programs to faith-based organizations,[9] as well as to describe existing networks of community agencies that provide mental health and substance abuse services.[10] In addition to this work in Los Angeles, we collaborated with other centers nationally to develop the approach more generally in mental health[11] and supported a community-academic collaborative dedicated to mental health recovery in New Orleans following the 2005 Gulf storms and floods.[12] Based on those experiences in developing infrastructures to support application of CPPR across health conditions, and in pilot programs to apply CPPR to mental health services research and services delivery, we proposed and were funded by the National Institute of Mental Health (NIMH) to develop a Partnered Research Center for Quality Care, as partnered infrastructure to support research on mental health services and outcomes under a CPPR framework. This article describes the goals, design and activities of that infrastructure and how the center continues to evolve through applying the principles and structure of CPPR to mental health research.

Nationally representative studies have documented a substantial gap between the quality of mental health care delivered and that recommended in national guidelines.[13,14] The quality gap

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is exacerbated by access problems for underserved minority groups and vulnerable populations such as children, the elderly, and persons diagnosed with serious mental illness. For persons in such groups, factors including limited financial access and living in resource-poor communities are commonly made worse by high levels of unmet need coupled with other barriers to care, including language and social stigma associated with mental illness or help-seeking.[15] For example, some persons with serious mental illness may avoid seeking services because of social stigma, negative prior experiences, or fear of involuntary treatment.[16–18] In addition, rates of access to evidence-based care for common disorders such as depressive disorders are low in community samples (20%–30%); rates of unmet need are especially high among underserved groups such as African Americans and Latinos.[19–22] Given these gaps and the demonstrated health benefits and improvement in functional status afforded by participating in evidence-based programs for mental disorders in vulnerable populations,[23–25] it is imperative to determine how to best engage these populations in understanding and realizing the potential benefits from such programs. The importance and timeliness of doing so is enhanced by passage of federal parity and health reform legislation that have potential to improve access and equity of the distribution of mental health services.

Community Based Participatory Research is a promising approach to engaging vulnerable populations to address health disparities[1,26–29] and to help individuals understand their options to receive services and improve mental health outcomes under new federal policies. By shifting research toward priorities of community members and leaders and promoting active community participation in research and program development, CBPR builds capacity in the community.[3] One form of CBPR is Community Partnered Participatory Research (CPPR),[30–32] a manualized approach that supports community and academic co-leadership in design, implementation, evaluation, and dissemination of research, and in building capacity of the partnership and community agencies to improve health of the community over time through joint planning and research.[30] Under this approach, academic partners are considered part of the working community and community members are considered active members in the research process. Together they form a council of stakeholders that supports and guides an initiative and oversees working groups that develop and implement action plans and evaluations. The council regularly reviews and reevaluates the direction of the research to ensure that core values, which include trust, respect, and equality, are upheld and to ensure productivity and mutual benefit. Community engagement activities reinforce these values and enhance motivation of all participants to improve communication and power sharing, through leveling the playing field. Activities include conferences with partnered presentations, skits demonstrating real world situations, and participation in community events and festivals. Initiatives are guided through stages, including Vision (development of mission, goals); Valley (implementation and evaluation of action plans); and Victory (products, dissemination and formulation of next steps and lessons learned). The model promotes the implementation of evidence-based interventions while attending to social and cultural diversity of local communities, and thus is a useful framework for integration of intervention and services research within an overall community-based participatory research approach.[31,33] Motivated by the promise of this approach, the demonstrated efficacy of the model in producing immediate results from pilot studies, and recognition that an infrastructure to support this model would lead to further innovative and efficient applications of this research paradigm, we developed the Partnered Research Center for Quality Care.

METHODS

The overall aim of the Partnered Research Center for Quality Care is to study how to improve mental health care quality and outcomes through authentic community-academic partnered research that responds to community priorities and builds community capacity using principles and strategies of community engagement. The framework guiding our center is illustrated in Figure 1. At the top of the figure are principles of authentic partnerships under the CPPR Model[30,31] used to initiate a community engagement process and to develop a network among key stakeholders. Also at the top of the figure, we highlight policy and research inputs into this process as they inform issue selection, and may affect the availability of resources for the work. The network is supported in identifying issues that are good fits of academic and partner priorities, resources and opportunities. The engaged network is supported by academic and community resources and capacities, in discovering or developing interventions at policy, practice, or local community levels that may plausibly improve quality of care in communities. Academic and community resources also result in partnered intervention implementation and evaluation, providing data on intervention outcomes for relevant stakeholders, including policymakers, networks, providers, consumers/survivors, and the broader community. Further, the lessons learned and capacities developed through the work increase capacity for partnered research and yield a library of priorities addressed, strategies developed, and a supported, vibrant partnership. This framework integrates prior models for improving access to quality

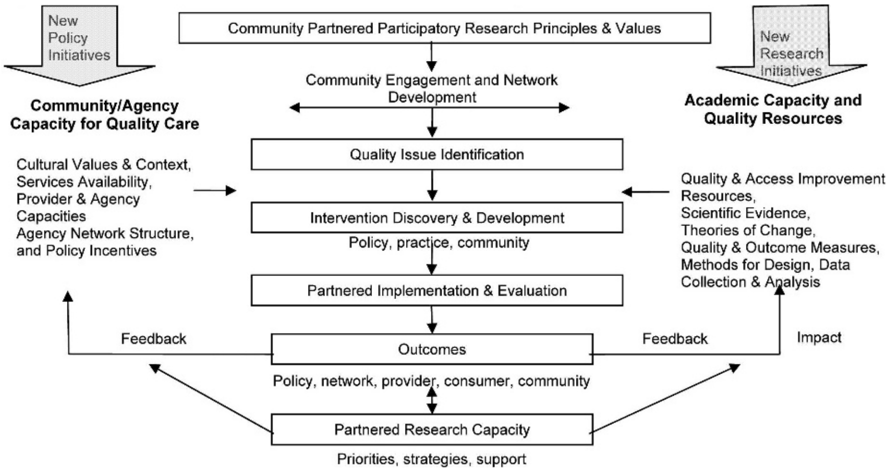

Fig 1. Framework for partnered research center for quality care

care, community-based intervention research, and partnered participatory research.[31,34–37]

To support this capacity-building enterprise, the executive committee, comprising core leaders, meets once a month to discuss center progress, potential new directions, and allocation of resources to advance center work. Through this monthly meeting, new ideas and priorities from each core and those generated through center activities such as book clubs or conferences feed back to the executive committee and decisions are made by majority vote (Figure 2). The executive committee also receives feedback, to assure direction and impact, from the policy advisory board, which consists of academic and community institutional and policy leaders. At the suggestion of a key community partner, and with consensus from the executive committee, it was decided that the policy advisory board's role be modified to allow for a bidirectional information exchange rather than a unidirectional provision of information, which characterizes a traditional advisory board meeting. Under the revised plan, the center will not only share accomplishments and obtain feedback, but also provide feedback to advisory board members through a knowledge exchange forum. The role of the partnered research expert review panel, which includes both expert scientists and their expert community partners, is to support rigor in application of scientific and community perspectives on partnered research, as well as to support application of this approach to research development across other programs, in a two-way exchange of approaches, strategies, findings, and programs.

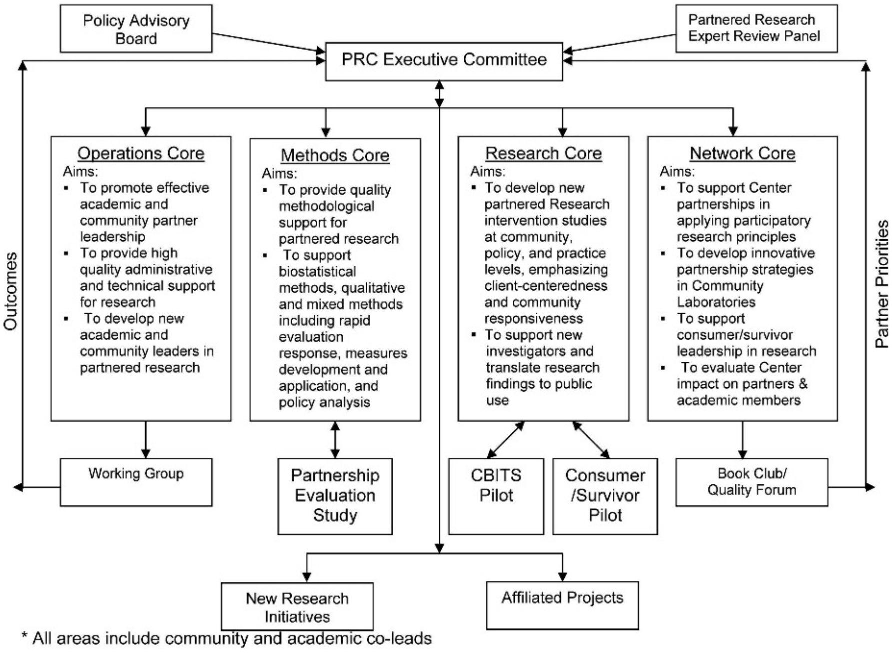

Fig 2. Partnered research center for quality care structure*

As seen in Figure 2, our center is composed of four cores, each structured to assure that the core values of CPPR are upheld, yet each serving a unique function designed to provide resources and facilitate the flow of information and relationships among all partners. Reflecting CPPR principles, each core consists of community and academic co-leads. The operations core provides administrative and technical support to partnered projects and to investigators who are developing projects under a CPPR framework. Through this core, and with approval from the executive committee, support is provided for the formation of working groups, which serve to build partners' knowledge base in a new research area and have the potential to develop into independent projects. The methods core provides statistical consultation from experts in the field on design, measures, and analyses issues. This core also oversees the Partnership Evaluation Study, which replaced the original networking pilot when the executive committee voted to reallocate resources in support of this project that aims to describe center partnerships and make recommendations for more effective future partnerships. The principal research core provides guidance to junior investigators and to developing projects, such as the pilot assessing the sustainability of Cognitive Behavioral Intervention for Trauma in Schools and the Peer Intervention to Improve Treatment Decision-Making. Finally, the network core provides support for establishing and maintaining healthy partnerships and effectively engaging community partners and consumers/survivors. This core serves a convening function and sponsors regular book club meetings and a yearly community quality forum to generate new research initiatives informed by partner priorities.

Despite having a distinct role in the center, each core aims to promote research that is conducted in partnership in order to address priority areas in mental health and there is much cross-collaboration among the cores. For instance, the community quality forum obtains broad academic and community input to jump-start new partnered initiatives, which are supported in their development through the methods core for technical matters and network core for partnership development. Being responsive to partner priorities necessitates a flexible center structure whereby activities may lead to unanticipated activities, which then may reshape the existing center structure. For instance, the network core-sponsored book club, which provides partners the opportunity to come together on a bimonthly basis and have an open discussion on readings selected by community and academic partners, led to the unanticipated activity of expanding a small book club into a community outreach event around resilience and recovery. This in turn led to the reshaping of the center structure via the formation of a consumer/survivor board and greater consumer/survivor participation in the executive committee. These unanticipated activities are expected to occur due to the nature of CPPR, but they are an unknown at the outset and become part of the center structure with approval from the executive committee.

The aims of the four center cores are aligned with the core values of CPPR: respect for diversity, openness, equality, empowerment, and asset-based approach. Respect for diversity highlights the importance of respecting and honoring that both academics and community members have skills to contribute and experiences that can help shape the research. Openness acknowledges the fact that there will be questions or disagreements that arise through the course of research and the best way to address these is by being open to listening to or expressing new perspectives, asking for clarification, and open to thinking outside of the box. Equality emphasizes that community and academic members of the group must share equally in decision-making power in all phases of research. Empowerment reminds us that all groups have power and that this power can be redirected to bring forth the strengths of each group. This is a two-way process; community members can be empowered through trainings prior to group meetings and academics can be empowered through inclusion in community events. One example of such a two-way process is the network core-sponsored book club, which is conducted informally as compared to a traditional journal club. For instance, one of our book clubs consisted of a collection of readings ranging from poetry to peer-reviewed journal articles and allotted time for sharing musical selections pertinent to the theme that each participant contributed. Partners discussed how the music related to the theme and, at the same meeting, discussed rigorous scientific methods that might not be thought feasible for discussion in such diverse groups. Through such activities, community leaders for methods work groups are developed, thus empowering community partners, and academic members are exposed to expressions of culture, thus empowering academic partners. Finally, it is important to have an asset-based approach that recognizes the strengths of both community and academic members in order to build capacity and remind everyone that each and every member has something to bring to the table. Table 1 lists several of the key principles of community engagement that are central to the CPPR model and provides examples of how the center structure facilitates the application of those principles, how these principles have led to new ideas, and how these ideas have in turn led to activities not initially planned.

PROCESS

To successfully engage in partnered research and build and maintain strong partnerships, the Partnered Research Center actively engages in CPPR methods in all activities as described below.

Executive Meeting Structure

The center leadership and key staff convenes once a month for our executive committee meeting, alternating our meeting site between an academic and community partner location, with the option of participating via phone. Most meetings begin with a community engagement activity, which sets a relaxed tone and allows partners the opportunity to interact informally before delving into the agenda. Meetings are set on a recurring schedule to ensure that center members have the block of time consistently available and reminders are circulated 7–10 days in advance of the meeting date along with the prior meeting's minutes and a proposed agenda. Center members are invited to revise the agenda to ensure that partner priorities are discussed. Typical agenda

Table 1. Examples of community engagement (CE) principles as applied to center work

CE principle	CE principle in action	Idea generated	Resulting activity
Co-planning of activities	Each center component is led by community and academic co-PIs with equal decision-making power	Modify traditional advisory board meeting to allow for reciprocal sharing of ideas and accomplishments	Knowledge exchange forum
Regular communication	Monthly core conference calls coordinated by a research assistant assigned to each core to facilitate communication	Hold unstructured meetings to allow for free discussion of current topics to stimulate new ideas and encourage discussion among partners in an informal setting	Bimonthly book club
Transparency	Partnered executive committee discussion of new ideas	Revise an already approved pilot project to allow for increased consumer/survivor involvement.	Draft proposal and circulate to center members allowing the opportunity to ask questions and give feedback prior to changing protocol
Funding	Center administrator circulates funding opportunities to center listserv	Discuss opportunities at executive meeting	Grant proposal review meetings for community and academic investigators to provide feedback prior to submitting to the funding agency
Commitment to productivity, impact, & accountability	Cores that meet regularly and bring forth ideas to the executive committee	Assess the impact of the declining economy on the mental health of the community	Partnered design, implementation and analysis of a survey administered at a community festival. Disseminate findings via scientific journals and community newsletters.
Understand priorities & histories	Community and academic co-PIs for each core and project	Increase consumer/survivor involvement to heighten awareness of recovery focus	Develop a consumer/survivor board
Recognition of community input	Include community members on all cores, committees and working groups	Support community member who has an idea for a research activity, but lacks resources to implement it	Funds allocated for a community scholar
Institutional recognition	Invite institutional and funding agency representatives to join executive meetings	Give community partners the opportunity to attend scientific meetings	Community and academic partners present together on a panel at Academy Health

items include: status updates from each core, planned grant submissions and how to allocate support for these, planned products such as peer reviewed articles or website updates, development of new pilot projects, working groups, or research fellows, and proposed new project affiliations or consultants to invite to center events or from whom to obtain expert advice on particular issues. The meeting is co-chaired by an academic and community member and all decisions are voted on by the group.

Decision Making

Decisions are made by majority vote with community representing at least half of the vote. Major decision points are included on executive meeting agendas, discussed, and then voted on by the group. If there is not an equal distribution of community and academic partners present, suggestions can be made at the meeting and then circulated via email. As trust has developed at our center, we are now able to reach decisions via phone or email follow-up.

Budget

Decisions made often have budget implications. The center budget was prepared for the entire five-year period of the current center at the time of funding and is resubmitted annually at the time of progress report submission. It is reviewed regularly and resources are reallocated with consensus of center members, within limits set in place by the National Institutes of Health. Such decisions are almost exclusively made at the executive committee meeting to ensure transparency and full disclosure. If urgent rebudgeting decisions need to be made, phone or in-persons meetings can be quickly scheduled. Having a center infrastructure allows for budget changes to be implemented without negatively impacting the work of the overall center.

Working Groups

The formation of working groups is discussed and voted on at executive meetings. Ideas for working groups develop often out of sideline conversations among center partners or investigators on affiliated projects. Ideas generated are then brought back to the executive committee and the working group structure as well as suggested participants are discussed. The committee also votes on how resources should be allocated to support the work group, which often includes the support of a research assistant to conduct literature searches, coordinate meetings, and follow up on action items. In line with center principles, working groups are co-led by a community and academic investigator, products are created for distribution to a community and academic audience, and the group often leads to future proposals or independent projects.

Affiliated Projects

Projects with aims consistent to those of the center can request affiliation. By affiliating with the center, projects will have access to resources such as staff support, consultation from center leaders, or in some cases financial support. In turn, the center gains from expanding its scope and supporting projects that advance the center mission.

Community Scholar

The decision to fund a community scholar was made by the center in order to nurture the development of community members so they may fill a role similar to that of a junior investigator. Community scholars are assigned a mentor for their project, are supported in identifying a research goal, and receive training on effective implementation. The project aims must fit with the overall center mission.

Memorandum of Understanding

The center developed a formal agreement, or memorandum of understanding (MOU), to outline center principles, policies, and define the role of affiliated projects at the center. The document was developed and circulated to all center members for review. All feedback was incorporated and the revised document was discussed and signed at one of the executive committee meetings. This article describes many of the components formalized by the MOU and a few outcomes that have resulted from engaging in this work.

RESULTS

In the early phases of the center we worked across the partnership to select and propose three R01s concerning the effects of policy, practice, and community-level interventions on quality of care. All three were developed with extensive partner and expert consultant input and each was funded and now are main affiliated studies within the center. The studies are: 1) an evaluation of the impact of the Medicare Remodernization Act (MRA) on elderly use of anti-anxiety agents; 2) an evaluation of the impact in Los Angeles County of the California Mental Health Services Act; and 3) Community Partners in Care, which evolved out of the Witness for Wellness Program to address the problem of depression in South Los Angeles. Other center work focused on a set of problems of mutual interest include: 1) depression and anxiety disorders in the general community, but especially underserved communities of color; 2) children exposed to violence and school based interventions; 3) common childhood disorders such as attention deficit disorder and depression; 4) severe and persistent mental illness, particularly schizophrenia; 5) communities exposed to disasters, especially New Orleans post-Katrina and long-term recovery. Table 2 provides a summary of selected active projects currently being conducted either through or in affiliation with the Partnered Research Center for Quality Care.

New priorities are emerging as the center progresses and as they do, working groups are formed to bring together key stakeholders in discussing these priorities and formulating an action plan. For example, a new focus on community resilience, as our communities and the nation face the impact of a declining economy as well as tragic events such as major disasters and community violence, led to the creation of a working group to develop conceptual frameworks or models and interventions to promote resilient communities. This group successfully convened over 20 stakeholders from local, state, and federal agencies representing Los Angeles Unified School District, RAND Health, UCLA, Los Angeles County Department of Public Health, the Veterans Administration Greater Los Angeles Health System, the National Institute of Mental Health, the National Institute for Occupational Safety and Mental Health, the Department of Health and Human Services, the American Red Cross, Tulane University, the University of Southern California, the University of Pennsylvania, the Substance Abuse and Mental Health Services Administration, the HHS Department of Preparedness and Response, and Healthy African American Families. As a result of this working group, the center has a new affiliated pilot project in Los Angeles County being conducted by the Los Angles Department of Pubic Health, Emergency Network Los Angeles, UCLA, and RAND to build community capacity and response around emergency preparedness and disaster recovery issues. Other examples of new priority areas include health information technology, the impact of health reform, and biomarkers, a topic of critical importance that has been difficult to address due to historical distrust of research in this field.[38] Working groups on each of these topics are currently being formed and will be active throughout the 2011 calendar year.

A key theme of these working groups is the importance of policy for sustainability. In acknowledgment of this and of recent potentially transformative policy changes for mental health services, the center has been actively exploring the salience of a CPPR approach for partnering with policy partners on topics ranging from medical home models for mental health with Los Angeles County and the State Department of Mental Health to the impact of parity legislation with man-

Table 2. Selection of Partnered Research Center for Quality Care projects

Project	Selected partners	Aims
Community partners in care	Behavioral Health Services, Healthy African American Families (HAAF), HOPICS, Los Angeles Urban League, NAMI Urban Los Angeles, Queenscare, RAND, St. John's Well Child & Family Center	Group-level, randomized comparison trial of a community-engagement, network-building intervention and a low-intensity dissemination approach, each designed to promote adoption of key components of two established, evidence-based quality improvement (QI) programs for depression.
REACH-NOLA: -Mental health infrastructure & training	Holy Cross Neighborhood Association, Common Ground Health Clinic, St. Thomas Community Health Center, University of Washington, REACH NOLA, Tulane Community Health Center at Covenant House, Kaiser Permanente, St. Anna's Episcopal Church, UCLA, RAND, Tulane University School of Medicine, Trinity Counseling and Training Center	A collaboration of many local and national nonprofit organizations, public agencies, and academic institutions that seeks to address depression and post-traumatic stress disorder (PTSD).
CBITS	Los Angeles Unified School District, Madison School District, Mercy Family Center, Queenscare, RAND, UCLA, University of California San Diego, University of Southern California	To evaluate, in a randomized controlled trial, a brief group intervention to address PTSD and depressive symptoms in students -To partner with a faith-based community to disseminate CBITS in parochial schools -To study implementation feasibility and sustainability in schools across three communities: Los Angeles, New Orleans, and Madison -To study a quality improvement approach to improve implementation of CBITS in the schools compared to implementation as usual
Adoption work	CASE, TIES for Adoption, UCLA	To develop a manualized intervention for children adopted from foster care aimed at decreasing risk for substance abuse and increasing family and child adjustment.
Decision Aid	CalMEND, UCLA	To pilot-test a clinician decision support tool for adults receiving medication treatment for serious mental illness in Medicaid-funded outpatient specialty mental health programs.
Resilience workgroup	DHHS, HAAF, LA Department of Public Health, LAUSD, NIMH, NIOSH, RAND, Red Cross, SAMHSA/CMHS, Southwestern Medical Center, University of Cincinnati, University of Pennsylvania, UCLA, USC, VA	To define community resilience and identify ways to assess communities' assets and strengths, critical measures, ways of tracking resilience, and to identify successful intervention models.
Mental Health Services Act Study	LA Department of Mental Health (LA DMH), UCLA, USC, Veterans Affairs	To document implementation of the MHSA in LA County and understand how an influx of funds into new specialized public mental health programs affects clients and providers in those programs and clients and providers in non-MHSA programs.
Stigma reduction	LA DMH, UCLA	To combat stigma and discrimination by conducting oral history interviews and identifying archival documents from numerous sources.

aged care partners to new partnerships around community engagement in preparedness and disasters. Policy partners range from community members to local and national partners. For example, the center initiated a partnership with a staff member from the White House Office of Community Engagement to explore the emerging issues in health care reform as applied to mental health and substance abuse services and persons with those needs.[39] Based on this commentary, Dr. Wells and Dr. Patel were invited to host a panel discussion at the 2010 Academy Health meeting on implications of health reform for mental health, from diverse stakeholder perspectives. Several representatives of the Partnered Research Center as well as investigators and policy spokespersons from other areas of the country participated in this panel and are now collaborating on publications outlining the potential impact of health reform legislation.

Partnered research efforts in mental health have also emerged in studies of care for persons with severe mental illness.[29,33,40–42] Due to the historical mistreatment found in the mental health system and the medical model having traditionally viewed consumers/survivors from a deficit model rather than a strength-based model, true partnerships between academic/clinical researchers and people who have been diagnosed with serious mental illness have been difficult to forge. One consumer/survivor expressed feeling that his presence on various projects or committees was solicited more for the appearance of diversity and inclusion rather than for substantive involvement and consideration. This lack of trust has now dissipated as meaningful inclusion and respect for input from center members has grown. For example, center investigators are currently in the planning stages of a pilot to manualize an intervention designed by a consumer/survivor partner to educate peers about illness self-management, especially medication issues and advocacy. The center is supporting manualizing this intervention and future training of peers on its use and supervision of its implementation. The center has also supported a PEERS fellowship program in which three consumer/survivor specialists joined the center for a year to work as research assistants on our evaluation of the Mental Heath Services Act. Each of these research assistants made valuable contributions to the project and two of them are continuing to work with the center beyond the completion of their fellowship.

In addition, below are a selection of case studies that illustrate how the CPPR model is being applied within projects and how the structure and functions of the project or the center as a whole, become modified in response to the input and resources available as the model is applied within the center infrastructure. For each case study, we briefly describe work according to the Vision, Valley and Victory stages and comment on how the projects utilize community engagement principles.

Case Study 1: Community Partners In Care

Community Partners in Care (CPIC) is a group-level, randomized comparative effectiveness study, where the compared interventions are use of expert consultation versus community engagement and planning as models for improving dissemination of evidence-based quality improvement interventions for depression in underserved communities in Los Angeles. The project itself was designed and is being implemented within a CPPR framework with community and academic co-leads, and directed by a council that has supported working groups addressing design, measures, implementation evaluation, and intervention development and implementation.[43]

Vision

At the beginning of the project, CPIC conducted a visioning exercise at an executive committee meeting where study partners were given a piece of paper and asked to respond to four questions: 1) what would you as an individual expect from CPIC? 2) what are your and your agencies expectations of CPIC? 3) what do you think the community expects from CPIC? and 4) what do you think researchers/ academics expect from CPIC? CPIC then held a general meeting with community stakeholders and potential partners. Participants were asked three main discussion questions to help us determine the appropriateness of the project's depression care intervention: 1) how do you define community? 2) what agencies, organizations or individuals need to be included to develop trusted and respected community solutions to reduce depression in the community? and 3) what innovative, creative solutions do you know of – or think should be used – to improve services for depression in the community? Scribed notes were taken at this meeting and these notes were then analyzed jointly by a group composed of two academic and two community partners from the CPIC Steering Council. A final version of the result was then drafted and presented to the CPIC Steering Council. CPIC then held its first policy advisory board (PAB) meeting. The goals of the PAB as determined by the steering council were to develop institutional and community/civic support for improving depression care and using the CPIC study as a catalyst for community learning about how best to do so. These informal discussions provided a rich insight into the array of issues for policy stakeholders in considering the study's goals and implementation in Los Angeles County.

Valley

Components of the main project, now underway, include agency, administrator, provider, and client recruitment, intervention development and implementation, survey administration for agency administrators, providers, and clients/community members, study operations and administration, and planning for main analyses and dissemination activities. Each activity is supported by working groups that are co-led by community and academic leaders, and for most meetings, and for the project as a whole, there is an emphasis on community engagement activities and relationship building. Key issues at this stage include keeping motivation across partners going across the many project activities, effectively using and motivating staff, and maintaining a balance of productivity and reaching goals and feasibility for community implementation. Examples of major adjustments owing to the CPPR framework have included adding an additional year to develop relationships with agencies to support modification of intervention materials, which has lead to a high level of participation at all levels (eg, 93 agency programs are participating across diverse types of community-based agencies and businesses) and productivity in terms of intervention training sessions, as well as completion of intervention planning activities and initiation of all phases of survey work with community input and co-leadership. We are also expanding the outcomes that we are studying to be of greater relevance to the community partners, for example, inclusion of job status, housing, and academic performance. In addition, we are expanding our inclusion criteria and sites for research to be more inclusive of vulnerable populations that are of concern in the community, such as the homeless.

Victory

Under a CPPR framework, it is important to acknowledge successes along the way, and in this case the substantial recruitment benchmarks and fielding of training conferences and programs such as webinars, have contributed substantially to building community capacity. In addition to positive feedback at such events, the community partners have received and passed on spontaneous comments from their social networks expressing appreciation and excitement for these activities. Because survey benchmarks for recruitment have been exceeded, the potential is high for this project to provide important new data on the outcomes of two models of community-based implementation of evidence-based programs.

The lessons learned from this case study in progress include that a broad randomized trial is feasible through this form of rigorous partnered research and can lead, with some adjustment for community implementation needs, to a productive and effective research study that is also viewed as contributing to community capacity in a critical area. In terms of implications for the center infrastructure, this has encouraged us to be bolder in the scale of partnered research that we propose.

Case Study 2: Post-Katrina and Rita Recovery

Vision

Dr. Benjamin Springgate was an Robert Wood Johnson Foundation (RWJF) Clinical Scholar when Katrina hit his hometown of New Orleans. He continued for three years as an RWJF Clinical Scholar, and in the early months after the disaster assisted with developing health services for emergency shelters for the state of Louisiana. Our center supported a community-academic partnered rapid assessment of needs one year post-storm that included unmet mental health needs, providing methodological expertise and partnership development expertise. Subsequently, the partnership evolved into a nonprofit organization (REACH NOLA) supporting academic-community partnered programs, services, and research for health recovery following the storms.

Valley

Based on the partnership development, and with the support of the expertise of the NIMH Center, Dr. Springgate secured an RWJF grant to develop community health and resiliency centers (focusing on mental health recovery) in New Orleans and funding from the American Red Cross Hurricane Recovery Program to support mental health recovery efforts through providing training in evidence-based practices in collaboration with community agencies. With this funding, along with substantial support from the RWJF, the partners were able to provide a series of seven trainings over two years, each with follow-up supervision in multiple components of evidence-based care. Designing and delivering these trainings required bringing together many diverse groups and working out differences during a stressful time, but ultimately led to increased community services delivery and capacity building. During this time, the NIMH-partnered research center supported qualitative evaluation of program development and impact and assistance with intervention technologies and implementation. This approach is also being explored for applicability to the oil spill in the Gulf States.

Victory

American Red Cross funding was the single largest philanthropically-supported, disaster mental health grant in the Gulf States after Hurricanes Katrina and Rita. Together with support from RWJF, this funding enabled trainings and additional consultations to reach over 400 providers from more than 70 agencies, and resulted in the development of a new community health worker program for mental health recovery,[44] as well as delivery of more than 110,000 individual mental health services to tens of thousands of community members. This work has been recognized by the leadership of SAMHSA and the Department of Health and Human Services, for its value as a model for the nation's mental health disaster preparedness and response.[45] In addition, the American Association of Medical Colleges cited the key role of this community academic partnered work in awarding its 2010 Spencer Foreman Award for Outstanding Community Service to Tulane University.[46] The capacity development between New Orleans and the center, has been two-way. For example, the real-world experience gained in New Orleans has been critical for implementing the NIMH Community Partners in Care study, in which we are directly using the New Orleans community health worker model and members of CPIC and of the NIMH Center have participated in every mental health recovery training in New Orleans.

The lessons learned for the center infrastructure are related to the feasibility of applying a similar model for research development and community capacity building for real-time needs, and the value of cross-project lessons and resources to both help communities in need and support improved research strategies.

Case Study 3: Cognitive Behavioral Intervention For Trauma In Schools

Vision

The vision for Cognitive Behavioral Intervention For Trauma In Schools (CBITS) was conceptualized by a lead community partner in Los Angeles Unified School District, Dr. Marleen

Wong and her unit of over 250 clinicians district-wide.[47] As a psychiatric social worker for over 20 years, Dr. Wong saw many students suffering from trauma-related mental health problems and saw those problems affecting students' ability to learn. She and her colleagues sought out research partners to develop an intervention that would address these needs. As initial meetings with this community-academic partnership emerged, the community partners defined the parameters of the intervention, with feasibility being central to the design and researchers suggesting evidence-based approaches and evaluation designs.[48]

Valley

What has emerged from this community-academic partnership is CBITS; an evidence-based intervention for youth exposed to violence that has all the practical aspects that allow it to be disseminated by the average school-based clinician, during the school day when counseling usually occurs, and with the limited resources and time that typically is available in schools. The center is supporting the next phase of studying ways to improve implementation of CBITS given that it is being delivered in a non-specialty mental health setting with limited organizational infrastructure to support implementation. As we pilot a quality improvement strategy to support implementation, our challenge has been in balancing the collection of new knowledge with doing research in an overtaxed service system.

Victory

As a result of positive findings from two evaluation studies demonstrating the effectiveness of CBITS,[48,49] this intervention has been disseminated across the United States, from Native American reservations in New Mexico and Montana, to school districts in Madison, Wisconsin, inner city areas such as Baltimore and Chicago, rural areas including Olympia and Yakima, Washington and the post-Katrina Gulf States, as well as internationally. This partnership has been supported by NIMH funding to support ongoing research activities that are coupled with services being funded by grants such as the RWJF, Carter Foundation, and SAMHSA's National Child Traumatic Stress Network. These funding streams have allowed CBITS partners to collaborate in developing an implementation toolkit for improving dissemination, an educational video for school staff that features community partners from education, mental health, and law enforcement, and web-based trainings and support. At the same time, research partners have studied quality improvement of CBITS implementation and factors that affect sustainability and further dissemination in schools.[50,51]

CBITS has been recognized by the US Department of Education as meeting the standards of the No Child Left Behind policy and has been identified as an evidence-based program by the National Child Traumatic Stress Network, the National Registry of Evidence-based Programs and Practices, the Promising Practices Network, and the Office of Juvenile Justice and Delinquency Prevention. Lessons learned from this case example for the center include the importance of applying models of community engagement across different age groups and types of infrastructures to yield a more comprehensive, overall set of evidence-based strategies to relieve public burden of mental disorders and the impact of risk factors for these disorders (eg, violence).

Unanticipated Activity: A Collaboration with the Los Angeles County Department of Mental Health to Create the UCLA Center for the Study of Public Mental Health

Vision

A major goal was to create partnered research collaborations that focused on public mental health care. In particular, we intended to partner with the Los Angeles County Department of Mental Health (LAC DMH) and University of Southern California (USC) in order to evaluate the impact of major policy changes on care in the County.

Valley

The implementation of the vision has proceeded in two phases. The first phase entailed the development and then implementation of an NIMH R01 to study the impact of the California Mental Health Services Act on care in Los Angeles County. Initially, the NIMH Center operations core created a partnered research-working group with the LAC DMH and USC. The working group took responsibility for the R01 development and implementation. The NIMH-funded grant followed principles of partnered research and community engagement.

The second phase developed out of this new partnership and was explicitly intended to create an infrastructure for sustainable, long-term collaborations between the LAC DMH, University of California at Los Angeles (UCLA), and USC. To this end, the partners created the UCLA Center for the Study of Public Mental Health. In addition to the federal grant support, the center coalesced around a set of funded initial activities, each fully conducted in partnership with LAC DMH and USC. This new evolving center has expanded its scope beyond its original focus on the relationship between policy and client outcomes to include issues such as public stigma of mental illness and development of media communication strategies (eg, http://www.pendari.com/DMH/), consistent with but somewhat outside the scope of the NIMH Center.

Victory

The "UCLA Center for the Study of Public Mental Health: A Collaboration with the Los Angeles County Department of Mental Health and USC" marked its formal creation with a conference titled, "Partnership for Mental Health: A Conference on Academic-Public Collaborations for Research on Mental Health Recovery and Wellness." The conference focused on the ways in which patients, researchers, and providers could employ rigorous scientific methods for addressing questions of mutual concern.

Lessons learned from this case study include that the application of the partnered approach to research development can also mobilize new growth directions that can meet important independent goals of center partners and feature their priorities significantly, over and above what the NIMH Center itself could support.

DISCUSSION

The Partnered Research Center for Quality Care, established in 2008, is just one of several research centers and programs whose inception can be traced back to the Community Health Improvement Collaborative (CHIC), established in 2003. At that time, several programs came together with the common goal of identifying an innovative approach in order to have real impact and to increase the uptake of services in underserved populations around various health issues, including depression.[2] That approach, now utilized by our center, is CPPR. Since 2003, CPPR has been further refined and manualized[30] and has increasingly provided the framework for center projects. Through this process we have learned that with concerted effort from academic and community partners, it is possible to build a dedicated health services research center that supports both rigorous scientific research and community engagement, with the potential to reduce the stigma often associated with seeking mental health services. It is this type of structure that has allowed CPIC, one of our affiliated R01s, to successfully engage and recruit close to 100 community-based agencies in resource-poor communities that historically have distrust of researchers and the research agenda. What began as a natural next step to the CHIC, has evolved into a formalized infrastructure that supports a broad partnership in conducting work to improve mental health outcomes and mental health care in communities. Indeed, having this extensive partnership with a range of key stakeholders has presented unforeseen opportunities and enabled the center to achieve a broader scope than initially proposed. We have found that it is feasible to conduct such work, albeit with a few challenges.

A partnered style of interaction at times requires extra effort, resources, and a commitment to work together despite the many challenges that will be encountered along the way. Being inclusive of diverse partners and stakeholders is necessary to the success of partnered work but can also lead to delays and/or conflicts as there will almost certainly be opposing perspectives that will need time to be worked out. Challenges to conducting partnered research include the time required to develop trust, accounting for unexpected changes in community-based programs and leadership, limited time and resources of community partners who may have other diverse tasks and goals as their primary focus, and mixed views of its value in academic circles.[38,52] In addition, some of the known challenges of conducting such research can be even more complex when also addressing stigmatized illnesses that may not be openly discussed in vulnerable communities. The existence of a secure infrastructure to spot and address differences of opinion, misunderstandings, or conflicting interests, makes these issues more manageable under a center infrastructure as the capacity and the expertise to respond increases over time.

Through involving partners, investigators, and staff in joint activities such as book clubs and center meetings and events, and disseminating findings and a common model, the center infrastructure helps to facilitate entry of new partners and investigators into the center. There is enough common history and understanding that the legacy of one investigator more easily passes to another, and similarly, investigators are more comfortable initiating projects with partners and are more likely to have some understanding of what it means to initiate and maintain a respectful research relationship. By establishing an infrastructure dedicated to an issue or approach, the transition costs of developing new initiatives or supporting new investigators is reduced. In addition, the group affiliation of a center lends a certain identity to a new approach and allows a more uniform body of work and research voice to emerge. Support for other groups and institutions via subawards or funding of community scholars is more easily achievable when there is a dedicated infrastructure and thus can lead to economies of scale and scope such that, for a given set of resources, increased productivity can be achieved. Having even modest resources available for new work, such as in-kind staff support, can encourage investigators to take more risks, and try out new ideas, thus potentially leading to more rapid innovation. While these advantages are well known in academic institutions, there are fewer precedents for established centers that support a co-owned, academic and community infrastructure.

Partnered work has without doubt become part of our culture or the way we do business. The center is structured as a collaborative learning enterprise, with activities to promote new ideas, bring diverse opinions and resources together, facilitate academic and community investigator development, and enable rigorous internal and external review. It is striving to achieve impact in real-time through increasing community and academic partners' capacity to engage in thoughtful, methodologically sound research around mutually identified problems in mental health. To document and disseminate the process of our work, our center developed an integrated manual for conducting CPPR, which was published in a special issue of *Ethnicity and Disease* in December, 2009.[30] This manual is also a key resource to projects conducted within the center such as the Community Partners in Care study, and is used as a main resource for training of fellows in the Robert Wood Johnson Clinical Scholars program at UCLA, along with other books on Community-Based Participatory Research.[1,3,52] While the center is still in its early stages of development, it has supported various products including publications in peer-reviewed journals, newsletters, storybooks or lessons learned books, policy briefs, poems and skits performed at various community events and conferences, research proposals and contracts and grants. To share more systematically what we are learning through conducting research under a partnered center infrastructure, we are currently conducting the Partnership Evaluation Study to evaluate the impact of the center's partnership model on center research. Through this study, and as the center develops, we are empirically evaluating whether or not this type of approach makes unique contributions to the research agenda, improves services updates, and promotes research participation and use of findings. Preliminary findings from this study will be available in the fall 2011.

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EFFECTS ON SCHOOL OUTCOMES IN LOW-INCOME MINORITY YOUTH: PRELIMINARY FINDINGS FROM A COMMUNITY-PARTNERED STUDY OF A SCHOOL-BASED TRAUMA INTERVENTION

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Objective: To examine academic outcomes of a community-partnered school mental health intervention for students exposed to community violence.

Design: Randomized controlled trial.

Setting and Participants: Sixth-grade students ($N=123$) from 2 middle schools in Los Angeles during the 2001–2002 academic year who had exposure to violence and posttraumatic stress symptoms in the clinical range.

Intervention: Students were randomized to either receive a 10-session standardized school trauma intervention (Cognitive Behavioral Intervention for Trauma in Schools) soon after screening (early intervention) or after a delay following screening (delayed intervention), but within the same school year.

Main Outcome Measures: 59 students in the early intervention group vs. 64 students in the delayed intervention group (screened in September or December) were compared on spring semester grades in math and language arts, controlling for the students' standardized state test scores from the previous academic year and other covariates.

Results: Students in the early intervention group had a significantly higher spring semester mean grade in math (2.0 vs 1.6) but not language arts (2.2 vs 1.9). Students in the early intervention group were more likely than students in the delayed intervention group to have a passing grade (C or higher) in language arts (80% vs 61%; $P<.033$) by spring semester; we also found a substantial difference in the number of students receiving a passing math grade (70% vs 55%; $P=.053$).

Conclusion: Through a collaborative partnership between school staff and researchers, preliminary evidence suggests that receiving a school trauma intervention soon after screening compared to delaying treatment can result in better school grades. (*Ethn Dis.* 2011;21[suppl 1]:S1-71–S1-77)

Key Words: Grades, Trauma Intervention, Schools, Cognitive Behavioral Therapy, Violence

Studies have documented the broad range of negative sequelae of youth violence exposure, including posttraumatic stress disorder (PTSD) and other anxiety problems, depressive symptoms, and dissociation.[1–4] If anxiety becomes chronic, it can disrupt children's ability to regulate emotional states, leading to hypervigilance, emotional numbing, and inattentiveness. Youth exposed to violence have decreased social competence and increased rates of peer rejection,[5] as well as decreased IQ and reading ability, lower grade-point average (GPA), more days of school absence, and decreased rates of high school graduation.[6,7] Cumulative life stressors in childhood, including exposure to violence, can lead to poor employment productivity, social relationships, and health in adulthood.[8]

To mitigate the long-term effects of violence exposure, effective psychosocial interventions for trauma-related symptoms in youth have been developed,[9,10] however, few youth, especially low-income minority youth, receive early interventions to prevent negative developmental outcomes from exposure to violence. As the Surgeon General's National Action Agenda for Children's Mental Health reports,[11] providing social emotional support in schools can help address issues of access to care for many children. School-based services may be particularly important for underserved ethnic minority youth who traditionally are less likely to receive such services. For example, a randomized study of effective treatments for youth with posttraumatic stress symptoms in post-Katrina New Orleans found that 91% of the youth completed the school-based intervention compared to only 15% who completed the clinic-based intervention.[12] Another study found that in contrast to ethnic disparities found among children accessing clinic based services, there were no differences across ethnic groups in youth seeking school-based counseling services.[13]

To address the disparities in care for low income ethnic minority youth with exposure to violence, a community-research partnership developed, implemented, and evaluated the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program, a skills-building approach to improve the well-being of traumatized students. This partnership, initiated by the community partners (author MW) who had identified the needs of students exposed to violence as a priority for service delivery, involved Latino bilingual bicultural school clinicians, school administrators, and clinician-researchers. The community partners played a leading role in the partnership, allocating district resources to create a program that could be delivered by school clinicians, work within the confines of schools, and ultimately improve care for students exposed to violence.[14] School partners defined the operational parameters of the program. An after-school version was piloted to minimize missed class

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time, but school partners found that few students in these urban neighborhoods could regularly attend the groups due to family obligations after school and safety issues related to returning home late. School partners then insisted that the program be delivered in one class period and during the school day when counseling usually occurs. With the limited resources typically available to schools, school partners also required a brief intervention that was not resource intensive. Research partners suggested an evidence-based treatment approach based on cognitive behavioral therapy techniques that had been found in previous studies to be effective in treating trauma symptoms. The resulting intervention, CBITS, has been found to fit within the framework of the school community and has characteristics that have been found to predict adoption of new innovations[15] such as relative advantage over usual care practice, compatibility with other behaviorally oriented practices in schools, and minimal complexity through clearly presented lessons that were developed in collaboration with school-based clinicians.

Given that the primary mission of schools is to educate, and that educators are under enormous pressure to demonstrate academic improvements on a yearly basis, a key factor in partnering with schools around the adoption of such early intervention services is the program's impact on academic outcomes such as achievement. Universal school prevention programs, especially those targeting externalizing behaviors, have begun examining achievement, academic engagement, and academic competency in addition to behavioral outcomes.[16,17] However, studies of academic performance outcomes are rare for programs addressing internalizing symptoms. One randomized study of a brief cognitive behavioral therapy stress management intervention for a general school population of adolescents in the United Kingdom found improved mental health and academic competence in the intervention compared to control group.[18] Despite methodological limitations, this study showed that following a 3-month intervention, achievement scores were significantly higher than in the control group. Another study examining a prevention program for elementary school children at risk for developing anxiety disorders found the program improved math scores, but had little effect on anxiety or reading achievement.[19] There remains, however, a paucity of evaluations examining the impact of early intervention programs for trauma-related mental health problems on classroom performance. In this study, using a community-partnered participatory research approach, the educational outcomes of a promising school-based intervention for youth exposed to violence are examined.

In previous studies of CBITS, our community-research partnership has reported on improvements in PTSD and depressive symptoms.[10,20] However, understanding how CBITS affects students' educational outcomes remains important to school stakeholders. Thus, improving knowledge about the impact of early interventions such as CBITS on school performance is critical for both improving the adaptive functioning of underserved populations who are affected by violence and being responsive to the interests and mission of community partners. The current study addresses this issue by describing student grades in language arts and math in two groups of sixth grade students, those who received CBITS soon after detection of symptoms and those who were delayed in receiving treatment.

METHODS

Procedures

This study was conducted at two middle schools in East Los Angeles, with primarily low income, Mexican-American students, described in greater detail in Stein, et al.[10] Following consent procedures, 769 English-speaking sixth grade students participated in a self-report screening for violence exposure and posttraumatic stress symptoms either in September or December 2001 (two cohorts of students screened). Students were eligible for CBITS if they endorsed substantial violence exposure, post-traumatic stress symptoms in the clinical range, were willing to discuss their traumatic experiences in a group setting, and did not appear too disruptive to participate in a group therapy intervention as determined by the school-based mental health clinician.

Of the 159 students who were eligible for CBITS, 126 consented/assented to participate in the study. Sixty-one students were randomized to the early intervention group and received CBITS immediately after screening and sixty-five students were randomly assigned to the delayed intervention group and received CBITS after waiting 4–5 months following screening. Because school partners preferred to provide the program to both intervention and control students in the same academic year, all participating students received CBITS during the same academic year. Ninety percent of students completed treatment (87% in the immediate group, $n=53$; 92% in the delayed group, $n=60$).

One hundred twenty-three students, the sample for this study, had grades and standardized state test scores available. Of the 59 students in the early intervention group, 26 students were screened in the first cohort in September 2001 and completed treatment in January 2002, and 33 students were in the second screening cohort and completed treatment at the beginning of April. Of the 64 students in the delayed intervention group, 31 students were in the first screening group and completed treatment in mid-May, and 33 students were in the second screening group and completed treatment in June. The study was conducted in compliance with the Los Angeles Unified School District's Research Review Committee and the institutional review boards of RAND and UCLA.

Intervention

Developed in partnership with clinicians and administrators from the local public school system (see Wong for community perspective;[14] Stein, et al for development of partnership[21]), CBITS incorporates standard cognitive behavioral therapy skills in a group format (5–8 students) to address post-traumatic stress, anxiety, and depressive symptoms related to violence exposure over the course of 10 group sessions and 1–3 individual sessions.[10,22] Designed for a multicultural student body, CBITS balances fidelity to core components of the cognitive behavioral skills with the flexibility of incorporating culturally appropriate examples and activities to teach those skills (further described in Ngo, et al[23]). The intervention had previously been pilot tested for feasibility and acceptability with immigrant Latino populations (Mexican and Central American students) in this school district.[20] Two full-time and one part-time school psychiatric social workers delivered the CBITS intervention during the 2001–2002 academic year, usually during one class period per week. School partners determined when the intervention was delivered, such as during non-academic periods and at different times each week to minimize the number of times a student would miss the same academic class.

The school mental health clinicians received two days of training in CBITS and weekly group supervision from the clinician investigators (authors BDS, LHJ, SHK). The school clinicians followed a treatment manual to insure that the intervention was standardized across clinicians.[22] Fidelity to the manual was measured by an independent clinician who rated randomly selected audiotapes of sessions (17% of the total number of sessions), assessing extent of session material completion and quality of therapeutic approach (ie, motivation and participation of group members, therapist empathy). The mean rate of content completion was 96% and quality of sessions was moderate to high across sessions.

Measures

To assess students' post-traumatic stress symptoms, we used the Child PTSD Symptom Scale (CPSS),[24] a 17-item child self-report measure (range 0–51) that has been shown to have good convergent and discriminant validity, high reliability[24] and high internal consistency[20] in school-aged children. Children rated how often they were bothered by each symptom in the past month on a scale from 0 (not at all) to 3 (almost always). For program eligibility, post-traumatic stress symptoms in the clinical range were defined as a sum score of 14 or more, consistent with moderate clinical levels of post-traumatic stress symptoms.

Students' depressive symptoms in the past two weeks were assessed using a 26-item Child Depression Inventory (CDI).[25] The CDI (range 0–52) assesses children's cognitive, affective and behavioral depressive symptoms, and has good test-retest reliability and validity.[26–28] A single item assessing suicidality was removed at the request of school partners.

Outcome measures of academic performance were based on spring semester grades from the 2001–2002 school year for math and language arts. Grades were abstracted from school records and coded as A=4, B=3, C=2, D=1, and F=0 for use as an outcome variable. Previous studies have documented the importance of students receiving a grade of C or higher, which often is the minimum grade allowed to advance to higher level courses and to participate in extracurricular activities such as sports.[29,30] Since this distinction also resonated with our community partners, we also compared the treatment groups by whether or not students had a passing grade of C or higher on their spring semester math and language arts final grades. Fall semester grades could not be used in this study as either baseline variables or outcome variables, because they reflect school performance during the first half of the school year, the same time period that some students in the early intervention group were in the process of receiving, but had not yet finished, treatment.

Annual state testing results from the previous school year were also abstracted, however, state testing results for the school year during which the trial took place were not available; testing is administered in May but results are not available until the following summer, after the study had ended. Prior year state testing scores were used to establish a baseline of academic functioning for each student. Specifically, standardized total state test scores were used as a covariate for examining spring semester math and language arts grades. Standardized test scores were reported on a scale of 0 to 100, with 100 being the highest score possible.

Analyses

To examine baseline characteristics, we compared the early and delayed intervention groups on child and parent characteristics, violence exposure, mental health symptoms, and prior year standardized test scores in reading, language arts, and math using t tests for numerical variables and Chi-square tests for categorical variables.

To assess the difference between the early and delayed intervention groups on spring semester mean math and language arts grades, we used hierarchical linear models (HLM) to account for hierarchical data structure; students are nested within treatment group, to address the possible influence of shared exposures among students within the same CBITS treatment group. Given that there are only two schools, school was treated as a fixed effect. In such models, our primary interest is intervention effects at the student level, while not ignoring the variability associated with groups. Intervention status is the main independent variable, and the standardized test score from the prior school year, PTSD symptom score, total violence score, sex, school site, parent employment status, and time of screening are covariates. To show effect sizes, we present unadjusted means and proportions by intervention groups, as well as adjusted differences or odds ratios (ORs) that are adjusted for the covariates listed above. We use PROC MIXED for continuous variables (Language arts and math grade) and GLIMMIX for binary variables (passing grade) in SAS System V9.2.[31]

Table 1. Sample characteristics at baseline by treatment group*

Characteristics	Early intervention (*n*=59)	Delayed intervention (*n*=64)
Child characteristics		
Age, mean years (SD)	11.0 (0.3)	10.9 (0.4)
Sex, *n* (% female)	27 (45.8)	27 (42.2)
Parent characteristics		
Education, yrs (SD)	8.3 (3.6)	8.7 (4.2)
Employment, *n* (% employed)	23 (39)	31 (49.2)
Married, *n* (%)	46 (78.0)	44 (69.8)
Household income <$15,000, *n* (%)	22 (37.3)	27 (42.9)
Violence exposure		
Witnessed violence, *n* (%)	59 (100)	64 (100)
Victim to violence, *n* (%)	58 (98.3)	60 (93.8)
Weapon related violence, *n* (%)	42 (71.2)	49 (76.6)
Total violence score, mean (SD)	26.1 (13.5)	26.3 (13.8)
Symptoms		
PTSD symptom score, mean (SD)	24.4 (6.8)	23.6 (7.2)
Depressive symptom score, mean (SD)	17.6 (10.8)	16.7 (7.3)
Standardized test scores from prior school year		
Reading score, mean (SD)	29.3 (19.3)	36.3 (22.8)
Language arts score, mean (SD)	40.3 (24.4)	47.8 (23.2)
Math, score, mean (SD)	39.7 (22.4)	41.4 (22.8)

* No significant differences between early and delayed groups ($P>.05$)

RESULTS

Students had a mean age of 11 years, with 44% ($n=54$) being female, and 40% ($n=49$) had family household incomes below $15,000. Overall, participants in this treatment study had significant levels of violence exposure, with 74% ($n=91$) reporting directly witnessing or being victim to knife or gun violence in the past year. The mean PTSD symptom score was 24, with a score of ≥14 representing at least moderate levels of PTSD. In general, standardized test scores from the prior academic year were remarkably low, with the mean score for reading at 33, math 41, and language arts 44 out of a total possible score of 100. Students in the early intervention group did not differ significantly on any of the baseline characteristics compared to those in the delayed intervention group (Table 1).

Table 2 shows the unadjusted and adjusted analyses for spring math and language arts grades. Students in the early intervention group had a 2.0 mean math grade, which was significantly better than those students in the delayed intervention group who had a mean math grade of 1.6, after adjusting for prior year standardized test scores and other covariates ($P=.048$). However language arts mean grades did not differ significantly across treatment groups. When spring semester passing grades were examined (grade of C or higher), 80% of those in the early intervention group compared to 61% in the delayed intervention group had received a passing grade in language arts (O.R. 2.9, CI 1.1, 7.5; $P=.033$, Figure 1). We also found a substantial difference in the number of students receiving a passing math grade, with 70% of students in the early intervention group passing math while only 55% in the delayed intervention group receiving a passing grade in Math (OR 2.3, CI 1.0, 5.3; $P=.053$).

Table 2. Random effects model predicting spring semester grades by randomized group, unadjusted estimates and adjusted analyses (*N*=123*)

	Unadjusted Estimate		Adjusted Analyses†	
	Early intervention group (*n*=59)	Delayed intervention group (*n*=64)	Between-group Difference	*P*
Grade			Mean difference, 95% CI	
Math, mean (SD)	2.0 (1.1)	1.6 (1.2)	.40 (.0, .8)	.048
Language arts, mean (SD)	2.2 (1.2)	1.9 (1.3)	.32 (−.1, .7)	.129
Passing grade, C or higher			OR, 95% CI	
Math, passing grade, *n* (%)	41 (69.5)	35 (54.7)	OR, 2.3 (1.0, 5.3)	.053
Language arts, passing grade, *n* (%)	47 (79.7)	39 (60.9)	OR, 2.9 (1.1, 7.5)	.033

* Students for whom we did not have group assignment (prematurely dropped out), were assigned to a single group number

† Adjusted for: standardized test score from prior year, sex, employment of parent, PTSD score, total violence score, time of screening, school site

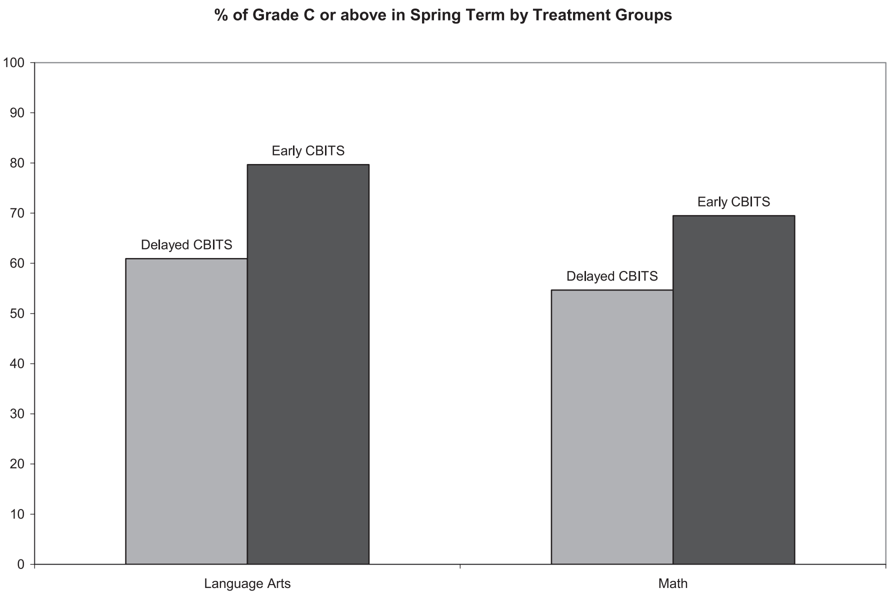

Fig 1. Spring language arts and math, percentage of students receiving passing grade, by early vs late treatment groups (*N*=123)

DISCUSSION

This community partnered research study provides important preliminary evidence that a school-based intervention for children exposed to violence may positively impact grades, a finding that is directly relevant to schools' educational mission. Our earlier work demonstrated positive findings on mental health outcomes (PTSD and depressive symptoms), but we had not yet examined the impact on academic achievement. These findings suggest that those students who receive CBITS soon after screening, compared to those who are delayed in receiving treatment, appear to perform better academically in terms of their math and language arts grades. This positive impact on academics from a brief, feasible mental health intervention for students with very high levels of violence exposure highlights important information for school administrators concerned with school performance indicators. This study is one of the first to suggest the linkages between academic and mental health outcomes within a mental health intervention context for children with internalized problems (eg, anxiety, depression). This study shows a possible impact on both language arts and math grades, building on the work of Keogh and colleagues and Cooley-Strickland and colleagues who found improvements in academics among children receiving interventions for anxiety and stress management.[18,19]

The fact that this study was able to demonstrate differences in academics among students who all received the program during the same academic year and only differed in the timing of the intervention is noteworthy. We interpret these findings to mean that receipt of the program immediately after mental health need is detected gave students more of an opportunity to focus and concentrate in school, and thereby improve their grades during the spring semester. In contrast, those who received the program following a delay in treatment had less time for their mental health improvements to impact their grades. Had the study included a control group that did not receive the intervention, the effects may have been more profound.

Our study findings also have important practical implications for educators who are considering bringing mental health programs to schools. The program was developed and the study conducted using community partnered participatory research (CPPR) in which community partners were critical in shaping the research question, conduct the study, and interpret the findings. Education is the primary mission of schools, and schools often have limited resources to put toward programs, requiring educators to look for evidence that interventions improve students' academic outcomes as well as mental health. The present study provides such information for educators interested in mental health programs. Conducting the study through an integrated partnership has helped to ensure real world relevance of the findings.

A number of studies have found that exposure to violence affects student academic performance. In a longitudinal study of middle school students, Henrech, et al found that witnessing violence was associated with lower academic achievement over time.[32] Those students who had not witnessed any violence were twice as likely to meet state academic performance goals. Others have found associations between violence exposure and lower high school graduation rates.[33] In recent years, a substantial amount of academic resources and educationally focused programs have been devoted to improving the academic performance of low performing students, who are at higher risk for dropping out in high school.[34] Our study suggests that at least for some of these students suffering from substantial psychological distress, a targeted and effective program addressing their mental health symptoms may also improve their classroom performance.

Future research should examine the potential mechanisms through which interventions like CBITS may impact academic performance, both directly and through mediating pathways. Cognitive theories of PTSD support the notion that following a traumatic event, one may develop maladaptive cognitive schemas in which individuals believe that the world is always a dangerous place.[35] Prolonged intense anxiety coupled with such maladaptive cognitions can ultimately disrupt youths' ability to relate adaptively to others and successfully manage emotions such as in the classroom setting, ultimately resulting in poor school outcomes. Children with posttraumatic stress symptoms may experience difficulty concentrating due to preoccupation and intrusive thoughts related to the trauma memory, or to poor sleep and stressors outside of school. Interventions such as CBITS, delivered at the early signs of psychological distress, may help to decrease these effects and improve students' ability to concentrate on their school work and focus in the classroom.

There are several limitations to the present study that are important to consider. First, both the early and delayed intervention groups received CBITS in the same school year, and given that grades were not measured exactly before and after treatment was delivered, it is difficult to interpret the effect that CBITS has on grades immediately post-treatment. In addition, due to school partners working under real world constraints while delivering CBITS for this study, we decided to screen in two cohorts, one at the beginning of the school year, and one mid-way during the year. Had we screened all students at the beginning of the school year, and then randomized them into four groups each getting CBITS at a different time of year, we could have more easily looked at the effect of receiving the intervention early in the school year vs later. Our comparison was limited to comparing students who received treatment immediately after being screened vs those who had to wait several months to receive treatment. Future research should include treatment and control groups that receive CBITS during different school years, in order to more fully examine what effect CBITS may have on school success and what potential mediators may be involved in this effect. Finally, given that we did not have resources to collect data following the completion of this study and did not have the foresight to obtain permission to collect achievement testing from the current academic year, this study is limited in not being able to assess change in achievement testing. Additional research is needed that uses multiple measures of school performance, including an administered achievement test before and after intervention as there are limitations to using grades as a measure of academic success.

Despite these limitations, the current study provides important preliminary evidence that a brief school-based intervention for students exposed to violence in the community can impact not only their mental health, but also their grades. At a time when both the mental health system and educational system are faced with difficult choices arising from constrained resources, an efficient, time-limited, school-based group intervention that can improve both students' mental health and educational outcomes may play an important role for districts educating students in communities with endemic community violence. Such community-partnered approaches to school-based interventions for students exposed to violence can fill a critical public health gap by providing treatments readily accessible for low-income minority students who could benefit from improved mental health and school functioning.

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PARTNERED EVALUATION OF A COMMUNITY ENGAGEMENT INTERVENTION: USE OF A KICKOFF CONFERENCE IN A RANDOMIZED TRIAL FOR DEPRESSION CARE IMPROVEMENT IN UNDERSERVED COMMUNITIES

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Community partnered research and engagement strategies are gaining recognition as innovative approaches to improving health care systems and reducing health disparities in underserved communities. These strategies may have particular relevance for mental health interventions in low income, minority communities in which there often is stigma and silence surrounding conditions such as depression and difficulty in implementing improved access and quality of care. At the same time, there is a relative dearth of evidence on the effectiveness of specific community engagement interventions and on the design, process, and context of these interventions necessary for understanding their implementation and generalizability.

This article evaluates one of a number of community engagement strategies employed in the Community Partners in Care (CPIC) study, the first randomized controlled trial of the role of community engagement in adapting and implementing evidence-based depression care. We specifically describe the unique goals and features of a community engagement kickoff conference as used in CPIC and provide evidence on the effectiveness of this type of intervention by analyzing its impact on: 1) stimulating a dialog sense of collective efficacy, and opportunities for learning and networking to address depression and depression care in the community; 2) activating interest and participation in CPIC's randomized trial of two different ways to implement evidence-based quality improvement programs for depression across diverse community agencies; and 3) introducing evidence-based toolkits and collaborative care models to potential participants in both intervention conditions and other community members. We evaluated the effectiveness of the conference through a community-partnered process in which both community and academic project members were involved in study design, data collection and analysis. Data sources include participant conference evaluation forms ($n=187$ over two conferences; response rate 59%) and qualitative observation field notes of each conference session. Mixed methods for the analysis consist of descriptive statistics of conference evaluation form ratings, as well as thematic analysis of evaluation form write-in comments and qualitative observation notes. Results indicate the effectiveness of this type of event for each of the three main goals, and provide insights into intervention implementation and use of similar community engagement strategies for other studies. (*Ethn Dis.* 2011;21[suppl 1]:S1-78–S1-88)

Key Words: Community Engagement, Community Conference, Community-Partnered Research, Collective Efficacy, Community Of Practice, Depression Care

INTRODUCTION

Community partnered research and engagement strategies are gaining recognition as innovative approaches to improving local health care systems and reducing health disparities in underserved communities of low income, historically-disadvantaged minority populations. These strategies may have particular relevance for mental health interventions in these communities in which there is often stigma and silence surrounding conditions such as depression and difficulty in implementing improved access and quality of care. At the same time, there is a relative dearth of evidence on the effectiveness of specific community engagement interventions and on the design, process, and context of these interventions necessary for understanding their implementation and generalizability beyond the initial group of stakeholders among which they were developed.

Community Partners in Care (CPIC) is a community-partnered participatory research (CPPR) study in two underserved areas in Los Angeles and the first randomized controlled trial of the use of community engagement as an approach to adapt and disseminate evidence-based depression care. Community-partnered participatory research is a variant of community based participatory research (CBPR) that emphasizes equal partnership with genuine power sharing and consistent collaboration in all phases of the research. Equal partnership is intended to encourage two-way capacity development as academic partners increase their ability to work in and adapt interventions to community settings and community partners enhance their skills at analyzing and applying research findings to solve problems that affect their communities.[1–3]

The CPIC study explicitly tests the effectiveness of community engagement (CE) strategies to motivate and mobilize community stakeholders to participate and take ownership in a CPPR project for improving depression outcomes. This article evaluates one of a number of community engagement strategies employed in the CPIC study. We specifically describe and assess the effectiveness of a kickoff community engagement conference used during the initial stage of the CPIC trial as a large-group, event-based intervention for activating individuals and agencies in a community-wide effort to improve access and quality for depression care.

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CONCEPTS UNDERLYING COMMUNITY ENGAGEMENT PROCESSES

Community engagement approaches spend much effort on building relationships through sharing perspectives and joint activities. To facilitate these efforts, CE strategies include the use of particular partnership structures, such as a steering council to identify priorities and coordinate efforts and workgroups to address specific issues or tasks. These approaches may also employ staged implementation sequences, such as Vision (developing a vision and mission), Valley (developing, implementing, and evaluating action plans), and Victory (developing products, dissemination, and celebration).[4–6] In the CPIC project, the purpose of these community engagement strategies is for diverse community and other stakeholders to build a village that supports various opportunities to learn about and engage in evidence-based improvement of depression care. One of the expectations being tested is that the participatory engagement and building of relationships and networks among partners will stimulate sharing of resources and new local solutions that facilitate access to quality improvement programs and treatments across the community.[7]

Building a village involves developing collective efficacy and a community-of-practice among stakeholders interested in addressing a community health need. Collective efficacy has been described as a certain sense of "Yes we can," a shared belief in a group's capability to solve a given community problem.[8–10] Such collective efficacy is reflected in such statements as, "I feel hopeful our community can make progress on improving access to care for depression," or "I am confident our community can create adequate resources to improve depression care."[8] Others have characterized collective efficacy as a combination of social cohesion among a group (ie, "This is a close-knit group") and the willingness of group members to act on behalf of the common good (ie, "People in this community are willing to help their neighbors").[11,12] As these statements indicate, collective efficacy represents a shared desire and readiness to solve a particularly pressing community problem or set of problems.

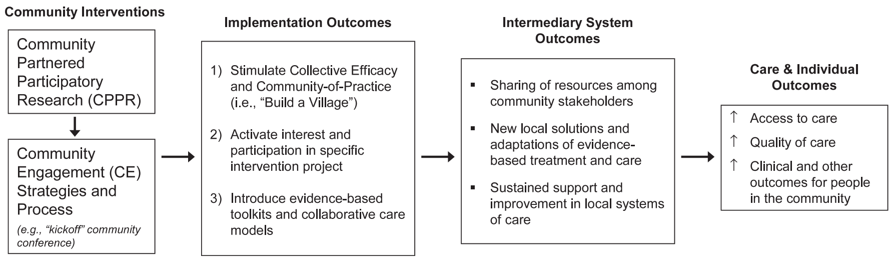

Fig 1. Logic Model of Effects of Community Engagement and Participatory Interventions

In addition to attempting to leverage the capacity of a group to solve a collective problem, CPIC's community engagement approach calls for building a dynamic learning and collaborative network to support specific interventions and action, similar to what some describe as a community-of-practice.[13,14] This concept has been used to define groups of individuals with like interests, typically of a technical or professional nature (or other calling), who share knowledge and skills in a free-flowing manner across community and organizational boundaries to transfer innovation and best practices within a network they create. Studies from the organizational learning and development literature indicate that when such communities or networks develop a constant interchange of ideas, sense of trust, and history of solving problems together among members, they may cultivate a common identity, purpose, and solidarity that serves to reinforce and perpetuate the group.[15,16] Research in health care interventions and quality improvement has suggested that developing a community-of-practice around a particular intervention has the potential to increase its sustainability over time.[17–19]

Figure 1 depicts the intended effects of community participatory and engagement interventions described above, from implementation outcomes, to intermediary system outcomes, to the ultimate outcomes of improved care and clinical, social, and economic outcomes for individuals in need or at-risk within communities.

This article focuses on the first set of hypothesized linkages, from the community interventions to implementation outcomes, with the subsequent chain of effects to be analyzed in later stages of the CPIC study. However, despite the wide use of community engagement and similar strategies in the fields of community organizing and development,[20] little research exists in the health services literature on any of these sets of effects, particularly in the context of a randomized controlled study to address community health needs. A key imperative for research is to examine how such strategies are implemented on the ground and the extent to which they do or do not generate expected implementation and intermediary system outcomes, in order to better generalize the strategies to other settings and differentiate between whether they were (in)adequately implemented versus (in)adequately effective.[21,22]

SPECIFIC EVALUATION AIMS OF THE COMMUNITY ENGAGEMENT KICKOFF CONFERENCES

Two kickoff community engagement conferences – one in each of the project's geographic study areas – were held during the initial stage of the CPIC trial phase to orient and further recruit agency participants. This article specifically describes the unique goals and features of these community engagement conferences, details how they were implemented, and evaluates their effectiveness in achieving the following implementation outcomes: 1) Stimulating a dialog sense of collective efficacy, and opportunities for learning and networking that will help build a village for addressing depression and depression care in the community; 2) Specifically activating interest and participation in CPIC's randomized trial of two different ways to implement evidence-based quality improvement (QI) programs for depression across diverse community agencies; and 3) Introducing evidence-based toolkits and collaborative care models to potential participants in both intervention conditions.

DESIGN OF CPIC'S COMMUNITY ENGAGEMENT KICKOFF CONFERENCES: KEY GOALS AND FEATURES

Design of CPIC

CPIC is an experimental study that randomizes participating agency sites of diverse kinds (eg, health and mental health clinics, social services, and community-trusted organizations such as churches and schools) into two conditions reflecting different ways of implementing depression care improvement. The first is a low intensity dissemination condition called resources for services (RS) that provides agency sites with training and limited technical support on evidence-based toolkits and collaborative care models for depression. The second is a high intensity, community engagement and network development condition called community engagement and planning (CEP) that provides the same resources as the low intensity condition, plus support for agency sites to collectively plan and commit to sharing resources and responsibility for depression care.[23]

The CPIC study is fielded in two racially and ethnically diverse, underserved communities in Los Angeles County – South Los Angeles and the Hollywood/Metro area. A kickoff conference lasting approximately three-quarters of a day was held for each of these areas. Since the kickoff conference was conducted before agency sites in an area were randomized and the conference was to include initial orientations to the depression care toolkits and collaborative care models for both conditions, all enrolled sites were invited to participate in a kickoff conference. This provided sites randomized to the RS condition an initial experience of community engagement (particularly the developing of a vision and mission for improving community depression care) before they began a series of teleconference training calls, while the CEP-condition sites went on to start their more intensive facilitated community planning and network development process.

In addition, the kickoff conference in each area was broadly publicized and open to members of the general public and other organizations not enrolled in the study at that time. Thus, the conferences provided an opportunity to attract potentially new agency sites and expand interest beyond study participants in order to generate a dialog, knowledge of approaches to improving depression care, and layers of awareness and support of the project in the wider community. The kickoff conference for the South Los Angeles study area was held on May 29, 2009 and for the Hollywood/Metro area on September 11, 2009.

Design of the Kickoff Conferences

Given the CPIC study's grounding in CPPR and the community engagement goals of the project, it was critical that the conferences not only imparted information on the project and depression (related to goals 2 & 3 of the conference), but also focused on building relationships and inspiring a community vision for depression care at the outset of the study (related specifically to goal 1 listed above). To accomplish this, the conference organizers on the project's overall steering council spent several months deliberately attempting to incorporate features that would further these design goals. These features included a philosophy emphasizing the perspectives and leadership of both community and academic partners, a programmatic structure and use of session formats intended to encourage dialog and exchange among attendees, and physical and logistical arrangements supportive of community participation and interaction.

At the beginning of each conference, organizers explicitly raised the issue of community and academic balance, as well as attempted to model this philosophy in practice throughout the events. During the introductory sessions, the study's academic and community principal investigators explained the CPPR principles on which CPIC is based, stressing that all activities are co-led by community and academic partners and decisions made with equal participation. They also described the history of their collaboration in concrete terms, contrasting such a community-partnered approach to more traditional research studies. In turn, attendees were invited to share their thoughts and concerns regarding community-academic relations. For example, one community attendee commented during the group discussion that "I participated in another project [that] had a religious background, African-centric," in which the academics later relegated community members to "a back seat on that project. It was Afro-centric at first, and then it was more White." She wanted to know how the CPIC project would be different.

Conference organizers additionally designed the program content to reflect a strength-based view of community expertise and resources, acknowledging the value of all types of evidence, including both expert and experiential. For instance, separate conference sessions highlighted collaborative models and experiences of local community agencies, as well as collaborative care models developed and studied by academics.

The programmatic structure of the conferences similarly modeled CPPR principles in practice, with all sessions having both academic and community co-leads. Moreover, a variety of session formats were used to engage attendees and promote interactive dialog including a skit depicting experiences of individuals trying to access and provide depression care in the community, panel sessions accompanied by question and answer periods, open discussions organized around general topics or community concerns, and dedicated group participatory activities (eg, an activity of linking arms and discussing a parable about the preparation of a pot of soup to feed a hungry community). In all sessions, discussion leaders encouraged sharing of personal experiences with depression and depression care in the community. Many of these stories were of personal experiences with depression – such as a community member who described the mental health ravages of being transient (like on a hamster wheel, the cycle starts to become normal) and going through intake in various homeless programs, but never being connected to mental health services. Others described their despair as case managers, nurses, or clergy not able to help or find help for community members they serve who have depression. This sharing of personal stories, testimonials, and even anecdotes was used as a method comfortable to many people for sharing perspectives, concerns, and passions in meaningful – and at times moving – ways, which may also stimulate others to join a dialog and inspire a common search for solutions.

The morning portion of the conferences consisted of whole-group sessions so that all attendees would experience the same introductory information, community sharing and visioning discussions, and opportunities for networking with other participants. After the provided lunch, the conferences consisted of concurrent sessions focusing on specific toolkits and components of the collaborative care model for depression, such as medication management, cognitive behavioral therapy (CBT), and care management and outreach.[a] These afternoon sessions were oriented toward individuals and agencies participating in CPIC's trial of the two implementation conditions but included other attendees (eg, from the general community) as well.

Other features related to logistics and use of the conference space may not appear so different than a typical community-based research conference but were considered by organizers from CPIC's steering council as important to supporting the community engagement principles and aims of the event. These arrangements included seating around multiple large round tables (as opposed to an auditorium-style set-up) that provided opportunity for a mix of agency representatives, community activists, academics, and other attendees to sit together. The breakfast, light snacks, and lunch served throughout the conference were intended to stimulate networking and informal discussion among attendees. Likewise, conference venues were chosen within the study area communities; conference registration, food, and all materials were provided without charge to attendees; continuing education units and medical education credits (CEU/CME) were offered to help professional service providers justify their participation; and effort was made to welcome and introduce attendees to others during the breakfast. All of this was meant to enhance the inclusive and community-oriented nature of the conferences.

Lastly, conference organizers attempted to tailor the program and content of the conferences to the two study communities, which represented different mixes of stakeholders and histories of collaboration. For example, several CPIC partners had previously held similar CPPR-based conferences in South Los Angeles, led by a community partner that has developed and extensively used community engagement models. Based on those experiences, the kickoff conference in that area was particularly attentive to historical concerns of the African American community related to trust with academic researchers and to providing a more structured sharing of community-derived service delivery models from lead local agencies as experts. The conference in the Hollywood/Metro area, which was expected to attract a different set of diverse stakeholders (including Korean and gay/lesbian organizations, and larger numbers of licensed professionals), placed earlier emphasis on the evidence-based models of depression care and did not include the skit, which had been created and performed by South LA community activists.

EVALUATION METHODS AND DATA

We assessed the effectiveness of the conferences through a community-partnered approach in which both community and academic research partners from CPIC's implementation evaluation committee were involved in all

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[a] The fourth afternoon session differed in topic between the two conferences (in South LA, it focused on Team Leadership for collaborative care and service improvement; in the Hollywood/Metro conference, the fourth session discussed the various support resources provided to agencies by the CPIC project).

aspects of conference evaluation design, data collection and analysis. The conference evaluation design also incorporated a mix of quantitative and qualitative methods, including conference evaluation forms (with both closed-ended survey items and write-in comments)[b] and qualitative field observation notes. This mixed method approach was intended to document self-reported experiences of attendees as systematically as possible while being attentive to group dynamics and observed behavior within the conference.

The conference evaluation forms consisted of an overall conference evaluation questionnaire (n=187 total across the two conferences; average response rate of 59%)[c] and separate conference evaluation questionnaires for each of the four afternoon breakout sessions (response rates per breakout session ranged from 69% to 100%, except for one with 25%).[d] At each conference, two academic and two community research partners took field observation notes. Both a community and an academic partner took observation notes of all morning sessions. Each afternoon breakout session was observed by only one research partner (either academic or community). The observation notes for each conference were combined into one document, which was then reviewed by the entire implementation evaluation committee (4 community and 7 academic partners) to clarify discrepancies and supplement observations. Differences in observations and perspectives on which evaluation committee members did not reach agreement were also noted in the final set of consensus observation notes, which were then used for analysis.

The qualitative analysis of the consensus observation notes and of the open-ended evaluation form comments focused on identifying key themes related to the goals of the conference. Community and academic partners involved in the analysis worked in pairs to identify comments from each data source related to the three goals, and then to categorize those comments into subgroupings reflecting common themes. Themes were then shared with all community and academic partners participating in the analysis, who decided on final sets of themes by consensus. For the quantitative data, the community and academic partners involved in the analysis first ascertained as a group the rating items from the conference evaluation forms that related to each conference goal. The lead author then conducted the descriptive statistical analyses for the indicators selected.

For each conference goal, we present evidence from each of our data sources (ie, descriptive statistics from the closed-ended evaluation form items, key themes and illustrative quotes from the write-in comments and observation notes) to evaluate the effectiveness of the conference and identify lessons learned. Both academic and community partners on CPIC's implementation evaluation team were involved in analyzing, interpreting, and writing up results from each data source.

RESULTS

Conference Attendee Characteristics and Participation

Before we evaluate each conference goal, we first describe the conference attendees and their participation in CPIC with data from the conference evaluation forms (Table 1). Across both conferences, two-thirds (67%) of respondents were administrators, providers, or other staff from community service agencies (including psychologists, licensed therapists and social workers, psychiatrists and other physicians, registered nurses, certified drug treatment counselors, and case managers). Nearly a quarter (23%) were other community members (such as clergy, community advocates, and students), and four percent were academic researchers.

A little more than half (55%) of conference evaluation form respondents were participants in the CPIC study,[e] while a sizable portion (29%) consisted of individuals not affiliated with an organization participating in CPIC at the time of the conference.[f] Below, we review findings for each of the three conference implementation goals in turn.

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[b] Open-ended evaluation form questions for the conference in general included ''What did you particularly LIKE about this conference?'' ''How will use what you learned today?'' and ''What changes for future conferences, or any additional comments, would you suggest?'' Open-ended questions on the evaluation forms for the individual afternoon breakout sessions included ''What was the most important information that you learned from this session?'' ''How will you change the work that you or your organization does based on the information from this session?'' and ''Please provide any additional comments about this session.''

[c] The overall conference evaluation questionnaire response rate was 61% for the South LA conference, and 57% for the Hollywood/Metro conference.

[d] This session also had the largest attendance for an afternoon breakout session at either conference (64 attendees).

[e] These CPIC participants included both CPIC Steering Council members who organized the conference, and participants from agencies enrolled in the study's randomized implementation trial. 10% (ie, 8 out 78) of Hollywood/Metro conference evaluation respondents were CPIC Steering Council members. CPIC Steering Council members were not differentiated from CPIC implementation trial participants on the evaluation forms for the South LA conference.

[f] Information on ethnicity and sex were not collected as part of either conference registration or evaluation forms.

Table 1. Roles and participation of Community Engagement Conference evaluation respondents

	Total (*n*=187)	South LA Conference (*n*=109)	Hollywood/Metro Conference (*n*=78)
Roles of participants			
Community agency staff	67%	64%	72%
Community member at-large	23%	25%	19%
Academic	4%	4%	5%
Missing/declined to state	6%	7%	4%
CPIC study participation			
CPIC Participant*	55%	46%	66%
Not currently in CPIC	29%	27%	32%
Missing/declined to state	17%	28%	1%

* 10% of Hollywood/Metro conference evaluation respondents were CPIC steering council members. CPIC Steering Council members were not differentiated on the evaluation forms for the South LA conference.

Implementation Goal 1: Stimulating a Dialog, Sense of Collective Efficacy, and Opportunities for Learning and Networking

Analyses of the evaluation form ratings, write-in comments, and observation field notes indicated that the kickoff conferences were effective at engaging the diverse stakeholders attending the events and stimulating at least an initial sense of community and collective efficacy around improving depression care.

Respondents to the overall conference evaluation forms rated the conference highly in terms of general feeling of engagement throughout the event, opportunities to network with other conference participants, and learning from talking and interacting with other attendees (average ratings of approximately 4 on a 5-point scale; see Table 2).[g] Even higher overall ratings were reported for feeling more hopeful about the ability of the community to improve depression care – an indicator of collective efficacy. The only marginally significant difference on these measures between the two conferences was for the item on opportunities for networking ($P<.10$), but the ratings for both were still around 4.0 (3.92 vs 4.13). These results were similar for respondents who were participating in CPIC at the time of the conference as well as those who were not (not shown).[h]

The analysis of the evaluation form write-in comments related to Goal 1 of the conference suggested that the level of engagement and dialog experienced by attendees was associated with themes of openness, friendliness, interactivity, and respect in the atmosphere generated during the conferences, as illustrated in the following examples:

> "Everyone had the opportunity to express ideas." (Hollywood/Metro)
>
> "I like that this was an open discussion, question and answers. I like the fact that there weren't any wrong answers." (South LA)
>
> "Interactive approach with client/community participation. Warm friendly organizers and speakers." (South LA)
>
> "The feeling that people were talking, not being talked to." (Hollywood/Metro)

A sense of community and collective efficacy was also expressed in write-in comments by a number of respondents that described having formed connections and common cause with others, as well as feeling inspired and hopeful by being part of a larger enterprise. Themes related to community-building in particular centered on "collaborative spirit," "inclusion," "networking and learning from each other," and pooling of strengths, which were evident in comments that respondents wrote on what they liked about the conference:

> "The unity of all parties." (South LA)
>
> "Everyone is here for one cause…" (Hollywood/Metro)
>
> "The collaboration between all different kinds of agencies and providers." (Hollywood/Metro)
>
> "The wide range of experiences and backgrounds of presenters and attendees." (South LA)
>
> "The networking, learning about the study and services available." (South LA)
>
> "I think CPIC will create an interactive network that helps my community." (Hollywood/Metro)
>
> "That it spoke from a strengths-based perspective and it acknowledged that the best way to beat depression is to get the community involved." (South LA)

Themes of collective efficacy were reflected in feelings of hope and desires to make change:

> "It left me with a sense of hope… the idea of finding community support for addressing depression, it's not all

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[g] Reported levels of engagement were similar for the afternoon breakout sessions (see first row of results in Table 5).

[h] Other analyses (not presented) which separated CPIC Steering Council members from other CPIC participants for the Hollywood/Metro conference (the only conference evaluation form that distinguished the two) showed CPIC Steering Council members to rate the conference slightly higher on these measures, but differences were only statistically significant for the item on having ample networking opportunities ($P<.10$), and the mean ratings for the other CPIC participants still remained near 4.0 out of the 5-point scale (ranging from 3.80 for learning from other conference participants to 4.15 for being more hopeful that the community can improve depression care).

Table 2. Mean ratings on general conference evaluation form items related to goal 1: Stimulating a dialog, sense of collective efficacy, and opportunities for learning and networking

How much would you agree or disagree with the following statements*	Total	South LA	Hollywood/ Metro
I felt engaged throughout conference.	4.08 (.722)	4.09	4.07
I had ample opportunities to meet and network with other conference participants.	4.04 (.785)	4.13†	3.92†
I learned a great deal from talking and interacting with other conference participants.	3.96 (.806)	4.05	3.85
I feel more hopeful now than before the conference that our community can make progress in improving depression care.	4.23 (.754)	4.26	4.21

* Scale ranged from 1=disagree strongly to 5=agree strongly.
† Mean ratings for this item differed significantly between conferences, *P*<.10.
Standard deviation shown in parentheses.

on my shoulders." (Hollywood/Metro)
"Let's get it on!" (South LA)
"The community seems to be ready." (South LA)

The observations of conference sessions echoed many of these themes. Both session leaders and conference participants spoke of the need to "work together," "build a village," "harness each other's resources," and "create bridges for depression care." Participants were observed to be very interactive and supportive of one another. For example, when a community stakeholder at the Hollywood/Metro conference stated how much he felt on his own in addressing the depression care needs of his clients, a member of the CPIC Steering Council responded, "You are not alone."

Engagement strategies, such as use of personal stories, appeared to elicit attitudes of empowerment and activate participants. As one attendee shared, "As a community member, we have a voice. We do not know how loud it is. You can share your depression story with others, so that they can seek help." Likewise, the seating arrangements and other strategies used to encourage interactions appeared largely to have resulted in the desired mixing, although some clustering among individuals of like backgrounds and previous familiarity was still observed, especially among academic participants.

Comparison of the conference observation notes did reveal a stylistic difference between the group dynamics at the two events which was not anticipated during the efforts to tailor the conference design to the community settings. Attendees at the South LA conference were generally quick to speak up, ask questions, and react to comments of session leaders and other participants. Attendees at the Hollywood/Metro conference appeared more reticent, particularly at the start of the day, although they readily participated when opportunities to do so were explicitly presented. It was not clear how much this difference was due to different levels of prior familiarity among participants or with the community engagement format of the conference in South LA. However, this difference did not appear to prevent either conference from attaining the objective of engaging participants around the issue of depression in the community, as reflected in the conference observations and evaluation form responses.

Implementation Goal 2: Activating Interest and Participation in the Randomized Improvement Trial

Our quantitative and qualitative evaluation data also provided evidence that the conferences were effective in terms of their second goal, activating interest and participation in the CPIC study. Eighty-nine percent of respondents on the overall conference evaluation forms agreed or strongly agreed that they would recommend the event to others if held again, an indication of general interest in participating in future CPIC activities (mean rating of 4.28 on a 5-point scale; Table 3). Respondents similarly perceived the relevance and likely influence of study materials and sessions on their work to be relatively high: mean score of 4.05 on the overall relevance of conference information and materials for their work (Table 3), and mean scores of between 4.21 and 4.47 on the likelihood that individual breakout sessions will influence their work (Table 5, second row of results).

Table 3. Mean ratings on general conference evaluation form items related to goal 2: Activating interest and participation in the randomized improvement trial

	Total	South LA	Hollywood/ Metro
How much would you agree or disagree with the following statements*			
I would recommend the event to others if held again.	4.28 (.765)	4.31	4.24
Rate the following educational aspects of the conference†			
Relevance of information and materials for your work.	4.05 (.859)	3.98‡	4.15‡

* Scale ranged from 1=disagree strongly to 5=agree strongly.
† Scale ranged from 1=poor to 5=excellent.
‡ Mean ratings for this item differed significantly between conferences, *P*<.10.
Standard deviation shown in parentheses.

Written responses to the open-ended items on the conference evaluation forms accentuated specific interests of participants with regard to the CPIC study and depression care. We identified three general themes: 1) raised awareness and interest in the issue of depression and/or its effects on the community; 2) raised awareness and interest in the collaborative care model upon which CPIC is based; and 3) stimulated interest and knowledge-seeking about the CPIC study itself and/or research on depression.

In terms of raising awareness or stimulating interest in the issue of depression, various participants noted "the importance of the topic" and "that depression is a serious problem in the community." Typical of comments related to interest in the collaborative care model, one participant wrote, "I like the overall concept and intent of the conference to address the pervasive needs of mental health with [the] collaborative method." A number of conference participants explicitly indicated that they wanted to become more involved in CPIC, with a few providing contact information and requests to be contacted. Others expressed interest in results of studies on depression or a desire to seek out additional research findings on depression and how to treat it. Several indicated that they better understood the CPIC study, although one respondent felt that the conference did not provide enough information on "next steps" for the study.

We speculate that some of these results may be attributable to how conference organizers and session leaders were observed to have presented and framed the CPIC study to participants. First, speakers emphasized the long-term benefits of treating depression with evidence-based care: "If you do depression care a little bit better, work using evidence-based toolkits, in interventions after 5 and 10 years, families are staying together and people live normal lives. Doing depression care [even] a little bit better makes a huge difference." Second, organizers and session leaders also emphasized how the CPIC study's collaborative model is intended to complement what agencies are currently doing: "Everyone here is doing a great job with the services you provide. We hope this [collaborative care model] will enhance it more. We want to make your job easier." Third, CPIC study leaders highlighted that all agencies – regardless of the intervention condition into which they were to be randomized – will receive benefits: "Everybody will get something…You will have a lot of resources. It is not a study where some get stuff, others don't." A final related observation was that several new participants enrolled in the study directly following the end of the Hollywood/Metro conference.

Table 4. Mean ratings on general conference evaluation form items related to goal 3: Introducing evidence-based toolkits and collaborative care models

Indicate how well this conference addressed each of its main educational objectives*	Total	South LA	Hollywood/Metro
To describe successful service delivery models for depression care.	3.99 (.824)	3.88‡	4.14‡
To summarize collaborative care models for depression.	3.99 (.890)	3.88†	4.14†
To understand the community engagement approach.	4.03 (.905)	3.96	4.12
To understand partnership development in addressing depression.	4.06 (.820)	4.03	4.11

* Scale ranged from 1=poor to 5=excellent.
† Mean ratings for this item differed significantly between conferences, $P<.10$.
‡ Mean ratings for this item differed significantly between conferences, $P<.05$.
Standard deviation shown in parentheses.

Implementation Goal 3: Introducing Evidence-based Toolkits and Collaborative Care Models

With regard to the conference's third goal of introducing evidence-based toolkits and collaborative care models, respondents, on the overall evaluation form, rated the conference highly on meeting its educational goals, including describing successful service delivery models for depression care, the collaborative care model in particular, as well as explaining the community engagement approach and partnership development as applied to depression care (mean ratings of 3.99 to 4.06 on a 5-point scale; Table 4).[i]

In addition, the individual breakout sessions that introduced specific evidence-based toolkits and components of the collaborative care model (eg, medication management, cognitive behavioral therapy, and care management/outreach) generally were rated as highly effective (mean scores of 4.30 to 4.55; Table 5), and respondents on average reported their self-perceived knowledge of the respective topics for each session to have increased—most for Medication Management (33%, ie, 4.23–3.18 / 3.18), least for Care Management/Outreach (15%).[j]

Write-in comments frequently indicated appreciation for the wealth of information and resources provided on

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[i] Mean ratings between the conferences were statistically different for describing successful service delivery models ($P<.10$) and summarizing collaborative care models for depression ($P<.05$). But the ratings for both conferences were still around 4.0 (3.88 vs 4.14).

[j] However, it should be noted that these ratings are based on self-perceived levels of knowledge (as opposed to tests of specific knowledge) and the rating of the "before" knowledge is actually measured after the session (which may introduce a retrospective bias).

Table 5. Mean ratings on conference evaluation form items for breakout sessions on toolkits and components of collaborative care*

	Total mean scores (across both conferences)		
	Medication management	**Cognitive behavioral therapy**	**Care management/ outreach**
Indicate the most appropriate rating for each item below.†	*n*=17	*n*=53	*n*=33
Extent session engaged participants	4.23	4.15	4.57
Likelihood the session will influence your work	4.41	4.21	4.47
Overall effectiveness of the session	4.41	4.30	4.55
Knowledge of the topic before the session	3.18	3.40	3.84
Knowledge of the topic after the session	4.23	4.12	4.42

* Table includes the three breakout sessions that were consistent across both conferences. A fourth breakout session was held at the conferences, but differed in topic.
† Scale ranged from 1=poor to 5=excellent.

the toolkits and collaborative care model:

> "Great info - very thorough for the time allotted. Thanks for disc drive and great book!!!"(Hollywood/Metro)
> "…great educational materials were provided. Thank you!" (South LA)

Numerous attendees mentioned that they intended to share toolkits and resources provided at the conference with colleagues at their agencies as well as use them in their own practice with clients. As one participant wrote "I have the tools now to help parents who feel depressed. I can better help them and refer them to other agencies." Specific tools that respondents intended to use included the PHQ-9 depression screening questionnaire, care management worksheets, and cognitive behavioral therapy:

> "Now I have CBT forms to use with clients in sessions." (CBT)
> "I will include CBT in group counseling sessions." (CBT)
> "I will educate mothers about depression and how depression can be diagnosed." (medication management)
> "I will be giving this information with our nurse… to enhance the identification and management of our clients experiencing depression." (medication management)
> "I can go back to my center and look at the overall community and guide our patients… on where they can get help and support." (case management/outreach)

Key information that respondents felt they learned from the medication management sessions included how to detect depressive symptoms, knowledge about antidepressive medications and managing clients on medication, and the potential benefits of depression care for clients. Key information that respondents reported they learned from the cognitive behavioral therapy sessions included general overviews of CBT's goals and how it treats depression, and specific CBT strategies and techniques (such as identifying thoughts and challenging dysfunctional thinking and its focus on changing behavior). Information considered important from the care management/outreach sessions centered on how to use the care management forms, as well as to identify and manage depressed clients. Some respondents wrote that they would need to adapt the forms for their setting.

These results may reflect how well the evidence-based toolkits and collaborative care models were introduced and the extent to which participants intended to use what was presented, yet they leave open the question of the conferences' effect on actual practice behavior (to be assessed in subsequent stages of the study evaluation). Pointing toward the latter, respondents to the evaluation forms identified needed supports and potential barriers they perceived would likely affect their use in practice. Needed supports included additional training and supervised practice, longer training sessions, regular training follow-up, and requests for individual agency trainings; training on how to start a dialog with the community and approach community members' needs; and more opportunities for networking and getting support from colleagues in regular gatherings. Potential barriers included system-level constraints (eg, HIPAA liability issues), being able to work out the concerns and ideas of multiple parties, potential in getting lost along the way, and being an isolated advocate for change within an agency (eg, "I can only change the way I do things, my organization works on policy and procedural changes").

Despite the effectiveness of the sessions in introducing the toolkits and components of collaborative care, the consensus review of observations noted that the conferences, particularly the first one, were less effective at conveying how these constituent elements fit and work together. Without a clear understanding of the central feature of the collaborative care approach utilized in the CPIC study – namely the coordination and communication across providers and agencies to serve the needs of clients – attendees seemed uncertain at times about the design of the CPIC initiative and how (or if) its various pieces cohered. This uncertainty may have been partly due to a lack of sufficient emphasis on the key features and use of the collaborative care model in CPIC, but also to the attention given to the variety of collaborative service delivery approaches in the community and to the relative complexity of the collaborative care model and agency-randomized CPIC trial.

CONCLUSION

Results indicated that this type of community engagement conference was effective at stimulating a collective sense of connection and efficacy, activating interest and participation in the CPIC study, and introducing evidence-based toolkits and collaborative care models among diverse stakeholders for depression care improvement. These results are particularly significant given the stigma and silence that often surrounds mental health conditions like depression in underserved minority communities.

Conference attendees, including wider community stakeholders not participating in the randomized implementation trial, rated the conference high in terms of satisfaction (eg, meeting educational objectives), engagement in conference sessions, networking and learning from other attendees, and common cause for improving depression care. Multiple themes across the write-in comments and observation notes indicated attendees felt a sense of being interactive and connected with each other and inspired to make a difference around depression care. Less evident was a clear understanding of the study design and collaborative care models, although this appeared to improve from the first to the second conference.

The breakout sessions, which focused on distinct components of collaborative care for depression, such as medication management, care management, and cognitive behavioral therapy (CBT), generally succeeded in introducing and generating enthusiasm for implementing these elements, but also identified the need for a variety of supports, such as additional intensive trainings, as well as potential barriers, such as limited ability of individuals to effect change within their own agencies and difficulty in reaching consensus across such diverse organizations.

Lessons learned included the usefulness of opening the conference to a wider community audience (ie, beyond formal participants in the randomized agency trial) to broaden the base of input and support of the initiative in the community, and the necessity of spending the time to adequately engage participants and develop common visions of action before expecting to embark on detailed community planning and implementation tasks in a community-partnered initiative. We also learned that, although it may not be possible to anticipate all differences in community dynamics and approaches to health concerns, attending to these features is important in being able to effectively frame mental health issues and engage stakeholders in specific communities around a highly stigmatized illness such as depression.

Limitations of the analyses reported here include that many of the data are based on the conference evaluation forms which, although anonymous, may be subject to social desirability bias. This is one reason we gathered extensive field notes of conference activities, in order to supplement the self-reported data with documentation of observed behavior and discourse. This evaluation is also limited in the extent to which it can differentiate the effects of these particular conferences from previous community engagement activities that attendees may have experienced, given that we do not have consistent data on the latter for all participants. This issue may be particularly relevant for the South LA conference, since the main CPIC community partner in that area has been a pioneer in the community engagement model adapted for the CPIC study. In one sense, however, the Hollywood/Metro conference represents a test of whether the model could be adapted and replicated in another community with different sets of participants and stakeholder experiences. The results from these analyses suggest that it was possible.

Similarly, the analyses presented here are not able to disentangle which components of the conferences are necessary or sufficient core features of the intervention for obtaining some minimum level of engagement. We provide detailed descriptions of the range of features and the rationales for their incorporation into the kickoff conferences. However, it would likely take systematic variation of designs across a larger number of conference events to more confidently assess the relative effects of specific features.

Lastly, the scope of these analyses is limited to the immediate effects and perceptions of the conferences in engaging participants. Although we present various results of the degree to which participants felt or were observed to be engaged in the conference itself, their reported intentions to use the project toolkits and care models, and their indication of interest to further participate in the study, the ultimate objectives of the CPIC study are to examine whether the community engagement process continues, particularly in the CEP arm, and whether it makes a difference in the ability of community agencies and stakeholders to improve care and outcomes for depressed individuals. However, in order to evaluate this chain of effects and the contribution of the kickoff conference, it is first necessary – as we do in this article – to assess if this initiation event was indeed engaging and in what ways.

In particular, whether a sustainable village or community-of-practice around depression care improvement develops in the community engagement and planning or resources for services condition of the CPIC study is for later phases of the study evaluation to assess. But the findings presented here demonstrate it was possible to initiate these processes at the kickoff of the project through such a conference, which represents one intervention in the community engagement tool box. We expect that the lessons learned in doing so will be applicable to studies founded on community-partnered principles as well as other types of community-based studies more generally.

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STRENGTHENING FAMILIES OF CHILDREN WITH DEVELOPMENTAL CONCERNS: PARENT PERCEPTIONS OF DEVELOPMENTAL SCREENING AND SERVICES IN HEAD START

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Objective: The authors investigated perceptions of parents with children in the Head Start program about the processes of detection and intervention for developmental concerns.

Design: Descriptive, qualitative study.

Setting: A large, urban Head Start agency, operating 14 centers and annually serving more than 1200 predominantly Latino children. During 2008–2009, a collaborative partnership with academicians from UCLA was created to evaluate their model of developmental screening and referrals.

Participants and Procedures: We conducted 5 focus groups with a total of 30 parents of Head Start children with developmental concerns. Parents were asked about where they go for information when they have concerns, how they perceived the developmental screening process and services, and how children and families have changed after being in the Head Start program. Focus groups were recorded, transcribed and translated into English, then coded in ATLAS.ti using the domains above and sorted into themes for analysis.

Results: Parents perceived the screening process as both diagnostically and therapeutically important, with multiple benefits ranging from closer parent-teacher relationships to improved parenting and understanding of developmental interventions. Families focused their discussion on the importance of social-emotional and behavioral development, with school readiness and improved expressive language as important but secondary outcomes.

Conclusions: For families of children with developmental and behavioral risks or concerns, a structured developmental screening process in a preschool setting, such as that provided by Head Start, may serve as a vital gateway for identifying and addressing concerns and promoting social-emotional learning, parent engagement, language development and school readiness. (*Ethn Dis.* 2011;21[Suppl 1]:S1-89–S1-93)

Key Words: Early Childhood Development, Developmental Screening, Early Intervention, Head Start Program, Preschool, Latino Families, Social-Emotional Development

INTRODUCTION

Developmental and behavioral challenges are common in young children, and the US health care system often does not adequately address parents' concerns. National surveys estimate that 12–17% of children in the United States have developmental, behavioral, or mental health disorders.[1–3] In addition to these children with diagnosed disorders, parents report concerns about child development or behavior in approximately 30–40% of young children.[4,5] Children whose parents express concerns but who do not have diagnosed disorders nonetheless score significantly lower on measures of intelligence, behavior and school achievement, so may be more likely ultimately to have difficulties in school.[6] Despite professional recommendations that pediatricians screen and monitor children for developmental risks and delays,[7] child health providers do an inadequate job of developmental screening[8,9] and many young children who are likely eligible for early interventions are not receiving services.[3] Also, parents have reported that they would like to have information from child health providers about children's development, learning and behavior, and could use more information than they actually receive.[10] These studies illustrate just some of the ways in which the current system of child health services fails to meet the needs of children and families with developmental needs.

National surveys estimate that 12–17% of children in the United States have developmental, behavioral, or mental health disorders.[1–3]

For children from racial and ethnic minority or low-income families, unmet needs are even more pronounced. Latino children are less likely than other racial and ethnic groups to have health insurance or a usual source of care.[11] Among children with symptoms that might benefit from mental health evaluations and services, the vast majority do not receive services, but Latino children and uninsured children have even greater unmet need compared to other groups.[12] Disparities also exist across physical and developmental domains, with children from low-income families faring worse in overall health status and disproportionately experiencing learning disabilities, speech problems and behavior problems.[13] This combination of high risk and less access to services makes the need to address developmental and behavioral concerns

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in low-income and minority children an urgent priority.

Due to the disparities in detection and service provision in the healthcare system, early care and education settings such as preschools may prove to be important additional venues for early detection of concerns, referrals to intervention services, and coordination of those services. Previous work by Taveras et al using preschool parent focus groups found that many parents identified their childcare settings as sources of health-related information, and would like more information about topics such as child development, discipline and behavior.[14] Head Start, the federally funded preschool program for low-income families, may serve an important role in providing and coordinating a variety of services for children and families with multiple needs, including nutrition, family social services, and physical, oral and mental health. Head Start programs are required to complete a number of health and developmental screenings for all children within 45 days of enrollment, and also are required to serve children with special needs, who must make up at least 10% of enrolled children.[15] For children with concerns identified during the screening process, Head Start facilitates access to intervention services. This comprehensive role in coordinating health and social services distinguishes Head Start from many other preschool programs and early care settings. A national, ongoing multicenter Head Start study, the Family and Child Experiences Survey (FACES), has enrolled several nationally-representative samples of Head Start children and parents between 1997–2010, to assess Head Start outcomes.[16] Qualitative data from the FACES study include semistructured interviews with a subset of Head Start parents, including parents of children with special developmental needs, but does not include parent perceptions of the developmental screening process.

The study presented here utilized a community-partnered approach to understand parent perceptions of the developmental screening process and intervention services in a large, urban Head Start agency. The study authors worked closely with Head Start staff to identify research questions and priorities for a mutually-beneficial investigation. The study sets out to explore a model process of developmental screening and intervention services in Head Start, which will shed further light on the experiences of Head Start families as we aim to improve early detection of concerns, especially for children and families who are at risk for disparate outcomes in terms of health, mental health, development and educational attainment.

METHODS

The study design and methods were developed in collaboration with Head Start staff and the study authors, using a community-partnered approach.[17] The agency serves more than 1200 children, aged 3–5 years, per year, in 14 different centers. During 2008–2009, 84% of families enrolled were Latino or Hispanic, with 75% of families reporting a primary home language other than English. Head Start parents were sampled by offering participation to all parents whose children had been identified as having developmental or behavioral concerns during the 2008–2009 school year. A total of 30 parents participated in 5 focus groups, ranging in size from 4–10 parents in each group.

The groups were conducted at Head Start centers during September 2009, four groups in Spanish and one in English, all facilitated by the primary author and 1–2 trained bilingual research assistants. Focus group questions were grouped into several domains: 1) where parents go for help regarding concerns about child development; 2) how they perceived the developmental screening process at Head Start; 3) what services they have received through Head Start as a result of the screening; and 4) the impact Head Start services have had on their children and families.

Focus groups were recorded and transcribed, and coded in ATLAS.ti using the four broad domains identified *a priori* and listed above. Additional, emergent themes were identified and used as additional codes, denoting specific components of the overall processes, including health, mental health, nutrition, social services and parent engagement. Transcripts were analyzed using deductive coding methods based on the domains already identified, and inductive coding for the emergent themes. Quotations related to each code were isolated and sorted, generating lists or piles to determine the most common responses and the range of responses. Preliminary data were presented to community partners for discussion and interpretation as soon as they were available, and are being used to guide our ongoing work, including quality improvement activities for the developmental screening and intervention processes.

RESULTS

Sample Description

Participants were predominantly female (90%), Latino (93%), with an average age of 33 years. The majority were born outside of the United States (83%) and reported speaking Spanish at home (69%). Most parents reported that their children were covered by public health insurance (81% in Medicaid, SCHIP, or a local public program), and 13% reported having private health insurance for their children.

Domains

Parent Help-seeking Regarding Developmental and Behavioral Concerns

When asked about concerns they have or had about their children, parents confirmed that their concerns were mostly related to speech and language development or to behavior and social-emotional development, including externalizing or disruptive behaviors such as temper tantrums, and also internalizing behaviors such as being shy or timid. Parents reported equally that they go to the child's teacher and to the child's health provider for information about such concerns, but noted a transition toward seeking help more from teachers and less from health providers once their children started school. Other sources of information discussed by parents included books, parent groups, family members, friends, neighbors, the school district, and the internet.

Screening Process

Overall, statements about Head Start's process of screening for concerns were very positive. One of the most common themes that emerged was that the screening process increases parents' awareness about their children's development; "The visit helped me pay more attention to my child. I realized I had not paid attention to the things they were asking about, so they help us pay more attention to see the new things they are learning." Parents often noted that the screening process raised awareness in areas they may not have realized were important; "Sometimes your child grows up and you don't notice if they can jump or if they can stand on one foot…[the screening] helps one notice more about their children in depth not just superficial." Along these same lines, parents noted that the screening process reminded them about needing to follow-up on routine visits to health providers, especially to dentists; "I am good with the medical but with the dental I thought they were too small but they're not too small…it serves as an eye-opener."

In addition to raising awareness about child health and development, many parents noted that doing the screening as part of a home visit helped the teachers get to know the child in a comfortable environment; "…[teachers] get to know you, your house, where you are coming from." The home visit was also an opportunity for the child and family to get to know the teacher, to be introduced to the staff and curriculum before the start of school; "The home visit helped my son feel more comfortable with the people from the school; before school started he was a little afraid….seeing the teacher outside of school makes them seem more human, less intimidating." Parents also noted that the home visit was an opportunity to express their concerns and receive feedback, describing the visit as a reciprocal exchange between teachers and parents, bringing their knowledge and observations together.

A few parents noted challenges they experienced during the developmental screening. Some of these suggested that parents did not completely understand what the questions were asking, despite being administered in their preferred language, and wondered what the "right" answer was; "Sometimes it is hard to understand the questions. Sometimes we reply and wonder, 'Is my child ok? Was that the right answer?'" Another parent complained, "I didn't know how to answer those questions. I had to think and I didn't know how to answer." Even after noting these challenges, however, parents went on to say that although the questions were sometimes hard to understand, the visits were good because they helped them pay more attention and set goals for their children's learning in school. One parent suggested that a good idea for the future might be to send the questions to parents ahead of time so they can think and observe before having to answer.

Services Received as a Result of the Screening Process

Parents listed many services that their children and families received through Head Start to address the concerns raised during the screening process. These included services for children such as special education and speech therapy, and also services for parents and other family members such as mental health services or counseling and parenting support groups or classes. One mother of a child with autism described the process of receiving family therapy with her son's father; "Me and my son's father, we got family therapy. When he first got the diagnosis of autism, there was a lot of denial. Now his father understands exactly what he has and what he can do to help him…his dad, after family therapy, he moved back in." Other parents described how Head Start helped to connect them to resources in the community such as food, housing and employment; "I had an economic crisis last year and we needed help with food…they gave us lists for low income housing, and have offered us food and clothes, which is marvelous." Another parent noted that assistance is offered even when parents do not ask for help; "The teacher happened to know there were lay-offs going on at the place I work, so she asked if I needed help."

Impact of Head Start Services on Children and Families

The most common theme to emerge was related to social and emotional development – children becoming more social, more independent, opening up more, helping others, participating more in class, and having improved behavior; "…the children have opened up more. Mine was timid and with the classes he has learned the letters and colors, is more social, he is excellent, has better behavior, is better." The second-most cited impact was enjoyment in watching children learn in general and become more interested in school; "Head Start made her more interested in going to school. She was eager to go to kindergarten." Finally, parents made statements about children learning specific new skills and knowledge, the most common being new words and increased expressive language, followed by improved nutrition, and learning colors, numbers, shapes, and being able to communicate in both Spanish and English. A number of parents noted that their families were more united, and that they were more engaged in their children's education after participating in Head Start. One father stated this very eloquently; "It's given me more enthusiasm for my son's education, and I think the more enthusiasm we have, the better it is for him…just as our children are developing, so are we."

DISCUSSION

Our findings from these parent focus groups suggest that structured developmental screening in a preschool setting may have a powerful ability to help high-risk families, including the Latino families and families of children with special needs in our sample. An interesting new finding from our work is that parents identify the developmental screening process itself as not only diagnostic but therapeutic—an opportunity to express concerns, to learn, and to engage in a dialogue with varied and sometimes unexpected benefits. Doing the screening in the context of a home visit also seems to have therapeutic value, helping the family and the teachers develop closer relationships that both ease the transition from home to school and improve parent-teacher coordination.

> *Our findings from these parent focus groups suggest that structured developmental screening in a preschool setting may have a powerful ability to help high-risk families, including the Latino families and families of children with special needs in our sample.*

Our results are consistent with a family resilience framework previously developed by the Center for the Study of Social Policy, which outlines five key protective factors that high-quality early care and education programs help to promote: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence in children.[18]

While this framework is often used as a model to prevent child abuse and neglect, comments by the parents in our sample illustrate how Head Start helped them build upon these protective factors in the face of poverty and financial stressors, concerns about their children's development and behavior, and family conflicts sparked by a child's autism diagnosis. Even compared to other early care and education programs, Head Start is unique in its emphasis on the whole child and the whole family, including connections to health services and mental health services for parents, for example, which may not always be supported by preschool and childcare settings.

The model of screening and decision making used at this Head Start agency allows for an ongoing process of detecting and addressing concerns, with multiple opportunities to listen to parents, observe children, and bring in various experts into that process to provide support as needed. This investment of time is usually not possible in clinical settings, and the health system has proven itself unable to meet the developmental needs of many children and families, especially low-income, predominantly Spanish-speaking families. Therefore, having supportive community venues with comprehensive services such as Head Start is not only vitally important but potentially paradigm-shifting. Interestingly, more than one parent who participated in our groups mentioned that once their child was in preschool, it was the first place they would come to express concerns and ask for help. The families we spoke to all looked to Head Start as an important resource for their children and for themselves.

It is interesting to note that most of the benefits described by families are ones that are not readily captured on the IQ and achievement tests that have historically been used to assess Head Start effectiveness. Parents discussed benefits mostly in terms of social and emotional, rather than academic, development. Even when parents spoke about school readiness, they mentioned skills such as learning letters, numbers, shapes and colors, but they clearly focused on other factors, such as children's ability to pay attention, their eagerness to attend school, their participation in classroom and home activities, and their pro-social behaviors. Also, for children with developmental risks such as speech delay, the processes of evaluation and intervention are intertwined with social, emotional and behavioral considerations – about the home language environment and the parent-child relationship, the relationship between developmental and mental health problems, and the manifestation of developmental delays as behavioral challenges. Parents' perceptions of Head Start services highlight the importance of both children's learning and social-emotional development, and the importance of maintaining a holistic approach when designing and evaluating Head Start programs.

This study has several limitations. First, it represents only a sample of parents at one Head Start agency. Although the agency is very large and represents similar demographics to the wider Los Angeles metropolitan area and school district, it is not nationally representative. Second, the parents who agreed to participate in the study may not be representative of all Head Start families in this agency or in other agencies. Finally, the perceptions presented here are just from parents, while a range of stakeholders are involved in the process. Similar studies with Head Start and school district staff would be useful, as well as quantitative analyses of results from developmental screening and monitoring tools. Taken together, all of these analyses would provide a more complete picture of the screening and intervention processes in Head Start.

This study also has several strengths. First, it uses a community-partnered approach designed to reflect the priorities of Head Start staff and other stakeholders in the community. Second, these qualitative findings shed light on Head Start's developmental screening process. Although the screening is federally mandated for Head Start agencies nationwide, little is known about how parents perceive the process. It is important to know that developmental screening and a range of services in Head Start help to strengthen vulnerable families. The experiences of these families may help to shape future studies, programs, and policies that may ultimately improve educational, developmental, and long-term health outcomes for high-risk children.

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PARTICIPATORY AND SOCIAL MEDIA TO ENGAGE YOUTH: FROM THE OBAMA CAMPAIGN TO PUBLIC HEALTH PRACTICE

Barack Obama's successful campaign for the presidency has been widely attributed to the use of social networking sites, mobile devices, and interactive websites to engage previously hard-to-reach populations in political activity. Campaign communication strategies may be applicable for youth health promotion efforts, particularly for the highly stigmatized issue of mental health. In this article, we examine elements of the 2008 Obama presidential campaign's use of social media technologies and content designed to foster effective political participation among youth. We outline how the same social media technologies may be applied to public health efforts focused on reaching and providing services to the 20% of young people who have a diagnosable mental disorder. We discuss the strengths and limitations of the application of these media to date, and raise questions about the future use of these media for engaging hard-to-reach populations in addressing stigmatized public health issues. (*Ethn Dis.* 2011;21[suppl 1]:S1-94–S1-99)

Key Words: Social Media, Mental Health, Youth, Health Communication, Community Outreach

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Social media, defined as communication forms that are digital, networked, and interactive,[1] facilitate rapid dissemination of public health information. Health departments and universities are among the early adopters of social media for health communication purposes, with many using Twitter (a service which allows users to send their followers 140-character updates via mobile device) and short messaging service (SMS), also known as text messaging, to convey emergency preparedness and disaster response information.[2–4] SMS-based efforts have successfully curbed outbreaks of infectious disease.[5] The Centers for Disease Control and Prevention (CDC) operates a comprehensive media campaign, which employs Facebook and other social networking sites, online videos, and Twitter to transmit health messages on myriad topics including pandemic flu, other infectious illnesses, and chronic dieasease.[6]

The public health sector's adoption of tech-based communication campaigns warrants exploration of the question: What can we learn from previous successful social media communication strategies? Political campaigns provide a relevant parallel in that they must also engage large segments of the populace that may be considered hard-to-reach and then motivate them to action. Barack Obama's 2008 presidential victory and the highest voter turnout in 40 years[7] have been attributed to the campaign's effective use of social media[8–9] to engage historically less politically active groups including young voters. Targeted messaging and interactive communication contributed to the 135% increase in youth votes in the first caucuses[10] and the participation of an additional 3.4 million under-30 voters than in the 2004 presidential election.[11]

Abroms and Lefebvre argue that lessons from the campaign's successful use of new media are applicable to public health communication broadly,[12] but they may be particularly relevant for engaging youth and other hard-to-reach populations around issues such as mental health that are both highly prevalent and stigmatized. In this article, we examine elements of the 2008 Obama presidential campaign's use of social media technologies and content designed to foster effective political participation among youth. We outline how the same social media technologies may be applied to public health efforts focused on reaching and providing services to the 20% of young people who have a diagnosable mental disorder.[13] We discuss the strengths and limitations of the application of these media to date, and raise questions about the future use of these media for engaging hard-to-reach populations in addressing stigmatized public health issues.

THE RATIONALE FOR USING SOCIAL MEDIA IN POLITICAL AND PUBLIC HEALTH CAMPAIGNS

Social media may represent a breakthrough for political and public health campaigns because unlike traditional unidirectional media such as billboards and television advertisements, they engage readily available technology to encourage active communication and participation among the target audiences. They offer the potential first to foster discourse, and subsequently to promote a sense of belonging to a like-minded or similarly-affected group. The ubiquity and familiarity of the media at this juncture make this type of engagement possible for those who may be otherwise difficult to reach such as youth populations and people of color. Fully 65% of people aged 18–29 years report using text messaging.[6] At the time of the election, over 17 million Americans aged 18–25 were users of Facebook, the world's most popular social networking site.[14]

With these and other social media, such as videos and blogs, the Obama presidential campaign did more than promote voting; it engaged people quickly, discreetly, and cost effectively in political activism through their handheld phones and computers. The campaign transformed these media – until this point used primarily to communicate with families, friends, and for business – to motivate their users and their social networks to involve friends and community members in online or text-based political and social discussion. Once activated, many supporters used these media to create their own politically-focused media content, and enlisted further support by sharing content with their media-capable personal networks. Others were motivated through the promise of a social media-facilitated connection to contribute to traditional campaign activities, such as phone banking, neighborhood canvassing, and hosting campaign house parties. The familiarity, ease of use, and ubiquity of social media technology and content opened new avenues for participation in the campaign and also strengthened traditional forms of participation that had been difficult to establish among similar groups in prior campaigns.

THE OBAMA PRESIDENTIAL CAMPAIGN'S APPLICATION OF PUBLIC HEALTH-RELEVANT SOCIAL MEDIA

For this discussion we arrange social media into the following format-based schema: 1. social networking websites and applications; 2. user-generated and distributed digital media; 3. cellular text messaging and Twitter.

Social Networking Sites, Other Websites and Applications

Social networking websites lend themselves to campaign and public health work by virtue of their capacity to tap unobtrusively into, and leverage large numbers of, formal and informal relationships. The Obama campaign applied multiple online social networking sites, including Facebook and MySpace, first to reach many youth and minorities and second to keep them engaged with campaign updates. Facebook proved to be the most popular social networking site for the campaign, tallying 2.4 million supporters on the Obama Facebook group by the end of the campaign.[15]

The campaign's MyBarackObama.com website integrated social networking technology. Users created personalized accounts and produced their own web-content to share through multiuser online discussion forums. The campaign drew from users' accounts to enrich the base of traditional campaign workers, sending them regular email and recruiting them to support classic election engagement efforts such as phone banking and neighborhood canvassing. Networked communication between the campaign and users, as well as among users, was focused, efficient, and cost-effective.[8]

User-generated and Distributed Digital Media

User-generated and distributed digital media offer several advantages to political and public health campaigns seeking to create and disseminate compelling messages rapidly and inexpensively. These media (frequently film or music) enable decentralized, volunteer, and creative constituent bases to produce their own campaign content. Film, songs, sound, visual art, digital audio, or visual effects can be shared with a personal network of contacts and spread virally to reach a much broader audience. Content can be disseminated easily to other recipients through email, social networking websites, cell phone applications, or digital media-dedicated web sites such as YouTube. Some constituents and media content recipients may perceive this horizontal, or peer-to-peer, communication as more reliable than vertical political or health messages that come from experts.[1] Campaigns also can take advantage of this trust and the ubiquity of the technology to disseminate internally-generated media content more cheaply than otherwise would be possible.

During the 2008 presidential campaign, 14.5 million hours of Obama campaign-created videos were viewed on YouTube,[16] a digital video sharing site popular with youth, in which the average age of a video uploader is 26.[17] This advertising venue represented an estimated savings of $47 million over comparable television advertisements.[16] Campaign content was easily shared with target audiences, and unlike television and radio spots, merged unobtrusively into potential voters' usual activities, like checking their email or Facebook page. User-generated videos – made by and for constituents – may be a particularly effective engagement tool for disseminating complex information and soliciting new support through online video sharing sites.[18] Constituents may develop a deeper sense of ownership in the outcome of the campaign through their creation of new political content. Such content was included in the nearly 1,800 YouTube videos posted on MyBarackObama.com,[19] and may have been more influential in shaping attitudes of likely voters than videos generated by the campaign itself.[20]

SMS and Twitter

In recent years, text messages and Twitter have become popular means of communication of brief messages. Applications to political and public health campaigns can facilitate rapid and bidirectional communication with target audiences, particularly among youth but increasingly among adults as well.

Obama supporters elected to receive text messages including campaign updates, local events, and public appearances, as well as reminders to vote. By sending information directly to mobile phones, the campaign not only utilized a means of communication familiar to the target population, but also overcame limitations in home internet access among target groups. Text messaging represented an innovative way to reach homes without landlines, which disproportionately comprise minorities and those under 30.[21] At about $1.56 per vote generated, text messaging represented a cost-effective method for communication, especially as compared to phone calls and door-to-door canvassing, which cost approximately $20 and $30, respectively, per vote generated.[22]

Twitter is used by one-third of adults under 30 and by over a quarter of African Americans,[23] representing another efficient means of communication with traditionally hard-to-reach populations. Over 112,000 people followed Obama's Twitter updates,[19] enabling them to remain connected to political developments and calls for action.

DISCUSSION

Campaigns – whether political or public health – face the common challenge of motivating populations to change their attitudes, beliefs, and behaviors to align with campaign goals. The successful application of social media to engage hard-to-reach populations in the context of Barack Obama's presidential campaign suggests that similar strategies may be applicable for promoting youth mental health. Integration of digital communication forms into education and outreach efforts shows promise for overcoming stigma and motivating help-seeking behaviors among the 70% of youth with mental disorders who do not receive adequate care.[13] Social media may also provide social support for young people who feel isolated or stigmatized by a mental disorder. Some examples of recent digital communication efforts to promote youth mental health are in Table 1.

The use of social media allows public health efforts to creatively engage hard-to-reach populations in symptom recognition, help seeking, and adherence to treatment, all in a manner that reduces barriers to access caused by the stigma attached to mental health issues. The National Institute of Mental Health, Mental Health America and Active Minds, Inc., a non-profit organization focused on eliminating mental health stigma on college campuses, all employ a familiar medium, Facebook,[24–26] to educate target populations about mental health symptom recognition and provide treatment resources. As Obama's campaign demonstrated, disseminating information via social networking sites effectively reaches target populations; in the case of mental health there is an added benefit of de-stigmatizing discussion of mental health issues. Just as potential Obama voters were engaged by the substantial presence of campaign supporters on social networking sites, youth who visit mental health-focused Facebook pages see thousands of profiles associated with these sites, conveying that there is broad support for those affected by mental illness.

Youth reliance on the internet as a trusted source of health information - nearly one-quarter have searched online for information about depression or mental illness[41] - suggests that web-based, interactive self-screening tools may be perceived as acceptable for discreetly identifying symptoms of mental disorders.[28–29] People who would not otherwise seek screening due to concerns about privacy may feel comfortable completing an online questionnaire because it requires no interaction with another person. Likewise, SMS and Twitter, with their ability to reach target populations rapidly and discretely, show promise for increasing awareness of available mental health services and facilitating youth entry into counseling. Messaging may be particularly effective when framed in terms of maintaining wellness or addressing stress, rather than recognizing symptoms of stigmatized mental disorders.[35] Obama's campaign strategy of using social media to elicit consistent assistance from supporters parallels recent mental health treatment adherence efforts. Text messaging has been used to maintain engagement of adolescent psychiatry patients between usual visits and was valued as a follow up-support to inpatient treatment for bulimia nervosa patients.[36–37]

Social media may even facilitate technology-based mental health service delivery for some populations and conditions. The Mississippi Department of Mental Health operates a youth-oriented helpline via web-based and text messaging to facilitate anonymous communication between users and mental health providers. [34] Therapy delivery via SMS or email on secure websites may be preferable to in-person contact for some tech-savvy populations and those who live in rural areas but have access to cellular phones and internet. The role of SMS in supporting effective delivery of cognitive behavioral therapy for depression for adolescents is being explored.[42]

Facilitating social support via online communities may represent social media's greatest implication for improving youth mental health. By creating a space for youth to share thoughts and life experiences, such communities may counteract one of the primary effects of mental health stigma – the loss of social engagement opportunities that

Table 1. Digital communication efforts to promote youth mental health

Social Medium	Description	Early Successes and Potential for Engaging Youth and Minorities
Social networking sites and interactive websites		
Social networking sites	Mental health information, tips, links, and reports are posted on Facebook pages supported by organizations such as National Institute of Mental Health (NIMH) Mental Health America, and Active Minds[24–27]	Wide variety of mental health information available to users. Enables limited two-way information exchange between CDC and subscribers. Web pages can be viewed without a social networking site account.
Online screening tools	Mental Health America and other organizations offer free online screenings for depression, substance abuse, anxiety, and PTSD[28–29]	Users answer screening questions anonymously. Those who screen positive for a mental health problem are provided information on local mental health resources.
Patients Like Me[30]	Website and online community users create health profiles (anonymous or public) detailing current health diagnoses, symptoms, and treatment	Provides basic health information. Users engage in on-line discussion with community members affected by similar mental or physical health issues. Users can track symptoms and medication use. User diagnosis and treatment information is aggregated and displayed in graphical format.
Post Secret Community[31]	Online community to share secrets and discuss mental health	89,000 registered users. Chat room format in which users post secrets, questions, and ideas for discussion. Users provide one another with social support, advice, and resources.
User generated digital media		
It Gets Better Project's YouTube channel[32]	Contains videos of adults offering hopeful messages for sexual minority youth. Created in response to the suicide of bullied gay high school student	Within one month: Over 650 videos featuring diverse adults were uploaded to site. Videos exceeded the channel's capacity. Nearly 2 million page views[33]
SMS and Twitter		
Mississippi Department of Mental Health's Helpline[34]	Users communicate with helpline staff via SMS or interactive website	Users send text messages or use interactive website to ask for help with mental health concerns. Anonymous communication reduces stigma and may facilitate entry into care.
Text messaging pilot project for college student mental health[35]	SMS messages focused on wellness, stress management, and adjustment to college were sent to all students' mobile devices	Students reported acceptability of receiving SMS, as long as messaging did not overtly focus on mental health. 5% of first-year students responded with requests for help.
Text messaging pilot projects for mental health treatment adherence	SMS messages were sent to adolescent psychiatry patients between visits[36]SMS messages supported treatment for bulimia nervosa[37]	Patients in both pilot projects found receiving SMS messages to be acceptable. SMS successfully kept patients engaged in psychiatric treatment.
Twitter	NIMH, Mental Health America, Active Minds and BringChange2Mind.org provide education and mental health resources through Twitter messages, or tweets[38–40]	NIMH has over 68,000 followers, while Mental Health America, Active Minds, and BringChange2Mind have nearly 2,000, over 1,600, and 1,200 followers, respectively.

can lead to self-harming behaviors.[43] Just as youth responded to political messaging provided by peers during the 2008 presidential campaign, they are likely to trust user-generated content presented by peers or people they perceive to be similar to themselves via familiar online websites or YouTube. The community art project PostSecret has become an unlikely source of emotional support for troubled youth.[31] Displayed on the PostSecret website are homemade postcards upon which participants anonymously write their secrets about such issues as relationships, family, sexuality, drug use, and history of abuse. The act of creating and sending a postcard may be an outlet for those who would not otherwise discuss their experiences and viewing the postcards may reduce feelings of isolation for those experiencing similar challenges. The site also hosts an online forum in which some 89,000 users discuss myriad topics including mental health concerns and provide support for one another.[44] Similarly, for those with a diagnosed mental illness, the for-profit, online community Patients Like Me.com, facilitates discussion among users facing similar ailments.[45] Patients Like Me users become credible sources of information, providing one another with emotional support and disease management suggestions. These discussions, along with the statistics on other users' diagnoses and treatment the site provides, create a sense of belonging to a group and may reduce users' feelings of detachment and shame.

The It Gets Better Project employs user-generated media,[46] a tremendously powerful tool in Obama's social media campaign, as a suicide prevention strategy for a subgroup that experiences disproportionately high rates of unmet mental health needs: sexual minority youth.[47] In response to the suicides of teens who experienced bullying due to their perceived sexuality,[48] gay, lesbian, bisexual, and transgender adults created and shared videos via the It Gets Better Project's YouTube channel to offer support to sexual minority youth who are harassed at school. With over 650 user-generated videos uploaded and nearly two million views, the widely popular project exceeded its YouTube capacity in just one month.[33] These videos, created by people who are perceived as trustworthy because they have experienced homophobia and discrimination themselves, offer bullied sexual minority youth hope that their lives will indeed improve.

CONCLUSION

Youth-oriented mental health campaigns would be wise to continue using social media—preferably in multiple forms—to encourage recognition of mental health symptoms and facilitate access to services when indicated. However, to effectively engage youth, the public health sector must take a lesson from the Obama campaign and from the aforementioned successful informal mental health efforts by allowing users to determine the types of information and services they desire, and to create social community networks that facilitate information sharing and support for health-seeking behaviors.

User-generated content was vital to Obama's election, as it provided a mechanism of feedback to the candidate and his staff, enabling supporters to help set the agenda for the campaign. Through their videos and messages, youth made clear which of the candidate's views resonated with their own. The campaign could then reiterate messaging that appealed to supporters and scale back others. Similarly, youth have responded well to social media-delivered mental health projects initiated outside of the public health sector because these efforts have been driven by those with a personal understanding of relevant issues. When youth with mental health concerns create their own content via participation in interactive health forums, they are transformed from consumers of health messaging into purveyors. They can be adept at communicating relevant information and may help facilitate peer entry into mental health care. Youth participants' provision of social support may also counteract the effects of stigma that deter treatment seeking.

The greatest strength of social media is not its capacity to simply send information to large segments of the population, but rather to engage previously underserved groups in accessing health information and becoming proactive consumers of health services. There is tremendous potential for its continued application to mental health, but the public health sector must more effectively engage youth in designing relevant messaging and services. As evidenced by their participation in PostSecret, Patients Like Me and the It Gets Better Project, youth are willing to engage in difficult discussions about mental health when they believe they are supported by a social community and they receive information from trusted sources. The public health sector can build on youth participation in these networks and media, and should encourage their development and effectiveness.

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PROJECT OVERVIEW OF THE RESTORATION CENTER LOS ANGELES: STEPS TO WHOLENESS – MIND, BODY, AND SPIRIT

Objectives: Unmet needs for depression and substance abuse services are a concern in urban communities. This article summarizes the design and recommendations of the Restoration Center Planning Project to better address depression and substance abuse while promoting resiliency and wellness for persons of African descent in South Los Angeles.

Design: A partnered participatory planning process during 18 months involving community members, faith-based and service agency leaders, and investigators from academic organizations was implemented. Leaders formulated a set of principles to address diversity of the group, hosted community conferences and working groups, while developing recommendations.

Results: The community-academic partnership recommended the establishment of restoration centers in Los Angeles (RCLAs) that would serve as a one-stop shop for holistic services addressing depression, substance abuse, related social and spiritual needs, and coordinated care with a network of existing community-based services. Specific recommendations included that the RCs would aim to: 1) support community resilience and improve outcomes for depression and substance abuse; 2) be one-stop shops; 3) promote cultural competency; 4) facilitate ongoing community input and quality review; 5) assure standards of quality within centers and across the broader network; and 6) support the enterprise through a multi-stakeholder community-based board dedicated to RCLA goals.

Conclusion: A community-academic partnered planning process acknowledged the importance of respect for diversity and formulated plans for the Restoration Center network including the integration of health, social, cultural, and faith-based approaches to services with a multi-agency network and community leadership board. The feasibility of the plan will depend on the subsequent implementation phase. (*Ethn Dis.* 2011;21 [Suppl 1]: S1-100–S1-106)

Key Words: African American, Cultural Competency, Depression, Substance Abuse, Mental Health, Health Disparities, Community-based Participatory Research, Mental Health, Faith-based

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INTRODUCTION

The Restoration Center Planning Project arose in response to several overlapping concerns and interests of community-based agencies, faith-based leaders, community members, and academic investigators interested in the development of South Los Angeles and in the health of African Americans in Los Angeles. From a more traditional perspective of identifying areas of unmet need, African Americans as a group face many areas of health disparities in the United States and limited access to quality of services, which has been shown to be related in part to being lower in average socioeconomic status.[1–4] In terms of mental health and substance abuse, African Americans do not exhibit higher rates of need compared to the national average after adjusting for other factors, they are disproportionately affected by limited access to services and more adverse outcomes, particularly in underserved communities, such as South Los Angeles.[5–11] With respect to mental health and substance abuse services, African Americans experience high rates of underutilization, prema-

> *"We need a place that can service the whole family, not just services funded by individual things. If I'm the mother and I'm stressed, I want to go to a place and get some services. I may have mild depression myself. I want a place where I can go talk and where I can get services for me and others and there's no cost directed towards it."* – Participant at "Presentation of Final Restoration Center Planning Report," Holman United Methodist Church, October 17, 2008

From the RAND Corporation (BC, KBW, EW) and Department of Psychiatry and Biobehavioral Sciences, David Geffen School of Medicine at UCLA (BC, KBW, KP) and West Angeles Church of God in Christ (PL) and New Vision Church of God in Christ (RW) and Ecumenical Congress of Black Churches (RW), Kaiser Permanente Watts Counseling and Learning Center (DAH) and Department of Social Work, College of Health and Human Services, California State University, Dominguez Hills (DC) and United Women in Transition (RG) and Healthy African American Families II (FJ).

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> *"When I think about the restoration center, the word "restoration" means to make whole again. Our actions need to speak as compassion. People need to trust that they are coming here for that. Compassion has to be shown in our actions. We need to meet people where they're at and reach out to them. "* – Participant at "A Dialogue to Plan a Community-Partnered Restoration Center," The California Endowment, August, 3, 2007

ture drop out, and lower quality of care.[12–14] In addition, despite similar rates of substance use, African Americans experience more severe social, health, and criminal related costs than White Americans.[15]

African Americans are diverse, as are underserved communities. In Los Angeles County, a recent 2011 State of Black Los Angeles report found that African American households were characterized by a wide-range of demographics and lifestyles.[7] For instance, of the African Americans residing in Los Angeles County, 28% were considered cosmopolitan achievers (upper-middle class professionals), 24% struggling strivers (most economically challenged), 15% family-focused middle (homeowners with modest incomes), 9% urban professionals (high income, advanced degrees), and 8% up-and-coming climbers (suburban white-collar couples). Moreover, the composition of Los Angeles' Black community is shifting with the influx of foreign-born immigrants from East and West Africa, Central America, and the Caribbean, who are estimated to make up 10% of the city's Black population.[16] Originating from countries such as Nigeria, Somalia, Honduras, Panama, and Ghana, Los Angeles' foreign-born Black population come with a variety of faith traditions including Sufi and Sunni Muslims, Seventh-Day Adventists, Catholics, Presbyterians, and a wide array of independent charismatic and evangelical denominations.[16] Consequently, not only are existing traditional faith communities being infused with new life, but different religious narratives are being formed.[16]

More than any other racial ethnic group in the United States, religion figures prominently in the lives of African Americans. Nearly 90% of African Americans claim a formal religious affiliation, 79% state that religion is very important in their lives, and 76% report praying on a daily basis.[17] The large majority of African Americans are Protestant (78%) compared to only 51% of the US population.[17] Faith-based organizations, in particular the Black Church, has played a particularly prominent role in promoting the health and well-being of African American communities.[18] The Black Church has been critical in contributing to the survival and resilience of African Americans in the face of innumerable adversities including displacement from their native homelands, slavery, racism and discrimination. The Black Church provided one of the few places that African Americans could internally organize, express their cultural heritage, and find dignity and spiritual strength.[19] Compared to other religious congregations, the Black Church has been more extensively involved in the delivery of social service programs, crisis intervention, and counseling for individuals with mental illness.[20,21] In Los Angeles, the Black Church has played a pivotal role not only in shaping the social, cultural, and political lives of African American, but has had a tremendous impact though its involvement in commercial revitalization, the development of senior and low-income housing, the establishment of schools, and the provision of social and spiritual services.[16]

From a strength-based perspective, it is important to identify areas of cultural and community strength, such as resiliency, community traditions and institutions, as vital resources to draw upon in the quest to eliminate health disparities. As found in the general US population,[22,23] but even more so with African Americans, spiritual beliefs and practices are integral and highly-valued resources when coping with mental health or substance use problems.[24,25] Thus, it is not surprising that the church is often the first place that African Americans turn to for help.[25,26] African Americans may be reluctant to rely on formal health providers who may be insufficiently prepared to address, and thus underestimate, the importance of religion and spirituality.[23,25,27] In some communities, especially for African Americans, faith-based institutions and other trusted community-based organizations are an important entry point for services in general including for mental health and substance abuse conditions.[28–33]

Thus, the Restoration Center Planning Project sought to bring together a diverse set of partners to attempt program development that simultaneously addresses specific areas of unmet mental health and substance abuse needs, while celebrating and building upon cultural and community institutions to promote resiliency as a primary outcome. The origins of the Restoration Center Planning Project resulted as much from an interest in promoting the community development and resiliency of South Los Angeles' residents (including African Americans in Los Angeles), as in the recognition of unmet need for care for specific conditions increasing the burden of illness in the community, such as depression and substance abuse. We felt that these conditions could serve as an important focal point on which to jointly address health disparities and resiliency as it has been previously shown that health outcome disparities in depression can be reduced through implementing evidence-based, comprehensive quality improvement programs for depression in primary care.[34]

To achieve these goals, an initial leadership group of community and academic leaders approached The California Endowment to support the conceptualization and planning of programs that would build upon existing community and faith-based services to address South Los Angeles' needs for depression and substance abuse care by integrating cultural and spiritual strengths into services. Other related goals included: considering the importance of person, family, and culture in wellness; incorporating resiliency in services planning and development; and promoting concepts of community leadership and accountability in designing and implementing services. The California Endowment agreed to support the project in 2007. This afforded the unique opportunity to call together faith-based institutions, other trusted community-based organizations, community members, and academics to leverage their varying perspectives and collective strengths to devise programs and services that would recognize and be fortified by the wealth of cultural and spiritual assets inherent within the African American community in Los Angeles. The resulting project design, plans and recommendations for services are the subject of this article.

METHODS

The project began in 2007 as a partnered, participatory planning project that was led by a leadership group including representatives of each of four stakeholder perspectives: faith-based, community service provider, community, and academia, with a focus on depression and substance abuse as signature conditions and resiliency and cultural strengths as overarching concepts. The leadership agencies, which we referred to as founding partners were West Angeles Church of God in Christ; The Ecumenical Congress of Historically Black Churches; Kaiser Watts Counseling and Learning Center; the Los Angeles County Department of Mental Health Services/South Los Angeles District; Charles Drew University, Healthy African American Families; the RAND Corporation; and UCLA Semel Institute Health Services Research Center. Over time, we added additional supporting agencies, including United Women in Transition and California State University Dominguez Hills. This leadership group met one to two times a month for 18 months to guide the planning process, with each of the four perspectives having equal voice in all decisions. The history of the agencies was such that most agencies had collaborated previously with at least one of the other agencies, but not all together. That fact, along with the diversity of types of stakeholders represented, and the project's mission to integrate concerns with unmet need and community strengths, were important contextual factors that led to the group's initial focus on developing a statement that acknowledged and reinforced the importance of respecting the diversity within the context of the project goals, which in many aspects became the guiding common principle of the project. The diversity statement is presented in Table 1. The statement acknowledged the diversity of the partners at the table, while having recognized that despite the differences in backgrounds, all were committed to improving the health and well-being for those of African descent in South Los Angeles.

Host Community South Los Angeles

South Los Angeles (LA) is a 100 sq-mile area of Los Angeles County that is composed of a series of contiguous communities with a shared history, demographic, health care and health outcomes profiles. South Los Angeles is generally considered to consist of several City of Los Angeles neighborhoods including Baldwin Hills, Baldwin Village, Baldwin Vista, Chesterfield Square, Crenshaw, Hyde Park, Jefferson Park, King Estates, Leimart Park, University Park, Vermont Square, Watts, and West Adams; as well as the independent cities of Compton, Florence, Hawthorne, Inglewood, Lennox; and the unincorporated areas of Willowbook. South LA has roughly 1.3 million residents with about one-third of the residents aged <18 and only 7.5% aged >65 years. Nearly one-third (31%) of residents are African American and almost two-thirds are Latino. The median annual income for South LA is about $27,000. Lack of access to health and mental health care providers is especially limited in local neighborhoods such as South LA with an estimated .30 physicians per 1,000 versus 4.06 per 1,000 in West Los Angeles; .09 community clinics per 1,000 uninsured and .9 hospitals per 100,000 versus .1 per 1000 uninsured and .9 hospitals per 100,000 in West Los Angeles. South LA has 5.8 mental health agency providers per 100,000 versus 6.9 available in West LA. And nearly one-third of the non-elderly adult population is uninsured.[6] While the African American community of South LA has significant unmet needs for health and mental health services, it also has higher rates of civic engagement than any other racial group in LA due to its higher voter registration and union participation.[7]

The leadership group structured the planning process around four components: a kick-off conference or day of dialogue; working groups with goals defined based on that kick-off confer-

Table 1. Diversity Statement for Restoration Center Planning

The Restoration Center Los Angeles Planning Committee remains committed to the belief that by bringing together community members, faith based organizations, mental health providers, substance abuse providers, and behavioral health researchers in a partnered planning process, we can improve the health and well-being for South Los Angeles Community members of African descent.

As a planning committee, we strive to respect the dignity, individuality, freedom, and beliefs of each member. At the same time, we strive to be a group where individuals and groups of all beliefs learn from each other. We aim to foster a sense of collective responsibility for each other's well-being and the well-being of the community as a whole by focusing on the common experiences of those of African descent in the South Los Angeles community. We acknowledge the challenges inherent in working within the different faiths and belief systems in the African American community of South Los Angeles, yet, we remain unwavering in our commitment to diversity and community for the common goal of creating health and wellness in our community. We seek to enable ALL members of our planning process to express their opinions and beliefs in an environment that recognizes the unique contributions of each individual's experience and beliefs. We believe that the diversity of each individual at the table in our planning process will permit us to take full advantage of the variety of insights, backgrounds, and beliefs of those who live, work and play in South Los Angeles.

Beyond the planning process, the project hopes to provide resources for and support actual operational centers that provide services and support to promote restoration, wellness, and health in the African American communities of Los Angeles. Just as the planning process seeks a process of respectful dialogue and consideration of diversity for developing a plan, we seek to plan for Centers that will themselves address the diverse needs and perspectives of the African American communities. We hope for centers that will be inclusive in addressing groups of different faiths and those who are not associated with a particular faith, as well as other types of diversity within the community. Similarly, we acknowledge the challenges of addressing diverse communities within one center, but seek individuals to help with planning who share this vision of restoration, faith-in-action, and services provision. In this way, we hope to develop the plans and resources for a community that can stand as one in declaring and promoting health, restoration, and mental wellness for all African Americans in Los Angeles, while serving as an example for other communities and cultural groups.

Please join us at the table to help plan the restoration center as we cannot hope to represent you unless you provide us feedback on your most valuable and unique perspective.

ence; a community feedback session to review, obtain input on, and celebrate the resulting plan; and a report summarizing the recommendations resulting from the work-groups and feedback. Each component is described briefly below.

Day of Dialogue

The leadership group hosted a day of dialogue at The California Endowment in August 2007 to review the concept for the Restoration Centers and obtain broad community input. One hundred eighty-nine representatives of faith-based institutions, community-based agencies and service providers, grass-roots community members, and academics attended the conference. The day included brief talks on the history and background of the project, initial plans developed by the leadership group, a reading of the diversity statement, and a call for participation in discussion groups. Those present discussed the Restoration Center in breakout groups. Each group was asked to respond to three questions: 1) What are the mental health services that are most needed in the African American community? 2) How can we navigate through the stigma associated with mental health in the African American community? and 3) How do we integrate a faith-based perspective into the Restoration Center given the diverse faiths of our community?

Workgroup members took notes and summarized key points on flipcharts. Key themes were summarized in an end-of-conference discussion, enhanced by leader review of notes and flipcharts. The consensus reached in the discussion groups and affirmed at the wrapup discussion was that although there were existing services in the South LA community, these services were often fragmented and not sufficient to meet the unmet need for mental health and substance abuse services, given the high level of need in the community. A common theme for solutions was for one-stop shopping at centers of excellence that integrated mental health, medical (primary care), and social services, within faith-based perspectives. Likewise, participants had diverse views about dealing with stigma. Several community participants proposed a media campaign for sanity. Many expressed that the church is an important partner in the community, and many expressed their desire to see services that integrate various faiths and speak to every faith without preference. The importance of offering services that could respect diverse faiths such as Christianity or Islam, as well as people without an active faith, was also emphasized by many present consistent with the diversity statement read at the conference.

Organizing Meeting for Working Groups

After the day of dialogue, the leadership sponsored an organizing meeting hosted at West Angeles Church of God in Christ. At that session, the feedback from the day of dialogue was reviewed and participants broke into workgroups: mental health and substance abuse needs and services; wellness and resiliency programs; and restoration center policies and operations. Ideas for action were reported back to the full body of participants, which approved the initial action plan concepts. Leaders for each working group were identified that included members of the founding partners as well as new agencies identified as interested from the initial organizational meeting.

Working Groups

The three working groups met twice a month over several months to give

Table 2. Recommendations for restoration centers

1. One or more restoration centers should be developed and sustained to support the wellness and resiliency of the community and to improve outcomes of depression and substance abuse. These centers should be targeted for persons of African descent and other vulnerable populations in South Los Angeles and surrounding areas. Centers may be full centers with a broad range of services (depression care, substance abuse care, social services, and resiliency / wellness activities). Developing centers would have one or more type of services and add other services over time.
2. Centers should be designed as one-stop shops for mental health and substance abuse problems and to build wellness and resiliency. Centers should provide and coordinate services for diverse populations, and consider the needs of individuals, families, and the community. Center functions include:
a. Coordinating access to the range of community services available for depression, mental health, and substance abuse, as well as holistic and alternative/folk medicine programs that support wellness and resiliency.
b. Providing outreach, education and training to increase community awareness and develop leadership, such as training for faith-based leaders to address mental health and substance abuse issues.
c. Providing direct services to fill gaps as needed.
3. The centers should promote cultural awareness and competency in program design and implementation.
4. Centers should support client and community participation in program design and ongoing review.
5. Policies and procedures should be developed to assure standards of quality of services. Management and financing training and support should be available to center directors and administrators.
6. The functions and activities of different centers should be supported and coordinated through a board or association of restoration centers. This body should also develop mechanisms to support the sustainability of centers.
7. This planning phase should be followed by phase 2 (a demonstration of at least one full center and a developing center). That demonstration should also evaluate the acceptability and impact of the centers and explore how they could be replicated and sustained in other areas of Los Angeles.

input to the leadership council. These meetings refined ideas generated at the day of dialogue, and developed the relationships between the diverse partners brought together by this project. For example, the mental health and substance abuse needs and services workgroup considered how the four different stakeholder groups defined needs and services, and sought to engage diverse service agencies and community members in reviewing options for programs. A key principle of the group was to respect existing community services and build on their strengths as well as to improve ties among them and support additional services quality and capacity. The wellness and resiliency programs reviewed existing community programs enhancing wellness from a holistic perspective and learned about faith-based programs and options for integrating services. The policies and operations group developed options for leadership and coordination, reviewed guidelines for safety and quality, and explored options for sustainability. Each group developed a brief initial report and set of principles or recommendations. Then the leadership group for the project as a whole integrated the principles and recommendations, which had some overlap, into an overall set of recommendations with supporting ideas from each of the groups in their distinct areas.

Community Feedback and Celebration

The planning project concluded with a presentation of the recommendations and findings of the workgroups and leadership group to the community, which included participants of the kick-off conference held at West Angeles Church of God in Christ. The project provided documentation in a report with supporting appendices that provided more detailed information. In addition, the leadership made small group presentations to policy leaders to develop support for implementing pilot demonstrations of restoration centers. A preliminary approval for one center is being considered through the Mental Health Services Act Innovations Funding from the Los Angeles County Department of Mental Health Services. The integrated recommendations, following community feedback, are presented in Table 2. Our partnership recommended a one-stop shop called a restoration center for coordinated services across mental health, substance use, physical health, and social services. The restoration center would not only provide support for services, but would focus on outreach, education and training for services with an understanding of cultural competence.

DISCUSSION

The goal of this project was to foster a unique unity of perspectives across faith-based, provider, other community, and academic perspectives that would serve to originate a services-delivery approach in support of the health and wellness of persons of African descent and other populations living in and near South Los Angeles, but with a major focus on depression and substance abuse on the one hand, and wellness and resiliency from a more holistic perspective on the other. The planning process built on both community traditions and processes for convening groups and on models of community-academic partnerships. For example, central structural features included a leadership group, a kick-off conference followed by a framing session for workgroups, followed by workgroup tasks, and resulting in a community-feedback conference and report with policy meetings to develop support. While these features are common in other projects represented in this special issue,[35,36] this project particularly focused on developing a diversity statement that positively affirmed and celebrated the unique and diverse groups involved in the project's efforts to promote community well-being. These features permitted the group and the community to actively explore different avenues to fulfilling the common goal, which was present from the kick-off conference to centers of excellence and became associated with the idea of a network of diverse services, to both build capacity and strengthen existing community services while orientating the whole toward a common mission. In fact, the leadership body identified examples of the Restoration Center concepts in faith-based centers of excellence, including some with many components of this model within faith-based organizations represented on the leadership council. Under the confluence of diverse partners, recommendations focused on the full integration of spiritual, clinical, and culturally valued community approaches around health concerns and resiliency, as well as the inclusion of the broader network and centers of excellence. Coordinating this scope of effort and achieving quality management at scale across faith-based and non-faith-based agencies was challenging. However, the leadership group and community felt it was critical to give voice to the kinds of services and programs desired by the community. It was the hope that the set of recommendations issued by the restoration center planning project would help influence and enhance existing models of care.

Portions of this larger agenda are being actively explored in different projects and programs from the original partners such as: a new center for family development at one faith-based institution; expanded explorations of faith-based approaches to engage the community by a public sector agency; a greater focus on integrated health and social sector approaches to mental health care by academic and community partners; and a resiliency class developed in a community-based randomized trial. The convening of diverse partners within the Restoration Center planning process fostered new interactions and relationships that led to connections to long-standing and existing programs within faith-based centers of excellence that had already embodied much of the set of recommendations issued by the project. Consequently, a new partnership between faith-based and academic leadership members was formed that led to recently-funded partnered-research initiatives to build upon and bring to scale existing faith-based programs that integrate spiritual and cultural strengths in addressing substance abuse and mental health needs. Through demonstrating the feasibility and effectiveness of these different pieces of the overall concepts, and continuing to engage policy stakeholders locally, the partners hope to arrive at specific opportunities to integrate these approaches and realize the goals of this project at some scale.

Limitations of this project included: it being focused primarily, although not exclusively, on one large, underserved geographic area of Los Angeles; primarily focusing on one ethnic group that is historically underserved and subject to diverse health disparities; and its being limited to a planning phase. However, this project illustrates the promise of a partnered approach to planning to reflect as well as unite diverse community and academic partners into a common mission that directly involves community input and stakeholders and generates a broader vision to address local mental health disparities.

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ADDRESSING UNMET MENTAL HEALTH AND SUBSTANCE ABUSE NEEDS: A PARTNERED PLANNING EFFORT BETWEEN GRASSROOTS COMMUNITY AGENCIES, FAITH-BASED ORGANIZATIONS, SERVICE PROVIDERS, AND ACADEMIC INSTITUTIONS

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Objective: To conduct a process evaluation of the Restoration Center Los Angeles, a community-academic partnered planning effort aimed at holistically addressing the unmet mental health and substance abuse needs of the Los Angeles African American community.

Design: Semi-structured interviews with open-ended questions on key domains of partnership effectiveness were conducted with a random stratified sample of participants varying by level of involvement.

Participants: Eleven partners representing grassroots community agencies, faith-based organizations, service providers, and academic institutions.

Measures: Common themes identified by an evaluation consultant and partners relating to partnership effectiveness, perceived benefits and costs, and future expectations.

Results: Findings underscore the importance of considering the potential issues that may arise with the increasing diversity of partners and perspectives. Many of the challenges and facilitating factors that arise within academic-community partnerships were similarly experienced between the diverse set of community partners. Challenges that affected partnership development between community-to-community partners included differences in expectations regarding the final goal of the project, trust-building, and the distribution of funds. Despite such challenges, partners were able to jointly develop a final set of recommendations for the creation of restoration centers, which was viewed as a major accomplishment.

Conclusions: Limited guidance exists on how to navigate differences that arise between community members who have shared identities on some dimensions (eg, African American ethnicity, Los Angeles residence) but divergent identities on other dimensions (eg, formal church affiliation). With increasing diversity of community representation, careful attention needs to be dedicated to not only the development of academic-community partnerships but also community-community partnerships. (*Ethn Dis*. 2011;21[Suppl 1]:S1-107–S1-113)

Key Words: Community-based Participatory Research, Faith-based, Mental Health, Substance Abuse, African American

INTRODUCTION

Community-based participatory research (CBPR) approaches have been heralded as a promising means toward the elimination of health disparities.[1] The CBPR approach focuses on the equitable involvement of community and academic partners throughout the research process with the aim of improving hypothesis generation and evaluation, community-informed interventions, and translation and adoption of research findings.[2] Hence, one of the key areas of focus within CBPR is the development and cultivation of relationships between outside researchers and community members.[3,4] A central issue within CBPR is how to balance the diverse, sometimes conflicting, needs and priorities of academic and community members so that synergistic collaborations that promote co-learning, mutual capacity building, and more relevant and actionable knowledge can be formed.[2]

Relatively less attention has been paid to the partnership building process between community members who often represent diverse segments and perspectives of the local community.

Interestingly, relatively less attention has been paid to the partnership building process between community members who often represent diverse segments and perspectives of the local community. Although subject to less investigation, CBPR does underscore the importance of recognizing the multiple voices of a single community.[5] A core principle of CBPR is to identify and work with existing communities of identity and to fortify the sense of community through collective engagement.[3] However, there has been limited examination of the participatory process when existing communities of identity overlap on some dimensions but diverge on others. In the case of African Americans, though largely connected by a shared collective history and ethnicity, they also reflect diverse experiences. African Americans are characterized by a growing heterogeneity in socioeconomic status, cultural beliefs and religious participation.[6–9] For ex-

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From RAND Corporation, Santa Monica, California (ECW, BC, KBW); Harbor-UCLA Medical Center, Department of Psychiatry, Torrance, California (BC); University of California, Los Angeles, School of Public Health (GS); University of California Los Angeles, Semel Institute Center for Health Services and Society (SS, RSK, KBW); VA Greater Los Angeles HSR&D Center of Excellence (SS, RSK); Healthy African American Families II, Los Angeles (FJ); West Angeles Church of God in Christ, West Angeles Counseling Center (PL); New America Foundation, Washington, DC (KP).

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ample, even though religion continues to be important in the lives of many African Americans, there is increasing variation in formal religious affiliation. A large majority, nearly 80% of African Americans, still claim a formal affiliation with the Christian Protestant church.[8–11] However, 12% of African Americans are unaffiliated with any formal religious institution. Nevertheless, even among unaffiliated African Americans, three in four report that religion is either somewhat or very important in their lives.[6] Rare are investigations on community-academic partnerships that involve community partners who represent diverse institutions and religious experiences within African American communities. Most evaluations in the CBPR literature in African American communities have focused either on the process of forming community–academic partnerships or on strategies to engage faith–based communities around health issues.[10,11]

The Restoration Center Los Angeles Project

The purpose of the present evaluation is to examine the partnership process of the Restoration Center Los Angeles (RCLA) which brought together a wide range of partners to engage in a two-year planning effort to create a set of recommendations to address mild-to-moderate depression and substance use problems affecting the South Los Angeles African American community. The planning effort centered on developing a set of guidelines for the creation of Restoration Centers that would address unmet mental health needs by building on existing community- and faith-based strengths and services, and by integrating the importance of supporting the wellness and resiliency of the individual, family, and community. The initial leadership group included founding partners who served as representatives for each of the following perspectives: community service providers, community grassroots organizations, faith-based organizations, and academia. Each partner entered into the RCLA planning process with different histories, traditions, and working styles.

A number of partners had collaborated previously on engaging the local community around depression and other health related initiatives.[12] From this prior collaborative work, a local variant of CBPR, called community partnered participatory research (CPPR) was developed. The CPPR approach has a structure and a set of principles that ensures equal participation and leadership of community and academic partners.[13] The CPPR model provided an important origin and guiding set of principles for some RCLA partners. Our faith-based RCLA partners brought the historical and collective role of the church in community activism and in providing for the physical and spiritual needs of the community. Faith-based organizations, in particular the Black church, have well-established infrastructures with long traditions, methods, and approaches to mobilizing resources and people to meet the needs of the community.[14,15] It quickly became evident that the RCLA partnership needed to develop a working style that could accommodate the diverse perspectives and traditions represented so that effective planning could be accomplished. Thus, an early product of the leadership group was the development of a diversity statement that acknowledged and reinforced the importance of attending to diverse perspectives in the RCLA planning process (for more details see Chung et al, in this issue). In addition, guardians of each of the four perspectives (ie, community grassroots, faith-based, service providers, and academia) were appointed and given voting power for major decision-making processes.

The initial leadership group created a larger RCLA planning committee that supported three workgroups which were charged with developing a set of plans within their respective topic area: 1) mental health and substance abuse needs and services; 2) wellness and resiliency programs; and 3) policies and operations. Each workgroup was asked to respond to questions such as: "What are the mental health services most needed in the African American community?" and, "How can we integrate a faith based perspective into Restoration Centers given the diverse faiths of our community?" A set of recommendations were developed and presented and approved in several open community forums held at the California Endowment, the West Angeles Church of God in Christ, and the Holman United Methodist Church. The final set of recommendations focused on providing services for mild to moderate depression and substance abuse in a one-stop-shop setting that integrated or co-located holistic wellness approaches (for further details see Chung et al, in this issue). This article describes a post-hoc retrospective evaluation of the RCLA partnership, which was conducted shortly before the last community forum in which the final set of recommendations was reported.

METHODS

Participants

Thirty-five RCLA members participated in planning committee or workgroup meetings between August 2007 and July 2008. The members were stratified into four exclusive categories based upon level of participation in planning committee meetings (ie, low to high attendance). Eighteen RCLA members randomly selected from these strata were contacted by phone with a maximum of three call attempts. A final sample of 11 RCLA members participated in face-to-face semi-structured interviews during October and November 2008.

Procedures

The interviews were conducted by an evaluation consultant from outside

Table 1. Partnership evaluation interview

Domain	Questions
Expectations	What was your motivation for first becoming involved? Can you tell me what you had hoped the planning process would accomplish? What were your expectations for the planning process? (Probe: What did you expect the leadership committee to accomplish? What did you expect the workgroups to accomplish? What do you think was the goal or end product that the planning process aimed to achieve during its first year?)
Group effectiveness/accomplishments	How has the Restoration Center planning process met your expectations? How has it exceeded expectations or fallen short? Why do think this is? What have been the major accomplishments of the Restoration Center planning process so far?
Facilitators/barriers	What factors have facilitated the accomplishments and/or hindered progress of the Restoration Center planning process?
Benefits/costs	What have you personally learned from your participation in the Restoration Center planning process? How do you think your knowledge was expanded? What personal skills were developed or refined? How has this process helped you professionally? What does your organization hope to accomplish by its affiliation with the Restoration Center partners? What have been the costs or problems for your organization's participation in the Restoration Center planning process (if any)? How about for you personally?
Future expectations	Do you think the Restoration Center planning process should continue? How do you think this should happen? Which additional organizations or people who should be involved? Are you committed to continuing your involvement?

the project at a location convenient for participants and lasted approximately 30–60 minutes each. The consent form was read to each participant who then gave oral consent before the interview was consulted. Each participant received a $10 gift card for their participation. The interviews were tape recorded and each was loosely transcribed and then common themes were identified. The semi-structured interview was based upon a conceptual framework for understanding and assessing the effectiveness of the CBPR partnership process.[16] Key domains of the interview included: expectations and perceived effectiveness of the group; facilitators and barriers that affected group effectiveness; perceived benefits and costs of participation: and future expectations of the group's effectiveness (see Table 1 for interview protocol). These domains are considered intermediate measures of partnership effectiveness.

Analyses

The 11 tape recorded face-to-face interviews were transcribed and analyzed by the evaluation consultant. Transcripts were analyzed for the common themes around partnership development, facilitators, barriers, benefits, and achievements. All identifiers were removed so that the raw responses could be interpreted by a subset of RCLA members. If any coded responses were unclear, the evaluation consultant edited the transcripts for further clarification and interpretation. All aspects of the evaluation and manuscript development were done in partnership with representatives from community, service providers, faith-based, and academic partners. Community partners refer to non-academic representatives from community grassroot organizations, service providers, and faith-based organizations unless explicitly stated otherwise.

RESULTS

Expectations and Perceived Group Effectiveness

The RCLA members expressed a range of motivations for initiating their involvement in the project. Approximately half of the participants were drawn to the project because of the content (ie, focus on mental health/substance abuse) or the concept (ie, holistic approach to mental health needs). Other participants were motivated by the nature of the work (ie, community-based), the expectation that a one-stop-shop that met community needs would be established, and the potential to engage in a healthy relationship with academic researchers.

The members reported divergent expectations about the end goals of the project. Nearly half of the participants believed that the purpose of the project was to develop an executable plan or blueprint of the operations, programs, and services that would constitute a Restoration Center. In contrast, approximately one-third of participants expected that an actual Restoration Center would be created and established. A smaller subset of participants thought that the end purpose of the project was to strengthen collaborations between partners.

Correspondingly, participants differed in the degree to which they felt that their expectations had been met. Some participants ($n=4$) reported that the project fell short in meeting their expectations. For example, a participant described having unmet expectations given that the participant believed that the funding agency would provide the financial resources needed to establish a center upon the development and delivery of a plan. Other participants

(n=4) had no expectations or were unsure about whether their expectations had been met. The remaining participants reported being satisfied with the results of the project but expressed that the project needed to continue to achieve further accomplishments.

One of the major accomplishments identified by many participants (n=7) was the facilitation of a planning process that involved diverse partners and perspectives (eg, theological, academic, community). One participant describing RCLA stated, "I think they have made quite a bit of accomplishments through their planning, getting the community involved, listening to the community, being a partner with research as well as community leaders." Another participant talking about the accomplishments of RCLA explained, "Because it had a collective of people from different backgrounds, different cultures, different ways of looking at life, different disciplines…you've got the theological perspective, you've got the academic perspective, you've got the community perspective." Participants said that staying committed to the project and producing a plan were major accomplishments. One participant responded, "…getting through the process, staying committed and coming together with a unified vision and plan." Another remarked, "…just bringing the community and the different perspectives to the table and coming out with the same goal is a major accomplishment."

Participants also noted the development of partner relationships and the level of engagement with the community as major accomplishments. Participants commented that relationships, partnerships, and real friendships had been formed and that trust was developed. In addition, the RCLA planning process was described as, "…getting community excited about the project." Other accomplishments included gaining knowledge about the partnership process and the demonstration of the cohesiveness of the faith-based community.

Barriers and Facilitating Factors

Several factors were viewed as facilitating the accomplishments achieved by the RCLA planning process. The diversity of community input and individual commitments to the project were seen as contributing to the progress of the project. Although the diversity of community perspectives represented in the RCLA planning process was cited as a major accomplishment, it was also regarded as a significant challenge. For example, one participant responded, "We had academics, faith-based community, mental health all at the table. I think it was an excellent group, I really do. Unfortunately, everyone had a real strong opinion and couldn't get past to come together as real partners." Some participants commented on the diversity particularly exhibited among the community partners. For instance, a participant remarked that "…some significant cultural differences that weren't addressed. There were different cultures. The diversity of African Americans, the diversity of the different groups that were at the table, the diversity of faith…I think that we underestimated those cultures and didn't give enough attention to it. "

Another factor that affected the process included concerns about the influence of pre-existing relationships between various community and academic partners that were established prior to the project as well as the occurrence of side interactions between different partners. Participants also said that disorganization, changes in leadership, and misunderstandings of the planning process impeded the partnership process. For example, a participant describing the challenges stated, "…the repetition of goals, of not being able to agree, no one being able to agree on how we should get started, how things should be in place, who should be the target population, and really how we can achieve the goals." In addition, another factor that was cited as hindering the process was the scale of the project goals which was described as being too large.

Some participants commented on the nature and timing of the partnership process. One participant stated: "…it takes time for people to trust one another. That everyone really is considering each other's interests and not in there just for their own interests, so I think that was one of the big challenges." Despite these challenges, commitment to the process was viewed as a significant factor that facilitated persistence with one participant noting, "…sticking through something and pushing through something and fighting for what we believe in…we stayed." Staying focused on the larger goal of the project was also identified as a significant factor to facilitate completion of process. For example, one participant said that the process was facilitated "once people realized they were working for the greater good and let go of egos, and sacrificed a little."

Certain elements of the leadership committee were cited as factors that facilitated the planning process. In portraying the leadership committee a participant remarked, "I think leadership assisted in providing information. They were open. They listened. They took into consideration suggestions that were made, wanted to work with us. I think they made us feel that they were looking to our well-being." It was also noted that "…when leadership committee members felt comfortable to speak up…" the process was facilitated.

Perceived Benefits and Costs

Participants acknowledged experiencing a variety of personal benefits resulting from their participation in the project. A substantial proportion of participants reported gaining knowledge or renewed awareness of group dynamics and process. One participant remarked, "…I think the thing that was reinforced for me was the fact that you don't get to ignore culture. It doesn't matter how significant the project is – you don't get to ignore culture. And that if you're going to enter into a project of diversity, that you've got to factor in time to understand the cultures that are at the table." Some participants disclosed new insights or increased understanding about different cultures. For example, a participant commented, "I also learned that there is this whole other community out there. They're taking care of their own, they're figuring out ways to help their community and there's lots to be learned from the people who work in the community." Several participants said that involvement in the project provided new networking opportunities. Many participants acknowledged deriving personal benefit from the partnership process including, "…the structure of bringing people together, talking things over, being more open-minded." Moreover, one participant remarked that, "…hearing those different perspectives and melding them into one and being able to go through the conflicts" was a benefit.

In terms of perceived organizational benefits, participants expressed a hope that involvement in the project would result in greater recognition of community needs and increased efforts to address them. Further along in the continuum, some respondents reported that their organization had desired that their affiliation with the project would lead to establishment of an actual center(s). Regardless, participants expressed that their organizations benefited by being "part of something that filled a gap," ensuring "the communities' voice has been heard," and "helping the community since there isn't a lot available in that area." Participants also said that future anticipated opportunities for collaborative work (eg, publications, funding) was a benefit anticipated by some organizations.

With respect to personal and organizational costs associated with participation in the project, more than one-third of participants said that being diverted from other work was a cost. One participant said that misinformation had caused detrimental effects for his/her organization. In contrast, nearly a third of participants reported being unaware of or having no costs related to their participation.

Future Expectations

The majority of participants ($n=7$) felt that the RCLA planning process should continue largely due to the expectation and needs of the community. One participant stated, "There are still a few planning aspects that need to take place, but let's move on. I can't say this enough - if an actual place doesn't come out of this, it will really hurt me. It's not good enough to begin something – you've got to finish it. We have a lot of Black people hurting." Community members' expectations for a tangible product in terms of establishing an actual Restoration Center was emphasized. A participant remarked, "…as much as we reminded them, it's about putting together a plan, they were hoping that something would ultimately come out of it. I know the community and they're gonna say, 'This is something that we need, this something we'd like to see, and it would help us tremendously because we're the ones that access those services on a regular basis.'"

The remaining four participants were unsure or expressed that the RCLA planning process should not continue in its current form and significant changes were needed. For example, a participant commented, "I'm not sure that this particular group could render something different eight months from now. There would have to be some significant changes in the group for us to…for time to render a different product." Another participant offered more concrete recommendations, "Again, it's got to be more structured. There have to be time limits that have to be enforced. Everybody has to have a clear understanding that this is a process that needs to end at some point. That everybody has an objective at the table and that they need to be understanding of the objectives and time, overall, of everyone at the table – respect that."

Participants also noted the need for self-evaluation and evaluation of the group should the partnership continue. One participant said, "I think we should continue to have meetings to determine how we're progressing. We should have meetings to see what we need to change…what's going well, what's working, what isn't working." Another participant stated: "I think that there's no way in the world that we can say, 'Don't do anything else.' I'm glad that I stayed with the whole process from beginning to end because I wouldn't have been able to get that last outcome. I think people need to really redefine what they are willing to commit to and be involved in…and I think they really need…everybody needs to really think about…their agenda…personally and professionally, within…whatever they want…and to see if it is in alignment with what the Restoration Center would do and be about."

DISCUSSION

The present evaluation examined the partnership process of the RCLA, which was a two-year planning effort to develop a set of recommendations to address the unmet mental health and substance abuse needs of the South Los Angeles African American community. Findings underscore the importance of considering the potential issues that may arise with the increasing diversity of partners and perspectives. In the case of the RCLA, a diverse set of community partners proved to be both its greatest asset and challenge. The RCLA members continually referred to the broad and diverse representation of individuals engaged in the planning process as a major accomplishment and benefit of the project. However, RCLA members also acknowledged that the diversity of community partners at times prevented further cohesion and progress within the partnership.

Within CBPR, partnership issues have mainly focused on the kinds of challenges created by the divergent views of academic versus community partners.[17] In contrast, relatively less attention has been paid to how the diversity of community representation impacts the partnership process. Interestingly, many of the challenges and facilitating factors of academic-community partnerships mirrored many of the processes that manifested between various RCLA community partners. For example, issues related to differences in expectations, trust-building, and the distribution of funds influenced the partnership development process between RCLA community partners. Although RCLA community partners were unified by the common goal of addressing the unmet mental health needs in their community, there was substantial variation in the expectations of what kind of final product the planning process would yield (ie, proposed plan for a Restoration Center versus the actual establishment of a Restoration Center). These findings demonstrate that the immediate needs of the community can continue to pull partners toward more action-oriented outcomes even when opportunities are afforded for the specific purpose of strengthening partnerships. The RCLA planning effort was made possible in part because of the funding agency's responsiveness to policy recommendations to support planning grants that help build infrastructure.[18] Thus, even in the infrastructure development phase of CBPR, expectations and tensions around the balance between process versus action outcomes need to be effectively managed.

Findings also highlight the added complexity of the partnership process with the expansion of community representation. A core principle of CBPR is to identify and work with existing communities of identity and to foster a fortified sense of community through collective engagement.[3] Although the challenges wrought with increasing diversity have been documented more generally,[19] there is limited guidance on how to navigate differences that arise between community members who have shared identities on some dimensions (eg, African American ethnicity, Los Angeles residence) but divergent identities on other dimensions (eg, formal church affiliation). The non-overlapping dimensions of identity may be associated with divergent perspectives that can affect the partnership process (eg, prioritization of goals, perceptions of community relevant solutions). Findings indicate that with the increasing diversity of community representation careful attention needs to be dedicated not only to the development of academic-community partnerships but also to community-community partnerships.

Despite the challenges encountered, RCLA members considered the development of a final set of recommendations for the creation of Restoration Centers as a major accomplishment (see Chung et al, in this issue, for further details). Recommendations included designing Restoration Centers as one-stop-shops for mental health and substance abuse problems and to build wellness and resiliency. Restoration Centers would also serve to coordinate access to a range of community services to ensure holistic care, to provide outreach, education and training to increase community awareness and leadership to address mental health and substance abuse issues and to deliver direct services to fill gaps as needed. In addition, Restoration Centers would promote program design, implementation, and ongoing review that incorporate cultural awareness and competency and client and community participation. The final recommendation stated that the RCLA planning phase should be followed by a demonstration project of at least one Restoration Center to evaluate the acceptability and impact of the Centers and explore how they could be replicated and sustained in other areas of Los Angeles. Efforts were made to carry out this final recommendation by exploring whether a Restoration Center could be implemented by individual partner institutions and by approaching county government agencies and private foundations.

When diverse partners are able to work in synergy, opportunities to develop new and improved solutions, more integrated and comprehensive programs, and stronger ties to the broader community are made possible.[20]

The RCLA members recognized the rarity with which such a diverse set of partners can be brought together to work collaboratively on a joint effort. Commitment and dedication to a greater good went a long way in aiding the RCLA partnership to weather some of the challenges common to CBPR partnerships. This was particularly evident during the final community feedback conference in which the set of recommendations were presented to the community at large. The RCLA members reported feeling energized by the community's excitement and enthusiasm for the plan and expressed the need to continue the effort. The members and the community-at-large recognized the huge potential in having diverse partners at the table to jointly address the pressing needs of the community. When diverse partners are able to work in synergy, opportunities to develop new and improved solutions, more integrated and comprehensive programs, and stronger ties to the broader community are made possible.[20] The RCLA experience illustrates some of the lessons learned by a diverse set of partners in their journey toward the actualization of the full potential of collaboration.

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