



# **Community-Partnered Approach to Improving Depression Services:**

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HEALTH

# Challenges of engaging minority communities in services and research

- Tragic historical legacy of research abuses of minority populations
- Distrust of government programs and health services
- Community-based participatory research approaches are recommended to build trust in research and services

# Community Partnered Participatory Research (CPPR)

## CPPR Principles:

- Transparency
- Respect
- Power sharing
- Co-leadership
- Two-way knowledge exchange



# Key Features of CPPR

- Core Principles
  - Equal power sharing and respect
  - Find the win-win
  - Support partner capacity/strength-based
- Structure
  - Partnered Council frames and guides initiative
  - Community Partnership Forum for broad input
  - Partnered Work Groups
    - Develop action plans for community approval
    - Implement and evaluate approved plans
    - Disseminate programs and findings
- Stages: Vision, Valley and Victory—equally important
- Jones and Wells, 2007; Wells and Jones 2009; [www.communitytrials.org](http://www.communitytrials.org); Jones et al., 2009

# Shifting the Paradigm from Involvement...

- One step removed from partnership
- Builds consensus on predetermined actions
- Report back to funders
- “For” not “with” partners
- Provides resources during the initiative
- Timeline for success regardless of community reality
- Predetermined agenda, plan, and method

# ...to Engagement

- Builds sustainable capacity
- Builds trust and co-ownership
- Honors shared agendas, plans, and methods
- Partners own the initiative, mind its collaborative nature
- Report back to partners and funders
- Work is done “with” not “for” the partnership

# Find the Win-Win: Incentives for Engagement

| <b>Sector</b>                          | <b>Wins</b>                                                                                   |
|----------------------------------------|-----------------------------------------------------------------------------------------------|
| <b>Children/families</b>               | Better daily lives<br>Indirect benefits to whole community                                    |
| <b>Community Organizations/schools</b> | Community, political, financial support, recognition, networking, resources                   |
| <b>Healthcare Agencies</b>             | More efficient or effective care,<br>Increased market share,<br>Positive image, tax write-off |
| <b>Government</b>                      | Improved implementation of programs, services; public trust in programs or research           |
| <b>Universities</b>                    | Greater impact, partnerships for research and training with 2-way knowledge transfer          |

# Model of Community Collaboration

© 2002 Jones, Martin, Pardo, Baker, and Norris



# How To Build Partnerships

- Identify trusted agencies that work with the population/condition of interest
- Develop a common understanding of mission
- Identify strategies to engage systems and communities; what works and what has not; who is engaged, who is not
- Develop messages and partnership strategies to engage stakeholders in the mission
- Formalize new networks for change
- Engagement model from Community-Partnered Participatory Research (Jones and Wells, 2007)

# Strategies for Partnership

- Invite people to the table, & stay involved
- Two-way knowledge-exchange activities
- Develop transparency: clear language and images
- Support working groups of stakeholders as equals
- Develop action plans & programs to support understanding and implementation
- Disseminate information & products
- Social activities that build relationships as people
- Learn lessons together: Turn conflict into strength!
  - Expect conflict as natural for coming together
- Listen to all perspectives and move forward

# Mental Health Infrastructure and Training Project (Red Cross, RWJF) New Orleans Post-Katrina

- “The project has meant setting aside many of the ‘rules’ about implementing programs for depression and trauma and following the needs, priorities, and culture of the community.”





# **New Orleans Redesigned Collaborative Care for Depression/Trauma**

- Lead community agencies
  - Simplified registry
  - Community health worker as care manager
  - Cognitive Behavioral Therapy
  - Staff self-care.
- Five 2-3 day trainings across all staff
  - More than 300 providers trained in a year
- Agencies and providers delivered more than 80,000 client services in a year

# Outreach and Engagement Story



# How Will We Know We Have Made Progress?

- Greater system and community engagement in improving the health condition in the community
- More connections (joint activities, agreements, other) across relevant groups
- Greater capacity and capability to shift the dialogue and programs from individual to system and community-level—similar to quality Improvement goals and activities, team-building
- More opportunities to leverage existing programs for broader purposes to address a given condition



New Vision Church of Jesus Christ



COMMUNITY PARTNERS IN CARE  
Compañeros Comunitarios en la Salud



DEPARTMENT OF MENTAL HEALTH



Working together in an *equal* partnership  
to learn how to improve depression care  
and build community strength



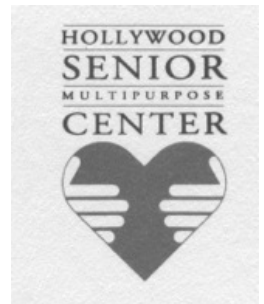
Watts Counseling and Learning Center



A family of services.  
A family that serves.



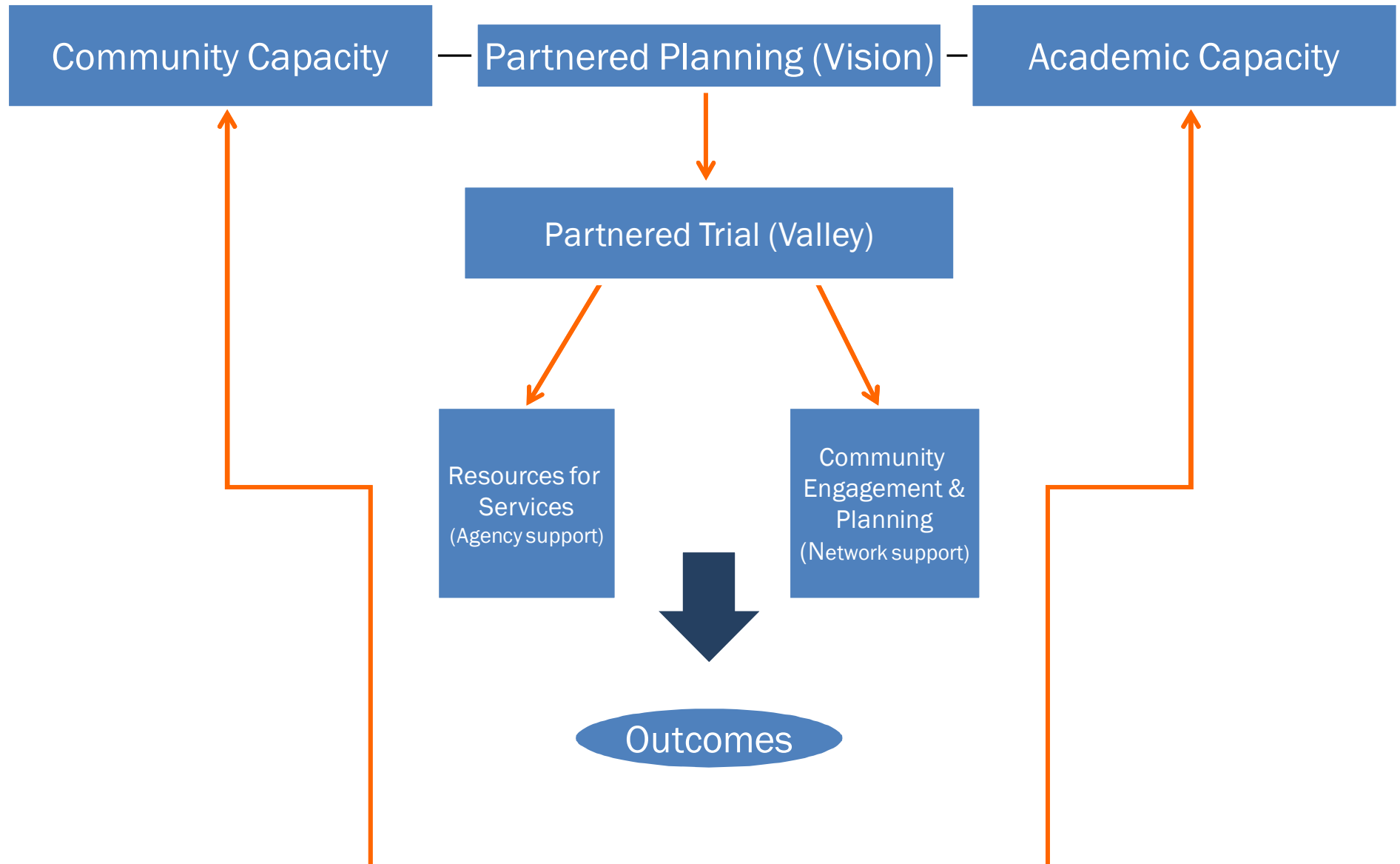
NAMI URBAN LOS ANGELES  
The Community's Voice on Mental Illness



How can we translate the benefits of  
high quality depression care  
into **better lives**  
for under-resourced,  
communities of color today?

“Little is known about the independent contribution  
of community linkages to improving health and  
behavioral health outcomes.”—SAMSHA 2012

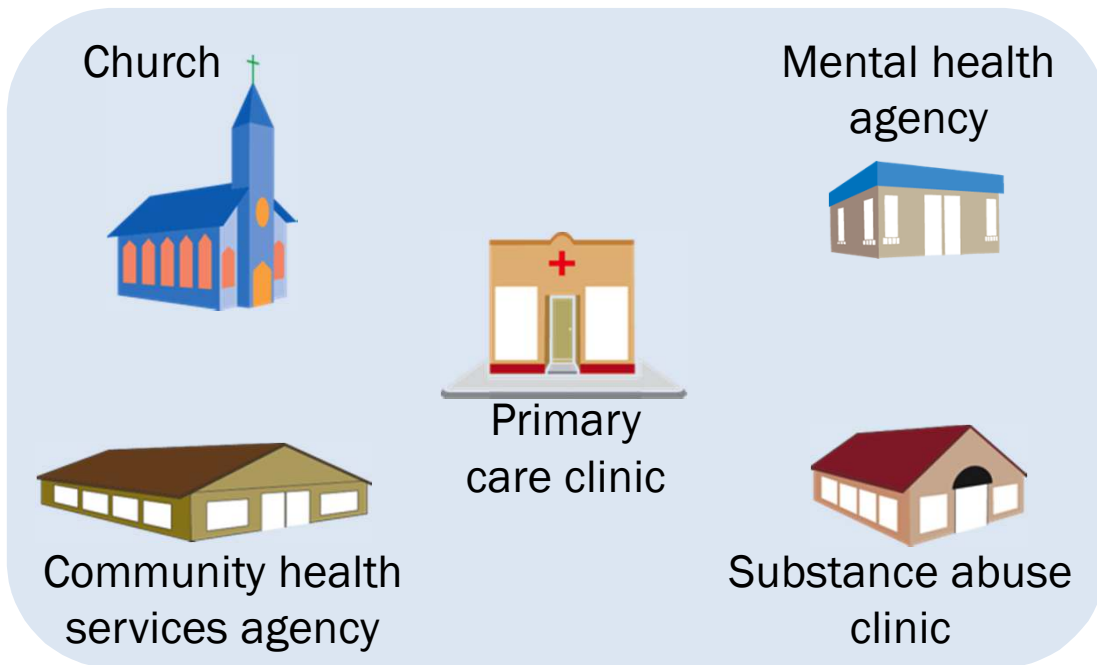
# Community Partners in Care (CPIC)



Partnered Dissemination (Victory)

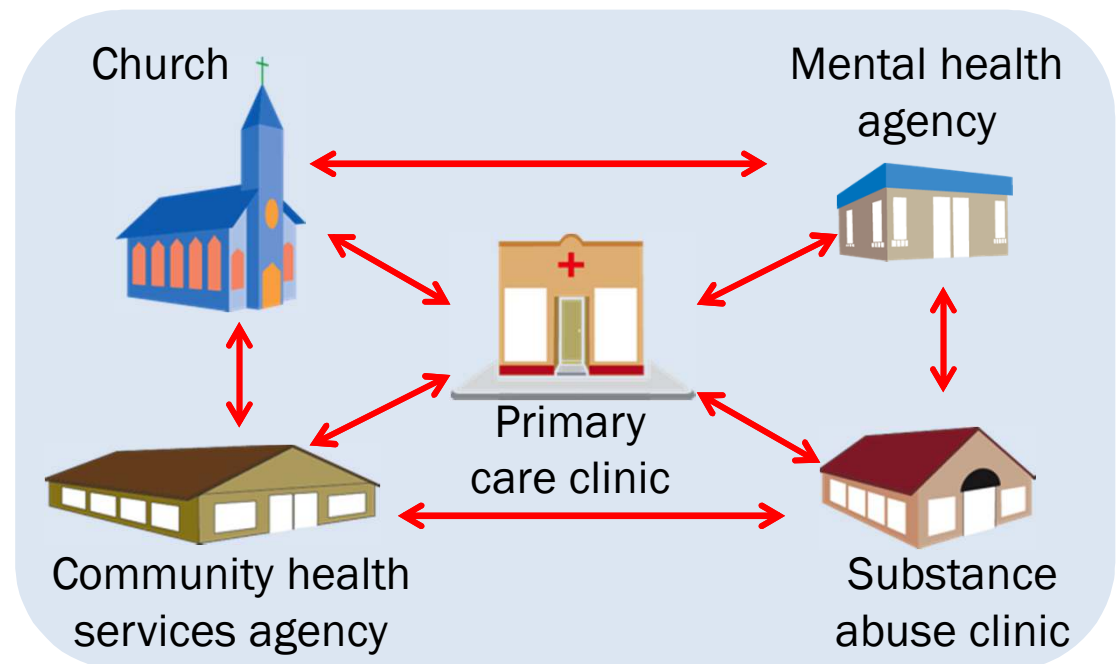
# Design of CPIC

- 2 Communities: > 2 million residents
- 93 programs in 50 agencies (MH, PCP, substance abuse, social services, homeless, faith-based, community centers, hair salons, exercise clubs)
- Programs randomized to technical assistance or community building to implement *collaborative care for depression*
- 4436 clients screened for depression
- 981 of 1322 eligible with depression enrolled & completed baseline survey



## 95 Programs in Los Angeles

Community engagement and planning



# CPIC collaborative care

- Team management (IMPACT)
- Clinical assessment and medication management and alternative health practices (PIC)
- Cognitive behavioral therapy for depression (We Care)
- Care management/case management/health workers (MHIT/New Orleans, PIC)
- Patient education resources (PIC)
- CEP: Support for networks to develop, modify training, and innovate in services delivery

# Community Input Expanded Study

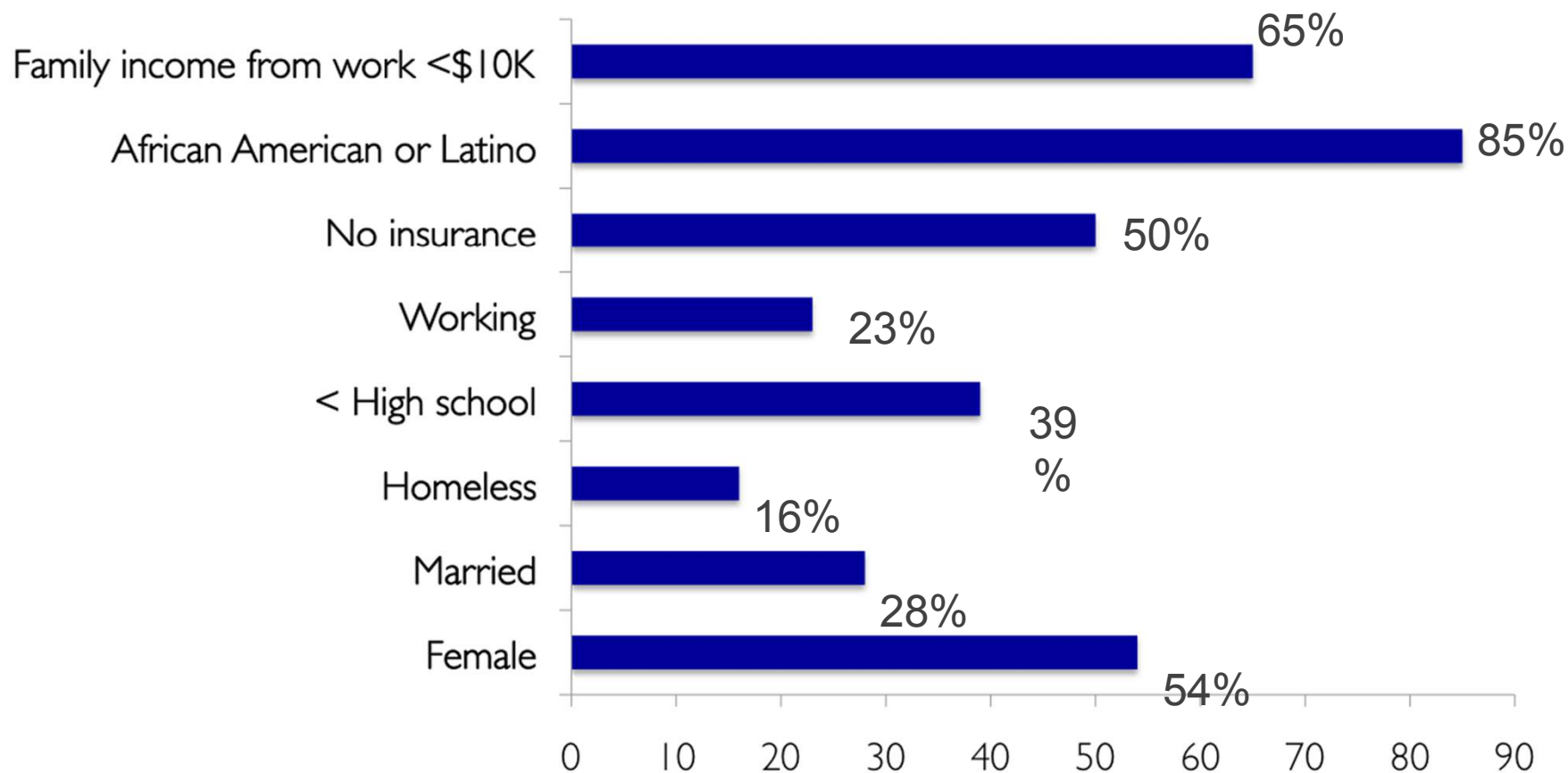
- *Sampling:*
  - Agencies: Added community-trusted locations
  - Providers: Added nonlicensed staff with client contact
  - Clients: Include the most vulnerable—homeless, HIV, prison parolees—
- *Intervention:*
  - Resources for Services: increase from 1 day conference to 12 webinars
  - Community Engagement and Planning: >120 training events; budget for Planning Councils
- *Randomization:*
  - Workshop on equipoise/Tuskegee
  - Community votes on design; selects seed numbers
  - Partnered presentations

# CEP Stone Soup exercise



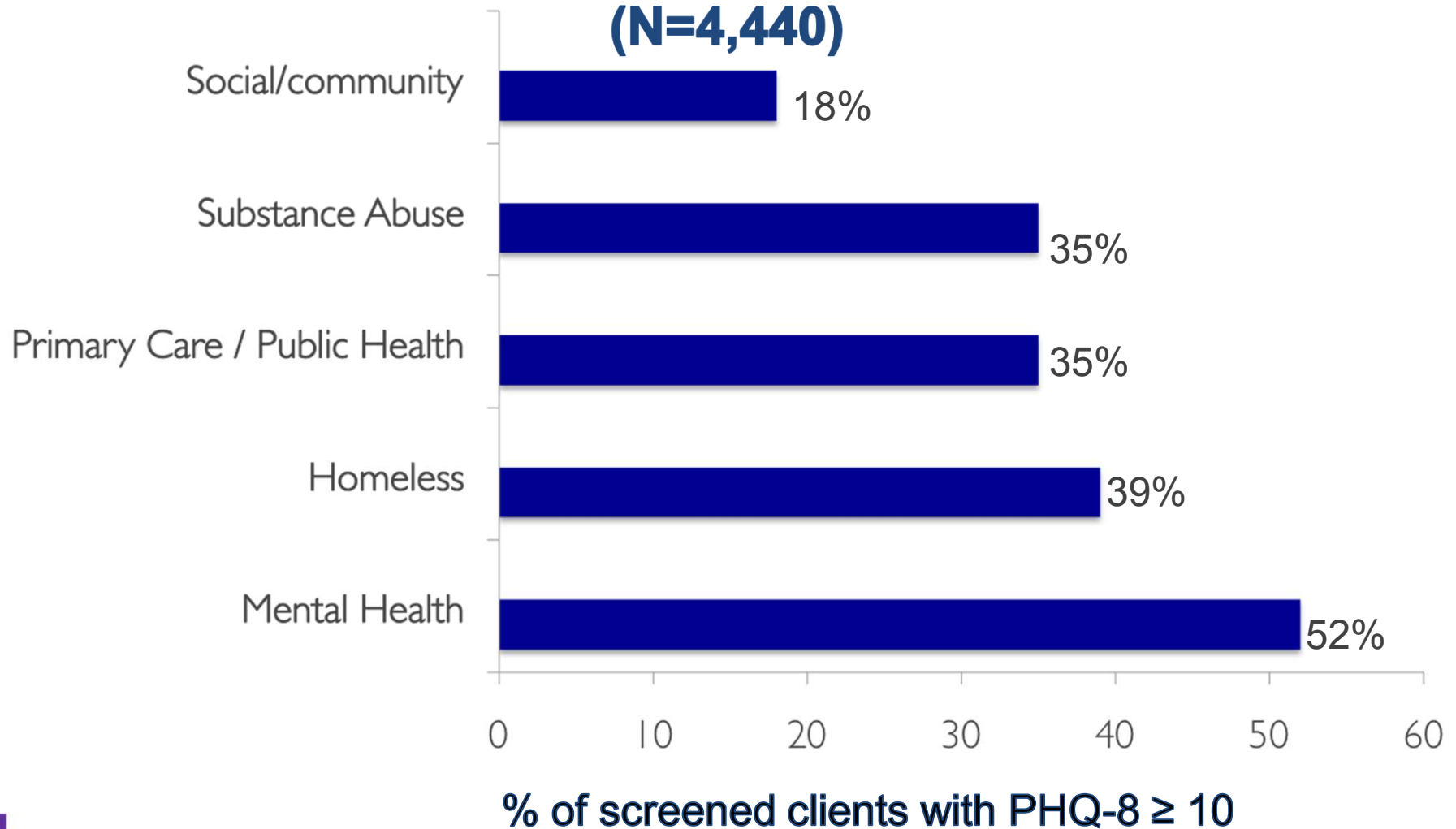
# Clients Are Diverse

(N = 4,440, mean age 47 years)

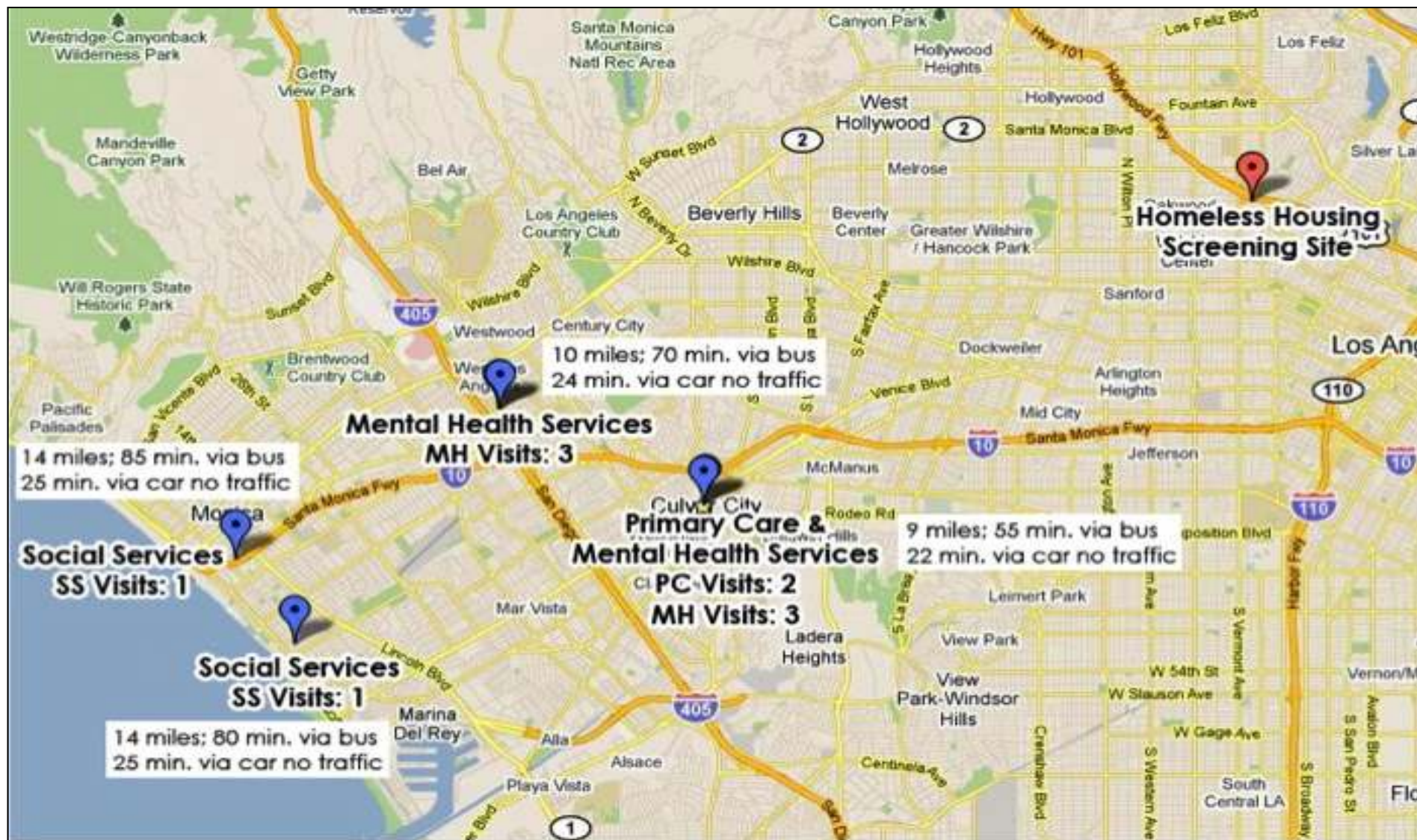


# Client Depression Common Across Program Types

(N=4,440)



# One Homeless Participant's Quest for Services

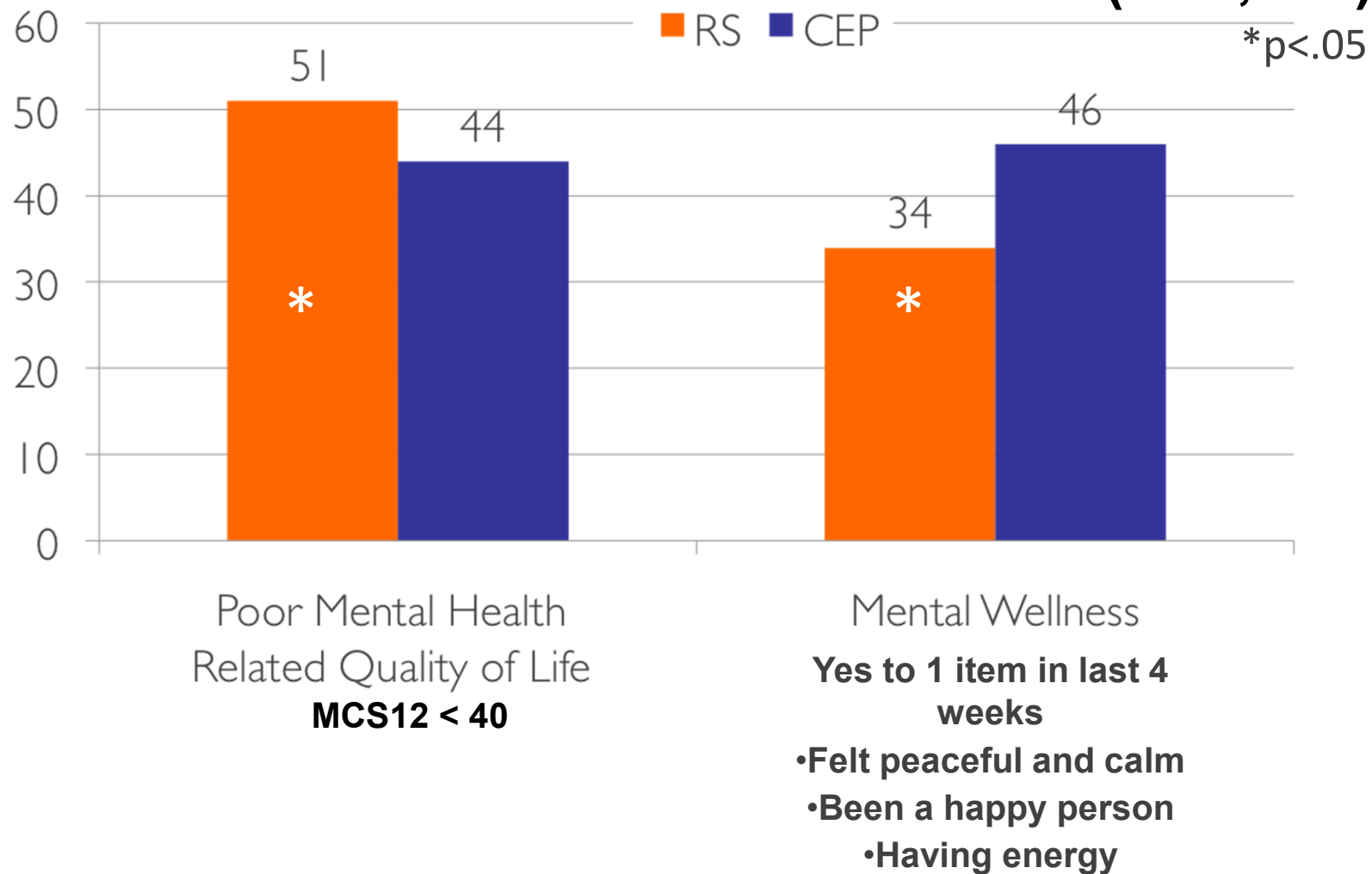


# Summary of 6-month Outcomes

- **CEP relative to RS increased provider participation in evidence-based depression training**
- **Both CEP and RS improved client mental health quality of life**
- **CEP was more effective than RS in client outcomes:**
  - improving mental health quality of life and physical activity
  - reducing homelessness risk
  - reducing behavioral health hospitalizations
- **CEP shifted** outpatient depression services away from specialty medication visits toward primary care, faith-based and park services for depression
- BUT: No difference in depressive symptoms, use of antidepressants or healthcare counseling for depression

*–So mechanism is not more “formal” treatment*

# CEP More Effective At Improving Client Mental Health (N=1,018)

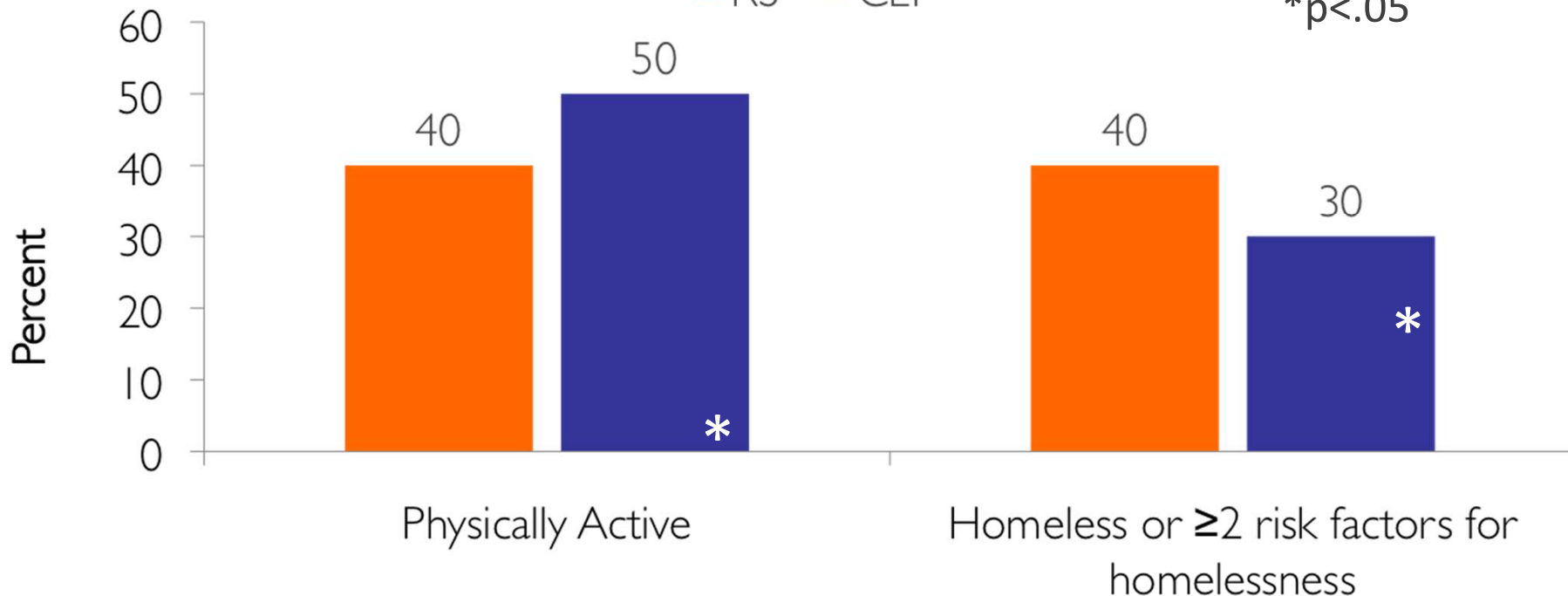


# CEP More Effective at Improving Physical Health and Homelessness

(N=1,018)

■ RS ■ CEP

\*p<.05



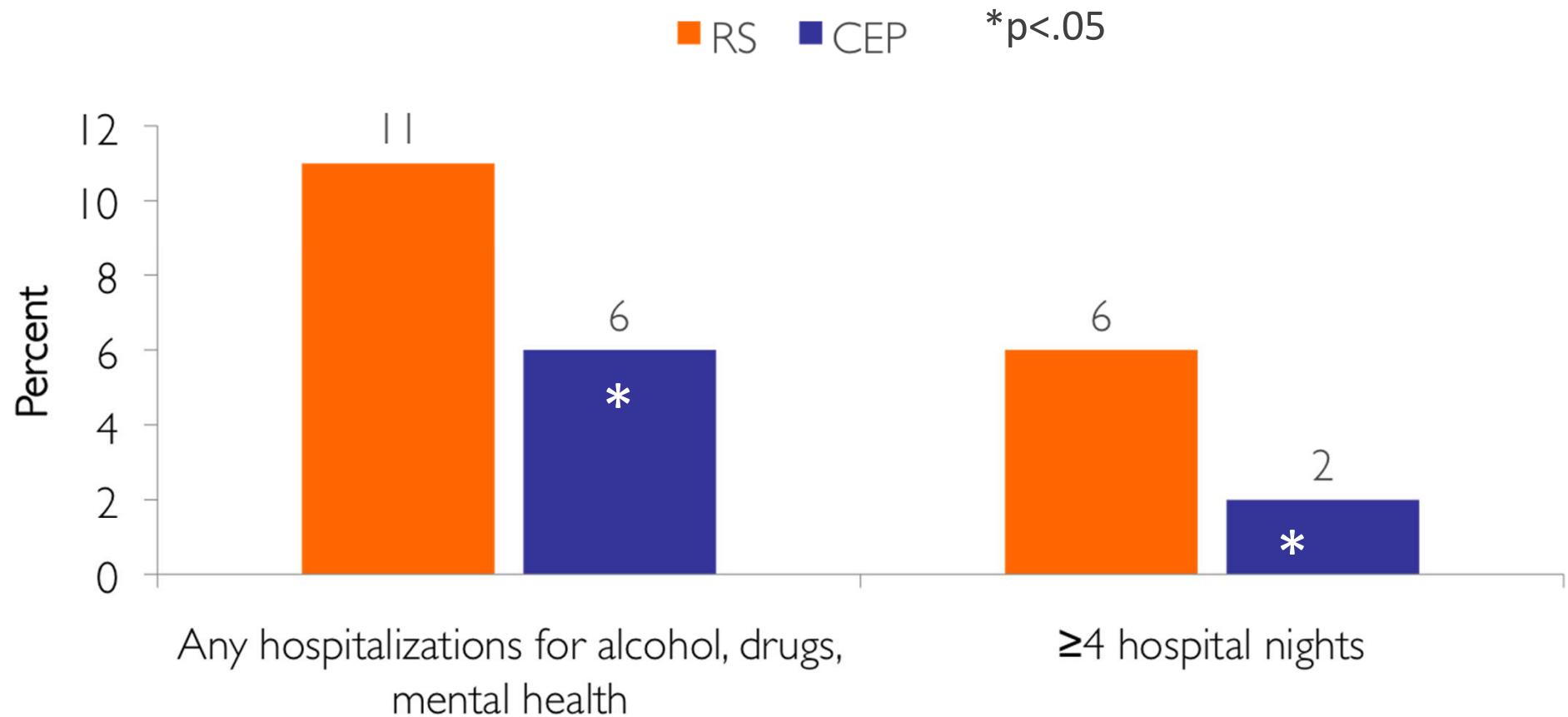
Yes to all health limits

- Moderate activity
- Stairs
- Physical activity

Risk Factors:

- food insecurity
- eviction
- severe financial crisis

# CEP More Effective in Reducing Hospitalizations (N=1,018)



# 12-month Client Outcomes

- Modest continuing improvements at 12 months relative to baseline in mental health related quality of life for CEP vs. RS
- Continued reduction in behavioral health hospitalizations for CEP vs. RS at 12 months
- Over the whole year, more improvement in mental health and less hospitalization in CEP

# CEP Start-Up Training Cost More...

## Because More Staff Were Trained

|            | RS       | CEP       |
|------------|----------|-----------|
| Total Cost | \$47,523 | \$249,459 |

Most costs are provider training time--you get what you pay for

No significant difference  
In total healthcare costs  
Over the year



# Celebrating Victory: The Win-Win

- Community Benefit:
  - All screened receive Resources Guide
  - Enrolled with suicide ideation:
    - Telephone intervention by study psychiatrist or psychologist—*all* appreciated it
- Products: partnered research papers, presentations
- Reputation/Visibility: locally and nationally
- Basis for new proposals and community funding
- Paradigm shift for community & academic partners

# Other Community Benefits

- Trainings: Over 150 training events in 18 months
- Leader Development: Trained experts (24 in CBT alone)
- CME, CEUs, certificates of appreciation
- Contributed resources for \$-matching requirements
- Research opportunities
- Data for community programs and policy makers
- Sustainable Resources: Website, toolkits, and leaders
- Hope: We can improve outcomes, save lives, and inform policy debates locally and across America together

# Challenges to Partnered Research

- Partners Need Resources: 1/3 academic, 1/3 community, 1/3 shared data and programs
- Infrastructure for Two-Way Capacity Building –
  - Training for academic investigators in Community Engagement
  - Training for community members in Research Concepts & Approaches
  - Developing a common ground—book club, retreats
- Supporting Partnered Presentations and Products
  - Mechanisms to facilitate community input
  - Supports for more vulnerable partners and patients

# Summary: How We Build Partnerships

- Build relationships and trust, supported by MOU
- Two-way knowledge-exchange activities
  - *Develop and use a common, simple language*
- Support working groups of diverse stakeholders
  - *Support for vulnerable partners*
- Develop joint action plans & programs
- Jointly disseminate information & products
- Social activities to build relationships

## ***In Partnership!***



# 2014 ACTS Team Science Award for CPIC!



Funders of CPIC Council: National Institute of Mental Health; National Library of Medicine; Robert Wood Johnson Foundation; California Community Foundation; UCLA Clinical and Translational Science Institute

# National Community Centers of Participatory Research Excellence

- Regional Hubs supporting local centers for community leadership in health
- Strong connections to academics and policy makers under a participatory model
- Co-leaders in research and evaluation to build community capacity to address community health priorities
- Social determinants of health/mental health, prevention and early intervention, community-centered healthcare

# Implications for Rutgers

- CPIC: Community Engagement and Planning is feasible and more effective than traditional training in evidence-based care and more effective in improving health and social outcomes, reducing hospitalizations while shifting outpatient services toward community agencies.
- The focus is on evidence-based strategies, adaptation to local culture, two-way knowledge exchange and stakeholder engagement.
- *Can this approach be adapted to partnered research in New Jersey communities?*

# **Discussion: HOW CAN IT WORK HERE?**

**What are your growth areas?**

**What are the challenges?**

**Potential strategies and lessons learned  
from CPPR**