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Developing a Community-Academic Partnership to Improve Recognition and Treatment of Depression in Underserved African American and White Elders

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Abstract

Objective—Reducing mental health disparities among underserved populations, particularly African American elders, is an important public health priority. The authors describe the process and challenges of developing a community/academic research partnership to address these disparities.

Methods—The authors are using a Community-Based Participatory Research approach to gain access to underserved populations in need of depression treatment. The authors identify six stages: 1) Collaborating to Secure Funding; 2) Building a Communications Platform and Research Infrastructure; 3) Fostering Enduring Relationships; 4) Assessing Needs/Educating about Research Process; 5) Initiating Specific Collaborative Projects (meeting mutual needs/interests); and 6) Maintaining a Sustainable and Productive Partnership. Data from a needs assessment developed collaboratively by researchers and community agencies facilitated agreement on mutual research goals, while strengthening the partnership.

Results—A community/academic-based partnership with a solid research infrastructure has been established and maintained for 3 years. Using the results of a needs assessment, the working partnership prioritized and launched several projects. Through interviews and questionnaires, community partners identified best practices for researchers working in the community. Future research and interventional projects have been developed, including plans for sustainability that will eventually shift more responsibility from the academic institution to the community agencies.

Conclusions—To reach underserved populations by developing and implementing models of more effective mental health treatment, it is vital to engage community agencies offering services to this population. A successful partnership requires “cultural humility,” collaborative efforts, and the development of flexible protocols to accommodate diverse communities.

Keywords

Community partnerships; depression; community-based participatory research

PUBLIC HEALTH CONTEXT

The elderly are especially likely to be under diagnosed or untreated for depression¹ and yet are at higher risk for committing suicide in comparison with other age groups.² Among the almost 35 million elders aged 65 and older, approximately 2 million suffer from some form of depression.^{3,4} Elders are frequently misdiagnosed and receive inadequate care despite the availability of effective treatment for depression.^{5,6} One contributing reason may be poor communication between clinicians and patients that increases the difficulty of detecting depressive symptoms.^{7,8} Although effective treatment strategies have been developed for broad dissemination in primary care, they have not been implemented.⁹

Despite the disabling nature of mental illness and the availability of effective treatments, less than half of the adults diagnosed with mental disorders receive care.¹⁰ Racial minorities and the elderly are less likely than the general population to seek treatment,¹¹ particularly African American (AA) individuals who have lived the experience of discrimination and racism.^{12,13} According to Walker et al.,¹⁴ racism and racial discrimination are the two leading factors that contribute to mental healthcare disparities. Mistrust of clinicians, the fear of hospitalization and treatment, and cultural mismatch between providers and patients¹⁵ are other recognized barriers to seeking mental health treatment.^{13,16}

COMMUNITY-BASED RESEARCH COLLABORATIONS

Reasons for mistrust include inadequate explanation of the research protocol,¹⁷ minimal or no community involvement in establishing the research,^{18,19} and negative past experiences,²⁰ some as historically rooted as slavery.^{17,21,22} It is, therefore, essential that clinical researchers develop relationships with community-based agencies serving minority populations to design and implement acceptable and evidence-based interventions for depression treatment.

We believe that the best way to address these issues of access, mistrust, and inadequate treatment is through collaboration with organizations that already serve older individuals especially minority seniors. In this report, we discuss the process of developing a partnership with 11 community-based social service agencies and healthcare centers in an effort to better reach underserved individuals and to bridge science and service. We also describe the partnership, the challenges and rewards, and early outcomes. Because our community partnership was established with both medical and social service agencies, we had the opportunity to identify multiple pathways to reach underserved populations.

Community-Based Participatory Research (CBPR) is the prevalent research approach to encourage public involvement and engage diverse communities to address research concerns that require working with different populations on ecologically based issues. These issues include social, cultural, political, and economic systems that influence behaviors and impact the access to resources.²³ The community engagement aspect of CBPR makes it a particularly relevant approach to reach the underserved, reduce mental health disparities, and work with populations who historically mistrust research and healthcare institutions.²⁴

Several essential elements of CBPR enable community partnership and citizen involvement to support the inclusion of organization leaders and citizens in the decisions and discussion area.^{24–29} The CBPR approach was used to develop shared approaches to resolve problems, reach people who need care, and raise awareness of health issues at the community level. This approach generated an opportunity to promote synergy between the community and community groups by using each member's unique perspective and distinct set of skills and experiences. This collaborative approach helped participants create projects and achieve

goals by having input into the research process,^{24,30,31} while empowering the community by sharing ownership of the products.

PROCESS OF DEVELOPING COMMUNITY/ACADEMIC-BASED PARTNERSHIPS—SIX STAGES

Our process of establishing a community/academic partnership developed slowly over a 3-year period. The partnership evolved through ongoing discussions and iterative review of ideas that eventually led to consensus at monthly meetings. We recognized distinct stages of the development through the review of notes recorded at the monthly implementation meetings, on-site meetings with partners, and other activities (i.e., in-services, outreach, and educational venues). Because the process continues to develop, we refer to it as a Developmental Model for Community-Academic Collaborations. In subsequent interviews with each of the community partners (CPs) at their centers, we discussed their perspectives of the challenges of developing the partnership and the resolutions. The CPs' comments are woven into the text to voice their views of the process of developing the partnership. Key definitions can be found in Table 1.

In the sections that follow, we describe six stages in our collaboration: 1) Collaborating to Secure Funding; 2) Building a Communications Platform and Research Infrastructure; 3) Fostering Enduring Relationships; 4) Assessing Needs/Educating about Research Process; 5) Initiating Specific Collaborative Projects; and 6) Maintaining a Sustainable and Productive Partnership, including implementing the research and interventions collaboratively identified. Table 2 lists the six stages, highlighting the activities, challenges, and outcomes at each stage.

Stage I—Collaborating to Secure Funding

The primary activity in Stage I was to establish initial relationships with community-based and academic partners to develop a working collaborative that would secure funding to fulfill a mutual mission. Preliminary findings from a large multisite study, PROSPECT,³² indicated that although the collaborative care model could be implemented in primary care for the treatment of depressed elders, engagement of AA elders was more challenging, and AAs had poorer outcomes than whites. These initial efforts (led by BM, CB, and CFR III) involved contacting potential partners in both the primary care and social service sectors to ascertain their interest in working toward reducing racial disparities in the recognition, assessment, and treatment of depression in older adults. A key part of the rationale for the selection process was to include partners who serve elders as part of their clients' population and who believe that depression would be a significant issue for their population to be able to address.

The development of this collaborative network began with university researchers who sought to concentrate on some of the barriers to care for older disadvantaged and AA adults. Mental health services investigators from Western Psychiatric Institute and Clinic at the University of Pittsburgh Medical Center, Advanced Center in Interventions and Services Research in Late-Life Mood Disorders developed relationships with the leadership of three community organizations committed to evidence-based care for minority elderly, the Coordinated Care Network (CCN), the Community Medicine, Inc., and the Mental Health America of Allegheny County. CCN is a faith-based integrated healthcare delivery system for underserved and uninsured populations. The Community Medicine, Inc. is a university-affiliated primary practice network. The Mental Health America of Allegheny County is a consumer mental health advocacy agency.

The initial efforts were led by BM and CB and involved a series of meetings with each potential partner to determine their interest in working with us on mental health issues and more importantly, for the researchers to gain a greater understanding about the context in which they work with older adults who might be suffering from depression. Over the course of approximately 1 year, numerous meetings were held with partners to collaboratively develop the focus of our work. University researchers took the lead in the development of the initial projects for which funding would be sought. Key issues that surfaced during these initial discussions involved the importance of sustainability and the need for open communication between researchers and CPs. Each agency expressed concern that any research program conducted should have a positive impact that enhances the mission of the agency after funding has ceased. Early thoughts from one CPs perspective stated the following, “Each of our partners had different things that brought them to the table—some was funding. From our perspective, we were looking for community-based outreach ... how we would fit in or fit at all.”

Agency representatives (usually the executive directors) also emphasized the need for open communication and many welcomed the opportunity to work in a truly collaborative fashion with university researchers. As one partner expressed, “It was not about the money for me, it was about the mission—the opportunity to definitely work with the university, the medical school, because there is often a gap in what we do in the field and what we do at your level. This was a great opportunity to work together!” Others saw this as an extension of the work that they had been doing within their own network, “It was intriguing—it was the first time I saw the network doing anything together, to be joined in a different way—to really have a dialogue.”

Differences of opinion were discussed openly and decisions were made through consensus. For example, one agency that belonged to CCN chose not to formally join the research partnership, because they did not want to “open the door to all of those researchers trying to study our community.” They had negative experiences with researchers who were insensitive and did not practice open communication. However, this health center agreed to participate in one project that interested them (the Depression Peer Educator Project), and this collaboration has been successful to date. Thus, CPs felt that it was important for each agency to decide how and if they would participate in specific projects.

Early challenges included developing shared goals and writing a grant proposal. Financial constraints had particular impact on the CPs, because their time expenditure was not fully compensated. Further, the initial set of ideas for collaborative projects was fairly open for discussion. Projects that were funded before the partnership did not offer the opportunity to receive input from the newly formed partnership; whereas, projects in the formation stage did (i.e., protocol design, participant burden, and community beneficence). One of the most difficult challenges for CPs was the distinguishable gap between research and practice. One of the CPs expressed, “I think the major problem is with academics understanding the practical ... It is frustrating. We function on two entirely different levels. We do not know academia, and academics do not know the day-to-day practice.”

Despite initial challenges, the partnership competed successfully for an National Institute of Mental Health Center (NIMH) funding (P30MH071944) with a Research Network Development Core (RNDC) (2005–2010) with the goal of establishing a research infrastructure for investigating models of effective evidence-based depression treatment in partnership with community-based organizations. These resources could then be applied for implementing a process that included extensive participation by CPs. Within the first few months, when funding became available, greater trust ensued. Partners were compensated for attending meetings and parking costs.

Currently, there are 11 diverse community-based agencies involved in the working partnership including: three community-based family healthcare centers and eight social service agencies (two of the social service agencies also offer healthcare services). Services include supportive housing and homeless programs, case management services to the underserved, and food services (e.g., soup kitchen). These agencies also include a Salvation Army Center that provides referral to community supportive services and two mental health consumer advocacy agencies.

Stage II—Building a Communications Platform and Research Infrastructure

The major activities during Stage II were to develop the working mechanisms for effective communications between the community-based organizations and the academic partners and to establish a research infrastructure. For the CPs, the challenges began with communications and developing an understanding of the mission of this newly formed partnership. One CP felt overwhelmed initially, “I’m going to be working with all these academics, who are all into research. I’m never going to be able to understand them, or to understand research.” Another CP expressed, “I noticed that we speak different languages ... It took time for both groups to develop an understanding of the languages.” The problem with the languages was resolved over time and interacting, especially as the RNDC investigators spent considerable time at the CPs’ sites.

Concurrently, although the partnership was in the formation stage, the Clinical Core of the Advanced Center in Interventions and Services Research in Late-Life Mood Disorders was anticipating that the RNDC partnership would be a possible recruitment source for minority populations. The National Institutes of Health recognizes that to better understand the causes of disparities in health, and to improve the interpretation of research findings, minority populations must be represented in clinical research. Internal challenges occurred when the Clinical Core had expectations for the RNDC partnership to help recruit AA into existing clinical protocols. As would be expected, this conventional clinical model did not mesh well with the philosophy of the CBPR approach supported by the RNDC partnership.

To demonstrate the methodological differences between the RNDC partnership and the Clinical Core, we place them within the context of four models of collaboration described by Hatch et al.³³ (Table 3): 1) advice or consent givers—researchers consult with a community adviser for advice without the community members being aware of the research; 2) gate keepers—researchers identify influential members of the community to endorse the research: however, the researchers retain complete control; 3) deliverers of programs—support is requested from influential leaders in the community to hire members of the community’s frontline staff (e.g., interviewers, outreach); and 4) community-engaged partners—community members actively participate in the research, providing input at each stage, including the identification of research topics, protocol design, assessment, data interpretation, and participation in presentations and authorship.^{34–36}

Our efforts were designed to fit most closely with the fourth of these models. As our experience demonstrates, CBPR increases opportunities to engage underserved individuals who historically mistrust researchers and institutions.^{24,37–40} During this early stage of the partnership, one partner commented, “There were too many vocal academics in the beginning ... People who I perceived to be in charge seemed to want to protect the community members from the academics.” For example, a clinical investigator was invited to a Partners meeting in an effort to recruit CPs for a research project. From a CPs perspective, “Some of the people who attended one or up to three meetings, came in with their own agenda and tried to make it our agenda ... I wondered what in the hell it had to do with what we are doing ... If there would have been one of those presentations every time, I would’ve stopped coming.”

In an effort to resolve the problem of minority recruitment, the Clinical Core later utilized recruitment efforts that more closely resemble Model 3 (deliverers of programs). For example, a depression-prevention project (P60MH000107) with the goal of recruiting 50% AA elders collaborated with academic researchers with influential community leadership in the University of Pittsburgh's Graduate School of Public Health during the research design, protocol development, and grant funding stages. This model is community based, but not community participatory, as the community is asked to be involved mainly as research participants, after protocols are largely established.

Stage III—Fostering Enduring Relationships

An essential part of developing and maintaining enduring relationships with our CPs was to clarify goals and parameters that would facilitate the development of a constructive working framework. In general, the Principal Investigator of the RNDC led discussions and facilitated input from the researchers and CPs. The mechanisms of discussing issues were perceived by CPs as follows:

“Many ideas have been discussed around the table each month. Typically, we discuss ideas during a meeting ... then present interpretation of ideas at later meetings, and discuss plans for moving forward.” Another CP stated, “It is an opportunity to keep on pursuing an issue until it is satisfactory to you and to us. It sometimes seems like it is too much, but you have to do it. You think there has got to be an easier way, but there is not. The variety of agencies involved is spectacular. It makes it harder to get a common understanding.”

The intention of many of our meeting discussions was to reach consensus regarding the goals and objectives of the projects while being aware of the benefits that a project may offer to the agencies. The research may not benefit the agencies directly but may influence the needs of the agencies indirectly. In one of the CP centers where we were conducting a study on doctor and patient communication one CP stated, “We do not know how it occurred but since your group has been here, we have on-site mental health help with outreach workers. The end result has been that your presence has helped make the clinic more full service and we can better help our people.”

Initially, some CPs entered this partnership with reluctance due to past experiences of unmet commitments from academic institutions, (e.g., program promises not met; funding not distributed in a timely manner). One concern voiced by a CP stated, “I did not want my place turned into a laboratory for academics to do their research and look at my people ... nor just to provide an opportunity for academics to write papers.” When concerns were raised, our leadership encouraged open discussion to address each issue directly. The concern with speaking different languages was resolved as follows, “We got more comfortable with the language over time. There was more interacting and you came here and saw ... you had an interest in helping the folks I deal with every day.”

The stage of fostering relationships was perceived by other CPs as an opportunity to grow and to share information about their agency. One partner commented, “I thought the mechanisms in the meetings did not allow people to get away with just sitting there ... I felt that the academics were very curious about us—they really wanted to know what we do. It really was positive and a wonderful curiosity and people got to brag on themselves.” Another partner commented, “There were two benefits—first, we have a stronger working relationship with you folks [academics] and second, at least an understanding, if not a working relationship with the other partners that we probably would not have developed alone ... It increased our awareness of the other agencies and what they do.”

Although the initial pilot projects were developed for implementation in primary care settings, we found that interest in depression care by the non-healthcare agencies provided a unique opportunity to develop methods to improve the recognition of depression and to increase treatment access. For partners interested in participating in these existing projects, we met on-site with the staff. The meetings were attended by the key members of the RNDC team (e.g., principal investigator [PI], research assistants) to determine whether our goals were aligned with those of each agency. We used insights gained from these meetings to make protocol modifications to “better fit” that agency. One CP commented, “The more you came here and got to know about what we did and how we worked helped us to trust you more. You were not just trying to get funding for yourself.”

Stage IV—Assessing Needs/Educating about Research Processes

In this stage, we had several objectives: 1) demonstrate our commitment to assist CPs in achieving their goals; 2) provide an educational process of collaborative research; and 3) collectively develop ideas for concrete research projects. To achieve these objectives and to be able to identify and establish new research projects beneficial to the CPs, all participating agencies worked collaboratively to design a needs assessment. This project demanded considerable time investment of the CPs (e.g., participating in focus groups and interviews, questionnaire development) and was a demonstration of their commitment. The goal of the needs assessment was to understand the services each CP agency provides, their perceptions of the mental health needs of their clients, common barriers experienced by their clients in accessing mental healthcare, and any other issues they encounter in providing services. We employed both face-to-face interviews and self-report questionnaires to obtain the data. Twenty-six agency representatives responded: 10 Executive Directors and 16 managers or staff who play key roles (e.g., program directors, board members). Collectively, these agencies serve on average 1,027 (range: 134–3,500) racially diverse individuals each month. The interviews took place at each of the 10 sites between May and August 2006. The needs assessment findings will be reported separately.

One of the most difficult challenges in developing projects and educational outreach is that of sustainability. A primary objective for all projects is to ensure ongoing funding for continued, uninterrupted support. Criticism from CPs working with researchers in the past has been that funds are available for short-term interventions only. RNDC goals have been to develop a working community-based research infrastructure that ensures sustainability of successful interventions. This required educating CPs about the research funding process and developing programs based on their needs. We spent considerable time working on proposal submissions to local foundations to secure ongoing funding for projects that were developed during the initial funding period.

We worked with our CPs to provide an educational process of collaborative research. One example was collaboration with one agency on a foundation grant submission in which they subsequently received funding. Another example was the RNDC PI who is a clinical psychologist provided scientific input to one health center for a grant submission to better address depression recognition and screening. The RNDC PI has also provided letters of support to agency partners for their own programmatic funding applications. In addition, the RNDC investigators and outreach staff provide a variety of research seminars for mental health education to the CPs regarding mental health, depression recognition, and screening. We are currently implementing a research training workshop to better educate the community about the Institutional Review Board and informed consent process.

Stage V—Initiating Specific Collaborative Projects

In the earlier stages of the partnership, before we secured foundation and state funding, we had limited financial resources to devote to program development but used the time to provide education and outreach to the CPs. The needs-assessment participants identified issues affecting their ability to provide services to their consumers, including the availability of training about mental health issues for their frontline workers (e.g., outreach workers, food service workers, and medical assistants). A collaborative grant-seeking effort between the RNDC and CPs resulted in funding from Staunton Farm Foundation to formalize educational efforts. The Mental Health Training Program for Front-Line Workers being developed will provide on-site training in five core competency areas: 1) recognition of common psychiatric disorders in adults; 2) communication skills; 3) boundary issues; 4) crisis management; and 5) cultural competency. The trainers are experts who participate in the partnership.

More recently, the Partnership developed a Care Manager and Depression Peer Educator model that is the focus of an exploratory grant application (R21). We responded to an NIMH grant program, “Community-Based Participatory Research at NIMH” to help us solidify the collaborative relationship through research activities designed to improve mental health-care for depression. We built upon the community-academic research capacity and partnerships already established to address the identified needs by pilot testing an intervention for identifying, referring, and following-up with people in need of mental health-care for depression.

Other ongoing efforts become established as needed and to gain the clients’ perspective. For example, the RNDC outreach and educational experts develop and deliver workshops in community centers to educate the elderly about depression recognition and treatments, and the identification of early signs of dementia. RNDC staff participate in CPs’ activities that include giving key-note addresses at fund raisers, assisting with clothing drives, and participating in CPs’ soup kitchens.

Stage VI—Maintaining a Sustainable and Productive Partnership

The value of commending the partnership and acknowledging the productivity of the collaboration cannot be underestimated as a means of sustaining it. These accolades come from investigators and/or CPs and serve to reinvigorate the relationship and express that we do not take each other for granted.

We have provided and will continue to provide grant-writing assistance to the CPs and we encourage members to collaboratively seek funding. Two CPs applied to become an NIMH Outreach Partner in August of 2006 and were funded as National Partners. This Partnership increases the ability of these organizations to provide culturally appropriate, science-based research information on mental health, mental illness, and substance-use disorders. The RNDC-Community Partnership has served as a platform to expand CPs work. In addition, we have collaborated on the development of a grant proposal recently submitted by one CP to a local foundation to support outreach and education regarding depression and comorbid diabetes, hypertension, and cancer across Southwestern, PA.

The CPs have suggested developing a consortium to establish greater crossagency use of services among the members by providing avenues to share resources. A subcommittee devoted to sustaining projects and programs has been formed. The CPs will assume responsibility for approaching federal, state, and county agencies to obtain sustainable funding to maintain programs. In this context, RNDC investigators and CPs received a \$300,000 contract from the Pennsylvania Department of Public Health to support shared projects.

DISCUSSION

To date, existing mental health services have been inadequate in reaching and effectively treating underserved individuals. It is imperative that mental health services researchers expand and modify interventions that will increase treatment participation by the diverse population of underserved persons who suffer from the debilitating effects of untreated depression. Research has traditionally been deeply rooted in a clinical model based on established protocols, testing specific treatments, and measuring outcomes in a clinical environment. This model has failed to reach underserved and minority populations because it does not address common barriers.

The CBPR model addresses this shortcoming by fostering partnerships with the agencies that serve these populations, seeking guidance from the community to assess its unique needs in the design of culturally appropriate interventions. Establishing a community/academic partnership is a complex undertaking that requires dedication and significant time commitment from both the academic and community members at each stage of development. Particularly during the first stage, community-based research efforts initiated by academic organizations, especially in mental health, may be impeded by a history of unbalanced control over the research protocol and administration, and by withdrawal from the community after introduction of valued programs that are sustained only for the duration of the research award. Researchers must be prepared to address these historical issues by establishing open communication with the CPs, sharing control of the agenda, interacting in a culturally sensitive manner with the individuals whose research participation is sought, and securing funds to sustain effective interventions and programs. This collaborative approach can be used to lay the foundation for evaluating the effectiveness of depression treatments, adapting them as needed, and disseminating them in diverse settings.

RNDC investigators and staff constitute a racially and ethnically diverse group who are culturally sensitive to working in community-based settings. The development of cultural competence or “humility” is an ongoing task for all members.⁴¹ As stated by Minkler, 27; p 691 “Although none of us can truly become “competent” in another’s culture, we can approach cross-cultural situations with a humble attitude characterized by reflections of our own biases and sources of invisible privilege, an openness to the culture and reality of others, and a willingness to listen and continually learn.”

Thus far, the partnership approach has shown promise in designing an intervention in reaching the underserved. We developed a proposal to identify, evaluate, refer, and follow-up persons with depression in community primary care and social service settings to evaluate the acceptability and to assess the feasibility. The proposed intervention is currently under review at NIMH. We have maintained a 3-year partnership, made stronger through the regular attendance at monthly meetings of representatives of the participating agencies. CPs serve on subcommittees to ensure continued input in all phases of research. Meetings have been instrumental in promoting trust between the CPs and the RNDC, strengthening members’ commitment to the collaboration, and obtaining foundation, state, and federal support to develop research protocols specifically designed to address needs identified by the community. This process empowers CPs by their sharing in the ownership of the programs and products developed. One CP shares her expertise as a trainer for the frontline worker program. By addressing concerns about communication, education, and cultural competency identified by CPs, we have established relationships that give every indication of an enduring collaboration.

CONCLUSION

To reach underserved individuals with mental health needs and to develop and implement appropriate and acceptable models of treatment, we believe that it is vital to enlist the help of community members. This approach necessitates more flexibility and openness than the traditional clinical paradigm by involving, at every stage, the leaders, agencies, and individuals living and working within each of the underserved communities. It also requires systematic, longitudinal efforts to establish and build the relationships with simultaneous attention to the “content” of community needs and the development of concrete products that benefit all parties.

We found that a working partnership has required “cultural humility,” collaboration, dedication, and the development of culturally sensitive protocols tailored to accommodate diverse communities. Our partners are the experts in the community; this is the premise on which we proceed.

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TABLE 1

Definitions

Term	Definition
Research investigators	Faculty and staff of the university-based Research Network Development Core (RNDC) at the University of Pittsburgh School of Medicine
Community partners	Partnering community agencies
Community	Refers to the individuals who reside in a diverse collection of ethnically and racially distinct neighborhoods in Allegheny County, Pennsylvania served by the RNDC-Community Partners and have a shared set of needs, interests, and values and common characteristics of socioeconomic status, educational attainment, employment rates, access to resources, and health disparities. They also have in common a rich network of social resources that include churches, community centers, and dedicated individuals

TABLE 2

Developmental Model for Community-Academic Collaborations

Stages	Highlights of Activities	Challenges	Outcomes
Stage 1: Collaborating to Secure Funding	Initial contacts with academic and CPs	Finding investigators and community leaders with mutual interests	Academic and community leaders develop partnership with overall goal of improving recognition and treatment of depression
	Getting acquainted	Significant time investment—projects for future funding are not supported currently	NIMH funding (P30MH071944)
	Establishing objectives and negotiations	Develop goals to encompass group diversity	Establish relationships
	Meetings to generate ideas, determine goals, write proposals and apply for funding Change in leadership		
Stage 2: Building a Communications Platform and Research Infrastructure	Establish working communications	Academics and CPs speak different languages	Increased interactions and time in the community resolve speaking different languages problem
	Share goals of existing research projects and interests with CPs	Expectation from Clinical Core for RNDC partnership to recruit AA minorities into existing clinical protocols	Projects—agencies desire to participate after adaptations to existing protocol
	Offer CPs an opportunity to participate in existing research projects		Clinical Core begins to have a better understanding of methodological differences
Stage 3: Fostering Enduring Relationships	Meet monthly for implementations meetings	Concerns regarding problems historically working with University	Communicate and address issues in monthly working meetings
	Discuss expectations, goals, and objectives	Reiterate information in subsequent meetings to ensure accurate understanding of group ideas	Develop common understanding of information
	Review information in meetings and report progress of projects		Develop shared values, respect, and trust
Stage 4: Assessing Needs/Educating about Research Process	Collaboratively develop and conduct a needs assessment to better understand the CPs' services, mental health care needs, and challenges affecting clients' access to mental health care	Significant undertaking of time: scheduling interviews, collecting qualitative and quantitative data, coding transcripts, analyzing data, and determining needs	Needs Assessment Report completed summer 2007—used by CPs to share with Board and by the partnership in seeking funding for needs
Stage 5: Initiating Specific Collaborative Projects	Using results from the needs assessment: review findings, generate research ideas, develop plans, projects, and goals to accomplish needs	Must increase staff to support needs	Product developed collaboratively Develop educational and outreach programs
		Work with limited financial resources initially to develop programs to support needs	Funding—frontline worker training from Staunton Farm Foundation

Stages	Highlights of Activities	Challenges	Outcomes
Stage 6: Maintaining a Sustainable and Productive Partnership	Establish relationships to continue projects, mutually develop budgets, seek additional funds, and make financial commitments	Continued support for most promising projects and programs that were developed	Develop depression care manager and peer educator model R-21 Develop sustainability subcommittee Develop consortium for utilizing resources Funding—NIMH Outreach Grant Funding—PA Department of Public Health

TABLE 3

Models of Community Research

Models	Access	Community Role	Outcome
1. Advice or consent givers	Often consultant or advisor works for human service organization and usually lives outside the community	The community members have no influence and are unaware of the purpose of the research	Research is community based but fails to achieve optimal involvement
2. Gate keepers and endorsers of the research	Identify influential people (e.g., churches, clubs, fraternal orders, and civic associations)	The research design is explained to endorser. Researcher retains total control of research project	Research is community based but the community role is essentially passive
3. Deliverers of research or programs (e.g., front-line staff)	Contact influential community leaders	Ask for guidance in hiring community people to work for the research project	Research is community based but not community involved. Members do not have a significant role
4. Active participants in the direction and focus of the research	Community members are collaborators	Community members provide input and negotiates in direction, design, focus, goals, conduct, analysis, and use of the study findings	Research is community based and community involved as well. The community members are aware and part of the decisions and direction

Note: From Ref. ³³.