

Project Descriptions**University of California Los Angeles/
RAND Corporation****Center for Research on Quality in Managed Care****Cognitive Behavioral Intervention for Trauma in Schools**

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LAUSD Crisis Counseling and Intervention Services, UCLA, RAND

BACKGROUND/RATIONALE: CBITS, a school-based mental health program for students exposed to violence, has been developed through a community-based participatory research partnership between Los Angeles Unified School District Crisis Counseling and Intervention Services, the UCLA Health Services Research Center, and RAND Health. The CBITS program was initially developed in response to the school district’s concern about the overwhelming number of students who talked about traumatic experiences. It became apparent that LAUSD and its staff knew about only the “tip of the iceberg” of trauma exposure among their students, and did not fully understand the negative effects the violence exposure had on the students’ mental health, their ability to learn, and to attend in school. A needs assessment survey by the CBITS team soon made it clear that violence exposure and PTSD were critical issues to the students of LAUSD. Not only did 85% of students report having witnessed violence in their community or at school, with 40% having exposure to violence with a knife or gun, but 27% reported PTSD symptoms in the moderate to severe range and 16% had clinical levels of depression.

The CBITS program was then developed in partnership with school-based clinicians to ensure that the intervention integrated the best available science in treating PTSD with the practical aspects of delivering a program in schools by school-based clinicians. It was also developed with the multicultural students and their families of LAUSD in mind and from the start was offered in languages including Spanish, Korean, Armenian, Russian and English and delivered by bilingual, bicultural school based clinicians. Dr. Wong first led the effort to develop the CBITS program with researchers from UCLA and RAND in 1998, which was specifically developed for use by school-based clinicians.

The following study results were published in JAMA in 2003.

OBJECTIVES: To develop a trauma-focused mental health intervention appropriate and sustainable for delivery in schools and by school-based clinicians. To evaluate this intervention

for effectiveness in decreasing trauma-related symptoms and improving functioning in students exposed to community violence.

METHODS: This study used a randomized controlled trial design to evaluate the effectiveness of the CBITS intervention. Sixth-grade students at two large middle schools in Los Angeles who reported violence exposure and had clinical levels of post-traumatic stress symptoms participated in the study. Students were randomly assigned to a 10-session standardized cognitive-behavioral therapy group intervention (n=61) conducted by trained school mental health clinicians or to a wait-list control group (n=65).

FINDINGS: Compared to the control group, students randomly assigned to the intervention had significantly lower post-traumatic stress symptom scores (8.9 vs. 15.5, adjusted mean difference -7.0 (95% confidence interval [CI -10.8 to -3.2]), depressive symptom scores (9.4 vs. 12.7, adjusted mean difference -3.4[CI -6.5 to -0.4]), and psychosocial dysfunction (12.5 vs. 16.4, adjusted mean difference -6.4[CI -10.4 to -2.3]). There was no significant difference in adjusted mean differences in teacher-reported acting out (-1.0[CI -2.5 to 0.5]), anxiety/shyness (0.1[CI -1.5 to 1.7]), and learning (1.1[CI -2.9 to 0.8]) classroom problems.

STATUS: The LAUSD in partnership with UCLA and RAND has been awarded funding through the Substance Abuse and Mental Health Services Administration (SAMHSA) as the lead school-based site to disseminate evidence-based practices such as CBITS as part of the National Child Traumatic Stress Network, a network of over 50 sites nationwide dedicated to providing trauma-informed services to youth with traumatic experiences. Following the results of the CBITS evaluation supporting the program's effectiveness in reducing symptoms of PTSD and depression, additional data has also suggested that as PTSD symptoms have decreased, grade point averages improve. This has led to increasing support from educators and school communities to adopt this intervention. The CBITS program has been disseminated to a wide range of sites across the country.

A number of additional projects have emerged to support the dissemination of CBITS: the CBITS manual, by Dr. Lisa Jaycox, has been published by Sopris West and now the LAUSD partners are preparing a compendium CBITS Implementation Toolkit; Dr. Marleen Wong has been awarded a Mark Taper Foundation grant to develop a Train-the-Trainer model for CBITS which has led to a number of LAUSD clinicians trained to disseminate CBITS both locally and nationally; Dr. Jaycox is developing and evaluating an adaptation of CBITS for delivery by teachers and other non-mental health professionals in schools (NIMH R01); Dr. Kataoka is studying quality improvement methods in schools to adapt CBITS for students receiving special education services (NIMH K Award); and Dr. Kataoka is also adapting CBITS for use in the faith-community (EXPORT Disparities Center pilot).

IMPACT: CBITS has been recognized by the U.S. 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 (NREPP), the Promising Practices Network, and the Office of Juvenile Justice and Delinquency Prevention (OJJDP). CBITS has been disseminated to a wide variety of communities over the past several years, from Native American reservations in New

Mexico and Montana, to school districts in Madison, Wisconsin, inner city areas such as Baltimore and Chicago, and rural areas including Olympia and Yakima Washington. This summer CBITS trainers from both UCLA and LAUSD will continue to train large groups of clinicians in the Gulf States as they prepare to support the survivors of Hurricane Katrina.

Identifying Effective Provider Incentives to Improve Depression Care

PARTNERS: Susan Ettner, PhD, Lisa Meredith, PhD, Michael Schoenbaum, PhD, Francisca Azocar, PhD, and Robert Branstrom, PhD

BACKGROUND/RATIONALE: Overview of provider-based incentives: Health care providers play a central role in delivering quality mental health care because they interact with most other relevant stakeholders, including patients and insurers. One possibility for increasing rates of appropriate treatment is thus to motivate providers to change patterns of care. Provider financial incentives, which tie performance to reimbursement, have garnered recent attention among purchasers. Such an approach is supported by the recent “Quality Chasm” report (IOM, 2001), which suggests that current payment systems include many barriers that inhibit high-quality care and recommends explicitly that organizations build stronger quality improvement incentives into these systems. While such incentives hold promise for improving care, their effectiveness is likely to depend on a number of factors, including whether the incentive is tied to the performance of individual providers vs. groups of providers; the amount of the incentive; and the interaction between performance-based payment systems and non-financial interventions (NHCPI, 2002). These and other factors determining a successful financial intervention have not yet been explored in the context of depression care in the specialty sector. Non-financial provider incentives may also influence performance improvement (NHCPI, 2002) by linking good performance with non-monetary reward. Many of these approaches are based on social psychological models that predict behavior and behavior change as a function of social influence from and comparison with peers, behavioral capacity (knowledge and skills), and expectations and how these factors interact with the practice environment (Bandura, 1986; Ajzen & Fishbein, 1980). For example, performance profiling may be a valuable quality improvement tool if good performance data are available and it is presented to providers in an easily interpretable format (including consistency across insurers) because providers can compare their performance with their peers. Other forms of behavioral-based non-financial incentives include publicizing performance, which may influence providers to provide more evidence-based care. Finally, practical interventions that alleviate burden to providers, such as eliminating administrative requirements or providing technical assistance for quality improvement, also have potential for improving care. While provider education alone is generally not sufficient for producing enduring provider behavior change (Davis et al., 1995), financial or non-financial incentives might be paired with provider education to reinforce and motivate good performance.

OBJECTIVES:

- To elicit and identify promising and viable provider incentive strategies that will improve care for depression with a large MBHO.
- To select the most promising option among the viable alternatives.

- To conduct a small pilot study to assess whether the most promising option is indeed feasible.
- To develop and submit a follow-on RO1 proposal that would implement and evaluate the most viable provider incentive packages.

STATUS: The co-PIs (Ettner, Meredith, and Schoenbaum) have biweekly calls with the UBH collaborators (Azocar, Branstrom). In the past year, we completed our round 2 stakeholder interviews and performed qualitative analysis with the data from both rounds. We then conducted an all-day stakeholder meeting in San Francisco to present the preliminary findings from the phone interviews and identify the most promising interventions, i.e., the provider behaviors to incentivize and the best financial and non-financial incentive methods to use in conjunction with each behavior. Prior to the panel meeting, we asked participants to prioritize several behaviors and to select one financial and one non-financial from the list of incentives identified for each behavior. Following the day-long meeting, the most promising behaviors identified by the stakeholder group were combination therapy and increasing the rate of guideline-concordant antidepressant treatment (e.g., incentivizing longer duration and/or more appropriate dosage). Per-patient bonuses were suggested as the financial incentives. Non-financial incentives included the provision of on-line tools and mailed educational information to clinicians as well as feedback mechanisms. We are currently examining the feasibility of the interventions identified through the consensus panel, based on the constraints of the UBH systems data. We have also been exploring the possibility of using UBH's existing outcomes data (the TOP survey) and case management process to build on our own intervention component.

Due to the unanticipated merger between United Behavioral HealthCare and PacifiCare Behavioral Health, it has become necessary for us to wait until the details of the new system have been decided (e.g., which outcomes management system will be adopted) before continuing to plan the implementation of the feasibility study. In the meantime, we have turned our attention to carrying out a series of analyses based on UBH administrative data (as described in the original grant application). The purpose of these analyses to identify the extent to which targeting each of the various clinician behaviors suggested as the focus of the intervention is likely to improve the quality of depression care. For example, we are assessing the extent to which combination therapy is already being provided to UBH patients and whether the antidepressants are being prescribed by psychiatrists or PCPs, using data from several large employers for whom UBH has linked behavioral, medical and pharmacy data.

Findings to date will be presented at the upcoming Academy of Psychosomatic Medicine in November.

SIGNIFICANCE: This project will develop some creative strategies to approach both provider incentives and attitudes in promoting quality of care for depression.

IMPACT: In addition to presenting our preliminary findings during two Center-sponsored seminars at UCLA, Drs. Meredith and Azocar gave an oral presentation at the 2005 Academy Health annual meetings.

RAPID EVALUATION AND ACTION FOR COMMUNITY HEALTH IN LOUISIANA (REACH-LA).

PRINCIPAL INVESTIGATORS: Benjamin Springgate, Jeanne Lambrew, Kenneth Wells, and the REACH-LA Community and Scientific Advisory Boards

BACKGROUND: The disaster of Hurricane Katrina and associated levee failures impacted regional health care services delivery and disrupted community social networks to a greater extent than any disaster in United States history. While emerging evidence reveals a variety of levels of health and community needs related to the disaster, there has been little systematic documentation of community priorities for health services as needs change locally during the disaster recovery period. In addition, there have been few efforts to initiate a community-engagement process that supports local voices in health policy planning.

METHODS: In April of 2006, I obtained funding for and convened a community advisory board (CAB) representing diverse interests in grassroots health programming in post-Katrina New Orleans. We have been working on a mutually agreeable agenda in the health area, and as the first step in this process the CAB nominated key informants representing leaders in health policy, health care services delivery, and community health from New Orleans. We are in the process of selecting which of them to interview about the current challenges and potential solutions for access to health services in the New Orleans area. We are using a maximum variation sampling strategy to select informants for participation in these semi-structured interviews. Interviews will be recorded, scribed, and transcribed for analysis using grounded theory. Themes from interview transcript analyses will serve as the basis for community based discussion groups that will be organized by the CAB. Community members during these discussion groups will be asked to identify local resources and community driven solutions for the health and health care concerns in the post-disaster New Orleans area. Notes and data from the discussion groups will be triangulated with the interview themes to identify similarities and differences in healthcare priorities and solutions across multiple stakeholder strata (i.e. health policy leaders, health services leader, community health leaders, and health care consumers). A first phase report will document the findings from this process for policy makers and health sector planners in Washington D.C. as well as locally. A community feedback conference will provide community members with a forum to plan action steps for the priorities that emerge in the course of this post-disaster community based participatory planning process.

RESULTS AND CONCLUSIONS: By the time of the November meeting, my community partners and I will be in a position to present results from the interviews and community discussions including themes that emerged and potential action items. Hopefully this experience will guide policy development specific to the adequacy of health services in the New Orleans area and serve as a model for post-disaster planning and policy development when other communities are similarly affected.

KEY WORDS: Hurricane Katrina, disaster, health policy planning

The Wellness Center Initiative: How do we evaluate and measure short and long term outcomes in a community based participatory project to enhance recognition and treatment of mental illness in South Los Angeles?

PARTNERS: Kavita Patel, Ron Wright, Kathy Daly
Los Angeles County Department of Mental Health, Ecumenical Congress of Black Churches

BACKGROUND: For African Americans who live in the community, rates of mental illness appear to be similar to those for whites (2001 Surgeon General Report)¹; however, in high need populations such as South Los Angeles, African Americans are overrepresented and have a much higher rate of mental illness. Safety net providers, such as the county’s mental health departments furnish a disproportionate share of mental health to African Americans. The financial viability of such care has been repeatedly threatened as the sources of public funding for such care are in competition with limited budgets and cost reductions. Innovative mechanisms to solve these barriers and disparities are important topic areas for mental health advocates and researchers. In a 2001 quality care report issued by the Department of Mental Health of California, the oversight committee (composed of key policymakers, researchers, providers and consumers) recommended that a key component of overcoming such disparities was the interdisciplinary aspect of mental healthcare delivery as well as the engagement of the communities in which affected populations reside. In Los Angeles County, the geographic service planning area known as SPA 6 has the highest density of African American mental health consumers.

According to the 2001 California Health Interview Survey (CHIS)², an estimated 17.3% (n=34,000) African Americans in South Los Angeles stated that they needed help for emotional/mental problems. The same study found that 13.4% of the African American population in South Los Angeles had great difficulties or delays in getting mental health care. When analyzed by insurance type, those individuals primarily insured by Medicaid had the highest degree of difficulty obtaining mental health care (27.7%). These findings, coupled with the recent recommendations of the State of a Black Los Angeles Report (2005)³ call particular attention to the need for innovative and creative mechanisms to both facilitate community/leadership engagement as well as deliver high quality, accessible mental health care to underserved communities.

This proposal seeks to address the disparity in care for mental health in the African American community of South Los Angeles through promoting implementation of an evidence-based, community partnered program in a county sponsored wellness center. In particular, a community based partnered approach between providers, researchers, community members/leaders and faith based organizations will serve as the core innovation of the proposal, thus allowing for any intervention or change to sustain itself over time and well after completion of the proposed project. Currently, the Los Angeles County Department of Mental Health has approximately three Wellness Centers which are structured on a peer-based interdisciplinary model of care.

¹ Executive Summary 2001 Mental Health: Culture, Race and Ethnicity a Supplement to Mental Health: A Report

² 2001 California Health Interview Survey (CHIS)

³ State of a Black Los Angeles Executive Summary and Report (2005)

A wellness center offers several advantages to the usual care system in public mental health. First, it is primarily peer and consumer driven which offers an alternative to the hierarchical model of mental health care in which a patient is treated by a physician who might not have a cultural or social contextual understanding of the various factors which have brought the patient to seek treatment in the first place. Second, it offers a place for treatment beyond medication; it offers an opportunity for empowerment, autonomy and support in areas traditionally not addressed adequately by healthcare providers such as employment, housing and language skills.

SPECIFIC AIMS:

1. To facilitate a community-based planning process for a Department of Mental Health Wellness Center in South Los Angeles in partnership with faith-based organizations and other community leaders
2. Assess early impact of wellness center on direct and indirect mental health indices
3. Develop framework for an evaluation process of both the planning and implementation of such a wellness center.

Witness for Wellness (W4W)

PARTNERS: Loretta Jones, MA and Kenneth Wells, MD, MPH; co-chairs
Healthy African American Families and University of California, Los Angeles

BACKGROUND/RATIONALE: Depression is one of the leading causes of morbidity and disability worldwide. Despite the existence of effective treatments, only one in four Americans with depression receives appropriate treatment, and the rate is especially low among African Americans. When African Americans and other minorities participate in quality improvement efforts in a health plan, clinical improvement is greater than among whites, and both groups benefit in terms of personal economic growth (Wells, et al., 2000; Schoenbaum, et al., 2001). Depression often occurs with other diseases such as obesity, heart disease, infant mortality, and diabetes, which persist in minority communities at devastating rates.

OBJECTIVE(S): The overall goal of W4W is to build community capacity to relieve the burden of depression within historically under-served and predominantly minority communities, primarily in South Los Angeles. The process of building community and academic capacity is another goal of W4W. W4W uses a community participatory partnership research (CPPR) approach developed by HAAF, Drew University, and Project EXPORT.

METHODS: There are three working groups that are part of W4W and are governed by the Wellness Council. The council used several features of the HAAF model for partnership to facilitate group development. The workgroups, Building Wellness, Supporting Wellness, and Talking Wellness, each chose its own research projects. Each workgroup has a community and academic co-chair. All the activities of each workgroup are chosen collaboratively from planning to execution. Building Wellness develops outreach strategies to improve access to

quality care. Supporting Wellness advocates for policy change for depression care. Talking Wellness works to decrease stigma around depression.

FINDINGS/RESULTS: Building Wellness is piloting a project to test the feasibility of implementing an online toolkit the group developed for non-mental health professionals to provide depression screening, education, and referrals for treatment. Supporting Wellness created a questionnaire that was collected at the African Marketplace. Talking Wellness supported a Spoken Word/Poetry event at the Pan African Film Festival, where they also collected answers to a questionnaire that had been developed by the group. A subgroup met separately to analyze the data and reported the results to the community earlier this year in a community forum. Supporting Wellness is developing a PSA about depression and has represented the community at stakeholder meetings to determine the allocation of Proposition 63 moneys for mental health spending in Los Angeles. Each of the workgroups of W4W was featured in its own article in *Ethnicity & Disease*, 2006, 16(S1).

STATUS: Each of the workgroups continues to meet monthly and work on their individual projects. Building Wellness is piloting a project that evaluates the feasibility of a toolkit to improve screening, education, and referrals for depression in non-mental health settings. Supporting Wellness is creating a PSA on depression and is participating in Proposition 63 stakeholder meetings to give feedback on how funds from the proposition should be spent. Talking Wellness recently organized their own retreat and is analyzing data collected in the form of questionnaires from the Report Back at the Pan African Film Festival.

IMPACT: This project has given the community the opportunity to work with researchers and to design its own research projects from conception through data analysis. Its work has been featured in a series of articles in the journal, *Ethnicity & Disease*. This project has allowed community leaders to emerge and develop; has increased community trust with UCLA; has created a model for implementing CBPR in the South Los Angeles community; and increased awareness around community needs.

Case Study: Witness4Wellness



Witness4Wellness (W4W) started in 2003, with a planning committee consisting of a community-lead, multi-stakeholder, academic-community partnership (Healthy African American Families (HAAF), Charles Drew University of Medicine and Science, UCLA, RAND, and about 40 healthcare and community service agencies) aimed at developing community-based approaches to improve health outcomes for depression in minority communities. A conference, “*Witness for Wellness: A Conference Identifying Depression and Its Impact on People’s Lives*”, was held in July 2003, with over 500 people attending. From that conference, three working groups were formed: Talking Wellness (to reduce stigma and get the word out about depression), Building Wellness (outreach/quality of care), and Supporting Wellness (policy/advocacy). The logo of a bus is used to symbolize the fact that members are welcome to “get on and off the bus” as their schedules permit. Each group has an academic co-chair and a community co-chair.

Depression is one of the leading causes of morbidity and disability worldwide. Despite the existence of effective treatments, only one in four Americans with depression receives appropriate treatment, and the rate is especially low among African Americans. Recent studies show that when African Americans and other minorities participate in quality improvement efforts in a health plan, clinical improvement is even greater than among whites, and both groups benefit in terms of personal economic growth (Wells, et al., 2000; Schoenbaum, et al., 2001). Depression is often co-morbid with other disparities such as obesity, heart disease, infant mortality, and diabetes, which persist in minority communities at devastating rates. Therefore, W4W has a stake in addressing multiple health disparities.

This partnership was the first to expand beyond dissemination with a more rigorous research oriented community-participatory research model that builds upon conference activities. It's designed to determine how to best discuss and understand the definition of depression in the community; facilitate improved awareness and recognition of depression among community members; facilitate the development of strategies to improve appropriate referral and access to treatment; and address issues that result from, and lead to, depression. Funding was provided by the Centers for Disease Control (CDC), the National Institute of Mental Health (NIMH), the National Center Minority Health Disparities (NCMHD), and the Robert Wood Johnson Foundation (RWJF). The details regarding this process and the preliminary work are the subject of a supplement to *Ethnicity and Disease*. (*Winter 2006, Volume 16, Number 1, Supplement 1*)

One of the main goals of the Witness4Wellness project is to build community capacity, and in 2005, tremendous strides toward this goal were made. For example, Talking Wellness and Supporting Wellness community members worked together *with* researchers and academia to formulate the questions for the surveys used during the Pan African Film Festival (February 2005, Los Angeles, CA) and African Marketplace (August 2005, Los Angeles, CA) and to analyze the data collected from those surveys. Talking Wellness members returned to the Pan African Film Festival in February 2006 and presented the findings from their survey at a “Report Back to Community”. Building Wellness community members are meeting with providers to get input for their website, which is a pilot that seeks to determine better ways to access care for depression. The pilot has been submitted to the Institutional Review Board (IRB) for approval. Supporting Wellness community members are preparing to analyze the data from the surveys they collected at the African Marketplace. They also attend Stakeholder committee meetings to make sure Community's voice is heard as the decisions are made as to how the money from Proposition 63 is spent. [Proposition 63 is an initiative that passed in California in November 2004; it allows for a 1% tax on people whose annual income is \$1 million or more. This money can only be used for mental health purposes.] They are also working on a radio PSA on depression. Community contribution was a key factor in the authorship of the articles that are featured in the special issue of *Ethnicity & Disease*. It's exciting to see work that community is doing acknowledged in a national medical journal! For more information on Witness4Wellness please go to: <http://www.witness4wellness.org/>.

Lessons Learned:

Community-Partnered Participatory Research (CPPR) can be fun, demanding, and moving. Our community members are learning how to conduct research for and on personally relevant issues, and our researchers are learning how to approach research in the community in ways that are thoroughly appropriate and respectful for the culture of the community. We are learning one

another’s languages. The project benefits from the racial, ethnic, gender, disciplinary, and institutional diversity. Partnering across centers and researchers in health disparities helped to stabilize investigators and funding. HAAF’s role as an “honest broker” was essential. We learned that Community has a strong interest in research, even as the researchers’ goals were reinvented. Other lessons learned include:

- Being there (over a period of time) and being oneself are the first and most essential keys to creditability
- Individual and organizational engagement in process is encouraged but not required: “easy entry, easy exit”
- Key members of both substantive area and evaluation team had histories of conducting community-based research
- Honest dialogue leads to stress and good ideas
- Resolve bureaucratic problems
- Use appropriate language and behaviors
- Have an ongoing evaluation of the partnership process
- Have vertical and horizontal translation of information
- Action planning process and meetings are task oriented



Witness4Wellness (W4W) is a community-based partnership for building community strength and overcoming the burden on communities of depression, particularly in communities of color. W4W is also a research project, in which research is used to help guide the program development and evaluate its impacts. W4W uses a full and equal partnership model in program development and research of academics and community, blending the PhD of the university with the PhD of the sidewalk. W4W Co-Chairs: Loretta Jones, Executive Director, Healthy African American Families; Dr. Kenneth Wells, Professor-in-Residence, UCLA Neuropsychiatric Institute and Senior Scientist, RAND



Healthy African American Families II (HAAF) is a non-profit, community-serving agency whose mission is to improve the health outcomes of the African American and Latino communities in Los Angeles County by enhancing the quality of care and advancing social progress through education, training and collaborative partnering with community stakeholders, academia, researchers, and government. HAAF services all of South Los Angeles and Service Planning Area 6 in particular. HAAF is widely regarded in the community as an advocate voice, and source of education and training around disparities and research, for the local community. HAAF regularly disseminates research to community in its major yearly events. HAAF’s partners include Charles R. University of Medicine and Science, UCLA, RAND, and over 150 community based organizations. Witness4Wellness is just one of their community/academic projects. For more information, please visit their website: <http://haaf2.org/>

Building Wellness

PRINCIPAL INVESTIGATORS: Loretta Jones, MA, Ken Wells, MD, MPH

PARTNERS: Craig Landry, LCSW, and Pluscedia Williams, co-chairs; and the Building Wellness Group. Healthy African American Families, University of California, Los Angeles, Charles Drew University, the community

BACKGROUND / RATIONALE: Depression is one of the leading causes of morbidity and disability worldwide. Despite the existence of effective treatments, only one in four Americans with depression receives appropriate treatment, and the rate is especially low among African

Americans. When African Americans and other minorities participate in quality improvement efforts for depression care, clinical improvement is greater than among whites, and both groups benefit in terms of personal economic growth (Wells, et al., 2000; Schoenbaum, et al., 2001). Depression often occurs with other diseases such as obesity, heart disease, infant mortality, and diabetes, which persist in minority communities at devastating rates, so interventions targeting depression often have effects on other conditions as well.

OBJECTIVE(S): Building Wellness is a workgroup formed under the umbrella of Witness for Wellness. The overall goal of Witness for Wellness is to build community capacity to relieve the burden of depression within historically under-served and predominantly minority communities, primarily in South Los Angeles. Under this overarching goal of the Witness for Wellness project, the goal of Building Wellness is to improve the quality of, and access to depression care in the community.

METHODS: Building Wellness combines principles from evidence-based research with community expertise and direction and by executing its collaborative agenda through a balanced academic-community partnership. The method is based on a model of community-partnered participatory research, which focuses on an equal relationship where academic and community partners are both involved from program inception to design, development, implementation, and analysis; and both academic and community are recognized to bring valuable skills and knowledge to the partnership.

FINDINGS/RESULTS: Building Wellness narrowed and focused its action plan to a project to test the feasibility of implementing an online toolkit the group developed for non-mental health professionals to provide depression screening, education, and referrals for treatment. It has since developed most of the content of the website and the measures for evaluating the pilot. The group checked with target community representatives throughout the process of developing the website, the questionnaires, and planning for implementation at various agencies. The progress of the group was featured in its own article in *Ethnicity & Disease*, 2006, 16(S1).

STATUS: Building Wellness continues to finish the website. It is developing training materials for the toolkit users and looking into having the toolkit translated into Spanish and Korean. The project is under review by the UCLA IRB. The group continues to develop its relationships with agencies in the target community through phone conferences and collaborative discussions. Once the IRB approval is obtained, the project will be implemented in the community.

IMPACT: This project has given the community the opportunity to work with researchers and to design its own research project. Its work has been featured in the journal, *Ethnicity & Disease*, a huge source of pride for the community members and the group as a whole. Within the time the workgroup has met, community leaders have emerged and developed their leadership capacity and understanding of research from an academic perspective. The group members have developed a more trusting and friendly relationship with the academic representatives. This process has created a model for implementing CBPR in the South Los Angeles community; and increased awareness around community needs.

Supporting Wellness at the African Market Place and Culture Faire

PRINCIPAL INVESTIGATORS: Kavita Patel, MD, MPH; and Susan E. Stockdale, Ph.D.

PARTNERS: Healthy African American Families.

BACKGROUND / RATIONALE: In Los Angeles County, Service Planning Area 6 (SPA 6) encompasses communities that are the most ethnically diverse and socioeconomically disadvantaged within the area. SPA 6 is also underserved in terms of mental health care. In addition, with the recent budget shortfalls experienced by the Los Angeles Department of Mental Health (LACDMH) and the passage of the Mental Health Services Act (MHSA), the LACDMH has developed a stakeholder planning process to set budget priorities and determine how new MHSA funding should be spent. One of the signature accomplishments of the Supporting Wellness working group was to obtain a seat on the county-wide stakeholder committee. The Supporting Wellness representative serves as the community voice for consumers in Service Planning Area 6, which encompasses South Los Angeles, Watts, Compton, and other underserved and socioeconomically disadvantaged neighborhoods. The SPA 6 communities have many concerns about access to and quality of services, particularly with regard to wait times at directly operated LACDMH clinics in the community and cultural competency of providers. While obtaining a seat at the stakeholder planning table is a step toward ensuring that community needs are voiced, a more systematic assessment of community members' attitudes and opinions about how best to meet the mental health needs of the community is necessary in order to ensure adequate representation. The African Market Place survey represents an attempt to “take the community's temperature” in this regard.

OBJECTIVE(S): The overall objective of the survey was to obtain community members' feedback on how to best improve access to services and quality of care for depression treatment in South Los Angeles. Other specific objectives included: 1) assessing community members' health and mental health priorities, knowledge about the impacts of depression on the community, and beliefs about depression and wellness; 2) determining the type of services (i.e., free clinics, alcohol and drug abuse programs, social service programs, faith-based programs, etc.) community members feel are most important for improving depression in the community; 3) assessing community members' opinions about the population (i.e., foster children, the elderly, homeless, etc.) that should be targeted by new services and programs.

METHODS: HAAF staff worked with the Supporting Wellness group leadership to coordinate the logistics of data collection. The academic members of the Supporting Wellness leadership applied and receive exemption for the study from UCLA's and RAND's Human Subjects Review Committees. Survey data were collected for 1524 visitors to the event over 3 weekends from the end of August 2005 through the Labor Day weekend in September 2005. Four young, male African American community members were trained to stand next to HAAF's table at the event, approach event visitors, and ask them to complete a brief survey. They were instructed in how to use the script approved by UCLA's IRB and to approach event visitors of all age, race/ethnic, and gender groups. The survey collectors were each awarded a stipend for their work, with bonuses for more surveys collected. Event visitors completing the survey were also given a token gift of their choice (a gel pen, twistable pencil, bottle of water, small notebook, etc.), and information on depression was provided at the HAAF table. Academic partner

personnel were present during the survey collection to answer questions and handle quality control issues.

After completion of data collection, statistical programming staff at UCLA developed a data entry form in Excel, and work-study students entered the survey data (under the supervision of statistical programming staff). The data were cleaned and a SAS dataset was constructed by the programming staff.

FINDINGS / RESULTS: Results have not yet been obtained.

STATUS: A sub-committee of the Supporting Wellness group is currently working on analyzing the data, writing up the results, and determining most effective means for disseminating the data. The Supporting Wellness group has considered a number of options for dissemination, including a community “feedback” session, policy brief(s) to local policymakers, and a public access television show or PSA.

IMPACT: The results from the study will be used in policy briefings and to appeal to local policymakers to improve mental health care services in South Los Angeles. The results will also be used to support the community representative at the LACDMH stakeholder committee table.

Talking Wellness at the Pan African Film and Arts Festival: A Community Partnered Participatory Approach to Community Engagement around Depression in South Los Angeles

PRINCIPAL INVESTIGATORS: Kenneth Wells, MD, MPH; Loretta Jones, MA

PARTNERS: Healthy African American Families

BACKGROUND / RATIONALE: Depression continues to be the largest source of medical disability amongst adults in the world with substantial disparities in access to appropriate care. National reports have indicated that stigma may be one barrier to care especially in minority communities. Participatory research approaches have been described in national reports as an approach to engaging minority communities in addressing health disparities, however, this approach has had limited application to depression.

Witness for Wellness (W4W) is a community partnered participatory research project between Healthy African American Families (a health advocacy organization), RAND Health, the UCLA Semel Institute Health Services Research Center, and Charles R. Drew Medical School. The goal of Witness for Wellness is to enhance the South Los Angeles’ community’s capacity to improve access and to improve the quality of services for depression. Talking Wellness (TW) is a community academic working group within W4W. TW’s goals are to improve the community’s capacity to talk about depression, to decrease stigma around depression, and to educate the community about depression. TW met over two years to develop a series of outreach events (comedy/ poetry events, the presentation of a documentary film on the impact of slavery on African Americans collective sense of self, a community photo exhibit on environmental

influences on depression, and an evaluation of an NIMH produced Public Service Announcement on Depression) and an evaluation strategy for the Pan African Film and Arts Festival.

OBJECTIVE(S): The objectives of this study are as follows: 1) To assess the feasibility of an academic – community partnership to create depression outreach events and then subsequently to evaluate these efforts in a community academic partnered participatory framework (data instrument development, data collection, data analysis, and data presentation); 2) To examine the impact of the community generated arts on measures of community engagement; 3) To assess the impact of an NIMH produced public service announcement on audience members’ knowledge, attitudes, and beliefs about depression; 4) To do a qualitative assessment of a discussion around a documentary film in engaging a predominantly African American community to talk about depression; 5) To examine the acceptability of reporting this data back to the community.

METHODS: A qualitative evaluation of the process of the development of the work and the group was done via field notes by a research assistant of each meeting and via direct observation by a Ph.D. level anthropologist. An evaluation of the impact of the differential impact of the events (poetry/comedy, community photo exhibit, NIMH public service announcement) was done via survey. The NIMH PSA used a non-randomized, cohort design with one group exposed to the PSA (107) and another group not exposed to the PSA (112) to assess the impact of the PSA’s on audience members knowledge, attitudes and beliefs about depression. The community photo exhibit utilized a post-only design (n=678). The poetry / comedy event utilized both a pre-post design (n=59) and a post-only design (n=53). The report back to the community utilized a pre-post design (n=84). Community members were active partners throughout the entire process: conceptual framework development, intervention design, survey instrument development, data collection, data analysis, and data presentation.

FINDINGS / RESULTS: The NIMH PSA study participants were 61% female and 75.9% African American. The mean age was 48.9 years. The PSA appeared to have a statistically significant impact on one knowledge item, “Most people would think less of a person who had been depressed” ($p < 0.02$) and a borderline impact on another item, “Depression is a medical illness.”

The community photo exhibit pilot participants had a mean age of 48.9 years, were 61% female, and were 75.9% African American. On measures of community engagement, 79.3% of audience members said answered agree or strongly agree to “I would recommend this photo exhibit to others in my community.”, 70.4% to “This event made me think about depression and wellness as important issues for my community.”, and 72.9% to “This event made me think about how my surroundings are connected to depression and wellness in my community.”

The poetry and comedy event was 72% female, 72.7% African American, and 13.6% African descent. 96.4% of the participants agreed or strongly agreed with, “I would recommend this even to others in my community” and 91.9% with “This event made me think about depression and wellness as important issues for my community.”

The data for the report back is being cleaned and analyzed.

The qualitative analysis of the film and the process of the development of the group is pending.

STATUS: The data has been presented at national conferences and a paper is currently being completed describing both the data outcomes and the participatory process of the work development.

IMPACT: This project shows that it is feasible for a community academic partnership to focus on research for a substantial period of time on a stigmatized topic. In addition, the project shows that it is feasible to enhance the capacity of grassroots community members to participate in the process of participating actively in research; as well as it is feasible for biomedical researchers to work in the context of a participatory partnership in an underserved minority community. The process of the development of this project has been used as a model throughout Witness for Wellness. The application of this approach has been used to develop other research projects and grant proposals.

