

FOREWORD

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Although the 1990s saw enormous change in the mental healthcare system in the United States, the treatment for depression disorders only rose from 20% to 33%, indicating a persistent need for more effective approaches to depression care.¹ In this supplement Ken Wells, Loretta Jones and colleagues give an insider's view of recent community/academic collaborations focusing on depression in the Los Angeles area. Readers are given a unique opportunity to see many of the key elements of community-based participatory research (CBPR) in action.² While the articles herein focus on depression, they, in fact, represent the intersection of multiple disease-specific and scientific disciplines, which support numerous community/academic activities that are truly community driven.

The core contributions of this supplement represent a seminal collective composed of both academic researchers funded through several large grant mechanisms and numerous community partners who are dedicated to providing and evaluating health services. Together, these partners are collaborating to create new care models and disseminate information of benefit to both the community and academia. Several publications represent the more traditional community-focused academic papers, while others describe the challenges and lessons learned from true CBPR activities within the Witness for Wellness Program. The latter describe research activities where community members have involvement in the conceptual design, implementation, data analysis and collection, as well as the formulation and writing of the manuscripts. Clearly, writing the manuscript relied more heavily on academic input, but was nonetheless structured to ensure community say and participation throughout the entire process. The accomplishments of the Witness for Wellness Program illustrate the potential for successful CBPR to address community-identified needs and to foster community member involvement in all stages of the research design and evaluation process.³

The Witness for Wellness Program is rooted in more than 10 years of intense collaboration between Charles R. Drew University, UCLA, Rand, Cedars Sinai Medical Center, and Healthy African American Families (HAAF) with support from the Centers for Disease Prevention and Control (CDC), the Kellogg Foundation, and more recently, the National Institutes of Health (NIH). The nucleus of these activities began with the initial funding of HAAF by CDC's Division of Maternal and Child Health. The evolving partnerships have been paramount in developing a critical level of trust between many of the

under-served Los Angeles communities and the academic community.

HAAF is unique in that it is an organization designed to act as a bridge to promote effective interactions between the grass roots community, community-based organizations (CBOs), the Los Angeles Department of Health Services, healthcare providers and researchers. Although funding always remains a critical issue for HAAF, as it is for most CBOs, HAAF is not restrained by the excess service demands that characterize most. This has played an important part in enabling HAAF to take such a pivotal role in giving a voice to the many members of the south Los Angeles community and in allowing many of these collaborations to move forward. Simultaneously, several community-based health service providers such as Queen's Care, the Venice Family Clinic and the T.H.E. Clinic have had long standing relationships with academia, balancing their unique missions for care with their commitment to participate in CBPR designs.

Over the last three years, formalizing a core of the evolving community/academic partnerships into a workgroup known as "The Community Health Improvement Collaborative" has enabled many of the partners to come together and address specific strategies. Of special concern has been the need to build upon and extend these relationships in a manner that can truly lead to a more substantive participatory relationship at each stage of the research process. A key element to the success of these partnerships has been the leveraging of several large institutional grants that have helped support this process. These include: the Center for Research on Quality in Managed Care from the National Institute of Mental Health, the Resource Centers in Minority Aging Research (RCMAR) from the National Institute of Aging, Research Centers in Minority Institutions Program (RCMI) from the National Center for Research Resources, and Project EXPORT (Excellence in Partnerships for Community Outreach, Research on Health Disparities and Training Center) from the National Center of Minority Health and Health Disparities.

It should be noted that the road has not always been smooth and that gaining trust has had many ups and downs. The need to broker opposing interests and competing/conflicting cultures across both health and social dimensions within the organizational and administrative framework of community/academic research partners is only the "tip of the iceberg" of the challenges in performing true CBPR.

The translation of research findings to improve community outcomes has, however, continued to fall short of expectations. The limited effectiveness of academia-driven research to inform programs, policies and services in the community setting is based in large part on the lack of insight from the academic arm. There is an ongoing failure to realize or accept that findings from controlled interventions within the academic clinics involve specific cohorts and strict inclusion/exclusion criteria. The studies are often designed with no or little input from the providers or intended beneficiaries in the community being served and are thus limited in their generalizability, potential to be embraced, and/or efficacy in the community setting.

The lessons of the collaborative work of the Witness for Wellness initiative demonstrate that community-based participatory research, when done well, completes the third critical link to bring bench research not only to the bedside, but to the community (the first two links are common at many academic centers). The insights from Witness to Wellness build upon extensive, more traditional clinical and health outcomes research conducted by Wells and colleagues that already include relatively novel primary care clinic and community and faith-based intervention strategies.⁴⁻⁷ These more recent findings provide us with a unique insight and a better understanding of potential approaches to treat depression in minority communities; the findings also offer viable models of care that can be successfully implemented in the community setting. An additional and significant benefit emerging from these expanding relationships is the formation of a coalition led by Dr. Michael Rodriguez at UCLA to create a health care disparities institute. This institute will build upon the established relationships and new models for action that have arisen over the last 10 years in the Los Angeles community and provide further support to bridge and engage communities throughout Los Angeles and other areas of California.

Equally as important has been the opportunity to: 1) develop leadership within these communities who will have an understanding of how research affects healthcare delivery; and 2) provide junior faculty with a sensitive approach and awareness of community needs and concerns in order to engage communities that are characterized by high levels of racial and ethnic minorities, and under- and uninsured individuals.

It is our hope that these series of articles, in conjunction with key commentaries, will bring renewed hope to commu-

nities around the country by demonstrating that there is, in fact, an emerging understanding and awareness within academia of the importance of truly embracing community input.

Ultimately, such an understanding and subsequent action will be critical for the NIH roadmap to effectively reach its mission to improve the nation's health by: 1) moving the scientific agenda forward to improve clinical outcomes; and 2) engaging communities in the health-related research process. There is a vision of a new paradigm where academic advancement is not limited solely to publications, but to innovations that actually improve the health of communities that we serve. It is essential that we, as academia, move from a fragmented perspective of research disconnected from the "subjects or communities" of research (research on the community) and move toward a true engagement with the communities that we intend to serve (research with the community). We must recognize that we are all part of the same community—that we are all part of the evolving process of improving health care and health for all. As we move closer to this vision, we will realize a true transformation of healthcare delivery based on seamless integration of health research, health promotion and practices, and a resolute intent to improve health outcomes.

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REFERENCES

1. Kessler RC, Demler O, Frank RG. Prevalence and treatment of mental disorders, 1990 to 2003. *N Engl J Med.* 2005;352(24):2515–2523.
2. Minkler M, Wallerstein N, eds. *Community-Based Participatory Research for Health.* San Francisco: Jossey Bass. 2003.
3. Jones L, Wells K. Witness for Wellness website. Available at: <http://www.witness4wellness.org>. Accessed October 21, 2005.
4. Miranda J, Duan N, Sherbourne C. Improving care for minorities: can quality improvement interventions improve care and outcomes for depressed minorities? Results of a randomized, controlled trial. *Health Serv Res.* 2003; 38(2):613–630.
5. Wells K, Miranda J, Bruce ML, Alegria M, Wallerstein N. Bridging community intervention and mental health services research. *Am J Psychiatry.* 2004;161(6):955–963.
6. Bruce ML, Smith W, Miranda J, et al. Community-based interventions. *Ment Health Serv Res.* 2002;4(4):205–214.
7. Dossett E, Fuentes S, Klap R, Wells K. Obstacles and opportunities in providing mental health services through a faith-based network in Los Angeles. *Psychiatr Serv.* 2005;56(2):206–208.