SUPPORTING WELLNESS THROUGH POLICY AND ADVOCACY: A CASE HISTORY OF A WORKING GROUP IN A COMMUNITY PARTNERSHIP INITIATIVE TO ADDRESS DEPRESSION

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This paper describes the implementation of a collaborative project with community and academic partners in Los Angeles, focusing on the experiences of the Supporting Wellness (SW) working group in a depression outreach/education initiative (the Witness for Wellness project). The first-year activities of the SW group involved infrastructure development to prepare for policy and advocacy work. Scribe notes from monthly meetings along with the authors' observations are the primary source of data for this article. One of the major accomplishments of the group was to obtain a position on a countywide stakeholder committee that makes recommendations to policymakers on mental health spending for the county. One significant challenge for the academic group members has been providing guidance and support for potential research projects. Although community partnerships with academia are a potentially useful approach for developing health interventions to address community needs and priorities, the experiences of this group illustrate that a substantial amount of time is required to develop the infrastructure for efforts to be successful. In addition, we learned the ''community perspective'' is essential to developing interventions that can address barriers to depression care that are unique to communities with high numbers of under-served, unserved, and inappropriately served residents. (*Ethn Dis*. 2006;16[suppl 1]:S1-43–S1-53)

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INTRODUCTION

Despite many advances in healthcare disparity research and valuable contributions to the research of vulnerable populations, a barrier still exists between the research community and the people whose lives are studied. This barrier is often exacerbated by the track record of researchers who have conducted research in a community, written academic publications, and then moved on to another study without affecting sustainable, positive change in the community. As a means of disseminating evidence-based interventions with delivery methods tailor-made to the needs and unique history and culture of the community, a community-partnered participatory research (CPPR) approach is particularly well suited to capitalizing on unique community strengths and to building capacity to implement effective programs. The Witness for Wellness (W4W) initiative is one such project, focusing on the problem of depression within the socioeconomically disadvantaged and underserved communities in south Los Angeles.

Encompassing a wide array of collaborative approaches to research, six principles are fundamental to community collaborative research efforts, including the W4W initiative.[1,2] First, the research is participatory, with researchers and community members involved in every aspect of the process, from identification of the problem to analysis, interpretation, and dissemination of findings. Research becomes a collaborative endeavor to which the investigators and community members contribute equally. It also involves a process of co-learning as researchers and community members learn from working with one another. Systems development and community strengths building become primary goals of the research process. Ideally, participants are empowered to make real changes and experience increased control over some aspect of their lives. Finally, CPPR seeks to balance research with community action to achieve social justice.

The W4W initiative blends a CPPR approach developed by Healthy African-American Families (HAAF), Charles R. Drew University, and their community partners with evidence-based approaches for improving depression care in community-based practices developed by RAND and the University of California–Los Angeles (UCLA). The CPPR approach emphasizes the partnered aspect of the more commonly recognized community-based participatory research (CBPR) model that is unfortunately too commonly used to describe community-academic research and scholarly activities with limited partnership. At the heart of the initiative are three working groups that seek to implement the goals of the initiative. This paper reports on the first-year progress of one of these working groups, the Supporting Wellness (SW) group. The mandate for the SW working group, as originally specified at the July 2003 conference, was to work with the community on policy and advocacy issues. The goal as stated in the SW July 2004 work plan was (and remains) ''to develop and promote policy to support wellness and reduce depression's impact on community and to advocate for protection of the

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community's vulnerable populations." Although the W4W initiative was originated as a CPPR project, the mandate contained no specific directions for the SW group with regard to developing a research activity. The mandate was intentionally designed to be broad and encompassing in order to provide flexibility for creativity and the generation of approaches sensitive to unique community needs and priorities.

In this paper, we evaluate the development and progress of this group towards the larger W4W goal of improving depression outcome for vulnerable populations in terms of the six characteristics distinguishing more successful from less successful community partnerships.[3,4] First, we provide a brief introduction to the W4W initiative, followed by a description of the development and progress of the SW group. Then we evaluate the successes and challenges of the group over its first year of development. Finally, we close with a discussion of lessons learned and future directions for the SW working group.

Primary Data Sources for this Paper

The SW working group meets on the third Friday of each month at HAAF in south Los Angeles. Meetings generally last approximately two hours, and all meetings are documented by a trained scribe (a research assistant) provided by one of the academic partners in the W4W initiative (UCLA). The academic and community partners who developed the W4W initiative agreed to document meetings in this manner, rather than by audiotape, as they believed that participants would not be as willing to speak freely if their words were being recorded verbatim. The scribe is not allowed to interact or interrupt the process with the exception of introducing herself as the scribe prior to the start of each meeting. The scribe uses a form developed by a member of the research and evaluation committee to record detailed notes on attendance, content and tone of discussion, issues and controversies that arise, and group dynamics. Although the scribes are acknowledged and accepted by participants as members of the working groups, the role of the scribe is passive observer: the scribe does not participate in the discussion. Occasionally the scribe will be called upon to provide information about occurrences in past meetings, but this is rare. The scribe notes along with the authors' observations are the primary source of data for this case study.

As a research product of the W4W initiative, the scribe notes are available to be viewed by any participant (academic or community) for the purpose of a specific research project or paper, so long as that person completes UCLA's or RAND's online training and certification process for using human subjects in research. One problem that arises from using scribe notes as "data" is that the scribe's own perspective of the world may unconsciously bias his/her interpretation of statements and incidents that occur in meetings, and this bias may be reflected in the scribe notes. Although the initiative had originally intended to have one scribe each from the community and from academia, ultimately the resources were not available to support a community scribe, and we could not expect a community member to take time away from his/her job to attend all meetings. Since research assistants from UCLA were readily available and could be counted on to attend and scribe every meeting, the job of scribing meetings fell upon the UCLA research assistants. Out of concern for bias in the notes, each working group was assigned one (academic) scribe, so that at least the biases in the data would remain somewhat consistent across a set of notes. Also, for this paper, the scribe notes were reviewed by one academic and one community member of the SW group to ensure that both perspectives were adequately interpreted and presented.

THE WITNESS FOR WELLNESS (W4W) PROJECT

The "community" in community partnership projects can be geographically bounded or can encompass a group of people who are in some way similar to one another or share a similar problem or interest.[5,6] The W4W initiative initially targeted vulnerable populations. However, in practice the focus has been primarily concentrated within service provision area 6 (SPA 6) of Los Angeles County, the location of the primary community partners and one of the academic partners, and includes several communities in south Los Angeles. With a population of slightly more than one million people in 2000, SPA 6 is primarily non-White (35% African-American, 59% Latino/Hispanic) and overwhelmingly poor (median household income, \$27,303; 32% below the federal poverty level).[7] Approximately 35% of the population receives some form of public assistance, and one quarter of children <18 years live in single, female-headed households. Service provision area 6 (SPA 6) also has one of the highest rates of death by homicide in Los Angeles County, an unemployment rate of 14.1%, and more than one half of adults ≥25 years living in this area have not completed high school. In sum, this area of Los Angeles County has a high concentration of residents that are socioeconomically disadvantaged and whose health and mental health needs are typically under-served. According to the California Health Interview Survey (CHIS 2001),[8] although the rates of need for care in SPA 6 are only slightly higher than those in Los Angeles County as a whole (16.4% vs 15.4% for Los Angeles County), only 3.1% report receiving specialty mental health care in SPA 6 compared with 6.6% for Los Angeles County. For those currently not insured, rates of use of specialty care are only 1.4% for SPA 6, compared to 3.6% for Los Angeles County as a whole.

While all communities are unique, the W4W community highlighted some particular issues around trust between African Americans and academic researchers. Incidents in the past have contributed to a level of skepticism regarding the motives and agendas of largely non-African-American academics. Significant participation from both sides was necessary for the W4W initiative to break down these barriers. Implementing a community-based approach to improving depression in this community thus has the potential to not only overcome the barrier of mistrust and suspicion but also to address the concerns of the community in culturally appropriate and sensitive ways. The importance of these issues cannot be underestimated, particularly with regard to depression care, as some studies have shown that African Americans are less likely to get treatment for depression for a variety of reasons (lack of access/financial barriers, discrimination, culture).[9] However, other studies have shown that when they do receive treatment, the improvement for non-Whites in functioning and other economic outcomes is as good or better than that for Whites.[10,11]

The W4W initiative grew out of a concern among academic and community members of the Community Health Improvement Collaborative (CHIC)[12] about depression among the largely African-American community in south Los Angeles. The community partner(s) identified depression as a problem that is not recognized and appropriately treated in their communities. Over the course of a few months, members of the CHIC collaborative explored the potential for a new initiative through a series of several meetings involving community-based organizations in the area, community members, academic partners, and Los Angeles County Departments of Health and Mental Health. These meetings culminated in the establishment of a Wellness Council to support the development of the new initiative on depression and a community-wide conference on depression.

Following an approach established by HAAF and the Centers for Disease Control and Prevention (CDC), several members of the collaborative contributed to the planning and design of the conference.[13] The conference, which was recorded and scribed, served as a forum for public discussion around the notion of depression as a community problem as well as a means to conduct research. More than 500 participants from a variety of racial, ethnic, educational, and religious backgrounds attended the conference. Three working groups (Talking, Building, and Supporting Wellness), each with a specific depression-related mandate, evolved from the conference and continued working toward improving depression outcomes in the community.

The governance structure for the initiative is based on a model developed and pioneered by HAAF and was established during the initial community meetings before the first conference. HAAF had previously demonstrated success with this model in their work with CDC on premature and low-birthweight babies in the African-American community in south Los Angeles. The academic and community partners decided to name the oversight body the "Wellness Council"; it is composed of community stakeholders, academic partners, and other community members. The Wellness Council serves as the governing body for the W4W initiative, overseeing the activities of the working groups, sponsoring major working-group activities, and supporting research. In addition to planning the initial conference, one of its first activities was to develop a collaboration agreement between HAAF and the academic partners (UCLA, RAND Corp., and Charles R. Drew University). The agreement, signed by HAAF and the academic partners, outlines partnership principles and procedures (including CPPR principles and rights, conflicts, and responsibilities) and a description of the initiative. The first tenet of the agreement is that at least one academic member and one community member serve as the co-chairs of the Wellness Council. Several members of the Wellness Council, including the principal investigators from each institution, serve on an executive committee, which has the ability to make interim decisions between the monthly Wellness Council meetings. This governance structure allows for decisions and projects to be handled in an expeditious fashion. The working groups are accountable not only to the Wellness Council but also to the community of south Los Angeles, and they periodically report on their activities at Wellness Council meetings and community conferences.

The initiative also has a research and evaluation committee, led by the academic partners, that develops the overall evaluation of the initiative and supports the evaluation of working-group activities and projects. Although some of the working groups have conducted evaluations of the impact of their activities on

Table 1. Supporting Wellness Work Plan as of July 2004

Action Plan	Methods	Timeline	Participants
Recruit group members and establish links to relevant groups and organizations.	• Attended local NAMI meeting. • Invitations sent to DMH consumer rep, will follow-up. • Will attend the local NAMI Chapter Directors' meeting.	Ongoing	All
Build cohesion and rapport among group members.	• Work on allowing/ensuring all group members to participate equally.	Ongoing	All
Develop a fact sheet about group to be used for promotion and member recruitment.	• Fact sheet drafted. Sheet was circulated to group members for feedback and will be revised accordingly. • Once completed, fact sheet will be distributed to local and state policymakers.	February–March 2004	Two with input from group.
Develop links to policymakers in Los Angeles County and state offices.	• Using the fact sheet, group members will contact policymakers and inform them of our goals and activities and try to identify areas for collaboration and resource-sharing.	Ongoing	All
Get informed about mental health policy and people/organizations in the field who could be potential collaborators.	• Gather and review materials. • Develop a directory/library/binder of resources. • Surgeon General's Report on Mental Health Disparities was circulated to group members. • Identify local organizations and/or individuals who are involved in health policy (eg, USC, community health councils, DMH client coalition).	Ongoing	All
Inform community about mental health policy and resources.	• Develop a glossary of terms regarding policy for community. Identify someone who can assist with the glossary. • Identify and distribute useful materials.	Ongoing	All
Organize trainings for group and community: Policy 101 Advocacy 101 Media Advocacy 101	• Group members will identify representatives from different organizations who could conduct the trainings (work on Policy 101 training, look into having someone from DMH lead a training, look into someone from UCLA's community and media relations to conduct a training on media advocacy).	March–August 2004	All
Brainstorm and share passions about what topics group will address. Rank and prioritize ideas.	• Group has discussed various policies that would be an appropriate focus. • Continue to share ideas and begin to narrow focus. • UCLA research assistant will begin to search for policy gaps and/or policies that are not working.	January–June 2004	All
Present topic ideas to the community and get community's feedback on goals and future activities of group.	• Formulate a list to be distributed to community participants at future trainings and report back meetings.	At community trainings and at meeting in July 2004	All
Based on community feedback, develop two to three action items for group and community, two to three policy goals, and a media strategy for dissemination and advocacy.		July–August 2004	All
Identify potential funding sources and seek funding.	• Suggestion to approach the California Endowment about their private/public partnership grants.	Ongoing	All

NAMI=National Alliance of the Mentally Ill; DMH=Department of Mental Health; USC=University of Southern California; UCLA=University of California at Los Angeles.

those who participated, research is not a primary activity of the working groups. Instead, the working groups' primary aims are to work with the community to develop culturally appropriate ways to improve community understanding and attitudes toward depression (Talking Wellness), appropriate intervention resources and outreach strategies to improve access and quality of care (Building Wellness), and policy and advocacy strategies to promote program goals and protect the needs of vulnerable populations (Supporting Wellness).

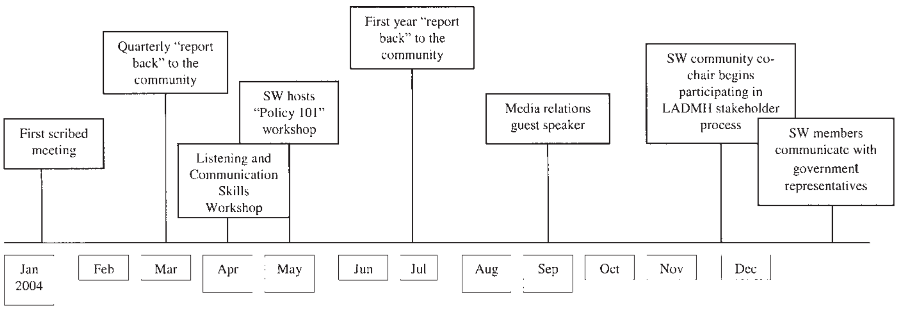

Fig 1. Supporting Wellness Working Group: Year 1 timeline of notable events and activities

SUPPORTING WELLNESS THROUGH POLICY AND ADVOCACY

In addition to academic participants from the social science disciplines and medicine, the participants in the original W4W community conference on depression were primarily individuals who work in mental health and social service-related fields in the African-American community in south Los Angeles, as well as interested community members and consumers of mental health services. After the conference, a series of orientation and planning meetings was held and attended primarily by the original conference participants interested in participating in the initiative. In these meetings, participants were randomly assigned to participate in one of the four "break-out" groups that eventually evolved into the W4W working groups. They were permitted to join the group that interested them most, based on a brief presentation of the topic area for each group. Thus, some of the SW group members (academic and community) joined the group because they were interested in working on policy and advocacy issues. A few of the SW participants subsequently admitted that initially they were not enthusiastic about participating in the "policy and advocacy" group, but seeking to expand their horizons, they remained in the group to which they were originally assigned during the orientation and planning meetings. In addition, some were recruited by group members who participated in the original depression conference.

The initial SW participants (who were overwhelmingly White) were primarily from academic institutions in the Los Angeles area and community-service professionals (primarily African-American) working with the largely non-White population in south Los Angeles. However, during the initial months of the project, the group composition and priority identification were dominated by the academic participants. Efforts to recruit community members increased, and academic members became more cognizant of their presence. Academic members made a conscious effort to curtail their influence in order to maximize community participation. Going into the second year, the membership of the group has shifted dramatically to include a majority of community (primarily African-American) members who are or have been consumers of mental health and substance abuse services. Consequently, more time is spent during the monthly meetings discussing possible policy and advocacy target issues that community members identify as relevant. Scribe notes also indicate that more community members are expressing their opinions, sharing personal stories, and reacting to commentary or findings. Despite the retention of community or academic affiliations, the members of the work group feel like colleagues and peers with a shared vision of improving a community. This aspect of the project has been critical to the successful implementation of key initiatives for the group and has also been cited as a critical factor in the success of most CPPR initiatives in a recent systematic review by Viswanathan et al.[14]

The first year of the project began in January 2004, and meetings were led by two academic co-chairs and two community co-chairs. Short-term goals for the group included trust building, coalition development, and co-learning. The process of co-learning has continued to this day and remains a hallmark of success. The first product for co-development by the group was the Supporting Wellness work plan (Table 1), which included explicit tasks and action items (see timeline in Figure 1). The development of the work plan occurred in several phases over the first year:

1. The establishment of common language and co-learning of culturally appropriate language to be incorporated into accepted health services research strategies.
2. Assessment of group's needs with respect to advocacy and policy skills that the group would need to carry the basic purpose of the group forward.
3. Articulation of aforementioned needs in addition to the perceived needs of the community at large into a comprehensible, flexible document.

The group taught each other common vernacular, research methodology, and cultural norms during each process of the product development. For example, the academic members were able to highlight the purpose and history of the institutional review board (IRB) for each of the academic institutions, and the community members were able to understand the need to plan research activities in advance and how to conduct intervention research with a respectful understanding of the ethical principles involved in community-based research. Several community members, including the authors of this article, completed the certification required to serve as UCLA human subjects committee investigators with an eye to possibly becoming more involved in the academic side of CPPR.

The work plan allowed the group to focus on three key activities over the first year: 1) educating members about policy; 2) building connections with the community; and 3) determining community wants, needs, and priorities. These three activities served as the three deliverables that the group contributed to the overall W4W project.

Educating Academic and Community Partners about Policy Issues in Mental Health

In order to educate themselves about policy issues, the role of advocacy and policy gaps, group members drew on their own experience (working with client populations) and knowledge (based on research activities and reports) of barriers to getting quality care. At a few of the meetings, group members presented information, based on their areas of expertise, to the group. In addition, group members discussed organizing policy workshops for the community and for the W4W working groups. A community expert who organizes and presents policy workshops came to a few of the meetings, and the group arranged a "Policy 101" workshop with the community expert to educate themselves about policy and advocacy. The workshop was subsequently held in May 2004 (see timeline, Figure 1) with members of other W4W working groups in attendance. The group also hosted a media-relations expert as a special guest speaker at the regular monthly meeting to advise the group on how to produce a media event and get the attention of policymakers.

Building Connections within the Community for Advocacy Outreach

In order to promote advocacy for mental health in the community at large, the SW group members spent a considerable amount of time during the first year of the project making contacts with other advocacy groups such as the National Alliance of the Mentally Ill (NAMI) and recruiting members from various community agencies (large and small) involved in providing mental health services or support. One group member began work on a fact sheet early in the first year, with the intention of having information about the group to distribute to media, policymakers, and community. However, after some discussion about whether separate fact sheets would be needed for different audiences, the fact sheet was never completed, and the member who began work on it eventually dropped out of the group. The attrition of members has not gone unnoticed, and community co-chairs have felt that one of their responsibilities is to ensure that members who leave have some follow-up contact so that we can understand the rationale behind their decision to leave the work group. This aspect of continuous evaluation and feedback will be incorporated into the second year of the project to ensure that challenges like these are measured and evaluated to determine their impact on CPPR projects such the W4W initiative.

Determining the Needs and Goals of the Community at Large

The work plan, along with work plans of the other two groups, was presented to the community in a quarterly feedback session in March 2004. The community members in attendance were asked to rate various aspects of the plan and provide feedback. The Supporting Wellness work plan was well received; however, the community expressed some concern over a possible focus of one of the other working groups on women or vulnerable populations. The community wanted any work that the groups did to be directed at everybody in the community. In this manner, community members were quite vocal about the target audience for any research efforts. At the July session, the W4W working groups presented their accomplishments for the year to the community and received feedback about future planned directions and activities. The SW group discussed the community feedback in subsequent meetings, and the development of the work plan is an ongoing process. For a more detailed summary of this process, please see the article in this issue by Patel et al.

Some of the most important products of the SW group are difficult to measure but ultimately are crucial to the sustainability of the project. For example, the authors of this paper have noted that the W4W initiative has contributed to the development of social networks, trust, and co-learning between and among the academic and community participants in the SW group. An unintended product of the SW group activities was less obvious and one that was not planned in advance: the development of a hidden curriculum of learning that took place outside the regular work-group meetings in the form of emails, phone calls, and long-lasting collaborations between individual group members. Common issues of discussion were organizational processes, agenda setting, and policy development.

The first-year activities of the SW group have provided the necessary trust and infrastructure for the group to begin development of an intervention project that could be taken to the scale of the larger community. As of publication, the group had identified a few priority policy/advocacy action items that it would like to target. So far, the activities of the group have focused primarily on community action and not on developing a traditional research project, although a structured assessment of the community action and formal feedback constitute an introduction to many community members on the traditional research paradigm. This process speaks to the large amount of knowledge that both the academic and community members had to familiarize themselves with. As noted above, a substantial amount of time so far has been spent educating group members about policy and advocacy and identifying a relevant issue within the community to be the target of policy and advocacy efforts.

Although the group held extensive discussions and did a lot of brainstorming, determining community needs and priorities was ultimately difficult without some kind of community assessment. In the regular monthly meetings, several members shared their experiences working with the community and their clients. Some discussion occurred about whether the approach to a depression intervention should be based on the bio-health model (individual centered) or the public health model (community centered). Some members pointed to environmental sources of stress and advocated work on policy/advocacy activities that would address these, while some believed that policy/advocacy activities should prioritize improving access and quality of care. A next step for the group will be conducting a community assessment to obtain data that can be used for a grant proposal to support a particular program or intervention or data that that might support the development of legislation or policy targeting a specific issue that can be presented to local or regional policymakers. In recent meetings, group members discussed the possibility of conducting a needs assessment at a community mental health fair they are planning to sponsor in partnership with HAAF.

EVALUATING FIRST-YEAR SUCCESSES AND CHALLENGES

Six characteristics distinguish community partnerships that produce real change from those that are less successful.[3,4] First, partnership size and diversity are critical to determining whether the partners can develop a shared vision, common goals, and a commitment to action; yet managing very large and diverse partnerships introduces coordination, communication, and conflict-management challenges that must be successfully overcome. Successful partnerships include not only a diversity of community voices but also implement management strategies to maintain direction and focus and develop political support through sustained contact with local and state policymakers. The SW group has made significant progress toward recruiting diverse community voices and developing a shared vision. One of the critical measures of success for the work group has been the group's ability to ensure equity in participation for any interested academic or community member. This process was standardized at the beginning of each session with the encouraged introduction of each meeting's attendee, regardless of affiliation or seniority. Part of the introduction also tapped into a personal construct of the attendee. Each attendee was asked to introduce himself or herself and make a statement or two about his or her source of passion for the project. A substantial amount of meeting time during the first year was spent on group members' expressions of their passions, why they were participating in the group, and what they hoped to achieve.

This process ensured that the working-group members understood each other's perspectives and motivations, establishing and reaffirming each meeting that all (academic and community) were united in the commitment to the goal of reducing depression in the community. We believe this process was essential to forming an identity as a group, collaboratively developing goals and group priorities, and establishing the roles that group members will play in the future of the group. Equally important was the nomination of academic and community co-chairs who worked together to ensure an equitable process.

The establishment of a process of transparent co-learning that facilitates the destigmatization of chronic mental illness while addressing the myths and realities of the recognition and treatment of depression has also facilitated the development of a shared vision among members of the SW group. For example, most SW work group community members felt that depression can be expressed in a number of ways, including music. References to rap, hip-hop, and the blues have all been used to describe the medical condition of major depressive disorder in one way or another. The use of such common references has helped in some ways to normalize depression as part of the African-American experience. However, the normalization of the illness does not translate into acceptance of the diagnosis and/or concomitant treatment of depression in the African-American community. Medication therapy is generally perceived as taboo, because as one member of the SW working group stated, "Only crazy people need medication." Community members were able to concomitantly understand the common myths and facts behind the diagnosis and treatment of depression. Several working-group members who were prominent mental health advocates within their community-based organizations stated that they learned how to navigate the mental healthcare system more effectively as a result of the partnership. Thus, academic researchers were able to gain insight into the cultural expression of depression, while the community learned about the myths of mental illness. In this manner, co-learning in CPPR can actually help generate possible intervention targets and treatment goals for a vulnerable population.

Second, the community partnerships that have successfully implemented their shared vision have three leadership components: a committed core leadership that all partners respect, an organization or component that provides stable leadership and legitimacy to the partnership, and a "subsidiary leadership" to whom tasks can be delegated. Healthy African-American Families (HAAF) and the academic partners provide the core leadership and "organizational drivers," establishing a leadership structure that is both respected within the W4W community and legitimacy with outside organizations and potential funders. The working groups provide the infrastructure of subsidiary leadership, and in this regard the SW group has contributed to the overall success of the initiative by providing leadership in policy issues. For a few members of the group, an important outcome of participating in the SW work group has been the development of leadership skills and civic engagement. These are relatively recent developments growing out of the activities of the first year.

With the budget problems of the Los Angeles County Department of Mental Health (LADMH) and the passage of the Mental Health Services Act in California in 2004,[15] LADMH developed a stakeholder process in order to set budget priorities and determine how best to spend limited funds for mental health. Members of the SW group who work at LADMH and have contacts among top administrators alerted the group to the possibility of participating in the stakeholder process as a representative of the community. The group petitioned the LADMH for a chance to participate and was included in the countywide stakeholder negotiation process (see timeline, Figure 1). The community co-chair of the SW group is one of two countywide community representatives on an eight-member stakeholder committee. Her responsibilities as a representative include bringing a consumer perspective to the policymaking process in addition to assisting with the dissemination of relevant information to the public.

Another more recent development involved a combined effort of community and academic group members to write letters to their local and national government representatives. The letter contained a brief overview of the project and the SW workgroup as well as an invitation to the monthly group meetings. It served as the first official correspondence to the key policy leaders in Southern California. This activity provided an opportunity, especially for the community member who is a consumer of mental health services, for those who do not routinely publicly express their views to voice their concerns about an issue directly affecting their well being. Supporting Wellness (SW) members are currently exploring other advocacy efforts, such as documenting the experiences of consumers of mental health and substance abuse services in south Los Angeles to use as data documenting community needs to be presented to local policymakers.

A third characteristic distinguishing successful from less successful partnerships is the ability to develop and maintain a focus on priorities and to clearly articulate the link between these priorities and desired outcomes. This focus requires outlining doable steps involved in the process and envisioning how each of these steps contributes to achieving a successful final outcome. Without a shared vision, however, partners may lose focus and ultimately have difficulty achieving the objectives. This may be the most critical challenge the SW group will face in the year to come, as members struggle to decide on a policy and/or advocacy focus for the group. In particular, some community members of the group recently expressed frustration with the slow pace of goal development. Much discussion among the group took place about developing one policy goal and one advocacy goal. In the January and February 2005 monthly meetings, members discussed two issues in which the group may have an opportunity to impact policy or develop an advocacy action item. These issues included police involvement and training for mental health crisis situations and problems with maintaining consistent medication regimens for children in foster care. Both of these issues are currently being explored in more depth.

Fourth, successful partnerships have the ability to manage conflict and direct it toward more positive ends. This process may involve anticipating problems before they arise, creating interdependencies among partners, maintaining a high level of trust over time, developing a fair and transparent decision-making process, and keeping partners informed of new developments as they arise. While the overall W4W initiative has faced some significant challenges in this regard, some steps have been taken on the part of the executive committee, such as developing a more fair and transparent decision-making process and anticipating problems before they arise. The SW group has managed to channel conflict to result in positive solutions by using a passive strategy identified as "avoidance" by Bazzoli et al.[16] Conflict avoidance involves ignoring issues that arise, avoiding overt conflict, and focusing on maintaining harmony. Bazzoli et al found that this style of conflict resolution was associated with completion of immediate action, but may compromise a partnership's ability to achieve long-term goals. Nevertheless, rather than focusing on conflict as it occurs, the SW group members focused on collaboration and equitable development, using conflict as a opportunity to hone individual passions into a shared vision.

Community and academic participation in a project such as W4W, namely, the conflict that can occur between two competing worldviews, was a significant challenge for the SW work group. In spite of efforts to ensure equal participation of all members, "community" and "academic" members have retained these labels as part of their group identity. However, while group members may acknowledge these different spheres of existence, mutual respect for the skills, attributes, and experiences of each has developed over time. An example from early in the first year illustrates how collaboration and equitable participation, which inevitably lead to conflict, are necessary in order to identify issues that are relevant within the target community, foster a sense of trust, and achieve buy-in from community members who are the target of the initiative. As part of the (continuing) effort to educate themselves about possible policy levers that the group could focus on, an academic group member distributed copies of the Surgeon General's report, *Mental Health: Culture, Race, and Ethnicity.*[17] Two academic and one community member subsequently met to outline the barriers to receiving mental health and substance abuse treatment, based on this report, and develop a list of potential policy action goals for the group. Because financial and access barriers are the most often cited, at the top of this list was a proposal to work on developing a community cooperative insurance plan through which the uninsured could obtain coverage and access the care they need for mental health. This plan was discussed during two or three meetings before the academic members realized that community members did not consider the lack of insurance to be a priority, nor were they convinced that this was the best way to address barriers to care.

Academic members were motivated primarily by a medical paradigm that locates the source of the problem within the individual. If you can treat the individual, then you can manage the disorder. In contrast, community members located the causes of depression in their environment (run-down neighborhoods, poorly functioning public utilities, police intimidation and brutality, gang violence, etc) and the supports for dealing with the disorder in the strengths of the community (unique cultural and artistic expressions, community institutions, their faith, families and friends). In the context of a discussion about culturally relevant treatment, one community member pointed to a problem with the traffic lights, describing how this led to a series of events that caused great anxiety for her. From the scribe notes for March 2004: "I'm curious, of all the people here today, has anyone realized what's going on today that could cause depression in this community? . . . The traffic lights are out. . . . there is gang activity in this neighborhood, the lights have been out since 7:30 this morning, I have to go get boys from school b/c they're scared, the anxiety level. What about getting our needs met? We talk about it being so lofty, but it's really basic to me." The proposal to develop a community insurance cooperative, while not completely rejected by the group, has been relegated to the back burner for the time being, as academic and community members explore other, more pressing community priorities.

Fifth, successful partnerships are better able to gauge their progress at each stage of partnership development and are thus able to transition from one stage to the next more smoothly. Although the SW group has made significant progress toward creating a shared vision, establishing trust, and managing conflict, it faces the critical challenge of being able to progress and transition to developing a more active agenda of community intervention and research. In this regard, one significant challenge for the academic group members has been providing guidance and support for potential research projects. Since the group has not settled on a research project to pursue, the academic members have had to help the community members learn how to frame issues in the context of research questions, a process that is usually completed before implementing most health service research projects. The workgroup is currently trying to identify one or two main areas of research and have required some guidance in the skills needed to conduct scientifically sound research.

Finally, the most successful partnerships were able to assess and reallocate resources (personnel, assets, competencies) in the face of changing partnership needs and priorities. In particular, new policies at the local or federal level may present new opportunities that partnerships can exploit. The SW group has demonstrated some success in this regard, as described above, in its willingness and ability to take the initiative to pursue stakeholder opportunities with regard to California's Mental Health Services Act.

CONCLUSION: LESSONS LEARNED AND FUTURE DIRECTIONS

The first-year development of the SW group of the W4W initiative was different from that of the other two working groups in that SW spent most of this time developing educational initiatives and other deliverables about both general and specific policy/advocacy issues. These products have allowed for the development of a larger intervention design with a focus on real-world community action. They also laid the ground work for a future that is likely to include: 1) defining a research focus unique to the purpose and focus of the group; 2) taking advantage of local policy opportunities (ie, opportunities to influence the use of funds from the MHSA); and 3) developing a focus on advocacy. With the development of leadership on the community side that occurred over the course of the first year and the current shift toward a more grassroots community membership, these last two directions for the group are likely to mature during the years ahead.

The first-year experiences of the SW group illustrate the challenges and benefits of a CPPR approach. First, community members were challenged to remain and participate during this entire process. The challenge came from needing to understand the goals, direction, and motives of the academics and their research intentions, which were not initially clearly communicated to community members. Community members wanted to know the underlying basis for this project and what the academic researchers intended to do with the information provided by community. Furthermore, community members often did not understand the policy and advocacy projects that the academics suggested the working group should focus on, slowing down and complicating efforts to formulate policy and advocacy goals.

The first-year experiences of the SW group illustrate the challenges and benefits of a CPPR approach.

Although the academics' perspective was based largely on the research literature on evidence-based treatments for depression and abstract theories about how healthcare systems operate, the academic members of the group intentionally did not have well-defined research and/or program objective in mind; the intention was for academics and community to develop goals and objectives together. Nevertheless, better explanation on the part of the academics about the underlying basis for the W4W initiative (ie, a collaborative approach to implementing evidence-based depression care in an under-served community) may have helped community members to become more engaged and stay engaged in the project. Although the academic members of collaborative efforts such as the W4W initiative may intentionally leave goals and objectives undefined in order to allow the community to provide direction about what the priorities should be, doing so can create tension and may actually lead to the disengagement of community members who may not fully understand the basis and motivation for the project.

Community members also felt overwhelmed by the pace of academia and the amount of information discussed and disseminated among the academic members before being brought to the regular monthly meetings of the group. This happened regularly because some of the academic members work together in the same office, and the work that they do for the W4W is (for most) at least partly compensated in their salaries, whereas community members require permission from their jobs and must juggle their schedules to give a few hours to the project. This imbalance complicates the ability of community members to be equal partners. The community members of the SW group have been very cognizant of this situation, and the other working groups also eventually experienced tension related to this issue. The imbalance has not gone unnoticed by the academic members, and efforts have been made to provide minimal compensation for some of the work group activities (for example, working on research articles, summarizing meeting scribe notes). The academic members recognize that engagement of community members is essential to the success of the project, and providing more equitable compensation for the work of community members may improve their ability to participate.

Supporting Wellness (SW) group members, especially community members, take pride in continuing dialog to better understand members' perspectives. Consequently, the larger W4W initiative highlights the importance of communication and how differences and problems that arise with regard to communication can affect the development of trusting relationships.[18] Diversifying recruitment, better and more systematic documentation, and opportunities for training could help improve not only communication but also data collection for research and active participation by community members. In a segregated world, people tend to communicate with and obtain information from other people who resemble themselves. In a collaborative project such as W4W that involves individuals from the spheres of academia and community, as well as people representing different cultural traditions, problems with communicating can exacerbate mistrust. Thus, both academic and community participants must keep in mind that subgroups with different perspectives exist within both domains. In other words, not all of the community participants are going to communicate or respond to communication in the same way, and the academic members likewise will not always share a common perspective. Thus, the working groups must continue to expand their memberships to include a good balance of both community and academic members. On the community side, youth, young adults, and men are currently not well represented. Another option, at the risk of becoming exclusive, is to focus on one particular segment of community (for example, women) and work to recruit more of this segment to participate in the group.

With the goal of improving communication in mind, the working groups could also improve documentation of events and meetings. This improvement is necessary because participation of both community and academic members can be irregular, and better documentation would improve the efficiency of communication (ie, old issues would not have to be rehashed in subsequent meetings). Second, documentation could also be developed to provide definitions for academic jargon unfamiliar to community participants and cultural colloquialisms that may be unfamiliar to academic participants.

Another possible addition to the W4W initiative to consider for the future is ongoing training and workshops on specific topics relevant to the collaborative process. For example, a workshop on understanding research and how/why it is used or on understanding the IRB process could help community members participate more actively in the research projects associated with W4W.

Although CPPR is a potentially useful approach for developing health interventions that address unique community wants and needs and are thus more likely to be successful, the experiences of the SW group and the W4W initiative illustrate that a substantial amount of time is required to develop the infrastructure for efforts to be successful. Existing community-academic networks, such as CHIC, may be exploited; however, the HAAF model that incorporates community members as true partners requires an extensive period of relationship building and group-identity formation. While the potential benefits are well worth the time invested, researchers interested in adopting this approach should be aware of this and plan their timelines accordingly.

The experience of the SW group also demonstrates that community perspective is essential to developing interventions with the potential to address barriers to depression care that are unique to under-served and disadvantaged communities. Although academic research has identified many interrelated barriers to care, without the input of community members, researchers may not fully understand how these barriers are related and may be compounded by the unique culture of specific communities. In addition, the implementation of CPPR principles helped establish a base of trust, so that community members can play a meaningful role in developing the solution, rather than having something imposed upon them from outside. As illustrated by one often-quoted statement of the W4W initiative, "Nothing about us without us."

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