TALKING WELLNESS: A DESCRIPTION OF A COMMUNITY-ACADEMIC PARTNERED PROJECT TO ENGAGE AN AFRICAN-AMERICAN COMMUNITY AROUND DEPRESSION THROUGH THE USE OF POETRY, FILM, AND PHOTOGRAPHY

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The design, implementation, and preliminary evaluation of an enhanced community-engagement program that uses poetry, film, and photography at a film festival in south Los Angeles is described. This project is one of several Talking Wellness projects designed to develop social capital and enhance community engagement in projects designed to improve the community's capacity to communicate effectively about depression, to decrease the associated stigma, and to participate in the design and evaluation of research interventions. The high degree of collaboration in the development and evaluation of this community participatory research model is illustrated by describing the selection and design of the intervention and the development of the survey questionnaires used for data collection. The project is described from the perspective of community members involved in the process. (*Ethn Dis*. 2006;16[suppl 1]:S1-67–S1-78)

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INTRODUCTION

Depression continues to be an important public health issue in the United States and internationally.[1] While substantial barriers for depression-related treatment exist for all racial and ethnic populations in the United States, African Americans, in particular, face substantially greater barriers to care relative to Whites.[2] The US Surgeon General's report on mental health and the recent Presidential Freedom Commission on Mental Health have both emphasized that stigma, particularly in ethnic minority populations, is a significant barrier to accessing care for depression.[3,4] They both suggest that messages designed to decrease stigma be tailored to the cultures of specific minority communities. However, research is currently lacking on effective, culturally appropriate communication strategies to address stigma-related concerns to encourage early intervention and to improve uptake of evidence-based treatments in minority communities.

This article adds to the participatory research literature by sharing the experiences of a highly collaborative, community-academic partnership formed to develop, to implement, and to evaluate a community-generated intervention designed to decrease stigma around depression. The intervention takes place in south Los Angeles, a predominantly African-American community. The intervention uses the arts—poetry and comedy performances, photography and film—to engage a community around the topic of depression. The evaluation uses a mixed methods approach (quantitative and qualitative measures) within a participatory framework to ascertain the interventions' impact on audience members. Through this partnership, we have learned that we can develop a collaborative relationship between local community leaders and academic researchers to design, implement, and evaluate a research study around a stigmatized issue like depression in a predominantly African-American community. We provide a brief description of the rationale for using a participatory research model and for using the arts as an intervention vehicle to engage the community. We also provide an overview of how the collaborative evaluation was developed and conducted with the community.

DEVELOPING CULTURALLY APPROPRIATE COMMUNICATION STRATEGIES FOR HEALTH IN AFRICAN-AMERICAN COMMUNITIES

An exploration of culture in the development of successful health communication strategies and contents specifically tailored for culturally diverse

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audiences requires the development of partnerships with diverse communities. As *Healthy Peoples 2010* points out, "General solutions cannot always be used to solve specific problems."[5] Developing partnerships with African-American communities is essential in this regard because one strong challenge of developing culturally appropriate interventions around health issues has been the exclusion of African Americans in research studies.[6] However, developing research partnerships with the African-American community has been challenging because of the history of racism and abuse of African Americans by the medical and public-health professions. Historical tragedies such as the Tuskegee Syphilis Study continue to cause African Americans to distrust the medical profession in general and researchers in particular.[7] And the current actual and perceived racial biases experienced by African Americans in healthcare access, healthcare quality, and health outcomes increases levels of distrust in medicine and public health.[8] This distrust has lead to significant challenges in adapting clinical and public-health research findings into culturally appropriate communication strategies that are suitable in African-American community settings.

COMMUNITY-ACADEMIC PARTNERSHIP MODELS TO IMPROVE RELEVANCE, IMPLEMENTATION, AND DISSEMINATION OF INTERVENTIONS AND EVALUATIONS

We used the Healthy African-American Families community-partnered participatory research model that builds on community-based participatory research models to further enhance the role of the community partners in research process and to address concerns around trust and enhance the relevance of research to the community's priorities and concerns.[9] Participatory research models have been used to address similar issues in asthma,[10] HIV prevention,[11] and healthy eating;[8] however, the participatory framework has been little applied to mental health.[12] Unlike "community-based" or "community-placed" research, community-based participatory research strategies involve community members at all levels and in all phases of the research process.[13,14] Specifically, these research approaches strive to have community members, academic researchers, community-based organizations, and public officials involved in all aspects of research, including the decisions about study objectives, methods of data collection, identification of data elements that are relevant, data analysis, and subsequent dissemination of research findings to the public. In addition, participatory approaches are likely to improve the cultural appropriateness and acceptability in the development of intervention and evaluation strategies. In doing so, both the intervention strategy and content, developed collaboratively, will likely to lead to the enhanced validity of results in targeted populations. At the same time as participatory approaches try to improve the quality, validity, and dissemination of research findings, they also strive to empower the community, to develop advocacy for improved health policy with and on behalf of communities.

WITNESS FOR WELLNESS AND TALKING WELLNESS: A COMMUNITY-BASED, PARTICIPATORY PARTNERED APPROACH TO ADDRESSING DEPRESSION AMONG AFRICAN AMERICANS

Witness for Wellness (W4W) is a community-partnered participatory research project developed between the University of California at Los Angeles (UCLA), Robert Wood Johnson Clinical Scholars Program, RAND Health, the UCLA National Institute of Mental Health (NIMH) Center for Health Services Research, and Drew University. The partnership's goals are to improve recognition and treatment of depression among African Americans in Los Angeles. The partnership approach is described in greater detail by Bluthenthal et al in another article in this issue.[15] Within W4W are three separate working groups composed of academic researchers and community members. Talking Wellness has a focus on developing strategies to help the community talk about depression and reduce stigma around depression. Building Wellness is developing materials to educate healthcare workers about depression. Supporting Wellness works to improve policy and advocacy on issues related to depression. We discuss below one of the programs developed in the Talking Wellness workgroup to use arts as a means to convey messages about depression to the African-American population. This program uses an iterative approach by which community-academic workgroups developed work plans and goals around a health problem that is presented to community members for appropriateness and acceptability.

Talking Wellness first met in July 2004 to begin to create a mission statement and to develop work plans to help the community talk about depression.

> "Our mission is to help people in the community begin to dialogue about depression so that friends and family members can recognize depression and help their loved ones reach a greater state of well being. Many people experience symptoms of depression, but they do not talk about it. If we make it a positive experience for people to talk about it, then we are one step closer to improving prevention and treatment for depression."

The Talking Wellness work group developed outreach events through the use of arts to improve the community's ability to safely communicate about depression, reduce the stigma associated with depression and its treatment, build new community strength, and address environmental stressors that may increase depression. The workgroup met once a month for more than a year to determine the best venues and approaches to engaging the community around depression. One of the first outreach events sponsored by the Talking Wellness group was a poetry event hosted for the community that focused on depression. Given the success of this event, the Talking Wellness group decided to host several different outreach events at the Pan African Film Festival.

Outreach Events at the Pan African Film Festival

The Talking Wellness workgroup chose the Pan African Film Festival as the venue for its outreach for a number of different reasons. First, this festival is viewed as an important cultural and community event in the African-American community of south Los Angeles. It has been held for more than 12 years in the Baldwin Hills Mall in February during Black History Month, with 40,000 to 50,000 audience members each year. At the same time, the Pan African Film Festival sponsors a crafts and arts exposition in the Baldwin Hills Mall where vendors and artists come from all over the world to present a celebration of African and African-American culture. An additional 50,000 people over a period of 12 days in mid-February attend the arts fair in the Baldwin Hills Mall. More importantly, the Pan African Film Festival was viewed as an event in which the entire community could participate. Community participants noted that the event was seen as a homecoming at which people who had grown up in the Baldwin Hills Village would come back to see family and friends in a time of celebration.

Between November 2004 and February 2005, the Talking Wellness workgroup discussed and planned the logistics for several outreach events at the Pan African Film Festival designed to enhance the relevance of and decrease the associated stigma around depression in the community. The community partners identified the Pan African Film Festival as a safe place, a type of homecoming for people of African descent representative of the Diaspora. Because the Pan African Film Festival has historically drawn large numbers of people who live, have lived, and/or who are stakeholders in the Baldwin Hills/Crenshaw community, it was a prime choice for a venue. The acceptance of the W4W project events as part of the Pan African Film Festival was facilitated by longstanding relationships between community participants and the Pan African Film Festival staff.

Community Outreach Events

The Talking Wellness workgroup chose to use creative arts as the medium for the outreach programs at the Pan African Film Festival. Creative arts such as performance and visual images can help communities identify their strengths and assets as well as shared problems and concerns around issues such as depression.[16,17] These media have been used as a communications tool to develop health education materials for menopausal native Australians[18] and culturally appropriate mental-health screeners for African-American children.[19] Because of the lack of available evidence on effective communication strategies to address depression in minority communities, the Talking Wellness workgroup chose to use arts as the medium for this outreach program. One community member of Talking Wellness stated,

> "Art is a spotlight on what is beautiful. It is also cathartic. It gives us the tools to transform even the most horrific experiences into something that heals; art gives us a voice to plumb the depths of despair until we can find the way out."

Community members of Talking Wellness further articulated the awareness that wellness is not a static state and that it exists on a continuum. They further noted that the artistic/cultural expressions of a people are indispensable to bringing about homeostasis, balance, and health and that the artist must emphasize this fact.

Four different types of outreach events were devised by group members: film screening followed by discussion, a poetry/comedy event, a photo exhibit, and the screening of an existing public-service announcement. When determining the content and framing of each of the events, the emphasis on both depression and wellness was seen as being central to community members of the Talking Wellness group. The community members of the group especially wanted both the positive and negative aspects of health to be discussed. Since depression was viewed as a stigmatized condition in the African-American community, the community members of Talking Wellness felt that an exclusive focus on depression for the content of the outreach program would not appeal to local community members. Instead, the community members of Talking Wellness recommended that the outreach program be designed with a balance between depression, which was felt to be negative, and wellness, which was felt to be positive, to present a more balanced view of the Talking Wellness message to the community. The themes of depression and wellness were thus woven into all of the content for the events. One last detail that the community members of Talking Wellness pointed out was that all of the events had to be open to the public and free of charge.

The first intervention the Talking Wellness group proposed was to a host a screening of the documentary film "The Healing Passage," accompanied with discussions after the film to engage the audience in the topic of depression. This documentary is about the middle passage and the experiences of Africans who were brought to the Americas as slaves from the 16th to the 19th century and the impact this has had on African-American culture and art. The film focuses on a discussion of how artists, musicians, and writers have transformed this unthinkable experience from one of pain to an experience of healing. The Talking Wellness group members believed that the historical tragedy of slavery has had a continuing effect on the mood of the African-American community. The workgroup believed one way to insert the dichotomy of depression and wellness into culturally appropriate terms would be to address the dichotomy of the suffering wrought by slavery and the corresponding release of this pain through the creative forces of art and healing. They also believed that screening this movie and having a discussion afterwards would lead to a discussion that would illuminate the complex social and cultural understanding of depression. The discussion after the film was led by the director of the film as well as a community facilitator.

The second intervention was a comedy and spoken word/poetry performance with local poets and comedians. Like "The Healing Passage," comedy and spoken word were seen as a means of expression to communicate ideas about emotions and depression in a way that would be a positive experience for the community. Spoken word or poetry was felt to be a culturally specific, African-American oral art tradition that has been used to communicate the hopes, desires, and stories of African Americans. As one community member described:

> "The efficacy of the spoken word to express concentrated emotion and its ability to invoke communal response has historical roots in the oral tradition of the West African *griot*. African-American literature in large part is an extension of the *griot*'s role, which is to hold memory, history, to praise, to advise, and to act as messenger. Spoken word can help to create an environment of safety in which communal catharsis takes place."

Comedy was felt by community members to be an appropriate way of balancing the seriousness of the topics generally broached by poetry. The combination of comedy and poetry was felt to highlight the thematic importance of the duality of depression and wellness. Three poets from the Baldwin Hills Village and three African-American comedians were invited to perform pieces based on their experiences with depression.

The third intervention was a photography exhibit in the Baldwin Hills Mall based on the theme of the influence of the environment on the mood. One of the participants in the Talking Wellness group had hypothesized that a unique way to engage the community around the topic of depression was to relate the concept of mood to aspects of the neighborhood through a photo exhibit illustrating both positive and negative environmental influences on mood. For example, photographs illustrating positive influences on mood consisted of landmarks in the community, while photographs illustrating negative environmental influences on mood included broken-down buildings.

Finally, the academic members in Talking Wellness wanted to compare the content of the outreach events developed by Talking Wellness to an existing educational intervention that was developed for the similar purposes of improving the awareness about depression and decreasing associated stigma. For this comparison, a national public service announcement developed by the National Institute of Mental Health for the campaign "Real Men, Real Depression" was screened before another film shown at the festival. This public service announcement features an African-American police officer talking about how depression affects his relationship with his children. The public service announcement was shown before a South African action film. The action film is about an African, male, "James Bond"-type figure who tries to protect South Africa's water supply from corrupt government officials.

A summary of the events, the designs, and the surveys collected are described in Table 1. The poetry and comedy performances can be viewed at www.hsrcenter.ucla.edu/mmc/projects/paff.shtml; the NIMH Real Men/Real Depression public service announcement can be viewed at http://menanddepression.nimh.nih.gov/personalstory_full.asp?ID=5.

BALANCING COMMUNITY CONCERNS WITH RESEARCHERS' NEEDS FOR A RIGOROUS EVALUATION

One of the greatest challenges faced by members of the Talking Wellness workgroup was the development of a rigorous evaluation of the effect of the events that would be relevant and

Table 1. Events, designs, and the surveys collected by the Talking Wellness Group

Event	Data Collection	Designs	Surveys Collected
Comedy/poetry	Survey	Pre/Post	108
Performance		Post only	
Photo exhibit	Survey	Post	678
NIMH PSA	Survey	Quasi-experimental cohort	219
Discussion of documentary film	Qualitative–audio recording and note taking		75

acceptable to the needs and concerns of the community and artists. The major concern for the academic members of Talking Wellness was the measurement of change in the audience members' knowledge, attitudes, and beliefs in a scientifically valid manner. In addition, another concern was the necessity of making sure that the evaluation would be acceptable to the institutional review boards (IRBs) of RAND and UCLA. The community members did not object to an evaluation of the impact of the different events on audience members. The major concerns from the Talking Wellness community members' perspective were that the evaluation not be too burdensome on the audience members' time. In addition, Talking Wellness community members wanted to ensure that the survey was appropriate for the educational level of the audience members who would be participating in the survey. Finally, both community members and researchers wanted to ensure that evaluation methods would not compromise the feeling of safety for the audience members in providing responses around sensitive questions.

BUILDING TRUST THROUGH SAFETY IN QUALITATIVE EVALUATION

The issue of safety was an especially sensitive topic around data collection for the presentation of the film. Options presented and discussed for the collection of data for this event were videotaping the event, audiotaping the discussion, scribing the discussion, and using surveys. The community members of Talking Wellness and the filmmaker contributed their opinions about data collection. They felt that a survey would fail to capture the nuances of how the film would elicit discussion around these topics. In addition, community members were opposed to videotaping the discussion because they felt it would be too intrusive and risked compromising the audiences' sense of safety in talking about a sensitive topic like depression. A practical concern was brought up from the perspective of getting people to participate in the discussion. Community members of Talking Wellness were concerned that the use of videotape would prevent audience members from talking because a comment might end up being identified with an individual person. Audiotaping and note-taking would be less intrusive and more anonymous. Another concern revolved the issue of trust. The community members of Talking Wellness did not trust that the academic members of the group would hold their promise not to show the videotapes to the general public. After considering the options, the Talking Wellness group came to a compromise to audiotape and to allow researchers to take notes of the discussion after the film. The audiotape was preferred by the community members of Talking Wellness as it was not as intrusive as videotaping and would allow people to feel safer in expressing their viewpoints during the discussion without being identified with their comments about depression. The compromise reflected a critical moment where community members were able to offer input on determining how to make the research more acceptable to the concerns of local participants, while at the same time making certain that the quality of the data collection would not be compromised. Note-takers led by a senior PhD anthropologist would take notes on the comments of participants in the discussion, describing intonation and body language. Community members wanted the project staff taking notes at the discussion to include at least one member from the community in addition to members from the research institutions to ensure the accuracy of interpretations and descriptions of body language as well as to ensure accurate depiction of language. One note-taker was an African-American male from the local community. Another note-taker was a White female who was a research assistant from UCLA. The anthropologist would take notes describing his impressions of the event. The discussion was audiotaped to ensure accuracy of the participants' comments, of interpretations and descriptions of body language, and to ensure accurate depiction of language. In addition, the IRB, the researchers, and the community members felt that a script needed to be developed to let the audience members know that the comments were going to be recorded. The script to the audience members also informed audience members that they should not speak if they did not want to be recorded and that they could participate without being included in the transcripts if they alerted the researchers that they wanted their comments deleted from the record.

Working Collaboratively to Develop a Survey Tool to Assess the Effect of Interventions to Educate Community Members about Depression

When considering evaluation methods for the other events (spoken word/comedy performances, the photo exhibit, and the public service announcements), the Talking Wellness group decided that quantitative data collection through a survey would be appropriate. We encountered multiple challenges in balancing the perspectives and needs of academic members with community members in developing the survey instruments.

The collaborative process had an effect on a number of issues. For example, the academic members of Talking Wellness exercised little-to-no control over the content and quality of the education interventions that were delivered to the Pan African Film Festival audiences, which is unlike many studies that use a theory of behavioral change to develop content and to measure impact. Another challenge was developing a set of survey items that would be amenable across the different events. All three events (the photo exhibit, the performances, and the NIMH public service announcement) address the topic of depression in a substantial way. Although we did not know what the exact content of the performances would reveal, several measurable domains might have been amenable to change based on the limited information we were given about the content. Because some of the performers—especially in the poetry/comedy event—were going to be talking about their own experiences with depression, we thought that some standard measures of stigma around mental illness, such as measures derived from social distance theory, could be used. Another thought was that some information would be transferred about the basic facts regarding depression so we could assess domains of knowledge, attitudes, and beliefs about depression. In the photography exhibit, we believed that domains that could be assessed would be attitudes about the participants' perception of the importance of depression in the community, stigma, the relationship between depression and environmental issues (eg, noise, graffiti), and the relationship between depression and social issues (eg, police brutality, gangs, unemployment).

Another source of tension between the academic and community members within Talking Wellness was the differing timeframe for the development of the content and the evaluation of the events. The academic members of Talking Wellness worked under an abbreviated timeline to develop an evaluation that would be approved by the UCLA and RAND IRBs in time for the event. Generally, the lead time for the development of these types of evaluations would be up to six months to a year or more to ensure that the evaluations would meet IRB requirements. In order to obtain expedited review, an application was put in for a survey evaluation that would lack any identifiers or any sensitive questions of the participants. The shortened time frame was a catalyst for highlighting tensions within the groups. For example, the academic members of Talking Wellness were concerned that the evaluation strategy would be rigorous enough to detect any potential changes in the audience members' beliefs and knowledge about depression while at the same time being approved by the IRB in such a short time frame. The time pressure forced the academic members to quickly develop the necessary instruments and evaluation strategies. Most of the community members of Talking Wellness had never participated in research development before and perceived the push by the academic members as an attempt to forego community input into the research process. The pressure of the timeline was evident during planning meetings between the community and academic members of Talking Wellness. During several planning meetings, several discussions surrounded the cultural sensitivity of the academic facilitator of the Pan African Film Festival evaluation (Chung). These discussions addressed issues regarding power sharing, community input, and the level of cultural awareness of the academic members of Talking Wellness. Although tensions increased in the short term, over the long term these open discussions reduced tensions and led to greater subsequent participation by the community members in further discussions around the evaluation of the Pan African Film Festival.

Much of the deliberation regarded the number of questions in the survey as well as the wording of questions. Initially >65 separate items were chosen by the academic members. Both community members and academic members, including an outside consultant, were given the questions and asked to review them. Over a series of two conference calls, members of the community were asked to partner with the researchers about the choice and wording of questions. As a note, many of the people who provided commentary on the survey and helped to develop and modify the survey had never participated in the design of a scientific study before. Several points of highly charged negotiation went into the development of the survey instruments. The length of the survey was an area of contention. All participants wanted to find the appropriate balance between items that the researchers felt were important with items that the community members felt were important, while trying to keep the survey as short as possible. Second, the community members were extremely sensitive to developing survey items that would be appropriate to the literacy level of the participants. Thus, another challenge in developing the survey was to balance the level of language and content needed to provide and obtain accurate information while trying to develop a survey that would be accessible for individuals with different literacy levels. The third challenge was attempting to come up with questions that would embrace the balance between health and wellness while at the same time developing a measure that would be a coherent measurement. For example, a healthy debate surrounded the development of a question that had been used in previous W4W events, "Depression and wellness are important issues for my community." Several of the academic members expressed the concern that since this particular question contained two disparate elements—depression and wellness—that the responses would give un-interpretable results. From the perspective of the community members on the survey design team, to word the question differently, "Depression is an important issue for my community," would in their eyes alienate local community members for two reasons. First, the community members thought it would be off-putting because of the way the question was worded—that to emphasize depression alone would be too stigmatizing. Second, the community members felt that if wellness were not emphasized, the survey would document problems in the African-American community. In another example, the academic members had initially included a question that may have been offensive to survey respondents. This particular question was a statement that respondents would have to respond to by circling a response on a scale ranging from 1 (strongly disagree) to 5 (strongly agree). Whereas the initial wording of the question was, "I have *no patience* with someone who is always feeling blue," one of the community partners suggested that the question could be better worded, "I feel helpless with someone who is always feeling blue."

The community members of Talking Wellness also helped ensure that the questionnaires included items that had significant meaning for the community. In one instance, the initial version of the survey instrument included an item that asked respondents to rank whether particular issues in the community, such as homelessness and crime, were related to depression. One particular community issue, police brutality, was on the original list but not on the shortened version. The community members were upset that this particular community issue had been eliminated from the survey question because they felt that it would resonate very strongly with the intended audience. After some discussion at one of the workgroup meetings, the workgroup voted unanimously to add that question back to the survey, as well as two additional questions that had also been eliminated. In the end, the workgroup compromised by allowing several questions that were important to the community; in turn, the community members allowed the academic members to retain 50 of the original 65 questions. A sample of the questions are listed in Appendix 1.

Designing an Intervention Assessment to Assess Change

The rationale of design was threefold. First, with the exception of the public service announcement, the design had to take into account that we could not predict the content of the events. Second, the design had to take into account that many of the measures we were using in our survey had not been validated. Third, the design had to be created in such a way as to accommodate the practical issues of our resources: space, time, and personnel to administer the surveys.

The methodologic issue that required outside consultation was the question of how to design the study to assess the effect of the events on the audience's knowledge, attitudes, and beliefs about depression. In addition, another piece of information that was important to assess was the event's effect on community priorities about depression and the relationship depression had to issues concerning community members of Talking Wellness such as crime, unemployment, housing, and community violence. Consultations were obtained from a media-effects specialist and a statistician and presented to the community members and researchers via email and via phone conference.

Several basic options were available to evaluate the effects of the photo exhibit, NIMH public service announcement (PSA), and the poetry/comedy event. The first issue was whether exposure to the intervention and control conditions should take place at the individual or the group level. The "real-life" nature of the film festival did not allow for random assignment of the intervention to different groups. The participants would self-select to determine which event they would be exposed to in the evaluation in the poetry/comedy event. The standard method for assessing group level changes in the media effects literature would be a repeated cross-sectional design.[20] The repeated cross-sectional design required us to randomly sample a portion of the audience before an exposure to an event and then randomly sample a different portion of the audience after an exposure to an event. Practically, this meant that we would have to administer surveys to a random portion of the audience as they walked into an event and then administer another survey as people walked out of an event. This design would allow us to measure a group mean change in the audience. The other option was to use a cohort design. A cohort design is more sensitive to individual-level changes in the audience. This design is not standard in the media-effects literature; however, the design is consistent with measuring the effect of interventions in the medical literature. This design is less optimal from a media-effects perspective because it can introduce pre-test bias into the data. For example, if we were to test how a particular event might affect knowledge and attitudes about depression, a concern was that the survey items would cue people to the rationale and the content in the post-test items.

A statistical consultant suggested that, in order to ascertain the best evaluation approach to these types of events, we should consider comparing

Table 2. Baseline demographics of survey sample

	PSA data				Poetry A and B		Photo Exhibit	
Analysis Items	***N***	**Overall (*N*=219)**	**Control (Not exposed) (*N*=112)**	**Intervention (Exposed) (*N*=109)**	***N***	**Overall (*N*=108)**	***N***	**Overall (*N*=678)**
Age, mean (SD)	**206**	48.8 (12.35)	48.4 (12.50)	49.3 (12.25)	**101**	44.0 (12.89)	**647**	43.9 (13.54)
Education, No. (%)	**214**				**107**		**662**	
Less than high school		1 (.47)	1 (.93)	0 (0)		3 (2.80)		42 (6.34)
High school diploma, GED		26 (12.15)	12 (11.21)	14 (13.08)		24 (22.43)		265 (40.03)
Associate degree		40 (18.69)	20 (18.69)	20 (18.69)		24 (22.43)		123 (18.58)
Bachelor degree		73 (34.11)	32 (29.91)	41 (38.32)		30 (28.04)		137 (20.69)
Master degree		56 (26.17)	33 (30.84)	23 (21.5)		22 (25.56)		76 (11.48)
Doctoral degree		18 (8.41)	9 (8.41)	9 (8.41)		4 (3.74)		19 (2.87)
Female sex, No. (%)	**217**	133 (61.29)	68 (61.82)	65 (60.75)	**108**	75 (69.44)	**674**	408 (60.53)

GED=General Equivalency Degree.

the different methods to see how the different methods would measure change in the audience in different ways, particularly for the spoken word/comedy event. Based on the consultant's advice, we developed two versions of the survey. The first version was a pre- and post-test of items that attempted to measure change attributable to the event on the audience. These items were knowledge, attitude, and belief items. The second version of the survey would have post-only testing of impact items with demographics in the first half of the survey. Placing the demographic questions at the beginning of the survey would allow us to administer all the surveys at once and give all audience members something to fill out before and after the performance. This would be less complicated practically than attempting to randomly sample a portion of the audience before and after each event. The two different versions of the surveys were randomly distributed to members of the audience as they entered the seating area. In essence this hybrid design randomized the audience to the two evaluation designs (repeated cross-sectional and cohort), through the random distribution of the two versions of the survey instrument.

For the evaluation around the NIMH PSA, one suggestion from our consultants was to randomize the placement of the PSA before a film that would have multiple showings. For example, the PSA could be placed before two showings of the film and then taken away from two other showings of the film to determine any differential impact of the PSA on the individuals in the audience. In this case, we would administer a post-test survey only of the audience after each showing. This design option for the NIMH PSA in particular would avoid the concerns about introducing pre-test bias and also avoid the practical difficulties of randomly sampling audience members before and after a showing of a movie in a "real-life" setting such as a busy movie theater on a weekend during a well-attended film festival.

The amount of latitude we had in terms of controlling exposure to the photo exhibit was less than any of the other events because the photos would be at a booth in a mall as opposed to a closed room. We would not be able to control the level and amount of exposure to the actual exhibit. A pre-post evaluation strategy was not feasible because of practical considerations. Therefore, the group decided that a post-test design would be the best method to administer the survey. Since the survey items were the same as items in the surveys for the other events, data could be compared across events. A summary of the baseline demographics of survey sample are described in Table 2.

COLLABORATIVE DATA COLLECTION

Data were also collected collaboratively. Both academic and community members of Talking Wellness participated in the survey collection. Although all of the academic members had been trained in IRB requirements for handling and collecting data, most of the community members were untrained. Because of the number of events and the length of time the events were going to be occurring, some concurrently, the personnel resources required to collect data from the different events far exceeded the capacity of the Talking Wellness group members alone to handle the project. For example, the photo exhibit alone required three individuals to hand out and to collect surveys for eight hours a day during the entire 12 days of the festival—a total of 284 man hours. In addition, the data collection for the public service announcement required a minimum of five people to collect surveys and hand out incentives as the film ended to ensure that an adequate number of surveys were collected. Most importantly, an individual who was IRB certified was needed at each event, meaning an individual who had completed the UCLA IRB training and understood the importance of ethics, anonymity, and the safe handling of research data. As a result, we issued a community-wide call to obtain assistance with the collection of data. All of the research assistants were compensated for their time. Academic research assistants were recruited from an NIMH-funded health services research center. Several lead academic and community members completed the online IRB training to supervise the research assistants. In turn, training for the research assistants was held before each event so that IRB guidelines around data collection could be explained. These trainings were lead by both community and academic members of Talking Wellness, and a certificate of confidentiality was signed by each research assistant. The certificate of confidentiality is an oath to assure the IRB that research assistants will keep confidential any potential identifying information they might glean regarding audience members' participation and responses during the data-collection process.

DISCUSSION

The development of each evaluation within the context of a participatory research model was a unique and valuable experience for both academic and community partners. One of the greatest assets of a participatory framework was the creation of better evaluation products. The community members gave substantial input into whether a qualitative or quantitative evaluation would be the most culturally appropriate for each event. The collaborative development of a protocol for the film discussion helped ensure that all methods and procedures would maximize the comfort and safety of the participants. Similarly, when designing the questionnaires for the quantitative evaluations, the participatory frame ensured that all of the questions were culturally sensitive and appropriate. A third way in which the community members greatly contributed to the questionnaire design was by offering input about wording, phrases, and/or colloquialisms for the survey that would better capture the particular attitude, level of knowledge, or belief that the question was intended to measure.

One of the greatest assets of a participatory framework was the creation of better evaluation products.

Another major advantage of evaluation design within the participatory framework is the opportunity for the mutual exchange of knowledge between academic and community partners. This process helped the academic partners better understand the limitations of their expertise when designing evaluations for a community-based intervention. The input of the community partners was crucial when trying to create a culturally appropriate and culturally meaningful evaluation for each intervention. For the community partners, this process enabled them to learn more about the scientific aspects of evaluation design. Because several of the community members were so interested in the process of evaluation development, they were willing to donate extra, unpaid time to be able to participate more fully.

The collaborative collection of data allowed for the community members to learn about federal and university requirements around data safety and anonymity. The academic members of Talking Wellness learned how to collect data effectively in community settings they would have never considered before the collaboration.

Although the participatory framework offered numerous advantages, two major challenges made the process somewhat contentious at times. The first major challenge was juxtaposition of academic research deadlines with a participatory process that only had one regularly scheduled monthly meeting. From the academic side came a great deal of pressure to ensure that the evaluation design was completed as quickly as possible for IRB submission. Although a few additional Talking Wellness work group meetings were called in the two months leading up to the film festival, members never had enough time to thoroughly discuss all of the logistics and issues surrounding the evaluation design within these meetings. Because of the time pressures, the overall process was not nearly as inclusive as would have been ideal. The Talking Wellness work group hopes to revisit some of these issues in the coming months as we move into the stage of data analysis.

A second major challenge of evaluation design within the participatory framework was the limited funding available for community partners. Although limited funding is an issue for community partners within this model in general, it is a substantial issue for community partners within the process of developing evaluations. Leading up to the Pan African Film Festival, we encountered many logistic issues and topics that needed to be discussed by the entire Talking Wellness group, which meant that decisions had to be made about which topics would be included on the agenda and which topics would be addressed outside the full group meetings. Ultimately, this forced community partners to make difficult choices about the items that would be up for full group discussion and full group inclusion. For several of the meetings, other items took precedence over the issues surrounding the evaluation design and forced Talking Wellness community members to make a difficult choice between donating unpaid time to be able to fully participate in the evaluation design process or being excluded from this process. As previously mentioned, several community members chose to donate unpaid time to be a part of the evaluation design process. In an ideal scenario, however, funding for community member time would be sufficient so that they would not have to make these decisions.

Many challenges exist in developing participatory partnerships for the health needs of minority populations. However, this discussion shows the feasibility of developing public-health communications evaluations about depression in partnership with a minority community.

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APPENDIX 1. PAN AFRICAN FILM FESTIVAL SAMPLE QUESTIONS

1. How much do you think you know about depression? *(Circle One Number)*

A lot	1
A moderate amount	2
A little	3
Almost nothing	4
Don't know	9

2. On a five-point scale, where 1 means Strong Agreement and 5 means Strong Disagreement, how much do you agree or disagree with the following statements? *(Circle One Number in Each Row)*

	Strongly Agree	Agree	*Neither Agree or Disagree*	Disagree	*Strongly Disagree*	*Don't Know*
a. Depression is a medical illness that affects how people feel, think, and function	1	2	3	4	5	9
b. Someone I know is depressed enough to need treatment	1	2	3	4	5	9
c. I have no patience with a person who is always feeling blue	1	2	3	4	5	9
d. I would be embarrassed if people thought I was depressed	1	2	3	4	5	9
e. Most people think less of a person who had been depressed	1	2	3	4	5	9
f. Most people in the community would treat someone who has depression just as they would anyone	1	2	3	4	5	9
g. Most people would be willing to accept someone who has had depression as a friend.	1	2	3	4	5	9
h. I feel helpless to make a difference with someone who is always feeling blue	1	2	3	4	5	9
i. Overcoming depression and wellness in the community requires planning and action	1	2	3	4	5	9

3. How much do the following conditions impact the community? *(Circle One Number in Each Row)*

	A Little	A Lot	Not At All	Don't Know
a. Diabetes	1	2	3	9
b. Depression	1	2	3	9
c. Alcohol and drug abuse	1	2	3	9

4. Are depression and wellness connected with the following issues in the community? *(Circle One Number in Each Row)*

	A Little	A Lot	Not At All	Don't Know
a. Violence	1	2	3	9
b. Abandoned/run-down buildings/empty lots	1	2	3	9
c. Traffic congestion.	1	2	3	9
d. Graffiti	1	2	3	9
e. Unemployment	1	2	3	9

5. Answer yes, no, or don't know to the following questions *(Circle One Number in Each Row)*:

	Yes	No	Don't Know
a. Have you ever participated in activities that were organized or sponsored by Healthy African-American Families (HAAF)?	1	2	9
b. Have you participated in activities of the Witness for Wellness or Talking Wellness programs before this event?.	1	2	9
c. Have you attended the Pan African Film Festival in prior years?	1	2	9

d. Do you know someone who has received treatment for depression?	1	2	9
e. Do you recall seeing a health announcement with an African-American male before the movie?	1	2	9
f. If you remember the health announcement could you briefly describe what it was about?	1	2	9

We would like to know some of your demographic characteristics so we can describe the participants in this event.

6. What is your sex? ***(Circle One Number)***

Male	1
Female	2

7. How old are you? ______________

8. Do you live in the United States? ***(Circle One Number)***

Yes	1
No	2

↓

What country are you from?________________________

9. If you live in the United States, what zip code do you live in? ________________________

10. It is particularly important for us to be able to describe the cultural background of participants. What is your race and ethnic background? ***(Circle All That Apply)***

African American or Black, not Hispanic, Latino, or Chicano	1
African descent	2
White, not Hispanic, Latino, or Chicano	3
Hispanic, Latino, or Chicano	4
Asian American	5
Pacific Islander	6
Other, (Please specify):________________________	7

11. What is your highest educational degree or certificate? ***(Circle One Number)***

Less than high school	1
High school diploma, GED	2
Associates degree	3
Bachelor degree	4
Master degree	5
Doctoral degree	6

12. Are you currently employed? ***(Circle One Number)***

Yes	1
No	2

13. How do you obtain information about health or illness? ***(Circle All That Apply, Optional)***

Newspapers, magazines, or books	1
Radio and TV	2
Internet	3
Health professional such as doctor or nurse	4
Mental health professional or therapist	5
Pastor, minister, or church elder	6
Friends and family/relatives	7