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Community Partners in Care (CPIC): Video Summary of Rationale, Study Approach / Implementation, and Client 6-month Outcomes

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Abstract

“Community Partners in Care (CPIC): Video Summary of Rationale, Study Approach / Implementation, and Client 6-month Outcomes” is a 2 minute, 46 second video summarizing the study rationale, study approach, and the 6-month outcomes. The video was produced by four agencies: Healthy African American Families II, a health advocacy organization in South Los Angeles; Behavioral Health Services, the largest substance/alcohol abuse service provider in LA County; UCLA; and RAND Health; contract filmmakers Eileen Cabiling and Joe Mango handled cinematography, editing, and video support. The individuals appearing in the video are key CPIC community and academic partners. The celebratory tone of the video is consistent with a

Community Partnered Participatory Research approach, a local variant of participatory action research, where study findings are celebrated by the partners, and dissemination efforts include approaches intended for general audiences, especially from low-income, low-literacy, minority communities, in addition to traditional academic products like peer-reviewed scientific manuscripts. The CPIC video offers a community perspective on the study results to our partners, the general public, other scientists and policy makers. We designed the video to teach community and healthcare partners how to adapt and implement the CPIC depression care model and to offer other community –academic partnerships an example of a non-traditional product developed for dissemination from an NIH-funded research study.

Product Description and Application Narrative Submitted by Corresponding Author

What general topics does your product address?

Arts & Design, Humanities, Medicine, Public Health, Social & Behavioral Sciences

What specific topics does your product address?

Community-based clinical care, Access to health care, Chronic disease, Community coalition, Community engagement, Community health, Community organizing, Community-based education, Health behavior, Health care quality, Health disparities, Health services research, Interdisciplinary collaboration, Mental health, Minority health, Partnership building, Social determinants of health, Social services, Substance use, Low Income Health, Community-based participatory research

Does your product focus on a specific population(s)?

Black or African-American, Faith-based, Homeless, Latino/Hispanic, Seniors, Uninsured, Urban

What methodological approaches were used in the development of your product, or are discussed in your product?

Community-academic partnership, Community-based participatory research, Quantitative research, Randomized trial

What resource type(s) best describe(s) your product?

Lecture/presentation, Training material

Narrative

1. Please provide a 1600 character abstract describing your product, its intended use and the audiences for which it would be appropriate.*

“Community Partners in Care (CPIC): Video Summary of Rationale, Study Approach / Implementation, and Client 6-month Outcomes” is a 2 minute, 46 second video summarizing the study rationale, study approach, and the 6-month outcomes. The video was produced by four agencies: Healthy African American Families II, a health advocacy

organization in South Los Angeles; Behavioral Health Services, the largest substance/alcohol abuse service provider in LA County; UCLA; and RAND Health; contract filmmakers Eileen Cabiling and Joe Mango handled cinematography, editing, and video support. The individuals appearing in the video are key CPIC community and academic partners. The celebratory tone of the video is consistent with a Community Partnered Participatory Research approach, a local variant of participatory action research, where study findings are celebrated by the partners, and dissemination efforts include approaches intended for general audiences, especially from low-income, low-literacy, minority communities, in addition to traditional academic products like peer-reviewed scientific manuscripts. The CPIC video offers a community perspective on the study results to our partners, the general public, other scientists and policy makers. We designed the video to teach community and healthcare partners how to adapt and implement the CPIC depression care model and to offer other community-academic partnerships an example of a non-traditional product developed for dissemination from an NIH-funded research study.

2. What are the goals of the product?

There are several goals of the Community Partners in Care (CPIC) video. First, we hope our video can provide an example of the type of product that can emerge from NIH-funded, community-academic partnered research. Second, within the community partnered participatory research (CPPR) framework, a key goal is to disseminate study results to general audiences. Dissemination occurs during the third of three distinct phases of a CPPR project: 1) Vision (research development); 2) Valley (study implementation and analysis of data); and 3) Victory (dissemination and celebration of study results). The “Victory” phase completes a project while building capacity for the next partnered activity. The specific goals of the “Victory” phase are to: a) publicly acknowledge and celebrate the success of the partnership’s work, b) develop and disseminate products, c) document the partnership and work, and d) share the story with others. Although CPIC has also disseminated the study through peer-reviewed publications and scientific presentations, we developed the video as a culturally-competent dissemination approach that would be transparently accessible and meaningful to the minority study participants in our participatory research study (40% of our participants have a high school or middle school education, 77% are unemployed, 80% are Latino or African American, and nearly 65% earn less than \$10,000 a year in family income). We have presented the video to CPIC-hosted community conferences for our institutional partners and study participants and scientific meetings, as well as to policy makers in LA County, the State of California, and Washington D.C. A related, but separate goal, of our CPIC video is in its planned use within a training curriculum to teach community and healthcare partners to implement the CPIC depression care models in other communities.

3. Who are the intended audiences or expected users of the product?

The intended audiences are: 1) general public, community partners, study participants, researchers, policy makers; 2) communities implementing the Community Partners in Care (CPIC) depression care toolkit; 3) community-academic partnerships seeking examples of products that can emerge from NIH-funded studies. Eventually, the video will be part of a

training curriculum for other communities who plan to implement the CPIC model of depression care.

4. Please provide any special instructions for successful use of the product, if necessary. If your product has been previously published, please provide the appropriate citation below

We designed “Community Partners in Care” as a stand-alone presentation and to be used in the context of a research or training program. It is accessible online and condenses a great deal of information within a dynamic format. The video could be the introduction or concluding segment of a detailed description of the partnership, research, and findings inspiring the video. In addition, we will incorporate this video within a training curriculum being developed to teach healthcare and community partners how to adapt and to implement depression collaborative care in low-income, safety-net, minority communities. Lastly, we anticipate other community-academic partnerships will find the Community Partners in Care video an innovative example for the dissemination of NIH-funded research.

5. Please describe how your product or the project that resulted in the product builds on a relevant field, discipline or prior work. You may cite the literature and provide a bibliography in the next question if appropriate

The Community Partners in Care Video emerged from a nearly decade-long Community Partnered Participatory Research (1-13) project, a manualized variant of Community-Based Participatory Research,(14-17) to reduce racial disparities in depression outcomes in Los Angeles County. Our community partners chose film and video as the best tools to disseminate the study and its results to our local communities in Los Angeles, the general public and policy makers. Our CPIC video builds on prior scholarship in participatory action research and on prior work by our group to engage low-income minority communities around depression, depression care, and research. All aspects of the development of the video were completed using community engagement principles.

The National Institutes of Health,(17) the Centers for Disease Control,(17) and the Institute of Medicine(16,18) recommend participatory research or community engagement approaches to engage low-income, minority communities around research and program planning. Participatory research models emphasize community engagement principles to assure the transparent, equitable inclusion of individuals (community members, patients, families) and institutional partners, especially those from low-income, under-served minority communities, to overcome the significant distrust engendered by the tragic history of biomedical research abuses (the classic example, the Tuskegee Syphilis Study, has left a lasting legacy of resentment and suspicion among African Americans).(5,6,14,19,20)

Use of the arts to engage local communities around depression and depression care has a long-standing tradition in participatory research and within our local partnership. In a prior community partnered participatory research project, Witness for Wellness, we addressed the broad goal of reducing the burden of depression on underserved communities of color in Los Angeles by using community-generated film, spoken word/poetry, and photographs to increase local engagement in the problem and to enhance the community’s collective

efficacy to improve access to high quality depression care.(1,2,4,21,22) Our prior success in using the arts to reduce depression stigma encouraged our community partners to commission the production of a culturally-competent video celebrating our partnership, study, and results.

6. Please provide a bibliography for work cited above or in other parts of this application. Provide full references, in the order cited in the text (i.e. according to number order)

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7. Please describe the project or body of work from which the submitted product developed. Describe the ways that community and academic/institutional expertise contributed to the project. Pay particular attention to demonstrating the quality or rigor of the work

The video describes Community Partners in Care (CPIC): a partnered, randomized, comparative-effectiveness trial to improve quality and outcomes for depression in the South Los Angeles and Hollywood-Metro neighborhoods. Depression is a main cause of disability in the U.S., and particularly challenging in under-resourced communities, where racial disparities persist in access, quality, and outcomes of care. Collaborative care approaches to depression quality improvement (QI) in primary care can reduce racial disparities through improving quality and outcomes of care for depressed adults. CPIC compared the effects of two depression collaborative care and QI implementation approaches: (1) a community engagement and planning approach (CEP), and (2) a more traditional implementation approach relying on technical assistance to individual programs (Resources for Services, RS). Healthcare and community-based programs (e.g., faith-based, senior centers, barber shops) were randomized to CEP or RS. Depressed clients of these programs were assessed at baseline, 6-month, and 12-month self-report, telephone survey follow-up on (a) primary outcomes: 12-item Mental Composite Score-12=40 (mental health-related quality of life); and (b) secondary outcomes: behavioral health hospital nights. At 6-month follow-up, CEP improved depressed clients' mental health-related quality of life, increased their physical activity, and reduced risk factors for homelessness, relative to RS. Moreover, CEP reduced behavioral health hospitalizations and specialty medication visits, but increased the use of primary care, faith-based, and park-based services for depression. To our knowledge, CPIC is the first randomized U.S. study demonstrating the added value of community engagement and planning beyond a more traditional approach to implementing depression collaborative care.

The study and the community engagement interventions were implementations of community-partnered participatory research (CPPR), a manualized form of community-based participatory research, with community and academic partners co-leading under equal authority in all research phases. Participatory research approaches engage low-income, under-resourced, minority communities under-represented in biomedical research and wary of exploitation by research professionals. CPPR emphasizes principles such as equal partnership and power sharing between partners. The study was designed and implemented by the CPIC Council, co-led by UCLA, RAND, Healthy African American Families II, Behavioral Health Services, QueensCare Health and Faith Partnership, with 25 other agency partners providing safety-net services (primary care, mental health clinics, substance use treatment agencies, social services agencies, churches, senior centers, homeless serving agencies, parks and recreation, barber shops, beauty salons, and fitness centers).

The depression QI implementation interventions compared, CEP and RS, relied on the same evidence-based toolkits to promote depression QI (screening, patient education, care coordination), medication management, and depression cognitive behavioral therapy. One-day conferences in South Los Angeles and Hollywood-Metro introduced and made available all materials to program staff and the community-at-large before randomization. RS programs were offered ten webinars and 1 site visit to provide guidance on care management, medication management, and cognitive behavioral therapy between December 2009 and July 2010. Between December 2009 and July 2011, CEP programs participated in partnered workgroups in South Los Angeles and Hollywood-Metro to develop implementation plans that supported better integration and locally-tailored depression QI materials and trainings (through conferences; in-person, webinar, and phone-based sessions). CEP programs offered more training and experienced increased staff participation in training relative to RS.

8. Please describe the process of developing the product, including the ways that community and academic/institutional expertise were integrated in the development of this product

The lead community and academic partners developed all aspects of the Community Partners in Care video in equal partnership. Our partners included: Healthy African American Families II, Behavioral Health Services, QueensCare Health and Faith Partnership, UCLA, and RAND Health. Two grants conceived and written by all the partners provided funding support for the CPIC video. The first grant from the National Library of Medicine (1G08LM11058) was written and funded in the spring of 2011 with the named partners and two additional partners, the Charles Drew University of Medicine and Science and the Los Angeles Biomedical Research Institute, as investigators. The second grant was also written with the lead CPIC institutional partners and funded by the California Community Foundation in 2012. The UCLA Clinical and Translational Science Institute provided additional support.

Our community partners conceived the video in a CPIC Executive Council meeting in the Spring of 2013, to complement the online publication of the CPIC 6-month outcomes paper

in the Journal of General Internal Medicine. The Council felt an additional dissemination tool should be developed to highlight CPIC study findings, using a form that would be transparently accessible and engaging to community members and decided to use the grant resources to develop a video.

An ad-hoc workgroup was convened to develop the video in the summer of 2013, consisting of representatives from the lead institutions including several authors on this peer-reviewed submission (Healthy African American Families II: Loretta Jones, Felica Jones, Aziza Lucas-Wright, Pluscedia Williams; Behavioral Health Services: James Gilmore; QueensCare Health and Faith Partnership: Elizabeth Dixon; 1st African Presbyterian Church: Terrance Stone; RAND Health: Paul Koegel; UCLA: Bowen Chung and Kenneth Wells). Local filmmakers, Joseph Mango and Eileen Cabiling, were commissioned to write and produce the video in consultation with the ad-hoc CPIC workgroup. The workgroup oversaw and approved all drafts of the video script, the production schedule, and the editing of the video through in-person meetings, conference calls, e-mail, and online “draft” review during video editing. The filmmakers shot the footage for the video before, during, and after CPIC Executive Council Meetings and at locations of our institutional and community partners throughout Los Angeles and was completed on September 21, 2013.

The full CPIC Executive Council reviewed the final video at a meeting in the summer of 2013 for approval and feedback. The CPIC Executive Council consisted of the following institutions: Healthy African American Families II, Behavioral Health Services, QueensCare Health and Faith Partnership, UCLA, RAND Health, and 25 additional agency partners and representatives: COPE Health Solutions; Los Angeles Urban League; Los Angeles Christian Health Centers; Los Angeles County Department of Mental Health and West Central Mental Health Center; Homeless Outreach Program/Integrated Care System; National Alliance on Mental Illness Urban Los Angeles; Avalon Carver Community Center; USC Keck School of Medicine Department of Psychiatry and Behavioral Sciences; Kaiser Watts Counseling and Learning Center; People Assisting the Homeless; Children’s Bureau; Saban Free Clinic; New Vision Church of Jesus Christ; Jewish Family Services of Los Angeles; St. John’s Well Child and Family Center; Charles Drew University of Medicine and Science; City of Los Angeles Department of Recreation and Parks; To Help Everyone Clinic; QueensCare Family Clinics, and the National Institute of Mental Health.

9. Please discuss the significance and impact of your product. In your response, discuss ways your product has added to existing knowledge and benefited the community; ways others may have utilized your product; and any relevant evaluation data about impact, if available. If the impact of the product is not yet known, discuss its potential significance

The CPIC video represents a significant fulfillment of the principles and goals of a CPPR project. All aspects of the video were developed in equal collaboration with the study partners using CPPR principles of respect, transparency, power sharing, and equal planning. The video represents an effort to disseminate the results from a rigorous, NIMH-funded,

randomized, comparative effectiveness trial in a form that all partners and study participants could understand. The celebratory tone and the inclusion of community partners within the video and throughout the video development process fulfills a key CPPR principle for broad dissemination of study findings.

The CPIC video has been used in several ways. We presented the video at a community conference in order to report back the findings of our study to participating communities, and received favorable comment from these broad audiences. The video has also been used in scientific presentations to the UCLA Clinical and Translational Science Institute, the National Institute of Mental Health, the California Community Foundation, the American Psychiatric Association, Academy Health, and the National Library of Medicine; and to policy makers, including the LA County Department of Mental Health and Department of Health Services and the Center for Medicare and Medicaid Services. In addition, the video was highlighted on the Robert Wood Johnson Foundation Clinical Scholars Facebook page. We have not conducted a formal evaluation of the CPIC video. However, as a result of our work, the County of Los Angeles has added a new goal to their Strategic Plan called the Neighborhood Initiative which will use the Community Partners in Care depression care quality improvement model as the approach to transition LA County mental health and health services for depression.

10. Please describe why you chose the presentation format you did

Our community-academic partnership chose video as the presentation format for several reasons. First, our partnership felt that a professionally produced video would be readily accessible by all low-income, minority community partners and participants in the study, even those with low levels of formal literacy. Second, our partnership felt the video would be the best medium to capture the diversity of our community and academic partners in ways peer-reviewed manuscripts would not capture. Third, our partnership has used the arts to engage local communities for nearly a decade. In a prior project from our community-academic partnership, Witness for Wellness, we successfully used video, film, spoken word, and photos in order to engage the South Los Angeles African American community around depression and depression care. The partners realized at the time that approaches using the arts had the potential to reduce stigma around depression. Fourth, the African American partners at Healthy African American Families II have often stated that the accomplishments of their community in the research projects are at risk of being forgotten because they are not documented. This video honors our commitment to document the faces and voices of CPIC leaders.

11. Please reflect on the strengths and limitations of your product. In what ways did community and academic/institutional collaborators provide feedback and how was such feedback used? Include relevant evaluation data about strengths and limitations if available

The CPIC video has several notable strengths. First, the video was produced as CPIC itself was conducted, using a Community Partnered Participatory Research (CPPR) approach.

CPPR emphasizes community engagement principles such as the transparent equitable inclusion of individual and institutional partners in all phases of research. Second, the video fulfills the “Victory” phase, one of three distinct phases of a CPPR research project. The video was produced and shot on location before, during, and after meetings with the lead community partners. Third, the partners determined the length and tone of the video as the most appropriate to make a rigorous, randomized trial understandable for broad audiences.

The length of the video format imposed multiple limitations on the CPIC video, in that we were not able to communicate the long history of the partnership, or describe in detail the measures, specific aims, and all of the project goals. An additional limitation is that we were not able to create a version of the video in Spanish or with Spanish language sub-titles.

An ad-hoc workgroup consisting of representatives from CPIC partners developed the idea for the video, reviewed all script drafts, participated in production, and reviewed all “drafts” of video edits. Partners provided feedback at all stages through in-person meetings, conference calls, and e-mail.

12. Please describe ways that the project resulting in the product involved collaboration that embodied principles of mutual respect, shared work and shared credit. If different, describe ways that the product itself involved collaboration that embodied principles of mutual respect, shared work and shared credit. Have all collaborators on the product been notified of and approved submission of the product to CES4Health.info? If not, why not? Please indicate whether the project resulting in the product was approved by an Institutional Review Board (IRB) and/or community-based review mechanism, if applicable, and provide the name(s) of the IRB/mechanism

Witness for Wellness and Community Partners in Care (CPIC), the two projects leading up to the CPIC video over the last decade, both employed a community-engaged scientific approach to translate and to disseminate the benefits of evidence-based, depression care interventions with low-income, minority communities in Los Angeles County. The institutional leads for the two partnerships were Healthy African American Families II, Behavioral Health Services, QueensCare Health and Faith Partnership (QCHP), UCLA Center for Health Services and Society, and RAND. Community Partnered Participatory Research (CPPR), a manualized variant of Community Based Participatory Research using principles of community engagement, guided all phases of the research. Institutional Review Boards at RAND and at the participating agencies approved all research procedures in both projects. Both projects involved collaborative power-sharing partnerships between the academic and community leaders.

Witness for Wellness, a large community engagement initiative, used CPPR principles of respect, two-way knowledge exchange to build trust in South Los Angeles, while involving a multi-disciplinary team (scientists, policy makers, patients, community members) in all

research phases. In the CPPR model, scientists are viewed as part of the community and expected to use their expertise to structure the project, while attending to community member perspectives. A partnership council guided the initiative and supported workgroups implementing separate components. The council reported back to the larger community annually for feedback. Witness for Wellness teams addressed depression stigma, quality of depression services and support for policy change.

CPIC, the follow-up to Witness for Wellness, compared the effects of two depression collaborative care implementation approaches: (1) a community engagement and planning (CEP) approach and (2) a more traditional implementation approach relying on technical assistance to individual programs (Resources for Services, or RS). Healthcare and community-based programs (e.g., faith-based, senior centers, barber shops) were randomized to CEP or RS, and depressed clients of these programs were assessed at baseline, 6-month, and 12-month through self-report, using a telephone survey follow-up. At 6-month follow-up, relative to RS, the CEP approach had improved depressed clients' health-related quality of life, increased their physical activity, and reduced risk factors for homelessness. Moreover, CEP reduced behavioral health hospitalizations and specialty medication visits, but increased the use of primary care, faith-based, and park-based services for depression. To our knowledge, CPIC is the first randomized U.S. study of the added value of community engagement and planning beyond a more traditional approach to implementing depression collaborative care.

To field CPIC, the community partners led recruitment of the community agencies with support by the academic team. The academic team led client recruitment but hired and trained community members for survey work; academic. Community leaders co-trained survey staff. Academic investigators developed the study measures based on the community partners' prioritization of outcomes of relevance to the community, such as mental health-related quality of life and homelessness. Clinician, community, and scientific intervention experts: (1) co-led the intervention development; (2) matched program pairs for randomization, and community leaders selected the seed numbers to initiate randomization; (3) made joint presentations to explain the reasons for and the process of randomization to the local community participants. Such procedures, used across the study, improved the clear translation of scientific methods, promoted engagement and partnership, and helped to assure the correct implementation of research and interventions.

All partners and authors approved the submission to CES4Health.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

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