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Improving Depression Care for Disadvantaged Adults by Partnering With Non—Mental Health Agencies

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Abstract

Reaching disadvantaged adults who need mental health care is challenging, partly because of mistrust of institutions, cultural insensitivity, and stigma. Researchers from Western Psychiatric Institute and Clinic and leaders of 11 non—mental health community organizations formed a partnership to improve depression care, especially for elders and individuals from difficult-to-reach racial and ethnic minority groups. The overarching goal is to reduce disparities by providing and improving care. This column describes challenges overcome in working with a heterogeneous group of agencies to address issues of mental illness, stigma, inadequate staff training, and privacy—challenges that influenced the direction of research and ensuing projects.

The prevalence of certain general medical and psychiatric conditions remains disproportionately higher among low-income minority populations in the United States. Specifically, disparities in rates of depression and in depression care across racial and ethnic, age, and income groups are a major public health problem. The nation's growing population of elders from racial and ethnic minority groups is an important concern because a significant percentage of older African Americans with mental disorders do not seek professional help.

The Advanced Center for Intervention and Services Research/Late-life Mood Disorders (ACISR/LLMD) of the Department of Psychiatry of the Western Psychiatric Institute and Clinic (WPIC) focuses on the study and treatment of mood disorders among older adults. Of all U.S. counties, Allegheny County, where WPIC is located, has one of the highest densities of elders. This cohort represents a generation who generally do not seek assistance for mental health issues. Mistrust in the mental health system resulting from cultural insensitivity and the lack of program sustainability has alienated seniors, particularly African Americans, inhibiting their participation in research conducted by WPIC. Thus a new approach to mental health research was needed.

A promising research paradigm that helps build partnerships between academic researchers and communities is called participatory research. For decades, public health practice has utilized community partnerships by activating public participation and empowering people to address health concerns. However, among academic psychiatric institutions, a participatory approach to research is still in the early developmental stage. Community-partnered participatory research requires the engagement of diverse populations in complex community environments. In the best situations, collaborations that involve diverse people, organizations, and resources contribute to the dynamics of creating “partnership synergism” (1). Academic and clinical partnership research has demonstrated that a collaborative approach can resolve issues such as mistrust between community providers and mental health researchers.

This report describes some of the challenges involved in a working partnership between mental health researchers and a heterogeneous group of non-mental health service agencies. The partnership was created to address issues of mental illness, stigma, inadequate training of agency staff, and privacy that influenced the direction of research and ensuing projects. It provides researchers access to populations of underserved adults that they would not be able to reach on their own. This report was developed from interviews conducted in 2007 and 2008 with 11 leaders of these organizations to evaluate the partnership after collaborations.

Partnership

In 2005 researchers from WPIC and leaders of community organizations formed the Research Network Development Core (RNDC) to create new research projects to pursue mutual concerns stemming from mental health disparities. Development of the partnership, which is described elsewhere (2), required patience and perseverance but resulted in the understanding that partnerships succeed when they embrace “cultural humility,” collaborative efforts, and flexible protocols to accommodate diverse communities.

The community partners are a diverse group of public organizations providing social services, advocacy, and primary care. They include four family health centers serving disadvantaged persons; five social service agencies providing food, programs, and services for homebound elderly persons, parent-child support services, and programs and shelters for homeless persons; two mental health consumer advocacy agencies; and a pharmacy services network for underserved populations. Three of these organizations provide both social services and health care. The representatives interviewed included executive directors, program directors, associate directors, clinical directors, and executives. The academic investigators are psychiatrists, clinical psychologists, an ethicist, a community relations liaison, an outreach coordinator, clinical social workers, public health researchers, a National Institute of Mental Health (NIMH) Medical Student Research Fellow, and postdoctoral researchers. The research investigators are primarily experts in mood disorders, such as depression, among adults and older adults.

Challenges

Getting it right by adapting

Before the RNDC was created the academics had research goals of reducing depression among African-American and white older adults. However, the public organizations serve people of all ages and all racial and ethnic groups. Thus the researchers shifted focus to include disadvantaged adults of any age in order to be aligned with the community partners. One of the initial inducements for community partners was their recognition of the need to lower the threshold for identifying an individual with mental health problems in order to prevent a crisis situation (for example, involuntary commitment). Thus the RNDC decided that the best use of the partnership would be to develop research projects to provide screening, recognition, and

treatment of depression for difficult-to-reach African-American and white adults and elders through the public organizations.

Setting common goals

Initially, the academic and community partners came to the table with very different ideas and expectations of the purpose of the partnership. Although the public organizations were not focused on mental illness, they were aware that mental illness was a problem for many of their clients. The first undertaking was a needs assessment to determine service agencies' understanding of mental health issues and needs of clients, staff training, and barriers to clients' receipt of mental health care. The assessments revealed the heterogeneity of the public organizations in their missions, clientele, funding models, and mental health resources.

Although it has been challenging to find common ground, the diversity within the partnership provided an opportunity to develop a unique synergy to better serve economically disadvantaged adults. Initially, some of the service agencies were reluctant to address mental illness with clients. For example, offering depression screening to "guests" at soup kitchens seemed inappropriate and intrusive. In contrast, the community health centers viewed mental illness as an appropriate adjunct to physical health care being offered to patients. Thus the partners had to consider the agencies' wide range of philosophies and resources when designing programs and projects. One partner commented, "Those assessments that were done came across to me, even from the beginning, as indicating that you all were trying to listen to what we were saying."

Staff training

All the community partners identified the critical need of educating and training frontline staff regarding mental illness. Although frontline staff had the most frequent interactions with clients, they possessed the fewest knowledge-based skills to identify and deal with behaviors symptomatic of mental illness. To address this need, the partnership developed a mental health education program for frontline staff funded by Staunton Farm Foundation that provided basic understanding of and specific skills for dealing with depression, psychosis, alcohol and drug problems, and mental health crises; sessions were also provided on cultural competence and maintaining professional boundaries.

Addressing stigma

A staff member at one of the service agencies noted, "There's a stigma regarding mental health in this community, and it's very hard to get people to show up for anything that has to do with mental health." Another partner stated, "We need destigmatization. We need ongoing education and a public relations process letting people know that depression is treatable and that stigma should not prevent them from getting the mental health care they need." In response, the academic researchers and clinicians have offered on-site mental health outreach, in-service training sessions, and depression screening initiatives. Also, a depression care intervention to reduce stigma among older adults with depression is under review. These ongoing efforts serve to support research endeavors and project development.

Awareness of elders' needs

The public-academic partnership has increased awareness of the needs of elders among the community partners. One advocacy partner commented, "Working with you all has inspired us— Allegheny County has such a large elderly population—to target them more intensely. At first our average age group was 40-year-olds. We get over 2,000 calls a month, and we noticed the age groups were getting older. We partnered with Meals on Wheels. We placed

advertisements on the trays for Meals on Wheels, and we saw that increased our callers from that population.”

Privacy

The need for on-site mental health services was frequently expressed, especially among social service agencies. However, many partners also expressed concern about privacy issues—that is, about their ability to protect clients’ personal information within their agencies and in the local community. Some difficulties are attributable to the structural design of facilities. As one participant noted, “Privacy is a challenge in this small space. ... Whenever we speak, we need to be extra careful because of the tight quarters.” Other difficulties are a direct result of the agencies’ community-based locations. Many of the agencies’ consumers reside in the neighborhood where the facility is located. “Because we’re right here in the community, people can see you going in and out,” one community partner said. Another partner noted that “many people know each other” or may be related to staff members. Although neighborhood proximity improves accessibility, it can create the illusion of a loss of privacy—if not an actual loss—and may diminish an individual’s desire to seek services. In response, the academic investigators provide partners with training and consultation about use of participatory research strategies to conduct depression research in the service agencies. In addition, because of the delicate nature of privacy issues, an ethicist in the RNDC provides research ethics consultation to researchers and community partners.

Benefits

Because of the time required for the participatory research process, success depends on both intangible and tangible benefits that the partners consider to be significant enough to sustain their effort. Both the process and the results of the needs assessment were early benefits. The needs assessment introduced the group to a systematic method of collecting information about each organization. Assessment results helped partners learn about their agencies, staff, and needs by means of a new and unfamiliar approach. Agencies used their individual reports to inform board members and in strategic planning, annual reporting, and funding proposals. Internally, leaders became aware of staff issues, concerns, and needs to help direct the organization’s growth.

The community partnership has successfully developed several projects and programs, including the educational program for staff described above, a depression screening study with primary care doctors and patients, a pilot study to develop a peer educator intervention for African Americans (funded by Staunton Farm Foundation), an intervention involving a depression care manager and a peer educator, and several mental health outreach programs, including a partnership with the Clinical and Translational Science Institute (CTSI) for mental health education in the community. In addition, community partners have collaborated successfully and received an NIMH Outreach Partnership Program grant and funding from the Pittsburgh Foundation to support an outreach and education program for co-occurring depression and chronic illness, including diabetes, hypertension, and cancer. The participatory research approach has kept partners engaged and has sustained their interest in additional research. One partner stated, “The partnership allows us to have a voice and transform that research into practice. Often with researchers they come and do the research and then you never hear from them again. You come back and explain what you found.”

Conclusions

The partnership has brought together public non-mental health organizations with different missions and resources and helped the group realize commonalities related to mental illness. The cohesiveness that has developed among the partners has helped to address the challenges

of working with the stigma of mental illness, mental health needs of elders, staff training issues, and privacy issues in developing projects and conducting research in the community agencies. The diverse blend of experts from the community and the academic investigators has created projects and programs that are better suited to and accepted by the community and with greater chance for sustainability than could have been produced by either group independently.

A participatory partnership approach requires greater flexibility than is traditional under a clinical paradigm and necessarily involves a considerable investment of time to cultivate meaningful and trusting relationships with diverse public organizations. Transferring research skills and knowledge to the community was part of the early engagement. We used the needs assessment as our roadmap. Community members were empowered by putting new approaches (for example, needs assessment) to practical use (for example, strategic plans, annual reports, and funding proposals).

Community agencies must continually adapt to changes in resources, both human and financial, to the needs of the clients they serve, and to the neighborhood environment. In addition, researchers must periodically adapt their research foci and develop new ideas for projects on the basis of funding priorities. Our next steps in the partnership include developing a consortium that will utilize the unique resources within the network, continuing to develop relationships for ongoing community outreach programs and mental health education (for example, the CTSI partnership), and using the RNDC platform to further investigate the area of depression prevention.

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