Improving Care for Older Persons With Schizophrenia Through an Academic-Community Partnership

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Translating evidence-based mental health interventions designed in research settings into community practice is a priority for multiple stakeholders. Partnerships between academic and public institutions can facilitate this translation. To improve care for middle-aged and older adults with schizophrenia, the authors developed a collaboration between a university research center and a public mental health service system using principles from community-based participatory research and cultural exchange theory. They describe the process that has led to a number of mutually beneficial products. Despite the challenges involved, building and maintaining academic-public collaborations will be essential for improving mental health care for persons with schizophrenia. (*Psychiatric Services* 59:236–239, 2008)

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To provide high-quality care for persons with schizophrenia, evidence-based pharmacological and psychosocial research developments must be efficiently translated into community practice. Academic-community partnerships can facilitate this translation (1,2). Using the principles of community-based participatory research (3) and cultural exchange theory (4), we developed a partnership between an academic research center and a large public mental health system with the goal of improving care for middle-aged and older people with schizophrenia and other psychoses.

Although community-based participatory research is established in many areas of public health research, it is less so in mental health systems (3,5). Featuring a process of shared decision making, community-based participatory research empowers the community as an equal partner in the research process. Public participation in all phases of research ensures clinical and cultural relevance to communities and contributes to the effectiveness and sustainability of the interventions and evidence-based practices (6).

Cultural exchange theory describes a transaction of knowledge, attitudes, and practices that occurs when two groups representing diverse cultural systems (for example, ethnic groups and organizational systems) interact and engage in a process of debate and compromise (4). Partnership development involves cultural exchange, a bidirectional process in which both parties contribute equally, derive benefit, and change as a result of the transaction (4).

We describe our use of the principles of community-based participatory research and cultural exchange theory to create a productive research partnership between the San Diego County Adult and Older Adult Mental Health Services (AOAMHS) and the Geriatric Psychiatry Research Center of the University of California, San Diego (UCSD).

The partners

Although there was a long-standing clinical collaboration between UCSD and the AOAMHS, there was little interaction in terms of research. In 2002, as part of a grant from the National Institute of Mental Health, UCSD and AOAMHS began a clinical research partnership.

AOAMHS annually provides publicly supported mental health services for about 40,000 San Diegans over age 18. The county is ethnically diverse—50% of AOAMHS users are Caucasian, 19% are Latino, and 5% are African American.

A collaborative process model

Public-academic partnerships combine two different organizational systems, each with its own values, styles, and limitations. The collaborative process model we employed to develop the organization and function of the partnership between the Geriatric Psychiatry Research Center and AOAMHS consists of five steps: building and sustaining the partnership, mobilizing community support and enhancing infrastructure for community research capacity, knowledge generation (research and training), knowledge transfer to community practice (dissemination and implementation), and evaluation of the outcomes and process (7,8). Applying the core principles of community-based participatory research and cultural exchange theory to the collaborative process model, we undertook the formation of an academic-public partnership.

Building community partnership

The collaboration began by discussing the goals and objectives of each partner, identifying areas of overlap, and recognizing benefits to each organization. Researchers often find bureaucratic processes in public service organizations cumbersome (9,10), and AOAMHS staff reported that they found some requirements of the university's bureaucracy cumbersome. Several other cultural differences were identified—for example, differences in decision-making styles. To the extent possible, we compromised to meet the objectives of the partnership. When consensus was not possible, we accepted the other's decision and respected the cultural context in which it was made (3,10). Creating feasible and useful joint operations for the partnership required time, trust, and mutual respect (9,10), and consequently, these interactions significantly changed both organizations.

Consistent with cultural exchange theory and community-based participatory research, the partnership began with a priority-setting process. The following initiatives were identified: recruitment into research protocols, needs assessment, utilization analyses, and public education. Below, we describe some of the processes that were important in building the organization and structure of the partnership and in achieving the jointly determined objectives.

Oversight and representation. The initial structure of the partnership consisted of three committees with equal representation from UCSD and San Diego County: a staff committee to discuss ongoing operations and projects, an administrative committee to discuss policy issues and resource allocation, and an executive committee to discuss overall priorities and progress.

Staffing. To create cohesion and increase communication, we hired staff specifically for the partnership. Functioning as equal partners in the decision-making process, we hired a community mental health liaison and a data analyst. These joint staff were housed at county facilities and employed by the university, providing an effective way of "blurring the lines" between the county and the Geriatric Psychiatry Research Center.

Bureaucratic arrangements. Several fiscal and administrative problems emerged in forming the partnership. For example, we initially planned for the county to administer the partnership budget through a subcontract with UCSD. Accepting external grant funding, however, presented the county with administrative and procedural challenges. The resolution required that each institution look beyond its distinct set of organizational priorities and loyalties. It was decided that UCSD would manage the budget and become the designated employer of all staff. The partners, however, retained joint determination of budget allocations, personnel selection, and supervision. This agreement was documented in a memorandum of understanding that outlined the terms of the collaboration and provided for annual review and revision.

Administrative challenges. One priority of the partnership was to develop mechanisms to enhance recruitment of representative community samples for research. UCSD and the county each had institutional mechanisms to track research projects. The county had limited capacity to review and monitor projects, thus restricting the number of protocols active in county programs. Working collaboratively, the partners standardized several processes to reduce the burden on the organizations and investigators. We jointly created databases to track projects, subject participation, and publications. The efforts of the shared staff facilitated identification of new recruitment sources and reduced the time spent on duplicative administrative tasks. As the result of this endeavor, policies and procedures at both organizations were modified.

Changes in context. Public-academic partnerships are established within a fluid context of changing priorities and other events that require flexibility and adaptation. For example, during the formation of the partnership, the privacy rule of the Health Insurance Portability and Accountability Act (HIPAA) was enacted. Complying with HIPAA resulted in a resetting of project timetables and the development of a new data use agreement and several other procedures to ensure that the data transfer was HIPAA compliant. That the collaboration survived and flourished in a changing context indicates the strength of the partnership and the validity of the pursuit.

Mobilizing support and enhancing infrastructure

To accomplish the second step of our collaborative process model, we developed several innovative mechanisms designed to involve the community and promote research.

Participation of community members. We formed a Community Advisory Board (CAB) chaired by a community member and composed of investigators, administrators, consumers, caregivers, and care providers. The CAB reviewed every research protocol before its submission to the UCSD Institutional Review Board and the AOAMHS Research Committee to assess public health significance, feasibility, and adequacy of protection of participants' rights. Input from the CAB assisted in identifying new recruitment opportunities, reducing participant burden, and improving communication between clinicians and researchers.

Technical and financial support. UCSD assisted AOAMHS in upgrading its research infrastructure by providing ongoing data management and analysis, general methodologic and other scientific support for outcomes assessment, and other practice and clinical research activity.

Increasing community-based research. The partnership provided an environment for the design and support of community-based studies and made funding for pilot projects available for these development activities. Projects from both university and county investigators were solicited and reviewed by the CAB.

Enhancing support. Both partners participated in increasing community awareness of and support for the collaboration by conducting educational programs throughout the county, and AOAMHS provided opportunities for improving UCSD researchers' understanding of community-related issues.

Expanding community capacity. The passage of Proposition 63 (Mental Health Services Act), which generates new tax revenue specifically for mental health services, required that each county assess and prioritize its own mental health needs. The UCSD-AOAMHS partnership was instrumental in conducting and analyzing the needs assessment and service utilization data that formed the core of the San Diego plan, which was approved by the state's review committees.

Knowledge generation (research and training)

The third step in the collaborative process model is to provide the background and descriptive analyses of the community system, providing a basis for future research and program development.

Needs assessment project. The partners conducted a collaborative qualitative study to assess the mental health needs of older adults in the community. Consistent with community-based participatory research, several community groups participated in the data collection, including the San Diego Older Adult Mental Health and Substance Abuse Coalition (see below), the National Alliance for Mental Illness (NAMI) of San Diego, and AOAMHS. A town hall meeting was held to share the results with the community and a report was also made available on the university and county Web sites.

Service utilization data analyses. Another priority that the partnership jointly agreed on was a review of AOAMHS service utilization. To accomplish the review, AOAMHS transferred its management information system database to researchers in the Geriatric Psychiatry Research Center in accordance with regulations of HIPAA, the UCSD Institutional Review Board, and the AOAMHS Research Committee. Although this was a lengthy process, the database has become a unique resource. It contains six years of service utilization data, capturing characteristics and service data for more than 40,000 consumers. These analyses have promoted a better understanding of service use and costs of mental health care and have assisted in identifying potential targets for the development of interventions. Several manuscripts coauthored by partners have been published.

Evaluation of systemwide interventions. Program evaluation is a critical activity for the county. The university's data management resources and analytic expertise have helped the county to examine the impact of systemwide interventions. For example, when AOAMHS had to eliminate all day rehabilitation programs because of budget reductions, we collaborated on a retrospective analysis of mental health service use by clients whose care was transferred to clubhouse programs. This project not only provided information that was important for county planning purposes, but it also demonstrated the partnership's ability to evaluate outcomes of a systemwide change in services, which will continue to be valuable to both partners.

Systemwide assessment of cultural competence. To comply with state requirements to evaluate the cultural responsiveness of AOAMHS care providers, the partners surveyed AOAMHS administrative, clinical, and support staff members. These survey results led to countywide programs to provide culturally fair assessments and culturally sensitive treatments. These findings were published in a report that has been widely disseminated county- and statewide.

Knowledge transfer (dissemination and implementation)

The fourth step in our collaborative process model involves communication of findings, with the goal of changing community practice. Although publishing in scientific publications is a necessary means of dissemination, it is insufficient. Thus we have sought to disseminate our research findings to the community in innovative ways.

Wellness Campaign. To increase public and professional awareness of the mental health needs of older adults, we jointly developed a major educational program, the Wellness Campaign, which consisted of a series of lectures by national experts that was held in accessible venues throughout the county.

Newsletter and Web sites. We collaborated on a quarterly publication distributed both electronically and in print that targeted individuals with psychoses, families, professionals, researchers, advocates, and the public.

San Diego Older Adult Mental Health and Substance Abuse Coalition. One of the innovative, collaborative methods of dissemination was the formation of a coalition of stakeholders that focuses on education and advocacy for the mental health needs—the San Diego Older Adult Mental Health and Substance Abuse Coalition. Recently, the coalition was adopted as a formal program of NAMI San Diego.

White House Conference on Aging. The partners cosponsored an officially sanctioned "miniconference" to the 2005 White House Conference on Aging, which resulted in a white paper published in English and Spanish. This document summarizes the proceedings of the meeting that was attended by more than 120 consumers, advocates, and providers of mental health care.

Development and dissemination of practice guidelines. Using practice guidelines for use of antipsychotics and other treatments for older people

with schizophrenia, the partners are developing programs to disseminate and implement these practice guidelines in the county's mental health clinics.

Evaluation of the process and the success of the partnership

To accomplish the fifth step in the collaborative process model, we recently surveyed academic and community stakeholders to evaluate the processes and outcomes of the collaboration. Overall, the partnership received high ratings on the quality and the dedication of the individuals involved in the collaboration and on innovative problem solving. Stakeholders also noted that the partnership would benefit from even greater involvement of consumers, caretakers, and clinicians. Respondents stated that the natural tension between priorities of different organizations sometimes resulted in conflicts of interest and challenges in identifying mutually beneficial projects, thereby hindering the partnership's efficiency. Feedback also suggested that a major priority should be to emphasize research that has a direct, observable, and sustainable impact on community practices. In general, most stakeholders agreed that the partnership had successfully evolved from two separate and complex organizations to a joint collaboration with shared goals.

In response to this feedback, we have made revisions in infrastructure and priorities for the ongoing research partnership. To increase the role of consumers and caregivers in the research planning and oversight processes, we have made three major infrastructure changes. First, we developed a Partners' Council with representatives from NAMI and frontline clinicians. Second, we formed a Consumer Liaison Unit, including a Consumer Advisory Board. Third, we increased interactions with local and national mutual support and mental health advocacy organizations.

Conclusions

Beginning with the collaborative process model and modifying it to include the basic principles of cultural exchange theory and community-based participatory research, UCSD and AOAMHS created a partnership focused on improving care for middle-aged and older adults with schizophrenia and other psychoses. Consistent with cultural exchange theory, the interaction between two organizations that differed in values, bureaucracy, and function required a substantial investment of time, strong commitment to the process, flexibility in the face of shifting priorities, and willingness to compromise and accommodate. This academic-public partnership has been a difficult undertaking, and many of the benefits have yet to come to fruition. Nonetheless, there are some tangible benefits to both partners. AOAMHS has developed an infrastructure to support research, educational programs, and the development of the mental health delivery system for older adults. UCSD has gained knowledge and awareness of conditions in community mental health services and improved its ability to develop and implement effective community-based research projects.

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