A Socially Just Leadership Approach to Community-Partnered Research for Reducing Health Disparities

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Abstract

Significant health disparities continue to plague many groups of people who have been systematically oppressed and largely unrepresented in health research. Community-based participatory research (CBPR) is a collaborative research approach that has been shown to be effective in addressing health disparities; a community–university partnership approach can be used to conduct this research. Counseling psychologists are well suited to establish and lead CBPR partnerships, yet there is a paucity of research to guide them in utilizing effective leadership approaches when conducting CBPR for reducing health disparities. Therefore, the aims of the present study were to (a) review existing leadership models applicable to conducting CBPR; (b) identify guiding principles of socially just leadership that emerged from the aforementioned review; (c) offer an example of how the guiding principles were used in a community–university partnership, highlighting challenges, solutions, and lessons learned; and (d) discuss the benefits of socially just leadership for counseling psychologists.

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Health disparities have been defined as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse conditions that exist among specific population groups" (National Institutes of Health [NIH], 2011). Health disparities negatively impact groups of people who have systematically experienced greater barriers to health based on their minority status or other characteristics historically associated with discrimination or exclusion (U.S. Department of Health and Human Services, 2010). Some examples of health disparities are (a) Black adults being disproportionately affected by cardiovascular disease, diabetes, HIV, hypertension, infant mortality, stroke, overweight, and obesity (Agency for Healthcare Research and Quality [AHRQ], 2014; Center for Disease Control and Prevention [CDC], 2013); (b) African Americans/Blacks, American Indians/Native Americans, Alaska Natives, Asians, and Latino individuals receiving worse health care than non-Latino Whites (AHRQ, 2014, 2015; CDC, 2013); (c) rural areas, as compared to urban areas, having fewer health facilities, a greater shortage of health care providers, and fewer preventive and specialized health care services, all of which contribute to health disparities (Belasco, Gong, Pence, & Wilkes, 2014; Marcin, Shaikh, & Steinhorn, 2015); (d) members of LGBT communities having higher rates of tobacco, alcohol, and drug use than members of other communities (Kerr, Ding, Burke, & Ott-Walter, 2015; Newcomb, Ryan, Greene, Garofalo, & Mustanski, 2014); and (e) American Indians/Alaska Natives having suicide rates that are approximately 50% higher than those of non-Latino Whites (Herne, Bartholomew, & Weahkee, 2014).

Reducing and eventually eliminating health disparities has been a national health priority for decades (U.S. Department of Health and Human Services, 2010). Yet, physical and mental health disparities continue to plague many groups of people who have been systematically oppressed and deprived of access to health resources based on social determinants of health (e.g., age, disability, education, food insecurity, gender, health care services, income, race, and social exclusion; Lasker & Weiss, 2003; O'Fallon, Tyson, & Dearry, 2000). These groups include those living in rural and inner-city neighborhoods, individuals below the poverty level, individuals without a high school education, older adults, racial and ethnic minorities, women, the LGBTQ community, and the mentally and/or physically challenged (AHRQ, 2015). Members of these groups typically experience limited socioeconomic and political power (Braveman, 2011). Furthermore, they typically have been marginalized in healthcare and wellness initiatives, and are underrepresented in health-related research (Braveman, 2011). Directly or indirectly, all citizens pay the health care costs of people who lack the economic and political power needed to obtain health care and engage in the health-promoting lifestyles that prevent costly chronic diseases (Tucker et al., 2014). It has been

estimated that the economic cost of health disparities in the United States exceeds $300 billion annually (LaVeist, Gaskin, & Richard, 2009). Therefore, health disparities need to be of concern to everyone, not just to those individuals experiencing these disparities.

A possible contributor to the difficulty in reducing health disparities is the lack of the collaborative processes necessary to address social determinants of health. Accordingly, health researchers have called for the use of collaborative research approaches. Such approaches have the potential to empower and engage groups most affected by health disparities as partners in health research and in implementing health-promoting interventions that may ameliorate health disparities in their communities (Andrulis, Siddiqui, Purtle, & Duchon, 2010; Griffith et al., 2010; Wallerstein & Duran, 2006). Empowerment is a group-based participatory, developmental process that gives oppressed individuals and groups increased control over their lives and environment, access to valued resources and basic rights, and the opportunity to meet important life goals (Maton, 2008). Empowering groups who experience health disparities to be equal partners in research and interventions designed to reduce health disparities is consistent with the tenets of social justice, which call for all groups in a society to have full and equal participation in efforts to meet these groups' separate and common needs (Vera & Speight, 2003). Social justice includes promoting a society in which the distribution of resources is equitable and all members are physically and psychologically safe and secure (Vera & Speight, 2003).

The community-based participatory research (CBPR) approach to addressing health disparities is consistent with the tenets of social justice. CBPR has two major distinctive features: (a) academic and nonacademic community members are coresearchers with unique knowledge bases, and (b) community members are important and necessary partners in efforts focused on eliminating health disparities (Jacquez, Ward, & Goguen, 2016). CBPR offers a paradigm shift from the traditional research practices that have characterized academics as experts towards a collaborative research process in which academics are also learners (Balazs & Morello-Frosch, 2013; Jacquez et al., 2016). Accordingly, the CBPR approach requires that community members be actively involved in all aspects of the research process, including selection of the research topic and methodology, participant recruitment, research implementation, data collection, interpretation of study results, and dissemination of research findings (Balazs & Morello-Frosch, 2013; Horowitz et al., 2009). Equitable collaboration among academic investigators and community partners has the potential to increase the relevance of the research and its potential for addressing public problems such as health disparities (Jacquez et al., 2016).

Counseling psychologists are well suited to colead CBPR along with community members, particularly when these community members are affected by health disparities. This is because counseling psychologists are trained in multiple areas that reflect the core values of social justice. These areas of training include strengths-based developmental research and intervention, multicultural and diversity research and practice, prevention science, group dynamics, and research partnerships and partnership leadership (Forrest, 2010). Partnership leadership structures and processes are particularly important because they have been empirically linked to successful efforts to address health issues within communities (Lasker & Weiss, 2003) and can serve to build the capacity of the partnership, mobilize collaboration, inspire shared vision and shared goals, and enhance trust among stakeholders (Kendall, Muenchberger, Sunderland, Harris, & Cowan, 2012).

Very little in the scholarly literature provides guidance to counseling psychologists regarding effective leadership models for using CBPR to address health disparities. Thus, in this article we sought to

1. Review existing leadership models that are applicable to conducting CBPR aimed at reducing health disparities.
2. Identify guiding principles of a socially just leadership approach to reduce health disparities.
3. Provide an example of how the guiding principles of a socially just leadership approach have been used to lead a multidisciplinary partnership established to reduce obesity disparities in two communities.
4. Identify challenges experienced in applying the aforementioned guiding principles and present strategies for overcoming these challenges as well as lessons learned.
5. Highlight the benefits of implementing a socially just leadership approach for counseling psychologists interested in conducting health disparities research.

Relevant Leadership Models and Approaches for Conducting CBPR to Address Health Disparities

Research in the field of leadership has evolved dramatically over time; specifically, it has undergone substantial theoretical shifts since the mid-20th century (Fassinger, Shullman, & Stevenson, 2010). Transactional models of leadership, which emphasize the power, expertise, and control of the leader over the followers, were at the forefront of leadership theory and research during the 1940s and 1950s (Fassinger, Shullman, & Stevenson, 2010).

Challenges to transactional models of leadership arose as early as the 1960s, making way for increasingly egalitarian, collaborative, and inclusive models of leadership to emerge throughout the late 20th and early 21st centuries (Fassinger, Shullman, & Stevenson, 2010).

In the 1960s, leadership theory and research first began to include the roles of followers and the importance of the leader-follower dynamic (Avolio, 2007; White & Shullman, 2010). By the late 1970s, models of transformational leadership had gained acceptance, resulting in calls for the autonomy of followers, the flexibility of leaders, and the importance of values such as justice in leadership (Bass, 1985; Burns, 1978). At least one investigation documented that members of marginalized groups prefer transformational leadership to more traditional transactional leadership, with its focus on a single leader (Fassinger et al., 2010).

Leadership via teams, or plural leadership, became an emergent trend in the 1990s and 2000s, resulting in various versions of this concept, including collaborative, distributed, and relational leadership (Denis, Langley, & Sergi, 2012). Even with the advances towards leadership approaches that emphasize plurality and justice, most modern leadership models fail to conceptualize equity, power, agency, and sustainability in ways that are consistent with CBPR (Denis et al., 2012; White & Shullman, 2010).

Despite the lack of a clear, best-fitting leadership model for conducting CBPR to reduce health disparities, two leadership models conceptualize leaders in ways that enable CBPR. These two leadership models are the inclusive leadership model and the community healthy governance (CHG) model. Both of these models involve egalitarian leadership and equitable engagement of multiple stakeholders. It is also noteworthy that the servant leadership approach (Greenleaf, 1977) may be useful for enabling effective CBPR; however, this approach may be unrealistic for individuals who work in university settings where service and humanism are undervalued, as reflected in evaluation processes such as tenure and promotion.

Inclusive Leadership Model

The inclusive leadership model emphasizes an interdependent relationship between leaders and followers characterized by egalitarian processes, shared goals, and mutual benefits (Hollander, 2012a). The following "four Rs" underlie the practice of inclusive leadership: respect, recognition, responsiveness, and responsibility (Hollander, 2012a). The values of fairness, trust, appreciation of diversity, transparency, and integrity are also important components of the inclusive leadership model (Alimo-Metcalfe, 2010; Hollander, 2012a, 2012b).

Inclusive leadership structures often adopt a team approach that emphasizes plural leadership teams (i.e., leadership teams comprised of multiple stakeholders). Furthermore, there is bidirectional influence between leaders and other stakeholders. As a result, these other stakeholders have real influence on the structures and practices of the leaders (Hollander, 2012a).

In addition to contributing to the structures, processes, and decisions of the organization's leaders, other stakeholders can also participate in leadership activities. For example, Hollander (2012b) suggested that followers can assist with scheduling, resource allocation, conflict resolution, and advocacy. Inclusion and recognition of the unique strengths of all stakeholders can lead to an organizational culture that encourages open expression of stakeholders' opinions and increased trust among all stakeholders (Bourke & Dillon, 2016; Bowers, Robertson, & Parchman, 2012).

The inclusive leadership model has clear implications for developing a socially just leadership model for conducting CBPR. However, inclusive leadership may be insufficient to promote the level of justice CBPR requires to address health disparities. The inclusive leadership model retains the distinction between leaders and other stakeholders, even though other stakeholders are conceptualized as active participants in decision-making and in some organizational processes. In contrast, CBPR requires that members of all stakeholder groups, including community members, have a place *on* the leadership team (Horowitz et al., 2009). The CHG model, described in the following section, goes beyond inclusive leadership and recognizes the importance of individual empowerment, supportive and cooperative relationships, synergy on collaborative problem solving and, ultimately, community health (Israel, 2003).

CHG Model

The CHG model provides a framework for diverse, multidisciplinary stakeholders (e.g., individuals, community members, organizations) to work collaboratively in a sustained way to address community health issues (Lasker & Weiss, 2003). In the CHG model, as in CBPR, research project participants have influence and control, and engage in a process of active listening, meaningful discourse, and consensual decision-making (Israel, 2003).

According to the CHG model, the effectiveness of a partnership is largely based on its ability to shape an environment that fosters broad-based internal involvement, influence, control, and empowerment, and that enables stakeholders to combine their unique skills, expertise, and resources (Weiss, Taber, Breslau, Lillie, & Li, 2010). The CHG model features a facilitative leadership approach that (a) promotes active participation by partnership stakeholders; (b) ensures equal power, influence, and control among partners; and (c) facilitates

partnership functioning (Lasker & Weiss, 2003). Important objectives of this leadership approach include facilitating trust and capacity building as well as empowering partnership stakeholders to contribute their unique ideas, opinions, and skills (Lasker & Weiss, 2003). By emphasizing empowerment, inclusion, and power equity among diverse partners, the CHG model is consistent with the tenets of social justice.

At least one study used the CHG model to evaluate a community health partnership (see Cullen, Giles, & Rosenthal, 2006). The CHG model was selected as a framework for evaluating the partnership because it attended not only to the larger health outcomes of the study, but also to the "intermediate processes of the partnership" (p. 18) in charge of conducting the research. Results showed that the CHG model was a useful framework for conceptualizing the process by which individuals and organizations work collaboratively to (a) identify and solve health problems at the community level, and (b) guide public health workers in project management. With its focus on equal partnerships and on leadership that promotes diversity, multidisciplinary representation, and power sharing among partners, the CHG model holds promise as a guide for researchers in their efforts to conduct CBPR to reduce health disparities.

The CHG model has not yet been widely applied to CBPR to reduce health disparities. This is likely because the CHG model does not specifically address how partners sustain their partnerships, or how they obtain the funding and other resources needed to achieve the major goals of the partnerships, such as the goal of improving the health of the community. According to Young et al. (2015), sustainable partnerships include sustained relationships, commitments, knowledge, capacity, values, funding, and programs. Such partnerships are needed to reduce health disparities given that the social determinants of health underlying these disparities are intractable and thus require sustained efforts to effectively address them. Additionally, it is important that partner leaders in sustainable partnerships prioritize the needs of others rather than primarily focus on their own needs, such as the need to collect research data quickly for tenure and promotion purposes. Giving such priority to the needs of others is characteristic of servant leadership.

Servant Leadership Approach

Servant leadership (Greenleaf, 1977) is a leadership approach that prioritizes the needs of others over leader self-interest. The primary purpose of, and motivation for, servant leadership is to serve others. Servant leadership also places emphasis on personal empowerment, the growth and flourishing of others, and trust—all of which are central to conducting CBPR for reducing health disparities (Greenleaf, 1977; Stone, Russell, & Patterson, 2004). Both

the inclusive leadership and the CHG models value humanism. However, prioritizing the needs of others (e.g., community partners experiencing health disparities) over self-interest, which is a major characteristic of servant leadership, is challenging for university research partners. This is because university researchers are bound to give at least equal priority to producing research publications that are needed to maintain their jobs and to earn job promotions. Because of this contextual pressure, engaging in servant leadership may have to remain an ideal for which to strive when conducting CBPR to reduce health disparities.

A Socially Just Leadership Approach to CBPR Aimed at Reducing Health Disparities: Recommended Practices

A socially just leadership approach is one that is consistent with the tenets of social justice; this approach is instrumental for conducting research and implementing interventions to reduce health disparities. Given that the groups most negatively impacted by health disparities (e.g., racial and ethnic minorities, community members with low incomes) have insufficient socioeconomic power to take charge of their health promotion and outcomes, socially just leadership is needed to enable communities to achieve health justice—the antidote for health disparities. CBPR, the inclusive leadership model, and the CHG model each suggest best practices for developing a socially just leadership approach to conducting research to reduce health disparities. These recommended best practices include the following: (a) involvement of diverse, multidisciplinary, and representative leadership teams; (b) establishment of egalitarian leadership structures; (c) promotion of equal power, participation, and influence; (d) identification of mutually beneficial activities and goals; (e) promotion of facilitative attitudes and values and implementation of structures for sustained goal attainment; and (f) empowerment of members of groups experiencing health disparities.

In the sections that follow, we provide an example of a socially just leadership approach in a real-world partnership. The partnership was formed to conduct CBPR aimed at reducing obesity disparities in two communities that identified obesity as a significant concern. One of these is a low-income community in Jacksonville, Florida. The other is a low-income community in Gainesville, Florida. The two communities are a 1½-hour drive apart. The formal name of the real-world partnership (of which all the coauthors are members and one is a codirector) involving these two communities is the Multidisciplinary Academic-Community Obesity Disparities Research Partnership (MACOD-R Partnership, henceforth called Partnership).

Several factors contributed to the impetus for forming the Partnership. First, a community needs assessment conducted in each community indicated that overweight and obesity were priority concerns among community members; in fact, the prevalence rates for these conditions were disproportionately high in these communities compared to those in middle-class communities within the respective cities. Second, at an obesity summit for both partner communities (e.g., patients and their families who utilize university-affiliated health care clinics in Jacksonville or Gainesville, providers, community stakeholders, obesity researchers, graduate and undergraduate students), participants noted the need to identify community-based obesity interventions that produce and sustain weight loss in adults and children. Third, the researchers at the obesity summit decided to form the Partnership in order to obtain funding from the University of Florida-Gainesville to conduct the aforementioned research studies.

The sections that follow describe the application of the recommended practices for socially just leadership that guided the establishment and functioning of the Partnership. In addition, we present the challenges we encountered in implementing this leadership approach and in maintaining this Partnership, and describe strategies for overcoming the associated challenges.

Involvement of Diverse, Multidisciplinary, and Representative Leadership Teams

Effective CBPR for addressing health disparities is framed and implemented by a team of researchers and community members who respect each other as equal partners with shared power. The Partnership consists of two codirectors (one from each partner community, one of them being a professor in counseling psychology), a research coordinator (a counseling psychology doctoral student), five leadership teams (i.e., the Obesity Disparities Seminar Series team, Obesity Disparities Research Fellows team, the Research and Grant Development team, the Evaluation and Analysis team, and the Sustainability team) and their cochairs, and an Advisory and Support team of academic administrators (see Figure 1 for the complete organizational structure). These individuals and groups work together in various ways to (a) develop, implement, analyze, and disseminate the results of projects to reduce health disparities; (b) prepare and submit grant proposals to fund these research projects; (c) train academic and community-based health disparity researchers; and (d) sustain the Partnership. Each codirector also serves as a member of a leadership team. The research coordinator facilitates the meetings of the Partnership, monitors the work of the leadership teams, and facilitates addressing their resource needs.
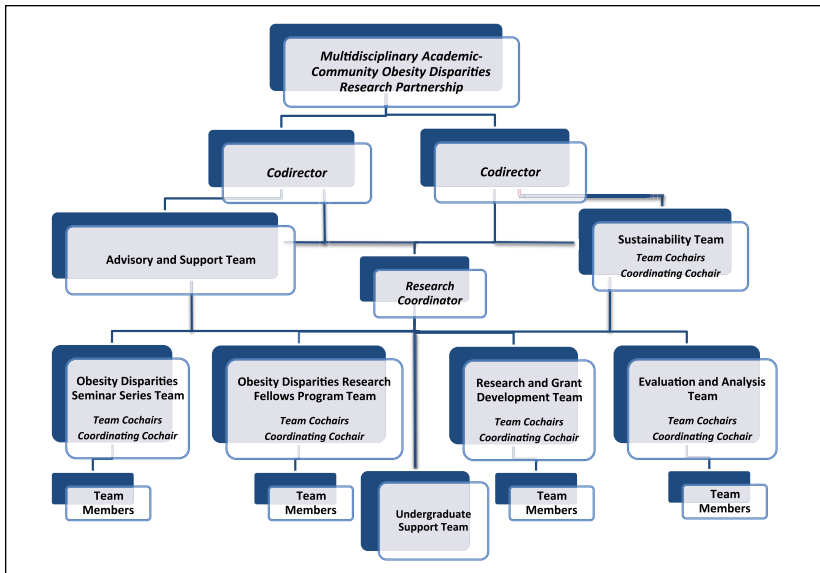
Figure 1. Organizational structure of the Multidisciplinary Academic-Community Obesity Disparities Research Partnership.

Each leadership team has three cochairs, at least one of whom is a community member (and patient) and at least one of whom is an obesity researcher. Additionally, each leadership team has various members who choose to serve on that particular team. Each team also has a graduate student coordinating cochair who assists the cochairs and team members in executing their tasks. Finally, the Partnership includes an Advisory and Support team of advisors and supporters interested in reducing obesity, such as academic department chairs, deans, and vice presidents. Most of this team consists of non-Latino White males (80%), which is representative of department chairs, deans, and vice presidents at the university. We note that the university is located in or near each of the participating communities.

The codirectors, cochairs, leadership team members, and coordinating cochairs are diverse with regard to race and ethnicity, gender, age, and sexual orientation. This diversity is likely the result of (a) the reality that the two communities whose obesity intervention research interests provided an impetus for developing the Partnership are culturally diverse and include many individuals with low incomes, and (b) the reality that researchers who co-conduct CBPR typically include disproportionately large numbers of minority

researchers who come from communities plagued by disparities in health care outcomes, access, and quality. As a result, these researchers are inspired to conduct community-engaged research to address such disparities.

It is also noteworthy that the Partnership is multidisciplinary and its members' demographics are represented in the communities where the research is conducted. The Partnership is multidisciplinary in that its members represent various types of community organizations (e.g., the local health department and local community health worker association) and include faculty members, providers, and graduate students from different academic departments and disciplines (e.g., counseling psychology, health and human performance, health policy, medicine, public health). In addition, the demographic characteristics (i.e., race and ethnicity, gender, age, and sexual orientation representation) of the members of the Partnership are consistent with the demographic characteristics of the two communities that these partnership members represent. Further, the major community stakeholders (e.g., churches, community health clinics, health advocacy groups) in each community are represented in the Partnership. Approximately half of the nonstudent members of the Partnership struggle with overcoming overweight or obesity. The membership diversity within the Partnership facilitates trust among partnership members and thus promotes partnership sustainability and effectiveness (Hollander, 2012a; Horowitz et al., 2009).

The Partnership consists of over 80 members, including researchers ($n = 34$), community stakeholders ($n = 12$), patients and family members of patients ($n = 17$), healthcare providers ($n = 11$), and graduate students ($n = 12$), as well as the Advisory and Support team of academic department chairs ($n = 5$) and deans/vice presidents ($n = 4$). This nine-person Advisory and Support team participates in the Partnership as needed by the codirectors of the Partnership and cochairs of the leadership teams. Approximately 50% of the 80 members of the Partnership participate in one of the leadership teams at any one time. The other 50% attend quarterly meetings of the Partnership and/ or participate in the activities of the partnership (e.g., participate in community seminars sponsored by the Partnership, help disseminate research findings from obesity research spearheaded by members of the Partnership).

One of the two codirectors of the partnership (the professor in counseling psychology), the research coordinator, and a member of the Advisory and Support team are among the coauthors of this paper. It is also noteworthy that a team of approximately 50 culturally diverse undergraduate students in a health disparities course taught by one of the codirectors are unofficial members of the Partnership who receive course credit for volunteering to support the activities of the Partnership (e.g., by staffing the registration desk for seminars spearheaded by the Obesity Disparities Seminar team).

Challenges. There are challenges associated with applying the recommended practice of involving diverse, multidisciplinary, and representative leadership teams in initiatives to promote health and reduce health disparities through community-partnered research. Such challenges in the Partnership included recruiting sufficient numbers of culturally diverse patients and other community members with obesity and their family members to be research partners, involving these individuals in the leadership teams of the Partnership, and facilitating and maintaining frequent participation of these individuals in the activities of the Partnership. The recruitment goals for the Partnership included recruiting10 to 15 culturally diverse members for each leadership team partner group (i.e., community stakeholders, healthcare providers, graduate students, patients with obesity and their family members, researchers) as well as six Advisory and Support team members. These goals were met or exceeded, with the exception of recruiting only 12 of the 15 culturally diverse patient and family members that we sought to recruit. Furthermore, only 10 of these 15 members became active partners. The challenge that deterred recruiting 15 patient and family members was difficulty reaching individuals from this target group who expressed interest in being Partnership members. Many such individuals did not have email addresses and either did not answer their phones or had telephone numbers that had been disconnected at the time of our efforts to welcome them to the Partnership.

Another challenge has been involving patients with obesity and their family members as well as other community members and stakeholders in (a) preparing research grants and articles, and (b) preparing and disseminating community-focused reports and flyers that present pilot study findings in easy-to-read formats.

Strategies to overcome the challenges. With consent from the members of the Partnership, the codirectors of the Partnership hosted a retreat to address challenges faced by the Partnership in general, as well as those specifically faced by one or more leadership teams, codirectors, cochairs, and members of the Partnership who were not members of one of the leadership teams. All retreat participants were invited by the codirectors to present challenges and suggest effective strategies for addressing them. Subsequently, a vote was taken to determine the strategies to be implemented. The retreat participants unanimously agreed, both at the retreat and at follow-up general meetings of the Partnership, to use several strategies to address the aforementioned challenges. The strategies that have been implemented or are in progress are (a) each leadership team is in the process of recruiting a patient or family member of a patient with obesity to join the Partnership; (b) patients and family members are now given a small honorarium to cover fuel and other expenses

incurred when attending each meeting and event (e.g., a seminar on obesity prevention); (c) separate group meetings now occur with patients and family members to promote sharing of their views regarding the activities of the partnership; and (d) patient, family, and community members, as well as graduate students in the partnership, have been recruited by the codirectors and the cochairs of the Sustainability team to coauthor research articles, community reports, and professional presentations.

Efforts are still underway to recruit more American Indian and sexual minority individuals to join the Partnership, as these two obesity disparity groups are underrepresented in the Partnership. A method we have successfully used to support this continued effort is to empower partnership members who represent these two identities to use their unique knowledge and expertise to design and implement recruitment strategies.

Establishment of Egalitarian Leadership Structures

Partnership teams that implement CBPR to address health disparities should have democratically elected leaders and transparent procedures and processes, and should promote representation, participation, and equitable distribution of power. The Partnership employs such an egalitarian leadership structure. Each of the five leadership teams in this partnership is led by three diverse cochairs who represent the members of these teams (i.e., community stakeholders, healthcare providers, graduate students, patients with obesity and their family members, researchers). These leadership teams and their cochairs function as semi-independent units within the larger partnership structure in that they establish their own leadership processes and goals. However, they follow the aforementioned guiding principles for socially just leadership.

Each of the leadership teams has culturally diverse team members from each of the two participating communities. The members of the leadership teams work with their respective cochairs as equal partners in deciding the work of the cochairs, in deciding the specific goals of their leadership team, and in executing the activities required for goal achievement. It is noteworthy, for example, that a community member on the Research and Grant Development team is currently serving as a coprincipal investigator on a grant proposal recently submitted by the Partnership focused on reducing obesity among African American women patients at primary care clinics.

Challenges. The Partnership experienced two challenges in employing egalitarian structures. One challenge was research member cochairs (vs. community member cochairs) taking over at meetings. For example, research

member cochairs typically gave leadership team reports at general partnership meetings. This left community member cochairs somewhat marginalized. The second challenge was that the cochairs of each leadership team began to shift too much of their work and associated power to the graduate student coordinating cochairs because the team cochairs were too busy to complete this work. For example, some of these students were asked to contact speakers for community events and research presentations, write the letters of invitation for these speakers, and give the team reports at the general meetings for all Partnership members. However, the written responsibilities of the graduate student coordinating cochairs are limited to recording and disseminating notes on meetings of their leadership team, providing input on the decisions of their respective leadership teams, and reminding team members of upcoming meetings.

Strategies to overcome the challenges. To overcome the aforementioned challenges, at the request of the cochairs for each team and the codirectors, team members reviewed and clarified the roles of leadership team members. These role clarifications were written and shared at a general meeting of the Partnership. Team members also agreed that the codirectors and cochairs would periodically check in with the graduate student coordinating cochairs and the doctoral student research coordinator for the Partnership to make sure that they are all engaging solely on tasks consistent with their roles and responsibilities. Additionally, members attending a general meeting of the Partnership decided that the duty to report on the progress of each leadership team would rotate among members of that team.

Promotion of Equal Power, Participation, and Influence

The recommended practice of promoting equal power, participation, and influence is an important defining characteristic of socially just leadership. This practice is essential to achieving the social justice goals of CBPR (Johnson, Diaz, & Arcury, 2016), and is necessary for establishing community-university partnerships that are effective in accomplishing their health outcome goals (Wilson, Campbell, Dalemarre, Fraser-Rahim, & Williams, 2014). This practice of power sharing, which should ideally occur within leadership teams as well as in a partnership as a whole, involves several strategies. One of these strategies is identifying and valuing the unique expertise of various stakeholders in a partnership. Implementation of this strategy is facilitated by (a) providing many opportunities for all members of the partnership to point out how each other's strengths contribute to the success of the partnership, and (b) creating and maintaining an environment in which all

members feel safe to express their opinions and ideas. This safety can be achieved in many ways, such as by leadership team members modeling open expression of ideas, providing encouragement for other members of the partnership to share their ideas, expressing appreciating to members of the partnership for openly sharing their ideas when they do.

It is important to note that participation and influence do not have to be equal across all domains of expertise. For example, patients, family members, and some community members in partnerships that conduct CBPR, would be unlikely to take the lead in determining the data analysis strategies for the research, unless they had expertise in this area. On the other hand, the researchers in the partnership are unlikely to take the lead in planning how an intervention can be adapted for the community setting in which it will be implemented (e.g., church).

However, community members and researchers should share expertise in all research and intervention decision-making. In fact, colearning and sharing expertise are key principles of CBPR (Israel et al., 2005). For example, researcher partners ideally should share the advantages and disadvantages of analyzing data in various ways, using lay language and requesting input from community members. Likewise, when churches are involved, church leader partners ideally should share the details about the organizational structure and resources of their churches, as well as their ideas about how to structure interventions to be tested in their churches. The researchers could then provide input on necessary components of the intervention for research.

Another strategy for promoting equal power, participation, and influence in partnerships to conduct CBPR is using a democratic approach when establishing processes and procedures. One of the principles of good community-university partnerships is that the "roles, norms, and processes for the partnership are established with the input and agreement of all partners" (Community-Campus Partnerships for Health Board of Directors, 2013; Wilson et al., 2014, p. 12821). This basic principle serves as the foundation for all of the recommendations for socially just leadership presented in this article.

Using the aforementioned democratic approach to socially just leadership requires removing barriers to participation as well as collaborative decision making. These barriers can weaken a partnership's ability to achieve its mutually beneficial goals (Lasker & Weiss, 2003). The most significant barriers to joining and participating in leadership teams are communication barriers. Some specific examples of these communication barriers are (a) not having access to, or having discomfort using, the Internet and/or email; (b) scheduling meetings during community members' work hours, thereby preventing their attendance at these meetings; and (c) using high literacy and scientific language. According to the Principles of Good Community-Campus

Partnerships, communication between partner stakeholders should be clear, open, accessible, and responsive to the needs of members (e.g., use of language that is understood by individuals at all formal education levels; Community-Campus Partnerships for Health Board of Directors, 2013; Wilson et al., 2014). The CHG model suggests that listening actively, empathizing, and using common language are essential in such partnerships.

Challenges. The challenges faced in the promotion of equal power, participation, and influence in the Partnership include the following: (a) codirectors' and some cochairs' initial underestimation of community members' ability to understand research documents and presentations, (b) community members' reluctance to share their views during leadership team and Partnership meetings, (c) difficulty finding conference call services that do not require members to make long-distance calls to participate, and (d) difficulty identifying a time when all 80 members could attend general meetings of the Partnership.

Strategies to overcome the challenges. Several strategies were used to address the aforementioned challenges. One strategy was that the Sustainability team reviewed the evaluations of the research seminars and found that community members in attendance (e.g., patients with obesity and their family members, and community stakeholders) reported understanding and enjoying these seminars, and finding them helpful. This was encouraging, as the codirectors have consistently asked all research presenters within and outside of the Partnership to make sure their presentations are understandable to a lay audience.

Another strategy is that the Sustainability team now routinely conducts separate informal telephone and in-person meetings with patients and family members and other community members in the Partnership to answer their questions and solicit their input on planned and past activities of the various leadership teams. For example, input on each aspect of an obesity research grant proposal was sought at these informal meetings. Additionally, the codirectors of the Partnership received approval from its members to audiotape meetings so that members who had to personally pay for meeting conference calls could instead listen to these audiotapes and provide their feedback on what they heard to any of the codirectors and cochairs. Furthermore, all members of the Partnership agreed that minutes of its general meetings would be emailed or mailed to all partner members.

A strategy has also been implemented to respectfully accommodate members of the Partnership and members of communities served by the Partnership who prefer to speak and obtain information in Spanish. Specifically, all instruments, informed consent documents, and other

written materials for potential and current community member research participants, are available in Spanish. Bilingual members of the Partnership serve as interpreters when needed to conduct separate discussion sessions, training sessions, and focus groups in Spanish. These and similar accommodations are facilitated by having several doctoral students and members of the Partnership who speak Spanish.

Identification of Mutually Beneficial Activities and Goals

It is important for partners, and specific subgroups within the partnership (e.g., leadership teams), to agree on ultimate goals for the partnership and on subgroup-specific goals. The establishment of a shared purpose among partners has been shown to lead to increased team cohesion, and thus better functioning shared leadership (Denis et al., 2012). The shared purpose may include having multiple goals related to both outcomes and process. For example, although the ultimate goal of the Partnership is to plan and implement CBPR to reduce obesity disparities in two nearby communities, the related goal of the Research and Grant Development team of this Partnership is to obtain research grants to fund this research. A related goal of the Sustainability team is to obtain local funding to support partnership activities, such as travel costs for patients and family members to attend obesity reduction-related events (e.g., community workshops on healthy eating, research seminars on obesity reduction interventions).

To maximize the benefits of Partnership activities for all members, including researchers and community members, the location of each of the different types of activities (e.g., research-focused activities, community intervention-focused activities) alternates between the two participating communities. Furthermore, members of the Partnership attend all activities, resulting in community members learning about obesity reduction research, as well as researchers learning about the communities' needs and interests related to obesity. This bidirectional learning increases the likelihood that diverse members of the Partnership can promote its various goals.

Challenges. The challenges experienced by the Partnership when identifying mutually beneficial goals and activities were the pressure by researchers on the Research and Grant Development team to give priority to its grant writing and related research project implementation goals over other goals of the Partnership. This pressure came from the need of the obesity researchers on this leadership team to obtain research grants and publish research articles to receive tenure and promotion, high job performance ratings, and/or to be competitive for professional positions.

Strategies to overcome the challenges. The following decisions were agreed to by the members of the entire Partnership in an effort to address the aforementioned challenges: (a) researchers and other members of the Partnership will each be provided a letter upon request regarding their important and time consuming work in the Partnership—a letter signed by the codirectors of the Partnership (one of whom is an endowed chair in health disparities research and both of whom have much experience in coleading CBPR); (b) researchers will be provided a letter of support from the Partnership to include in their research grant applications, aside from grant applications submitted by the Partnership; and (c) researchers can use pilot data obtained by the Partnership to help support their own independent grant proposals. The letter mentioned in item (a) of this paragraph includes information on the rigor and importance of CBPR and the increasing funding of such research by the NIH, the CDC, and other funding agencies; consequently, these letters can be very helpful as documents in support of tenure and promotion, even at research-intensive universities. Furthermore, the letter provides education about CBPR and potential funding for such research that decision makers in the tenure and promotion process tend not to know. The hope is that they may subsequently view such research more favorably in their evaluation of tenure and promotion packets. Together, the aforementioned decisions inspired the members of the Research and Grant Development team to support the work of the other leadership teams and learn more about conducting CBPR, rather than just preparing grant proposals and research articles as their only work in the Partnership.

Promotion of Facilitative Attitudes, Values, and Structures for Sustained Goal Attainment

Leaders of CBPR must have an authentic commitment to the recommended practices for socially just leadership. A cornerstone of these practices is facilitating attitudes and values, and implementing structures, that promote and sustain the goals of a CBPR partnership. When the partnership involves culturally diverse community members and aims to make lasting changes in one or more communities, this cornerstone aspect of socially just leadership is particularly important and challenging. It requires culturally sensitive leaders who deeply believe in, and strive to promote, values and actions that foster working together to make long-term, positive community changes. Lasker and Weiss (2003) reminded readers that "community collaborations appear to benefit from having leaders and staff who believe deeply in the capacity of diverse people and organizations to work together to identify, understand, and solve community problems. These kinds of individuals understand and appreciate different perspectives, are able to bridge diverse cultures, and are comfortable sharing ideas, resources, and power" (p. 30).

Both the partnerships and their leadership structures must be sustainable. This sustainability is achieved through meaningful involvement, ownership of solutions and outcomes, strong group dynamics and relationships, trust among all members of the partnership, and acquisition of resources to support the partnership (Lasker & Weiss, 2003; Young, Patterson, Wolff, Greer, & Wynne., 2015). Positive group dynamics and strong relationships are fostered through use of the aforementioned democratic features of a social justice leadership approach. Trust and respect among leadership team members and other members of a partnership are facilitated by open communication, such as sharing of all information relevant to the partnership, including details about the expenditure of funds supporting the partnership. Resources to sustain a partnership come from grants and financial support by business stakeholders. In community-university partnerships, the university partner can, and ideally should, provide some of the needed resources to support these partnerships, particularly given that such partnerships typically aim to improve the community of which it is a part.

Challenges. One challenge that the Partnership has faced is that many of the cochairs and members of its leadership teams have had minimal previous experience interacting with community members who identify as racial and ethnic minorities, sexual minorities, and/or other minorities. Yet, there is strong interest among members of the leadership teams in developing the attitudes, values, knowledge, commitment, and skills needed to work respectfully and cooperatively with all members of the Partnership and to help empower health disparity communities in promoting their own health.

Other challenges involve sustaining goal attainment. These challenges included deciding (a) the funding needed to sustain the Partnership and its research and service activities, and (b) how to use the funds in ways that are equitable and promote trust of the codirectors of the Partnership (who are the individuals held responsible for the funds awarded to the Partnership from its university partner). Another sustainability challenge is measuring the outcomes of the partnership, including those related to sustainability.

Strategies to overcome the challenges. The Partnership conducts health promotion events in minority communities, which provides opportunities for cultural immersion to the cochairs of the leadership teams and other members of the partnership who have had limited interactions with members of communities experiencing health disparities. Activities at retreats and other in-person meetings of the Partnership also are designed to provide awareness of health and health care injustice, and thus inspire genuine commitment to socially just leadership and to the goal of health justice by all members of the Partnership. Cochairs and members of the leadership teams who hold the

values and attitudes that are core aspects of social justice also share these values and attitudes with their peer leaders who are new to the social justice approach required to conduct CBPR to reduce disparities.

To overcome the sustainability-related challenges, the codirectors of the Partnership and the cochairs of the leadership teams, along with the other members of the Partnership who were involved in its creation, have formed a Sustainability team whose primary responsibilities are to obtain funding and other resources (e.g., cost-free places for holding research, educational seminars, and activities) to sustain the Partnership and promote awareness of the Partnership and its work. The Sustainability team, in collaboration with one of the codirectors of the Partnership, was successful in obtaining multi-year funding from the partner university's Vice President for Research to support the Partnership. This funding was awarded with the understanding that the Partnership would work through its Research and Grant Development team to prepare grant proposals to reduce obesity disparities using CBPR. Determining the amount of funding to seek was a participatory process that involved having each leadership team set its goals and related activities for each of 3 years and then provide a minimum budget required for achieving these goals and activities. The resulting multicomponent budget was instrumental in bringing about the decision of the aforementioned Vice President of Research to provide the funding requested in the collective budget.

To promote trust and respect among all members of the Partnership, the codirectors suggested, and the members of the Partnership agreed, that the funding received would be allotted to the leadership teams based on their submitted budgets. The cochairs of these teams are responsible for documenting expenditures and keeping them within their respective budget allocations. The Sustainability team also created a community-focused brochure and flyer and a researcher-focused brochure and flyer for the purpose of disseminating information about the Partnership and its activities—documents that are used in grant proposals and in public relations efforts that sustain and increase membership in the Partnership.

To facilitate evaluation of the sustainability of the Partnership, the Evaluation and Analysis team collects data on (a) the level of participation in the Partnership by its members; (b) the usefulness of, and satisfaction with, research, intervention, and education seminars as perceived by community members and others who attend these seminars; and (c) each leadership team's self-rated levels of success in achieving its goals and objectives. These evaluation activities are consistent with published program evaluation standards set forth by Yarbrough, Shulha, Hopson, & Caruthers (2011), emphasizing that program evaluations should be culturally sensitive and consistent

with the views and values of the stakeholders. The Evaluation and Analysis team and the Sustainability team also cohost an annual retreat for the Partnership to identify actions needed to strengthen it, as well as identify problems and solutions to help sustain the Partnership.

Empowerment of Groups Who Experience Health Disparities

Empowerment of racial and/or ethnic minorities, sexual minorities, individuals who are medically underserved, and other individuals, families, and communities with limited power who typically experience health disparities is recognized as (a) a global strategy for reducing health disparities (Thompson, Molina, Viswanath, Warnecke, Prelip, 2016; Tucker, Arthur, Roncoroni, Wall, & Sanchez, 2013; Tucker et al., 2013; Wallerstein, 2002), and (b) the cornerstone of the guiding principles presented in this article. This empowerment requires sharing of social and economic power by those who have much of this power with those who have limited power, which is not easy. For example, in community-university partnerships, university administrators and researchers may be resistant to sharing grant funding with community member partners (Sadler et al., 2012; Wilson, Campbell, Dalemarre, Fraser-Rahim, & Williams, 2014). Additionally, researchers engaged in CBPR are typically reluctant to change their research methods to accommodate the views and wishes of their community partners (Sadler et al., 2012; Wilson et al., 2014).

Empowerment often comes with knowledge of one's own power; thus, it is important to train community members in CBPR so that they learn their rights and responsibilities, and their value and importance in this research. Accordingly, the NIH and other federal agencies are increasing funding for projects to train community health workers and other community leaders to engage in CBPR as full research partners.

Challenges. There were three challenges to enabling the leadership teams and codirectors in the Partnership to advocate for and promote power sharing across the various constituencies. These challenges included (a) addressing policies of the partner university that obstruct academic leaders in this partnership from including their community member partners as coinvestigators on their grant proposals, (b) following policies of the Institutional Review Board (IRB) for the partner university that make it extremely difficult for community member leaders in the partnership to become IRB-approved investigators for CBPR projects, and (c) overcoming the limited knowledge among community member leaders and some of the academic researchers in the Partnership regarding how to conduct CBPR.

Strategies to overcome the challenges. Three strategies were implemented to overcome these challenges. First, the codirectors of the partnership and members of the Research and Grant Development leadership team engaged in a series of meetings with the institutional review board (IRB) to develop community-friendly procedures for community members to become IRB-approved investigators on CBPR projects. An example is the implementation of shorter and simpler training requirements for community member researchers. Establishment of these procedures was a major accomplishment, one that removed a major barrier to community leaders' research involvement in the Partnership and that promoted the empowerment of community members to be equal research partners.

The second strategy is that the codirectors investigated the policies of the partner university regarding coinvestigators and found that community members can be coinvestigators on certain grants from funding agencies that allow it. Fortunately, the number of funding agencies that allow community member coinvestigators will likely increase given the growing number of federal agencies that are funding CBPR (e.g., AHRQ, CDC, Environmental Protection Agency, Housing and Urban Development, and some of the NIH, such as the National Institute of Minority Health and Health Disparities). It is noteworthy that some federal agencies that fund community engaged research actually strongly encourage the inclusion of community member coinvestigators (e.g., Patient-Centered Outcomes Research Institute).

In the third and most recent strategy, the Partnership took a major step toward empowering groups who experience health disparities. Specifically, it partnered with the Florida Community Health Worker Coalition, Inc. to obtain funding to train community health workers, members of the Partnership, and interested others to engage in CBPR and promote minority health across and beyond Florida. Specifically, an R13 grant proposal was recently funded by the National Institute of Minority Health Disparities to offer a conference designed to provide this training. Because community health workers (i.e., individuals in a community who are trained to varying degrees to promote the health of their respective communities) are increasingly recognized as valuable partners in CBPR, the aforementioned coalition was chosen as an ideal community partner for cosponsoring the CBPR training conference.

Lessons Learned

We have learned important lessons with regard to implementing a socially just leadership approach. One lesson learned is that a socially just leadership approach to reducing health disparities ideally involves multidisciplinary leadership teams that include members of the health disparity group

prioritized (e.g., racial and ethnic minorities) among the cochairs of these teams. Additionally, socially just leaders must be informed about the suggested practices that characterize a socially just leadership approach. Involving counseling psychology students as coordinating chairs of the leadership teams has proven to be an ideal way of training the next generation of socially just leaders in counseling psychology.

Counseling psychology students and others in socially just leadership roles should, as part of their training, acquire first-hand knowledge about CBPR. They can learn through activities such as reading articles on CBPR and socially just leadership, reviewing grant proposals on CBPR, attending seminars on CBPR, and participating in cultural immersion activities (e.g., attending services at a Black church) in minority communities negatively impacted by health disparities. These activities are included as requirements in a graduate course taught by one of the codirectors of the Partnership and offered yearly through the counseling psychology program. The course is titled *Health Disparities Research and Intervention Approaches: Using a Social Justice Lens*, and it had been taken by some of the graduate students in the Partnership. Most of the counseling psychology graduate students also were and continue to be members of this professor's culturally diverse research team that is conducting CBPR aimed at helping to reduce obesity disparities. We are hopeful that such research can occur, and the aforementioned course can be taught, in many counseling psychology programs.

We also learned that enacting an approach that is informed by the recommended practices for socially just leadership requires leaders who are willing to share power with their peer leaders, including members of the community who are leadership team members. This power sharing often requires more than just a willingness to share power. Socially just leaders (including community members, researchers, providers, community stakeholders, and graduate students) often have to be agents of change in removing structural and policy barriers to equality.

Another lesson learned is that socially just leadership is ideal for conducting CBPR to reduce health disparities. This is because social justice and CBPR share core values of inclusion, empowerment, cultural sensitivity, and equity. Yet, valuing social justice and CBPR among health disparity researchers is not easy, particularly among individuals who grew up with privilege and power, and who may not be completely comfortable relinquishing it. Yet, with the support of leaders who do value social justice and CBPR, and with engagement in cultural immersion experiences in health disparity communities, even leaders with privileged backgrounds can embrace socially just leadership and support social justice-promoting activities in general, and CBPR in particular.

Finally, socially just leadership to reduce health disparities through CBPR requires leaders who are researchers to adapt their science to the community structures and community environment in which their research will be conducted. This adaptation takes time, but often improves the quality and translational utility of the research. Furthermore, community-adapted research provides improved utility in addressing community health concerns, as well as a greater likelihood that research results can and will be used by members of the community.

There are numerous practical challenges to conducting CBPR to reduce health disparities. For example, time constraints and deadlines often tempt partnership leaders to forego the recommended practices for socially just leadership in an effort to complete partnership-related projects on time. Partnership leaders need to understand the importance of beginning CBPR projects early to account for the additional time needed to engage in collaborative decision making. Establishing leadership teams specifically to monitor partnership functioning in CBPR can reduce some of the missteps that could arise from having to attend to many research-related initiatives at once.

Benefits to Counseling Psychology of a Socially Just Leadership Approach for Conducting CBPR to Reduce Health Disparities

The field of counseling psychology has historically been committed to the key processes involved in reducing health disparities, including prevention of disease and the development of primary interventions that are responsive to individual and group differences. Furthermore, the field has emphasized recognition of human strengths, promotion of well-being, and the enactment of advocacy for social justice and health justice, all of which has positioned counseling psychologists well for their increasing role in addressing health disparities (Buki & Selem, 2012).

Although engaging in a socially just leadership approach to conducting CBPR has many challenges, the benefits of conducting research in this manner are worth the costs. Counseling psychology researchers who hold strong personal and professional social justice values are likely to find socially just leadership rewarding in that it promotes community empowerment and works to dismantle the dominance and mistrust that have historically plagued the relationship between researchers and community members.

The socially just leadership approach presented in this article offers unique opportunities for academic counseling psychologists to emerge as leaders within their university. For example, counseling psychologists can engage other researchers who otherwise may never have been exposed to socially

just leadership and the CBPR approach to reducing health disparities. At best, this could help to change the culture of universities to value and respect the participation of community members in research. Without such a culture change, research will continue to be more beneficial to researchers than to communities in need.

Another benefit of the socially just leadership approach is that it offers counseling psychologists a practical structure and specific strategies for leading research efforts to reduce these disparities. It is equally important that the suggested leadership approach fosters the training of future counseling psychologists (i.e., graduate students in counseling psychology doctoral programs) to be socially just leaders prepared to colead CBPR to reduce health disparities.

This article serves as a call for more counseling psychologists to engage in methods of research and leadership that promote health justice and empowerment. Because the recommended practices for socially just leadership exemplify the values of social justice, these practices may be a particularly good fit for counseling psychologists. Furthermore, the Partnership offers a useful example of how academic counseling psychologists can apply the recommended practices for socially just leadership in their work to reduce health disparities.

Declaration of Conflicting Interests

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