

Chapter 2

Community-Based Collaborations: Designing, Conducting and Sustaining Prevention Programs

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Public health issues have stimulated collaborative prevention and treatment research among researchers, service providers, community members, and consumers. Community-based collaborations can enhance the relevance of research questions and maximize the usefulness of research findings. In addition, collaborative partnerships can help you develop study procedures which are acceptable to potential participants and are sufficiently flexible to navigate common obstacles to conducting research in community settings. Further, community collaborative research efforts can expand community-level resources to serve as a foundation for sustaining evidence-supported intervention and prevention programs after research or demonstration funding has ended (Israel et al. 1998; Institute of Medicine 1998; Schensul 1999; Hoagwood et al., 2010; Wandersman 2003). Perhaps most importantly, collaborative research efforts can shorten the time for translating scientific findings into service options within “real world” communities (Bell et al. 2008). Thus, collaborative research partnerships have direct benefits to both you as the investigator and community members, by ensuring that a proposed study will focus on public health issues of highest relevance to key stakeholders and yield information that can be applied to the “real world.”

You need to be aware of the commitment that policy makers and funders have to increasing the levels of community collaboration that support proposed studies. For example, included in the National Institute of Mental Health’s (NIMH) strategic plan, is an emphasis on the need to “strengthen the public health impact of NIMH-supported research.” You would do well to heed these goals, as community collaboration is essential to achieve this objective.

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2.1 Definitions of Community Collaborative Research

A range of descriptions and definitions of participatory or collaborative research have been offered (Altman 1995; Arnstein 1969; Chavis et al. 1983; Singer 1993; Israel et al. 1998). There is agreement on some central themes and core foundational principles of participatory research efforts. On the most basic level, participatory research has been described as “providing direct benefit to participants either through direct intervention or by using the results to inform action for change” (Israel et al. 1998, p. 175). Further, what distinguishes community collaborative research from other investigative approaches is the emphasis on the intensive and ongoing participation and influence of consumers or community members in building knowledge (Israel et al. 1998). Research questions that result from collaboration between researchers and community members tend to reflect concerns, and acknowledge the importance of community-level knowledge and resources (Institute of Medicine 1998; Minkler and Wallerstein 2003; Secrest et al. 2004; Schensul 1999; Stringer 1996).

In a seminal paper, Israel et al. (1998) indicated that community collaborative research activities are defined by: (1) a recognition that community development must be a focus of research activities; (2) a commitment to build upon the strengths and resources of individual communities; (3) ongoing attention to involvement of all members of the collaborative partnership across phases of a research project; (4) an integration of knowledge and action for mutual benefit of all partners; (5) the promotion of a process that actively addresses social inequalities; (6) opportunities for feedback; (7) a commitment to addressing health problems from both a strength and an ecological perspective and; (8) dissemination of findings and knowledge gained to all partners (Israel et al. 1998).

Figure 2.1 provides a summary of five core principles that can impact both the process and outcome of collaborative efforts (McKay 2010). These include: (1) agreement and investment in shared research goals; (2) equitable distribution of power, including fair involvement in decision making and opportunities to modify aspects of the research process; (3) recognition of skills and expertise associated with both university training and community/consumer experience; (4) ongoing opportunities for communication based upon commitment to honest exchanges and willingness to raise concerns without blame and; (5) trust. As indicated in Fig. 2.1, each of these collaborative principles can be assessed along a continuum, with the far right hand side being defined as the most intensive level of collaboration, while, the left hand side mirrors low levels of collaboration.

2.1.1 Goals

First, the development of shared research goals that are acceptable to both you and key stakeholders is necessary to ensure productive collaborative efforts (Israel et al. 1998; Labonte 1994; Reed and Collins 1994). Clearly, a common

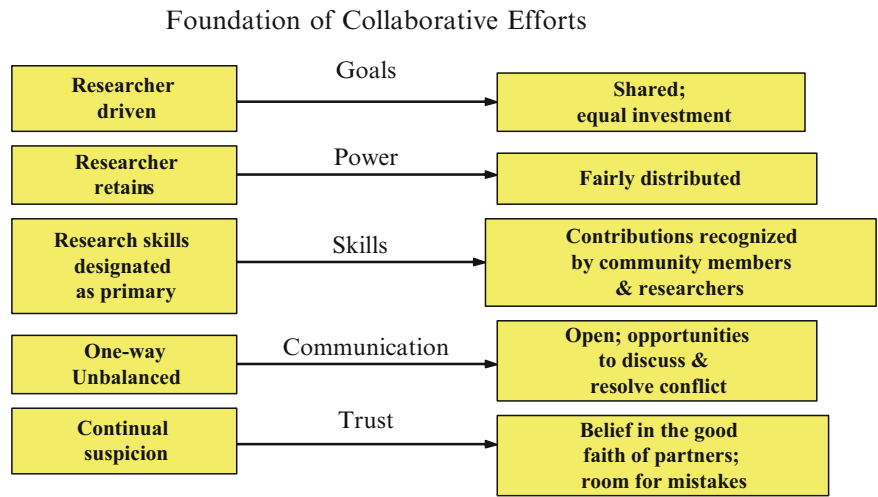


Fig. 2.1 Foundational principles of community-based collaborative research

goal shared by public health oriented researchers and consumers, families, service providers, and communities is the need to improve the health of all members of the community. However, specifying the goals that will guide your partnership and focus research efforts can require a melding of perspectives and priorities that often appear divergent initially. In the business world this is known as “shared vision,” and is necessary but not sufficient to establish a collaboration (Senge 1994). One practical way that collaborative partnerships have developed shared goals is by crafting a mission statement meant to guide the joint work (see Madison et al. 2000 for an example).

2.1.2 Power

How power is distributed in relation to the decision-making process is a critical concern in the formation of your collaborative partnerships. Wood and Gray (1991) identify sharing of power as being critical to the creation of longstanding partnerships. Many researchers and community members have voiced concern that unless power is shared among partners, rather than held by university-based researchers, the collaboration is essentially a facade (Hatch et al. 1993; Israel et al. 1998; Roe and Minkler 1995). You and your community collaborators each exercise their power in different ways. For example, your power as a researcher takes the form of specialized expertise (e.g., research and proposal writing skills) and access to research funding. Community members, on the other hand, exercise their power by both supporting research efforts and providing access to participants or by blocking opportunities to conduct research within their settings or

communities. The establishment of a study oversight or collaborative board which participates fully in the planning and direction of the project is one vehicle where you can ensure that power is shared (McKay et al. 2006; National Institute of Mental Health Multisite HIV/STD Prevention Trial for African American Couples Group 2008).

2.1.3 Skills

Distributing power among partners requires mutual respect for the skills and competencies of each collaborative partner. An important activity early in the partnership might be for you to identify the skills and competencies each partner brings to the collaboration (McKay and Paikoff 2007). For example, in collaborations with community members, there could be recognition that community members have knowledge regarding acceptable recruitment strategies or cultural practices that could be incorporated into innovative service delivery approaches. In modern business practice, this is accomplished by “team learning” (Senge 1994).

2.1.4 Communication

The development of shared goals, processes by which power is shared, and respect for individual and collective skills, all require ongoing communication between members of the partnership and a willingness to engage in productive conflict resolution. A “researcher needs skills and competencies in addition to those required in research design and methods, for example, listening, communication (e.g., use of language that is understandable and respectful), group process, team development, negotiation, conflict resolution, understanding and competency to operate in multicultural contexts, ability to be self-reflective and admit mistakes, capacity to operate within different power structures, and humility” (Israel et al. 1998, p. 187).

2.1.5 Trust

Closely linked with the necessity for ongoing opportunities to communicate is building trust between members (Friend and Cook 1990; Wood and Gray 1991; Singer 1993). Unfortunately, many community members can recount prior negative experiences with university-based research projects (Madison et al. 2000; Stevenson and White 1994). There is often substantial concern regarding your motivation to conduct research projects and questions regarding whether you are committed to the setting or community once your research funding is expended (McKay and Paikoff 2007). To quote Steven Covey:

Among the various human assets, relationships are particularly important. Weak relationships cause poor communication, tension, disagreements, jealousy, back-biting, and criticism – negative elements that are costly, both to the organization and to us as individuals. They drain time, energy, and resources that we might otherwise turn into corporate profit and personal fulfillment (Covey 1992).

These are core tenants of participatory research with an emphasis on the involvement of key stakeholders in every aspect of the research process. There have been few systematic attempts to identify the choices available to community/research partnerships throughout a given research project that would make this goal a reality. McKay and colleagues (Madison et al. 2000; McKay and Paikoff 2007) have identified a range of concrete opportunities to collaborate, and conceptualized possible levels of intensity during each research phase based upon prior work of Hatch et al. (1993). This model of collaboration across the research process is represented in Fig. 2.2 and incorporates key aspects of the paradigm.

2.1.5.1 Low-Intensity Collaborations

Hatch et al. (1993) propose that initial collaborative efforts may begin with a less intense form of collaboration whereby researchers consult with persons representing agencies or institutions within a specific community with for advice or consent.

At the next stage of collaboration, you need to identify key informants from the community (e.g., representatives from churches, business, etc.) and seek acceptance of the research project. Although this group of key informants is considered to be representative of community stakeholders, the research agenda and therefore, the decision-making power remain with the researcher. As collaboration proceeds, you might seek influential community leaders to provide advice and guidance at a particular point in a research study. You could then invite them to participate on a community advisory board (CAB) (NIMH 2008). Further, their assistance is actively sought so that community members can be hired by the project as paid staff and fill positions, such as interviewers or recruiters.

2.1.5.2 Moderate to High Intensity Collaborations

Hatch et al. (1993) indicate that although additional input is sought as collaborative efforts intensify, key decisions about research questions and decisions regarding research methods, procedures, and interpretation of study results are critical. At the highest level of collaboration, you should ensure that the university and community work together to develop the focus of the research and an action agenda. Then, all partners are responsible for pursuing these shared goals. At the most intense level of collaboration, there is true partnership between you and community members. The decision-making process is therefore a shared enterprise that recognizes the specific talents of both university and community members.

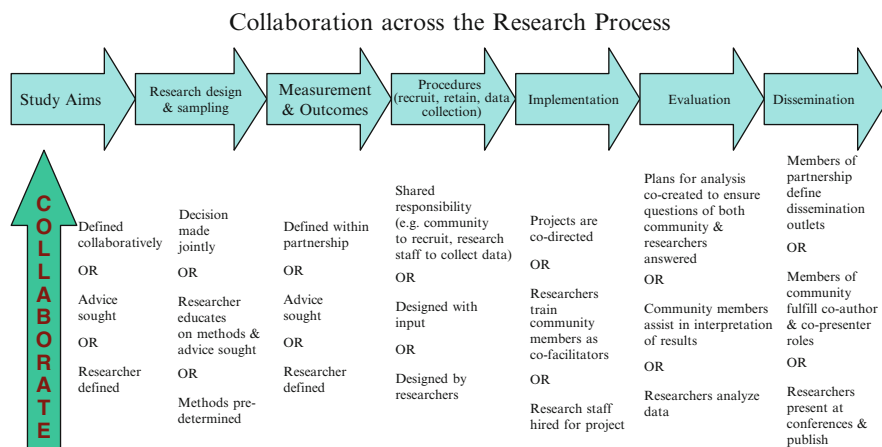


Fig. 2.2 Collaboration across the research process

As indicated in Fig. 2.2, researchers and community members can collaborate across all phases of the research process. For example, within an intensive community collaborative partnership, study aims are developed together. Thus, primary goals and objectives of a research study are informed by both the perspective of the most pressing community needs, as well as the knowledge brought by the researcher of broader health concerns, influences on health, available evidence-informed interventions and interests of research funders. Study aims can be collaboratively developed using a range of mechanisms, including community planning meetings, discussion forums, or the organization of advisory or collaborative working groups (see McKay, 2010).

Next, based upon primary research goals, decisions regarding research design, sampling and measurement need to be made. While you and your team possess much of the expertise associated with sampling strategies or measurement tools need to be shared in order to truly collaborate. You must begin a process where community collaborators become advanced consumers of research. Figure 2.3 graphically depicts the process that you need to create where knowledge about research can be exchanged.

A major task in the initial stage of collaboration is the establishment of a mission or values statement that addresses all parties' visions for the collaborative work and serves as a guide for future work in order to exchange information regarding research options and get productive feedback (Bell et al. 2007). Such a mission statement may contain any or all of the following elements: (1) summary of overall goals of a research study; (2) intention regarding translation of study findings to impact public health of community; and (3) description of a set of processes, both procedural and interpersonal, that will be employed to ensure that all activities and exchanges fuel the mission of the partnership.

Only after this initial phase, can the partnership focus on the exchange of information. A major task in this phase of the partnership is the development of a common language that facilitates communication between you and your team and your community partners. For community members, immersion in the planning and implementation of a research project helps further their understanding of the research, while for university members, immersion in the community aids in their understanding of the context of the work.

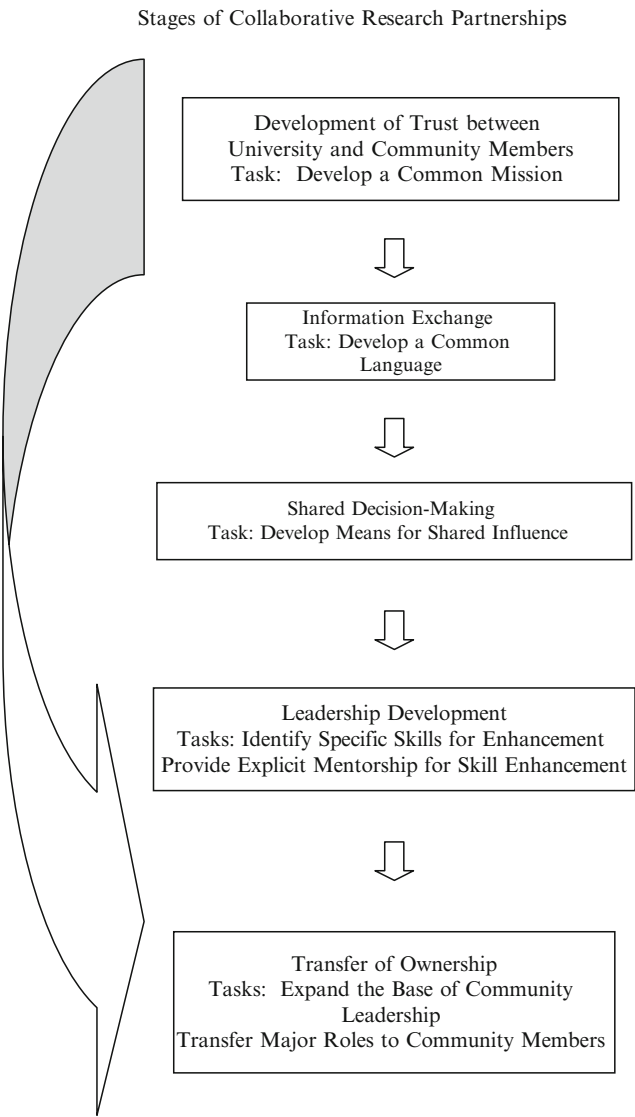


Fig. 2.3 Stages of collaborative research partnerships

In addition, it is incumbent on you to organize some type of introduction to research methods for all members of the partnership. McKay (2010) have published the contents of an 8-week community-oriented research seminar which focused on: (1) formulating research questions; (2) generating testable hypotheses; (3) reading and reviewing the literature; (4) strengths/challenges of research designs; (5) available sampling strategies, and; (6) conceptual description of data analytic approaches. Following this introduction, community members can then participate in reviewing: (1) research procedure used throughout the project, including recruitment or data collection procedures, and selection of measures; (2) progress of data collection and entry; (3) preliminary analyses; and (4) proposed presentations and publications of findings.

2.1.5.3 Shared Decision Making

Once a level of research understanding and competence is obtained by community members, your community-based collaboration can move into the third stage of shared decision making. In this stage, the task is to share influence, such that multiple stakeholders are involved in determining the direction of the work. This decision-making can be applied while planning for a grant application and then once funding for a research study is in place. Community collaboration can be critical because many research studies confront obstacles to involving community participants in projects given stigma and misgivings regarding research participation, particularly within historically disadvantaged community contexts (Bell 1996; Washington 2007). Collaborative partnerships may focus on increasing recruitment and retention in prevention research projects and might develop strategies such as incorporating consumers as paid staff or community members as interviewers or recruiters. These community representatives can fulfill liaison roles between youth and families in need and prevention programs (Elliott et al. 1998; Koroloff et al. 1994; McCormick et al. 2000). In some cases, community members can be the first contact that a youth or adult caregiver has with a specific prevention project.

As one moves to the right along the continuum in Fig. 2.2, community/university partnerships can also focus on facilitating the implementation of prevention approaches. For example, preventative interventions can be delivered by “naturally existing community resources,” such as teachers (Atkins et al. 1998) or parents (McKay et al. 2000). However, the involvement of community members in the delivery process of interventions or in key research activities, such as data collection required specialized training and supports. For example, the research/community partnership may undertake intensive joint training that would be of mutual benefit to all parties. Training modules on engagement and communication within a community context that are led by key community members can be of tremendous benefit to research staff, while manualized intervention protocols, or standardized instruments can prepare community members to more fully participate in all aspects of the research study (Bannon et al. [under review](#)).

2.1.5.4 Community Leadership for Sustainability

Finally, the penultimate stage of your university-community collaborative partnerships concerns community members taking a leadership role in disseminating research findings and putting them to use on behalf of their community. The outcome of this stage of your collaboration is planning to sustain the program within a community-based organization once research or demonstration funding has ended. Former U.S. Surgeon General (1977–1981), Dr. Julius Richmond has noted that in order to institutionalize interventions, three forces need to be present (Bell et al. 2007). (1) The first is the need to have a knowledge base or good science behind the intervention being institutionalized. (2) The second is having what Dr. Richmond, a pediatrician, referred to as having an “effector limb,” or an infrastructure that will actually implement the science. The presence of an “effector limb” is necessary to move “the science to service;” without one, the tendency is that the efficacious research gets published and put on a shelf, only to benefit the subjects in the experimental condition. We believe that one of the best means of developing an infrastructure to deliver the intervention is to develop a sound business plan that includes community collaboration. (3) Finally, the third essential element in institutionalizing an efficacious intervention is the development of the “political will” to get it put into practice. Community collaboration is critical to planting the seed to develop “political will.” Who better to demand that the community benefit from the research performed in their community than the community members that took active part in the research itself?

Further, within this stage of university-community collaborative partnerships, research findings can be publicized within the target community. This affords an opportunity for community members to participate in the preparation of study findings in the form of reports to policy makers, brochures to influence community members and publications in more traditional academic outlets. Further, defining opportunities for community members and researchers to co-present at local and national conferences provide important chances to enhance skill and truly collaborative partnerships for the field.

2.2 Summary

Finally, you must consider the strategic value of developing community collaborations in your career. Research, theories, models, measures, and technologies of how best to collaborate with the community are essential. You need to understand and learn the skill sets used in community collaboration, as outlined in this chapter, as a starting point. In our efforts to train novice investigators on how to collaborate with communities, we have suggested some of the leadership strategies found in business literature and have recommended such authors as Covey (1992), De Pree (2008), Senge (1994), Goleman (2005), and others. Science has clearly articulated efficacious prevention intervention models for various mental disorders, substance

abuse problems, and problem behaviors (Institute of Medicine 2009). The challenge for research and the future of research lies in our ability to construct and test models that move “science to service” in short time frames.

In sum, community based collaboration is important and has many benefits. Building relationships within your target community before writing your grant proposal is vital because it can provide you with valuable input with regards to relevant research questions and expectations, effective recruitment procedures and methods, and support via the fulfillment of various roles, through the individuals who are closest to the target communities. Then, intensive collaboration across the research process provides an opportunity to have a much larger pool of individuals invested in the success of the study and ready to take “real world” steps based upon findings. Finally, and critically important, if we want our research to help more than it currently does, we need community participation to move our science to service.

References

- Altman, D.G. (1995). Sustaining interventions in community systems: On the relationship between researchers and communities. *Health Psychology*, 14(6), 526–536.
- Arnstein, S. (1969). The ladder of citizen participation. *Journal of American Institute Planners*, 35(4), 216–224.
- Atkins, M., McKay, M., Arvanitis, P., Madison, S., Costigan, C., Haney, P., Zevenbergen, A., Hess, L., Bennett, D., & Webster, D. (1998). Ecological model for school-based mental health services for urban low-income aggressive children. *Journal of Behavioral Health Services and Research*, 25(1), 64–75.
- Bannon, W.M., Dean, K.M., Cavaleri, M.A., McKay, M.M., & Logan, C.A. (under review). A measure of urban community parents’ intention to collaborate in community-based, youth-focused HIV prevention programs. *Journal of Prevention and Intervention in the Community*.
- Bell, C.C. (1996). Taking issue: Pimping the African-American community. *Psychiatric Services*, 47(10), 1025.
- Bell, C.C., Bhana, A., McKay, M.M., & Petersen, I. (2007). A commentary on the triadic theory of influence as a guide for adapting HIV prevention programs for new contexts and populations: The CHAMP-South Africa story. In McKay, M.M. & Paikoff, R.L. (Eds.), *Community collaborative partnerships: The foundation for HIV prevention research efforts* (pp. 243–261). Binghamton, NY: Haworth Press.
- Bell, C.C., Bhana, A., Petersen, I., McKay, M.M., Gibbons, R., Bannon, W., & Amatya A. (2008). Building protective factors to offset sexually risky behaviors among black South African youth: A randomized control trial. *Journal of the National Medical Association*, 100(8), 936–944.
- Chavis, D.M., Stucky, P.E., & Wandersman, A. (1983). Returning basic research to the community: The relationship between scientist and citizen. *American Psychologist*, 38(4), 424–434.
- Covey, C.R. (1992). *Principle-centered leadership*. New York, NY: Simon & Schuster.
- De Pree, M. (2008). *Leadership jazz*. New York, NY: Doubleday Publishing.
- Elliott, D., Koroloff, N., Koren, P., & Friesen, B. (1998). Improving access to children’s mental health services: The family associate approach. In Epstein, M. & Kutash, K. (Eds.), *Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices* (pp. 581–609). Austin, TX: PRO-ED.
- Friend, M. & Cook, L. (1990). Collaboration as a predictor for success in school reform. *Journal of Educational and Psychological Consultation*, 1(1), 69–86.

- Goleman, D. (2005). *Emotional intelligence*. New York: Bantam Books.
- Hatch, J., Moss, N., Saran, A., Presley-Cantrell, L., & Mallory, C. (1993). Community research: Partnership in black communities. *American Journal of Preventive Medicine*, 9(Suppl 6), 27–31.
- Hoagwood, K., Jensen, P., McKay, M., & Olin, S. (2010). Redefining the boundaries: Community-research partnerships to improve children's mental health. In Hoagwood, K., Jensen, P.S., McKay, M., & Olin, S. (Eds.), *Collaborative research to improve child mental health services*, 3–14.
- Institute of Medicine (1998). *Bridging the gap between practice and research: Forging partnerships with community-based drug and alcohol treatment*. Washington, D.C.: National Academy Press.
- Institute of Medicine. (2009). In O'Connell, M.E., Boat, T., & Warner, K.E. (Eds.), *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, D.C.: National Academy Press.
- Israel, B.A., Schulz, A.J., Parker, E.A., & Becker A.B. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, 19, 173–202.
- Koroloff, N.M., Elliott, D.J., Koren, P.E., & Friesen, B.J. (1994). Connecting low-income families to mental health services: The role of the family associate. *Journal of Emotional and Behavioral Disorders*, 2(4), 240–246.
- Labonte, R. (1994). Health promotion and empowerment: Reflections on professional practice. *Health Education Quarterly*, 21(2), 253–268.
- Madison, S., McKay, M., Paikoff, R.L., & Bell, C. (2000). Community collaboration and basic research: Necessary ingredients for the development of a family-based HIV prevention program. *AIDS Education and Prevention*, 12, 281–298.
- McCormick, A., McKay, M., Marla, W., McKinnwy, L., Paikoff, R., Bell, C., Baptiste, D., Coleman, D., Gillming, G., Madison, S., & Scott, R. (2000). Involving families in an urban HIV preventive intervention: How community collaboration addresses barriers to participation. *AIDS Education and Prevention*, 12(4), 299–307.
- McKay, M. (2010). Collaborating with consumers, providers, systems and communities to enhance child mental health services research. In Hoagwood, K., Jensen, P.S., McKay, M., & Olin, S. (Eds.), *Redefining the boundaries: Creating partnerships for research to improve children's mental health*. Oxford University Press.
- McKay, M., Baptiste, D., Coleman, D., Madison, S., Paikoff, R., & Scott, R. (2000). Preventing HIV risk exposure in urban communities: The CHAMP family program. In Pequegnat, W. & Jose Szapocznik (Eds.), *Working with families in the era of HIV/AIDS*. California: Sage Publications.
- McKay, M., Hibbert, R., Lawrence, R., Miranda, A., Paikoff, R., Bell, C., Madison, S., Baptiste, D., Coleman, D., Pinto, R., Bannon, W., & CHAMP Collaborative Boards in New York & Chicago. (2006). Creating mechanisms for meaningful collaboration between members of urban communities and university-based HIV prevention researchers. *Social Work in Mental Health*, 5(1/2), 143–164. Also published in: McKay, M., & Paikoff, R. (Eds.). (2007). *Community collaborative partnerships: The foundation for HIV prevention research efforts*. New York: Haworth Press.
- McKay, M. & Paikoff, R. (Eds.). (2007). *Community collaborative partnerships: The foundation for HIV prevention research efforts in the United States and internationally*. West Hazleton, PA: Haworth Press.
- Minkler, M. & Wallerstein, N. (2003). *Community based participatory research for health*. San Francisco, CA: Jossey-Bass.
- Reed, G. M. & Collins, B. E. (1994). Mental health research and service delivery: A three communities model. *Psychosocial Rehabilitation Journal*, 17(4), 69–81.
- Roe, K.M., & Minkler, M. (1995). Combining research, advocacy, and education: The methods of the grandparent caregiver study. *Health Education Quarterly*, 22(4), 458–476.

- Schensul, J.J. (1999). Organizing community research partnerships in the struggle against AIDS. *Health Education and Behavior*, 26(2), 266–283.
- Secrest, L.A., Lassiter, S.L., Armistead, L.P., Wyckoff, S.C., Johnson, J., Williams, W.B., & Kotchick, B.A. (2004). The parents matter! program: Building a successful investigator-community partnership. *Journal of Child and Family Studies*, 13, 35–45.
- Senge, P. (1994). *The fifth discipline*. New York: Doubleday.
- Singer, M. (1993). Knowledge for use: Anthropology and community-centered substance abuse. *Social Science Medicine*, 37, 1, 15–25.
- Stevenson, H.C. & White, J.J. (1994). AIDS prevention struggles in ethnocultural neighborhoods: Why research partnerships with community based organizations can't wait. *AIDS Education and Prevention*, 6, 126–139.
- Stringer, E.T. (1996). *Action research: A handbook for practitioners*. Thousand Oaks, California: Sage Publications.
- The NIMH Multisite HIV Prevention Trial Group (Witte, Co-investigator, New York site). (2008). Methodological overview of an African American couple-based HIV/STD prevention trial. *Journal of Acquired Immune Deficiency Syndromes*, 49(1), s3–s14.
- Wandersman, A. (2003). Community science: Bridging the gap between science and practice with community centered models. *American Journal of Community Psychology*, 31, 227–242.
- Washington, H.A. (2007). *Medical apartheid*. New York: Doubleday.
- Wood, D.J. & Gray, B. (1991). Toward a comprehensive theory of collaboration. *The Journal of Applied Behavioral Science*, 27(2), 139.

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