Toward New Models for Research, Community, and Consumer Partnerships: Some Guiding Principles and an Illustration
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This article comments on four articles in this Special Issue pertaining to collaborative partnerships in community-based child mental health research. Several guiding principles are reviewed, and illustrations are provided based on the Research Evaluation and Training partnership between the University of Hawaii and the Hawaii Department of Health.

Key words: community, dissemination, evaluation, implementation, partnership. [Clin Psychol Sci Pract 15: 144–148, 2008]

The articles in this Special Issue make a compelling case that despite increased emphasis on externally valid, community-relevant child mental health services research (Chambers, Ringeisen, & Hickman, 2005; Fixsen et al., 2005; National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention, Development, and Deployment, 2001), service organizations’ and academic institutions’ goals often are in conflict. In what is often a zero-sum game of resources, researchers’ interests can be in conflict with those of the service organizations with whom they wish to partner. Academic clinical psychology has often supported the “lone investigator” model, under which researchers cultivate and accumulate grants and publications, not collaborators or partnerships. The articles by Frazier, Formoso, Birman, and Atkins (2008), Garland, McCabe, and Yeh (2008), Sieber (2008), and Sanders and Prinz (2008) outline the considerable complexity involved with truly collaborative research. Their examples suggest that the academic paradigm may be starting to change; however, the articles also point out that there are as yet no clearly articulated guidelines for going forward (e.g., Frazier et al., 2008). Building from the excellent ideas and insights in the articles in this issue, we offer a few of our own ideas about possible guiding principles and follow with an illustration of another research–community partnership in action.

Partnerships Must Include Not Only the Researchers and Service Agencies But Also Consumers
Research and delivery of mental health services stand to benefit tremendously if families and youth are involved in the process of collaboration. When possible, this partnership can happen at all stages of collaboration, including feedback on service delivery, formulation of research questions, identifying service and research gaps, and dissemination of findings. True collaboration will enrich all parties and lay groundwork for more informed collaboration over time.

Relationships Must Be Equitable
Projects should be based on a win-win-win proposition, in which consumers, researchers, and service agencies all
stand to benefit—not just the long-term benefits of adding to the research base. This involves the exchange of control and information about the aims and interests of each stakeholder. For the researcher, this represents compromise. Goals need to be transparent from the outset, and collaboration begins with an open discussion of what each party hopes to gain (e.g., obtaining grant funding, improving services or satisfaction with such services). In some traditions, scientific knowledge held by researchers was not shared at a deep level with consumers or service agencies. This can lead to an imbalance of power; sharing both broad and specific findings from science relevant to community partners balances that power, helps ensure equitable and ethical relationships, and builds scientific literacy throughout the collaboration.

**Partnerships Are Best When Built to Last**

Frazier et al. (2008) wisely stated that “community members and agencies are cautious about collaborating with researchers who may abandon them when the money runs out” (p. 125). Similar problems can arise from personnel changes (e.g., investigators moving to different departments or universities; turnover in agency leadership). The traditional approach of building collaboration around specific projects and individuals fails to safeguard the relationships from the kinds of changes that are routine in research and in practice.

One mechanism to deal with these types of threats to collaboration includes formalizing (or institutionalizing) a collaborative unit in both the academic and service settings. Such a unit would be committed to community collaboration, developing and supporting agency research, and evaluation capacities, and ideally would have a well-codified architecture for decision-making and resource allocation. For example, detailed documentation of roles, policies, and procedures can ensure that the collaboration may last beyond the specific research project or key personnel in place.

**Partnerships Should Be Committed to Capacity Development**

With newly emerging science–practice models (e.g., Weisz, 2004), ready access to information (e.g., Web-based searching), and sophisticated data-management systems, the worldviews of researchers and practitioners should be (and likely are) overlapping more. In this context, there are opportunities for scientist–practitioners to contribute to agencies and to communities in ways other than those derived from single specific studies (e.g., practice development, supervision, data-driven decision-making). A healthy collaborative partnership would seek to develop the strengths and capacities of the existing workforce (e.g., agencies inspiring a new set of questions in researchers; researchers developing the scientific literacy of service staff). Moreover, a successful partnership would support informed advocates for equitable collaboration and strengthen commitment to the fidelity of whatever programs have been implemented (cf. Sanders & Prinz, 2008). Finally, the involvement of new staff or graduate students would help prepare the next generation of leaders and provide additional insurance against workforce turnover threats.

**ILLUSTRATION: THE RESEARCH EVALUATION AND TRAINING PROGRAM**

It is with these guiding principles in mind that the Research Evaluation and Training (RET) Program grew out of an evolving collaboration between a university and a state department of health. This relationship is characterized by over 50 years of development and innovation and by over 10 years of formal partnerships regarding children’s mental health (see Chorpita & Donkervoet, 2005, for review). Recent developments include a state committee to identify and support implementation of evidence-based services (Chorpita et al., 2002), mechanisms for case and system review based on current scientific knowledge (Chorpita, Daleiden, & Weisz, 2005), data-driven quality improvement procedures (Daleiden & Chorpita, 2005), and routine reports about system functioning (e.g., Daleiden, Lee, & Tolman, 2004; Daleiden & Tolman, 2005).

On a personal level, both authors have been involved in many and varied community partnerships over their careers. The first author was instrumental in developing the Hawaii System of Care’s commitment to empirically based services and decision-making, has partnered with local health and education agencies in developing clinical training for both university students and the broader community, and has collaborated with these same agencies in implementation of a multisite randomized effectiveness trial. The second author has served as a research psychologist within public mental health and as the behavioral health representative for statewide HIV
planning; has conducted National Institute of Mental Health–funded research deeply embedded in the community; has worked with family violence, substance use, and health organization and agencies; and is currently the principle investigator for the RET project described herein.

RET is a health science and service learning partnership between the State of Hawaii's Child and Adolescent Mental Health Division (CAMHD) and the University of Hawaii. RET’s mission is to provide leadership on systems of care research and evaluation, create service-learning opportunities in behavioral health research and evaluation, and provide leadership and support for scientific literacy and data-driven decision-making within CAMHD and across other child-serving agencies. RET activities support and promote career paths in behavioral health and public service and prepare developing professionals for leadership roles in behavioral health service systems. RET strives to integrate system of care principles, high ethical standards, and scientific rigor to produce research and evaluation services that generate new knowledge, produce new decision support tools, and improve the quality of Hawaii’s child and adolescent system of care.

RET is staffed by one full-time clinical psychologist housed within the University of Hawaii, but with primary responsibility to CAMHD. One day/week is reserved for non–CAMHD professional activities. An additional faculty member is funded for about one day/week to provide support to the full-time psychologist-researcher, to support supervision of practicum students, and to develop special projects. Two students are funded through graduate assistantships within the University of Hawaii but are housed in CAMHD.

RET as an Educational Tool

Consistent with Garland and colleagues’ (2008) comment about the need for education and training in community-based research, RET makes available advanced practicum placements for students enrolled in the University of Hawaii scientist–practitioner clinical studies program. Practicum students are selected based on their background in direct services to youth and families, their interest in systems of care issues, and their willingness to participate in service learning opportunities in a complex service delivery environment. In general, advanced graduate students with child clinical foci are preferred. Each practicum is half-time (20 hours/week) and students are awarded tuition waivers and stipends roughly equivalent in amount to research assistantship positions. Students are provided weekly group supervision with the PhD-level psychologists and weekly over-the-shoulder supervision on specific projects. Monthly, didactics are provided, focused on systems of care, organizational psychology, program and systems evaluation, advanced statistical modeling, and managing complex data systems. Early in the training year, students are exposed to a wide variety of systems events and personnel so that they begin to develop personal relationships with key stakeholders and begin to learn about the day-to-day working of the system. Eventually, students are assigned to projects that fit with their interests and learning goals.

RET as a Research Engine

RET leads to, oversees, or consults wide variety of research and evaluation projects emanating from academe or the system of care. Projects range from quite applied and practical designed to inform local decision-making to projects designed to make substantive contributions to the scientific literature (and, not incidentally, to advance academic careers of those involved). Examples of project activities focused at the local-applied end of the continuum include producing annual reports about system functioning, supporting quality improvement projects, conducting or managing various employee, provider, and consumer surveys, and providing evaluation services to special projects or systems grants. Although these projects are designed for and funded by local interests and needs, many of them have contributed to the wider national debate and understanding about child mental health services (Chorpita et al., 2002; Daleiden & Chorpita, 2005). Other projects fall more on the academic, knowledge generation end of the continuum. Some recent and current projects include outcome assessment of multi-systemic therapy in a complex system of care (Mueller, Tolman, & Daleiden, 2006), psychometric qualities of monthly treatment progress ratings, descriptions of actual practices within treatment as usual (Nakamura, Daleiden, & Mueller, 2007), treatment planning drift over the course of services (Young, Daleiden, Chorpita, Schiffman, & Mueller, 2007), and predicting rate of improvement in youth receiving “high-end” public services (Tolman,
Stumpf, Mueller, & Daleiden, 2007). RET also serves as a liaison between CAMHD and the academic community and supports legitimate research activities within the system of care. To date, specific research initiatives and National Institute of Health grant proposals have been supported.

RET as a Workforce Development Tool

RET works to facilitate science-in-practice initiatives and workforce development. Providers and systems administrators are regular targets for science-based discoveries made through the program. The goal is to use science to improve client and system outcomes and to increase the “buy-in” of all stakeholders about the value of science in service delivery. As such, we believe we are developing a workforce (and consumer population) that is science literate and able to meaningfully digest and incorporate scientific findings into day-to-day decisions and able to contribute new ideas and a critical voice to RET.

Challenges, Opportunities, and Future Plans

Nearing the end of its third year, RET has experienced many growing pains and occasionally learned lessons the hard way. We agree with Seiber (2008); this is no “quiet, predictable, secure life.” RET contracts are renewed annually. Because RET is based on soft money, most of the faculty will not be in tenure-track positions. Faculty hiring requires approval from both the CAMHD and the University of Hawaii, and annual reviews are based on performance in both sectors, each with its own set of values and expectations (Sieber, 2008). The RET leaders need to balance the legitimate systems needs with their own academic interests and university demands. Certain scientific enterprises (e.g., implementation research, service system research) fit more readily than those requiring high levels of control (e.g., efficacy trials).

RET has provided exciting opportunities to develop genuine, long-lasting, equitable, interesting, and meaningful collaborations with community partners. RET is privileged to inform and be informed by its interactions with agencies, consumers, and other community partners. RET has already managed personnel shifts (at the faculty and student level) and is developing an infrastructure that will allow for continued collaboration as personnel come and go. The project profile is growing and more academics and practitioners are becoming involved. Federal grants available to systems of care provide additional opportunities for child clinical psychology science in practice. RET’s annual evaluation has been consistently positive, and participation and presentations at various community agencies often have energized participants to move forward. We have learned that community members do appreciate data (and science) when these data emerge from true collaboration and are contextualized within the complex human environment faced in the day-to-day life of the youth and families we serve.

CONCLUSION

The contributing authors in this Special Issue are all pioneers in their approach to community-research collaboration. As such, they face issues and challenges that often have little precedent. These issues and challenges are similar to those faced in Hawaii as the RET Program continues to grow and develop. Our cursory attempt to offer some of our own guidelines about these issues is merely intended to further the discussion among research teams such as Frazier et al., Garland et al., Sieber, and Sanders and Prinz. The more this type of dialogue continues, the better the chances of an equitable and ethical new paradigm for collaboration among researchers, community agencies, and consumers. We believe this can only be good for psychology.

REFERENCES


Received September 28, 2007; accepted September 28, 2007.