MAKING COLLABORATION WORK: KEY COMPONENTS OF PRACTICE/RESEARCH PARTNERSHIPS

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Drawing on our experiences as researchers and community-based providers, this paper outlines several key components of successful practice/research collaboration: forming equal partnerships, bilateral communication, ensuring nonhierarchical collaborations, and appropriate dissemination of outcomes. Many concrete benefits can result from collaborative research projects, including additional services, program development, and training for service agency staff. Building partnerships takes time and a good amount of planning and negotiation prior to writing proposals. However, these collaborations can result in more effective efforts to solve common problems and reach common goals.

INTRODUCTION

The calls for collaborative relationships between researchers and community providers are not new. Across multiple disciplines, such as substance abuse treatment, HIV prevention, and public health, it has been recognized that if there are questions that are best answered in community settings, it makes sense that all

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entities involved in the issue (e.g., providers, researchers, treatment consumers) work together toward the solutions (Arcury, Austin, Quandt, & Saavedra, 1999; Bowser, Mishra & Reback, in press; Fisher & Needle, 1993; Grinstead, Zack, & Faigeles, 1999; Sullivan & Kelly, 2002). In the substance abuse field, the majority of community-based treatment agencies have provided 12-step-based care to the exclusion of evidence-based approaches (Institute of Medicine [IOM], 1998). One reason for this is that compared to 12-step care, evidence-based approaches are relatively new. Because community-based agencies have found it of interest only recently to seek out researchers, and vice versa, there are few existing models to demonstrate the successful elements of a practice/research collaboration. However, it is clear that treatment providers and researchers provide vital contributions in such collaborations. Researchers have scientific and technological capabilities to conduct a study. Community providers have access to the population and are often members of the target group, thereby bringing cultural understanding to the research. When successful, a practice/research partnership can offer advantages to both parties that neither could access on their own. When the relationship has problems, however, the result can be painful, often leaving strained relationships, misunderstandings, and missed opportunities to bring cutting-edge treatments to often underserved communities. This article discusses many of the important practice/research themes recognized by the researchers and community providers at the 2-day conference, “Common Ground, Common Language, Common Goals: Bringing Substance Abuse Research and Practice Together,” held in Los Angeles (April 2001) and draws on the experience of one community provider involved in the National Institute on Drug Abuse-funded Clinical Trials Network.

**Historical Problems in Practice/Research Partnerships**

Historically, community providers have been distrustful of scientific research establishments (IOM, 1998). Community providers often feel that researchers do not fully understand the problems of the individual treatment consumer and focus too heavily on the end result, i.e., the research findings. Much of this distrust is well founded. Community representatives talk about feeling exploited by researchers (Stoller, 1998). Perhaps the most common complaint heard from the community is a feeling of powerlessness in relation to the research team (Reback & Simon, in press). Despite these potential problems, research-to-practice partnerships can succeed (Bowser et al., in press; Grinstead et al., 1999; Rotheram-Borus, Rebchook, Kelly, Adams, & Neumann, 2000; Sullivan & Kelly, 2002), and the substantial benefits that result from such partnerships justify providers and researchers facing the risks involved in joining forces. Based upon the successful partnerships we have observed and been involved in, we have delineated important lessons that can
serve to advise ongoing and developing practice/research collaborations (Rawson, McCann, Huber, Marinelli-Casey, & Williams, 2000).

**Key Components of Successful Practice/Research Partnerships**

**Establishing a Relationship Between the Researcher and the Community**

Those who have engaged in practice/research collaborations tend to believe that the most successful partnerships are formed early in the research process (Zweben, Cohen, Obert, Vandersloot, & Marinelli-Casey, 2000). Community providers often like to meet with the researcher (and his/her team) on multiple occasions well before a grant has been written. Providers feel offended when a researcher calls in the eleventh hour and asks for a memorandum of understanding or a letter of support for a project that has not been discussed. Researchers gain the trust of the community by attending meetings and listening to and addressing the fears expressed by community professionals or consumers about becoming involved in research projects. Part of this dialogue will focus on addressing historical abuses research as well as consumers’ feelings of discrimination, powerlessness, trauma, abuse, stigma, homophobia, and racism (Gamble, 1997; Markel, 2001; Shilts, 1987; Stoller, 1998; Thomas & Quinn, 1991). Researchers must be aware of and sensitive to these concerns in order to assure the community that the consumers they will be treating will not be abused through their participation in the research. In order for a practice/research collaboration to work, the relationship between the researchers and the community must be established in an atmosphere of mutual trust and respect.

**Providers Should Seek Out Researchers**

Similarly, agency staff should get to know the researcher and decide if this is the person or team they want to work with. Researchers are not hard to find. The community provider can go to the Web site of their local university or research institute and read about the faculty. These biographies should indicate the research interests of the faculty. Agencies can find faculty whose research interest matches their goals and then either request copies of relevant articles from the faculty members or read abstracts of their articles on Web sites such as the National Library of Medicine’s PubMed (http://www.ncbi.nlm.nih.gov/PubMed/). If still interested, agency members can make an appointment to meet and “interview” the researcher. The collaboration should be a mutual choosing of partners. When community providers have an active role in forming the relationship, the powerlessness that they often feel in relation to researchers should be lessened. An equal partnership begins with both the community provider and the researcher choosing to work together because they have discovered that they have common goals.
Creating an Equal Partnership

Once the relationship has been established, it is crucial that the community partners have representation and input in all aspects of the research project (Beamish & Bryer, 1999; Sormanti, Pereira, El-Bassel, Witte, & Gilbert, 2001; Telleen & Scott, 2002). The community providers may or may not have experience in writing research grants, but they certainly know their consumers and community. They can inform the researcher about the appropriateness of all facets of the research design from recruitment to the intervention and measures. They also can inform the research team about the needs of the community, as well as what design is valuable and practical for the community, not only during the research project but long after the project, and the money that goes with it, is gone. In other words, the provider can help design a study that fits their particular community. If the dialogue begins before the grant is written, the provider can offer the cultural components that the researcher might otherwise miss. Given that the researcher usually writes the grant, forming a partnership after the proposal has been written could result in a project that is not an equal partnership between the provider and the researcher and has no benefit to the community (Sormanti et al.).

The pace of the research project can be an area of potential misunderstanding (IOM, 1998). Providers often hope for answers to multiple questions from a single study or that a study will answer questions for a variety of patient populations. It is often the case that multiple studies will be needed in order to thoroughly answer providers’ questions, resulting in long delays between the formation of questions and the generation of answers from research. Moreover, the wheels of research grind slowly. Multiple layers of approval are required to begin the study or to change or eliminate any process during a study, even when the benefits of such changes are obvious. Given the length of time and effort required to design and mount a research study, it is crucial that both parties agree on the research agenda.

Maintaining Bilateral Communication

The researcher and the community provider come from two different worlds, with often dissimilar backgrounds and experiences (IOM, 1998). Hence, it has been observed that the two parties speak two different languages (Reback & Simon, in press; Riger, 2002). The researcher discusses such issues as human subjects, IRBs (institutional review boards), and the bureaucracies of their particular research institute or university, while the social service provider discusses services and specific consumer needs.

Communication is essential for a successful collaboration, but communication must go beyond simply learning the other’s language. It is easy for a community provider to learn the requirements of an institutional review board; however, it is
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harder to understand the constraints and priorities of the researcher. Good research requires multiple levels of control over the procedures used in a study. Individuals outside both the research and the community teams may need to review reports as part of quality assurance activities or human subject protection. The researcher must respond to the demands of their funder.

The community provider must, first and foremost, meet the needs of their consumer. Additionally, community providers often have contractual requirements with county or state funding agencies as well as a board or directors they must report to. The community partner would like to know that the researcher is committed to the betterment of their community, not just to the specific research project. The researcher needs to know that the community provider is committed to their research project, which, in the long run, will help the provider better serve the community. Both can be accomplished through ongoing, bilateral communication between the provider and researcher.

ENSURING A NONHIERARCHICAL COLLABORATION

To ensure an equal partnership in the collaboration, it is suggested that the parties be listed as co-investigators on the grant. If the researcher must be the primary principal investigator to ensure funding, then listing the community partner as a co-investigator, as opposed to a consultant or a subcontractor (which reflects a hierarchical relationship), will lead to a more equal partnership. Another way to prevent any hierarchical imbalance is to establish a community advisory board (CAB) with representatives from community advocate groups, the research team, as well as consumers (Wolff, Young, & Maurana, 2001). An active CAB should meet regularly, weekly or biweekly during the start-up stage, and then monthly, bimonthly, or quarterly throughout the duration of the project. The community partners need to be fully involved in the project, including planning the design, executing the project, interpreting the findings, and disseminating the results (Beamish & Bryer, 1999; IOM, 1998; Sormanti et al., 2001).

PARTNERS IN DISSEMINATION AND PUBLICATIONS

At the completion of the project, it is often the researcher who has access to the data. A major complaint of community agencies where research takes place is that once a project has ended and the researcher leaves, they are never heard from again. Findings may be published in the scientific media – and even be cited frequently by other scientists – while the community remains relatively unaware of the findings or their importance. The researcher’s commitment needs to be to the community, not just to the community research project. As data becomes available, it should be disseminated at a community or CAB meeting. If appropriate, the researcher can
put together a data report to distribute to the community provider and consumers. Failure to provide the community with the research findings, even when the results are “no differences,” breeds distrust toward the investigators and their motives, which can generalize to all researchers.

Some providers request input in all scholarly manuscripts that result from the collaborations, while other providers are not interested in that level of involvement; however, all articles that result from the collaboration should acknowledge the collaboration and be forwarded to the providers. Usually the researchers take the lead in writing the manuscripts, but the community partner should be given an opportunity to review the manuscript in draft form and offer input and suggestions. Some community providers, having found that scholarly manuscripts are not useful in their setting because they are written for an academic audience, have suggested that findings from the project be published in a popular magazine as well as a scholarly journal. Researchers should inform providers that it could take years before a manuscript makes it to publication in a scholarly journal. However, researchers need to accept that providers are on a different time schedule. Consumers are walking through the door everyday. At the completion of the project, it is the researchers’ responsibility to produce a community report that is accessible and useful and can be broadly disseminated in the community. This report can include findings from the project as well as recommendations regarding program implementation.

**Benefits of a Practice/Research Partnership**

A researcher and community provider come together because they recognize a problem that they both wish to address and a goal they both wish to achieve (e.g., treatment for substance abuse in a particular community). Additionally, both the researcher and community partner realize that the contribution of the other is necessary to study the problem and attain the goal. A practice/research collaboration can benefit both parties but in very different ways. A research project can provide material benefits, such as computers or other needed equipment, to community-based agencies that may otherwise not have the resources for such items (IOM, 1998). Research collaborations have allowed small agencies to offer staff training, including learning how to use diagnostic instruments, and to hire additional staff. A research project can answer the questions posed by the community and, while the project is running, the researcher can augment existing programs through the research activities and usually provide free treatment services to the consumer. Additionally, researchers have the ability to evaluate existing programs as well as new services. Researchers can assist the provider in writing contracts and grants by contributing literature reviews as well as data.
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The community partner provides the researcher with access to the target populations as well as the community input necessary to develop a culturally appropriate study. Many research studies cannot be conducted without the collaboration of a community provider. Empirically proven treatment is a collaborative effort and the outcomes benefit the community provider, the researcher, and the consumer.

CLINICAL TRIALS NETWORK: CREATING RESEARCH-TO-PRACTICE COLLABORATIONS

The Clinical Trials Network (CTN) is one example of a research-to-practice collaboration. The mission of the CTN, which was created and funded by the National Institute on Drug Abuse (NIDA), is to more quickly move promising science-based drug addiction treatments into community settings (NIDA, 2002). As in every practice/research partnership, there have been struggles and rewards. The following is a description of the CTN and an account of one community provider’s experience as a partner in the CTN.

A BRIEF HISTORY OF THE CLINICAL TRIALS NETWORK

The CTN was inspired by the 1998 Institute of Medicine report, *Bridging the Gap Between Research and Practice: Forging Partnerships with Community-based Drug and Alcohol Treatment* (IOM, 1998). In an effort to improve substance-abuse treatment throughout the country, in 1999 NIDA awarded $55 million in grants over 5 years to establish the CTN. Initially, five regional research training centers (RRTC) were selected to participate in the CTN effort. Each RRTC (represented by a university-based principal investigator) contracted with up to five community treatment providers (CTP) and together they constituted the “nodes” in which research protocols would be conducted. Soon after, a sixth node was added, and then in 2000 an additional six RRTCs were brought on board, resulting in the involvement of more than 70 community-based treatment programs. In 2001, an additional three awards were made, bringing the total number of research sites to 15, with a total funding of over $154 million over 5 years. When complete, the CTN will consist of 20 to 30 regional research training centers. Each center will contract with 5 to 10 local community treatment providers who will represent a wide variety of treatment settings and models.

AEGIS MEDICAL SYSTEMS’ PARTNERSHIP WITH CTN

Aegis Medical Systems, Inc., of Southern California, is a community treatment provider (CTP) that has been involved with the CTN project since its inception. Working with UCLA as its RRTC, Aegis has been involved in conducting two NIDA-supported CTN protocols in 2 of its 30 clinics. One study involves a
medication trial of buprenorphine as a detoxification treatment for heroin addiction. The second protocol is a behavioral study investigating motivational incentives in the treatment of stimulant abuse.

The experience of bringing such scientific research into a traditional community treatment setting has been both exciting and stressful. Many obstacles had to be overcome and many lessons were learned. A new language had to be mastered by treatment staff, that of science and research, complete with new forms and data-gathering instruments. This expansion of vocabulary carried with it an expansion of curiosity and eventually an expansion of knowledge. New time lines and schedules had to be integrated into an already busy, and some would argue, over-scheduled day. New procedures, including nontraditional urine testing systems, computer-based data entry, the use of unique assessment and diagnostic instruments, and distribution of rewards associated with contingency management (e.g., vouchers for a drug-free urine sample) needed to be adopted. Perhaps the most challenging obstacle has been the ongoing blending of two philosophies, that of the scientific world with that of the treatment/practice world. Surprisingly, most treatment staff welcomed the opportunity to participate in the CTN, even though it meant sacrifices and extra work. A sense of participating in something new and unique, something that seemed to set their treatment programs apart from many others, has proven to be a positive outcome of the experience. As many mistakes as there were to be made along the way, so were the number of important lessons to be learned and knowledge to be gained.

Learning to plan for contingencies – in the field of substance abuse treatment where staff turnover can be a problem – was a lesson learned. In many cases, when clinical staff leave a program, other clinical staff replace them with minimum disruption to the program. However, when research staff who have been specifically trained on a particular research protocol are lost, it is far more difficult to find a suitable replacement in a short period of time. Unlike with clinical staff, when research staff are lost they must not only be replaced by people who have the skills and experience to take these positions, but also must go through protocol specific and good research practices training required by study sponsors. For example, when a dispensary nurse who has been trained on protocol specific dispensing practices is lost, another nurse may be hired who is equally competent at nursing, but has neither the background nor the specific training that the exiting staff member had. Often, this is a problem that manifests itself repeatedly throughout a lengthy clinical trial. Cross training of other staff may be an idealistic goal to deal with such contingencies; however, many community treatment programs are unable, due to financial constraints, to have staff go through additional training beyond that which is required for program management. Finding the right people and developing a
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Cohesive and smoothly functioning research team within the community treatment program is an essential and, oftentimes, frustrating challenge that must be met.

The blending of practice and research, as is currently being accomplished in the NIDA CTN, is a work in progress. There remain a significant number of problems to be worked through and challenges to be met, which will require time and effort. The dissemination of lessons learned and sustainability of effective treatment programs are examples of such problems and challenges. An effective mechanism must be developed to disseminate the lessons learned through the CTN projects to other clinical treatment providers and researchers. This dissemination process has not yet been fully developed and will require substantial efforts before it is fully realized.

An additional concern is the sustainability of treatment practices found to be effective through the CTN. The fact that, as an example, a motivational incentives protocol shows promise or beneficial outcomes in a clinical treatment setting does not necessarily guarantee that such a methodology is sustainable in the “real world” of community treatment programs. This issue of sustainability is extremely important because if these methodologies are not sustainable without research funds, there will be little enthusiasm for adopting new and evidence-based treatment models. Sustainability must be addressed during the concept development phase of a collaborative research project.

What has been clearly demonstrated so far, however, is that the blending of research and practice can be done and done in a way that all parties benefit. Researchers benefit by being able to test their new and innovative treatment approaches in community settings. The ability to see how a new treatment strategy is applied and how it fares in a treatment setting with consumers is essential in today’s cost-conscience environment. Additionally, researchers are able to learn from the information and knowledge they glean from community providers who are experienced in delivering treatment services to very challenging populations. Community providers benefit from the collaboration by being able to offer and try new treatment strategies within their agencies. Often, community providers get very set in their treatment ways and very locked into their particular philosophy of addiction and treatment. In collaborating with researchers offering new treatment strategies, the service provider is allowed to explore and experience options, which may not otherwise be available to them. Additionally, community providers will often gain new knowledge related to assessment, technology transfer, as well as the scientific process itself when participating in collaborative research projects. All parties benefit from the experience of blending research and practice by the new and valuable personal and professional relationships that are established as a result of these collaborative efforts. These new relationships between researchers and...
practitioners will, in many cases, continue long beyond the completion of any given clinical trial and will, ultimately, benefit the consumer, to whom all of these efforts are primarily directed.

**SUMMARY**

The bridging of practice and research promises to benefit both community providers and researchers. The two parties are drawn together by a mutual goal, i.e., providing the optimum treatment opportunity to the consumer. Some of the key components of a successful practice/research partnership are researchers knowing the community and agency they want to work among, full involvement in the partnership by the community provider, effective communication between collaborators, a nonhierarchical relationship between collaborators, and appropriate dissemination of outcomes to the community studied. These components are not exhaustive but may be useful for those interested in forging a practice/research collaboration.

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