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Developing and Maintaining Partnerships as the Foundation of Implementation and Implementation Science: Reflections over a Half Century

Sheppard G. Kellam

Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, 624 N. Broadway, Baltimore, MD 21205, USA

Sheppard G. Kellam: skellam@jhsph.edu

Public health depends on its base of community support, and each public health program depends on this support for its survival. As a broad field public health is dramatically intrusive; it invades the most private lives of citizens, including instructions how to brush your teeth, injections of bacterial vaccines into your body against disease, guidelines on what to eat, prohibitions against smoking, limits on ages of individuals allowed to use of alcohol and prohibitions against use while driving, prohibitions against use of illicit drugs at all. Even sexual practices receive strong instructions such as promoting safe sex behavior such as condom use. Public health law requires vaccinating the community's children before school entry, and even requires chlorine—a poison—in the community's drinking water. In teaching public health I have often cited the first rule: "Don't get kicked out of the community". And that brings us to the issue of partnerships, the foundation on which all public health is built. These reflections are about the required but complex nature of relationships among community organization constituents, service delivery agencies, and research institutions and investigators to carry out programs—from priority setting to their initial testing of efficacy, then effectiveness, and now into implementation and "going-to-scale".

We might think that this issue is so basic that it would be on the top of any curriculum for training researchers in the multiple disciplines that comprise public health and who need to work in communities. This is not the case even in schools of public health. The set of papers published here is an important, good step in this direction. Those of us in any discipline who consider the population in its environment as their purview must make the basic principles of community partnerships a necessary subject for both research and practice.

In reading the varied papers in this volume and in our own experience beginning in 1963 in Chicago's Woodlawn community and then in Baltimore from 1984 to the present time, it is clear that there are variations in the required structure of partnerships due to the period in our society's history, the local political conditions, the nature of the public health problem being addressed and the stage of development of specific interventions. Even the time period

in which we work can be an influence on the nature of partnerships. In universities in 1963 when we began our work in Woodlawn on the south-side of Chicago, there were not yet Internal Review Boards to examine the ethical issues of research practices. This absence gave rise to excesses by researchers when there was much less recognition of the need for partnerships, and the nature of the governance over what gets done to the population under the flag of public health. Neighborhood citizen organizations newly empowered in the 60s and 70s often confronted service delivery agencies, and universities as well. Their goal was to have a voice in the qualities and quantities of services offered and the research carried out, thereby requiring new arrangements and structures of how partnerships and their governance could be formed. The role of the researcher and that of community leaders and service providers began to be explored. In the 1960s the local community of Woodlawn was demonstrating against the Chicago school district for a voice in policy making and opportunity to observe the quality of teaching. The local community organizations together formed a Woodlawn Community Mental Health Board and confronted the School District, then negotiated our entry into the school classrooms. My esteemed mentor Saul Alinsky focused on the distinction between community citizen organizations' priorities and those of service delivery agencies. While the service agencies were paid from "downtown" and responded to distant leaders, the local ministers, local business organization leaders, block club and parent organization presidents and welfare union leaders were leaders by virtue of their local selection by their own citizen *groups*. Each community has its own history, culture, and values even within a large metropolis like Chicago. In Woodlawn the Board represented the 25 or so major community organizations in this neighborhood of 90,000 people. The Board set priorities with the researchers and service staff, passed on all service and research programs including the nature of measures used, and negotiated with agencies when collaborative arrangements were needed such as programs within schools. The researchers represented the science and protected the research and service quality but under the aegis of the Board. This process took a year or more to work through and is a continuing process half a century later as Ensminger and colleagues implement follow-up studies of the 1966 total population of Wood-lawn first graders.

In the Baltimore prevention trials from 1986 onward, the conflict between the community organizations and the school district was no longer as intense as it had been in Chicago two decades earlier. Our public support for the multiple levels of randomization and other design procedures was developed differently than in Woodlawn/Chicago. The Baltimore City Public School System (BCPSS) formed a Board overseeing the evaluation procedures while each school's parents participated at the local school building level. The differences are described elsewhere (Kellam 2000). In spite of the array of differences in the nature of the partnerships required from one program, or community, or time period to another, the steps involved in the outline of procedures I describe below would seem to be generic enough to discuss them as a shared template across public health problems, interventions and communities.

What follows is a simplified list of steps for developing and maintaining public support for programs.

1. *Analyze which agencies' and community organizations' support is required.* Determine through careful qualitative and network analyses of people's perspectives on what organizations and leaders are critical to be part of a base of support for a particular program and who the leaders are who need to be heard and included.
2. *Determine the order of engaging with each leader.* Ask others who should be the first and second to be pursued.
3. *Engage and work through trust with the leader of each key agency and community organization in strategic order.* This step is one of careful listening, not selling. Visit in each leader's home or office and learn each leader's own sense of vision, mission, priorities and long term strategies.
4. Discuss how the program you might offer could be an aid to the mission and vision of the leader under their oversight.
5. *During the meeting with each leader in his/her office, ask about what other organizations or agencies share these interests.* Search for mutual self-interests between the leaders and organizations/ agencies.
6. *After repeating visits to each leader and when trust has been established with each leader suggest bringing together the needed partners around the determined mutual self-interests in a mutually agreed upon site.* This first meeting should be chaired by the leader rather than by the researcher/ implementer of an intervention.
7. *At the first meeting begin to work through the group's trust with the service/ researcher program leader and with each other.* Foster discussion of their individual and mutual interests and priorities. Identify with them possible needed/ missing program elements for accomplishing programs they have identified where partnership with investigators might help.
8. *Plan general outlines of potential program(s) with them.* The essential element is that the programs are perceived as stemming from and overseen by the base of support of the community and its agencies.
9. *Form a stable board for oversight, establishing priorities, approving methods, measures and design.* Leadership of the board needs to emerge from the board. The intervention program leader's role is that of technical/scientific staff leader with the Board sitting as overseer and adviser to insure community values and service agency guidelines are protected.
10. *With board oversight, the use of the school information system is potentially a powerful tool in moving from an intervention focus to a system of developmentally integrated services.* School information systems have traditionally been used for tracking children over time and school locations to provide a continuing record of achievement and to some extent behavior and have been under the oversight of the School District. Potentially they can be used for following children/families/school and service agency transactions over time to integrate services and to improve and monitor children's progress over time. Such information systems are usually

guarded to protect confidentiality, but with Board oversight, it was possible to use them in Chicago and in Baltimore with such a Board overseeing their use. Although at that stage of program effectiveness testing, their use was more to follow the children and their progress to test the course of impact rather than to integrate services with other agencies. It should be possible to use them on a need-to-know basis for important coordination of services to help integrate services within and across schools and the more reparative agencies such as child family services, juvenile justice, primary care settings, mental health and other agencies. For other stages of life other information systems exist in different social fields such as the work place on total populations and could be available with proper base-building (Kellam et al. 2011).

The importance of the above template is that it can facilitate teaching others how to think about forming partnerships within the specific social and cultural milieu but with caveats about necessary variation. Equally important, *these steps are potentially measurable*. As we move beyond effectiveness trials and enter the phase of *implementation science* the measures of public support can provide indicators for predicting adoption of programs by communities; fidelity of program implementation; sustaining of programs; and large scale dissemination. Continuing such measures over stages of implementation can provide early and on-going indication of the need for repairing or enhancing the breadth and depth of the partnership to insure continued fidelity and protect against weakening and even disappearance of programs through lack of continuing public support. The core of this measurement can make use of both qualitative methods for assessing the leadership of organizations and agencies that need to be at the table and network analysis mapping the interrelationships of needed organizations and agencies. Measuring the network of organizations in the partnership can identify those organizations that are included but also those not yet included but that may need to be. This process of continuing developmental network analysis would seem vital to the course of public support for program continuity and fidelity and going-to-scale (Brown et al. 2011).

There are three major purposes of measuring the strength of the base of political support: (1) to determine if a particular model of support is a sufficient model to promote each stage of program implementation: adoption, implementing with fidelity, sustaining and going-to-scale and its long term institutionalization; (2) to enable comparison of two or more models of political support to determine the relative strengths and weaknesses of each; and (3) to provide immediate opportunity to add or strengthen elements when omissions in the base of support are detected.

This measurement combining qualitative inquiry and network analysis can be foundational in the emerging science of implementation research. Repeated measures of the support network can provide a developmental trajectory of the progression of the partnership as the stages of implementation proceed. It can allow predicting degrees of successful implementation or problems of loss of support through the course from adoption through stable institutionalization. It can alert those responsible for maintaining support and direct effort to strengthen the support base. Over time it can monitor and enhance the adoption, fidelity, and enduring institutionalization of effective programs.

Added to the methods of prevention science, within a broad social systems view this implementation stage requires *social network analysis* combined with *qualitative assessment* of the required support of community citizen organizations, service agencies, and academic institutions for each stage of implementation through institutionalization. We need to predict problems that can be fixed to reduce the danger of lack of adoption, poor fidelity, or deteriorating political support. While public health is delivered and accepted at the local level, our analyses need to focus as well on city, state and federal levels in assessing the base of support.

Public health generally and increasingly over the last half century requires researchers and practitioners to study and develop with care and sensitivity public support for our research and for implementing effective preventive and treatment interventions. Moving forward requires that this be a required foundation for our training and for our rapid evolution from research to practice on a community-wide scale. We are now debating our nation's health care as it moves fitfully toward a system of care rather than poorly integrated and poorly distributed services. For children's and families' development, integration of health and human services needs to be integrated around schools. Child and family services can be tied into school based information systems that can facilitate integration of services (Kellam et al. 2011). All of these advances in thinking and development are fundamentally built upon the strength of the partnerships that are required for each stage of implementation and implementation science. Indeed we can conclude with the sobering concept that the social-cultural fit and strength of the public base of support are at the foundation of implementation of human services and implementation science.

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