

ASSESSING ORGANIZATIONAL READINESS AND CHANGE IN COMMUNITY INTERVENTION RESEARCH: FRAMEWORK FOR PARTICIPATORY EVALUATION

This paper describes a study currently underway that uses a collaborative approach to assess organizational capacity to form partnerships around mental health and substance abuse care. Employing many of the principles of community-based participatory research, the study's primary objective is to collaboratively develop a conceptual understanding and generalizable, practical measures of organizational capacity. The intent of this collaborative approach is to increase the rigor and relevance of the assessment framework while strengthening the ability of health partnerships and stakeholders to understand and track community organizational capacity. The study investigators developed an initial model of community dissemination based on the research literatures on organizations and the diffusion of innovations. Through the collaborative process, the specific goals of the project shifted substantially to match the partnership interests and concerns of community agencies. One of the benefits of a collaborative approach has been to use researchers' academic knowledge to catalogue potential factors and the wealth of community co-investigators' experiential knowledge of interagency dynamics to identify specific relevant dimensions of capacity. This initial exploratory study represents a first step toward developing a general approach to conceptualizing and tracking the organizational capacity of communities. The model and measurement framework may have wider applicability to capacities to partner around and implement a variety of health-related interventions within communities. (*Ethn Dis.* 2006;16[suppl 1]:S1-136-S1-145)

Key Words: Community Based Participatory Research (CBPR), Organizational Capacity, Evaluation, Mental Health, Substance Abuse

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INTRODUCTION

In spite of the development of evidence-based treatments, many individuals still do not receive the care they need for mental health and substance abuse conditions.¹⁻⁵ The successful dissemination of new modes and methods of care requires that they be adopted by and tailored to a diverse array of healthcare systems, professionals, and clients.^{6,7} A promising new approach to dissemination is through a participatory research model that engages existing networks of community organizations (see Wells, Staunton, Norris et al).⁸ However, very little is known about how the capacity of community organizations to partner around specific interventions or programs affects dissemination of evidence-based treatments.^{9,10}

In this paper, we describe a study currently underway, the Healthcare for Communities Partnership Initiative, that uses a collaborative approach to assess the capacity of community organizations to form partnerships around mental health and substance abuse care and to implement community-based interventions. Employing many of the principles of community-based participatory research (CBPR), the study's primary objective is to collaboratively develop a conceptual understanding and generalizable, practical measures of organizational capacity in local health and related services systems. In particular, we aim to identify the relevant strengths and sets of expertise of local organizations, as well as successful strategies and conditions for partnering and drawing together these capacities to address mental-health and substance-abuse issues in a community.

The Healthcare for Communities Partnership Initiative . . . uses a collaborative approach to assess the capacity of community organizations to form partnerships around mental-health and substance-abuse care and to implement community-based interventions.

BACKGROUND AND FRAMEWORK FOR THE STUDY

Public-private partnerships in the provision of health and mental health care have become increasingly important for strengthening the safety net and ensuring adequate access to care in disadvantaged and under-served communities.¹¹ Collaborations that engage leadership and mobilize efforts at multiple levels (i.e., families, groups, agencies, organizations, etc) across multiple domains (ie, schools, law enforcement, faith-based organizations, housing agencies, etc) can facilitate change among peer groups, organizations, and local community and thus are more likely to successfully promote environmental change.¹² However, assessing successful change at the community level is difficult, and broader geographic and

socioeconomic conditions (such as poverty and discrimination) may further complicate successful accomplishment of partnership goals.¹³

Awareness is growing that health-improvement initiatives can more fully realize their potential by better taking into account the capacity and readiness for change reflected in the organizational and cultural contexts of community settings. These contexts include multiple stakeholders operating at different levels within and outside local communities (eg, consumers, community groups, health providers, insurers, government programs, etc) that vary in capacity on a range of dimensions (eg, cultural norms, resources, community linkages, etc). For specific chronic conditions and for mental health and substance abuse problems in particular, specific approaches have been developed to address system- and/or practice-level capacity to improve services in correspondence with evidence-based goals.¹⁴⁻¹⁶ Some of the recommendations include the need to address system-level issues,^{17,18} yet our understanding of which contextual factors are most relevant for capacity and how to usefully measure these factors to guide interventions within community settings is still limited.

Concepts of Capacity

As the UCLA/RAND NIMH center has increasingly engaged in health-intervention studies with community partners over the past several years, the importance of better understanding such organizational and community capacity has grown as well. In particular, our interest in capacity for furthering the center's collaborative dissemination of health interventions has focused on "capacity," defined as the ability and potential of community organizations to:

- (1) partner with other organizations;
- (2) provide some or all components of an evidence-based intervention; as well as
- (3) change and adapt in order to implement interventions to im-

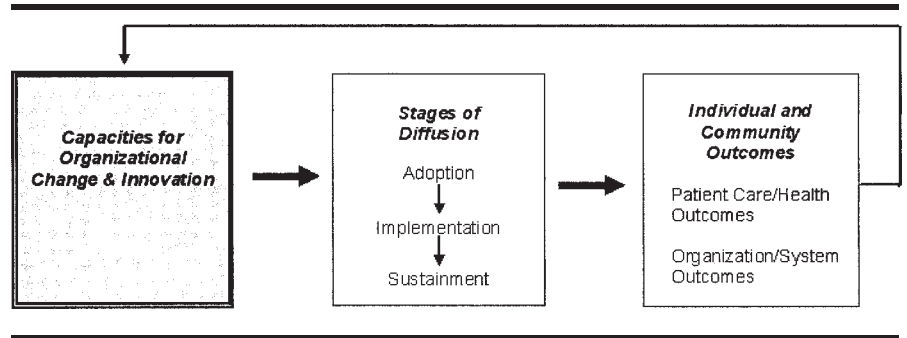


Fig 1. Model of community dissemination. Change and strength-building

prove the quality of care in the community.

As a consequence, center investigators developed an initial model of community dissemination based on the research literatures on organizations and the diffusion of innovations.¹⁹⁻²¹ Figure 1, adapted from this model (Mendel et al, 2004),²² highlights that these capacities affect not only the potential of organizations for "uptake" in the sense of adopting health interventions and entering into partnerships, but also the ways in which these are implemented in practice and whether they can be sustained. Each of these stages of diffusion in turn affects the eventual outcomes for individuals and local systems, which should improve the capacities of communities over time. Thus, the model views community dissemination of interventions more broadly as both a population health improvement and community capacity-building process.

The model also elaborates a number of broad categories of capacity (shaded box in Figure 1) identified in the research literatures, which the Health Care for Communities Partnership Initiative used as a starting point in the development of its framework for assessing organizational and community capacity. These domains of capacity, which are applicable across varying stakeholder organizations and groups in a community, include:

Norms & Attitudes. This domain encompasses a range of collectively held

beliefs and values about particular disease and health conditions, expectations and priorities of organizations, and different aspects of organizational culture and philosophies that may enhance or detract from the ability of organizations to change, implement new initiatives, or collaborate.

Organizational Structure & Process.

This aspect of capacity relates to the structure and way an organization operates, including differences in mission, size, decision-making process, and services offered that may or may not be compatible with other organizations, as well as may be more or less suited to specific health interventions.

Resources. These include an array of resources that organizations possess, such as funding, people, space, information, and how these resources may be applicable for a specific health initiative.

Policies & Incentives. This domain relates to regulatory policies, incentives and constraints of insurance and funding programs, and rules and policies of local organizations themselves that may affect the ability of organizations to collaborate or to implement specific interventions.

Community Linkages. These are the patterns of links and interactions among organizations (eg, through referrals, joint programs, or planning activities) and the roles that various agencies play in these existing sets of relationships in the community.

This latter domain of community links in particular emphasizes insights from social network theory,²³⁻²⁵ which provides an especially useful perspective for the Healthcare for Communities Partnership Initiative study. Communities can be conceived as networks of relations among various stakeholders. These sets of relationships among stakeholder organizations and groups have the potential to evolve into forms of networks that can be characterized as moral communities with distinct values and norms, including norms of reciprocity, feelings of obligation among exchange partners, and high levels of trust.²⁶ Such types of networks (“moral communities”) enhance learning among members and can improve their economic performance and permit more effective management of resource dependencies (ie, agencies rely on one source or a few similar sources for funding, personnel, information, etc). As applied to community agencies involved in improving community mental health and substance abuse outcomes, this last function of networks (management of resource dependencies) in particular is relevant for our research. A strong network of collaboration characterized by high levels of trust among community organizations is likely to reduce uncertainty and can alleviate sources of external constraint as exchange partners become more adept at partnering and working together to accomplish community health goals. For example, a community agency can alleviate constraints imposed on service provision by funding agencies through partnering with another service provider for the services it is unable to provide for its clients.

COLLABORATIVE ASSESSMENT OF ORGANIZATIONAL CAPACITY

The HCC Partnership Initiative, funded for an initial period of one year

by the Robert Wood Johnson Foundation, employs a participatory approach to capacity assessment by including representatives of leading community mental health and substance abuse agencies along with academic investigators in each phase of the project development, from planning and data collection to analysis and dissemination of results. Evaluating capacity typically involves an outside expert approach that may not take into consideration the goals and culture of the organizations being assessed nor involve the organizations in the process, except as interview subjects or providers of data. This process of capacity assessment could yield data of value for research, but it may not be very useful for the systems or agencies for evidence-based interventions. The intent of the collaborative approach used here is to increase the rigor and relevance of the assessment framework while strengthening the ability of health partnerships and stakeholders to understand and track organizational capacity in the community. We combine these two goals because in the context of communities, tracking and assessment can largely be viewed as exploitative or designed for the purposes of researchers or other external institutions instead of the community.

Drawing upon the expertise and local knowledge of community stakeholders as well as the research skills and academic knowledge of investigators, we view this process as an exercise in co-learning. Although study investigators applied for and received the funding and outlined the initial design of the study, these have evolved substantially over time through the ongoing dialogue of the collaborative process. Indeed, one of the more interesting aspects of the partnership initiative has been the unique way in which the community-academic collaboration has advanced the initial capacity model and research design even during its relatively short period of development to date, as described below.

Collaborative Assessment in Practice

Conducted through the UCLA/RAND NIMH Center for Research on Quality in Managed Care, the partnership initiative study has taken advantage of an existing research collaborative, the Community Health Improvement Collaborative (CHIC), involving academic researchers affiliated with the center, the RAND Corporation, the Martin Luther King/Drew Medical Center, and a number of local community partner organizations in the greater Los Angeles area.

In the first phase of the project, the academic investigators distributed and presented a preliminary project description of the partnership initiative at a UCLA/RAND NIMH center meeting, inviting center partners to comment. About a month later, partners involved in providing care or support for mental disorders or substance abuse and center researchers working in this field were invited to attend a “kick-off” meeting. Four representatives from center partner agencies demonstrated their willingness to be involved in the study by attending this meeting and subsequently agreeing to serve as a community co-investigators for the project. The agencies they represent include a faith-based health partnership, a community-based resource agency targeting African-American families, Los Angeles County Department of Mental Health, and a large mental health and substance abuse provider. Collaboration with these specific partners affected the decision to target specific geographic areas within Los Angeles County (ie, the areas in which they are located and are, coincidentally, the poorest and most under-served), and we anticipate that it will also affect which community agencies are chosen and agree to participate in semistructured interviews and focus groups. As the study progresses, the research team will continue to assess how the participation of these particular partners affects the study products and outcomes.

The collaborative discussions that followed proved highly valuable in navigating and deciding a range of critical issues related to the purpose and design of the study. Part of the success of these discussions has rested on the ability of community and academic participants to establish a highly collaborative form of dialogue; for instance, during the initial “kick-off” meeting, the structured slide presentation quickly gave way to a much more open-ended—and productive—discussion on participants’ experiences with interagency partnering around mental health and substance abuse issues in the community and mutual expectations regarding the partnership initiative project. Specific instances of the influence of community partners on study design and progress are described in more detail below.

Through a series of planning meetings, academic and community co-investigators jointly defined the objectives of the study and scope of the project and resolved research design issues. A basic strategy for conducting semistructured interviews with directors and administrators of local community agencies, as well as a rough outline of plans for sampling, recruitment, and dissemination of findings, had been included in the initial grant application. With regard to study objectives, prior to the first meeting with the UCLA/RAND NIMH center’s community partners, investigators outlined a set of goals and purposes of the study. The initial goal was assessing the community organizational context for implementing specific interventions that were ongoing—the Witness for Wellness initiative and the QueensCare CBITS pilot (see articles in this issue by Bluthenthal et al. and Kataoka et al.) and were important to the RAND/UCLA NIMH center. In addition, the center and its partners were interested in developing a more general approach to understanding capacity for intervention implementation relevant to other future projects and

other centers. However, because of limited time and resources, the scope of the study could not accommodate both these objectives.

Although the center investigators began with the primary purpose to collaboratively develop an approach to understand and measure the capacity of organizations to partner around mental health/substance abuse quality and quality improvement interventions, the specific purposes and goals of the project were developed with feedback from center community partners and political developments in mental health funding. Through collaboration, the study team developed the following specific goals: 1) identifying community and partnership strengths, gaps, common interests and challenges; 2) identifying current policy opportunities related to improving services quality; 3) informing design and implementation of specific evidence-based mental health and substance abuse interventions; and, 4) tracking changes in the organizational capacity of communities and health partnerships over time.

The broad objective of the study shifted from a focus on capacity to implement specific interventions to general capacity to partner primarily for two reasons. First, in the process of collaboration, researchers learned that assessing general partnership capacity was important to the center’s community partners, once they understood the implications for their operations. For example, particularly in the context of often-constrained resources in the public sector and in serving the uninsured or underinsured, partnering to achieve broad programmatic as well as individual client care goals is essential. Learning from other organizations about what makes a successful partnership was seen as a highly desirable goal. This fundamentally shifted the goals of the project away from assessing capacity to implement a specific intervention and toward capacity issues of more relevance to the partners. In addition, the partners gave

the feedback that focusing on capacities needed for implementing interventions that they were not using did not have as much practical value as focusing on the goals and successes of current partnership efforts.

Second, with the passage of the Mental Health Services Act in California in 2004 we had a unique opportunity to examine how a policy intervention affecting funding streams might affect organizational capacity and encourage new partnering efforts around mental health. Political developments at the state and county level during this initial phase of the project also highlighted the potential importance of the latter goal to track capacity to partner over time. Early in the study design (November 2004), California voters passed the Mental Health Services Act (MHSA, Proposition 63), which established a tax of 1% on individuals earning \$1 million or more per year. The revenue will fund expanded mental health services for children, adults, and seniors with severe mental illness; prevention and early intervention programs; and innovative programs to improve access and quality of care and improve capital facilities and provider availability. The tax is expected to generate revenue of \$250 million in the first year, \$700 million the second year, and increasing amounts thereafter. Los Angeles County anticipates receiving ≈\$40 million for fiscal year 2004–2005 for planning and capital development and \$200 million for fiscal year 2005–2006. The Department of Mental Health (DMH) established an extensive stakeholder process in Los Angeles County involving local providers and community and consumer groups to develop a plan for spending the MHSA funds. By expanding the financial resources available for mental health and substance abuse services, the impact of this development on local networks of community organizations and organizational capacities to partner is likely to be substantial. Thus, this has pro-

vided academic and community co-investigators a unique opportunity to collect baseline information on community organizational capacity and network structure and characteristics before implementing this landmark funding program in California.

Collaborative Development of Project

As mentioned above, the primary method for collecting data will be semistructured interviews with administrators and staff of organizations serving people with mental health and/or substance abuse needs in targeted communities. The interview protocol developed through collaborative planning discussions will ask questions about the different capacities, strengths, and sets of expertise that each organization brings to bear on mental health and substance abuse issues in the community and explore the experiences and local knowledge of organizational participants on partnering with other local agencies to combine organizational strengths and address community health needs. In addition, the study will conduct focus groups with consumers of mental health and substance abuse services in the community to understand issues of interagency collaboration from the perspective of those whom local systems are intended to serve.

The project is currently awaiting final institutional review board (IRB) approval to begin the sampling of community agencies and participants and the collection of data. In the meantime, at the suggestion of the community co-investigators, research team members have been attending various community and coalition meetings (such as the Proposition 63 stakeholder process) to become more familiar with the particular issues and dynamics facing community groups. (The study received an IRB exemption for these observations of community meetings.)

The success of the collaborative research experience thus far can be at least partly attributed to the previous experiences and familiarity of the community co-investigators with working collaboratively. Little effort was necessary to achieve the buy-in so crucial to collaborative efforts, as the community co-investigators were already sold on the concept of collaboration. However, this buy-in points to a source of bias that is likely to affect the results: community agencies that have had successful collaborative experiences (research or program-driven) are the most likely to agree to participate in a collaborative research partnership, thus ensuring a successful collaborative research process. In hindsight, the study investigators probably should have attempted to anticipate and measure the effects of this collaboration on center partners and administered pre- and post-study questionnaires to assess the effects. However, process notes are being recorded for each partnership initiative meeting, and conference calls and follow-up interviews with center partners can be conducted once the study concludes.

Holistic Approach to Community Capacity

The community co-investigators have had a similar sense about how to proceed, and general consensus has been reached so far about the direction and focus of the research. No major differences of opinion have arisen about what should be done, and discussions have been respectful even though study team members differ widely in terms of their specialized areas of expertise. This consensus has undoubtedly made the collaborative research process smoother and helped to further the goals of the research. Given the limited time and budget of the study, the initial inclination was to narrow and separate the geographic scope of the project as well as the range of services to be studied in each of the targeted communities. Through discussions with our

community co-investigators, we noted that community needs and services often combine in practice and that the study would benefit from a more holistic approach to conceptualizing and measuring capacity.

In particular, community co-investigators emphasized the importance of studying general capacities of organizations to partner (thus the inclusion of questions on experiences in this regard in the interview protocol above) as well as specific strengths and resources that an organization may possess. The study team also realized the need to include the range of organizations serving people with mental health and/or substance abuse disorders in a community (not just participants in the CHIC network), as well as the variety of ancillary support services outside the standard mental health and drug treatment sectors (especially primary care and housing services), if the project intended to more fully identify the potential for partnerships in the targeted communities. Although sample selection will prioritize agencies that provide mental health and substance abuse services, we also plan to include at least a few agencies that provide ancillary services.

The joint study team eventually selected two sets of communities for the project representing two health services provision areas (or SPAs) within Los Angeles County with diverse populations and needs—south Los Angeles (a primarily African-American area since World War II with an increasingly Latino population) and Hollywood/Metro (another highly diverse, underserved area that includes notable Latino and Asian communities, as well as the downtown Skid Row area with a substantial population of homeless individuals). The study team had originally left open the possibility of implementing separate arms of the study in different communities, with separate community advisory groups and even focusing on different sets of services in each area (eg, mental health services in one commu-

nity and substance abuse services in the others). The holistic approach advocated by the community co-investigators resulted on agreement to address both major needs in each community and maintain a single study team to increase cross-learning between efforts in each community as the project progresses.

Community Sampling and Recruiting Strategies

To usefully map the networks of organizational linkages and assets within a community, as the partnership initiative seeks to do, requires a fairly comprehensive inclusion of relevant agencies defined within the scope of the study. Consequently, defining the boundaries of the sample and identifying all relevant agencies is an especially critical methodologic task in such network-related studies.^{27,28} The collaborative process has been effective in helping the study team identify means of sampling and recruiting participants who otherwise might be “under the radar” of traditional research or who by their nature may be suspicious or resistant to being studied.

Given the holistic approach adopted, the study takes advantage of the local knowledge of the project’s community co-investigators and other community experts to help in this bounding of the sample of local organizations for the study in each SPA area. In conjunction with a center statistician, we developed a modified “snowball” sampling strategy, in which our panel of community experts identifies local organizations they consider important or potentially important to serving people with mental health and/or substance abuse needs in each community (whether or not the community expert’s own organization collaborates with any of these agencies). These may include mental health and drug treatment providers as well as other services, such as primary care, housing, social services, and other kinds of agencies. Panel members will first list those agencies through

free association, then be asked to review a full roster of agencies based on community resource guides and directories to ensure that the sample does not inadvertently exclude relevant organizations. A similar method of bounding a network sample was used by Kwait, Valente, and Celentano (2001).²⁹

Once this comprehensive pool of agencies is compiled from the responses of all panel members, each agency will be categorized according to its clientele population (children/youth, adult, elderly, pregnant women), service mix, relative size, and whether it represents a primary or secondary resource for persons with mental health or substance abuse needs in the community (also rated by the community expert panel). This will allow the study flexibility in narrowing or broadening the scope of the agency sample, as well as the use of more or less intensive data collection methods (eg, in-person interviews at primary agencies versus telephone interviews at secondary agencies), given the potential for generating a relatively large sampling pool of agencies in relation to the project’s resources. Room will also be left in the final sample for additional agencies that are repeatedly mentioned in interviews of this initial sample of agencies.

The insight of community co-investigators into the perspectives of community members and agencies has also benefited the study in terms of recruiting study participants. In addition to helping identify contacts and potential respondents in various local organizations, community co-investigators have suggested strategies for recruiting individuals within these agencies, such as including interview respondents at more than one level within large, complex agencies, suggesting methods to limit the frequency of contact to reduce burden on potential participants, and referring to those who are interviewed for the study as participants or respondents, rather than as informants.

With regard to the latter, community co-investigators reminded academic investigators to pay close attention to the language used in the study, as certain terminology common in research circles belies attitudes and biases in academia that community members may find disconcerting or objectionable, if not confusing. For example, researchers and IRB applications frequently refer to interviews conducted with members of communities and community agencies as “key informant interviews,” yet in African-American communities in particular, the term “informant” may have very negative connotations of individuals who betray other members of the community. This example illustrates the broader issues of language in community-based participatory research and the challenges of accommodating the norms of both academic and stakeholder communities within these types of studies.

Strength-Building Emphasis

As noted earlier, the original model for the study emphasized capacity-building but in somewhat vague terms and generally limited to feedback at the end of the project. The joint discussions between academic and community co-investigators further oriented the study toward identifying the positive strengths of local organizations and framing the research issue as one of understanding how to most usefully bridge and combine these current islands of capacities and expertise in the community. The discussions also helped flesh out the strength-building features of the study (eg, including community investigators in data collection and analysis activities, as well as planning and dissemination) and recognize additional opportunities along the way for these to occur (eg, by keeping the single project team across both communities).

Community Dialogue Process

In spite of efforts to disseminate results through traditional means (ie,

conference presentations and academic journal articles), the communities that participate in CBPR projects frequently perceive few benefits to participating and do not receive much useful information from the research. One problem is that academics need to explore more “community-friendly” means of dissemination; however, the support mechanisms for dissemination are most often inadequate, especially in terms of resources.

As with the strength-building approach, the study team further elaborated mechanisms, through a community dialog process, for joint sharing and interpretation of findings with the community at large. Our community co-investigators have also been instrumental in reminding the researchers that this study is taking place in the community rather than a controlled environment, and therefore the researchers will have to be flexible and responsive to participants. With this in mind, we currently envision not only reports, but also community dialogue meetings to which study participants and any other interested parties in the community will be invited to discuss findings and help derive implications. In addition, we are considering other opportunities, such as through the focus groups with community members, to both provide preliminary feedback as well as gather additional information. The details of these project activities are still in formation but will most likely be modeled on current approaches used by UCLA/RAND NIMH center partner agencies, such as presentation of research findings followed by small break out discussion groups that may be transcribed to capture information useful for refining results and improving future collaborative studies.

This process will include setting (and fulfilling) expectations with study participants on how data will be used and results fed back from the project. Our community co-investigators em-

phasized that community will have the expectation of getting something tangible in exchange for the information provided. Collaborative research not only entails a data-gathering effort but must also provide usable products for the community and technical assistance for using those products. One concern discussed by the study team involves reporting results in a way that can be tailored to individual organizations’ needs (and capacities) without identifying particular organizations. Study investigators hope to identify, through the community dialog process, common threads and ways of improving capacity by building on individual strengths. Ideally, the results could be used by a broad community coalition of organizations for strategic planning in the provision of care and support for alcohol, drug, and mental health disorders.

Incentives for Study and Community Participation

The joint study team has also spent considerable time at several points in the project’s development discussing the need to provide adequate incentives and benefits for community participation. Here we have been concerned not simply with compensation for interview and focus group participants but with building a constituency within the communities of individuals and agencies that will be interested in hearing the results and engaging in a discussion of implications along the lines outlined above. One incentive for community agencies to participate is that a study such as this (ie, one that maps community agency networks and collects information on organizational capacity) can provide useful information that takes into account the real-world context within which they operate and is directly relevant for the partnership issues they currently face. In addition to generally providing a better understanding of community resources and strategies for partnering under different

conditions, community co-investigators have pointed out the value of translating results into opportunities and products tangible and worthwhile to community organizations and members (eg, identifying specific funding opportunities or potential methods for real-time information on community resources).

Participatory Tracking of the Project

Tracking the participatory process within the project is essential to provide the joint study team with formative feedback for adjusting the course of the study and to document key features of the collaboration that will help improve future partnership efforts. To begin tracking the participatory process, a research assistant scribes each project meeting, including detailed notes of conversations and decisions made, which can be qualitatively analyzed to understand the various roles taken on by team members and the unfolding of the project over time. We are also in the process of developing a set of questions for the co-investigators to discuss during time set aside in regular project meetings on the group’s internal participatory process as well as the relationship of the project to external groups in the community.

Benefits of Co-Learning

Beyond guiding the project in certain directions, the interaction between academic and community perspectives has allowed the study to overcome limitations of traditional academic as well as conventional community approaches to these types of capacity assessments.

Identifying Relevant Aspects of Capacity

Academic studies on the dissemination and the diffusion of innovations typically seek to isolate whether a specific indicator of capacity (such as organizational culture, relationships with other agencies, resources) has a noticeable effect on the adoption or spread of

a particular new care practice or program. Some examples include whether direct links to other organizations that have adopted a care management system increase the likelihood that an organization will implement the system, or whether an organizational culture characterized as risk-taking increases rates of adoption of new services, holding levels of resources constant. Unfortunately, this approach has generated a myriad of potential indicators of capacity—many similar to each other—that appear to influence the processes of dissemination and diffusion (ie, the ability and willingness of organizations to interact with others and change their programs, structures, and routines).

One of the benefits of a collaborative approach has been to combine researchers' academic knowledge to catalogue potential factors with the wealth of community participants' experiential knowledge of interagency dynamics to identify specific relevant dimensions of capacity. For instance, members of the project's senior advisory group discussed at length the implicit and explicit criteria they use to judge the suitability of potential agency partners. Our community co-investigators stressed a shared vision, as reflected in agency personnel attitudes and opinions embraced by both administrators and front-line staff. Without a strong commitment to the mission of the agency, the shared vision cannot be implemented. This was referred to in discussions as the three V's: vision, value, and victory. A shared vision, value, and victory must be achieved at the personal, organizational, and community levels. Achieving this requires time, patience, flexibility, negotiation, and attention to building personal relationships that cross the boundaries between institutions.

Another aspect of partnership formation that may not be perceived as capacity in the conventional sense is compatibility of agency resources. Partnerships are often formed as a result of an agency's need to provide a service,

and thus agencies may seek out services that will enhance or compliment what they already provide. Under conditions of scarce resources and under-funding, partnerships are often formed as a means of survival: if a provider had the resources and capacity to function alone, no incentive to form partnerships would exist. For community-based providers with limited funding, the ability to change—a dimension of capacity that academic research has found to be important—can be the most difficult aspect of collaboration.

Discussions with our community co-investigators further underscored the relative lack of general understanding in the academic literature into these processes across different types of agencies and settings. This discussion led to the use of open-ended questions in the interview protocol to systematically elicit dimensions of capacity most salient to respondents in different organizations, with fewer questions measuring the level of specific predefined indicators.

Process Orientation

Another limitation of traditional academic approaches, especially in health-services research—evident even in the initial model developed by center investigators—is an emphasis on factors, ie, facilitators and barriers, as opposed to the manner in which various influences are ordered and interact over time to produce change in organizations and outcomes for clients. Thus, the study team included questions related to partnering under different conditions and organizational experiences on when partnering is (and is not) successful. These types of questions provide case stories and examples better suited to illustrating process dynamics and the application of conceptual constructs to partnering and intervention activities.

Real-World Dynamics of Partnering

The collaborative discussions of the project team also have helped attune

academic investigators to some of these real-world dynamics of community partnering and collaboration, even before beginning fieldwork. For example, community co-investigators highlighted the effects of ebbs and flows in funding related to fluctuations in partnering activity, the importance of funding requirements and constraints as well as amount, and the fact that many collaborations are born out of necessity to fill immediate organization and client needs as opposed to representing perhaps more deliberately planned forms of partnering.

EXPECTATIONS GOING FORWARD

Collaborative assessments of organizational capacity can improve not only the current state of theory with regard to organizational capacity to disseminate evidence-based interventions but also the understanding of which dimensions of capacity are most relevant for community agencies interested in partnering around specific programs or health interventions. To the extent that regional efforts to provide integrated systems of care become more widespread and funding for developing partnerships becomes more readily available, this type of research could become more important in public health and mental health in the future. Such systems take a more holistic approach, addressing multiple needs of clients such as education, housing, mental health, probation and involvement with the justice systems, and other social-service needs (such as welfare or child welfare). The systems of care philosophy requires that agencies work collaboratively, contending that this is necessary to ensure the well-being and future status of clients.

Furthermore, the collaborative nature of the partnership initiative views assessments as recurring points and opportunities for community discus-

sion, rather than simply as traditional evaluation endpoints. The plans for iterative community dialog are designed to shed new light on interpretation of results and the implications of the findings and will greatly determine the value of the assessment framework and measures developed by the project through their usefulness to both community and academic partners in the process.

In particular, we anticipate that the model for assessing organizational and community capacity will help inform the future design and implementation of evidence-based mental health and substance abuse interventions in communities. First, the analyses proposed are expected to help discover new opportunities for partnering among agencies in the communities studied, including providers of mental health, substance abuse, and related services. The process-oriented data will also be useful in understanding the characteristics and dynamics of community organizational contexts that affect partnering and the implementation of interventions to improve access and quality of services. The study team also anticipates that one result of the study will be the formation of true and sustainable partnerships between academic researchers and community. The model that we develop as well as the process-oriented data can be used to build bridges between academic institutions and community organizations interested in collaborative research, possibly reducing the amount of time required for the prerequisite relationship-building. However, some relationship-building will still be necessary and is a valuable part of the process.

Moreover, the partnership initiative affords the ability to track changes in the capacity of communities and health partnerships over time. Mapping the network of relationships among local organizations, as well as their specific resources and sets of expertise, provides

a measure of the health sector "social capital" of the community in terms of the extent and composition of inter-agency links.³⁰ Such measurements can show the intermediate outcomes of health partnerships in increasing inter-agency connections and interactions. They can also serve as a baseline for evaluation of the effects the Mental Health Services Act or other significant events in the community on local agency networks, patterns of collaboration, and distribution of resources.

This kind of uniquely assembled information is further expected to encourage community-wide perspectives on community needs, priorities, and strengths through the collaborative assessment and dialogue process. In the face of our fragmented local systems of care, such community-wide perspectives are often difficult to reach and sustain, even under the best of intentions. The study team anticipates that the study will result in community and individual empowerment, which requires not only a knowledge transfer but also the development of technical skills within the community. One of the community's strengths lies in its members' expertise regarding priorities, needs, and abilities. Rather than using this expertise as a means to obtain buy-in from the community, one goal should be for at least some community members to be capable of providing training on using the study products to improve community organization capacity to partner.

We intend this initial, exploratory study to be the first step toward developing a general approach to conceptualizing and tracking organizational capacity of communities. We believe the model of collaborative assessment and measurement framework, while developed in the context of mental health and substance abuse needs, may prove to have wider applicability to capacities to partner around and implement a variety of health-related interventions within communities.

. . . we also expect that the results of the study will be used to develop and test community-level interventions to build organizational capacity . . .

Finally, we also expect that the results of the study will be used to develop and test community-level interventions to build organizational capacity, for example the establishment of an oversight body or ombudsman to foster the development not only of existing networks but also other needed services and to help consumers navigate the system as well. Another possible intervention could involve the development of a community center of excellence to act as a research clearinghouse for all communities. Such a center would ideally house community journal reviewers, human subjects review from the community perspective, a library of journal articles (community and research), and other resources for empowering community members involved in research activities. This type of empowerment could help to break down the barrier of mistrust that frequently occurs between academic and community members involved in a collaborative. The community could become more engaged in the research process and begin working towards identifying and fulfilling its priorities.

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