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Research Brief

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Collaboration in the Chicago Women's Health Risk Study

The agencies and individuals that collaborated on the Chicago Women's Health Risk Study (CWHRS) had a common goal: to help a broad array of practitioners know which abused women are in domestic situations that pose a high risk of death. Previous research identified who in the general population was most likely to be abused. However, it did not determine which abused women were in a situation where the risk of serious injury or death may be especially high or evaluate potential interventions from the woman's perspective, and it rarely addressed the many barriers to safely leaving a dangerous situation. The CWHRS was designed to provide this practical information.

Nearly 40 individuals collaborated on the study, including domestic violence activists and service providers, research site representatives, academics, and representatives from the Mayor's Office on Domestic Violence, Chicago Public Health Department, Cook County Medical Examiner's Office, Chicago Police Department, Cook County Hospital, Erie Family Health Center, and a neighborhood advisory group.

Collaboration was a key element of the CWHRS from the start of the project. In the beginning, however, none of the collaborators anticipated the level of intense interaction, shared responsibility, and conflict resolution this project would require. As the research project evolved, the collaboration did also. Eventually, we realized that we had begun to create a "collaborative culture," an environment that values inclusion and spends the time and resources necessary to support it. This brief will outline the tools we used to develop and maintain that collaborative culture. By sharing what we have learned, we hope that readers working on their own collaborations may benefit from our experience.

Background

The idea for the Chicago Women's Health Risk Study arose when informal discussions between researchers and health professionals grew into a series of meetings to design the parameters of a study. The relatively small numbers made it possible to develop basic goals and methods and write and revise a proposal, but the atmosphere of the group remained closer to a traditional research partnership. During the initial implementation stage, however, the collaborative model began to emerge, as new members were included and the group began to do the crucial work of the study. When data collection began and the focus of activity moved to the health centers, the collaboration widened to include participating staff of each site. At this stage, a truly collaborative group had become a reality. The final phase of the study reassembled the collaborators to work on the interpretation, analysis, and dissemination of study results. The broad diversity of collaborators made it possible to develop products intended to inform policy and practice across a wide constituency.

What is a collaborative culture?

The following attitudes and values characterized collaboration in the CWHRS:

Shared standards and flexibility. Agreement on fundamental standards, while remaining open to new ideas and alternative ways to meet these standards.

Synergy. Belief that the interaction of diverse perspectives would lead to better ideas and solutions.

Equalized power. Valuing each individual's ideas and contributions, and trying to diminish hierarchical

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power structures based on degrees or titles.

Permeable boundaries. Encouraging each collaborator to contribute to both research and practice aspects of the project, regardless of their background.

Group decision making. Allowing considerable time to weigh differing positions and find a resolution.

Assumption of good will. Rejection of the politics of divisive alliances and suspicious confederations. This made consensus possible to achieve.

Collaboration maintenance. Because we valued our collaboration, we allocated time, energy, and resources to maintaining it.

Creating and maintaining a collaborative culture

Though the collaborative culture was not an initial goal of the project, as it developed, we recognized it and began to preserve and enhance it. The following suggestions, gleaned from our experience, helped to create the conditions for our collaborative culture to grow.

■ Set a collaborative table

Involve a broad array of professionals and institutions, that, by their investment in the process, can enhance the adoption of policy suggestions arising from the research. Intimate partner violence is a complex social problem, addressed by a wide variety of agencies and individuals. CWHRS collaborators represented criminal justice, law enforcement, public health and other city agencies, local hospitals and clinics, activists from the domestic violence advocacy community, and others.

Include individuals who have specific skills and diverse backgrounds. These characteristics may incude statistical expertise, experience working with battered women, or compassionate bureaucrats able to cut through their agency's red tape.

Involve people who make substantial contributions to the project as part of the collaborative team. The CWHRS included staff at the health care sampling sites in collaborative decisions and publications, and considered interviewers to be part of the collaborative team.

Reach out to service providers and consumers at each site where the survey is being administered. Site task forces addressed many important issues, such as ensuring culturally competent and linguistically sensitive survey questions, and developing site-specific safety and confidentiality protocols.

Allow flexibility in the composition of the group. The CWHRP team changed over time, with a substantial majority who stayed throughout the project. Some wanted to contribute only to part of the project and dropped out of active membership after that part was accomplished. Others joined the collaboration at a later stage of the research. Anyone who was willing and eager to contribute was welcomed.

Although some collaborative groups have found that funding agencies set up barriers to collaboration (Edelson & Bible, 1998:3), the CWHRS was very fortunate in this regard. The grant monitor contributed substantially to the project, and became one of the collaborative team.

■ Develop key shared standards

In many collaborations (for example, Galinsky, et al., 1993), researchers focus on scientific standards while practitioners focus on client safety and interaction standards. In contrast, shared standards were a cornerstone of the Chicago Women's Health Risk Study. Through long hours of intense deliberation, we developed a few inviolable principles for research and practice. Each collaboration member understood these standards, and carried them out in project decisions.

A practice standard, for example, specified that women would be interviewed in a safe and private place. Meeting this standard proved to be a very difficult task in the large inner-city public hospital and public health clinics that we used as interview sites. It was accomplished only through repeated and lengthy meetings with site staff at each clinic. Because everyone involved agreed that this standard was inviolate, we found a way to meet it in every case.

Two fundamental research standards were utilized: the same questions were used to screen all women, and selection bias was minimized. Because the inclusion of high-risk but underserved women was a priority, we avoided procedures that would exclude these women from the sample.

Shared standards became the backbone of the CWHRS and the foundation of the trust necessary to accomplish our tasks. We found that to develop shared fundamental standards, the following practices were useful.

Limit the number of standards. Standards must be clear and limited to a small number. Each collaborator must understand, support, be able to explain to others, and put into practice each of the standards. This is difficult if the standards are numerous or vague.

Build trust via reciprocal learning. The CWHRS provided opportunities for group members to "tour" the worlds of other group members, and shared articles and publications relevant to the study with everyone involved in the project. We created conversations where practitioners asked research questions and researchers asked practice questions.

Allow sufficient time to come to consensus about the standards. Though unanimity is not required for many project decisions, it is for these few principles.

■ Maintain the collaboration

Collaboration must be a priority throughout the project's design, implementation, analysis, and dissemination. Even after a collaborative group has been established, it will not necessarily be effective—or even continue to exist—unless considerable resources are devoted to maintaining it. The CWHRS began with a commitment to the philosophy of collaboration without knowing how much planning, time, and nurturing it would take to achieve. To maintain communication, facilitate participa-

tion, incorporate the contributions of group members, and resolve conflict, the group developed some useful techniques and social mechanisms.

Maintain communication. To keep everyone informed, regular mailings were sent to those involved in the project containing detailed minutes of general and focus or task group meetings, the current budget, and copies of articles or publications relevant to the study. Also, more effort was made to keep individuals updated who were unable to attend meetings. Each contact was a conscious attempt to share information and to reinforce the partnership. In each contact, we provided information, asked for suggestions and comments, and then followed up on those suggestions.

We were persistent. We did not wait for the collaborators to contact the project, but took responsibility for contacting them. In addition, the CWHRS group tried to accommodate each member's unique situation and style of participation.

Build an institutional memory. The CWHRS kept detailed minutes and other records. As an institutional memory, the minutes had many uses, one of which was communication with people outside the Chicago project. Individuals requesting information about the project, such as those who were developing a similar project or who were applying to work on the Chicago project, received packets of past minutes.

For those who wanted information about the project but who were not interested in the detail of the minutes, collaborators wrote and periodically updated a "Project in Brief" document. This provided an overview of the project's design and activity to date. The brief proved to be invaluable. It was used in communications with the Institutional Review Boards of each of the agencies where we were screening potential respondents. It also was attached to correspondence with individuals and agencies that might provide assistance.

Take care of the collaborators. It is vital to address the personal repercussions of working on domestic violence. This is true for all of the collaborators, but especially true for those who interact directly with the study's respondents. Listening to stories of violence can be disturbing and have negative consequences for mental health, attitudes toward abused women, quality of work, and longevity with the project.

Early in the project a collaborator recommended that we hire a therapist to provide routine debriefing and stress reduction sessions for the interviewers. The entire advisory board and the funding agency avidly supported this counseling position. A therapist experienced in working with domestic violence survivors and program staff created a safe place for the interviewers to discuss the personal impacts of hearing often painful and frightening stories about violence, taught them relaxation and self-care techniques, and helped them bond as a group. This reinforced the interviewers' empathic attitudes, which were the foundation of their effectiveness. We believe that their dedication to the study and their longevity with the project was due in part to this intensive bi-weekly intervention and the ways in which we included them as integral parts of a team effort on behalf of ending violence against women.

Facilitate participation. The collaborative culture of openness and flexibility requires some degree of open-ended discussion and brainstorming. This may be particularly necessary in a project such as the CWHRS, in which safety issues were important considerations and many of the methods had never been tried before. Participants were encouraged to contribute their expertise and to raise new issues. Although these agenda digressions may seem to waste time, they sometimes brought us to a critical new insight. In addition, the discussion process built an atmosphere of mutual respect and trust.

To handle difficult or contentious issues, it was sometimes better to delegate tasks to smaller teams of participants who would report back to the group. For example, a team of collaborators met to organize the two-week interviewer training class. An Instrument Committee worked on developing the questionnaire. A small group of collaborators with experience in support services and safety issues met to set procedures and standards for contacting respondents.

Foster mutual respect. At each collaborator meeting, much time was spent on introductions. The principal investigator often took time to thank members for their contributions, and if new people were present, to embellish their personal introduction by mentioning their accomplishments and creating an atmosphere of respect.

We experienced the value of taking time to give people credit and publicly acknowledge contributions.

Break through rigid role boundaries. In a collaborative culture, role boundaries should be permeable. In the Chicago project, differences among individual collaborators, such as researchers versus practitioners, or investigators versus advisory board, were not clearly delineated. Perhaps because of the fluid way in which the collaboration developed, we avoided assigning prescribed, excessively narrow roles to each collaborator. It was never assumed that only researchers would be responsible for creating the research instrument, and only activists would work with clinic and hospital sites, for example.

As a result of permeable role boundaries, activists handled tasks usually reserved for academic researchers, such as developing and testing an instrument measuring social support, and researchers were involved in many site-related activities, like developing site protocols for screening and encouraging the support of site staff. This flexibility encouraged unforeseen and valuable cross-fertilizations.

The principal investigator was an expert in homicide research, but had little experience in domestic violence intervention or research. She was eager for substantive contributions from the other collaborators and did not desire unilateral control. Her often-voiced respect for the expertise of other collaborators helped to establish a climate of mutual respect, openness, problem-solving, and inclusiveness.

Project staff provided tangible assistance for collaborators to develop products based on study results. For example, we developed a Power Point slide presentation describing the basic methodology of the project. Collaborators used this as a template when they gave a lecture or workshop and shaped it to meet the needs of their audience.

The interviewers were encouraged to share their impressions on how well women responded to the survey instrument and to suggest ways to rephrase or re-order the questions. We believe this created a more meaningful and culturally sensitive tool, that enhanced the accuracy of data collected.

Conclusion

Although the CWHRS model would not suit everyone, we found multiple benefits from our collaborative culture. Everyone who participated in the project benefited, because each collaborator learned, taught and stretched. At the beginning of the project, we recognized and appreciated each other's strengths. Over time, we were surprised to find new talents and capabilities within ourselves.

The institutions that participated benefited from the collaborative culture, because they increased their awareness of domestic violence and better understood their institutional response to identifying and assisting victims. Health clinic staff were trained in domestic violence issues and support. Most importantly, however, the project became a catalyst for institutional change in many of the participating agencies, bringing them closer to universal screening for domestic violence. This would not have happened if the institutions had not been full collaborative partners in the project.

Respondents in the CWHRS benefited because they had the chance to talk about the violence in their lives with a respectful, non-judgmental listener and received a token, but often helpful, fee. For the abused women, the relationship with their interviewer lasted for a year or more, and many of them looked to her for information about community domestic violence resources. In addition, all respondents knew that they had contributed to efforts to decrease violence against women.

Finally, the quality of the research product benefited from the collaborative culture. The extensive collaboration on survey instruments, based on shared research and practice standards, produced questions that were relevant to the realities and risks in the lives of abused women and were written in culturally competent and non-judgmental language. Secondly, if we had not worked intensely with each health center to create a safe and respectful interview climate to include high-risk but underserved women in the sample would not have been met.

Further, the collaborative culture enabled us to work until we found safe ways to collect initial data, retain women in the study over the 12-month study period, and search for and interview proxy homicide respondents. Without the efforts of the whole team, we would not have found, hired, trained and supported the best possible interviewers. Data interpretation benefited from the collaborators' experiences in understanding women's responses to abuse, and their suggestions for data analysis led to new information of critical importance to practitioners. Finally, due to the diversity of our collaboration, we anticipate being able to disseminate our results widely and to influence policy more effectively.

The collaborative culture in the CWHRS was slow to develop, led to long decision making processes and required compromise on all sides in order to reach consensus. Nevertheless, we firmly believe that our model of equal collaboration between researchers and activists was a fundamental reason for the reliable, valid, and practically useful information produced by the study. Ultimately, practitioners hoping to reduce the danger of death or life-threatening injury to women experiencing intimate violence, and the women they serve, will be the ones to benefit most from the collaborative culture. We would challenge others contemplating similar research to consider our less traditional model.

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