

**Building Community Campus Partnerships in
Underserved Communities:
An Essential Step to Effective Services**

Case Study for the Principles of Partnership
Best Beginnings: A Child Abuse Prevention Program in New York City

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This paper is supported in part by the Community Campus Partnerships for Health (CCPH) Fellows Program, with grant support from the Helene Fuld Health Trust HSBC Trustee and the Corporation for National and Community Service. The views expressed are those of the Fellow and not necessarily the funding agencies. CCPH is a national non-profit organization that fosters health-promoting partnerships between communities and higher educational institutions.

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Principles of Partnership were developed by the Community Campus Partnerships for Health (CCPH) to help facilitate and strengthen partnerships between communities and higher educational institutions.¹ This paper applies these Principles to Best Beginnings, a child abuse prevention program in New York City.

Best Beginnings was created by a partnership of three distinct not-for-profit organizations: (1) Columbia University College of Physicians and Surgeons/Department of Pediatrics at the New York Presbyterian Hospital (Columbia) (2) The New York Society for the Prevention of Cruelty to Children (NYSPCC), and (3) Alianza Dominicana, Inc., a community based social services agency (Alianza). The target community is Washington Heights, a high need community in New York City. Two of the organizations: Columbia and Alianza are located in this community.

The goals of Best Beginnings, a voluntary, home-based service for high-risk expectant families and new parents are to: Promote optimal child health and development, prevent child abuse and neglect, support positive parent-child bonding and relationships and enhance parent self-sufficiency.

After five years of planning, Best Beginnings was launched in 1994. It was inspired by the Hawaii Healthy Start program, which documented a significant reduction in child abuse in their participating high-risk families.

¹ Seifer, S. and Mauana C., “Developing and Sustaining Community-Campus Partnerships: Putting Principles into Practice, *Partnership Perspectives, Volume I, Issue II, 2000, p. 7.*

Initially, I shared my interest in starting up a similar program in New York with The NYSPCC Board of Directors. They were very enthusiastic about pursuing this new avenue of child protection. I attended a conference in Hawaii on this service and learned that a medical home is an integral part of this program. I approached Nicholas Cunningham, Director of General Pediatrics at Columbia. At the same time one of my Board members contacted a colleague who was on the Board at the Hospital. They were both eager to pursue this joint venture, and Dr. Cunningham and I set up meetings with key staff.

At the time, Columbia, the primary medical provider in Washington Heights, and the community did not have a history of working together to meet the needs of the families who live in this high need community. Nineteen per cent of the women had late or no prenatal care and 84% of the families were on Medicaid assistance. Two thirds of the population was Latino, a majority having recently emigrated from the Dominican Republic. This community also had the second highest filing rate in Manhattan for child abuse reports.²

After several meetings, we defined the roles of the two partners: NYSPCC with its expertise in protecting children, its experience in grant writing and its simple administrative structure and Columbia with its medical and educational expertise, and its research capabilities would divide the tasks in that fashion. We identified other agencies in the community recognizing that it was crucial for the success of the project that a community based organization such as Alianza be an integral part of this program. We identified grant opportunities, worked together on preparing proposals and were awarded a multiyear grant

² New York State Department of Health statistics, 1994.

from the William B. Hoyt Children and Family Trust Fund of the New York State Department of Social Services (NYSDSS). There was one hitch—at the same time NYSDSS had identified Washington Heights as a community to be part of its Neighborhood Based Alliance program. Under this program, all of the service providers in the community would work together in identifying needs and providing services in the community: Alianza was the lead agency. Even though we had contacted Alianza when we were preparing our proposals, they were not one of our partners. At the behest of Alianza, the Commissioner convened a meeting and we agreed that Alianza would be a partner in the Best Beginnings program—the tri-partite partnership was formed. We were on our way: an inauspicious start, but not surprising, given the history between the two agencies located in the community and the third agency from outside the community. The success of Best Beginnings illustrates how a partnership created for practical considerations can succeed and thrive.

A Directorate was created to be the governing body of Best Beginnings. It was comprised of representatives from the sponsoring agencies: some of who have changed over the years. The members were senior staff who had the authority to make decisions, but who had the time and interest to devote to the program. We focused on starting up this new service. We met regularly (initially once per month and after the program was launched and on track, bimonthly). When special tasks arose we created subcommittees to address them: such as recruiting staff, planning an Open House, focusing on research, holding a Legislative Breakfast, and meeting with foundations.

Best Beginnings is flourishing. There are over 300 families currently receiving the service. The budget of over \$1.5-Million has diversified funding from the New York State Office of Children and Families (formerly NYSDSS), the US Health and Human Services Abandoned Infants Program and various private foundations. In 2001, seven years after its inception the NYSPCC transferred Best Beginnings to the community, and the lead agency is now Alianza, in partnership with Columbia. There is a randomized trial of the service and the data is being analyzed. Best Beginnings was the first child abuse prevention program of this type in New York—there are now 27 programs throughout the state with a total budget of over \$20-Million and is credentialed by Healthy Families America of Prevent Child Abuse America.

Method

The partners reflected on the Nine Principles of Partnership and the key ingredients for this successful venture. Recognizing that every partnership is different, I hope that the experience of the members of the Directorate will be helpful to others who venture forth on these uncharted waters.

I interviewed all members of the Directorate for this paper: Director, Division of General Pediatrics at the Department of Pediatrics of Columbia University College of Physicians and Surgeons/New York Presbyterian Hospital (both current and prior); Administrator, Department of Pediatrics, New York Presbyterian Hospital; Medical Director, 180 Street Ambulatory Care Center, New York Presbyterian Hospital; Director, Community Pediatrics, New York Presbyterian Hospital; Executive Director, Alianza Dominicana, Inc.; Professor,

Columbia University School of Social Work; and the Best Beginnings Research Director (former Program Director).

The former Program Manager of Best Beginnings worked with me in developing the questions and was present at many of the interviews. She shared her views as well. The interviews took place in person (except for one telephone interview) and were private except for the presence of the former Program Manager at some of the interviews. The interviews ranged from one hour to over two hours.

I asked the partners to reflect on each Principle in the context of Best Beginnings and respond to the following questions: (1) To what extent have we applied this principle? (2) How important is it to the success of Best Beginnings? (3) How could we improve in this area? (4) What are the barriers to fully implementing this principle, and how might we overcome them? (5) How might we assess the extent to which we are successfully applying this principle at Best Beginnings and improving on it over time?³

I also asked general questions: (1) Are there any other principles you might suggest which resulted in the success of the Best Beginnings partnership? (2) What is the most important ingredient that made the Best Beginnings partnership work? (3) Has this partnership changed your relationship with the other partners? If so, how? (4) What should be included in a toolkit for other communities who are thinking about creating a community-campus partnership?

Principle 1: Partners have an agreed upon mission, values, goals and measurable outcomes for the partnership.

³ Seifer, S. and Maurana, C., “Developing and Sustaining Community-Campus Partnerships: Putting Principles into Practice”, *Partnership Perspectives, Volume, Issue II, Summer 2000, p.10.*

Everyone agreed that this principle is of crucial importance. One member said, “Without a meeting of the minds there is no way to move a partnership forward.”

The partners shared a common mission: Delivering effective prevention services in a community and demonstrating it in an empirical way. All agreed Best Beginnings was an important service to offer children and families in the community. One member stated, “It is essential that there be a coming together. It took a while to reach this place and it would have been faster if we had a history of working together, there were some rocky moments at the start.” A challenge for the partners was to understand what the others could provide to this project. Columbia felt, “We can do it alone. We have the expertise and the resources. Later we recognized the contributions of the other partners.”

One member stated, “It was an exceptional experience for the research and practitioner piece to work so well together. There was tension, but we were working in the same direction.” Another member attributed this ability to work together to the fact that, “the two senior staff of the program: Elizabeth Anisfeld, Program Director, whose area is research and Milagros Batista, Program Manager, whose area is practice, respected each other and did not get in each others way.”

There are three stages for establishing a partnership: identification, development and maintenance.⁴ We identified the need, but did not identify all

⁴ Cauley, K., “Principle 1: Partners have agreed upon mission, values, goals and measurable outcomes for the partnership,” *Partnership Perspectives*, Volume I, Number 2000, p.16.

the partners before the grant was awarded. A planning grant might assure full participation from the start.

Indicators of how widely a vision is shared include who shows up at the meetings, who do the talking, who volunteers for what kinds of work, who seeks credit and how benefits are distributed.⁵ Although the partners adopted the same vision, the community-based agency did not have the depth of staffing or resources to be as participatory as the hospital was. It is not unusual that well-established organizations such as The NYSPCC and Columbia would have disproportionately more resources than a community based organization.

Time challenges come from a variety of angles and are intertwined with a lack of available resources to tackle community problems.⁶ There are natural pulls on the various partners. It is important to make the meetings worthwhile to all participants and to have representation by all partners. This presents a challenge because the medical center is very large and has many staff that can participate, whereas a community based agency tends to have few people who can attend meetings on a regular basis. At a minimum, the Executive Director should identify a senior staff person to attend meetings.

⁵ Taylor-Ide, D. and Taylor, C. Just and Lasting Change: When Communities Own Their Futures. The Johns Hopkins University Press, 2002, p. 41 from Boyte, H., and Kari, N. The Democratic Promise of Public Work (Philadelphia: Temple University Press, 1996)

⁶ Lantz, P. Viruell-Fuentes, E., Israel, B., Softlery, D., and Guzman, R. "Can Communities and Academia Work Together on Public Health Research? Evaluation Results from a Community-Based Participatory Research Partnership in Detroit" *Journal of Urban Health: bulletin of the New York Academy of Medicine*, Volume 78, No. 3, September 2001, p.503.

Collaborations are built on the belief that working together will be more successful than working separately.⁷ A history of positive working relationships may be considered a facilitator and the absence of such history an impediment.⁸ But that impediment can be, and in the case of Best Beginnings, was overcome.

Principle 2. The relationship between partners is characterized by mutual trust, respect, genuineness and commitment.

“Trust is critical,” stated one member. However, Best Beginnings started with “minimal trust.” The Washington Heights community had a deep distrust of Columbia University and felt that their interest was in collecting data to publish papers, not improving the community and also a distrust of the NYSPCC and its intentions since the community did not know them and they were neither from the community nor Latino.

One member stated, “the barriers were the different worlds that each of the partners came from: Alianza, a social services agency steeped in local community service; NYSPCC, governed by the lawyers rule of law; and Columbia, a medical and educational facility focusing on medicine and research. However, without trusting each other the partnership could not have gone forward.”

This principle needs continual work. One member said, “The key is human contact—one person to another.” The members agreed that the contact among the partners at regular meetings that were directed at “developing and

⁷ Aldridge, A., “Lessons Learned From Building Collaborations,” *Protecting Children, A Community Approach to Child Protection Efforts, American Humane Association, Children’s Services*, Volume 17, Number 2, 2002, p. 4

⁸ Israel, B., Schulz, A., Parker, E., and Becker A., “Review of Community Based Research: Assess Partnership Approaches to Improve Public Health, *Annual Review Public Health*, Volume 19, 1998, p. 182.

then implementing the program provided a forum for interchange of ideas and views, and a reiteration of our long term goals.” Another factor was my presence. I served as a mediator between the campus and the community and was seen as fair by everyone. I was also seen as the taskmaster who moved the partners forward.

One of the major factors for Alianza’s trust was the presence of Milagros Batista as the Program Manager. One member stated, “including Milagros was the major factor in developing trust.” Alianza will rarely participate in a project unless a member of the community is integral to the partnership. Finally, Elizabeth Anisfeld, the Program Director, was self-effacing; goal directed and gained the trust of the staff.

One of the partners stated, “There is not 100% trust among the partners, which is understandable. We all have our own agendas.” But the partners had enough trust to make it successful. A member stated, “People are not comfortable talking about trust. To address that difficulty, we might have found a way to put the subtext on the table, to put a process in place without causing hard feelings. Education of the members about how to disagree, yet run an efficient meeting would have been helpful.”

The most frequently stated challenge to conducting effective community-based research is lack of trust and perceived lack of respect, particularly between researchers and community members.⁹ It takes hard work to confront real differences and negotiate the pragmatic and altruistic goals that truly bring

⁹ Ibid., p. 183.

the collaboration together.¹⁰ Setting up the base of this working partnership would not have been possible without purposefully establishing and striving to develop trust among all partners.¹¹ The Best Beginnings partnership was very task driven. As the partners completed their tasks, trust developed.

Principle 3. The partnership builds upon identified strengths and assets, but also addresses areas that need improvement.

One member stated this principle was the “hallmark for the project.” The members of the Directorate respected each other’s strengths and had “a genuine interest in improving the lives of families.”

However, some found it difficult to address areas that needed improvement. As one member said, “There was discomfort in bringing up shortcoming of some of our partners.” As with Principle Two an outside facilitator might have enabled us to address concerns in a constructive way.

One of the great strengths of this partnership was the marriage of service and research. The research and service components were represented on the Directorate and got to know each other, despite tension from time to time. Their close relationship resulted in securing grants in both the public and private sectors. All partners felt that the relationship between researchers and practitioners was significantly better than in other similar services.

It was clear what the assets and strengths of the partners were. Alianza was known and trusted in this community and provided many social services to families throughout the neighborhood. Columbia was a well-respected medical

¹⁰ Hoel, J.L., Cross System Collaboration: Tools That Work, Child Welfare League of America Press, Washington, D.C., 1998, p.23.

¹¹ Op. cit., Lantz, “Can Communities and Academia Work Together....?” P. 500.

facility known for providing excellent medical care. The NYSPCC had expertise in starting up and delivering child abuse and neglect programs. These complementary assets were strengths to the partnership.¹²

Principle 4. The partnership balances the power among partners and enables resources among partners to be shared.

The power was shared in Best Beginnings in providing the services. This sharing was considered a “strength of the partnership....” One member said, “It worked well, Columbia gave the families access to their clinic and its residency program, NYSPCC provided expertise and training in child abuse and the resources of its administration and Alianza gave Best Beginnings families priority of access to their services.” Alianza also “housed the project and volunteered one of its key staff as Project Manager.”

However, on the issue of funding one member stated “Power flows with the money.” There was a feeling among some of the partners that the lead agency held the power. There was a sense that “one needed to bring money to the table to be heard.” The partners from the community-based agency felt that “one cannot forget that Columbia and NYSPCC had the prestige, money and power. Although there is a balance of power on the day-to-day decision making, if they did not want something, it wouldn’t happen.” One member stated that this principle is not essential and that “Power does not always have to be balanced. If the partners feel that there is fairness and respect when decisions are made, it is OK for the power to be unbalanced.”

¹² Op. cit., Aldridge, P. 3.

One member stated, “A reason the Best Beginnings partnership worked so well was because of the personal relationships that developed and the communication that occurred.” Another pointed out the need for “an evenhanded leader to keep the balance of power on an even keel since alliances would shift back and forth over time.”

Perfect equity is surely unattainable.¹³ However, it is something to strive to attain. Sharing resources and balancing the interests of communities’ research, and public health in a partnership is a significant challenge.¹⁴ The institution at all levels must buy into the partnership as the first step towards sharing of resources and balancing power.

Principle 5. There is clear, open and accessible communication between partners, making it an ongoing priority to listen to each need, develop a common language, and clarify the meaning of terms.

Although this principle was viewed as important, it needed work. The members stressed the importance of having senior staff at the meetings to assure that each organization was represented.

One member stated, “Smaller collaborations tend to work better than large ones...big ones tend to fall apart.” Another said, “This tight collaboration with a clear mission kept it on track and working well.” The Directorate facilitated the communication. It served the function of assuring communication and the routine of this forum got everyone in the room and kept things moving. In addition, one member felt, “The sidebars were helpful.” One member suggested holding quarterly meetings for all members of the Directorate and monthly meetings for

¹³ Op.Cit. Taylor-Ide, p. 249.

¹⁴ Higgins, D., and Metzler, M., “Implementing Community Based Participatory Research Centers in Diverse Urban Settings” *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, Volume 78, No. 3, September 2001, p.492.

the core members. This structure might have been more productive and mindful of the time constraints of the members.

To achieve this principle, there must be a willingness to listen to and to recognize and appreciate the others—especially in the medical setting; doctors are often viewed as authority figures who are trained to tell other people what to do; it has not been part of their culture to work on an equal footing with the members of the community. This challenge must be met before this principle can be achieved.

Direct open communication is the impetus for developing trust and a connection with each other.¹⁵ Top down activists and grass roots community members must work in partnership, putting an end to wasteful arguments about who is in charge. Communities, not officials or experts, are the foundation of sustainable action.¹⁶ When officials and experts demonstrate humility, community enthusiasm becomes contagious.¹⁷

Principle 6. Roles, norms, and processes for the partnership are established with the input and agreement of all partners.

Members of the Directorate consider this principle important. However, they felt that the process cannot take place in a vacuum and should occur after the program has started—“you can’t set roles, norms and processes without the program in place.” Best Beginnings partners focused on the work of starting up and sustaining a child abuse prevention program; the partnership was a natural outgrowth of that work.

¹⁵ Op. Cit. Hoel, p. 45.

¹⁶ Op. cit. Taylor-Ide, p.240..

¹⁷ Ibid., p.36.

One area where there was a need for a process at Best Beginnings was to make clear and consistent “our statements about Best Beginnings in public forums to assure that we were on the same page.”

Recognizing that the partners come from organizations with different histories, cultures, powers and priorities¹⁸ it is important for the partners to establish and agree to common norms, roles, and processes. The activity is less important than the how choices are made and the work is done.¹⁹

Principle 7. There is feedback to, among and from all stakeholders in the partnership, with the goal of continuously improving the partnership and its outcomes.

A threshold question is: Who are the stakeholders to be included in the partnership? Some members strongly believe that parents should be part of the Directorate. One member stated, “Their voices would have be very helpful to the program.” They suggested creating a Parent Advisory Board, with a parent representative on the Directorate.

The regular meetings of the Directorate were “A problem solving venue that was critical to the success of the partnership.” One member stated, “Assessment took place only at significant junctures in the program—such as when the lead agency shifted from NYSPCC to Alianza.” One suggestion was to hold an annual retreat to look at the “big picture” and to focus on a strategy with goals and timelines for the coming year. This process might have included all the stakeholders including the staff, the organizations and the parents.

¹⁸ T. Morison, “Partnership and Collaboration: Rhetoric and Reality” *Child Abuse and Neglect, Volume 20 No. 2* February 1996, p.130.

¹⁹ Op.Cit, Ide-Taylor, p. 37.

Partnerships are complex approaches to organizing work, because they blend different missions, cultures, work styles, deadlines, financial concerns and expertise.²⁰ A successful partnership depends on building and sustaining communication mechanisms among the various partners.²¹ It is important to acknowledge value in each partner's perspectives and priorities and for each partner to feel comfortable articulating his or her needs.²² The partnership relationship facilitates the reciprocal transfer of knowledge, skills, capacity, and power²³ and successful partnerships mature through continual adjustments in complex relations.²⁴

Principle 8. Partners share the credit for the partnership's accomplishments

The members consider this principle very important, "People want credit for what they contribute" and the members were generous about "giving credit where credit is due." There should be a mechanism set up on how to and who will prepare and get credit for presentations, articles and research papers. Not everyone felt that they were properly represented outside the partnership.

Sharing credit enhances the trust among the partners, outcomes of the project and the partnership itself. Inability to mitigate the egos and turf battles

²⁰ Provan, K.G. (1983). The federation as an interorganizational linkage network. *Academy of Management Review*, 8(1) 79-89 in Sebastian, J., Skelton, J., and West, K Principle 7.... (2000) *Partnership Perspectives*, 1(1) 57.

²¹ Ibid. 57.

²² Baker, E., Homan S., Schonhoff, Sr. R., & Krueter, M., "Principles of Practice for Academic/Practice/Community Research Partnership" *American Journal of Preventive Medicine*, Volume 16, Number 3, 1999 p. 89.

²³ Op.cit. Israel, p. 179.

²⁴ Op. cit. Taylor, p. 43.

has been the downfall of many a well-meaning collaboration.²⁵ Guidelines that partnership members establish are helpful in avoiding unnecessary conflicts.

Principle 9. Partnerships take time to develop and evolve over time.

All the members expressed a hearty “Amen” about this principle, which encompasses the others. One member stated, “You must have a long-term perspective from the start.” The members who came on board after the partnership was established found it to be “a well-oiled partnership.” It is a fluid structure that constantly must focus on issues of communication and “whether the structure of the partnership facilitates power sharing and balance.” A member who was involved from the beginning stated, “After a year the partnership grew to another level. There was trust and acceptance after getting to know each other and understanding each other’s different styles.”

Even though the members of the partnership had a personal and good relationship with each other, without the commitment of the organizations it would not succeed—it needs the institutions to assure the continuance as staff joins and leave.

True partnerships are built on long term, committed relationships.²⁶ Partnerships go from initial formation, to planning, implementation, maintenance, and institutionalization.²⁷ As in any relationship, a partnership needs trust and positive feedback for growth and success to occur. It is not realistic to expect

²⁵ Op. cit Aldridge, MJ, p. 6.

²⁶ Maurana C, Beck B, Newton G, “How Principles of Partnership are applied to the development of a community-campus partnership” *Partnership Perspectives* Volume 1 No. 1 1998, p.51.

²⁷ Butterfoss FD, Goodman RM, Wandersman A. Community coalitions for prevention and health promotion. *Health Education research* 1993, 8(3): 315-30 and Florin P, Mitchell R Stevenson J, Identifying training and technical assistance needs in community coalitions: a developmental approach *Health educ research: Theory and Practice* 1993; 8(3); 417-32 in Baker et al p.91.

that different groups and people will come together and immediately have the trust needed to reach a goal—even if it is a common goal—they will each view the way to get there from their own background and experience. In a partnership ideas must be expressed and respected with a coming together by all partners on a mutually agreed upon way—but it is a process and takes time.

Are there other principles that contributed to the success of Best Beginnings?

A Principle not articulated, but identified as a key element for the success of a partnership by both the members of Best Beginnings and the literature is the presence of a strong leader who is trusted by all partners and who will be there when conflicts arise. This leader has the vision to see the partnership through on both a macro and micro level and facilitates the work of the partners in reaching their goals.

A person or organization needs to assume leadership, not in terms of “running the show” but in terms of “skill and resources” that of managing the structure and organization that will assure the coalition works effectively as a social organization: Someone needs to chair meetings (or keep track of the rotating chairs) to structure agendas, to monitor follow-through as tasks and to lead the partners in focusing work on relevant issues and managing conflict.²⁸ The effective leader supports and facilitates the implementation of the operating norms of the partnership. The leader must provide visible, direct, and consistent

²⁸ Op. cit. Hoel, p.26.

personal support to the partners.²⁹ This person is critical to the success of the partnership and must have the respect of all the partners.³⁰

What is the most important ingredient that made the Best Beginnings partnership work?

The ingredients clustered around three areas: (1) common goal and vision, (2) key person and institution responsible for starting up and stewarding the partners and the partnership, and (3) personal relationship among the partners.

Specifically the members listed:

- The NYSPCC with its Executive Director as the moving force—the point person from the right agency who brought everyone on board and onto the same page—who kept the members focused on their goal.
- Support and confidence of the Board of Directors of the NYSPCC lead agency, which in turn secured the confidence of the Chairman of Pediatrics at Columbia and then the Chairman of Alianza.
- The members had a clear vision and mission.
- The Directorate, which helped guide what, we did by meeting regularly and communicating with each other.
- The human contact—if the partners connect, then they can do the things necessary for a successful partnership.
- A true community based partner who contributed to the legitimacy in the community and therewith the ability to attract and retain a community based staff and the retention of participants.

Has this partnership changed your relationship with your partners? If so, how?

The members all agreed that the Best Beginnings partnership has changed their relationship with their partners, for the better. Members stated, “Columbia has never been so close to Alianza.” Other projects have emerged

²⁹ Ibid. p. 34.

³⁰ Op. cit., Israel, p.186.

between the partners that were easier to move forward and they have been able to “hit the ground running.” Some of these projects included service learning of residents in community pediatrics and a closer relationship between Alianza and the Columbia clinics. One member stated that, “Prior to Best Beginnings there was an adversarial relationship between Columbia and Alianza, two leading institutions in the community.”

Toolkit

Ingredients of a toolkit include:

- Common vision
- Reciprocal relationship
- Workshops for caseworkers on the culture of a hospital
- Steps necessary to build a partnership
- Examples of successful partnerships
- Video
- Survey of Literature
- Define what each partner brings to the partnership
- Interview questions used for this article
- CCPH Nine Principles of Partnership

Conclusion

The keys to a successful partnership are: (1) A clearly defined goal, (2) Each partner sees benefit to its organization, (3) Strong neutral leader who is trusted and respected by all partners. All partners must feel they are benefiting from the collaboration.

Successful collaboration entails the investment of time and attention to detail. The key is continually making sure that all sides is treated fairly and that they are getting something out of the partnership. When this occurs trust is established. Partners' first allegiance is to their organization: If there is a common and specific goal, it can supersede individual interests. With hard work and a willingness to listen and work together, a partnership will become greater than the sum of its parts to the benefit of all.

Skilled leadership is crucial if a collaborative is to succeed.³¹ Partner representatives need the support of their organization and the authority to make decisions for their organization. The personalities of the representatives of the partnering organizations are key to a successful partnership. Some people partner better than others, and some of the necessary skills are flexibility, openness, patience, interpersonal sensitivity, and communication skills.³²

Acknowledgement

I greatly appreciate the contribution of the members of the Best Beginnings Directorate who have devoted their time, commitment and intellect to the success of Best Beginnings for many years: Nicholas Cunningham, Neil Guterman, Matilde Irigoyen, Wanda Lay, Mary McCord, Dodi Meyer, and Moises Perez. I especially want to thank Elizabeth Anisfeld and Milagros Batista both members of the Directorate as well as leaders of Best Beginning. Their vision and continued guidance sustained the program. I deeply appreciate their sharing with me their thoughts and reflections on this partnership, which constitutes the

³¹ op. cit. Hoel, p.55.

³² Ibid. p. 41.

heart of this article. I also thank the three organizations for their unwavering support of Best Beginnings and the partnership that created and sustained it. This paper is supported in part by the Community Campus Partnerships for Health (CCPH) Fellows Program, with grant support from the Helene Fuld Health Trust HSBC Trustee and the Corporation for National and Community Service. The views expressed are those of the Fellow and not necessarily the funding agencies. CCPH is a national non-profit organization that fosters health-promoting partnerships between communities and higher educational institutions.

About the Author

Anne Reiniger is an attorney and social worker and was Executive Director of the New York Society for the Prevention of Cruelty to Children for 15 years. During her tenure there she developed Best Beginnings, a community based primary prevention home visitation program for families in an underserved community. It has been replicated in 26 sites around New York State. She was a leader in the creation of the New York State Home Visiting Council and co-chair of its Advocacy Committee.

Ms. Reiniger served on the faculties of Columbia University School of Social Work and Fordham University Graduate School of Social Service. She is Secretary of the Board of Directors of Prevent Child Abuse America and on the Advisory Board for the Community Pediatrics Program at Columbia University College of Physicians & Surgeons.

Ms. Reiniger lectures at national conferences and recently presented a workshop on community partnerships at the National Conference of Prevent Child Abuse America. She has written articles which have been published in Child Abuse and Neglect: The International Journal, Mediation Quarterly and The Family and Conciliation Courts Review. She is editor and contributing author of The NYSPCC Professionals' Handbook on Providing Supervised Visitation.