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Why Collaborative Solutions?

HOW OUR HELPING SYSTEMS ARE FAILING US

ON SEPTEMBER 11, 2001, the New York City Police and Fire Departments had difficulty coordinating their actions because they were operating on different radio frequencies. Urgent messages between emergency professionals could not get through as they dealt with the tragedies at the twin towers. It seems that this is a metaphor for many of our modern approaches to community problem solving—we are struggling because groups that need to work together are on different frequencies, both figuratively and literally.

In the late 1980s, I heard Ann Cohn Donnelly, former director of the National Committee to Prevent Child Abuse, tell a story of being a young social worker and getting a request from one of her inner-city parents to come to the woman's house on a Saturday morning. Donnelly arrived and found a room filled with people like herself. The mother of the family announced, "You are all social workers working with our family. I am going to leave the room. It would be really helpful for our family if you would talk to each other."

Then there was the time I was working with a rural community coalition that was addressing issues of hunger and homelessness. The coalition members gathered the leaders of six local churches to find out what the religious groups had been doing to alleviate hunger among homeless community members. We asked who was serving warm meals during the week. Representatives of two churches raised their hands. We asked when these meals were served. The people from the first church said, "On Sunday, of course." And the people from the second, rather sheepishly, said that they also served food on Sundays. In this small community, neither group knew that the only hot meals being served to homeless residents were served on the same day. One of the churches agreed to move its hot meal to the middle of the week.

Here's another story. In a poor former manufacturing city in Massachusetts with a population of about forty thousand, we held a meeting of representatives of the existing community coalitions. These coalitions had been formed to coordinate activities on various topics. Coalitions such as these are often created out of goodwill, but the number of independent groups can proliferate due to external pressures—for example, state agencies that require coalitions dedicated to single topics. That was the case here. In this meeting, with ninety representatives of community agencies and city departments, we identified more than thirty-five coalitions working in a hodgepodge manner across the community. This array was confusing and wasteful. Similarly, a colleague has told me that in Mexico City there are more than ninety HIV programs. Duplication of effort seems rampant.

Too often we work as individuals rather than as part of a community or of a community of helpers. It is an "I" world rather than a "we" world. As a result, our approach to community problems is often ineffective.

This is not just a community problem. It happens in our individual lives as well. On a daily basis all of us encounter many ways that our world disconnects and makes our survival harder. People don't talk with each other. People won't work with each other. Your physician won't speak to your specialist or your acupuncturist. Your child's teacher doesn't speak to your child's therapist or privately hired tutor. Your plumber can't make time to talk to your contractor. This lack of collaboration in our world hurts us all.

I recently had a painful swelling and clicking of a finger in my left hand. My personal physician diagnosed this as a "trigger finger" and didn't think he could do much to alleviate my discomfort. He referred me to a surgeon, who suggested a cortisone shot or surgery. My holistic chiropractor suggested a regimen of supplements and tied the new symptoms to other systemic problems I was having. My acupuncturist treated my difficulty and cured it! But none of these people ever talked to each other.

Community Solutions Demand a New, Collaborative Approach

Our communities and our world face such complex problems that we no longer can solve them by gathering a few experts in a room and letting them dictate change. We need new ways to find solutions. Many of us now understand that the emerging problems that communities face have such complex origins that we can only fix them if we use comprehensive community problem-solving efforts rather than single-focus approaches. We need to meet and communicate and partner with each other, and we need to include representatives from all parts of our communities.

We cannot reduce youth violence using only a public safety approach. To find a solution, we need to have neighbors, clergy, and the young people themselves involved. We cannot fight childhood obesity by just asking individuals to show more self-control. We must also address school policies on access to junk food, as well as the advertised appeal and offerings of fast-food restaurants. Asthma rates in inner cities cannot be reduced without involving hospitals, health centers, housing authorities, environmental protection agencies, neighborhood groups, and the families of those most affected. Community solutions demand community collaboration.

In many communities, neighbors are disconnected from each other and continue to focus on their differences rather than their common interests. Organizations and institutions that might be working together to pursue a common purpose are too often ignorant of each other and focused on their own singular tasks.

I have spent much of my professional life in the community-based health and human service system, and was stunned early on to discover that this system does not make enough of an effort to collaborate in order to deliver the best possible services to those in need. Instead its habits are based on competition and fragmentation, and it resorts to collaboration only under great pressure. Because of this lack of collaboration, the so-called helping system has become extremely dysfunctional.

These dysfunctions have become so bad that they now provide a major impetus for changing the way we work. They are pushing us to create processes that encourage collaborative solutions to problems. This is true not only in health and human services, which is my area of concentration, but also across many other systems in the United States and around the world—in education, community development, community planning, national program development, and international peacemaking.

How Our Traditional Community Problem-Solving Methods Fail

Not only are our systems non-collaborative, our traditional problem-solving mechanisms are flawed as well. As nations, states, neighborhoods, and organizations attempt to solve problems, address issues, and build a sense of community, the one-dimensional approaches that have worked in the past utterly fail them. The problem-solving systems that we are accustomed to now struggle with a whole array of limitations. I'll spend some time considering how the old ways are failing, but here are the realms in which they fall apart:

- Fragmentation
- Limited information
- Duplication of efforts
- Competition
- Crisis orientation
- Lack of connection to those most affected and their communities

- Blaming the victims and ignoring social determinants
- Lack of cultural competence
- Focus on deficits
- Excessive professionalism
- Loss of spiritual purpose

Now let's take those shortcomings one at a time.

Fragmentation

We approach problems in pieces. Our helping system sees people through a fragmented lens. For example, in health care each of our medical specialists knows our organs, but who knows our whole being? The fragmentation is even worse than my "trigger finger" example suggests. My ophthalmologist knows my eyes, my internist knows my gut, my psychologist knows my mind, and my chiropractor knows my spine. But who knows how my eyes, gut, mind, and spine interact? Who understands how each of these aspects of who I am is affected by events in my life—personal traumas, losses, changes in diet, or exposures to toxic chemicals? In communities it is the same. My life, just like your life, is affected by all aspects of the community each of us lives in—by its businesses, government, parks, health systems, neighborhoods.

I once presented a theoretical case to a meeting of human service providers who all worked in the same community. I described a woman in her mid-twenties who lived in poverty, drank a little too much, couldn't find work, and got a little too rough in spanking her children; who was married to a man who was a little too rough with her; whose kids were involved in street gangs; and who generally felt hopeless and depressed. I asked the room full of people, "If this woman came into your agency, how would you understand her and what would you do for her?"

The responses were fascinating. In short order, the group offered seven labels and diagnoses: depression (mental health agency), substance abuser (substance abuse agency), victim of domestic violence (domestic violence agency), child abuser (child welfare agency), disempowered woman (women's center),

victim of economic inequality (poverty agency), and at risk for homelessness (housing agency). No one could see her as a whole person. This fragmented reaction was not due to the people's individual limitations but rather was produced by their agency missions, their personal training, and the compartmentalized helping system that compelled them to look at one aspect of this woman at a time.

Fragmentation of our helping systems and fragmentation of our solutions waste resources and prevent us from implementing holistic approaches that will make people's lives substantially better. To be effective and appropriate, to really *solve* problems, we *must* use holistic approaches.

Limited Information

Those of us attempting to solve problems usually do not have all the information we need to generate the best possible solutions. Too often our information is limited by our personal or organizational view of the issue.

Human service agency personnel who work with complex families that are affected by multiple problems need to have resources and referral sources in multiple agencies across a community. Yet they often only have good referral relationships with one or two outside agencies. Consumers themselves are also short of the information and resources they need in order to make smart choices about where to get appropriate help and to find out whether they are eligible for that help.

Health care access is a perfect example of how missing information stymies attempts to provide health insurance for the uninsured. Not only do we have to provide affordable and accessible health coverage programs for citizens, we then have to get them information so that they can enroll in the programs we have made available.

My fellow workers and I learned this after Massachusetts created legislation that effectively provided universal health care coverage for all children. (This achievement was the precursor of the federal children's health program called at the federal level SCHIP, the State Children's Health Insurance Program. The federal program is called State CHIP or SCHIP because it allows each state to do its own children's plan under some federal requirements.) Legislating coverage does not mean that all those in need will get what they're newly entitled

to, and eligibility is not the same as enrollment (DeChiara and Wolff 1998). We spent four years in a massive outreach and education campaign across the state trying to get enrollment information to all the pockets of uninsured children and their families. This mainly meant working with groups who were the recipients of state outreach grants, groups that represented the yet-to-be-reached individuals—immigrants, cultural and racial minorities, the rural poor, and others. Access to the right information was as important for our goal of moving uninsured children to coverage as was the legislation. (The full story of the Health Access Networks is told in Chapter Seven.)

Sometimes changes can be made successfully only if we develop new channels for sharing information. Deinstitutionalization, the process of changing from predominantly institutional to community-based treatment for people with mental illnesses, provides an example of how important clear, open, and multidirectional communication can be.

For nine years, I chaired a group called the Mayor's Task Force on Deinstitutionalization for the city of Northampton, Massachusetts. Both a state mental hospital and a Veterans Administration hospital were in the process of closing their long-standing mental health units and releasing patients into the community. This produced a fair amount of chaos, conflict, and confusion in the city. The mayor had brought together all the critical players for monthly meetings, and he asked me to be the chair. I learned a lot from the experience, and will discuss it in depth in Chapter Four. In short: although the initial meetings involved much high-volume disagreement, we were slowly able to quiet the discourse and get people to hear each other (Wolff 1986).

What did they learn? What information was exchanged that made a difference?

People working in the mental health system learned that when a city police officer waited in the emergency room of the general hospital for the mental health department's psychiatrist to show up to assess a violent patient, the mental health system was tying up fully one-third of the city's available police patrols. The mayor and the police learned why the patient who broke a window in an ice cream shop on Friday night and was admitted to the state mental hospital that evening had been released back into the

community two days later. The patient could not be kept hospitalized without being legally declared "dangerous to self or other," and window-breaking didn't count toward that status.

Both of these situations had caused great conflict between the city and the mental health system. Each resulted from a simple lack of information. However, the resulting problems could only be dealt with when the appropriate people were sitting in a room together and were ready to start hearing each other.

A lack of crucial information keeps consumers from finding appropriate resources, and keeps helpers from effectively working with each other. We all need reliable information and good communication systems.

Duplication of Efforts

We often think there is duplication of services and waste in the helping system. In reality the big problem comes from duplication of efforts, more than specific services. This means that several groups in a community are working on the same problem without knowing about each other. Collaborative solutions cannot be found until people begin to consolidate their efforts.

Here's an example of duplication of effort in one small community. The topic is reducing teen pregnancy. One group gathers at the family planning agency, another addresses the problem at the state Department of Public Health, and a third forms at the high school. The groups don't know about each other.

This happens again and again.

In the federal government, the cabinet-level Department of Homeland Security was established because the events of 9/11 made it clear that the several agencies responsible for making the country secure were not working together. Combining a number of mega-institutions under one secretary by no means guarantees that those organizations will coordinate their efforts, in the same way that moving a group of agencies into the same building does not guarantee that they will coordinate their services. We will see different results only if these groups follow the principles that lead to collaborative solutions.

At the kick-off meeting of the year for a community coalition in a small community, we asked the participants, "What's new in your agency? What's

happening?" Three different mental health counseling agencies had representatives in the room. One agency had been in town a long time. It had recently lost contracts, so its staff member told about offering fewer services. A small counseling agency had expanded by merging with an agency outside the community. Its report included a marketing plan for expanding services. The third agency was brand new to the community. It had won the contracts that used to go to the first agency, and its representative talked about the organization's new commitment to the area.

As we looked around the room at the other participants who came from agencies that provided services in other areas, we saw a lot of blank looks. We knew what those blanks were covering up: the other people in the room were struggling with the question, "Now, with all these changes where do we refer people who need mental health help?"

We asked the representatives of the mental health agencies to explain to people how the three organizations worked together, where people should go for which services, and whether their offerings included any overlapping services. The mental health providers acknowledged that those were great questions, but said that before they could answer they first had to talk to each other and figure out what to say. "Good idea," we said, astonished that they hadn't already done this. Later in the meeting, a beeper went off. People from two of the three mental health agencies quickly reached for their briefcases and pockets. Someone remarked with feeling, "Duplication of efforts?"

Duplication of efforts is wasteful. We all need to be willing to coordinate our efforts.

Competition

Competition is a way of life in the United States. It is deeply embedded in the U.S. economic and political systems and it has many advantages, but it is a significant barrier to promoting communal, collaborative approaches. The competitive approach is surprisingly pervasive in the helping systems. This can be seen clearly in cities and towns where two hospitals or hospital systems compete with each other in what is as much a life-and-death battle for the institutions as are the fights for survival that go on for individuals in the hospitals' ERs.

In one Massachusetts city, two hospital systems were competing for organizational survival. One hospital refused to treat patients who belonged to the HMO owned by the other. Clients and providers pay a price for competition of this type. People end up confused, and resources are wasted. It is also hard for the hospitals to focus on addressing community needs when they are working so hard on putting each other out of business.

I was once in a situation in which two mental health agencies had been on the brink of merging when the merger collapsed, leaving bitter feelings between the people in the two agencies. A few months later, the Department of Mental Health awarded new service contracts. One agency received the contract for outpatient mental health services. The other received the contract for medications. The two would now share a considerable caseload, with one agency providing psychotherapy and the other supplying medications for the same set of clients. One had to wonder how successful this collaboration on patient care was going to be in an atmosphere still cluttered with bad feelings.

I know it may sound like heresy to say this, but we need to get competition out of the helping system; it seems to cause much more harm than good. Competition and helping do not necessarily go well together. We need to replace competition with cooperation and collaboration.

Crisis Orientation

Much of contemporary culture is crisis oriented. We respond to the day's crises and rarely have time for prevention or for envisioning a better future. Because we don't emphasize planning, we attempt to solve each new problem as an emergency.

I'm a proponent of prevention and have been for a long time. I've studied ways to prevent problems, and early on I read that embracing prevention requires a mature culture, one that is capable of thinking and acting with a vision at least ten years ahead, not just the two years until the next election.

In the United States, people clearly have trouble thinking ten years down the road.

For example, President Kennedy founded the community mental health movement with a stated goal of preventing mental illness and mental

retardation. I worked for years doing prevention work in community mental health centers. During that time, studies indicated that prevention was a low priority. In spite of President Kennedy's intention, less than 1 percent of the resources committed to community mental health went to support preventive efforts. This imbalance remains in health care today—prevention is a stepchild. Prevention programs on substance abuse and smoking are becoming more popular and are gaining some public acceptance, but in most areas we're not making much headway.

Even when we make great progress in preventing disorders, we seem to be willing to drop the ball as soon as we've grasped it. For example, the legal settlement with the tobacco industry produced a flood of money and programs intended to reduce tobacco use. Just as the data were beginning to indicate how successful this work was—in particular, documenting dramatic reductions in tobacco use by young people—state legislatures, urged on by tobacco lobbyists, raided the settlement dollars to cope with budgetary problems and gutted the programs. Tobacco use among young people started to go back up.

To replace our crisis orientation with a prevention approach, we need to envision the future. We need to have long-term goals, and we need to develop plans to help us reach them.

George Albee, an early mentor of mine and a passionate advocate for prevention, always reminded us that "[n]o mass disorder afflicting humankind has ever been brought under control by attempts at treating the individual" (Albee and Gullotta 1997, 19). Prevention targets the society and the group, and if it's effective the individual never acquires the disorder. Treatment targets the individual, but never gets at the cause of the disorder. Yet we chronically attack mass disorders with treatment and we ignore prevention. Prevention needs a place of significance in the system.

Lack of Connection to Those Most Affected and Their Communities

Our traditional problem-solving processes are seriously handicapped because they are not connected to the communities where they seek solutions and to the people most affected by the issues. When a problem arises, we tend to turn

for answers to the "usual suspects," in most cases to professionals designated as experts on the topic of our concern. We should instead turn first to the people who are living with the problem.

We have two layers of helping systems, one that we easily recognize and one that we tend to overlook. The first is the formal system, composed of professional helpers: agencies and organizations staffed by specialists. The second is the informal, community-based system and includes neighbors, family, friends, and others. The formal system lacks connections to the communities and tends to ignore the informal system. I'll come back to the idea of the formal and informal helping systems throughout this book.

Our habit of turning to the experts means that we rarely talk to the people who have the most direct, personal experience with the problem we want to solve. If we are addressing problems involving young people, we tend not to ask the young people what they think. If we do think to include young people in our discussions, we are likely to ask the ones who are easiest for us to talk with, not those who are struggling with the problems we want to help solve.

In one city, I was asked to consult with the mayor's long-time friend, who was charged with planning a youth center for their community. It took me a few months to convince this man that he would do well to talk to those most affected by the issue—some of the community's young people. The older and younger people finally got together. When asked what they would like at the new youth center, the young people stated, "Dances on the weekend." The mayor's buddy told them that the youth center was not going to do that, so what else would they like? At that point, the process began its gradual, and inevitable, dissolution.

In 1994, the state attorney general in Massachusetts issued community benefits guidelines intended to make sure that hospitals with nonprofit status served the communities around them instead of accumulating large cash reserves (Commonwealth of Massachusetts 1994). These guidelines outlined the free services for communities that these entities were expected to provide as a result of their designated nonprofit status. A group of us worked with the attorney general to determine how these services would be decided upon and delivered. We did succeed at insisting that the institutions conduct

community assessments to discover what the community members, those most affected by the issues, felt were their greatest needs. Most institutions actually completed these assessments. However, we learned later—when we saw the required annual reports—that the actual benefits given to the communities by the hospitals and HMOs had almost no correlation with the needs revealed by the assessments. Instead the organizations directed their activities toward their own interests.

So even when we ask community members what they need, we don't necessarily listen to what they say. Getting the needs of those most affected to drive the system is not easy. It requires new ways of thinking about power, a topic I will take up later.

The ways in which nonprofit service agencies are governed also play out this disconnection from the people most affected by an issue. The members of nonprofit boards are increasingly out of touch with the people who use the services of the agencies that they serve. This is ironic in light of the origins of nonprofit boards, which were designed as a way of keeping an organization in touch with its community. Nonprofits now draw board members from outside the affected community, or include board members for reasons more related to fundraising capacity than community insight.

As Gus Newport, former director of the Dudley Street Neighborhood Initiative and former mayor of Berkeley, California, stated, "Engagement gives us credibility because if we are successful at that we generally act in the community's best interest. How or why have we devolved to think we can design and maintain meaningful programs without including the people that these programs are meant to benefit?" (Newport 2003, 12). Although nonprofits often say they exist to empower the community, it is hard to succeed at this task without being deeply engaged in that community. Mark Lundberg, a senior program officer at the Otto Bremer Foundation, makes a particularly telling observation about this: "From a human rights perspective programs that don't involve and engage people in their design and implementation aren't really set up to enable people to claim their own futures. Engaging community members in the governance of organizations is central to the kind of transformational work the best nonprofits want to be responsible for" (quoted in Crosby 2003, 26).

It's bad policy and bad practice not to engage the community and those most affected by the issues where we want to see change occurring. This lack of connection needs to be replaced by resident-driven approaches.

Blaming the Victim and Ignoring the Social Determinants

Too often, the helping system blames the victim for the disorder (Ryan 1971) and fails to understand the environment and the social context. Research indicates that a huge portion of a person's capacity for good health is set by social determinants such as income, race, and socioeconomic class (McGinnis, Williams-Russo, and Knickman 2002). Only 10 percent has to do with access to health care. When we consider community problems, we need to understand them in context. Once we've identified the social determinants, we need to make a commitment to both social change and social action in order to change these social determinants and get the positive results that we want.

Here's one example of attending to social determinants. The Boston REACH 2010 program works on issues of racial disparities in identification and treatment of breast and cervical cancer in black women. The REACH 2010 brochure states the issues clearly: "Fact. If you're a black woman living in Boston, you have a greater chance of dying from breast or cervical cancer than a white woman. Why? Racism may play a key role in determining your health status. It may affect your access to health services, the kind of treatment you receive, and how much stress your body endures. The REACH 2010 Coalition can help" (Boston Public Health Commission 2008).

Here's another. Asthma rates have been increasing at epidemic proportions in communities across the United States. The traditional approach to asthma is to have one physician treat one identified patient. As our understanding of asthma has grown, we have learned that each asthma sufferer has "triggers," which are environmental factors that stimulate the onset of the asthma reaction. This knowledge should force us to look at the settings where the triggers are found. We in the helping system are especially concerned about children with asthma, so we need to examine the air quality in places where children go, including schools, school buses, homes, public housing, and YMCAs. Now that we understand the concept of triggers, it becomes clear that asthma treatment and reduction involves more than the medical

establishment. We are not going to succeed in reducing asthma unless we get many systems to act, and to act collaboratively. To allow each system to act independently will fragment our efforts and will confuse both the families affected by asthma and the community that is trying to reduce exposure to the triggers. To solve the problem, we need to expand our view far beyond the single suffering individual.

In the same vein, proposed solutions for the epidemic of obesity in the United States initially focused on and blamed overweight individuals and pushed for diets and self-discipline. Later attention was shifted to also include the environment: the obese person exists (and eats) in a physical location where foods high in fats and sugars and processed ingredients may be all that are available or affordable. We have needed to look at the food suppliers in our neighborhoods and our schools. We have begun to work with new types of policy change, such as bans on trans fats. Our ability to see obesity as a product of many social determinants expands our understanding of the issue and lets us seek a broad range of community-wide interventions.

Ignoring social determinants also limits our success in achieving community change. When we look at the whole community as an organism whose health we can improve, we open the door to a more comprehensive understanding of the issues and to broad community involvement in devising solutions.

Lack of Cultural Competence

The term *cultural competence* is used to describe an approach that is sensitive to and appropriate for our increasingly diverse communities. To paraphrase the work of Juan Carlos Areán, who at the time he made these observations was a program manager for the Men's Resource Center and Family Violence Prevention Fund, cultural competence involves understanding and celebrating the values, customs, beliefs, and histories of different cultures. It requires an awareness of one's own culture, empathic understanding of oppression, and critical assessment of one's own life situation, whether privileged or not. He points out that this self-awareness results in the ability to effectively operate in different cultural contexts (Areán 2000).

Cultural competence characterizes the best of the American spirit.

The flip side of cultural competence is seen in the multicultural incompetence of our present problem-solving approaches, which often lack comprehension of the cultures and people whom we wish to help. Without a focused attempt to reorient our thinking, our helping systems and community problem-solving systems often reflect the prejudices, sexism, racism, homophobia, and class-related biases that have also shown up in America's history, alongside its strengths. We know the white, male, middle-class ways of delivering services. However, our existing systems are often not responsive to and competent to deal with more varied populations.

Early in my work on increasing health care access, I was surprised to learn that many major health providers—hospitals, HMOs, and health centers—did not provide language interpretation for their clients. When we began our work on health care access, if a Spanish-speaking patient came into the ER the hospital staff would have to go to the cafeteria to get the only Spanish-speaking employee in the hospital and request translation help. The medical shortcomings and the legal and medical risks of this approach were mind-boggling. After years of advocacy, pilot project development, and other efforts, we began to see a shift in understanding and in the availability of language-sensitive treatment. We had to invest a lot of time and money to really make the systems move on this issue. Why should something so basic and important as the use of culturally competent and trained medical interpreters be so hard to get in place?

Here's how one coalition worked, over time, to eliminate several cultural barriers that were holding its entire community back. Located in a city in central Massachusetts, the Worcester Latino Coalition was committed to increasing access to high-quality medical interpreter services. At one point, coalition members met with the CEO of a large hospital to explain that pulling Spanish-speaking cafeteria workers into the emergency room to translate did not constitute the provision of quality medical interpreter services. After a pleasant discussion, the CEO smiled but indicated that he had no intention of changing the hospital's practices. A few years later, this coalition joined up with others across the state and created the Babel Coalition (one of the most cleverly named social change coalitions I have known). This larger group got legislation passed that required hospitals

across the state to provide appropriate interpreter services. Now the CEO paid attention.

When we were designing domestic violence prevention programs for the Cambodian community in one mid-sized city, we encountered many barriers to using the prevention approaches that had succeeded for us elsewhere. The Cambodian women we worked with informed us that talking about domestic violence was a taboo in their culture. They told us that if we wanted to make progress we would have to get the approval and buy-in of the male elders and priests. And that is how we proceeded.

When the state of Massachusetts wanted to get all uninsured children enrolled in health care, the officials in charge were specifically concerned about the many uninsured children in immigrant communities throughout the state. Yet they initially proposed a comprehensive media blitz that would be conducted mainly in English. It took intensive lobbying to convince them that they could better reach these children by issuing outreach mini-grants to small immigrant-serving organizations across the state that had good links to these communities.

In Chapter Two, I will tell how the Cleghorn Neighborhood Center developed and will give you more information about the many wonderful things it has accomplished. In this context, I'll just mention that when some community residents went to take their GED tests in Spanish, as had been approved and prearranged, the signs to the testing room were in English and the instructor administering the test spoke only English and would not allow an accompanying translator to help. As much as some in the community had stated that they wanted their new immigrant residents to become established contributors to the wider community, others made that an uphill battle.

Approaches to communities must be culturally competent if we expect them to succeed at reaching the "minority" populations that will soon constitute a majority in the United States.

Focus on Deficits

John McKnight, who has been at Northwestern University near Chicago, is one of the most articulate critics of our helping system. He observed, "It

isn't until the capacities of people are recognized, honored, respected and lifted up that the outside resources make much difference" (McKnight 1990, 9). This is not the way our helping systems have been set up. Instead, they focus on deficits. McKnight's writings forced me to challenge the ways I had been thinking and operating for many years in coalitions (McKnight 1989; Kretzmann and McKnight 1993). He offered me a refreshing view of both the community (and its capacities) and the helping system (and its strengths and limitations).

McKnight considered the health and human service systems, which I've referred to as the formal helping networks, as secondary to empowering and valuing the assets and capacities of individuals and communities, or the informal networks. He warned of the negative impact the formal helping system can have by saying that the professional human service approach can "push out the problem solving knowledge and actions of friend, neighbor, citizen and association." He suggests that as the "power of professionals and service systems ascends, the legitimacy, authority and capacity of citizens and community descends" (McKnight l989, 9).

McKnight's perceptions opened my eyes to the realization that helpers love deficits. We helpers love to be needed, and nothing shows we are needed better than people's deficits. The more deficits (or needy people) we have in our communities and the more problems (deficits) each of those individuals has, the more clients we have. Then we have longer waiting lists and it's easier for us to plead for more funds. The entire helping industry is built on deficits. For those of us who have gone into helping professions because we really do want to make the world a better place, it can be hard to accept our reliance on seeing the negative.

McKnight's doubts about the positive impact of professional helpers are countered by his profound respect for and belief in the strength of communities. He believes that "ultimate knowledge is always in the communities not in the experts" (McKnight 1990, 9). He preaches that *the community way* is America's real strength. He notes that nineteenth-century French observer Alexis de Tocqueville, casting a critical eye on the newly founded United States, remarked upon a praiseworthy thing: that in this country

there are groups of ordinary people who get together to solve problems, and these groups, called associations, give power to citizens to make more power by solving problems (Tocqueville 1956, 198).

The usual approaches used by professional service providers are tied to the concept of deficits. Generally, providers "do for" people, as opposed to "doing with" them. In an agency-based approach, the agency labels the problem, controls the resources, and decides on the solutions. In a community-based approach, all those key tasks are done by the community members themselves. (In Chapter Four, there is a tool that will help you assess your group's current situation and future intentions; see Tool 3.)

The focus on deficits hurts both communities and providers. The providers do want to make positive change. Alternatives that emphasize assets and strengths and that are focused on finding collaborative solutions based on these assets offer more hope and produce better results than do repeated trips down the well-trodden paths of the one-size-fits-all deficit-oriented formal system.

Excessive Professionalism

Who do residents first turn to for help? In addressing community issues, it is always fascinating to ask people where they turn for help when they first know they have a problem. Maybe it's a problem with a newborn, a teenager, marital relations, loss of a family member, a health concern, or a sudden layoff. People tell us again and again that they first turn to family, friends, and neighbors. They do not usually go directly to professional helpers.

Yet whenever we as helpers address a new issue, the first thing we do is create a directory for the professional providers. This directory lists resources on topics such as being a new mom, what to do if there is violence in the family, where to go for help with Alzheimer's, and so forth. Hoping to get this information to the people who need it, we send these directories to other providers, ignoring the fact that the people we want to reach are off talking to their family members, friends, and neighbors.

I worked on issues of domestic violence in the mid-1970s. Domestic violence was just emerging as an issue in the field, and services were provided mostly by women who had experienced domestic violence. Those women,

who knew firsthand what was needed, were creating shelters and programs to help others in similar situations. These activities were supported by the women's movement and feminists. Having those most affected by the issue involved at the heart of the decision making was an enormous strength. This was self help at its best. Although my mental health agency secured funding for these programs, I generally stayed away from the meetings. Women on the agency staff represented our group instead. It was clear to me that—as a man and a professional—I was less than welcome in these settings. Nonetheless, there were many ways I could be an ally and could support the work on the treatment and prevention of domestic violence.

Thirty years later, the situation surrounding work on domestic violence has changed dramatically. I've been invited into meetings with people who are running state-wide coalitions on the prevention of domestic violence, and they bemoan the fact that few survivors of domestic violence work with their agencies in any capacity—as volunteers, in staff positions, or as board members. We have professionalized domestic violence. It has become another diagnosable disorder, and we relegate its treatment to professionals. We have therefore lost the invaluable link to the communities and the contributions of the people most affected by the issue—those who understand it best, from the inside. In so doing, we have moved from a social change to a social service model.

This is the system flaw of "excessive professionalism." Instead of just relying on professionals, we need to combine the strengths of the formal and the informal helping networks when we pursue collaborative solutions to a community's problems.

Loss of Spiritual Purpose

People go into the helping professions for altruistic reasons—they want to contribute; they want to help. Much of this impulse toward generosity comes from what might be called a higher purpose, a spiritual purpose, if you will. Yet the business of helping can be anything but spiritual and can challenge providers to keep their faith.

I remember a bad moment early in my career. I was working for a mental health agency as a therapist. The agency was in turmoil, with arbitrary

decisions coming down from above, staff conflict, and autocratic leadership. These combined to produce an atmosphere of general discouragement and low morale. One day, I found myself angry and thinking, "I'll show them, I will do a really bad session of therapy for my next client." This thought terrified me. The client's welfare has always come first for me, easily overshadowing any work aggravations. Even just having the thought was upsetting, and my guilt at having formulated it led me to be even more committed to helping that next client.

But that dismal day offered me a profound insight into how the agency process can invade the work. I worry that the morass of insurance requirements and forms that now overwhelms and enrages therapists and all providers may be having a similar effect. It is very hard to maintain a personal sense of balance and goodwill, and the desire to be helpful, within the present helping system. That is scary.

I was once part of a well-funded multiparty coalition. The big group's intention was to increase the well-being of communities by integrating the resources of smaller local coalitions, academic institutions, and government. I have often referred to this as "the coalition from hell" or "the take the money and run coalition." Its interactions usually involved conflict, and the people almost always distrusted each other and were more than occasionally disrespectful. If we could not create a community of well-being among ourselves, how could we hope to create communities of well-being in the areas where we worked? Indeed, we could not.

In seeking collaborative solutions we need to align our internal processes with the goals we are trying to create in the community. We need to be spiritually grounded, and we need to maintain our clear connections to what called us to the work in the first place.

What Does This Tell Us, and What Do We Do Next?

All the limitations to our helping system that I've noted in this chapter lead away from collaborative solutions and foster fragmentation. As a result, we continue to fail in our attempts to solve major problems facing communities

and nations. We need new ways, ways that overcome these limitations and give us the strength to build healthy communities.

John Muir is often quoted as saying, "When we tug at a single thing in nature we find it attached to the rest of the world." We know this is true of the natural world, and we have begun to understand it in other dimensions of our lives. But there are parts of our world where we have not yet perceived the truth of this statement or begun to formulate new ways to achieve our goals. "Business as usual" and "let the other guy do it" have blinded us to areas in which we need to change our ways. This is especially true when we address community issues, whether we do so as a group of residents or a group of institutions. We need to train ourselves to see how our tugging at any specific issue connects us to many other elements in our community and beyond it. Then we need to learn how to use this connectedness as a source of strength.

The new physics and new science continue to elucidate the interconnections of all entities. Vibrations in one part of the world affect energy levels a great distance away (Wheatley 2006). Many religious and spiritual traditions speak of the oneness of all beings. On a practical level, people who are working to solve problems, whether these involve local, national, or global concerns, are finding success with approaches that acknowledge interdependence and employ it to find new answers. We hear more and more that the creative ideas of the future will emerge from work that crosses disciplines, fields, and sectors, as well as political boundaries.

As I think about how a helping system might be designed in an ideal world, I find it useful to map a course suggested by spiritual principles. Although we might rely on a variety of academic theories and assumptions when we do the actual work, at the core our planning and efforts need to refer to questions of what we value. Where value questions are involved, spiritual principles can provide the clearest direction.

This doesn't need to be complicated. In fact, we may miss seeing the key to change because we try to make it harder than it is. Some of the spiritual principles that can guide our new directions are oneness and interconnectedness; trust, love and compassion, hope, appreciation, curiosity, acceptance of differences and valuing all people; attunement; and deep listening. The four

that I concentrate on, because they seem to encompass all the others, are acceptance, appreciation, interdependence, and compassion. These will be discussed in more detail in Chapter Eight.

Through use of the spiritual principles, a workable alternative can be discovered for each problem described in this chapter:

- Fragmentation → holistic approaches
- Limited information → effective and accessible communication
- Duplication of efforts → coordination
- Competition → cooperation
- Crisis orientation → prevention
- Lack of connection to those most affected and their communities → citizen-driven
- Blaming the victim and ignoring the social determinants → healthy communities approach
- Lack of cultural competence → culturally relevant approaches
- Focus on deficits → focus on assets
- Excessive professionalism → integrate formal and informal helping networks
- Loss of spiritual purpose → aligning our goals and our process

The community collaborations that I have watched and worked with throughout my career offer us hope in addressing these issues and in building healthy communities. These new collaborative solutions understand any problem in light of its entire range of settings—local, national, and international.

The collaborative-solutions approach assumes that

- We will attend both to the individual and to the total environment in addressing any issue.
- The interactions among those participating in seeking solutions will use all available tools—networking, coordination, cooperation, and especially collaboration.

- The solutions that emerge will be culturally competent and relevant, mainly because those most affected by the issue will be engaged in the solution process and they will bring their wisdom to the process.
- These collaborative solutions will draw on the strengths of each of the participating individuals and organizations and systems and the solutions will tap into both the formal and the informal systems.
- A mobilized and empowered citizenry will be central to finding collaborative solutions that work at all levels of our society.

My work and that of many communities and colleagues around the globe on numerous issues convinces me that collaboration is a powerful force for creating healthy communities. It's not easy, but it's much easier and so much more rewarding than staying stuck. What we need now is some clear guidance about how to go about the collaborative process in a way that leads to successful community change.

That's what this book is about. I have ideas, examples, and techniques that will help you work in your community to solve the problems that are most important to you and your neighbors.

Let's get going.