AHEC/Community Partners

Building Healthy Communities

Coalition Building: One Path to Empowered Communities

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Abstract:

American communities are struggling with issues of citizen participation, intolerance, violence and a sense of not being empowered. There is a need to develop interventions to create competent and empowered communities which include competent helping systems, and empowered and mobilized citizens. Based on the literature of community development, empowerment and coalition building this article describes interventions to strengthen the capacity of communities to solve their own problems by mobilizing, coalescing and leveraging resources. Health and Human Service Coalitions aim to improve the community's quality of life by: developing the community's local planning capacity, increasing collaborative problem solving, promoting greater cooperation, developing an advocacy capacity of the community, and increasing information access. Case examples from urban minority and rural mill town communities illustrate the process and outcomes of two such coalitions. Results are described as leading to more effective, responsive and competent helping systems and more empowered and mobilized citizenry.

COALITION BUILDING: ONE PATH TO EMPOWERED COMMUNITIES

According to societal observer Bill Moyers, "the struggle of communities is probably the struggle of our times." (1990) There is ample evidence of the reality of Moyers' observation. In its extreme we see neighborhoods where the devastation of drugs has made living unsafe. Children get shot. Families live in terror. These communities have become war zones.

What is less obvious, but also illustrative of the struggle for a livable community, is the difficulty of engaging citizens in participation in their own communities, schools, and neighborhoods. "Across the political spectrum the consensus is emerging that our nation's most pressing problems - from environmental devastation and drugs to declining participation in elections - simply cannot be resolved without the reinvigoration of public life. The very complexity, depth and scope of today's problems require more active practice of citizenship, motivated by a perception of a 'commons' in which we have a stake." (Boyte and Lappe, 1990, p. 417) Horwitt has noted similarly that "the most fundamental problem facing the country is the disconnectedness of individual people from government and politics." (1990, p. 414)

At the same time, there is a growing number of reports of intolerance of diversity in any form: racial, sexual, religious, or ethnic. Our communities cannot seem to embrace all their citizens as equal members.

In our experience both communities and citizens report feeling helpless and unable to do anything about their situations. They are disenfranchised - disempowered - often both as individuals and whole communities. It is not easy for these citizens to realize that they can have an impact on their lives or their communities.

These conditions recall those reported by Alinsky (in Horwitt, 1989, p. 105) over twenty-five years ago, "In our modern civilization, multitudes of our people have been condemned to anonymity - to living the kind of life where many of them neither know nor care about their own neighbors - millions of our people know deep down in their heart of hearts that there is no place for them - that they do not count. They have no voice of their own, no organization to represent them, no way in which they may lay their hand and their heart to the shaping of their own destinies."

In light of the above, a move to systematically build empowered and competent communities is needed. Iscoe defines a competent community as "one that utilizes, develops or otherwise obtains resources - including the full development of human resources. These resources would lead 'members' to make reasoned decisions about issues confronting them, leading to the most competent coping." (1974, p. 608) An empowered community is one that is able to gain mastery over its life.

The World Health Organization's (Ashton, Greg & Barnard, 1988) use of the concept of "healthy cities" provides another view of competent and empowered communities. According to Duhl, a healthy city or a healthy community is one "that is continually creating and improving those physical and social environments and expanding those community resources which enable people

to mutually support each other in performing all the functions of life and developing to their maximum potential." (Duhl, 1990, p. 98) Indeed, Hancock, who has developed the concept of "healthy cities" with Duhl, states that the prerequisites for health include "a just, equitable society, a sustainable ecological system, peace, shelter, food, education, and income." (1991)

In the author's view, an empowered community has two components: first, a competent helping system, including both formal and informal elements; and second, an empowered and mobilized citizenry. An empowered community would thus have both individuals and a community as a whole capable of gaining mastery over their lives.

The concept of competent helping systems is a subset of the broader goal of creating "competent communities" (Iscoe, 1974) and "healthy communities." (Duhl, 1990; Hancock, 1991)

If we are to create competent helping networks and empowered communities in the 1990's, we will need to create new responses to service system difficulties. This will require a paradigm shift - a new way of looking at our world. This new view will be built upon a set of key concepts - coalition building, empowerment, and community development. Many of these concepts have overlapping components. In this paper each of these key concepts will be explored, and case examples from the Massachusetts Area Health Education Center Health and Human Service Coalitions, one attempt to help communities move toward competent community helping networks and empowered citizenry, will be presented.

LITERATURE REVIEW

The process of coalition building to develop competent communities is based on two interconnected strategies, community development and empowerment, and related tactics of coalition building.

Community Development

Chavis and Florin have defined community development as "a process of voluntary cooperation and self-help/mutual aid among residents of a locale aimed at the improved physical, social and economic conditions." (1990, p. 2) They elaborate on four aspects of this definition:

- The process of citizen action
- Voluntary participation and cooperation and collaborative problem solving
- The process goal of empowerment
- The focus on holistic, community-wide outcomes (1990)

Although the term community usually focuses on a geographic domain, increasingly the definition allows for both geographic and non-territorial associational networks. The "sense of community" (McMillan & Chavis, 1986) that is critical is defined as "members having a sense of belonging and being important to each other." The development process builds on the sense of community, and helps to mobilize members of that community to create change.
Chavis and Florin (1990) enumerate eight potentials of the community development process:

- It is comprehensive
- It addresses stressful environmental conditions
- The process itself is primary prevention
- It can incubate social innovations
- It expands resources for services
- It can reach the hard to reach
- It can create community compatible services and programs
- It fosters ownership and institutionalization

Fawcett, Paine, Francisco and Vliet (1991) delineate various models of community development including: social planning, social action and locality development approaches. Social planning involves a top-down approach rather than a bottom up model of social action which relies on community organizers and conflict tactics. Finally, a community development approach involves broad-based citizen involvement. Indeed, most authors now see the need for both top-down and bottom-up involvement in community development approaches. Minkler (1989) has noted the role of community development in health education and health promotion, as well as its links to the concept of healthy cities.

Thus we see that the concept of community development is the basis of organized approaches to communities that can lead to empowerment and can be essential to the development of effective community helping systems. Community development is an overriding concept for the approaches described in this paper.

Empowerment

Empowerment in its simplest form is, "the process by which individuals and communities gain mastery over their lives." (Minkler, 1989, p. 3) Rappaport has elaborated and emphasized the 'process' nature of the concept, "empowerment is viewed as a process; the mechanism by which people, organizations and communities gain mastery over their lives." (1984, p. 3) The Cornell Empowerment Group (1989) states that "empowerment is an intentional, on-going process centered in the local community, involving mutual respect, critical reflection, caring, and group participation, through which people lacking an equal share of valued resources gain greater access to and control over those resources."

As empowerment became the catch-all phrase of the last decade, including its use by a conservative Republican administration to describe its domestic policy, it becomes important to clarify the various meanings of this term. Wallerstein and Bernstein emphasized the definition of empowerment that includes, "a social action process that promotes participation of people, organizations, and communities." (1988, p. 380) They note that empowerment encompasses concepts such as prevention, community connectedness, self development and social justice. Fawcett, et. al. (1984) broaden the concept of empowerment from an individual focus to the idea of community empowerment. Swift and Levin (1987) indicate that empowerment is both a process and a goal which, unless understood can confuse the meaning of the term.

Finally, LaBonte explores the political aspects of empowerment and offers some cautions regarding its universal use in the 1990's. He notes, "empowerment is a noble word, but the reality of political and economic distribution of power does not yield 'win-win' scenarios. Socially disadvantaged communities empower themselves, in part, by reducing the constraints imposed upon them by wealthier and more powerful interests." (1989) He urges a sophisticated political understanding and the need for political analysis in community empowerment efforts. The coalition building efforts described in this paper attempt to promote individual and community empowerment and have certainly faced the political realities suggested by LaBonte.

Coalition Building

Along with empowerment, coalition building has become another popular catch-all phrase for the 1990's. Coalition building is included as a key strategy in federal funding for teen pregnancy, infant mortality, substance abuse prevention, and minority health. In communities across the nation, one hears of a wide range of coalitions on any of a number of issues.

According to Cheri Brown a coalition is, "an organization of diverse interests groups that combines their human and material resources to affect a specific change the members are unable to bring about independently." (1984, p. 3) Feigherty and Roger note that a coalition is, "an organization of individuals representing diverse organizations, factions of constituencies who agree to work together in order to achieve a common goal." (1990, p. 1) Rosenthal and Mizrahi's research of a wide range of coalitions found that Coalitions are a "complex organizational form that provide a unique way for distinct and separate organizations to work together while reserving allegiance to their own. Coalitions both provide the necessary structure for unified effort and preserve the autonomy of member organizations." (1990, p. 1) Feigherty and Roger (1990) differentiate three types of coalitions based on their membership - grassroots, professional, and community-based. The last are "broad-based community coalitions of professionals and grassroots leaders." Zapka (1991) notes that literature on coalition behavior emerges from game theorists, social psychologists, and political scientists, and that there has been limited information on synthesizing these various perspectives. The literature on coalitions appears both diverse and unintegrated.

Mizrahi and Rosenthal (1991) have been involved in a systematic study of the dynamics and development of a large number of coalitions in the New York City area. This work delineates types of coalitions, reasons for formation, social change targets and strategies, membership, and structure. These authors are even beginning to differentiate coalition effectiveness outcomes. Fawcett, et. al. (1991) are developing a research model for looking at health coalitions that examines community health goals, community actions, community outcomes, behavioral risk factors and the impacts of such behavior on mortality and morbidity.

Much of the work regarding coalitions and coalition building is defined in studies of inter-organizational functioning, behavior, and relationships. Mulford and Klongan (1982) have described some of the process of creating coordination among organizations and detailing the steps. Gray (1985) suggests that collaborative efforts are based on a complex set of interdependencies rather than a focus on any single entity. She has proposed a developmental

view involving three stages of interorganizational collaboration including problem setting, direction setting and structuring. Wolff (1979) described steps of human service network development as including three stages: an initial stage of opening up communication and an exchange of information, a second stage of increasing the personal support network of members through shared feelings and perceptions, and a third stage of developing collaborative action through systematic use of problem solving steps.

This paper describes a series of coalition building activities planned to develop empowered communities by fostering community development and competent helping systems. The work described below is based on extensive coalition building experience in communities across Massachusetts for the last decade and consulting to similar efforts across the country.

Service System Concerns

In almost any area across the country, there exists a multi-million dollar health and human service system which includes everything from daycare to welfare, social services to mental health, clinics to hospitals to nursing homes to municipal recreation departments. These services carry a joint mission of improving the quality of life for the citizens of that region. Despite the millions of dollars spent on this mission in any single community, there is often no one responsible for overseeing the 'system'. When we assessed the helping networks in communities we often found them quite lacking in numerous variables.

From our experiences, a series of issues and questions facing these community systems has emerged. Are our formal and informal helping systems working to solve our communities' crises? How are they responding to the struggle for community and the growing sense of disenfranchisement by our citizens? What is the state of the helping systems network as a system, not just as individual services? How are our helping systems assisting the development of empowered communities?

It is helpful to define those variables that can be used to differentiate between competent and dysfunctional helping systems. Some of these dimensions focus on the formal helping systems, others on the informal helping system, and yet others on the issues of community development and empowerment. The variables help articulate issues that are barriers to both a competent helping system and an empowered citizenry. These same variables also suggest community goals and coalition building tactics to reach those goals. (see Table 1) The tactics reflect experiences with the AHEC Coalitions described in this paper.

1. Duplication of Effort versus Coordination. In many communities, politicians and business people often claim that there is an enormous duplication of service. Though there may indeed be a few instances of service duplication, on a more frequent basis one can find examples of duplication of 'effort'. One example of such duplication can be found regarding the issue of teen pregnancy. A group of teachers and parents work in the local high school on the issue. Meanwhile, across town at a local church, another group meets to talk about it. And a third group, at the family planning agency, is having the same discussion. Typically none is aware that other community members are engaged in the very same process. In a competent community this

duplication of effort would be replaced with an increasingly coordinated system. Coalition building tactics to promote coordination include information sharing meetings, problem solving task forces, and the development and publication of local service guides.

2. Fragmentation versus a Systemic/Holistic Approach. Most federal, state and local service dollars are awarded in the form of categorical funding. Funding is provided for agencies that offer specific services for targeted problems. Rarely is funding given to serve the whole person and all of his or her needs.

I once presented a hypothetical case to a group of community service providers. In this case, a twenty-two year old woman arrives at the agency's door, having taken her three and five year old children and moved out of her apartment, to flee from her physically abusive husband. She reports a drinking problem, severe financial problems, difficulty finding work, fear that her husband will find her and beat her, and a sense that she might lose control with her children. I asked each agency to think about how they would see her. As they reported to me, at one agency she would be seen as a problem drinker; at another, as a displaced homemaker; at a third, as a potential child abuser; at a fourth, as a victim of domestic violence; at a fifth, as an oppressed woman; at a sixth, as a general anxiety disorder. No one could really see her in all the above ways or try to integrate her various needs with services available. This was not a result of their intellectual limitations. Rather, it was the result of categorical funding and professional definitions that create this fragmented system.

In a more competent community, this woman would have access to a network of services, so well integrated, that all agencies could share a holistic view of her problems in living and provide a coordinated range of services. Coalition building tactics to promote a more systemic approach include development of comprehensive service protocols describing existing services and giving an overall view of the system. Collaborative planning activities by coalitions also foster a more holistic approach.

3. Competition versus Cooperation and Collaboration. In many states and communities there exists an overtly competitive environment, where health and human service agencies actively compete with each other for clients and resources. Although appropriate for a capitalist supply/demand market, this is not a helpful part of service delivery systems. It makes for poor service delivery when one hopes for coordination and collaboration among the formal providers in the community. At one moment an agency is asked to pit itself in a life-or-death competition against another agency for money, and then is asked to coordinate and collaborate their services with their competitors. This inconsistency contributes to many failed attempts at coordination and collaboration.

There are also blatant failures of coordination and collaboration between the formal providers (agencies, hospitals, etc.) and the informal providers (natural helpers, clergy, etc.) For example, in most communities churches and human services work in separate tracks -- rarely communicating or collaborating.

A more competent community network would encourage instances of cooperation and collaboration; both around individual cases in terms of coordinated service delivery, and also in terms of systemic approaches to emergent problems, crises, long-term planning, prevention and community development efforts. The coalition building tactics that promote cooperation and collaboration include monthly meetings with a topic focus, the development of collaborative projects, and problem solving task forces.

4. Crisis Orientation and Remediation versus Prevention. In spite of research which has documented the effectiveness of various prevention efforts, our helping systems continue to be dominated by a remedial and crisis orientation. The recent decade of limited dollars in human services and health has often seen an overemphasis on dealing with narrowly defined remedial situations (i.e. the most severely ill). A more competent community network would return to the goal of a balanced service system - a system ranging from remediation to crisis intervention to early intervention to prevention.

With the prevention efforts that do emerge, we continue to see the failure of coordination. In any one community we see efforts on sex education, HIV education, substance abuse prevention, social competence promotion, and health promotion - all working in an independent, un-integrated manner. In its most extreme form, all these efforts individually approach the school system saying, "please let us in". Since we know that many of the basic building blocks for these efforts (self-esteem, decision-making, social supports) are often common, it's wasteful not to promote coordinated prevention approaches to schools and communities. Clearly a competent community system would make significant commitments to coordinated preventive interventions. Coalition building tactics that promote a preventive view include the development of new prevention programs, the development of a coordinated approach to prevention issues, and eliciting community support around preventive topics.

5. Multi-cultural Insensitivity versus Culturally Relevant Services. Our helping systems must take a multi-cultural approach in order to provide competent services. Too often our helping systems rely on traditional modes of delivery that were developed by white, middle class males and may be inappropriate when applied to all other populations. These systems, like the rest of our American society, tend to be insensitive to women and people of color.

When agencies try to deal with increasing service access, they usually take the traditional models to new geographic or ethnic communities. But recognizing cultural diversity means more than delivering traditional models in new locales. It means that a competent system will develop alternative modes of delivery that are culturally relevant to the needs of the various racial and ethnic populations of the community, and developed in partnership with these communities.

One glaring example is the lack of interpreter services in community hospitals. It is interesting to note that school systems are required to provide teaching staff for various linguistic minorities (through English as a Second Language or Bilingual Education programs), whereas in our health care system we rarely enforce those requirements with the same vigor as the education system. This requirement of multi-cultural diversity may be one of the greatest challenges to developing competent communities. Culturally relevant services can be developed through coalition building

tactics, specifically those that develop coalitions in communities of color, where these minority coalitions then bring specific issues to the larger community for both problem solving and advocacy. In non-minority coalitions, developing culturally relevant helping systems can be addressed through the active recruitment of persons of color from the community into leadership positions within the coalition. In both cases the coalitions can challenge the larger systems to address issues of cultural relevance.

6. Excessive Professionalism versus Integration of Formal and Informal Helping Networks. Excessive emphasis on professionalism has increased during the last decade. Many authors have challenged the dominance of professionals in the planning and delivery of services. Collins and Pancoast (1976) have promoted partnerships with natural helpers. Lofquist (1989) suggests viewing clients as resources rather than as patients with deficits. Egan and Cowen suggest that:

> "It is no longer realistic to expect highly trained professionals to be the major providers of helping services. The demand for quality, low cost services that are accessible to all persons, regardless of income level, race, religion, sex or sexual preference makes it imperative that community people in their own systems serve as the key helpers. The challenge of the professional is to develop the humility, willingness and methodology to give away the philosophy, knowledge and skills pioneered in the past." (1979)

McKnight states that "it isn't until the capacities of people are recognized, honored, respected and lifted up that outside resources make much difference." (1989, p. 9) He further suggests that professional human service approaches first emphasize the deficits and needs of individuals rather than their assets and capacities, and second "push out the problem-solving knowledge and actions of friend, neighbor, citizen and association."(l989, p. 9) Indeed, he suggests that "as the power of professionals and service systems ascends, the legitimacy, authority, and capacity of citizens and community descends." (1989, p. 9)

In line with the recent national emphasis on individuality, greed and entrepreneurship, many professionals have marched forward to claim various domains of helping. In so doing, they have attempted to promote the concept that only professional help works. The dominant professional mode of thinking emphasizes the exclusive role of professionals to be both the service deliverers and the service planners.

Too often groups of professionals will plan a new service for a targeted population, without talking to the targeted population. These professionals then set up the delivery of that service, and when no one comes to utilize the service, they complain about the clients' lack of motivation, apathy, etc. Rarely do they reflect upon the professional stance that led to the misguided development of that service.

There is clearly a role for all helpers - professionals, informal caregivers, natural helpers and mutual help groups. A competent community would value each and try to create ways in which they can work together and integrate their efforts. Coalition building tactics that lead to integration of formal and informal helping networks include developing formats in which both formal and informal providers get together and develop joint projects, creating ways to

meaningfully involve clergy, business and citizens to become involved in coalition activities, and the development of neighborhood organizing efforts.

7. Limited Information versus Information Accessible to Clients, Providers and Care-givers. Communities consistently report severely limited information around problems and resources for clients, and for formal and informal caregivers. For the complex, multi-problem individuals and families that present themselves at the doors of our agencies, knowledge of many referral sources is needed. This limitation has severe consequences for clients who attempt to access various components of the helping system to meet their needs.

One hears this complaint from clients when they say, "I get chased around from one agency to another, why can't someone tell me where to go?" One hears it from legislators and from local officials who say, "Just give me one number where someone can call and access the whole system. Why do we need to know all of these phone numbers?" One hears it from agencies who say, "Oh, I didn't know you had that service to offer." One hears it from clergy when they ask if certain services are still available. All of the above are instances of failures to communicate the needed information to the clients and the formal and informal helpers.

In a more competent and empowered community helping network, relevant information exchange could occur on a regular basis to keep everyone well informed about resources, problems, and their potential solutions. Coalition building tactics that increase information include the development of coalition newsletters, coalition service guides, and active work with the local media. In many ways, the greatest impact on information exchange occurs when members of the community, formal and informal, get together and exchange information before, during, after and in-between coalition meetings.

8. Lack of Planning versus Planned Efforts. The failure of community helping systems to act in a planful manner is often very apparent. Often planning is lacking within individual agencies and state systems since each tends to function more in a demand or crisis mode. Few community systems require that any individual or office oversee the network of services and provide a planning function for the community. Without planning, integrated long-term goals for the community are virtually impossible to reach and organized attempts to deal with present systemic problems are equally difficult. The intrinsic incompetence at planning of many community helping systems is clearly illustrated when new problems emerge. Over the last five years, almost every community has had to deal with homelessness and AIDS; problems that were new to the helping systems, and did not fall clearly under any individual agency's domain. The usual response to these problems was to say "Oh my God, what a tragedy it is that we have homeless or HIV infected individuals in our community. I sure wish we could do something about it, but it's not our domain." In most communities it was not until the situation became quite severe that individual agencies, organizations or coalitions came forth to deal with these emergent problems.

A competent community would have a planning capacity for the helping system that would actively involve a broad range of the community's members in the planning process. A more competent and empowered community network would also have sensors that could pick up the early signs of these problems, and begin to gather the relevant components of the community,

both formal and informal, together to understand the problem, map out a strategy and clarify the domains of responsibility. Coalition building tactics that promote planning are inherent in the whole mechanism by which coalitions function. The systemic identification of priority issues and the development of problem solving task forces to address those issues are planful approaches to human issues in a community. In addition, as new issues emerge, coalitions have the capacity to develop ad-hoc task forces to address those issues.

9. Inequality versus Equality. Our traditional helping system often provides access to resources unequally for citizens based on race, sex, ethnicity, geography, sexual orientation, financial status, etc. If one does a systemic analysis of client/citizen need and client/citizen resource utilization, one often discovers these examples of unequal access. One example is the failure of health facilities and hospitals to effectively serve patients of various linguistic minorities. The 33 million Americans without health insurance are another dramatic example. Transportation, racism, sexism, and finances are all potential barriers to service. Competent community networks would provide equal access to all services and resources needed by each citizen in the community. Coalition building tactics that promote equal access include systematic attempts to remove barriers such as the development of interpreter services for health care, new transportation access systems, and advocacy for change in state regulations around health care for the uninsured.

10. Detachment versus Connection to Community. Finally, our present helping system remains disconnected from community and clients in numerous ways and thus suffers both in the planning and the delivery of service. Services are usually not designed based on client/community stated needs; interventions are not modified to adapt to the cultural needs of the residents, community assets are not utilized, services are not evaluated by the community. Generally, the human service system runs on a parallel but separate track from the community. A competent community network will be connected to the community and the clients, and based upon the stated needs of the citizens in the community. Coalition building tactics that lead to connection with community include the active involvement of citizens in defining issues, gathering data and mobilizing community resources. The process becomes the basis for coalition service planning efforts. In addition, the active use of community assets such as volunteer clearinghouses leads to better connection to the community. (See Table 1 for a full listing of concerns, community goals and coalition building tactics.)

The above analysis of community helping systems suggest that when the systems function competently they are: coordinated, holistic, planned, accessible, collaborative, preventive, comprehensive, and culturally relevant. They provide accessible information, deal with emergent problems, and maximize both formal and informal helping. When competent, these community helping systems are integrated into the community so as to promote the individuals' and community's capacity to solve their own problems.

A CASE EXAMPLE OF COALITION BUILDING IN MASSACHUSETTS

The Massachusetts Area Health Education Centers' (AHEC) Health and Human Service Coalitions have been developed over the last seven years to strengthen the capacity of communities to solve their own problems by mobilizing, coalescing and leveraging resources. This social experiment, which evolved during the 1980's and has been carried into the 1990's, is an example of a community intervention that attempts to create more empowered and competent communities by increasing interagency coordination and collaboration, and by enhancing community development.

The general mission developed by these coalitions is to improve the quality of life in the community. The specific coalition goals in each local community are

- To develop a local planning body for issues affecting the quality of life
- To collaboratively solve problems regarding the major issues facing the community
- To promote greater cooperation among all of those in the local helping network
- To develop an advocacy capacity
- To provide information to community providers and citizens on issues and resources
- To monitor the coalition's progress and effectiveness

There are presently five such Health and Human Service coalitions across the Commonwealth of Massachusetts, in both rural and urban communities. With the help of funding from the W.K. Kellogg Foundation, this effort is now being expanded to ten new communities. The oldest of these coalitions was created in 1983; the newest began in 1989. One new coalition has been started almost every year since the beginning of the coalitions.

Origins of the Massachusetts AHEC Coalitions

It is important to understand the origins and context of such a program. The Massachusetts Area Health Education Centers (AHEC) are committed to continuing medical education and innovation in medical education. Frequently AHEC is involved in increasing medical students' exposure to community settings. Seven years ago, three medical students were placed in a small rural mill town area of Massachusetts which was experiencing 17% unemployment. The students reported a dismal picture: human suffering, a need for social and health services, and a small, resource-poor helping system that was extremely stressed by the excessive needs created by high unemployment.

The author was hired as a consultant to visit the communities and talk to a wide range of community leaders to decide if the Area Health Education Centers could play a role in helping the community. What became apparent in these initial assessment visits was that there were no mechanisms for the community to either mobilize its resources and plan on how to cope with the vast needs or coordinate advocacy to bring in new resources. Although the Governor had designated the area an 'Area for Economic Opportunity' (which meant the investment of resources to improve the economic climate), there was no concomitant commitment of resources for health and human services or quality of life.

In partnership with the local hospital, mental health service and the Chamber of Commerce, it was agreed to launch the Health and Human Service Coalition to bring community forces together. A small planning group sketched out goals and objectives and planned a gathering shortly thereafter that would attempt to bring business people, state legislators, local government, human services, health services, clergy, and citizens together to commit themselves to solve the community's problems. This was the birth of the first AHEC Health and Human Service Coalition.

The first meeting served as an informal key informants' assessment of needs and assets, and identified the need for information and referral services. As one state legislator noted, "All of these unemployed workers are calling my office. I don't know where to send them." Thus, the first effort undertaken by the Coalition was the development of a community directory of services entitled "Linkages", and a proposal to the state for the funding of an information and referral service. Collaborative problem solving was modeled from the start. The directory was developed in partnership with the Job Training Partnership Act agency which had a similar need for a directory. The development of the information and referral service was done in partnership with the local poverty agency. Lobbying for funding for the information and referral service was the coalition's first successful effort at advocacy. Nine months later when the one person information and referral service opened, (supported by the local antipoverty agency) it was swamped with phone calls about homelessness and imminent homelessness. This led to the second coalition effort, the development of an emergency homeless shelter in the basement of a local church.

This brief synopsis gives a description of how quickly a community can become mobilized and focused under the umbrella of a coalition. All groups involved, including the facilitators, were amazed by the coalition's success. As a result of requests by State Legislators, and some targeted initiatives by AHEC staff, the coalitions spread to four more communities.

Membership in Coalitions

The issue of membership is hotly debated at the start of any coalition. In the Massachusetts AHEC Coalitions, membership is defined as those who "buy into" the mission of the coalition. The mission is generally to improve the quality of life for citizens living in that community. Because the membership in the coalition is so broadly defined, membership is virtually open to anyone. Inclusiveness is a critical coalition building block. In our experience those who have been actively involved in the work of the coalitions have included health and human service workers, local town and city officials, state legislators, the business community and Chambers of Commerce, clergy, school staff, and citizens. It is important to note that many of the people falling in the above categories live and work in the same community and thus, are also representatives of that community.

Staffing of Coalitions

AHEC Coalitions, in all but one case, are staffed programs. Staffing is generally limited to 12-20 hours a week. The coalitions are intentionally understaffed settings, guaranteeing that any new programs developed must be spun off to other community organizations. Staff are local

citizens, hired from the community via the steering committee of the coalition. Staff members report to and are supervised by the AHEC Director of Community Development. In one city, the AHEC effort was of a consultative, technical assistance nature and this model also has proven to be successful. At the end of three years of technical assistance, that coalition was able to run on its own without staffing. Where staffing is in place, total coalition costs for a single year are approximately $25,000.

Coalition Activities

Basic coalition activities include monthly meetings of the membership with generally 20-40 individuals attending. These meetings can have a topic focus, or can be for information exchange, legislative forums, or discussions of advocacy. The initial monthly meeting of each year focuses on a key informants' assessment which sets the priority activities and goals for the coalition for that coming year. Based on these priorities, a series of task forces are set up to address each of the identified issues. In most cases, the coalition personnel attend all task force meetings and staff those meetings.

The task forces themselves are short-term, focused, problem-solving groups that attempt to systematically assess the problem, locate the available resources and come up with doable solutions. Task forces are committed to action and are result-oriented. It has been found that coalition members will not stick with this process unless concrete products emerge, and emerge early in the process. Coalition task forces in the past have focused on issues such as homelessness, affordable housing, information and referral, child sexual assault, transportation, violence, substance abuse, child care, advocacy, accessible health care, interpreter services in hospitals, etc.

Each coalition generates a monthly newsletter which is a forum for distributing summaries of meetings (rather than minutes) and other relevant materials. The newsletters in each community are mailed to 300-400 individuals and are widely read. Most recently coalition newsletters are being developed for specific local citizen neighborhood groups.

A variety of additional activities have emerged from coalitions. They have been involved in developing assessments of needs and capacities through many techniques: formal surveys run by a market research organization, informal data gathering, surveys of agencies and organizations in the community, and consumer surveys. Coalitions often generate publications including: call guides of services in the community, transportation guides, and reports documenting specific issues and needs in the communities. In-service training programs for the community-at-large or for human service professionals in the community and public education campaigns have also been organized by the coalitions. Coalitions become involved in local, state or national advocacy efforts which include campaigning for dollars to create local programs, for state programs such as universal health care, and for national programs in collaboration with groups like the Children's Defense Fund.

Once the coalitions have been started, the coalition staff take on the roles as:

- Trouble-shooters and mediators in disputes in the community helping system
- Contact people for state agencies who wish to assess needs or deliver programs to the community
- Designers of special events such as annual luncheons, legislative breakfasts and informal social gatherings of health and human service and other community workers

Where staffing exists, the role of staff focuses on the 'nitty-gritty' work that doesn't often get done in other collaborative efforts and is especially hard to delegate: such as minutes, seeking out 'lost' members, bringing new people into the Coalition, and running meetings.

Coalition Structure

In most cases the coalitions have not incorporated nor have they developed formal by-laws. Instead, they have developed principles and rules for operation. Coalitions generally have a steering committee as an interim decision-maker between monthly meetings and as a group that helps guide and plan coalition activities with the hired coalition coordinator. There are exceptions to this structure, such as a Latino Coalition that preferred a consensus decision-making model involving the whole Coalition instead of a steering committee (in part this was to broaden leadership and control beyond the two or three 'designated' Latino leaders in the community). Each coalition has spent time looking at the issues of incorporating and creating formal by-laws but has generally chosen to avoid such formal structures. Essentially the guiding principle has been to create the minimum administrative structure needed to function effectively.

Evaluation of the Coalitions

Modeled on the work of Fawcett and colleagues (1991), a formal evaluation process is being implemented for the existing coalitions and for the newly created W.K. Kellogg funded coalitions. Data collection began as of the Summer of 1991. For the purpose of this article the process of these on-going coalition activities are best illustrated through two anecdotal case studies that illustrate the outcomes in terms of creating competent helping systems and empowered communities.

Case 1 - The Northern Berkshire Health and Human Service Coalition

Background The Northern Berkshire area is comprised of three medium-sized towns with populations from 8,220 to 16,797, surrounded by six smaller communities with as few as 634 residents. It is a geographically remote area in the far northwest corner of the state more than three hours drive from the State capital. North Adams and Adams, the two largest communities in the Northern Berkshire region, have long histories as mill towns; however, during the 1980's the area's largest mill closed. No new industry of any significance has come into the area, and high paying manufacturing jobs have been-replaced with low paying service jobs, often without fringe benefits, such as health insurance. As in much of rural New England there is a fierce attitude of self-sufficiency which is an enormous asset in terms of the community's rallying and taking care of its own. However this same attitude is a significant deficit in terms of people's

resistance to using formal helping resources when needed. The Northern Berkshire Health and Human Services Coalition was formed at the request of the area's State Senator in 1986.

Moving Towards a More Effective and Responsive Helping System The process by which the Northern Berkshire community addressed the issues of homelessness and affordable housing illustrates the coalition's role in the development of a more competent helping system. In response to member interest, one of the monthly meetings in the second year focused on the issues of homelessness and affordable housing. As a result, a task force began to look at the problem. Two medical students on a community rotation offered assistance to the task force in checking train yards, church basements, etc., to assess the degree of homelessness -- an especially difficult issue to grasp in a rural area. When the community was first confronted with the scope of the problem, many community leaders told the coalition that they didn't want this publicized, that they were trying to attract new industries into the area and that talking about the community's problems would scare away new business. However, the coalition's persistence, involvement with the media, and data collection became the rallying point for the community to address the issue.

Through a remarkably successful process, various components of the community were brought into the solution. State and federal governments were lobbied for funds to develop the Family Life Support Center which would provide some shelter capacity, but would mainly focus on the prevention of homelessness. It was to be a collaborative operation, calling on the resources and skills of many agencies in the community. In the first major advocacy attempt by the coalition, using vigorous lobbying of State agencies hand in hand with their local legislators, they were able to pressure the State into partially funding the Family Life Support Center. The local private sector generated a one hundred thousand dollar campaign to help fund the initial purchase of the structure. The local congressman helped obtain Federal resources for the purchase of the building. The local General Electric plant volunteered over three hundred workers to assist in the renovation of the structure in a much publicized event, and the local newspaper and city council began a yearly tradition of a "sleep out" on the streets to raise pledges for the Family Life Support Center.

In a community that had rarely ever acknowledged human service problems, the coalition had become a catalyst for a significant community effort. The holistic and preventive nature of the services set up at the Family Life Support Center; the cooperative efforts among human services and providers across the community: the model of service delivery that was tailored for the residents of this distinct area, and the employment of many volunteers and community helpers, were all signs that this newly identified problem was being dealt with in a manner illustrative of a competent helping network.

Moving Towards an Empowered Community In the fifth year of the coalition's existence, the impact of the coalition beyond typical human service issues became more apparent. The coalition began to stimulate a number of activities that were directly related to empowering the community. Several organizations and individuals had expressed concern about a small neighborhood in the city that had been deteriorating at a rapid rate. A neighborhood meeting was called, co-sponsored by the coalition and a variety of human service agencies in the city; numerous citizens turned out. In a short period of time, this has grown into a strong neighborhood association with its own

newsletter. The group, the United Neighborhood Organization (UNO), focuses on several issues: public safety issues in collaboration with the police, housing issues in collaboration with the local community development corporation, and quality of life in collaboration with the coalition. A neighborhood clean up, the hiring of a local neighborhood organizer, and the declaration by the press that this is the one effort in the community that registers some degree of hope, have all reinforced the sense of effectiveness of this effort.

Five years after the coalition began, the economic decline of this area continues unabated. Prior attempts to build broad based economic development efforts have often failed. Recently, the area's State Representative, who had been one of the founding members of the coalition prior to his election, began an economic development strategy that involves a wide spectrum of the community and is modeled directly on the successful process of the Health and Human Services Coalition. This "economic summit" is also showing promise of success and has been a process that has engaged many parts of the community.

Both the neighborhood association and the broader use of the coalition methodology for economic development illustrate the impact of the coalition on developing a more comprehensive, competent and empowered community.

Case 2 - The Worcester Latino Coalition

Background The mission of the two year old Latino Coalition is to improve the quality of life for Latino residents who comprise 9% of the Worcester population. Worcester is the second largest city in the state of Massachusetts with a population of 169,759. Due to some of the most restrictive election laws in the nation, combined with an at-large form of city government, there have been no Latino community members elected to the city council or the school committee. Thus, the Latino community in Worcester has been shut out of the electoral process. Indeed, the overall strategy has often been described as one of keeping various components of the minority populations fighting with each other so that the power structure remains untouched within the community. Earlier attempts to create a coalition within the Latino Community were short-lived. The Worcester Latino Coalition was formed after a comprehensive community assessment initiated by an AHEC Latino staff member.

Moving Towards a More Effective and Responsive Helping System In the first year of the coalition's existence, members identified access to health services as a critical issue and noted that language was one of the greatest barriers to service. This began a two-year effort to address the issues regarding interpreter services in the hospitals and health maintenance organizations (HMOs) in the city. Initial meetings with hospital staffs encountered caution and resistance and the coalition began to seek new ways to state their needs and demands. When no comprehensive standards for interpreter services were to be found, the coalition developed its own, by working closely with the U.S. Health and Human Services Office of Civil Rights. With these new standards, the coalition then sponsored a city-wide conference on interpreter services, and made sure that all hospitals and HMOs were in attendance. Out of this conference came a working task force that has been identified by the Office of Civil Rights as one of the most effective interventions it has seen in dealing with interpreter services in hospitals for linguistic minority

populations. The task force has brought new resources into the community, to develop after-hours and weekend interpreter services programs, and to train hospital interpreters. This example again illustrates a-move toward a more effective and responsive helping system that is able to deal with a diversity of needs within the community, and represents a cooperative approach to problem solving.

Moving Towards an Empowered Community The Latino Coalition's relationship with state legislators illustrates another example of community change. In most non-minority communities the AHEC coalitions have moved quickly within the first year to work closely with State legislators, having legislative forums, legislative breakfasts and even candidate debates. The Latino Coalition was considerably more cautious on this issue, and it took until the end of the second year for a legislative breakfast to be held. At this meeting, however, over forty members of the coalition were present, with three State Representatives as well as a State Senator. There was a clear sense on both sides of the table that a new era had been launched. As a direct result of that meeting, the most serious effort in recent years at increasing voter registration among Latinos has been started by coalition members.

Toward the end of the coalition's second year, some of the wider community impacts of these more focused activities have begun to emerge. One of the clearest needs within the community has been for a broader base of leadership within the Latino community beyond the two or three leaders usually designated to represent the Latino community in almost every city effort. A new level of leadership is emerging, as new coalition members begin to take control of issues such as voter registration. Increasing the number of registered voters among Latinos, and facilitating the development of community leaders are both illustrative of creating a more empowered community.

Discussion

What these case studies fail to illustrate are the rocky roads that lead to these outcomes. In the development of both of these coalitions, there have been serious crises that have threatened the leadership and the existence of the coalition. Crises have developed when agencies within the community felt threatened by the coalition's activities and success, and have attempted to bog the coalition down in lengthy discussions of by-laws and other process issues. This became very discouraging for coalition members. Other threats came when the coalitions demanded greater representation on decision-making bodies and those with power in the community were angered.

What becomes clear as one engages in Coalition building activities is that there is a necessity to enter these activities with a sense of long-term commitment, a sense of persistence, and a willingness to take risks, for these are critical for social change.

Despite these challenges, the experience with the AHEC Coalitions has been very encouraging. Communities have responded enthusiastically to these interventions. The coalitions have been successful in the introduction of specific new developments in their communities (child sexual assault prevention curricula in schools, shared housing programs, after school programs, homeless shelters, parenting programs, volunteer clearinghouse, etc.) and in the promotion of more general process changes in the community system (increased communication, cooperation, and collaboration). These efforts have proved to be sustainable over time and capable of surviving crises and attacks.

From these coalition communities the emergence of empowered and competent communities can be seen, illustrated by more competent helping systems and a more empowered citizenry.

At a time when so many other interventions are failing and so many systems are discouraged, the AHEC Coalitions continue to be creative forums for community problem solving. New efforts at systematic evaluation will hopefully bear out our positive subjective analysis and clarify what is associated with success. The anecdotal success of these coalitions and the vast opportunities for research of community phenomena will hopefully encourage others to try carefully planned coalition building interventions to promote competent communities.

Table 1

Service System Concerns, Community Goals,
and Coalition Building Tactics

Concerns with the Health and Human Service System	Community Goals	Examples of Coalition Building Tactics
1. Duplication of effort	Coordination	Information sharing meetings Problem solving task forces Service Guides
2. Fragmentation of services	Systemic/holistic approach	Comprehensive service protocols Collaborative planning
3. Competition	Cooperation	Problem solving task forces Topic-focused monthly meetings Develop resources for collaborative
4. Crisis orientation/remediation	Prevention	Develop new prevention projects Coordinate existing prevention efforts Elicit community support for prevention
5. Multi-cultural insensitivity	Culturally relevant services	Develop coalitions in communities of color Challenge larger system to address issues of cultural relevance

6. Excessive professionalism	Integration of formal and informal helping network	Create ways to meaningfully involve clergy, business and citizens Bring formal and informal providers together Neighborhood organizing
7. Limited and inaccessible information	Effective and accessible communication	Coalition newsletters, service guides Work with media Create settings to encourage members to get to know each other
8. Lack of planning	Long-term planning	Systemic identification of priority issues Problem solving task forces on current and emerging issues Regular review of issues, goals and plans
9. Inequality	Equal access	Advocacy for change of state/local programs Address barriers by developing new systems
10. Detachment from community and clients	Connection to the community	Bring community and providers together Involve community in defining issues, gathering data and mobilizing resources

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