Thomas J. Wolff

Award for Distinguished Professional Contributions to Independent Practice

Citation

"Thomas J. Wolff is a nationally recognized consultant working with individuals, organizations, and communities. His practice, anchored in the values of social justice and collaboration, has focused on building strong communities and, by so doing, strengthening the well-being of the people within them. His work has had a profound and enduring impact upon American society. He pioneered the concept of local community coalitions, which have become national models for community-based health and human service delivery. He has advanced public recognition of psychology as a profession and provided the bedrock for what we now term 'community-engaged scholarship.'"

Biography

Thomas J. Wolff was born in 1944 in Kew Gardens, Queens, in New York City, the middle of three sons to Godfrey and Ellen Wolff, German Jewish immigrants who had fled Nazi Germany in 1938. Kew Gardens was a community of many similar Holocaust-surviving families. His father arrived with nothing in his pockets and built a highly successful office-equipment business in Manhattan. His mother painted abstract art. Wolff's commitment to social change and social justice had its roots here.

Presently, Wolff lives in the town of Leverett in rural Western Massachusetts with Peggy, his wife of over 40

years. They have two daughters: Rebecca Blouwolff is a middle-school French teacher who, with her husband Josh, has two children, Jonah and Liora, and lives in Brookline, Mssachusetts; Emily Kain is a public health educator who lives with her husband Andrew in Portland, Maine.

Wolff's work and thinking evolved as he went from being a clinical psychologist to becoming a community psychology practitioner committed to issues of social justice and to building healthy communities through collaborative solutions. He learned the ins and outs of what it takes to achieve community change through various professional experiences. He has been a director of mental health programs, a creator of statewide systems of grassroots healthy community efforts, and a consultant to nationwide organizations addressing a wide array of issues. His dissatisfaction with the traditional helping system led him to create a wide range of community innovations and to work with many types of communities—urban and rural, majority communities and communities of color.

His undergraduate work was done at Clark University, where he first majored in biology before transferring to psychology, guided by the excellent teaching of Mort Weiner and Bernie Kaplan. Clark was a thriving learning environment, and the Psychology Department was especially focused on critical thinking and exchange.

Wolff went on to the University of Rochester, entering their clinical psychology program, which under the leadership of Emory Cowen developed a new focus on community mental health and primary prevention. His dissertation evaluated the impact of prevention programming on campus. In Rochester he also became involved in political work through the remnants of Saul Alinsky's FIGHT (Freedom, Independence, God, Honor, Today) organization and in the political campaigns of Eugene McCarthy and Bobby Kennedy.

One of Wolff's first positions was in the Student Mental Health Service at the University of Massachusetts, Amherst. Here, his time was split 50/50 between clinical work and community mental health on campus. This arrangement allowed him to explore the connection between what he saw as a clinician and what he saw on campus. He consulted with dormitory staff, trained student leaders to become campus change agents, developed family programs in married student housing, and worked extensively with peer counselors. His thinking built upon the emerging work on empowerment in community psychology by Julian Rappaport, his Rochester classmate. Many of the community interventions on campus were conducted with his colleague Ted Slovin from the Counseling Center.

In 1977, Wolff became the director of consultation, education, and prevention at the Franklin Hampshire Community Mental Health Center in Northampton, Massachusetts. His contributions there included repositioning an Area Agency on Aging to focus on empowerment of elders as

well as remediation, and creating prevention programs and systems change around child sexual assault and domestic violence. George Albee's conceptualization of primary prevention influenced him. Albee included political, social change and oppression in his formula for primary prevention in mental health.

Wolff was actively involved with the National Council for Community Mental Health Centers and was their chair of the Council on Prevention. In 1984, he received their Award for Outstanding Contributions to Prevention in Mental Health. His work in community mental health was guided by Carolyn Swift and Bill Berkowitz, who became lifelong mentors and colleagues.

Through his work at the Community Mental Health Center, Wolff became the chair of the Mayor's Task Force on Deinstitutionalization in Northampton; he served for nine years and learned firsthand the power of collaboration to solve complex social problems. Here, he discovered how different institutions and their leaders could be in total disagreement at the start of a project and still find productive ways to work together for the good of the community.

Throughout his career Wolff maintained a close relationship with the American Psychological Association's Division 27 (Society for Community Research and Action; SCRA). He founded and co-chaired its Community Psychology Practice Council for 10 years with Greg Meissen. He led SCRA in an interactive visioning process, designed two summits for practitioners, helped create the *Global Journal of Community Psychology Practice* with Editor Vince Francisco, and was a catalyst for the creation of the Competencies for Community Psychology Practice for the field. Graduate students were always partners within the Community Psychology Practice Council.

Between 1985 and 2002, Wolff founded and directed Community Partners, a technical assistance and training program affiliated with the University of Massachusetts Medical School, Worcester. The program provided guidance and support in coalition building and community development to Massachusetts communities. He started in 1985 by consulting to the North Quabbin, a rural area of Massachusetts which had just lost one of its two major manufacturers, thrusting one of its towns into chaos. There, he began this first community-wide coalition-building effort focused on a plant closing. With the support of local legislators, his work spread to two other communities. With the help of funding from the W. K. Kellogg Foundation, he expanded the scope of this project in Massachusetts and built Healthy Communities Massachusetts, which assisted numerous communities in creating concrete changes (e.g., transportation, dental access, and early childhood prevention programs). The community coalitions Wolff helped develop were pioneers and became national models. Wolff then became connected to the global Healthy Communities movement and was influenced by the national leaders of that effort, Tyler Norris and Judith Kurland.

Wolff presently oversees Tom Wolff & Associates, a consulting, training, and speaking service. His focus is coalition building, collaborative solutions, social change, program sustainability, and building healthy communities. Consulting clients have included federal, state, and local government agencies; foundations; hospitals; nonprofit organizations; professional associations; and grassroots groups. Examples of the coalitions that have been enhanced include the Coalition to Prevent ADHD Medication Misuse, the Center for Medicare and Medicaid Services' End Stage Renal Disease Networks, the Institute for Community Peace, the Internal Revenue Service's VITA (Volunteer Income Tax Assistance) program, the U.S. Breastfeeding Coalition, Connect 2 Protect (C2P) Fenway, the Cleghorn Neighborhood Center, and Holyoke Unites/Holyoke Se Une.

Recently, Wolff has focused on issues of racial justice through the Boston Public Health Commission's Center for Health Equity and Social Justice. By providing training and consultation, he has supported numerous coalitions across New England addressing health equity and racial justice issues tied to health disparities.

Wolff is committed to "giving community psychology away." To that end, he has published numerous resources for community activists. His newest book is *The Power of Collaborative Solutions: Six Principles and Effective Tools for Building Healthy Communities*. Earlier writings include *From the Ground Up: A Workbook on Coalition Building and Community Development* (1995) with grassroots organizer and colleague Gillian Kaye and *The Spirit of the Coalition* (2000) with William Berkowitz. His writings combine theoretical understanding with rich stories and on-the-ground experience.

For 20 years Wolff has partnered with the Community Tool Box (with Steve Fawcett, Christina Holt, Jerry Schultz, Bill Berkowitz, and Vince Francisco; http://ctb.ku.edu), which provides 7,000 pages of free resources on community health and development to over 7 million users a year. His own website (www.tomwolff.com) is a source for free community-building material for thousands.

Wolff is a fellow of Division 27 of the American Psychological Association, which granted him its 1985 Award for Distinguished Contributions to Practice in Community Psychology, its 1993 Henry V. McNeil Award for Innovation in Community Mental Health, and its 2010 John Kalafat Award in Applied Community Psychology. In 2000, he received the "For the People, Against the Tide" award from Health Care for All for his "outstanding efforts to energize and educate local communities in areas of health care justice." He has held academic appointments at the University of Massachusetts, Amherst, in its School of Public Health and in its Medical School's Department of Family Medicine and Community Health.

Wolff has always been actively involved in the communities where he has lived, and in Leverett he has served as an elected member of the School Committee, as chair of the town's Affordable Housing Committee, as chair of the town's Democratic Committee, and as one of the founders of the Leverett Peace Commission.

He remains passionate about looking at issues from a community psychology perspective and empowering local communities to solve their own problems.

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Community Psychology Practice: Expanding the Impact of Psychology's Work

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This article introduces the reader to community psychology practice by defining the field and its key principles and then illustrating through brief case stories what community psychology practice looks like in various employment settings. An exploration of the development of the field includes a review of the competencies of community psychology practice. Finally, the emerging opportunities for community psychology practice for psychologists are outlined. Well-publicized issues such as health disparities give psychologists an opportunity to bring social problems such as racism, sexism, homophobia, and income inequality to the forefront and to create community-wide efforts to improve the ways in which people live. Community psychology practice offers psychologists a format and a set of competencies for moving forward on this work by focusing on approaches that are ecological, community centered, population based, preventive, focused on systems change and empowerment, and multidisciplinary and that bring those most affected by the issues to the heart of the decision making.

Keywords: community psychology practice, social change, grassroots, health disparities, social justice

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Keywords: community psychology practice, social change, grassroots, health disparities, social justice

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Exciting opportunities are emerging for socially conscious psychologists to expand their practice to the larger community. This involves an evolution from working with individuals to working with whole communities, from working on issues of remediation to working on issues of prevention, and to focusing on empowerment, social change, and social justice. This has been my path: from clinical to community practice.

In this article I introduce the reader to community psychology practice by defining the field and the key principles and then illustrating what such practice might look like in various employment settings. This overview of how community psychology practice developed concludes with a review of the related competencies, as well as a look at upcoming opportunities.

Community psychology emerged as a subfield of psychology out of the tumultuous political times of the 1960s. It is "[t]he subdiscipline of psychology that is concerned with understanding people in the context of their communities, the prevention of problems of living, the celebration of human diversity, and the pursuit of social justice through social action" (Nelson & Prilleltensky, 2010, p. 23). The vision for the field of community psychology, as adopted by the Society for Community Research and Action (SCRA), Division 27 of the American Psychological Association, is to "have a strong, global impact on enhancing well-being and promoting social justice for all people by fostering collaboration where there is division and empowerment where there is oppression" (Society for Community Research and Action, n.d.).

The field demands the capacity not only to study issues but also to act to make the world a better place. From the earliest meetings that gave birth to the field of community psychology (Anderson et al., 1966), the founders understood the need to combine academic theory, research, and field practice. Practice translates research, values, and principles into meaningful action; practice is the means through which community psychology impacts communities and organizations. This is how community psychology practice "walks the talk."

What Is Community Psychology Practice?

Given this premise, what *is* community psychology practice? Although the field was established in the 1960s, the first official definition of what it means to "practice" community psychology was not articulated until 2006. That definition, which came into being through work done by the Community Psychology Practice Council of SCRA, states that community psychology practice aims "to strengthen the capacity of communities to meet the needs of constituents and help them to realize their dreams in order to promote well-being, social justice, economic equity and self-determination through systems, organizational and/or individual change" (Julian, 2006, p. 68). Community psychology practitioners are those who do community work in line with that definition. They may or may not have originally been trained as

community psychologists, but they need to have a set of relevant applied competencies in community and organizational programming, capacity building, social change, and research (competencies that are detailed later in this article).

Community psychology practice acknowledges that community is the level where change needs to happen and that change occurs by strengthening the capacity of communities to address their problems and realize their dreams. Several core beliefs and principles have guided the field. They include an ecological perspective; prevention; social and systems change, the empowerment of residents; and multidisciplinary approaches.

An Ecological Perspective

This approach is based on an understanding that behavior is a function of the person and the environment. Community psychology practitioners often rely on public health concepts to expand and articulate the ecological view. One of these concepts concerns the social determinants of health (SDOH), which describes the power of multiple systems to impact people's physical and mental health (McGinnis, Williams-Russo, & Knickman, 2002). These determinants include social capital, education, transportation, employment, food access, socioeconomic status, environmental exposures, health behaviors, access to health services, housing, and public safety.

Public health research demonstrates that only 15% of our overall physical and mental health is determined by access to care, while the rest is a function of the SDOH (McGinnis et al., 2002). Marmot (2008) also suggested that the SDOH are of key importance to mental health. Thus we need to address the SDOH variables that impact a community's emotional, as well as physical, well-being.

Unfortunately, most psychological, medical, and human service settings where I have worked emphasize the organism/person. This emphasis excludes consideration of the impact of the person's environment and of the interdependence of person and community.

Prevention

Prevention has been a core component of a community psychology approach from its start. George Albee (1984) was an early advocate for prevention and described primary prevention as reducing the incidence of disorder. In his formula, some key factors influencing incidence rates included exploitation as a stressor and social change as an asset. Albee clearly thought societal and social justice issues were critical to prevention.

Social and systems change, along with empowerment of residents, are also core principles of community psychology. Julian Rappaport, an early leader in the field, defined empowerment as "[t]he mechanism by which people, organizations and communities gain mastery over their lives" (Rappaport, Swift, & Hess, 1984, p. 3). The aim of empowerment

is "to enhance the possibilities for people to control their own lives" (Rappaport, 1981, p. 15). Rappaport (1977) described community psychology as being at its best "when it is responsive to grassroots groups who require not treatment, cure or re-education but support with political, social, and psychological resources" (p. 53).

In grassroots approaches, the people most affected by the issues are at the heart of the decision making and are involved in the community organizing and problem-solving processes. Saul Alinsky was a major force in community organizing when community psychology emerged as a field in the 1960s, and the field's emphases on grassroots and power are in part a tribute to his work (Alinsky, 1971).

Multidisciplinary Approaches

A multidisciplinary approach involves a willingness to learn from any field, practitioner, or community member who can increase our effectiveness in discovering community solutions. Community psychology practitioners frequently partner with specialists in organizational development, public health, civic engagement, politics, and all sectors of the community.

What Does Community Psychology Practice Look Like?

Based on these principles what does community psychology practice look like in the real world? It operates in a wide variety of settings, including government, foundations, large medical centers, public health settings, self-help groups, prevention organizations, community mental health centers, evaluation organizations, nonprofits, health care facilities, consultation and evaluation practices, comprehensive community initiatives, Internet sites, and neighborhoods. Community psychology practitioners work to influence these systems to move in the direction of the principles listed above.

In the remainder of this article I will show the principles of community psychology practice in action in various situations and settings, as the field and as my work within it developed over several decades. Beyond the historical value of this perspective, the settings correspond to those that many clinical and community psychologists already work in. They will illustrate the opportunities for community psychology practice that are available today as well as others that are coming into being. Following the examples is a presentation of the competencies needed to succeed in delivering high-quality service.

College Campus Mental Health Services

I first learned the power of the ecological perspective in the course of my earliest employment in college mental health services (Wolff, 1974). I spent time both as a clinician (seeing students for psychotherapy in the campus mental health service, which was part of the student health service) and in broader campus contexts, where I wore a community

mental health hat. The two activities were closely correlated and worked in parallel, even though one focused on remediation while the other emphasized prevention and community development.

For example, on a number of occasions clinicians were asked to write letters granting permission for students to move out of their dormitory areas for mental health reasons. The issue was not usually with the students themselves but reflected their inability to live in a 23-story dormitory with other inhabitants screaming out of their windows at all hours of the night and occasionally tossing items out of the windows. Along with other campus personnel, we set out to help the people in charge of the dormitories build healthy communities and thus reduce noise and dangerous behavior. Through consultation, training, and teaching a course for dormitory staff on "Building Community and Organizing for Change for Student Leaders" (Wolff, 1974), we succeeded at this venture to such an extent that students began to rate the dorms where the course had been taught as the most desirable rather than the least desirable on campus. In both my clinical and community psychology roles, I was learning how the concept that behavior is a function of the person and the environment played out.

The situations of married students on campus revealed this in another way. In the mental health service, we often saw students or their spouses who described the toll taken by their campus lifestyle. Usually the husband was the graduate student (this was the early 1970s), totally absorbed in his work and quite stressed, while the wife was caring for their young children. They lived on the edge of the campus in university-owned housing for married students. They often got by on almost no money. Life was hard. For the undergraduate students, the university had an *in loco parentis* stance and provided dormitory housing with resident assistants, programming, and staff. For the married students, the university provided virtually nothing: not even a playground for the almost 100 young children living in the complex. My community psychology practice response was to start Programs for Families (Levine & Wolff, 1977), a grassroots community-building effort that employed moms and dads living in the complex as change agents and community builders. Through their organizing and advocacy, a playground was built. In addition, through a partnership with the campus Early Childhood Program, they established an infant/toddler play group in the married-student village.

My community psychology practice work in that university college setting had the goal of reaching students through peer helpers (in the community mental health jargon of the day, "indigenous paraprofessionals"). Peer helpers included sex educators, drug counselors, resident assistants in dorms, and, last, student leaders whom we trained to become more effective change agents (Wolff, 1974).

University campuses were the first setting where I began to perceive and work to ameliorate the helping system's

dysfunction (e.g., duplication of effort, lack of coordination, and competition among agencies). Myriad student affairs agencies worked on similar issues (e.g., substance abuse) and yet did not talk, plan, or act collaboratively. We formed The Resource Network to create those missing interorganizational links. This was my introduction to the work that would dominate my professional career as a community psychology practitioner: coalition building and collaboration.

Lessons for psychologists today. These examples illustrate the potential for a community psychology practice based in a mental health outpatient clinical setting. The clinical and the community practices can work successfully hand in hand, using an ecological perspective to address both community and individual issues.

Community Mental Health Centers

Another setting that illustrates the possibilities for community psychology practice is the community mental health center (CMHC). As the director of consultation, education and prevention (CEP) at a new CMHC in the 1970s, my job became 100% community psychology practice. A community-wide needs assessment at this new CMHC had determined three areas of focus for the CEP unit: child sexual assault, domestic violence, and elder mental health. As a new director with an understanding of community deeply embedded in community psychology, I saw my task as one of approaching these three issues from a uniquely community psychology perspective, incorporating the principles of ecological perspective, systems/social change, prevention, and empowerment.

To start, I sent my staff out to talk to anyone in the communities in our "catchment" area who had any link to the three issues. We approached individuals and organizations in both the formal and the informal helping systems. We were very taken with the ideas of self-help, mutual help, and natural helping networks (Collins & Pancoast, 1976). To our surprise, after three months we knew more about the system of helping on these issues than almost anyone else, since most others never listened to as many different folks with different perspectives as we did. For example, around issues of domestic violence we talked not only to the shelter staff and the police but also to the women's advocacy groups, hospitals, churches, poverty agencies, and natural helpers such as hairdressers. We also began to see the power of bringing these various players together to coordinate protocols, learn from each other, and change systems. This was especially powerful for the shelter, the police, and the hospital.

In the area of child sexual assault prevention, we worked with the existing literature to create prevention programs that could be used in the schools. This included developing a program with a local puppeteer on "good and bad" touch for young children. Through this we gained the ability to bring child sexual assault prevention programs into the schools, a

very difficult challenge at that point in history. This involved not just prevention programming but also negotiating systems change.

In the area of the well-being of local elders, we partnered with the local Area Agency on Aging (Gallant, Cohen, & Wolff, 1985) and helped it reorient its perspective based on the empowerment thinking of community psychologist Julian Rappaport. The agency changed its perspective to one of promoting healthy long lives for all the elderly, as opposed to just delivering services to the most fragile elders, which was the national priority at the time. The agency motto became, "Our best services are those that empower elders to discover their own strengths, their own talents, and their own solutions."

Lessons for psychologists today. In the 1970s we had a consultation, education, and prevention mandate from the National Institute of Mental Health for CMHC services. Today we can continue to strive to include these three components in all mental health delivery systems. In the present era, there is no federal mandate for comprehensive CMHC services, including prevention. However, the need for a full range of services remains. Psychologists hold influential positions in many state and local mental health systems. We need to advocate for a comprehensive mental health system that includes consultation, education, and prevention services.

Mayor's Task Force on Deinstitutionalization

As so often happened in my career, my next shift in focus came about totally inadvertently. This change involved learning to address our dysfunctional helping systems through collaboration and coalition building.

One piece of my work at the CMHC illustrates how community psychology practice can address the societal issues that surround mental health care. The Mayor's Task Force on Deinstitutionalization was formed in Northampton, Massachusetts, to address the community repercussions related to the deinstitutionalization of two local facilities, a major state mental hospital and a large Veterans Administration hospital.

I literally stumbled into this work. One summer evening, I was asked to represent the CMHC in a meeting about the placement of two emergency service beds in downtown Northampton. The subject of deinstitutionalization was rubbing many people raw, including the police, the fire department, and the mayor's office. The meeting was chaotic. The police and fire department representatives raised serious concerns about safety issues tied to having mental health patients in beds in the downtown area, as did a city councilor from the affected neighborhood.

The mayor listened. The Department of Mental Health accused the city of stigmatizing the mentally ill. The mayor got angry. The room was filled with conflict and hostility. I used my best group-process skills to identify the issues, the disagreements, and future directions. Ultimately the group

agreed to establish the two emergency service beds; however, the mayor announced that he would not tolerate such a level of discord in his community. He said he was creating a Mayor's Task Force on Deinstitutionalization. Then, pointing at me, he said, "And you, young man, will chair it!" This is where I began to learn about finding collaborative solutions to divisive community problems.

At first, conflict dominated. Meetings got loud. The mayor could be the chief hothead. But everyone sincerely desired what was best for the community. The differing groups began to understand more about each other's worlds. Early in our process, a woman released on a day pass from the state mental hospital set fire to a downtown building, causing the deaths of two elderly women. This crisis turned up the pressure on the task force.

Over time the police sergeant and the director of the emergency mental health program began to sit down once a week to discuss their caseloads, which overlapped by 40%. This was one of the most profound learning experiences of my career and where I really began to learn what it takes to forge collaborative solutions. I spent the next nine years (1981–1990) discovering how people who were in total disagreement could find productive ways to work together (Wolff, 1986, 1987).

Lessons for psychologists today. The journey of the Mayor's Task Force on Deinstitutionalization provided amazing lessons on the dysfunctions of the uncoordinated helping system. In this case, the ecological perspective of community psychology involved seeing beyond individual clinical situations and perceiving deinstitutionalization as a community issue. Although we are no longer deinstitutionalizing state hospitals, we are still dealing with multiple forces impacting the issue of severe mental illness in our communities. Success at this work requires that we become comfortable working with political and community leaders from varied settings. I came away from this experience greatly impressed with the power of the collaborative process and with an even greater respect for and understanding of politicians and the political process.

Today this same plight of the chronically mentally ill continues. Now, however, the state psychiatric hospital has been replaced by the local jails. The opportunities for psychologists to address the systems-level issues remain.

Healthy Communities and Community Coalition-Building

Community psychology practice also has a significant role in facilitating multiparty collaborations aimed at building healthy communities. A medical school was the next place where I learned and practiced community psychology. A colleague from the University of Massachusetts Medical School's Area Health Education Center who knew of my interest in coalition building asked if I would engage in a short-term consultation in two old mill towns in the north-central area of Massachusetts. The recent dramatic closing of a large manufacturing plant that was a major employer had thrown the community into turmoil. The once stable, although not thriving, community was now full of hungry families who could not make mortgage payments. My colleague asked me to work with an informal group that was getting together to address the issues. This was a direct request for coalition building in an area with a population of 30,000.

I spent the summer of 1984 working with this group to plan a major community meeting for the fall. The group consisted of representatives from the chamber of commerce, a mental health center, a hospital, local legislators, clergy, and others. The goal of the fall meeting was to help the community name the issues and mobilize to seek solutions. Our successful launch that fall began what was then called the Athol Orange Health and Human Services Coalition. We thought this was a short-term intervention. No one had any sense that we were at the start of a 20-year adventure. But we were about to discover a great deal about each other and about this amazing process of building collaborative solutions (Wolff, 2010).

In our first years, we started monthly meetings to exchange information and increase our capacity to advocate for the area. Then, with the support of our state representatives, we successfully lobbied the state for funding to provide information and referrals to families in need of services. Once this service was running, we became aware of significant family homelessness. We began an emergency shelter in a church basement that evolved into the first rural family homeless shelter in the western part of the state.

We continued this pattern for over two decades. We engaged the community, identified an issue, and moved to a solution. At the end of the first years, the coalition expanded beyond health and human services. It took a new name, the North Quabbin Community Coalition, and created new mechanisms for grassroots engagement.

This work is an example of applying community psychology principles such as community building, collaboration, and advocacy. The coalition building involved working with whole communities. Employing an ecological model led to significant and locally led community change.

The North Quabbin success spawned other requests for similar needs assessments and coalition building. The first came from North Adams, in the northwestern corner of the state, another community experiencing a major plant closing. Shortly after, we were asked to work at the other end of the state, in the communities of Cape Cod.

After a few years of managing the three coalitions, it became clear that these highly successful programs might provide a model with wider application. The W. K. Kellogg Foundation granted funding to expand the model to other Massachusetts communities, to evaluate the process, and to disseminate our findings. The grant allowed us to create an office that we named Community Partners. Until then, I had worked out of my private clinical office as a consultant with

almost no support. At this point I became an employee of the University of Massachusetts Medical School.

We began a newsletter, *The Community Catalyst,* which ultimately reached a much wider audience. We soon became a national resource on successful coalition building. We translated what we learned in the communities into easy-to-understand tip sheets to help hundreds of communities across the country that were struggling with similar issues.

It was interesting to discover that ideas and resources for coalition building were coming from a variety of sectors, including public policy, organizational development, public health, and international community development. We drew from all these fields to strengthen our own work and to create an interdisciplinary and multisectoral model for spreading information about coalition building.

While we worked, we had been struggling to define the true goal of coalition building in difficult, poor, and disenfranchised communities. Were we trying to repair damage, or to build something more positive? It became clear that the goal of the coalitions was to improve the quality of life for all residents by building healthy communities (Wolff, 1995).

Drawing on the emerging international work on healthy communities, we formally launched Healthy Communities Massachusetts in 1994 and began a *Healthy Communities Newsletter* and the Healthy Communities Institute, which trained teams in the basic skills of building healthy communities and then supported their work. With faculty from across the country, we provided training in community mobilization, strategic planning, evaluation, managing diversity, and the basics of coalition building to over 50 Massachusetts communities. We lobbied the state to adopt a healthy communities model (Wolff, 2003).

One fascinating aspect of the coalition work was our engagement with politicians. We started each local coalition with the support of the local legislators, who were supporters of and advocates for our work and ultimately became the coalitions' key source of funding. They would insert what is known as "outside language" into the annual state budget to support the coalition work. This tedious process involved the House budget, the Senate budget, the conference committee, and often an override of the governor's veto. We would in turn honor these allies for bringing resources or policy change to our communities. Each January, we would have a fascinating meeting with the state senators and representatives from each of the coalition regions. The commitment of these legislators to this process was much deeper than that of state agencies, because they were committed to improving the quality of life in their home communities.

Lessons for psychologists today. Kirk and Neigher (2013), writing about the future of health care and community psychology, observed that U.S. health care systems are moving to a population health model with a focus on prevention. They noted that this shift requires a new set of skills and competencies: Many of the competencies of the new health care systems fall within the skills and experiences common to community psychologists. Kirk and Neigher enumerated those competencies as community program development, community and organizational capacity building, and community/social change. The area of multisectoral collaboration for community health continues to grow, creating more opportunities for community psychology practice.

Independent Practice Consulting and Training

An independent practice on coalition building and community development started as early as my work with the Mayor's Task Force on Deinstitutionalization, and in the last 15 years it has become my full-time effort. My work centers on coalition building/collaborative solutions and on healthy communities, community building, and community development. It is fascinating to see who has sought out consultation and training in these areas. The range of clients speaks to the breadth of the potential market for psychologists in community psychology practice. Here is a brief sampling of my clients:

- The Internal Revenue Service seeking consultation and training on their VITA (Volunteer Income Tax Assistance) program.
- The Centers for Medicare and Medicaid Services looking to increase collaboration with their End Stage Renal Disease Networks (quality improvement around kidney dialysis).
- The Healthy Wisconsin Leadership Institute wanting to train Healthy Communities teams from communities around their state.
- The U.S. Breastfeeding Coalition wanting training and consultation to start up breastfeeding coalitions in every state.
- The Institute for Community Peace requesting training and consultation to develop violence-prevention and peace-promotion coalitions in communities across the country.

Center for Health Equity and Social Justice, Boston Public Health Commission

Work with the Boston Public Health Commission's (BPHC's) Center for Health Equity and Social Justice illustrates how community psychology practice can address key issues facing the nation, such as health disparities, health equity, and racial justice. For six years, from 2006 to 2013, my work with this center has been especially intriguing. It has focused on policy change driven by local coalitions and communities. The simple fact that a large U.S. city's health department has an office named the Center for Health Equity and Social Justice is not only surprising but attests to the cutting-edge vision being manifested by this organization's

leadership. An early video on the work of the BPHC provides a good overview (Boston Public Health Commission, 2010).

As a community psychologist, I was able to support this important work in social change through (a) organizational consultation with regard to their goals, mission, and structure; (b) specific training at sites on topics such as sustainability and differentiating policy solutions from program solutions; and (c) ongoing coaching of individual coalition staff and the steering group, to help them set goals and manage barriers. These efforts show the relationship between community psychology and policy change (Wolff, 2013).

I began my work with this innovative grassroots program in 2010 when it was called Boston REACH (Racial and Ethnic Approaches to Community Health) and focused on racial disparities in breast and cervical cancer survival rates for Black women in Boston. Boston REACH provides an excellent example of what a community can accomplish when it acknowledges the issue of racism in health and then creates a comprehensive social-change effort to address inequalities. The success of Boston REACH allowed it to receive additional funding from the Centers for Disease Control and Prevention to support similar efforts in 17 other communities across New England.

All of these efforts were built around key concepts that are central to the Center for Health Equity and Social Justice's beliefs and also illustrate the best of community psychology principles. The situations encountered allowed for the full use of my consulting skills to support the communities in accomplishing their goals. Together these key concepts became a powerful force for transformative community change. (Baril, Patterson, Boen, Gowler, & Norman, 2011; Wolff, 2013).

Addressing institutional and structural racism. The BPHC operates with an explicit understanding that racism is at the root of racial and ethnic health inequities. Racism affects health directly (causing stress and anxiety) and indirectly (by its impact on the social determinants of health).

Focusing on social determinants of health in relation to racism and health. By looking at community health from the perspective of the social determinants of health, groups can examine the ways in which institutional racism plays out in each realm (Baril et al., 2011). As the powerful documentary film series *Unnatural Causes . . . Is Inequality Making Us Sick?* makes clear, "Your zip code may be more important than your genetic code in determining your health" (Adelman & Smith, 2008). This wonderful phrase could summarize all of community psychology.

Grassroots community engagement. The Center for Health Equity and Social Justice's approach is based on a core belief that grassroots involvement is essential to solving problems. Part of the solution lies in getting a broad-based coalition—including both providers and residents—to tackle issues like racism.

Policy change. The project has an explicit focus on creating long-lasting policy and social change that will endure as a legacy. Examples include zoning changes to allow construction of a supermarket in a low-income community; lobbying the governor to fund summer jobs for teens; working with the superintendent of schools to create an annual Racial Justice Review of educational and disciplinary disparities; and creation of a Food Policy Council by City Hall.

Shifting from social service to social change. For traditional nonprofit agencies, the greatest challenge often came in the explicit shift from social service to social change. For example, the BPHC center is less interested in the creation of new education programs for Black men at risk of diabetes than in changing the institutional racism in housing, food access, and employment policies that put Black men at higher risk for the disease.

Collaboration. Finally, the center understood that in order to accomplish changes of this large scope a community must develop a broad-based coalition of residents, agencies, government, the private sector, and others that will work together collaboratively.

The Community Toolbox

As I and my colleagues have learned how to work in communities, we have also developed tools to spread the knowledge. One substantial way this has happened is through The Community Tool Box (Schultz et al., 2000). For 20 years I have been a partner/consultant with the Work Group at the University of Kansas and with others in the development of this website (http://ctb.ku.edu/en), which has 7,000 pages of free material on community health and development and engages over 7 million users each year. This is an example of community psychology practitioners giving community psychology resources away in order to support communities around the globe in solving their own problems.

Lessons for Psychologists Today

After doing collaborative work for 30 years, I began to understand that a handful of key principles are critical for success. These six principles of collaborative solutions became the foundation of my book *The Power of Collaborative Solutions* (Wolff, 2010):

Engage a broad spectrum of the community. Collaborative solutions require that we bring all the parties into the room with each other. That step alone is a triumph. Then we need to create an atmosphere of respect in which racial and cultural diversity are celebrated as central to the community's or the organization's wholeness. Until we are able to understand that our diversity is our richness, we will struggle to find collaborative solutions that truly meet the needs of our communities.

Encourage true collaboration as the form of exchange. We often use the term *collaboration* glibly, without defining what we mean. Arthur Himmelman (2001) did us a great service by differentiating collaboration from networking, coordination, and cooperation:

- *Networking:* exchanging information for mutual benefit.

- *Coordination:* exchanging information and modifying activities for mutual benefit.
- *Cooperation:* exchanging information, modifying activities, and sharing resources for mutual benefit and to achieve a common purpose.
- *Collaboration:* exchanging information, modifying activities, sharing resources, and enhancing the capacity of another for mutual benefit and to achieve a common purpose by sharing risks, resources, responsibilities and rewards.

Himmelman helped us see that collaboration is sophisticated, multilayered, and radical. To "enhance the capacity" of the other requires a significant transformation.

Practice democracy and promote active citizenship and empowerment. In successfully seeking collaborative solutions, we need to see how we are encouraging and supporting civic engagement in a way that allows the airing of diverse issues and the pursuit of new solutions. This goes beyond just bringing those with the least power to the table. It means designing ways for all views to be heard and respected—not an easy task. It also requires that we support those most disenfranchised in learning to successfully practice active citizenship and that we create settings in which that can take place.

Employ an ecological approach that builds on community strengths. Our systems continue to show an inability to simultaneously take in both the person and the environment. When the issue of obesity lands in the press, coverage blames either the victim or the candy/soda manufacturer. We have a hard time understanding the role and interactions of the two. Another key component of collaborative solutions involves identifying and building on a community's strengths and assets rather than focusing on its deficits (Kretzmann & McKnight, 1993).

Take action by addressing issues of social change and power based on a common vision. Collaborative solutions do not come about automatically by just getting the right people around the table and talking respectfully. Change happens when a group decides to take action. Too often in coalitions we sit around and study issues to death and never get around to making a difference.

In collaborative solutions we are looking for action that addresses issues of social change and power based on a common vision. So one of our first steps is to create a common vision that has been agreed upon by all the sectors of a community. When we begin to act on the vision, we have to be willing to address issues of power. As Judith Kurland, one of the founders of Healthy Communities in America, has stated, "Our work is not just about projects . . . programs . . . or policies. Healthy Communities is about power. Unless we change the way power is distributed in this country, so that people in communities have the power to change the conditions of their lives . . . we will never have sustainable change" (Wolff, 2010, p. 166).

Engage spirituality as your compass for social change, and align the goal with the process. Gandhi is reputed to have said, "Be the change that you wish to see in the world." This speaks eloquently to the final component of collaborative solutions. We must create collaborative processes that parallel and reflect what we hope the outcomes will look like. If we seek a community that respects its diversity, we must get there through collaborative processes that model diversity and respect. If we want to create a caring and loving community, then our collaboration must be caring and loving. This is the spiritual aspect of the work that we rarely talk about (Wolff, 2010).

Developing a Field of Community Psychology Practice

Over the last 50 years of its development, community psychology has had to address the overriding questions of how to develop a professional practice that is (a) clearly defined; (b) skillful and based on established and accepted competencies; (c) effective; (d) acknowledged as legitimate; (e) visible to the public and to those in the field; and (f) supported by peers and institutions. Over the past decade, the Community Psychology Practice Council within SCRA (Division 27) has addressed these issues explicitly (Wolff, 2011). A highlight of that work has been a collaboration with SCRA's Council on Educational Programs that led to the articulation of key skills and competencies required of a practicing community psychologist. A set of 18 competencies for the field (see Table 1) has been adopted by the SCRA Executive Committee (Dalton & Wolfe, 2012).

The second major accomplishment of the Community Psychology Practice Council was the creation of the *Global Journal of Community Psychology Practice,* an online peer-reviewed journal that is available for no charge in English and Spanish. The journal has now published more than 200 manuscripts, reviews, tools, videos, and other resources.

The Future of Community Psychology Practice

Community psychology practice can be a key component for the future of psychology. My experience provides some examples and suggests how others could engage in their own community psychology practice. In outpatient settings, community psychologists can join with or initiate efforts to address community issues that impact the emotional health of our clients. In mental health systems, we can integrate public health approaches that expand beyond individual, remedial efforts to include prevention and population-based approaches. Although many state mental hospitals are closed, we can bring visibility to the plight of the chronically mentally ill. Our greatest opportunities may lie with joining in the population-based efforts of the Healthy Communities movement and the changes coming through the Affordable Care Act (Obamacare). We can help with community-wide assessments of the social determinants that impact the physical and mental health of our communities, and then we can initiate or join collaborative efforts to address those issues.

Table 1
Community Psychology Practice Competencies (Dalton & Wolfe, 2012)

Competency	Definition
Foundational principles	
These foundational principles represent fundamental values and perspectives of community psychology, as well as competencies for applying those values and perspectives in practice. To apply any competency in practice, a community psychologist would articulate and use ecological and empowerment perspectives, competently work across cultural boundaries, form inclusive partnerships with community members and organizations, and employ critical ethical reflection.	
1. Ecological perspectives	The ability to articulate and apply multiple ecological perspectives and levels of analysis in community practice.
2. Empowerment	The ability to articulate and apply a collective empowerment perspective, to support communities that have been marginalized in their efforts to gain access to resources and to participate in community decision making.
3. Sociocultural and cross-cultural competence	The ability to value, integrate, and bridge multiple worldviews, cultures, and identities.
4. Community inclusion and partnership	The ability to promote genuine representation and respect for all community members, and act to legitimize divergent perspectives on community and social issues.
5. Ethical, reflective practice	In a process of continual ethical improvement, the ability to: • Identify ethical issues in one's own practice, and act to address them responsibly. • Articulate how one's own values, assumptions, and life experiences influence one's work, and articulate the strengths and limitations of one's own perspective. • Develop and maintain professional networks for ethical consultation and support.
Community program development and management	
6. Program development, implementation, and management	The ability to partner with community stakeholders to plan, develop, implement and sustain programs in community settings.
7. Prevention and health promotion	The ability to articulate and implement a prevention perspective, and to implement prevention and health promotion community programs.
Community and organizational capacity building	
8. Community leadership and mentoring	*Leadership:* The ability to enhance the capacity of individuals and groups to lead effectively, through a collaborative process of engaging, energizing, and mobilizing those individuals and groups regarding an issue of shared importance. *Mentoring:* The ability to assist community members to identify personal strengths and social and structural resources that they can develop further and use to enhance empowerment, community engagement, and leadership.
9. Small and large group processes	The ability to intervene in small and large group processes, in order to facilitate the capacity of community groups to work together productively.
10. Resource development	The ability to identify and integrate use of human and material resources, including community assets and social capital.
11. Consultation and organizational development	The ability to facilitate growth of an organization's capacity to attain its goals.

(table continues)

Table 1 (*continued*)

Competency	Definition
Community and social change	
12. Collaboration and coalition development	The ability to help groups with common interests and goals to do together what they cannot do apart.
13. Community development	The ability to help a community develop a vision and take actions toward becoming a healthy community.
14. Community organizing and community advocacy	The ability to work collaboratively with community members to gain the power to improve conditions affecting their community.
15. Public policy analysis, development, and advocacy	The ability to build and sustain effective communication and working relationships with policymakers, elected officials, and community leaders.
16. Community education, information dissemination, and building public awareness	The ability to communicate information to various segments of the public, to strengthen competencies and awareness, or for advocacy. To give community psychology away. • Communication • Diffusion of innovation • Social marketing
Community research	
17. Participatory community research	The ability to work with community partners to plan and conduct research that meets high standards of scientific evidence that are contextually appropriate, and to communicate the findings of that research in ways that promote community capacity to pursue community goals.
18. Program evaluation	The ability to partner with community/setting leaders and members to promote program improvement and program accountability to stakeholders and funders.

We cannot shy away from difficult and controversial social justice concerns such as racism, sexism, homophobia, and income inequality. Well-publicized issues like health disparities give us an opportunity to bring these topics to the forefront and create community-wide efforts to improve our communities.

Psychologists can do all these things from any setting: from community-based organizations, government, academia, and even independent private practice. Community psychology practice offers a format and a set of competencies for moving forward on this work. Psychologists can adapt to change by focusing on approaches that are ecological, community centered, population based, preventive, focused on systems change and empowerment, and multidisciplinary and that bring those most affected by the issues to the heart of the decision making.

These are opportunities American psychologists cannot turn down. We need to view this work as our future.

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