The idea of generalist practice is an old one. The origins of the generalist concept are as deep as the social work profession itself. Social work pioneers such as Mary Richmond and Jane Addams have stressed the importance of understanding people in relation to their environment. The social workers’ long-standing commitment of a dual focus on the individual and on the society supports the fundamental notions of generalist practice.

Although the notions of generalist practice are old, the emphasis of a generalist perspective in social work reemerged as social work programs began to offer Baccalaureate of Social Work (BSW) degrees. The BSW programs, as stipulated by the Council on Social Work Education, required education from a generalist perspective. Currently, most BSW programs focus their curricula on generalist practice, and MSW programs use the first year, or foundation year, for education on the generalist approach to practice. As Landon (1995, p. 1102) concludes, “in the quest for a theory for this broad practice base, social work education adopted notions from general and social systems theories and ecological thinking to undergird the foundation for all practice.”

Generalist practice has reemerged as central to social work education. But what exactly is generalist practice? How is it defined? Not surprisingly, there is no one definition of generalist practice. However, important themes emerge in the various definitions.
Several generalist social work practice books describe generalist practice as beginning with a decision as to what the unit of attention should be—an individual, a family, a small group, an agency or organization, or a community (Johnson & Yanca, 2009; Krist-Ashman & Hull, 2008). The generalist model promotes a multimethod and multilevel approach, an eclectic theory base, and the dual perspective of social work. Schatz, Jenkins, and Sheafor (1990) generated a three-level model of generalist practice:

1. The generic or foundation level of knowledge necessary for all social workers, regardless of later specialization, includes the purposes, values, focus, and knowledge base of the profession.
2. The initial generalist level includes competency in direct and indirect practice based on multilevel assessment and the capacity to intervene on multiple levels, perform various practice roles, and evaluate practice ability.
3. Generalist practice at the advanced level delineates knowledge needed for practice in greater depth and in relation to more complex and technical issues.

Lastly, any discussion of the generalist perspective would be remiss to omit a discussion of the ecological perspective. The underlying theory of social work is rooted in social systems theory, particularly ecological-systems theory. Gitterman and Germain (2008, p. 20) describe the theoretical underpinnings of an ecological perspective, or what they refer to as the life model:

Ecology is a science concerned with the relations between living organisms—in this case, human beings and all the elements of their environments. It is concerned with how organisms and environments achieve a goodness-of-fit or adaptive balance and equally important, how and why they sometimes fail to do so.

Ecological-systems theory provides an understanding of the person-in-environment perspective, stressing how critical interactions occur between individuals and their environments. This model directs social work practice at the interface of these systems and helps social work practice maintain a dual emphasis. Social workers assess an individual in relation to the opportunities and obstacles that exist in one’s environment.

In this chapter you will read three case studies that explicitly address a generalist perspective in social work practice. The first case study by Patterson, Jess, and LeCroy describes an ecological perspective and shows why it is considered the cornerstone of good generalist practice. It takes the fundamental concepts from ecological theory and illustrates how they can be used in direct social work practice. The case study demonstrates how the notions of ecological theory are tantamount to generalist social work practice.

The case study by Lortie presents a complex situation for a social worker in a hospital setting. It elucidates how generalist practice with a person-in-environment perspective must consider the resources available to a person. It is an excellent example of how critical good case management can be and shows that case management services represent social work at the interface of the person and the environment. A lot of social work practice revolves around helping individuals cope with a difficult environment.
In addition to helping them cope on an individual basis, we must help bring services to bear on their problems.

The last case by Chapelle extends the generalist model to community-based work. Too often, social work is focused narrowly on the individual. As this case demonstrates, good social work practice can take place at the community level. Using basic concepts of community practice, this case shows how a social worker can approach large-scale change in a community.

Together these cases represent a sample of how direct-line practitioners view generalist practice. It should give you a good, practical feeling for what it means to do generalist practice. Also, it should alert you to the difficulties and complexities of doing good social work. When our attention is focused on personal problems and social concerns, multilevel methods, and ecological understandings, we are faced with drawing on a broad range of skills and abilities. Social work practice offers a challenge for those who want to tackle social problems but need a large toolkit.

REFERENCES


Case Study 1–1

Using the Ecological Model in Generalist Practice: Life Transitions in Late Adulthood

SHIRLEY PATTERSON, JAN JESS, AND CRAIG WINSTON LE CROY

This case uses the ecological perspective as a guide to generalist practice. This perspective offers a framework for how the social worker organizes her work and helps the client cope with a serious life transition.

Questions
1. Why is the ecological perspective considered a good framework for generalist practice?
2. What were the essential skills and abilities the social worker used in this approach?
3. How were ecological concepts used to help the social worker?
4. How was the concept of person and environmental fit used in this case?

I met Mrs. Lilly Goodman at the medical center in Kansas City on the long-term care unit where I work. She is a 77-year-old woman who is thin, small in stature, with straggly gray hair, who peers at you above her glasses, which keep slipping down her nose. When I met her for the first time, I was struck by her sad demeanor. However, as I got to know her, I came to love her wry sense of humor that is often masked to those who do not know her well.
Mrs. Lilly Goodman has been a hard-working laborer all of her life. She grew up in poverty—living in apartments and moving frequently as her father sought new work opportunities. She was not encouraged to go to school and, in fact, quit school after completing a fifth-grade education. Despite this, she is a well-spoken woman who is articulate, well-read, and has seized new learning opportunities all of her life.

Mrs. Lilly Goodman began work as a “cleaning lady” at 12 years old and has been doing it ever since, until she became too frail to continue. She recounts the very day she could not work anymore: “It was about half past noon when I bent over to put fresh sheets on the bed. As I tried to straighten up, my back experienced sharp shooting pains and I knew that I could not work any longer.” As she tells me about her life, I can sense the confident, proud woman that she is. As she talks, you quickly get to know that one of her greatest achievements and joys is her home. She bought and paid for her own home, and she is very proud of having accomplished this goal. Also, her home is a central source of comfort: “I have lived in my home now for 30 years. I have one of the neighborhood’s best gardens. My neighbors stop by to see me on a regular basis.”

I try to think back to what life must have been like for her prior to landing in the hospital. I can see her getting up early in the morning to tend to her flowers, sitting and reading in an old overstuffed chair, and having a few old friends over for afternoon tea. Everything is different now. Her independence has come to an end, and she has not had much time to prepare for it. After suffering two strokes, one right after the other, and developing crippling and painful arthritis, I know that her life must have changed dramatically.

She, however, has not accepted these changes. Mrs. Goodman has consistently told the hospital staff that she plans to return home to live as soon as she gets out of the hospital. Because staff were unsure about the possibility of her returning to home, I was brought in as the long-term care social worker. Mrs. Lilly Goodman did not directly ask for help, but she willingly accepted my offer for help, proffered help—I was reaching out to her.

An ecological perspective was used in thinking about and guiding my approach to practice (Gitterman, 2009; Gitterman & Germain, 2008). From an ecological perspective, Mrs. Lilly Goodman is best understood as someone who is in a life transition. She is at a place in her life where she is facing a major transition—from an independent person who took care of herself to a person who is dependent and needs some assistance. There are three aspects of her life transition that help in thinking about how to offer her help:

- Her developmental stage
- Her change in status and roles
- The crises she faces

Mrs. Lilly Goodman is in the final stages of growth. The developmental stage that confronts her has a biological base, and the associated tasks of this stage of development
arise out of biological pressures and the social and physical environment. In other words, her residency in long-term care is not of her own choosing; rather, it is a result of illness, limited resources, and lack of family support.

Mrs. Lilly Goodman is also being thrust into some very new statuses, none of which she is particularly happy about. These include being:

- A resident of a nursing home
- A displaced homeowner
- A dependent person
- An older adult with fairly limiting health problems, which are difficult for her to accept

In addition to new statuses, Mrs. Lilly Goodman has new roles that she must adapt to, including being:

- A lucid, ambulatory resident among many residents who are neither
- A protected mother (and mother-in-law) in a sheltered environment
- A welfare recipient, who receives Medicaid to supplement her social security that pays for her care in the long-term care unit

These roles are a striking contrast to the Mrs. Lilly Goodman of only a few months ago—someone who lived independently, tended her garden, cared for her home, and shared tea in the afternoon with friends.

As the team of workers at the hospital staffed this case, they recognized that Mrs. Lilly Goodman faces several life stressors. They are considered critical life stressors because they are situations that exceed the personal and environmental resources she has for managing them. The critical life stressors she faces include:

- Loss of health
- Denial of the limitations her strokes have caused
- The threat of losing her home
- Her daughter’s poor health, which prevents her from providing her mother with support

Client strengths are an important part of the ecological model (Gitterman & Germain, 2008). As I thought about Mrs. Lilly Goodman, I needed to be aware that there is an innate strength in her—toward health, continued growth, and the development of new potentials. Although many of the people on the team exclusively discussed her limitations and what she could not do, I was always quick to point out her strengths—what she could do. As a social worker focused on helping Mrs. Lilly Goodman obtain self-determination, I empathized with her desire for discharge in order to live in her own house. Out of respect for her, I wanted to honor her wishes. Also, I knew that health could not be easily separated from obtaining satisfaction and meaning in life.
As the team members began to get to know Mrs. Lilly Goodman, they could see a determined woman who really did deserve an opportunity to try to return home. The team agreed that this was a reasonable goal that everyone could help her achieve. We set about a specific set of actions to make this happen.

Being in the long-term care unit had taken an emotional toll on Mrs. Goodman. Over time she had become increasingly despondent. The first goal was to rejuvenate her passion to seek a more meaningful life. To do this, we agreed to provide her with our support to supplement the limited support she received from her daughter in her wish to return home. We spent time talking with Mrs. Goodman about her home—getting her to tell us what it was like and to describe what her priorities would be when she returned. One team member who is an amateur artist sat down with Mrs. Goodman and drew a picture of her house—the outside and inside. You could observe an instant impact from this intervention. This helped shift her focus away from being a “patient” and helped her focus on what she wanted to achieve.

The team knew that to release Mrs. Lilly Goodman back to her home, they would have to be confident that she could function independently. This called for an assessment of the feasibility of discharge. To conduct this assessment, different team members took on separate tasks.

The occupational therapist conducted a cooking evaluation with Mrs. Goodman. This was done in the hospital occupational therapy kitchen. The assessment did not focus on her skills of cooking but on her stamina in cooking for herself. Mrs. Goodman rather enjoyed this challenge. Trying these tasks gave her an opportunity to show others what she could do. Each team member was instructed to help emphasize the positive competencies that she was able to demonstrate. Indeed, Mrs. Goodman did have the necessary stamina for cooking.

The nurse set out to help Mrs. Goodman plan daily activities while she was still on the long-term care unit. This was done to help her develop the stamina to live alone and care for herself. Mrs. Goodman was encouraged to take on increasing amounts of daily living activities. Also, to improve her physical stamina, the nurse worked with her to increase the amount of walking she could do.

As the social worker on the unit, I helped Mrs. Goodman assess what resources and support she would need when she returned home. I talked with her about the kinds of resources other older persons I had helped found useful, such as homemakers, visiting nurses, meals-on-wheels, transportation, telephone reassurance, neighborly support, and the kinds of supplemental income she might be eligible for when she returns home. I also helped Mrs. Goodman realize that she was facing new changes in her life and that she had a lot of adaptations to make. I wanted her to become more accepting of her new challenges. I tried to help her see that she could face these new challenges with new solutions. Although adaptations had to be made, some resources could help make those adaptations easier.

Our work culminated when we decided to take Mrs. Lilly Goodman to her home for a visit. This allowed the team to make further assessments to bolster our confidence...
that she would be able to go home. In particular, we wanted to assess her physical environment. How easy was it for her to manage her home environment? Was her cooking stove easy to operate? Would she be able to run a bath for herself? How would she get the laundry done? We also examined the outside environment. How easy would it be for her to take the trash out? What kind of neighbors did she have? Would they be able and interested in helping her occasionally? We wanted to know what kind of support was available to her in her social environment. As we assessed the daily skills needed to operate a home, we could see how difficult it was for someone like her—with two strokes and painful arthritis.

Lastly, the team brought Mrs. Goodman and her daughter together for discussion of the home assessment and to provide specific information about finances, the daughter and son-in-law’s support, and how the daughter felt about her mother’s wish to go home. The team wanted to assess the quality of Mrs. Goodman’s interpersonal interactions.

These assessments were focused on action, which takes place in physical, social, and interpersonal environments. The team approach operationalized the notion of treating Mrs. Lilly Goodman as a whole person. We were attempting to deal with all aspects of her life in order to facilitate a smooth life transition. From an ecological perspective, when habitats are rich in resources required for growth and development, then human beings thrive. However, when habitats are deficient in vital resources, then physical, social, and emotional functioning are adversely affected.

The primary function of the social worker in addressing life transitions is to help people move through stressful life transitions—to help them adapt and cope. The social worker acts simultaneously as an enabler, facilitator, and teacher. Our work with Mrs. Lilly Goodman certainly sought to enable her by embracing her desire to return home as an important way to help her cope with her life transitions. We helped her develop a plan to return home and helped her assess that plan realistically. We sought to empower her as an individual.

Overall, the team acted as facilitators by serving several different functions. The team supported Mrs. Lilly Goodman’s competence through building her skills. We set realistic and measurable goals. For example, we made a contract with her to take more walks in the long-term care unit and assume responsibility for her medication. This aided her stamina and gave her renewed confidence in her own abilities.

We mobilized environmental supports by encouraging Mrs. Lilly Goodman’s participation in an organized group in the hospital that was discussing discharge planning. We helped shift her focus from “patient” to consumer. In so doing, we helped her recognize that resources are available to her and that they can be used to help her meet her goals. She became more active and involved in working with us.

We also actively sought to help her develop a sense of self-direction. We knew that to empower her, she would have to take some degree of control over her life and accept increasing responsibility for her decisions and actions. Making age- and health-appropriate decisions and taking purposeful action was key to helping her fulfill her wish to return home. Team members facilitated this by setting up problems that she had to solve. For example, when it was decided that we should visit her home, she had
to make the arrangements with her daughter to secure the house key. Although these actions were small, together they combined to create a new sense of self-direction.

Teaching was an important function in helping Mrs. Lilly Goodman. I took a major role in teaching her several critical skills. For example, I provided pertinent information about how she could manage following discharge from the hospital. This included not only talking about community resources but also teaching her exactly how to use these resources: where to find them, how to contact them, what to say to them, and how to follow up on contacts made. I knew from past experience that too often social workers only talk about resources rather than teach clients how to use resources.

Although ultimately Mrs. Goodman decided that she did want to return home, I provided a great deal of education concerning other alternatives that would be available to her. I helped her learn about the range of available options, such as assisted living, boarding homes, and the like. Although none of these alternatives were what she wanted, it helped her see that when you are facing difficult life decisions, resources are available to help you find the best fit for your circumstances.

My teaching also included helping her restructure her perceptions about certain issues. In particular, her reliance on her daughter’s moral support and her own continued insistence that she could still care for herself as she had always done in the past. Lastly, the team members taught her the importance of systematic problem solving, which takes into consideration the individual abilities of the person and the resources available to the person. The problem-solving process was highlighted when we asked Mrs. Goodman and her daughter to meet with us to discuss what needed to be considered for a feasible and safe discharge.

CONCLUSIONS

This case study described the elements of the ecological perspective in recognizing and dealing with an older adult’s life transition. The approach included understanding the developmental stage, the changes in status and roles, and the life stressors present in Mrs. Goodman’s final stage of growth and development. The social worker—in conjunction with a team of professionals—worked to enable, teach, and facilitate discharge planning for the client. Of course, the unanswered question is: Did Mrs. Lilly Goodman go home?

She did not. After all the planning and work, she decided that the obstacles were too many and the support insufficient. In effect, there was not a good enough fit between her individual abilities and the resources and support in the environment. In the end, it was her decision, which made her subsequent adaptation much easier. Mrs. Lilly Goodman benefitted tremendously from the work the team had done. She made progress toward adaptation and learning to cope with her nursing home “home.” She still is not completely satisfied, but now when she talks about going home, she adds, “I’d like to, but I’m not sure I can. I’m not the same person I used to be.”

Further adaptation occurred for Mrs. Goodman a year later when she assumed a resident leadership role by assisting the long-term care professional team in designing
an outdoor space for the residents to enjoy, spring through fall. Materials and labor for this project were donated by a local construction company, a concrete company, and a landscape nursery. The outdoor living space consisted of lovely tree and shrub plants, picnic tables and benches, comfortable seating areas, and a raised garden bed that accommodated wheelchairs. The latter, of course, was Mrs. Goodman’s idea. As I look from my office window, I often see her tending her own flowers and helping other residents tend theirs.

REFERENCES

Finding resources for families is one of the most important functions for social workers. This case study describes the social worker’s effort to find resources for a family with a very sick child.

Questions
1. What were the social worker’s goals in this case?
2. What resources were identified for this family?
3. How could the family have been helped to better use the resources that were available?
4. Why were resources critical to the success of this case?

Today, Jeffrey asked me to have lunch with him. It’s been so long since a guy asked me to lunch that I was startled for a moment, but then I accepted, especially since I was kind of down and Jeffrey is a bright 12-year-old with cystic fibrosis who has spent the past week in the hospital where I am a pediatric social worker. Every day he has been stopping by my office to borrow the Game Boy or ask for candy, and today he said, “So, do you eat lunch?”

“Yes, I do.”
“Do you like to eat here in the hospital cafeteria?”
“Usually that’s all I have time for.”
“I have a cafeteria pass. I’ve been eating in the cafeteria.”
“I saw you there yesterday with your grandmother.”
“When are you going to eat lunch today?”
“When I finish these phone calls.”
“Would you like to eat with me, in the cafeteria?”

How could I say no? So we went to lunch, and he forgot to bring his medicines that he has to take before every meal to help with his digestion. I had to call his nurse, who said she would give the medicines to me if I came back to the floor for them. So I climbed the stairs, got the medicines, and rushed back to the cafeteria, collected Jeffrey from a table he had chosen that had no seats left for me, and we sat down to lunch.

During our conversation, he asked, “So what do you do?” And I tried to explain to a 12-year-old my job of hospital social worker, which coincidentally had earlier that week involved having a letter sent to his school asking that he be encouraged to remember to take his medicines every day before lunch. I briefly explained how, in addition to working with upset families, dealing with crisis situations, and contracting with children to take their medicines, I help people get things they need, solve problems, and find resources. And Jeffrey looked at me seriously and said, “That’s easy. You have an easy job. You just help people get stuff.”

I didn’t mention the long hours of overtime for which I do not get paid, or the doctors who ask me to do the impossible for their patients and then fail to call me back when I page them, or seeing the sad eyes of parents whose babies die. And I didn’t mention how the long hours are worth it when the doctors tell me I’m awesome, or when a child who was near death in our pediatric intensive care unit walks back into the hospital for a visit and gives me a hug. So just for you, Jeffrey—though you may not understand it all—because you asked and because the job sounds so easy, here’s a story about what I do to help people “get stuff.”

Late in the work day, I usually check with the inpatient units to see if there are any last-minute problems before I leave for the day. On this particular day about eight months ago, I went to the infant and toddler unit about 4:30 p.m. One of the pediatric doctors approached me and said, “Sometimes you seem to be able to work miracles with patients, and we have a family coming in that sure could use one. They are, to put it mildly, a social disaster. The patient is a 7-month-old baby boy who needs a liver transplant. The family has just moved to town to place the baby on the transplant list and wait for a liver. We think Child Protective Services (CPS) is involved with the family for noncompliance with medical care. The baby is very sick, the father is unsupportive, and the mother is not with it. If they can’t get their act together, the baby will have to be taken away from them in order to qualify for the transplant. We were hoping you could help us out.”

The next morning, I met the family. One of my colleagues, the social worker for the liver transplant team, had completed a psychosocial assessment, and she gave me a copy. Her job was to assess the family and recommend whether they met the criteria to be placed on the transplant list. In this case, the family was intact and consisted of
the parents, Joe and Rosa, and their four children. In addition to the baby, Nathan, they had three girls aged 5, 7, and 9. Joe worked construction and Rosa took care of the children. Joe’s family lived in a city about two hours away. Joe and Rosa had recently left that city to be closer to the hospital for the liver transplant. They had a small two-bedroom apartment and one old car. One of baby Nathan’s problems was “failure to thrive,” meaning that his height and weight were below the fifth percentile for his age. The transplant team’s assessment was that Nathan needed to improve his nutritional status and gain weight before he would be eligible for the transplant. I decided my job was to do what I could to help the family meet those criteria.

I spent a lot of time that morning talking to Rosa about her problems in caring for Nathan. She explained, “This is so hard. I have to do it all myself. Joe doesn’t help. Nathan cries all day to be held. I have three other children to take care of. I have to cook, clean, wash clothes, shop, and carry Nathan around all day. Joe comes home at night and wants to know what I did all day. Why is the apartment so dirty? Why isn’t dinner ready? Joe’s family lives 2 hours away, but no one will come and help. They didn’t even help when we lived there. Everyone thinks I should be able to do this on my own. But I am just so tired.”

Then I talked to Joe, who said, “I have to work in order to make money to provide a home and food for my family. If I don’t work, I don’t get paid. Then where do we live, what do we eat? I work hard all day, sometimes 10 to 12 hours. I come home, the apartment is dirty, there’s nothing to eat, the baby is crying. My wife should be able to take care of the home while I work. I’m so tired when I get home.”

After talking to them, I realized this was a story I hear all the time from families of chronically ill children. Caring for a child with complicated medical needs takes so much time and energy that there can be little left for the basic necessities of life. Caring for a sick child places added stress on a family, especially when that family is already stressed from inadequate resources, poor finances, and isolation. The problem is even worse for a single parent. How does a single parent work and meet the health needs of the child? How does a single parent find a childcare worker who can administer medication, perform treatments, recognize emergency situations, and not cost more than the parent earns at work?

In talking with parents of chronically ill children, I have often brought up the subject of counseling. Rosa gave the common response to this suggestion: “I’ve had counseling. The counselor says, ‘Tell me all your problems.’ So I do. Then the counselor says, ‘Now don’t you feel better?’ Well, I don’t. I don’t need to talk about my problems, I need to do something about them. I don’t need someone to talk to, I need someone to hold this baby so I can cook dinner.” Rosa’s experience with her chronically ill child is similar to that of parents with other disabled children (King & Meyer, 2006). Moersch (1978) observes:

Parents need the understanding of professionals, but they also need concrete services to help them in managing and living with the . . . child. Some parents . . . have reported that they always had plenty of people to talk with them about their feelings . . . but it was very hard to find someone who could tell them what to do with feeding, toileting, or behavior problems.
It is even harder to find someone to help do those things with the child. A social worker is in a unique position to help the family find whatever resources are available to help the family cope. In working with chronically ill children and their families, the use of social work does not change the course of the disease, but it does help families address the cumulative impact of the challenges they face. A central role for the social worker is in linking services to the needs of the child and family—with a focus on not just the child but the entire family facing the crisis.

My first task was to assess the family’s current resources. They had a place to live, the baby had the state’s healthcare insurance, the father had a job, and the baby was receiving Supplemental Security Income ($484 per month), which is available to families caring for a chronically ill, disabled child. In their hometown, the state’s health insurance plan had assigned a case manager to the family to help with resources. After meeting this overwhelmed family, however, that case manager had called Child Protective Services (CPS). The CPS worker concluded that the family was doing the best they could under the circumstances. CPS offered the mother a parent aide, but then the family moved to our city and CPS closed the case. The family was very angry at the insurance case worker. I usually try not to get CPS involved when a family is apparently doing their best with what they have. In these situations, I involve CPS only as a last resort when all else has failed. Calling CPS, as this case illustrates, risks alienating the family from the healthcare team. Joe asked for a new case worker from the insurance company.

After investigating all of the above, I assessed that the following services might be available to this family:

- A local children’s shelter provides volunteer parent aides to visit families who are at risk once a week. I called this service, and they were willing to move Nathan’s family to the top of the waiting list and assign a parent aide immediately.
- Being diagnosed as “failure to thrive” placed the baby at risk of developmental delay and made him eligible for Department of Developmental Disabilities (DDD) services. These services include home visits by a developmental specialist, case management, and respite care in the home. I made a referral and asked them to expedite the intake procedure.
- The state provides long-term care benefits to patients with chronic illness and disability. These benefits include home nursing, physical therapy, occupational therapy, and respite services. I started the application process.
- When parents are in the hospital with a sick child and spend most of their day with that child, they often have to eat in our hospital cafeteria. This expense can add up over time. I gave families a meal ticket to eat in our cafeteria when they have no money, are from out of town, and sometimes when I just can’t think of anything else I can do for them. I gave Nathan’s parents a meal ticket for lunch in the cafeteria about once a week.

The baby was discharged home. I thought the family now had some concrete resources to help them meet their child’s healthcare needs. However, things did not turn out as I had planned. Rosa contacted the parent aide program and decided that because the aide would only come out and talk to her and not hold the baby while she cooked, she did not need this service. Rosa failed to return the calls of the DDD intake worker and never set up an appointment. Rosa tried to keep her appointment with the
long-term care office but got lost on the way and never found the office. Joe lost his job and had to go on unemployment. Nathan missed two doctor appointments because Rosa forgot one and didn’t have transportation for the other.

The baby was then readmitted to the hospital, still losing weight, and started on tube feedings through his nose into his stomach. The doctors were now very concerned about the family’s ability to cope with these tube feedings at home. I began to worry about the family’s ability to properly care for the baby. Families can be overwhelmed, but they still must find a way to meet the needs of the child, or that child may be in danger.

The medical team wanted to consider other placement options for Nathan outside of his home. There was discussion of a CPS referral. The team agreed that the baby needed a placement where he could receive the appropriate medical care and gain weight. However, in this situation, as in many, the child was so bonded to his parents that removing him from his home would possibly do more harm than good. As well as medical care, Nathan needed his family’s love to get him through a major transplant surgery. In addition, we had a good relationship with this family, and I did not want to jeopardize that relationship by making a CPS referral. As sometimes happens when I am faced with the decision of whether to call CPS or not, I began to think I should have become a nurse instead of a social worker, but then I consoled myself with the idea that as a social worker I get to work with families and patients, but I don’t have to deal with bodily fluids.

We decided to hold a meeting with the family and the involved physicians and social agencies. We drew up a contract with the family. We set weekly doctor appointments for the same day and time each week, alternating one week with the pediatrician, the next with the specialist. We set down in the contract exactly what was expected of the parents in caring for their son. I listed the set doctor appointments and phone numbers to call in case of emergency. I listed instructions on how to get transportation to appointments by calling the insurance plan 24 hours in advance. I gave Rosa a calendar with her appointments written on it. I gave her a notebook with paper and pencil to list her questions for the doctors. I included all instructions in this notebook, along with the contract and the calendar. I also included food logs to list exactly what she fed Nathan each day.

I set up Home Health to come out daily to check the tube feedings, weigh the baby, and look at the food logs. I convinced the insurance company to use our hospital’s home health agency, even though the insurance did not contract with them, so that Nathan would be seen by one of our pediatric nurses instead of an agency nurse who might not have the appropriate pediatric experience. I had DDD do their intake at the hospital with Rosa. I had the long-term care worker do a home intake so Rosa did not have to drive to their office. I gave Rosa a copy of Nathan’s medical records to give to the long-term care worker and expedite the process.

The baby was again discharged. Rosa lost the medical records and could not master tube feedings. She could not reinsert the tube herself when it came out. Instead of calling for help when the tube came out, she would wait for the nurse to show up the next day to reinsert the tube. As a result, Nathan missed valuable feeding time. The baby was readmitted, still not gaining weight.
This time, with the parents’ permission, I gave the medical records to the DDD intake worker. Then, since Joe was still out of work, we encouraged him to become more active in his son’s care. So Joe slowly became Nathan’s primary caregiver. Because he was out of work and spending so much time at the hospital, Joe began to ask for a meal ticket every day. And to encourage Joe to continue to participate in Nathan’s care, I gave him one. I began to see Joe and Nathan on a daily basis then, as Joe would wheel his baby down to my office in a wagon to get his lunch ticket and while Joe sang he would move Nathan’s arms to make the baby do the Macarena. Rosa visited too. Because Joe was now caring for Nathan, Rosa began to talk about going to work to support the family. Together we explored her options for employment. We discussed her providing respite care for disabled children in her own home. We discussed her becoming a patient care technician at the hospital. We discussed her returning to school to improve her secretarial skills. Then one day Rosa asked about how to become a court interpreter. She was bilingual in English and Spanish and thought this was a job she could do. I made several phone calls, found a training program that offered financial aid, and gave her this information with my encouragement.

It was time for Nathan to go home again, but now he was being fed through a tube directly into his bloodstream instead of through his nose into his stomach as before. I talked to Joe about an out-of-home placement for Nathan. There is a house in our town that provides care for children with complicated medical needs. I encouraged Joe to consider this option so Nathan would gain weight and get his liver transplant. Joe was furious that I would suggest a “nursing home” for his son. Joe insisted that, with proper training, he and Rosa could learn to adequately care for their son. So the doctor and I decided to try to place Nathan at a special care unit at another hospital. The unit could provide intensive discharge training for the family and assess the family’s ability to care for the baby themselves. But Nathan’s insurance did not have a contract with that hospital. We had to call the insurance plan and try to convince them that Nathan needed to be transferred to the other facility. They said no. We called again. We wrote a letter. The doctor called the medical director of the insurance plan and finally the insurance agreed. Nathan and Joe went to the special care unit, and Nathan was discharged to his home within a month.

Two weeks after this discharge from the special care unit, the home health agency called to say that Rosa had been discussing future plans with her home health nurse. Rosa planned to enroll in the court interpreter program, get a job, and then divorce Joe. The agency also reported that Nathan’s sisters were not attending school. Everyone was in a panic over this information. If Joe and Rosa were having marital problems and getting a divorce, it would jeopardize Nathan’s chances for getting a transplant. Someone had to talk to the family about getting counseling and sending the girls back to school. I thought about trying to get the hospital to authorize a social work visit at Nathan’s home, since I do not usually provide this service, but then the baby developed an infection and was readmitted to the hospital. Rosa assured me she would send her daughters back to school. Joe began to approach me about meal tickets again. However, I had used so many that we were running out of funds, and all I had to offer him were $1 discount coupons. He scoffed at them: “What can I get with this? Soup? I need more than that. Look, I’m down to my last $20. Oh well, it’s better than nothing. Want to see Nathan do the Macarena?”
Shortly after this, Joe found a job and went back to work with a better understanding of how difficult and time-consuming Nathan's care could be. The family asked me to help them find a bigger apartment. They had contacted a local agency that helped families of Mexican heritage with housing. I wrote a letter about how Joe and Rosa were working together to care for their child and needed a bigger place to live. The agency gave them a subsidized, three-bedroom apartment. Joe and Rosa moved into their new place and stopped talking about divorce.

Then a DDD case manager called me and said she had been assigned to the family but could not find them. I asked her to come by the hospital to see the family and get their new address and phone number. This case manager helped with the long-term care application, and Rosa finally got DDD services, long-term care services, and someone to provide respite and hold Nathan while she cooked. Nathan was discharged, and we did not see them again for a long time.

One day their doctor, the same one who initially approached me about the family, stopped me in the hall and said, “You know, Nathan is a real success story. His family really turned around and is taking great care of him. He's gaining weight, he's on the transplant list, and now all he needs is a liver. You really are a miracle worker.”

I think to myself, “Sure, I am a miracle worker and this job is great when a child gets well and walks back in to give me a hug, but sometimes it is not so great.” Remember, all the psychosocial intervention that I can offer cannot change the course of a chronic disease.

Nathan was readmitted to the hospital for the last time about a month ago. He was so jaundiced from his liver disease that he looked as if he could glow in the dark. The doctors decided to keep him in the hospital until a liver became available for him so that he would be at the top of the list. Then Nathan got an infection and began to decline and was transferred into intensive care.

At this point, everyone realized that Nathan was dying—everyone except his mother. I went to see her after the transplant doctor talked to her about the baby being taken off the transplant list.

Rosa said to me, “The doctor told me that Nathan is going to die, but I don't believe him. I know God will save my baby. He will get over this infection and then get stronger and then get his transplant.”

I couldn't argue with her. I remember hearing a mother of a seriously ill child telling another mother one day, “You have to be strong for your child. You have to believe that he will be okay. It's the only way you can get through it. You have to believe he will get better or you simply can't deal with it.”

So I said to Rosa, “You understand that your son is very sick and that what he needs now is a miracle?” She nodded, and I said, “Well, we all hope you get it.”

Sometimes facing a child's death is just too hard for parents, and they need to have hope until the very end to get through it. Because I was at a loss this time for what to do, I gave them a meal ticket. Joe said to me, “So my son has to get this sick in order for me to get a decent meal around here.”

Soon afterward, Nathan developed another infection. The doctors talked to the family again about the lack of hope in this situation. They explained to the family that the baby
was being kept alive now by machines and drugs that were only postponing his death. Faced with this information, the parents decided to disconnect the machines and stop the drugs. When I went in to see Rosa, she said to me, “How will I get through this? I’ve never felt love like this for anyone. How can I let him go? What will I do with his new shoes?”

So I called Nathan’s doctor, and he came and knelt down beside Rosa and gently explained exactly how the staff would disconnect life support and what would happen. We encouraged her and Joe to hold their baby and sing to him. When the staff was ready to disconnect Nathan from the machines, Rosa looked to me and said, “Am I going to be okay?”

I don’t usually give advice, but I nodded and said, “Yes, you are going to be okay. I know you can get through this for your baby.”

So the staff turned off the monitors and the machines and the medications, and we left Rosa and Joe holding Nathan and singing to him as he died peacefully in his parents’ arms.

Afterward, I went back in. The nurse was taking the baby from Rosa to place him back on the bed, but he was still hooked up to tubes and wires and difficult for the nurse to manage. She looked to me and said, “I need help, take him.” So I held out my arms and took the body of the baby from the nurse and felt something cold and wet on my hands and realized that as a nurse she was wearing gloves that protected her from bodily fluids, but as a social worker I was not. We put Nathan back on the bed, and his mother washed him and dressed him in an outfit from home and put on his new shoes. We gave her a quilt to wrap him in. We took pictures for the family. We made a set of Nathan’s handprints. While Rosa stayed with Nathan, I spent some time with Joe and discussed funeral options and grief counseling for the family. Then at the family’s request, I told Nathan’s sisters that their brother had died.

Finally, the family packed up Nathan’s belongings and came by my office to say goodbye. Nathan’s youngest sister was holding a bear. “Watch,” she said, and she pressed the bear’s paw and the bear sang “Hey, Macarena.” That’s when I cried.

So, Jeffrey, as you can see, I can help people get stuff. In fact, sometimes it seems that I can do miracles. But you are right, that is the easy part. I can get an insurance company to buy a $20,000 piece of equipment for a patient; I can get a pilot to fly a child to doctor appointments monthly for free; I can get a stressed, single mother 8 hours a day of attendant care for her child so the mother can work. But I can’t do the hard part, as Joe reminded me one day when I asked what he needed, if he wanted to talk. He said, “I need for my child to not be sick anymore. I need for him to live. Talking about it won’t make him better. But I could use one of those lunch tickets.”

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Case Study 1–3

A Strengths-Focused Approach to Community Development

JEANNINE K. CHAPELLE

Community development is a social work strategy to improve people’s lives by enhancing certain aspects of the life that they have in common. This case study describes an effective approach to community development that leads to obtaining specific goals for the community as well as the development of the community’s capabilities—in particular, the leadership capabilities of the community members.

Questions

1. How is a strengths-based perspective used in this case study?
2. What made the community development project successful in this case?
3. How did the social worker get the community involved in community development?
4. What role do you think community development can play in the social service agencies you are familiar with?

Community development is at once an art and a science. Its medium is the quality and character of human cooperative action. Its methods of investigation, intervention, and evaluation conform to rigorous standards. The success or failure of a community development project is as much influenced by the rapport and mutual respect the
change agent establishes with the community as by the theoretical framework within which the agent operates. Practitioner beliefs about the competence of community members to participate in the change process determine the approach they take and the outcomes they expect.

This case study examines how a strengths-focused approach to community development produced positive results in an urban area in the Southwest, which I shall call Sandstone City. The reader will walk the journey with one of the participating families and observe their growth and development through the community change process.

WHEN WE ONLY LOOK AT THE PROBLEMS

Historically, most community work has taken a problem-focused approach, which Griffen-Wiesner calls Needs Mapping (Griffen-Wiesner, 2005). The change agent trained in this approach enters the community and conducts an assessment to determine the presence and degree of dysfunction and maladaptation (which may be reflected in high crime rates, drug use and trafficking, domestic violence, or many other indicators). The key questions asked are, “What is wrong? How do we fix it?” The change agent analyzes the data from the needs assessment, perhaps presenting the results to the community at a public meeting, and suggests a course of action in which the community is encouraged to participate. The change agent is often in a position to acquire grant monies and other resources to support justifiable interventions, monies that will likely be granted to service providers rather than community residents. A neighborhood with a high degree of dysfunction will capture more resources, thus its members are encouraged to uncover and publicize their problems (Griffen-Wiesner, 2005). Evaluation strategies are designed to measure changes in frequency and intensity of problem behaviors. Approaching community development from this perspective, the focus is on the relative presence or absence of dysfunction. Behaviors that support health and well-being often go quietly unnoticed.

When I entered the high-risk neighborhood in Sandstone City, the residents were already weary of research and community development. In the words of Jasmine, a 35-year-old single mother of two young sons living on Aid to Families with Dependent Children (AFDC):

I’ve lived in this neighborhood all my life. I don’t know why they’re sending someone else in here. We’ve had enough of that already. Nothing ever happens. Oh, yeah, they ask us what we want, get folks all fired up. Sometimes things are better for a while. But then the money runs out, they leave, and we’re just where we were before. Nothing ever changes. I don’t guess it’ll be any different this time.

On the continuum of human services, the process of Needs Mapping described previously has value. It gives the change agent baseline data, identifies service needs, and provides a point of departure for appropriate intervention. But Jasmine has pointed out the dark side of a project that is expert-driven and problem-focused, where neighborhood residents are the recipients of services rather than active participants in planned change. Kretzmann and McKnight (1993) describe it this way:
Many lower income urban neighborhoods are now environments of service where residents come to believe that their well-being depends upon being a client. They begin to see themselves as people with special needs that can only be met by outsiders. They become consumers of services, with no incentive to be producers.

**WE MISS SEEING THE STRENGTHS**

The missing element is the vast resource of the community itself. Residents know their community's history and are well aware of the needs that exist. They have witnessed the development of problems over time, know what has been tried before, what has failed, and most likely why it did. Each community resident has strengths: a lifetime of experiences, knowledge, and acquired skills. Locating and mobilizing these strengths for community development is what Griffen-Wiesner calls Assets Mapping. Here the role of the change agent shifts from expert to partner: One who helps create a supportive environment that encourages participation, facilitates the expression and implementation of ideas, and promotes beneficial alliances with people, agencies, and organizations that can provide resources to the change process. Within this perspective, people are viewed as competent contributors (Benard, 2012; Griffen-Wiesner, 2005; Henderson, 2007; Saleeby, 2012).

The goal of community development should be to engage community members and their organizational partners in an active, ongoing process of creating conditions and fostering personal attributes that promote the well-being of people (Hardcastle, 2011). The key question to be answered is, “Under what conditions do people in communities experience well-being?” This is very different from asking the question, “What problems need to be fixed?” It represents a search for strengths rather than deficiencies, successes rather than failures, competence rather than inability, and pushes development toward self-sufficiency rather than dependency. The question urges us to identify and do more of what works.

More than four decades of research on resiliency has given us reliable information about the characteristics of conditions that support human well-being. They include the following (Benard, 2012):

- The community is organized to provide networks of social support for its members.
- Needed resources are available (healthcare, housing, education, recreation, etc.).
- All members (youth and adults) are valued as resources and contributors to community well-being and have meaningful opportunities to use their knowledge and talents for the community’s benefit.
- Families, community, schools, and other social institutions share power and collaborate for positive change.

With the essential elements of a strengths-focused approach to community development in place, let us turn our attention to Sandstone City and the neighborhood development project undertaken there.
THE COMMUNITY CONTEXT

Sandstone is a city in the Southwest desert with a population of about 300,000 people. It is located in a drug-trafficking corridor, with easy access from Mexico by interstate highway. The city’s population is becoming increasingly diverse; however, the majority of that diversity occupies only a few neighborhoods in Sandstone City. Those neighborhoods define a high-risk corridor that bisects the city, according to numerous police, city, and university studies.

The neighborhood chosen for development is home to about 1,000 families. Only 20% of the residents in this census tract define themselves as Caucasian. The remainder make up a rainbow of ethnic diversity. This neighborhood’s unemployment rate is twice that of Sandstone City, with a median income less than half that of the city as a whole. Its children are half as likely to graduate from high school and twice as likely to drop out. By all measures, the neighborhood is considered to be at high risk.

Residents have seen many intervention programs come and go. A social service agency, which I shall call the Mountain Center, is located adjacent to the neighborhood and offers a large menu of services, including GED classes, home repair, emergency food boxes, assistance with utility payments, and subsidized childcare. Long before the doors to the Mountain Center open, neighborhood residents who need services line up in front of the building. If you happen to be waiting with them, you will see children running and yelling exuberantly in the cool morning air, women clutching electric bills, pink slips, landlords’ letters—telling their troubles to those standing near them as if rehearsing for the intake and assessment clerk inside. It was there I first saw Jasmine. She caught my attention because of the contrast she provided to the chattering crowd. Her children were under her affectionate but strict control. Together they seemed to form a bubble of family space that outsiders were not invited to penetrate. I waited quietly with the others for the doors to open, to begin my first day employed by the Mountain Center as a neighborhood program developer.

SANDSTONE NEIGHBORHOOD PROJECT—FIRST CONTACT

Based on my knowledge of anthropology and community development, I chose to enter the neighborhood as a learner and participant in community life. My first task, to discover the families with children in this neighborhood, was accomplished by hosting a neighborhood party for kindergartners and their families. Crafts, face painting, clowns, games, and food produced an impressive turnout, and many names with telephone numbers on a sign-in sheet. A videotape of the party was the first documentation of the project.

My second task was to contact those families after the party to arrange interviews to learn about the neighborhood and the issues about which people were most concerned. This would also give me the chance to explain my role.

Jasmine’s name was in the middle of the list. Her youthful voice on the other end of the telephone line sounded suspicious. I explained who I was and why I was calling. The
long pause and slow, deliberate monosyllabic response did not bode well for successfully scheduling a meeting. When I mentioned that I got her name from the kindergarten party list, she became excited. She asked, “Do you have the videotape? Can I see it?” My positive response clinched the interview.

As we watched the videotape together, I realized that one of Jasmine’s great strengths was her passion for her children and her burning desire to give them opportunities to learn new things. I wondered if this commitment might extend to other neighborhood children. As the tape rewound, Jasmine cast her eyes downward and seemed embarrassed. “I don’t know why I came. I don’t usually do things like this. I don’t know what made me say yes to this interview.”

I asked a series of open-ended questions designed to elicit her views about the most important issues in the neighborhood. I included questions that set the stage for community development: “What can families do to start to solve the problems you face in this community?” and “What people or organizations can help families?” By encouraging people to tell their stories in a reflective manner, they are likely to produce narratives that move them to consider the possibility of action (Seidman, 2005). Jasmine didn’t know what families could do about the community’s problems, but she thought that getting together to talk about it might be a good idea. I thought that was a good idea, too.

THE FIRST 6 MONTHS

After collecting information through neighborhood interviews, we held our first meeting in the recreation facility at the Mountain Center. By unspoken agreement, this was a dress-up occasion. Jasmine appeared self-conscious in her pretty skirt and blouse, and her feet seemed unaccustomed to walking in her midsized heels. Many of these women had lived in the neighborhood all of their lives, yet few knew even one other person in the room. I kept the atmosphere informal, imposing no structure. Although we sat in a circle, Jasmine was able to isolate herself from the others by keeping empty chairs on either side of her.

We talked about our families, one thing we all had in common, while the children played outside. Then one of the elders who had been quiet spoke, “It’s hard being a mother,” she said. “Take Mrs. Johnson’s 17-year-old granddaughter. She just had a baby, and her mother was so mad that she threw her out of the house. Mrs. Johnson, bless her, took her and the baby in, but that young girl doesn’t know the first thing about raising a baby, and doesn’t have anything for it.” She concluded, “It just breaks your heart.”

I watched with fascination how the group changed following this story. The guarded politeness that had characterized the beginning of the meeting was dropped. Women leaned forward, listening intently. They began to talk about what they could do to help this young girl. One offered baby clothes that her son had outgrown. Another knew a place that might donate diapers. Yet another said she would crochet a nice blanket. When the “virtual” box of baby items was complete, the room grew quiet again. I took this as my cue to ask, “I wonder if it might be helpful for this new
mom to be able to talk to some experienced mothers?” After a pause, the excitement returned:

“We could go see her and let her know we’re there to help her learn to take care of that baby.”
“I know I was scared when I had my first one! I was sure glad my momma was there to tell me what to do.”

Soon the plans were made for the whole group to call on the young mother and welcome her baby to the neighborhood. The Baby Box project was born.

After that first Baby Box delivery, the community grapevine was abuzz. Calls began to come into the Mountain Center informing us of recent or impending births and asking if boxes could be made. One of the volunteer mothers took responsibility for gathering and storing the needed items. Although she could have assembled and decorated the boxes in her home, she chose instead to bring all of the materials to the Center. Other mothers, including Jasmine, began to drop by to see if a Baby Box was under construction and to offer their help. With quiet efficiency, each person offered her talents to the project: Thelma was renowned for her pretty rainbow blankets made from the leftovers of many skeins of yarn; Sherry made a weekly visit to used clothing stores to collect the baby clothes that didn’t sell; Connie made sure the local merchants saved their cardboard boxes for her; and Tina just had a knack for decorating them.

I asked once if they wanted to have requesters fill out a card with their names, addresses, and telephone numbers so we could keep track of them. Their reaction was immediate and unequivocal: No forms! “We have to fill out enough forms at welfare and every other place. No one who comes to us will ever have to fill out a form!” Although such a procedure would have given them useful information, they clearly did not want to replicate a system that many felt robbed them of their dignity. I respected that; this was their project, and they could make the rules. In the first 6 months, 10 boxes were delivered by this grassroots social support network. No funds were allocated to the Baby Box project—the volunteers managed it through their relentless quest for donations.

The group continued to meet on Friday mornings. Although Jasmine didn’t often initiate conversation with the others, she responded pleasantly to inquiries about how her family was doing. Her children became fast friends with the sons of another woman who came regularly. Jasmine smiled more and seemed to be more comfortable with the group—but her chair was always the closest to the door.

**THE SECOND 6 MONTHS**

When Jasmine arrived at the Mountain Center recreation facility one Friday, about 6 months after we had begun meeting, a lively discussion was well underway:

“Do you remember that box we delivered to Mrs. Scott last week? She asked me how could she get help to get her mother’s house fixed. There was water all over the floor in that last rain we had.”
Tina joined in, “I know what you mean. I’m always getting asked for advice. My neighbor always comes and talks to me about her sister and those devil drugs. She wants her to get help so bad. I wish I knew better what to tell her.”

Connie spoke emphatically, “We need to know how to be better resources to our neighbors.”

“What would need to happen to improve your ability to be neighborhood resources?” I asked.

“I guess we would need training,” said Connie.

That simple conversation launched an impromptu planning session about how this could be accomplished. My questions to the group included: What kind of training would you need? How many topics should be covered? What agencies do you know in town that have this expertise? Where would the training take place? Who should come? By the end of the morning, a plan was in place. They identified six social service agencies that might be potential resources, and Tina volunteered to set up meetings. The group wanted to hold classes in their homes, “like a Tupperware party,” rotating the responsibility for hosting among them. To my surprise, Jasmine asked if the first class could be at her house.

As they completed their plan, I reflected on the changes I had seen in my 6 months working in this neighborhood. That first experience of success with the Baby Boxes gave this group of volunteer mothers the confidence to tackle even bigger issues. They had formed the habit of thinking in terms of community conditions and had learned a simple planning process that they could use to take action on any issue of interest to them. I did not have to organize them; they organized themselves when they perceived that they were in an environment where people valued them and believed they had something important to contribute. Their unfailing attendance at the Friday morning meetings and their participation in the projects they designed convinced me that such an environment is addictive. With sufficient dosage of this supportive milieu, they began to discover strengths they didn’t know they had and to take some risks they would not otherwise have attempted. Jasmine had predicted 6 months earlier, “Nothing ever changes. I don’t guess it’ll be any different this time.” But this time the focus had shifted from deficiencies to individual and community strengths. The community was being supported in taking responsibility for its own well-being. And that was making all the difference.

A SELF-ACTUALIZING COMMUNITY

The Sandstone neighborhood development project continued to innovate and grow in its second year. The Baby Box project had welcomed more than 65 new babies to the neighborhood and proudly displayed their pictures on a special bulletin board in the Center. Women called to sign up as soon as they discovered they were pregnant. Many of the recipient mothers volunteered to visit other new babies and their families because they wanted to give back some of the support they had received. A local nonprofit family resource center was so enthusiastic about the
project that they provided scholarships to the Baby Box families so they could attend infant massage workshops. The donations of baby clothes grew to include children and adult sizes, so a neighborhood clothing bank was opened and staffed by neighborhood volunteers.

The group completed the training they had designed, which included sessions on locating resources and making referrals, effective communication, the early warning signs of drug abuse, and effective parenting. A local foundation, impressed by the neighborhood’s proactive projects, awarded scholarships to three volunteer mothers to attend a 2-day facilitator training given by a renowned international organization. Soon afterward, the leadership for Friday morning meetings began to rotate among the members. Coordinator position descriptions were written for the volunteer work that occupied most of their energy, including Baby Boxes, donations, and youth and family recreation.

In the summer of the second year, the issue that emerged in the circle’s discussion was a concern about how to keep elementary and middle school–aged children occupied and out of trouble during summer vacation. The Sandstone neighborhood group collaborated with Junior Achievement to bring their youth entrepreneurship program to the neighborhood. New faces blended with familiar ones as parents were recruited to mentor the eager young officers of Kids’ Business Opportunities (KBO), a neighborhood babysitting business. Mentors and young entrepreneurs celebrated together at the end of the summer, when the business paid a 20% dividend to its stockholders.

The core group made outreach a priority. Proud of their achievements, they wanted to invite more people to add their skills and wisdom to the group. They were eager to share with others the joy of transforming ideas into reality, making this Sandstone neighborhood a better place to live.

LOOKING BACK: JASMINE’S STORY

The most visible consequences of development occur at the community level, but before those changes are discernible, transformation is happening at the individual level. This was particularly true in Jasmine’s case. When I met Jasmine, she was a guarded, private, young single mother on AFDC. Although she grew up in the neighborhood, she knew very few people who lived there. Most of her friends had long ago moved away. She didn’t seriously entertain the thought of working, partly because she felt she had no marketable skills. It didn’t really occur to her that her future would hold anything very different. And then, as she describes it, a “miracle” happened: She agreed to do an interview about her neighborhood.

She found herself among women who made no judgments. “They just accepted me for who I was,” she said. Over time, she laid aside the protection of her aloof, inaccessible exterior and added her talents to the work being done. Her leadership skills blossomed with each training workshop she attended. “I can’t believe I’m up here in front of these people. I never would have done that. You can ask anybody—that’s just not me.”
Jasmine had always had a way with children. “I play with them and they like me. They know I respect them and won’t put up with no stuff.” But instead of seeing this as a unique skill, she was afraid it was a sign of immaturity. At the Mountain Center, Jasmine was asked to help plan family recreation activities. She basked in the appreciation she received for planning the games, setting up basketball and other sports, and involving the young people in planning special events. When KBO started its business, Jasmine volunteered as a mentor and helped the young people decide how to market their services.

It has been 4 years since I met Jasmine. She moved away from the neighborhood after 2 years with the community development project, but we stay in touch. She wants to be a basketball coach and started taking classes at the local community college to get her AA degree. She had a great deal of trouble with her classes in high school, so she’s surprised to find how much she enjoys her college courses. “I never thought I would be able to get up in front of the class and talk, but it is just like being at the Center.” She and her children sit down to do their homework together, and she tells me she is proud that they see her getting her education. “I want them to know that learning is fun, and you can do it your whole life.” I smile as I remember that my first insight about her was her commitment to her children’s education.

Jasmine is working two jobs, each of which she loves. During the school day she is a teaching assistant at her youngest son’s school. She also works for the city’s Parks and Recreation Department as a recreation assistant in their after-school program. She credits the community development project with helping her recognize her gift for working with children. “I feel good when I’m at work. I look forward to getting up and going to work each morning. I feel like I’m really making a difference.” Even with two paychecks it is hard to make ends meet, and her family has allowed her and her children to move back in with them until she can save up enough to get her own place.

Although Jasmine no longer lives in the neighborhood, she continues to include the volunteer mothers as part of her social network. They touch base by telephone once a month and reunite to share each one’s significant life events: birthdays, weddings, funerals, or the birth of a new baby. “These women, they’re part of my family now,” she says. “We went through good times and bad together. We’re part of one another and you can’t take that away.” Indeed, you can’t.

**SUMMARY**

In a strengths-focused approach to community development, the change agent proceeds from the premise that people have the skills, knowledge, and abilities necessary to create the conditions that promote well-being in their communities. The change agent’s role is to consciously build a supportive environment that encourages people to express their strengths and participate in the development process (Baker, 2003). The art and the science of effective community development blends the formation of supportive social relationships with the focused, intentional planning necessary to bring about sustained change.
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