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Community Psychology V4.0
Invited Address to the 2011 SCRA Biennial Conference accepting the award for Distinguished Contribution to Practice in Community Psychology [2010]

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Atlantic Health System, Morristown New Jersey
June 18, 2011

Introduction and presentation by

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(www.scra27.org)

William Neigher is a community psychologist specializing in strategic planning, program development and evaluation research. He has worked in these areas with the United Nations, the U.S. Senate, Harvard University, the National Institute of Mental Health, the World Health Organization, Hoffman-LaRoche, and Memorial Sloan-Kettering Cancer Center. He has held positions in senior management and as a consultant in health and human services.

He received his B.A. with honors in psychology from the University of Massachusetts, and his M.A. and Ph.D. in psychology from Yeshiva University in New York.

He is a Fellow of SCRA, APA, and a past-President of the Eastern Evaluation Research Society, New Jersey Program Evaluation Action Association, and the New Jersey Association of Mental Health Agencies. He also served on the SCRA Finance, Fellow, Program, Cowen and Kalafat award committees, the Advisory Board of GJCPP, and as a member of the Practice, and Community Health Interest Groups. In his role as a leader in the Practice Group, Bill has put forward the concept of a Values Proposition for Community Psychology and Community Psychologists, and these have had a pivotal influence in shaping recent growth in the field. [end of quote] He has also been an active and highly valued member of the SCRA Executive Committee, the first Practice Council representative, during this past year.

[quote] His publications include articles in the American Psychologist and Evaluation and Program Planning among nearly 50 books, chapters, and journal articles. A consultant to federal and state government, he served as Chair of the Federal Grant Review Committee for the SBIR research program at NIMH under P.L. 97-219. He currently directs planning and system development for the Atlantic Health System in New Jersey, and in that context forges numerous community relationships and collaborations.

Bill is a genuine example of what a community psychologist can do from a career based fully in the context of non-academic practice settings. [end of quote] The selection committee, comprising past winners of this award, concurred!

Dr. Neigher, Congratulations!

Thank you Pat for that most kind and generous introduction.

My first thought about these remarks, to be honest, was to try to convince you that I somehow deserved this honor. But the meeting is only three days long, so that is not going to happen. I have fifteen minutes.

My name is Bill, and I am a community psychologist.

I didn't start out to be one. But I became one anyway. You can blame, or credit Emory Cowen and his work, values and support. How many of us have paid him that tribute?

Seated: Emory Cowen, John Kalafat; Standing: William Neigher, Bruce Miller, Ken Maton

The case for prevention, "baby-steps" he called it in one seminal article [his presidential address to this organization, Cowen, 1977] , was a compelling call for redirection in my career. The value proposition for ***preventing*** problems before they occurred and lessening the severity of those that presented themselves just made compelling sense.

But remarks these days should start with disclosure statements, so in that spirit let me tell you that in spite of having a doctorate in philosophy, I have never taken a course in philosophy.

And after completing my doctorate I continued to teach college. I have never taken an education course.

I most recently taught community psychology to doctoral students at The Graduate School of Applied and Professional Psychology [GSAPP] at Rutgers University. I have never taken a course in community psychology either.

And other than my times spent teaching and consulting, most of my career has been in senior management in health and human services. Guess what?

At this point you may have two thoughts:

1. Only in America; and
2. Did anyone in HR ever check his qualifications?

My doctorate is in social psychology, in Gordon Allport's words "how the thought, feeling and behavior of individuals are influenced by the actual, imagined, or implied presence of others." [1968, p3.]

Where then did I pick up the skills and competencies of our craft and our profession-- on the job; from many of you, and believe it or not, from teaching others.

What's the point here? Being an effective Community Psychology practitioner requires

- skills and competence with performing them,
- attributes that include making second order change in organizations and communities,
- and the ability, working through others, to change thought, feeling and behavior.

We are not born with them, not always trained in them, and not always good at all of them as the Value Proposition survey you heard about on Thursday (June 16, 2011) showed [Neigher, Ratcliffe, Wolff, Elias and Hakim, 2011].

But we can learn them, and together with others in different fields with shared values, try to make positive change. And we can go to The Community Tool Box for fantastic resources to apply and to teach to others [www.ctb.ku.edu].

At Swampscott our founding fathers [and one founding mother, Luleen Anderson] realized that there were not enough clinicians to treat current, let alone future problems. We would need a different paradigm, and others to help.

Today a bold SCRA vision seeks to have "strong global impact" www.scra27.org/about. With about 850 members, we will need "a bigger boat" and more to row.

One of the selection criteria for this award is someone who has managed health and human services. In other words, has done little or nothing by themselves, but has enabled the good works of others. Don't feel sorry for me; management is an honorable profession. Well, anyway it's a profession. At least it's a living.

No phony self-effacing banter here; that's what management is: "getting work done through other people."

If you think about it, the values of community psychology and SCRA have similar attributes—invest in the empowerment of others. Then again there is the messy problem of the real world.

As Kurt Lewin famously said, "There is nothing so practical as a good theory."

And I quickly learned its corollary: "In theory there is no difference between theory and practice; in practice there is." And totally unprepared for practice I was.

I always figured I would have a career as a college professor, but quickly figured out after several years of teaching at Lehman College, CUNY, that I really didn't know very much, and had done even less.

A flawed Federal initiative in community mental health, based on an inadequate social experiment in Scandinavia, richly funded and poorly executed gave me my opportunity.

President Kennedy's initiative for a "bold new approach" to mental health care in America lead to the passage of the Community Mental Health Center (CMHC) act [PL 94-63]. Those federal funds included "indirect services"—consultation and education, as well as training and research and evaluation. And in the beginning they did not have to pay for themselves; all of you subsidized by first position. Thank you.

Two psychologists profoundly influenced my career, my way of thinking about psychology, and my values and orientation as I put them into practice.

Emory L. Cowen, past President of SCRA [1975-1976] and a founder of our field developed the Primary Mental Health Project at the University of Rochester. Aimed at children in the primary grades, he used non-professionals as "child aides" to work in the classroom with kids at psychological risk.

My CMHC collaborated with a child study team leader in the Passaic NJ public schools to replicate his program. We promised an evaluation before we asked for year two funding. As things turned out our main effect was p =<.06, and I wondered on what basis we would ask for continuation support.

Charles Windle

I met Charles Windle of NIMH at a conference. Somehow or other I managed to whine about my dilemma with my "almost significant" findings. After listening somewhat patiently he said simply: "just because it isn't publishable doesn't mean it's not actionable."

A major insight beyond my immediate comprehension, he asked me what "harm" the program might do even if the odds ratio was that there were no real differences between pre and post intervention measures 6% of the time.

Chuck was a passionate advocate for citizen participation in the evaluation of the CMHC program, and influenced the transparency of how data was made public.

One of our Past Presidents in a well-regarded book on community mental health cited a dozen principles as guidelines. The final one said "regardless of where your paycheck comes from, think of yourself as working for the community." I soon realized its perilous corollary: "Think of yourself as unemployed."

Showing your organization's dirty laundry in public, regardless of regulatory directive to the contrary, will not win favor with management. In our article "Advice for Trapped Evaluators" Chuck Windle and I [Windle and Neigher, 1978] described three contrasting purposes for internal program evaluation: ***advocacy, accountability and amelioration***. Applied concurrently the ethical challenges for the evaluator were significant. By negotiating up front with administration, program directors and Trustees, the evaluator can apply one model with consistency and in the best case, impunity.

Three individuals who worked for me helped change the world, and taught me the valuable lesson of empowering others while ignoring everything I ever told them to do.

John Kalafat

John Kalafat was Director of Training and Education for the Community Systems Division of St Clares Hospital CMHC. He was my employee, friend, colleague, co-author, constant source of annoyance, and director of our Postdoctoral Fellowship in Community Psychology. During the seven years of that Fellowship we continued to teach and learn from others. One of our Fellows, Ken Maton, of course went on to become President of SCRA [1998-1999].

Seated: Seymour Sarason, Michael Siman; Standing: Ken Maton, William Neigher, John Kalafat

John was an SCRA Fellow, and a Past President of the American Association of Suicidology, John reminded me of the phrase that "forgiveness is nine times easier to get then permission." Unfortunately he was talking about me.

The SCRA John Kalafat Award celebrates his contribution to our field as teacher, mentor, trainer and researcher. Bill Berkowitz received the first award at our last Biennial; Tom Wolff and Isaac Prilleltelsky shared the award presented at this conference on June 16th.

Ed Madara conceived and developed the New Jersey [www.selfhelpgroups.org] and the American Self Help Clearinghouse , developing over 1100 groups, and serving more than 100,000 people over its 30 year history.

Self-Help Group Clearinghouse Celebrates 30th Anniversary

The Self-Help Group Clearinghouse, a unique department of Saint Clare's Behavioral Health Services that helps both lay persons and professionals to find and start community support groups, is celebrating its 30th anniversary of service with an Open House on Jan. 21st from 1 p.m. to 5 p.m. Visitors will have an opportunity to see how the Clearinghouse helps callers using its own computerized database system with contacts for over 6,750 local N.J. groups and 1,100 national, online and model self-help groups.

Clearinghouse staff and volunteers help callers find and form support groups. Pictured (l-r): Barbara White, Elaine Romito, Ed Madara, Barbara Blumenfeld, Baiba Ozols, Dr. Paul Riddleberger, Michael Reale, Wendy Rodenbaugh, Howard Lerner and Pat de la Fuente. Not pictured: Pete Ladato, Lois Fallat, Ruth Clark and Steven Sobierajski.

The Clearinghouse has helped well over 100,000 people to link with local and national support groups through its statewide helpline 1-800-367-6274, more easily remembered as 1-800-FOR-M.A.S.H. (Mutual Aid Self-Help). The peer support groups help people with most any illness, disability, addiction, caregiver concern, parenting problem, abuse experience, bereavement situation, or other stressful life transition.

The Open House is also part of "Self-Help Support Group Awareness Month," a January health observance the Clearinghouse initiated years ago to help more people learn about the wide variety of volunteer-run community support groups available, as well as the potential for lay persons to join with their peers to form needed new groups. Alongside its data on existing groups, the Clearinghouse provides callers with information on those individuals who are seeking the help of others to get new groups started in their area. Over the years, the Clearinghouse has also assisted individuals in the development of over 1,100

The *1993 Ann Klein Advocate Award* Winner in New Jersey, Ed was described this way: "Your vision of self-help shaped an international movement, touched countless lives, and enriched our values."

But perhaps former **Surgeon General C. Everett Koop, M.D.** said it best in his nominating letter:

"I don't know any single person in the United States who has done more for the self-help movement or who is recognized by more people as the individual who stands most strongly for the benefits of self-help and mutual aid."

Ed won this Distinguished Contribution to Practice Award from SCRA in 2001.

Sidney Greenwald

I hired Dr Greenwald to help us design a continuing care retirement community [CCRC], including a nursing home and independent and assisted living. Recognizing my incontrovertible lack of experience, he took me to visit one of more than 40 SNF's he had owned or operated over a long career.

We ran into an older gentleman on our tour, a man from housekeeping with a wet mop and pail. He greeted Sid warmly; they hugged. "Tell my friend Dr Neigher what you do here" Sid asked. "I'm in infection control" he said. And he proceeded to tell me with pride about getting on his hands and knees to clean behind each toilet to help protect their elderly residents from illness, and even death from infection.

That lesson, why Sid really brought me there, was that our employees need to be "owners," not "renters;" their buy in to the mission and vision of the organization is critical to success.

Joseph A. Trunfio

For most of the past three decades I've worked with Joe Trunfio as my direct report. Now President and CEO of Atlantic Health System, Joe got his doctorate and trained as a clinical psychologist. But importantly he did a postdoctoral fellowship in Community Psychology at Albert Einstein College of Medicine with SCRA's first President, Robert Reiff (who served from 1967-1968).

Seated: John Kalafat, Robert Reiff; Standing: William Neigher, Michael Siman, Bruce Miller

Joe enabled everything we did, protecting us from the medical staff when he could and helped us move from "soft" money to funded staff positions.

One person in a leadership position made all the difference. Today he directs 11,500 staff, 2100 volunteers and 2300 members of the medical staff. In the Fortune Magazine 2011 survey of America's top 100 places to work, Atlantic Health's employee ratings placed us at #54; ahead of the Mayo Clinic, Starbucks Coffee, Aflac, Adobe, and…….Microsoft.

Let me end with some thoughts about our future.

With ***health care reform***, the *Patient Protection and Affordable Care Act* [PL 111-148], comes a number of opportunities to apply the values, principals and tool kit of Community Psychology. For one, "population-based" interventions target health promotion and illness prevention—in other words, "wellness" at the community level. It addresses directly the current "perverse incentives" of reimbursement based on the volume of procedures and testing and moves us to episodes of care based on ***efficacy and efficiency.***

Enabling legislation doesn't guarantee implementation, and amendments, waivers and withholding funding will come by the truckload. But there is evidenced-based value in the more than 2400 pages of provisions in this foundational change to Federal healthcare policy.

Some of these include:

Healthcare Reform and Community Psychology

National

- Establishes **a fund for prevention** and public health programs
- Addresses **health disparities**
- Provides **incentives for the prevention of chronic disease** in Medicaid
- Creates a task force to review **effectiveness of community interventions**
- Provides training in **cultural competency** and health literacy
- Creates a plan for a public-private partnership for a prevention and **health promotion outreach** campaign to raise public awareness of health improvement across the lifespan.

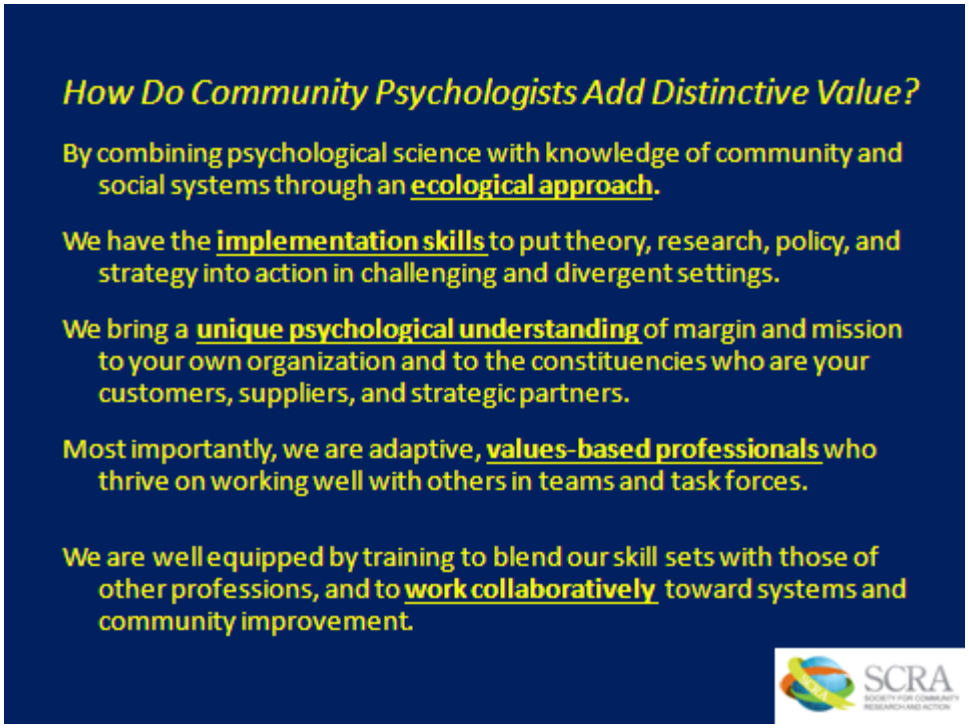
- **Interprofessional health teams**, including behavioral health, to support primary care practices
- Provide training in **cultural competency and health literacy**

- Establishes a fund to provide for an expanded and sustained national investment in **prevention and public health programs**
- **Community Transformation Grants** for the implementation, evaluation and dissemination of evidence-based community preventive health activities in settings that may include schools, the workplace, special populations and the reduction of health disparities
- **Coverage of preventive health services** without co-payment
- Coverage of **annual wellness visits and personalized prevention plans**
- Provides incentives for **prevention of chronic diseases** in the Medicaid program
- Authorizes the CDC to assist employers with **development of wellness programs** and provide grants for **community health interventions**
- Requires States to conduct **needs assessment for communities with high-risk populations** and prevalence of social issues such as poverty, domestic violence, unemployment and school drop-outs
- Authorizes a Task Force to **review scientific evidence related to the effectiveness of community preventive interventions**, and
- Creates a plan for a **public-private partnership for a prevention and health promotion outreach** campaign to raise public awareness of health improvement across the lifespan.

Several years ago an external consultant to our organization offered me some very good advice. Our senior management team was unmoved, unswayed, and annoyed by an initiative I thought ***essential***. I charged on with oblivion to the obvious indifference my attempt at changing the organizational culture had generated. He finally said to me, "being right doesn't matter here; you don't have a 'paying customer' for this. He was right. My colleague in that adventure is no longer with the organization.

Dan Fishman and I wrote an article for *The American Psychologist* entitled "American Psychology in the 80's: who will buy?" It asked the same question: is there a "paying customer" out there for our services, absent government and grantor subsidy in hard times. [Fishman and Neigher, 1982].

That was the part of the motivation for our ongoing work with the ***Value Proposition for Community Psychology***, initiated under the watch of Mo Elias when he was SCRA president.



Developed with the Practice Council, it "makes the differentiated business case" for employers to hire us. What distinguishes us in that big stack of resumes? Is it the 17 skills and competencies we say we have and practice, the context in community science we have for putting them together, or the values that underscore what we do?

The "next step" in the VP work is the 2015 Global CP employment outlook survey being pilot tested now. We will ask current and future employers from a dozen workplace settings to rate how important our skills are to them now, and in the future. That will help our training programs align the curricula, and our field to brand and position ourselves in the competition for work in the changing marketplaces to come.

My work in health and human services has focused on program development and evaluation, and on community needs assessment and strategic planning. Grounding most of this work is the guiding principles and values of community psychology, summarized below [Dalton, Elias and Wandersman, 2007]:

Part of my responsibility as Director of Planning and System Development at the Atlantic Health System is to guide a strategic planning process anchored by our Vision, Mission, and Values. [Atlantic Health System, www.atlantichealth.org] is a multi- provider health care system serving northern New Jersey. In addition to two acute care facilities with more than 1100 beds, the system includes the second largest cardiovascular program in the New York metropolitan area, a children's hospital, neuroscience and rehabilitation institutes, and comprehensive cancer center. It is the primary academic and clinical affiliate in New Jersey of Mount Sinai School of Medicine and The Mount Sinai Hospital.]

In 2009 we added four new words to our Mission Statement: "within a healing culture." The context is below:

- Deliver high quality, safe affordable patient care ***within a healing culture***
- Educate, in an exemplary manner, present and future health care professionals
- Innovate through leadership, and

- Improve the health status of the communities we serve.

A healing culture recognizes the multi-faceted nature of well-being (including physical, emotional, spiritual, social, environmental and community levels), and whose staff work in partnership with patients and their families for healing. Healing is defined as more than recovery from illness or injury; it is allowing a patient to reach his or her optimal health, with a focus on illness prevention and health promotion. How we enable our healing culture is defined by the four attributes below, relating to our Mission and Values:

Our mission change was not only a chance to re-imagine our organizational culture, but also a parallel process aimed at increasing the *adaptability of our patients, families, and communities*. We are re-framing the goal of our healthcare delivery system – we cannot always guarantee complete recovery from illness or injury; what we *can* do is enhance the opportunity for more adaptable patients.

The assumptions behind the model and its implementation initiatives are grounded in Darwin's famous observation, and in a corollary from U.S. public health data:

- "It is not the strongest of the species that survives, nor the most intelligent, but rather the one most *adaptable to change*." Charles Darwin.
- "In the United States, patients that make the best recovery from illness or injury are not always those with the most doctors or those that get the most healthcare, but rather those most *adaptable to change*." William Neigher.

For the conceptual framing model we adapted the algorithm of George Albee [Albee, 1982] on preventing psychopathology to one specifically focused on health. "***Adaptability***" is our key dependent variable: the ability to sustainably change with a dynamic environment.

Operationally, we define it as the *ratio of resilience to vulnerability*. By defining it this way, we are recognizing the individual nature of health and healing. While we can't always decrease an individual's vulnerability to illness, we can help enhance the numerator, increasing their resilience and in turn their adaptability, by connecting them to resources, teaching coping skills, and otherwise intervening along the continuum of care to promote healing. Here below are the three constructs with their operational definitions:

- ***Adaptability***: in this model the ability to respond to continuing challenges to health status.
- ***Resilience***: The ability to bounce back from injury, illness, or adversity.
- ***Vulnerability***: Combined present or future risk of adverse change to physical, psychological, environmental or social status.

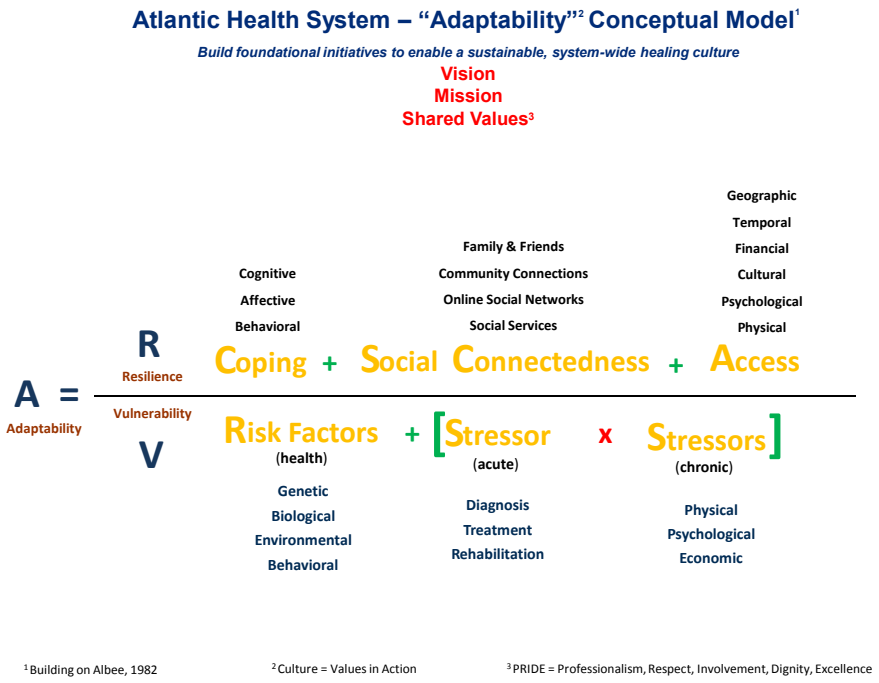
Resilience has in turn three defined elements:

a. ***Positive Coping***: Managing the physical and emotional challenges that accompany an illness or injury and their progression over time.
b. ***Social Connectedness***: The characteristics of social relationships (quantity, quality, diversity and strength) and their perceived or potential social support.
c. ***Access***: The ability to get timely, appropriate, patient-centered services across the continuum of care.

Vulnerability also has three elements:

- ***Health Risk Factors***: Elements that increase an individual's vulnerability to poor health or outcomes during treatment or recovery.
- ***Stressor (acute):*** The physiological or psychological factors that accompany an individual's current health status.
- ***Stressors (chronic):*** The "baggage" we bring to current threats to our health status--chronic physical or psychological conditions in the context of everything else that is going on in our lives.

These constructs and elements come together in the conceptual model below, along with their dynamic relationships:



[1] Building on Albee, 1982 [2] Culture = Values in Action [3] PRIDE = Professionalism, Respect, Involvement, Dignity, Excellence

SCRA 4.0

In the basement of the Strand bookstore on 12th St and Broadway in the New York City's West Village there was a "remainder bin" for unsold new and used books. Browsing one day, a familiar cover caught my eye—the first book I had done. A closer look confirmed it, offered for resale at 99 cents. I was somewhat distressed that a project I had

worked on for years was now worth only 99 cents. And then the second blow to my ego arrived: even at 99 cents there were no takers!

And it's that exact figure, 99 cents, that centers the end of this talk.

In Thomas L . Friedman's book *"The World is Flat"* [Friedman, 2006] he describes "uploading; harnessing the power of communities" as one of the stages of internet development. From downloading, to uploading, to an interactive web experience in real time the internet is one of the forces that now creates a worldwide "level playing field."

How many of you have a "smart phone?" How many "apps" are on it? On my iPhone is one called "Around Me." When I touch it gives me categories like "hospitals, banks and coffee." There is a Starbucks 400 yards from here it says, and its navigation is information, location, directions, and assistance in getting me there with interactive GPS.

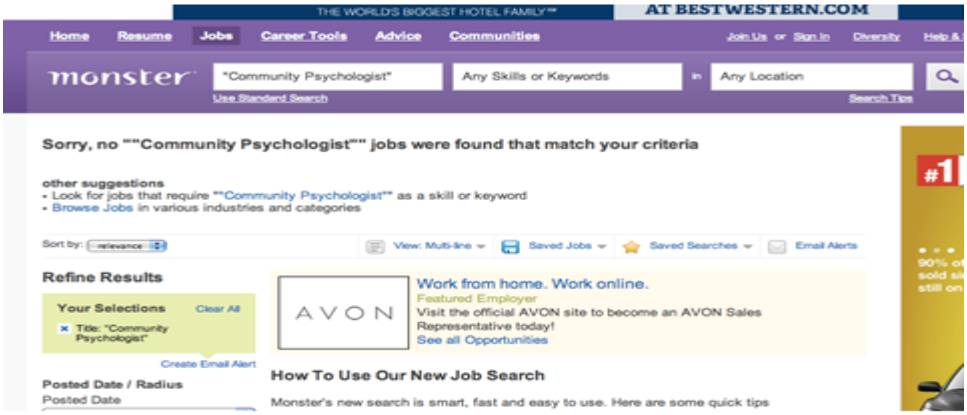
There is a lot you can get for 99 cents today; and many applications you can download for nothing. SCRA, like many organizations, has evolved since our inception. Perhaps the first three stages could be conceptualized as "define and differentiate" [V1.0]. The second might be "proof of concept" [V2.0], and the third "translational impact" as we measured the effectiveness of our interventions in ecological perspective [V3.0]. But what is next? What would ***SCRA 4.0*** look like?

Imagine if you now were to touch an ***app with the SCRA logo.*** Where would it take you today?

- To resources like the ***Community Tool Box?*** www.ctb.ku.edu
- To our website or ***Facebook page?*** www.scra27.org
- To the ***Global Journal of Community Psychology Practice?*** www.gjcpp.org

Just what you could get on your laptop. But what if…it could connect you to virtual communities, instantly welcoming new members or inquiries, working on simultaneous solutions to community issues. Think about what that app could do, and how we could create its demand. Is the Value Proposition community psychology brings to the public today worth their investment of time, interest, and perhaps even 99 cents?

But with all the promise there are challenges ahead:



- ***Craig*** doesn't have a list for us, and Monster.com can't find us a job.

- Past presidents describe SCRA as ***"high relevance and high invisibility;"***
- and since 1983 we've ***lost two thirds of our APA members.***
- SCRA's vision of ***"…strong, global impact"*** remains challenging.

All are opportunities for positive change, and the challenge all of us share as stewards of this field of community science. We have exciting new tools and others to collaborate with:

Our Global Journal of Community Psychology Practice can reach over a billion people today with smartphones, with a "publication lag" in nanoseconds.

Margaret Meade said of course that *"all it takes is for a few concerned citizens to change the world. In fact, it has never happened any other way."*

I've been fortunate to have known a few of those people. Some are at this Biennial; as are some I think who have not done it yet but will. That would be you.

It's why I think Emory Cowen signed his letters with "ameliora, Emory" and why the Jewish value of "tikkun olam," perfecting the world, still speaks so clearly to the promise of our field.

Molly and Abe Neigher, my parents, were never exactly sure what a community psychologist was. But through their example of how they put the values of our family and our faith into practice, they would have made great SCRA members. To them I am profoundly grateful.

And to Susan, Aaron and Debbie Neigher, who constantly remind me that "I am not funny," my unconditional love.

This award is greatly appreciated, and a wonderful incentive to "keep practicing" until I get it right.

A video of the Award presentation and remarks can be found at http://www.scra27.org/neigher_award

References

Albee, G. (1982). Preventing Psychopathology and Promoting Human Potential. *American Psychologist*, 37(9), 1-43-1050.

Allport, Gordon. (1968). The Historical Background of Modern Social Psychology. The Handbook of Social Psychology [2nd Ed.] Gardner Lindzey and Elliot Aronson, Eds, Vol 1, p 3. Reading, Massachusetts: Addison Wesley.

Cowen, E.L. (1977) Baby-Steps Toward Primary Prevention. *American Journal of Community Psychology*, Vol. 5, 1-22, No. 1.

Dalton, J.H., Elias, M., and Wandersman, A. (2007). *Community Psychology: Linking individuals and communities (Second Edition)*. Belmont, California: Wadsworth.

Fishman, D. B., & Neigher, W. D. (1982). American psychology in the eighties: Who will buy? *American Psychologist*, 37 (5), 533-546.

Friedman, Thomas L. (2006) The World is Flat. New York: Farrar, Straus and Giroux.

Neigher, W.D., Ratcliffe, A.W., Wolff, T., Wolff, T., and Hakim, S.M. A value proposition for community psychology. Global Journal of Community Psychology Practice. www.gjcpp.org, in press.

Windle, C., & Neigher, W. (1978). Ethical problems in program evaluation: Advice for trapped evaluators. *Evaluation and Program Planning*, Vol. 1, No. 2, 97-107.