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### Generations of Hope Communities: Augmenting Social Services with Neighborhood Care

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GHDC WHITE PAPER

# Generations of Hope Communities: Augmenting Social Services with Neighborhood Care

*As individuals, and as a society, we have everything to gain,  
and everything to lose, in how well or how poorly  
we manage our need for human connection.*

- John Cacioppo & William Patrick<sup>1</sup>

## Abstract

In our first paper on Generations of Hope Communities (GHCs),<sup>2</sup> we defined these communities as intentionally created, geographically contiguous intergenerational neighborhoods, where some of the residents contribute volunteer work and others are facing special challenges around which the entire community organizes.<sup>3</sup> We stated that the goal of a GHC is for members to support each other and to shift the way social problems are addressed, from an over-reliance on traditional service systems to a holistic response that includes reliance on neighborhood care. We presented the philosophical and core operational principles that ground any GHC, and we described Hope Meadows – the first GHC – which was created to support families who adopt children from foster care.<sup>4</sup>

In this paper, we elaborate on the Generations of Hope Community model, beginning with a brief overview of the vulnerable populations that could be supported by these communities, followed by a discussion of community connectedness, and of key strategies and practices of GHCs. We then discuss the unique role and unconventional nature of professional staff practices in a GHC and how these lead to a new kind of organizational capacity that can augment conventional social services by aligning them with neighborhood care.

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<sup>1</sup> Cacioppo & Patrick (2009) p. 269

<sup>2</sup> Eheart, Hopping, Power, Mitchell, & Racine (2009).

<sup>3</sup> In this paper we use the term Generations of Hope Community (GHC) to refer to any community initiative which has formally expressed its intent to incorporate the essential features of the GHC model into its structure and operational practice.

<sup>4</sup> For more on Hope Meadows, see Smith (2001); and the organization's website at [www.generationsofhope.org](http://www.generationsofhope.org).

## Vulnerable Populations

The GHC model is being adapted in locations across the United States to support an expanding list of vulnerable populations. Communities based on this model provide nurturing environments for people who have experienced severe “traumas of belonging” – who are often disconnected from or lack a strong supportive family and community. Children and youth from the foster care or juvenile justice systems, for example, often have extremely truncated social networks, as do people who face homelessness. Others, such as adults with developmental disabilities or veterans who are returning with a disability, may find themselves living lives of exclusion and isolation.

Vulnerable people frequently experience sustained forms of disadvantage, hardship, and loneliness; the result can be life-long adverse consequences that threaten their well-being and lead to high psychosocial and economic costs. All need a safe, secure, inclusive environment with neighbors they know, who understand them, and who will provide support, as well as opportunities to play indispensable roles in the lives of others.

Such populations may include adults with developmental disabilities; children and youth in foster care or aging out of foster care; homeless lesbian, gay, bisexual and transgender youth; mothers returning from incarceration; Wounded Warriors; and youth returning from incarceration.

### *Adults with Developmental Disabilities*

Living in community is vitally important for adults with developmental disabilities, ideally in neighborhoods designed to reduce the stigma of difference and optimize diversity. In 2006 there

were an estimated 4.7 million persons with an intellectual and developmental disability (I/DD) in the United States, and 2.8 million of these were receiving residential support from family caregivers.<sup>5</sup>

Over 700,000 persons with I/DD were living with caregivers aged 60 or older. Such aging caregivers need assurance that their adult children will continue to have a familiar place to live, with caring staff and neighbors to help them thrive. The GHC model provides the kind of supportive housing environment that adults with developmental disabilities need to continue to live semi-independent, yet integrated lives, in a family and community setting.

### *Children and youth in foster care or aging out of foster care*

Many children who enter foster care never return to their birth parents nor are they adopted. As of September 30, 2011, there were over 100,000 children waiting to be adopted.<sup>6</sup> In addition, approximately 28,000 youth “age out” of the system every year.<sup>7</sup> These children and youth often experience multiple placements, resulting in disconnection from people and place, and making their transition to adulthood especially difficult. They need a stable, supportive place to live where they can develop feelings of belonging

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<sup>5</sup> Braddock, Hemp, and Rizzolo (2008).

<sup>6</sup> U.S. Department of Health and Human Services, *The AFCARS Report No. 19* (2012 )

<sup>7</sup> McCoy-Roth, DeVooght, & Fletcher (2011 )

and strong connections to adoptive kin or kin-like family, and to friends and neighbors.

### *Homeless Lesbian, Gay, Bisexual, and Transgender Youth*

As many as 400,000 LGBT youth face homelessness each year, and over half of these youth have been sexually assaulted and/or have attempted suicide.<sup>8</sup> They desperately need neighborhoods where they have food, shelter, and safety; where culturally competent social service professionals make available mental health services, educational opportunities, substance abuse treatment, etc. Most of all, in order to flourish, these youth, like all others, need positive social relationships with adults who have understandings of adolescent development, who respect them, who are role models and mentors, and who will be there for them in good times and in bad.

### *Mothers Returning from Incarceration*

According to the federal Bureau of Justice Statistics, the number of incarcerated mothers increased by 122% between 1991 and 2007.<sup>9</sup> In 2007, approximately 65,000 women in federal and state custody were mothers – two of every three incarcerated women. They were mothers of nearly 150,000 minor children, about half of whom were under the age of nine. Over 10% of children in the foster care system have a mother who is or was incarcerated, and these children are less likely to be reunited with their parents or to

be adopted, and are more likely to “age out”.<sup>10</sup> Reentry for mothers is often particularly challenging due to difficulties in reuniting with their children, and prior histories of sexual abuse, domestic violence, and mental illness. A recent research review by Volunteers of America found that

the need for more gender-responsive programming and services for [mothers who are] female offenders is one of the biggest challenges currently confronting the reentry field”.<sup>11</sup>

A GHC can meet this challenge by offering a supportive community for both these mothers and their children.

### *Wounded Warriors*

Nearly one in three military service members (500,000) deployed to Afghanistan and Iraq suffer from post traumatic stress disorder, major depression, or traumatic brain injury; others return with severe physical injuries.<sup>12</sup> A GHC offers Wounded Warriors and their families a place to reengage within a supportive environment where they can continue to provide service to others. Among the senior volunteers who live in the neighborhood will be older veterans who bring a special understanding of what a returning veteran needs to readjust to civilian life. In a GHC, Wounded Warriors will be able to live in a neighborhood designed to meet their unique needs and utilize their talents.

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<sup>8</sup> Center for American Progress (2010 )

<sup>9</sup> Glaze & Maruschak (2008 )

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<sup>10</sup> Ross, Khashu, & Wamsley (2004 )

<sup>11</sup> Volunteers of America (2009 )

<sup>12</sup> Froomkin (2011 )

### *Youth Returning from Incarceration*

The Children's Defense Fund reports that over 70,000 children and teens are housed in juvenile residential facilities in the United States.<sup>13</sup> As youth return to their communities from incarceration, they often "need support to stay in school, find a job, and manage substance abuse and mental illness".<sup>14</sup> They need a different way to live that draws upon a continuum of resources to support their development as caring and contributing members of society.

The GHC model promises these youth an enriched environment, not based on an adult parole system of surveillance, but one based on the developmental needs of adolescents and young adults. In this environment, these youth will develop a sense of belonging and self-worth, and have multiple opportunities for meaningful engagement.

What all these groups of vulnerable people have in common is the need for nurturing family or other kin-like support and a strong community, as they attempt to transition from a position of loneliness, disadvantage, and powerlessness to one of inclusiveness, competence, and strength. Like all of us, they need quality ties to people, place, and purpose. GHCs are uniquely able to support the well-being of populations of need through the cultivation of intergenerational community connectedness.

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<sup>13</sup> Children's Defense Fund (2012 )

<sup>14</sup> Children's Defense Fund (2011) p. J-2

### **Community Connectedness**

There is now a substantial corpus of research showing that social connectedness and community involvement are two of the most powerful determinants of well-being.<sup>15</sup> Social relationships matter.<sup>16</sup> Both physical and emotional health are affected by the presence, absence, and quality of ties to other people.

Physical and emotional support available from others reduces the negative effects of stress, and even in the absence of stress, health is enhanced by the extent to which a person is integrated into the social networks to which he or she belong.<sup>17</sup> Multiple studies from around the world have shown that "people who are socially disconnected are between two and five times more likely to die from all causes, compared with matched individuals who have close ties with family, friends, and the community".<sup>18</sup> And psychologists John Cacioppo and William Patrick report that loneliness seriously impacts health and well-being, while "restoring bonds among people can be a cost-effective and practical point of leverage for solving some of our most pressing social problems."<sup>19</sup> Further, people report

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<sup>15</sup> See for example Butrica & Schaner (2005); Cornwell, Laumann, & Schumm (2008); Mark & Waldman (2002); McKnight & Block (2012)

<sup>16</sup> Seligman (2011; Lippman, Moore, & McIntosh (2011; Diener, Wirtz, Tov, Kim-Prieto, Choi, Oishi, & Biswas-Diener (2009)

<sup>17</sup> Cohen (2004)

<sup>18</sup> Putnam (2000) p. 327

<sup>19</sup> Cacioppo & Patrick (2009) p. 250-251

better health when they live in neighborhoods whose residents believe they can count on one another.<sup>20</sup> This sense of collective efficacy appears to affect physical well-being regardless of many other neighborhood and individual conditions.

It is less clear what produces collective efficacy, but one of the more significant factors appears to be residential stability. People who stay in place are more likely to develop the kind of ties and norms of behavior that lead to believing in their collective ability to help one another when needed and to meet common challenges when they arise.<sup>21</sup> Another important factor in the development of relationships is simple physical proximity, which increases the frequency of communication between persons, which increases their knowledge of one another. When people know one another, trust is more apt to emerge and strengthen.<sup>22</sup> People who trust one another are able to coordinate their actions better and get more done together.

In short, nurturing environments are necessary to foster successful development and prevent the development of psychological and behavioral problems.<sup>23</sup>

## Generations of Hope Communities

Generations of Hope Communities (GHCs) cultivate the largely untapped potential of intentional intergenerational community living to

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<sup>20</sup> Browning & Cagney (2002)

<sup>21</sup> Sampson, Morenoff, & Earls (1999)

<sup>22</sup> Forsyth (1998)

<sup>23</sup> Biglan, Flay, Embry, & Sandler (2012)

address social problems. A GHC marries the organic functioning of a neighborhood with the purposefulness of an organization. As a place, it strives to be an “abundant community,” one where neighbors join together to become the architects of the future they want to live in.<sup>24</sup> As an organization it has a social mission to address the unmet needs of vulnerable people through the development and ongoing functioning of a community where all residents contribute to the welfare of each other.

With encouragement from a small staff, neighbors in a GHC can provide extraordinary levels of care and support within the normal course of daily living. As a network of caring intergenerational relationships develops over time, the focus of problem-solving can shift from one of intervention *in* community to community *as* intervention.

This strategy of Intergenerational Community as Intervention (ICI) is a central component of the GHC model. Conventional programs such as tutoring and after-school programs are augmented by non-traditional supports such as picnics, special neighborhood gatherings, and caring “grandparents”, all provided within and by the neighborhood. Other services such as therapy, case management, and job training may be offered within the neighborhood, or outsourced to professionals or programs beyond the neighborhood, but always they are adapted to interface with the GHC model.

Elsewhere we have written about key practices in a GHC: caring about and for people and place; the use of inclusive, non-stigmatizing

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<sup>24</sup> McKnight & Block (2012) *xiv*.

language; meaningful engagement in community activities; and the relation of all these practices to mental health.<sup>25</sup>

Such practices are essential to weaving the philosophical and operational principles of a GHC into the fabric of neighborhood life. They enable everyone in the community to become involved in supporting one another, thus fostering individual and community well-being and shifting the initial focus of problem-solving from professional service providers back to the community. This of course does not happen automatically, and requires GHC staff to think about both the implementation of a new service model and their different roles and responsibilities within it.

## A New Service Model

Typical social service interventions are largely provider-driven and rely on professional expertise to be effective. Most social service professionals have not been trained to work within an empowered community, to rely on the strengths of that community, and to support rather than direct community initiatives. Their education and prior work experience usually prepares them to take charge in situations where their skills and knowledge apply and where other participants are not similarly equipped. An analytical approach – the person who stands apart from a problem in order to better understand it and devise an appropriate solution to it – is considered the “professional” approach. This approach seemingly enables professionals to define, with some

precision, the problem they hope to solve and to carefully design the means through which the problem will be solved. In implementing conventional practices, staff provide a service that is often time-limited and close-ended, rule-driven, professionally controlled and behaviorally specific, and provided to or for someone.

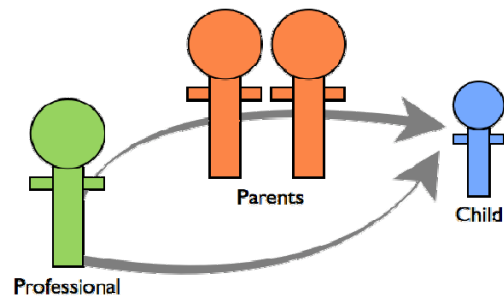
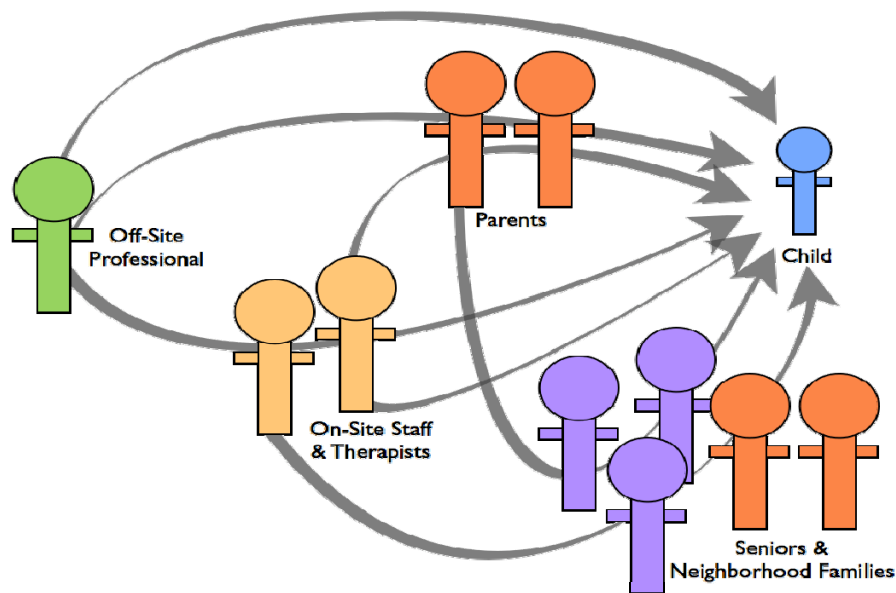


Figure 1. Conventional Service Model

In conventional service delivery models, it is easy to see the directionality and structure of service. Professionals with expertise and training offer services to individuals with defined needs (Figure 1). For example, a therapist might provide parent management training to the guardians of a child in foster care who presents with disruptive behaviors. In this scenario, the therapist would meet with the family for a number of sessions and educate them about the approach to dealing with this child. Should a crisis occur during times outside of the session, the family might call the therapist for assistance. If available, the therapist may offer some guidance over the phone or ask them to come to the office for an urgent consultation. The directionality of the intervention is clearly from the professional to

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<sup>25</sup> See Power & Eheart (2000); Power, Mitchell, Eheart, & Hopping (2011); Power, Eheart, Racine, & Karnik (2007); Karnik, (2010)



**Figure 2.** The strategy of Intergenerational Community as Intervention (ICI)

the family, and takes place largely in the context of the therapist’s office.

The ICI strategy changes this dynamic by positioning the professional in the role of a consultant and putting a small cadre of seniors and neighborhood families in the immediate geographical vicinity of the family (Figure 2). This structure better reflects the dynamics of the neighborhood where seniors and families reside side-by-side. In a GHC older adults and families are the people one turns to first for help. The reach of office-based care is limited compared to the potential of neighbors that can provide support and advice at crucial times. Such psychosocial supports have long been recognized as essential aspects of medical and psychiatric care, but rarely have programs been built to enhance and draw specifically on this aspect of support.

In the example outlined above, the family would work simultaneously with the therapist and community members to problem solve and address the behaviors of the child. In addition to

using parent management training provided by the therapist, at a time of crisis, the parent might turn to a neighbor for assistance. It may be something as simple as this other person sitting with the child until the tantrum ends so that the parent can take a short walk to draw him or herself back together. Clearly if the behaviors go beyond the ability of the families and seniors to address, then immediate involvement of staff is indicated and the involvement of outside professionals may become necessary. But in the event that the community can address the situation, then the therapist would be informed of the events the next day or at the next appointment.<sup>26</sup>

While a GHC strives to look and feel like a “normal” neighborhood, it is not, nor is it a “normal” social service program. This is, in part, because care is the predominant social practice in these neighborhoods. But it is also

<sup>26</sup> See Karnik (2010) for further elaboration.



because, as a hybrid neighborhood/program, a GHC must consciously adapt and evolve.

As a social practice, writes political scientist Selma Sevenhuijsen, “care can be seen as a mode of acting in which participants perceive and interpret care needs and act upon these needs”.<sup>27</sup> Members of a GHC learn how to care for one another, based on each person’s needs and abilities and what they bring into the community from their previous experiences. Caring practices result in a stronger sense of belonging and commitment to one another, thereby making it easier to coordinate efforts and cooperate in seeking to solve individual and group problems. Community development scholars John McKnight & Peter Block advise that “the place to look for care is in the dense relationships of local neighbors and their community groups. If they have a competent community, it will be because they care about each other, and they care about the neighborhood”.<sup>28</sup> Acts of care can bring smiles or tears, exhilaration or exhaustion, be deeply felt or hardly noticed; these acts can bring a neighborhood together in profoundly social ways, ultimately alleviating social problems.

As a hybrid neighborhood/program, a GHC is an always-evolving social form, with programmatic features that, for the most part, are being continuously reconstructed to adapt to the community’s changing understanding of itself. As residents age, their needs change, and as their needs change, the program must change. Children become teens and teens become young adults. Eventually they will move away as they form

lives and families of their own. The needs of families continually change as parents strive to support the developmental tasks of children. Seniors’ health declines and their engagement in the community changes; they may need to be hospitalized; or they die, leaving grieving family, neighbors, and friends. These types of changes, although normal for any community, create challenges for GHC staff. It is an unfolding story that cannot be captured within typical ways of designing social service programs and practices.

### GHC Staff: New Roles and Responsibilities

Unique to GHC staff is their crucial role in implementing the ICI strategy. As such, they face the challenge of learning different roles and responsibilities from those they may have come to expect as human service professionals. To enable the community itself to become the initial intervention, staff must balance “taking charge” with providing the support that empowers community members to take responsibility for one another. This does not mean, however, that the residents of the neighborhood are left completely to their own devices, as this can lead to the formation of exclusionary cliques or dominance by given individuals, while solely staff-led efforts can undermine the motivation residents have to form ties naturally or take responsibility for their community.

Staff in a GHC ideally play a supportive background role: they generate support and guidance that is continuous and open-ended, holistic, asset-based, and community-

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<sup>27</sup> Sevenhuijsen (1998) p. 22

<sup>28</sup> McKnight & Block (2012) p. 24

grounded. They encourage opportunities to restore personal agency to a vulnerable child or adult, to a family, to an older adult. And they allow the community, in seeking solutions, to largely determine the shape of relationships, commitments, and obligations.

All of this is different from familiar service delivery paradigms and can be difficult to master. Staff of a GHC have to walk a fine line between taking charge and standing back, and recognize that they can be most successful when their work is characterized by consent rather than control. Consent requires building relationships that are collaborative, reciprocal, trusting, and friendly. Staff are most effective when their relational practices are characterized by acts of care and consensus building; when they listen, help, respond, and show respect rather than tell and direct.

As a result, GHC staff and residents cannot have a conventional staff/client relationship. Staff must “walk with” members of the community, being neither “insiders” nor “outsiders”.<sup>29</sup> They must be both personally involved and committed to improving the lives of the GHC residents. Over time a sense of connectedness and neighborliness is established, based on working together toward a common purpose with a like-minded group of people, creating an ethic of care and community responsibility. By “walking with” members of the community, staff are able to provide leadership in implementing a new approach to both prevention supports and intervention services. Following is a partial list of these leadership tasks:

### *Prevention Supports*

- help establish and maintain intergenerational relationships grounded in care and support,
- encourage a sense of belonging through contributing to a shared purpose and place,
- encourage persons to become and remain engaged in the life of the community,
- help enable persons to develop a strong sense of security within a safe place, and
- provide developmentally appropriate information to foster well-being.

### *Intervention Services*

- offer training to community residents to enable them to provide effective support to their neighbors,
- enhance the capacity of community volunteers to meet the needs of the vulnerable population,
- guide the community to understand that professionalized care is not necessarily better care,
- develop innovative operating protocols and partnerships with programs and professionals in the broader community, and
- implement and extend the GHC model through aligning resources of the neighborhood with social services.

To a great extent, the degree to which staff become strong leaders in implementing the ICI strategy determines whether a GHC is successful. But in their success, GHCs arguably introduce a new kind of organizational capacity, which in turn may

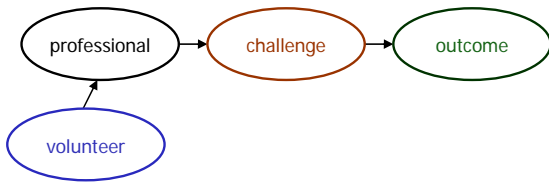
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<sup>29</sup> Richardson (1997)

hold the promise of a paradigm shift in the way social services and supports are imagined and provided.

## A New Kind of Organizational Capacity

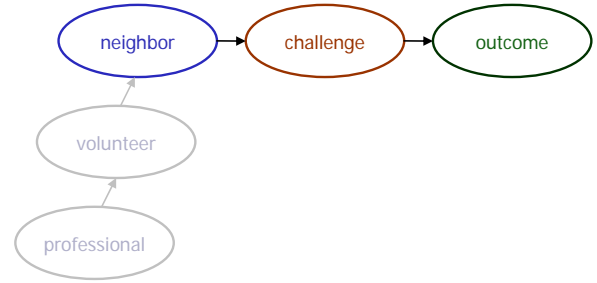
Integral to the design of a GHC are the older residents who become involved as volunteers in exchange for material support, such as reduced housing costs. When volunteers are added to conventional social services, it is usually in a way that is designed to take some of the burden off the professionals, allowing them to do what they were trained to do (Figure 3).



**Figure 3.** Typical service configuration

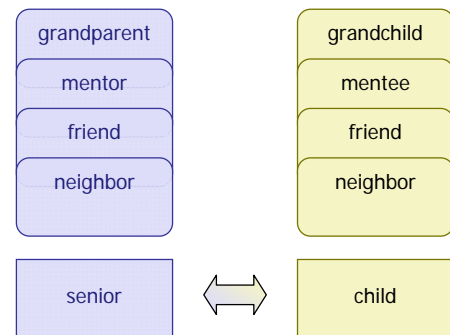
Volunteers may, for example, staff an afterschool program or mentor a high school student, leaving professionals free to provide casework and counseling. The result is that more can be done without adding paid staff; it has augmented what might be called its “Instrumental Capacity”.

What is new in the GHC model is not the presence of volunteers, but the role they play in increasing organizational capacity. In a GHC professionals support the efforts and activities of residents, and encourage them from behind the scenes or in more understated ways. One effect is that the salience of the role of volunteer also begins to recede, after jump-starting relationships that continue to mature and develop on their own (Figure 4).



**Figure 4.** Service configuration in a GHC

Moreover, the same volunteers are available to assume multiple roles as friends, mentors, tutors, neighbors, etc. This is one of the ways a GHC can leverage resources beyond what is possible in more conventionally structured program models, where senior volunteers might be paired with specific children around targeted needs, and only encounter them in that context.



**Figure 5.** Multistranded relations in a GHC.

In a GHC where the volunteers are already neighbors, they may become friends, and friends may become mentors, and mentors may even become “grandparents.” Children are similarly called into multiple roles as they engage with seniors, thus establishing more complex or “multi-stranded” relationships than are typically possible in conventional volunteer programs (Figure 5).

We refer to the resulting organizational resource as the “Core Capacity” of the GHC service model. From a staff perspective it can be a challenge to cultivate and work with this kind of capacity, because it is so indirect. The key then is to find staff who are skillful in helping to realize, and who firmly believe in, the potential of this new mode of organization.

But to fully realize the promise of this new approach to care and service, it will be necessary to work with traditional social service providers, policy makers, and the general public to align this new model of neighborhood care with traditional social services.

## Augmenting Social Services with Neighborhood Care

Nel Noddings has argued persuasively that, in order to help people develop successfully and enable them to contribute fully, we must pay more attention to human relationships – to continuity of place, people, and purpose.<sup>30</sup> Although this need for continuity of place, people, and purpose is a fact of life for all of us, having this need met is especially problematic for people who are disconnected from family and community – those who need more than traditional social services can provide; those who need a GHC.

When we think about what enables our own children, ourselves, or others to achieve a positive sense of well-being, we think of the importance of being securely embedded in a web of close family and community ties. It seems highly unlikely that formal institutions can ever be designed to do the

things that only a supportive family and neighborhood can do – create a daily environment of connection, engagement, and care. Institutions are not an adequate replacement for a cohesive, multigenerational neighborhood which enhances individual development, provides parents and other caregivers with the support they need, and gives older people the opportunity for a meaningful, productive culmination of their lives.

McKnight & Block write that it is not the job of formal institutions to provide nurturance – nor should it be:

Our institutions can offer only service – not care – for care is the freely given commitment from the heart of one to another; it cannot be purchased. As neighbors, we care for each other. We care for our children. We care for our elders. We care for those most vulnerable among us. It is this care that is the basic power of a community of citizens. Care cannot be provided, managed, or purchased from systems.<sup>31</sup>

A GHC is a nurturing, caring community, a place where older people, more apt to be present during the day, are able to watch out for the neighborhood’s children and for the neighborhood as a whole. Children and youth, in turn, are surrounded by adults who pay attention to them, care for and guide them, and where parents or guardians, mentors and grandparents find extra measures of support where and when needed.

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<sup>30</sup> Noddings (2002).

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<sup>31</sup> McKnight & Block (2012) p.4

## Conclusion

In this paper we have argued that an intentional intergenerational neighborhood, as a new social service model, can augment typical social service interventions by providing extraordinary levels of care and support for many different populations of need.

The GHC model proposes that by cultivating a network of mutually caring intergenerational relationships, problem-solving can shift from intervention *in* community to community *as* intervention, and that in the process a new kind of organizational capacity may emerge. The human connections that arise in a GHC do so within the normal course of daily living, through an extraordinary alignment of ordinary conditions. Under these conditions the caring practices of neighbors, guided by a professional staff, acquire the power to change people's lives.

While it may seem that the quest to create a GHC involves extraordinary processes of change and conversion, our work has revealed the power of the ordinary – power that comes, as psychologist Ann Masten has written,

from the everyday magic of ordinary, normative human resources in the minds, brains, and bodies of children, in their families and relationships, and in their communities.<sup>32</sup>

For vulnerable populations, becoming re-embedded within a supportive family and intentional community can seem so ordinary that it is too often overlooked and undervalued.

As simple as this seems, the stakes are high. As Cacioppo & Patrick remind us, in the quote which

began this paper, we have everything to gain or to lose in how we manage our need for human connection. It is this connection which is the cornerstone of augmenting social services with neighborhood care. This alignment is within our grasp, and offers the promise of broadening our capacity for solving some of our most pressing social problems.

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<sup>32</sup> Masten (1998) p. 235

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