Getting Along

Notes on the Care and Feeding of an Interagency Team

by John Franz

Learning to Trust

Trusting to Share

Sharing to Survive

Intellectually, human service managers know that they could provide better services for their communities if their organizations were able to collaborate when serving clients with complex needs. But in the real world collaboration rarely comes easily, and often doesn't come at all.

What stands in the way of improved cooperation among agencies like the schools, probation departments, child welfare services, mental health providers and public health departments? Quite a bit:

- They are competing with each other for ever-shrinking resources.

- They often have different and sometimes contradictory approaches to meeting the needs of clients.

- Their professional languages and cultures are often different and occasionally incompatible.

- Past competition and conflict stand in the way of building trusting relationships - each is always afraid that the others will pull out of a difficult situation leaving the remaining agency holding the bag.

- Each operates within a different regulatory and budgetary framework that impedes efforts to provide flexible services in concert with other providers.

For the individuals and families who need help, the problem is even more acute. They find that different forms have to be filled out for every service, different rules and procedures apply, and that sometimes the very things they are required to do by one agency get them in trouble with another.

The purpose of this article is to briefly outline some ideas that have been found helpful in addressing these difficulties. There are no foolproof strategies. Agencies in many communities are trying to find better ways of working together. Few, if any, have found completely satisfactory solutions. And there is no guarantee that a plan that works in one place will do so in another. Just as the most effective client services should be specially designed to address the unique needs of the individual or family, so too must each system of collaboration take into account the characteristics of the community it serves..

Collaboration should occur on two levels: informal and formal. Informal collaboration occurs in the context of individual clients and families and involves efforts by the line staff and supervisors of various agencies to find ways to work together on an ad hoc basis. Formal collaboration occurs at the system level and involves the development of a network of inter-organizational structures, procedures and resources designed to permit multiple types of coordinated services to be delivered through a single point of contact.

Both kinds of collaboration are important. But when fiscal or political restraints prevent the development of formal collaborative systems, line staff in many communities have found ways to work together to help specific individuals and families - even when their agencies lacked the wherewithal to cooperate to any meaningful extent.

On the other hand, attempting only system level collaboration can be very frustrating for both families and staff. Collaboration for collaboration's sake often results in nothing more than endless meetings held to discuss how little is being accomplished. The only reason to go through the hard work interagency collaboration requires is so we can do a better job of efficiently meeting the needs of our human service customers.

INFORMAL COLLABORATION

The core task in informal collaboration is building a team to help meet the needs of a specific individual or family. The trick is, of course, to find reasons for the members of the team to want to work together, and to create opportunities that will allow them to do so.

1. Document the client's perspective

If you are a service provider attempting to help an individual or family with complex needs, where should you start in building a team? One of the best places is with the client. Listen to the person or family to find out what is going on in their lives, who they are already interacting with, what they need, and why they need it. From the client's perspective, you can learn who they've already talked to, what forms they've filled out, what roadblocks have already been encountered, who has helped and who has slammed the door and who seems to understand the client best.

This information provides tools you can use to motivate other people to join the collaborative team, and suggests a context and focus for the team's efforts. Armed with these additional insights, when you invite someone to be part of the team, you can tell them more than just the negatives. You can share things about the family that make them unique and interesting to be with, and you can explain how aspects of their situation fall within the purview of your colleague's agency.

2. Know the system map

Sometimes it seems like 95% of client advocacy is knowing who to call. (The other 5% is getting the person on the other end of the line to say yes.) A required in-service for anyone joining a new human service agency should be a guided tour through the rest of the human services universe in the community: schools, public health, private and public mental health and alcohol and other drug abuse services, child welfare, juvenile justice, alternative education and counseling programs, legal aid services, developmental disability services, housing, protective payee and guardianship services, WIC, early childhood and birth to three services, youth activity programs, SSI and medical assistance gateways, supportive living programs, family support agencies, domestic abuse shelters, big brother, big sister, specialized youth camps, parents anonymous organizations, 12 step programs and energy assistance, to name a few of the more common elements. The pity is that most staff learn these connections by chance. Sometimes there is even a first call for help organization in a community that works to keep up with what is currently operational, and other human service professionals don't even know that it exists.

System mapping is a skill. Mostly it starts with having a few phone numbers and then the perseverance to get at least get one or two more numbers when you call, even if you get a "no" along with the numbers. Its important to always be friendly. The person who doesn't help you the first 3 times may be just the ticket on call number 4. Of course, once you start asking for help, you also have to be ready to give it.

For every entity (unless some of the issues of formal collaboration discussed below are taken care of) there is a separate set of eligibility criteria and priorities as well as different gatekeepers and gatekeeping mechanisms, funding sources, and levels of availability. Asking and getting those matters straight right from the start not only helps you help the client and team develop strategy, it also lets the person on the other end of the line know you are sensitive to the bureaucratic rules they are living under.

3. Building relationships

There are lots of books on team building skills. At the heart of most of them is the knowledge that different people are motivated in different ways. But for most people, the first step in forming an affiliation with a team effort is a sense of common vision with the other members of the team. If we can agree on what it is that we want to accomplish, at least in a general sense, we can acknowledge that there are differences in the way we do things, in the professional or bureaucratic structures in which we work, in the ways we will get paid (if we will get paid at all) for our efforts on behalf of the team, and even in some of the values that we apply to our work and to our lives.

Transcending these barriers requires that the members of the team, beginning with the primary client or family, have a sense of valued participation in the process and feel an ownership in the outcomes the team is seeking to achieve.

One way to create that sense of participation and ownership is to start with a vision-setting experience for the team. The team leader might ask each member to describe the strengths that are present at the table: What has the client or family accomplished that might have been forgotten in the current crisis? What do the other members brings with them in the form of skills, resources, commitment and caring?

From a recognition of hidden (and not so hidden) strengths can come a sense of direction: is there a basic goal to which all the members of the team, especially the client or family, can commit? The goal might be to help a parent and child live together again in a safe home or to support a young adult with a cognitive disability who has been having problems with alcohol in his efforts to become a sober, productive working person.

Moving from vision to action usually requires a couple of intermediary steps. The basic goal needs to be expanded into concrete objectives which highlight what it would mean to be doing okay within each of the key domains of the person or family's life. Once the objectives are listed and agreed upon, the divergence

between each one and the client's current situation can be identified. Those differentials are the needs the team must address. The points of greatest divergence usually identify the priorities for team action. Or sometimes, by examining the linkages between objectives, the team may discover a pivotal need that appears less important but from which many of the other more obvious problems cascade.

Ad hoc collaboration brings several gifts to the effort to support people with complex needs, but two key contributions should be enhanced creativity and improved access to resources. Once the team has agreed on a fundamental goal, and on the key needs of the client or family, the members can jointly brainstorm potential strategies for meeting those needs. The heart of the matter comes at this point. Once it is clear what the client or family needs, and what options there are for helping them meet those needs, the team must choose from among those alternatives the most effective system responses, and commit themselves to carrying them out.

Helping change happen in the lives of people with complex needs often means that agency staff must find ways to transcend the apparent limitations of their positions - and their supervisors have to either give them permission to do so, or blink long enough for them to get the job done. Without this movement to action, collaboration becomes, once again, just a bunch of people sitting around talking about somebody else's problems.

FORMAL COLLABORATION

1. Characteristics of integrated systems of care.

How can you tell if you have a good system of formal collaboration in place in your community? If creative, multi-system planning like that outlined above happens naturally and regularly, and if the teams that form around individuals and families with complex needs have access to flexible resources for putting their plans of care into action, then you are definitely on your way. You'll know you have arrived when those individuals and families tell you that their needs are being met efficiently and effectively.

When we talk about inter-agency collaboration, we often speak of building a system of care, meaning that through better relationships among the human services agencies in a community a separate entity begins to form which consists of the network itself and the processes that are used to activate it. In general, effective systems of care seem to have certain attributes. They tend to be:

• Generic. The system responds readily and rapidly to whatever type of need an individual or family might present.

• Integrative. The system readily combines strategies from many different disciplines and matches them to the unique capabilities and needs of each individual or family.

• Adaptive. The system creatively develops new resources as needed to produce positive outcomes for its clients, rather than relying solely on pre-established, categorical services.

• Person-centered. The system takes its lead from the individual or family being supported and defines its goals within the perspective of their personal and cultural context.

• Empowering. The system builds toward enhancing or establishing naturally-occurring internal or external strengths and supports for clients with enduring vulnerabilities.

• Transformational. The system is able to change itself in response to the changing needs of the community the system is meant to serve.

2. Movement towards increased integration of services.

Communities don't move from the traditional hegemony of human service fiefdoms to cooperative integration over night. Generally, there is a gradual process of development interrupted at certain points with short bursts of rapid change and consolidation, then more slow progress. To some it feels like it's always one step forward and two back, but that is because once the system takes a step forward the goal is that much clearer, but so is the distance that remains before the goal is achieved. It should also be remembered that many times system improvements simply result in higher expectations.

There are, however, certain stages that seem to characterize the times of slow progress in between the points of rapid transition. Different authors have used different terms for them, but in general they follow this pattern:

• Cooperation. During the cooperation stage, staff from one agency can at least talk to staff of other agencies about people who are being served by both agencies. The discussion is informal, usually off the record, and each

agency must develop its own, independent plan of care. However, through their informal contacts, the staff of each agency do their best to make sure that their efforts don't interfere with what their colleagues are trying to do.

• Coordination. The system makes a shift to the coordination stage when options are created that allow members of different agencies to formally sit down with each other and the family to work out their plans of care. Each agency still has a separate plan, but those plans acknowledge what the other agencies are doing and there is a formal sequence of activities and services. At a minimum, in systems at the coordination stage, mechanisms are in place so that clients aren't regularly booked to attend appointments at different agencies at the same time.

• Collaboration. In the shift from cooperation to coordination, agencies moved from informal to formal communication around planning and service delivery. The next step, collaboration, means the development of a joint plan in a single document. This is often one of the toughest stages for systems of care because of the differing requirements of the statutes under which each agency operates. The Children Come First Act, s.46.56 of the Wisconsin Statutes, was an effort to break down some of these barriers, but many remain. Sometimes this problem can be avoided because by collaborating, agencies avoid the need to access formal systems that mandate specific records and documents. When this isn't possible, collaborative teams prepare a joint plan that reflects what each of the statutory agencies will be including in their categorical plans and reports.

• Integration. At the collaboration stage, clients still must move through the separate processes of each of the agencies who are part of the system of care, it's just that through improved communication the agencies make these steps easier. When systems make the evolutionary shift to integration, those duplicative procedural pathways are eliminated. Thus, when an individual or family with needs in multiple areas makes contact with any element of the system, the provider helping them has the means to immediately access all the elements of care necessary to address the full range of their concerns. The response is unique and flexible. If a team is needed to help develop or implement the plan, that can be set up. If specialized funds or resources are needed, they will flow through the primary point of contact to the individual or family and those who are helping them.

3. Making it happen.

Van Morrison wrote a song called "You Don't Pull No Punches, but You Don't Push the River." That philosophy might also apply to the efforts necessary to keep systems of care evolving toward improved collaboration.

The work of building an integrated network is similar to that noted above for preparing a coordinated service plan for an individual or family - just lots harder and more frustrating. Usually a team of stakeholders and consumers forms around the needs of the community, the same way a team forms around the family's concerns. These leaders must have the drive and commitment it takes to make change happen and to survive the inevitable setbacks. They also need the authority to implement the ideas the team comes up with. It helps a lot if there are flexible staff to support the community team's efforts.

A common vision must be created that is strong enough to motivate the stakeholders to build the bridges and make the changes that are required in collaborative systems. There should be a system map that documents the current service structures in the community, the connections that exist among them, and the participants who must be part of a jointly operated system. Also, the route to improved collaboration starts from the best of what currently exists. Many community teams lead off with extended discussions of everything that's wrong. That just gets everyone depressed and does nothing about creating a foundation for the new system. Motivation for change may come from past disasters, but the plan for change should begin with existing strengths. Once that starting point has been identified, the direction for system development can be chosen based on the areas of greatest need.

Trust is also an essential component for collaboration at either the individual or the system level. At the system level, each of the stakeholders who will be contributing resources and staff to the collaborative effort have to trust that when they put in their share, so will their partners. Trust in this situation often emerges from mutual need, and from understanding the extent of mutual interdependence among agencies - no matter how much everyone wishes that they could keep on operating free of encumbrances and obligations.

Trust is earned as well as learned. Groups at the early stages of forming a collaborative system may want to examine options that allow appropriate responses to agencies that pull out of agreements in which they had said they would participate. If everyone in an interagency arrangement understands that individual agencies aren't going to be allowed to join only in those collaborations that are helpful for them, while pulling out of those that may be more costly, the partnership will have a better chance for long-term success.

4. First steps

Here are some suggestions about the early stages of the collaboration process, drawn from contacts with a number of communities who have begun the struggle of learning how to work together: After each suggestion a short vignette is offered as an example.

• Start talking and don't quit Keep communications open. Don't let under-the-table issues subvert the process.

In Bryant County, the schools and the child welfare department began discussions around services for homeless youth. Middle management staff met a few times and hammered out a basic plan. When the plan went up to administration for approval, an official from the schools felt that her district could be left holding the bag if the project didn't work out. She shared this information privately with a few people in her office, but officially her response was to let the proposal sit on her desk until the school year had started and there was no time to put anything into place.

Whenever the child welfare representatives on the committee asked how the review was going on her end, she would reply, "We're working on it, but everyone upstairs is all tied up with fall budget planning."

• Prioritize needs. You can't do everything at once. So, pick the biggest need, or choose the most fixable need. But pick something and get started.

In another county, a broad based group had been formed to develop a plan for long term collaboration across several agencies, including mental health, child welfare, schools, public health and probation. After a year of meetings, the group has come up with several proposals, but each has been shelved because one member or another has come up with a new focus of concern. First it was kids with behavior problems and developmental disabilities, then it was kids with severe learning disabilities. Most recently, just as they were about to finish off a plan to support families with parents who have cognitive disabilities, the representative from the child welfare agency announced that he had just been given the directive that because of budget cuts, the only area his organization could work on was families where a child has been removed because of physical abuse. Without child welfare's involvement, the meetings degenerated into monthly discussion groups.

• Identify key stakeholders and include them. If the person who can kill the deal isn't at the table, he or she probably will kill it.

An interagency group was working to develop a plan for serving youth with severe emotional disabilities. Schools, mental health, and social services were all active and enthusiastic participants. The goal was to reduce the use of residential treatment and get better outcomes through community-based services. However, they left the juvenile court judge off the planning team. When she saw the plan she went through the roof because she thought this ad hoc group had decided that it would tell her when she could and when she could not send a child to a residential treatment center. She responded by over-riding every dispositional plan that included diverting a youth to this new community-based alternative, in effect upping the use of residential treatment dramatically in their small county.

• Don't bury conflicts, but don't let them bury you either.

The object is not to get everyone at the table to join hands and sing "We are the World." The object is to get something done. If the conflict is germane, you're going to have to deal with it. But if it will continue no matter what, accept your differences and move on.

Peter, an assistant superintendent at the school district, and Larry, a unit supervisor at the county child welfare agency have had it in for each other for years. But they only talk about each other outside of meetings. When the schools and social services were putting together a collaborative plan for early support for high risk kids in the primary grades, Peter and Larry both ended up on the committee. Discussions were usually short, but nothing seemed to be getting done. Each reported back to his supervisors that the other was sabotaging efforts at putting a plan together.

• Learn by doing.

Listen to the people at Nike, even if you don't buy their shoes. You can plan until forever. Try something. If it works, do more of it. If it doesn't, try something else. Talking is rarely as effective as doing.

The Kenyon County Interagency Council has been meeting for a year and a half to develop a multi-agency project to improve services for families with children who have severe and chronic health problems. All the right people are there, and the Council has produced some wonderful proposals. When one of the parents on the

Council complained that she was feeling frustrated because her son was still missing more that half his classes, the chairperson answered, in a voice meant to sound comforting, ""Rachel, we know how hard this is for you, but we have to make sure we have it right before we start. Children's lives are at stake."

• Focus on outcomes. It may be messy, but if it works, it's a whole lot better than an elegant failure.

At the poster session during a state meeting on interagency planning, most of the attention was focused on the two counties who had prepared full color, laminated charts. One attendee, however, stopped by to take a look at a booth with a half hand-written, half typed set of charts. It took a while to figure out the numbers, but suddenly he noticed something. "Wait a second," he said to the young woman in jeans standing next to the chart. This says that your group served 63 kids last year."

"That's right. Is there a problem?"

"How could you do that many? The folks over there only served 12."

"We couldn't afford to spend a year planning. There were too many kids who needed help."

• Expect to make mistakes.

Those of us caring for people with complex and enduring needs rarely bat .300, let alone 1.000. Hard fought failures are better than not trying at all.

Two veterans of the interagency service wars were giving a presentation on a plan of care that had been developed with a family whose 14 year old daughter had multiple emotional, physical and behavioral problems. In their talk they detailed the many supports and interventions that had been used, and the creativity of everyone on the child and family team. After they finished, a person in the audience raised their hand and asked how the young woman was doing now.

With a breaking voice, but looking straight at the person asking the question, one of the presenters answered, "She committed suicide 4 months ago. But every single one of us on the team, especially her parents, believe we gave her the best options available."

A few of the people listening understood.

• Listen to the customers.

Sometimes collaborative efforts focus more on making the agencies happy than on meeting the needs of the agencies' clients. If you're not helping your customers meet their goals, its not collaboration.

Brighton County's Multi-Agency Planning Committee voted not to have parents of children who might be eligible for services as voting members. "It would be a conflict of interest," the chair of the committee argued. "They'd just try to get as much out of us as they could."

The collaborative project the committee developed focused on middle school children with substance abuse issues. It included a sophisticated system for communication between the schools, social services, and the mental health clinic that had been contracted to provide counseling for the students.

After a year of operation, only 6 youth had been through the program, and 4 of those had relapsed within 6 months of discharge. The project was discontinued. The Committee's findings including this notation: "We overestimated the number of youth with this problem. Our study shows that actually the reputation of widespread usage is generated by the actions of a small group of hardcore users."

• Give yourself time to succeed.

Everybody seems to want everything right now. As stated at the beginning, collaboration is really hard work. Very few communities get it right, right away.

Pekin County developed a collaborative support program located at the juvenile court. It was intended as a diversion project for first offenders, or youth who had committed multiple small offenses who also had a prior history of abuse or neglect. In the first 4 months, only 3 youth went through the program. The staff person who had been hired spent most of her time sitting in on staff meetings at the various cooperating agencies.

Then the judge called her into a hearing. A twelve year old girl had been charged with party to a sexual assault growing out of a gang-style initiation of another girl. The twelve year old defendant had herself been the victim of sexual and physical abuse at the hands of an uncle two years earlier, but had never received any counseling or support. To the staff person, the judge said: "I want you to pull

together what ever it will take to meet this young woman's needs, and still insure that the community is protected."

It took all of the contacts she had developed during those endless staff meetings for the staff person to set up an effective team and a workable plan of care.

• Celebrate successes.

You have to have some fun in all this. Early on you may need to use a fairly broad definition of success, which is fine, because any reason for a party is a good reason.

A new interagency program was being uniformly ignored by the very agencies that supposedly helped get it started. Staff were frustrated because they were getting so few referrals and those that did come in were either inappropriate or deep-end clients that everyone else had given up on.

The program director decided to adjust the first level program objective. She told staff, "Your first task is to build an interagency network. Anytime you can get someone from another agency to help out in any way, let me have a copy of that person's name, address, phone number and agency."

The network began to grow rapidly when staff found that for every name they dropped off with the director, a chocolate truffle would appear on their desk the next morning.

CONCLUSION

In this brave new world of post-industrial altruism, the fundamental nature of community-funded human services seems to be changing. What stays the same (or just gets worse) are the needs of the people our agencies came into being to serve. In this maelstrom of change, there is no better lodestar than the voices of our clients. As long as they are telling us that our efforts are helping them improve their lives, we know we are at least close to the proper path. Perhaps, at its core, collaboration simply means searching for better ways for our agencies to listen to these voices together.

Appendix A

Key Elements in Interagency Agreements

Introduction.

At some point, most formal collaborative systems are reduced to paper in the form of some sort of interagency agreement. It is not possible to prepare a useful model interagency agreement. Even if two communities wanted to develop identical interagency programs (which probably would be a bad idea in itself), each would be starting from a different place. Therefore their paths to this common goal - which would be reflected in the terms of the interagency agreement - would be different.

However, an outline of a basic interagency agreement may provide a framework on which a local team can develop and define their own unique approach to collaboration. The following outline describes 10 sections that are found in one form or another in most interagency agreements.

I. Define the nature of the agreement.

If it's just policy, it won't matter. Real commitments have to be spelled out concretely. Who is going to do what, and why. Also, the type of agreement should be identified. Communities have used memos of understanding, contracts, corporate charters and other vehicles to capture the terms of their agreement.

II. Identify the purpose and the participants.

An early section of the document should state:

- The parties who are included, whether they are public or private agencies, corporations, individuals, local, state or federal agencies, etc.

- The fundamental goals of the effort.

- The nature of any new entity being created to house the effort.

III. Define the people who will be served through the project.

If certain conditions have to be met to be eligible, state them clearly. If you want the project to be able to make exceptions, be sure to include that authority as well.

Remember there are dangers in applying the medical model where it doesn't fit well. Eligibility can be the result of a process, a condition, a situation or all three.

If the community has identified a priority issue for the focus of the project's efforts, make sure that the focus isn't too narrow, and that the project will have the flexibility to respond quickly to the next issue that arises.

IV. Define the process for accessing and delivering integrated services.

This should include the administrative component, as well as the access, intake, evaluation, service delivery and outcome testing elements.

V. Define the process that will be used for paying for any services that are delivered using the collaborative project.

What are the sources of funding? Will funds from a variety of sources be blended to maximize their impact? If so, will all funds be usable for all clients? Will the process differ for clients from different referral sources? Are third party payors (like medical assistance) going to be part of the funding base? What will method will be used for utilization review? What is the specific fiscal buy-in from every participating organization. (An important rule in collaborative systems is "If you' don't pay, you can't play.")

VI. Define the roles of the participants.

Who can do what, when? How will each agency meet its own external demands (statutes, court orders, etc.)?

VII. Define a conflict management process.

There are at least three types of issues that will have to be dealt with somehow: inter-agency disputes, client-provider disputes and formal grievances.

VIII. Define the evaluation process and standards.

What are the program priorities?

How will they be measured?

Who will measure them?

How often will measurements be taken?

How will the results be used?

IX. Public input.

How will representatives of the public be kept informed and invited to participate? Will any sort of external sampling process be set up to monitor broader impact? Will reference or focus groups be developed?

X. Family participation.

If the program will be serving children and their parents and siblings. It must have the parents present for planning and service delivery. Mechanisms should be in place for direct membership on the planning group, for detailed feedback from participants and for including support groups for family members.

Appendix B

The Community Problem-Solving Faire

In order to get informal collaboration started several components should be in place:

1. Folks from different agencies and systems need to be able to talk to one another easily.

2. The people who need help from multiple systems need to be able to describe their situation openly to people who have the authority and willingness to do something about it.

3. An atmosphere of trust must exist which supports innovation and cooperation.

4. Communication should happen quickly among everyone involved.

One way to create this type of situation without elaborate procedural or technological preparation is through a Community Problem-Solving Faire. Here's the recipe:

Start with one large, open meeting space such as a school lunchroom, the main room at a community center, or a ballroom donated by a kindly local motel.

Around the outside walls of the room place tables with snacks, hot dishes, cookies, salads, etc., brought in by the participants.

In the room next door place a child care center.

In the center of the room set up tables and chairs with signs above them. The signs should indicate that a representative from the child welfare agency is at one table, an official from the public housing agency is at another, someone from the mental health center is at another, as well as public health, the police department, a local bank, the gas and electricity utility, the county board, the school district, the juvenile court, etc. At each of those tables under the signs place folks who have or have been delegated the authority to solve problems on the spot.

At other tables, the signs should simply say "Listener." At these tables place volunteers who know about the matrix of services within the community. Their job is to do what the signs say: listen to the stories of those who come to the Faire with concerns, but who aren't sure what tables they should visit.

Anybody, citizen, recipient, or agency employee can come to the Faire and ask for help in solving a problem. They may start with a listener who will help them figure out which tables to visit, or them may just drop in and speak with someone at one of the agency tables. Once their problem has been presented, if it can't be dealt with by someone at just one table, people from several tables may gather together to see what can be done. The only rule is that no one can be punished for bringing a problem to the Faire.

Visitors to the Faire may bring suggestions as well as problems. "Why don't we try this?" or "We got it done this way, but it might work a lot easier next time if we do it differently."

The outcomes may be changes in rules or policies, a different approach to services for a specific client or family, or simply a better understanding of how things work. People at agency tables might be connected via fax or modem to their offices and thus be able to send back memos documenting the changes, or to access needed information.

When visitors, or those operating booths aren't directly involved in a problem solving session, they can use the opportunity to get to know other folks at the Faire and perhaps begin developing stronger relationships.

The Community Problem-Solving Faire shouldn't just focus on human services issues, but on the myriad questions, large and small, that arise in the life of any community. It might be, however, that each month, a different mix of public and private agencies and organizations would set up booths for the Faire, with only a few central agencies always present.

We need to learn to talk with one another again. Maybe a monthly community party would be just the way to get started.