Collaborative Leadership

Sharing Power and Influence

Participant's Guide

TurningPoint
Collaborating for a New Century in Public Health

Collaborative Leadership Skills – A Critical Component

Because collaborative interaction is challenging, it takes special skills to shepherd a group through this developmental continuum. Collaborative leadership is apparent in those who inspire commitment and action, lead as a peer problem solver, build broad-based involvement, and sustain hope and participation. Based on research with noted leadership experts and the public health practice community, the Turning Point Leadership Development National Excellence Collaborative identified a number of core collaborative leadership capacities in 2001. This National Excellence Collaborative, funded by The Robert Wood Johnson Foundation and made up of public health practitioners from around the country, has worked to better define, describe, and build the skills of collaborative leadership among those who participate in public health work.

Collaborative Leadership Practices

Clearly there are a number of critical skills and capacities collaborative leaders should possess. Many of the skills are not necessarily unique to a collaborative form of leadership and have already been described in the literature and developed into training curricula. The work of the Turning Point Leadership Development National Excellence Collaborative, however, has illustrated six key practices that are unique to the practice of leading a collaborative process. They are:

- Assessing the Environment for Collaboration: Understanding the context for change before you act.
- Creating Clarity – Visioning & Mobilizing: Defining shared values and engaging people in positive action.
- Building Trust & Creating Safety: Creating safe places for developing shared purpose and action.
- Sharing Power and Influence: Developing the synergy of people, organizations, and communities to accomplish goals.
- Developing People – Mentoring and Coaching: Committing to bringing out the best in others and realizing people are your key asset.
- Self-Reflection – Personal CQI (Continuous Quality Improvement): Being aware of and understanding your values, attitudes, and behaviors as they relate to your own leadership style and its impact on others.

Each of these elements is key to the collaborative process. They are not mutually exclusive but support each other and provide a comprehensive picture of the essential skills of a collaborative leader.

Assessing the Environment: This is the capacity to recognize common interests, especially the capacity to recognize and understand other perspectives. It is a fundamental quality of collaborative leadership. Collaboration seeks goal attainment around shared visions, purposes, and values. When he or she brings different points of views to an issue or problem, a collaborative leader facilitates connections and encourages group thinking that identifies clear, beneficial change for all participants. The goal is to set priorities and then identify barriers and obstacles to the achievement of priorities.

Creating Clarity: Having clarity of values is a quality that characterizes collaborative leaders. Whether it is commitment to a cause that transcends the self, the recognition of a spiritual

reality or imperative, ethical and moral standards that provide guidance—whatever the source of the inner gyroscope—collaborative leaders seem to exhibit clarity of purpose, often about creating and sustaining a process. "Visioning and mobilizing," in relation to clarity of values, has to do with a commitment to a process or a way of doing things. Often "mobilizing" refers specifically to helping people develop the confidence to take action and sustain their energies through difficult times. Clarity leads to focus which leads to increased group energy (power). Often too little time is spent in the process of "informal exploring" to understand problems, thereby developing clarity. A shared vision can be inspiring.

Building Trust: The capacity to promote and sustain trust is often overlooked in the collaborative process. Leaders sometimes believe that, once individuals or groups are gathered together, a plan can be made easily and commitment obtained. If a collaborative leader fails to engender trust among participants, however, their involvement will wane, and the best ideas and innovative approaches will not be shared. In this context, the collaboration will have lost its capacity to draw the best ideas from those involved.

Sharing Power and Influence: The capacity to share power and influence is an uncommon trait among leaders. American society traditionally rewards individual achievement, but collaboration cannot be achieved through a solo effort. Participants in the decision-making process need to feel empowered in order to contribute fully. Too often it is only the head of an organization who receives public accolades, despite the fact that the success was only possible through the shared effort and wide range of experience of a large team of people. Rather than being concerned about losing power through collaboration, leaders need to see that sharing power actually generates power...that power is not a finite resource.

Developing People: This practice is best described as a genuine concern for bringing out the best in others, maximizing the use of other people's talents and resources, building power through sharing power, and giving up ownership or control. These are themes that relate to realizing and promoting the potential in other people. Coaching and mentoring creates power, which increases leadership capacities and builds confidence by encouraging experimentation, goal-setting, and performance feedback.

Self-Reflection: Collaborative leaders are personally mature. To be successful leading a collaborative process, individuals must use self-reflection to examine and understand their values and think about whether their behaviors are congruent with their values. At critical junctures in the collaborative process, through reflection, successful leaders make time to consider verbal and nonverbal communication within the group. They think critically about the impact their actions and words have on the group's progress toward achieving its goals. Great collaborative leaders have the ability to recognize the impact of their behavior and adjust accordingly.

The following pages provide background material for learning activities in which you will be engaged during this workshop.

Eight Sources of Power

1. **Position power (authority).** Positions confer certain levels of formal authority (i.e., professors assign grades, and judges decide disputes). Positions also place incumbents in more or less powerful locations in communications and power networks. It helps to be in the right unit as well as the right job: a lofty title in a backwater department may not mean much, but junior members of a powerful unit may have substantial clout (Pfeffer, 1992).
2. **Information and expertise.** Power flows to those who have information and know-how to solve important problems. It flows to marketing experts in consumer products industries, to the faculty in elite universities, and to superstar conductors of symphony orchestras.
3. **Control of rewards.** The ability to deliver jobs, money, political support, or other rewards brings power. France and Italy were among many countries rocked in the early 1990s by scandals involving political bosses who kept themselves in power through control of patronage, public services, and other payoffs.
4. **Coercive power.** Coercive power rests on the ability to constrain, block, interfere, or punish. A union's ability to walk out, students' ability to sit in, and an army's ability to clamp down all exemplify coercive power.
5. **Alliances and networks.** Getting things done in organizations involves working through a complex network of individuals and groups. Friends and allies make that a lot easier. (Kotter,1982) found that a key difference between more and less successful senior managers was attentiveness to building and cultivating links with friends and allies. Managers who spent too little time building their networks had much more difficulty getting things done.
6. **Access and control of agendas.** A by-product of networks and alliances is access to decision arenas. Organizations and political systems typically give some groups more access than others. When decisions are made, the interests of those with "a seat at the table" are well represented, while the concerns of absentees are often distorted or ignored.
7. **Framing: control of meaning and symbols.** "Establishing the framework within which issues will be viewed and decided is often tantamount to determining the result" (Pfeffer, 1992, p. 203). Elites and opinion leaders often have substantial ability to define and even impose the meanings and myths that define identity, beliefs, and values. Viewed positively, this provides meaning and hope. Viewed cynically, elites can convince others to accept and support things not in their best interests. This can be a very subtle and unobtrusive form of power: when the powerless accept the myths promulgated by the powerful, overt conflict and power struggles may disappear.
8. **Personal power.** Individuals with charisma, energy and stamina, political skills, verbal facility, or the capacity to articulate visions are imbued with power independent of other sources. This could include various types of influence such as ingratiation, exchange (quid pro quo), and personal appeal.

Source: Bolman and Deal. *Reframing Organizations*, pp. 169-170.

Case Study: A Matter of Faith

In 1991, the Health Department in Genesee County, Michigan, began collaboration with Faith Access for Community Economic Development (F.A.C.E.D.), a faith-based community organization, to better meet the health needs of the population. In this interview, Health Department Director Robert M. (Bobby) Pestronk and F.A.C.E.D. Executive Director E. Yvonne Lewis discuss with Interfaith Health Program Senior Scholar Fred Smith how this collaboration began and what it has meant to both organizations.

Fred Smith: *Our task in this conversation is to convey a living image of what interfaith health partnership can be. Who are you and what do you lead?*

Yvonne Lewis: I represent F.A.C.E.D., a community-based, faith-based organization under the direction of Concerned Pastors for Local Organization, an association of ministers within Genesee County. In the late 1960s and early 1970s, ministers began to feel a responsibility to rise up and take on issues, but by the late 1980s they realized that although they had addressed issues, there was no mechanism in our county through which they could implement programs to deal with those issues. In 1991 they organized F.A.C.E.D., which is multi-denominational and multi-ethnic and in which large and small churches work collectively to both address issues and implement programs.

Bobby Pestronk: I come from a very different organization. All of you have someone like me in your communities. I am the director of a local health department. Genesee County has about 430,000 people, 80 percent European American and 20 percent African American. The city of Flint, within the county, has a population of about 130,000, and is about 53 percent African American and 47 percent European American. I am a civil servant, working for a governmental organization, and I report to and serve at the pleasure of nine officials, each elected from a county district. My budget is about $22 million and the majority of that is public money raised through taxes–state, local and federal–and fines, penalties, et cetera. When I was appointed for the first time, a longtime African American leader in the community said, "Bob, there's one thing to know: always count to five. If five of them don't like you, you're out of a job." That's the world that I live in.

Fred Smith: *Talk about the journey, the story of how this collaboration came about.*

Bobby Pestronk: I had an epiphany one day while I was visiting one of our health centers. The health department has a sort of mother ship in Flint and two other clinics downtown. The clinic in the north end predominantly serves African Americans and the one in the south end predominantly serves European Americans. In addition, we have a string of clinics that operate one or two days a week in the rest of the county. Many work with faith organizations, which allow us to use their space.

As I was leaving the health center on the north end of town one gray winter day, I noticed for the first time–even though I had been there numerous times before–an elementary school just across the street. It is an old elementary school, built in the 1920's. I realized, however, that I didn't know the principal of that school or what was going on there. I wondered

if my staff did. I went back into our clinic and asked whether any of the staff had ever visited that school. No one had. I thought, "That's really very odd."

A short time later (my friends in the faith community would probably say God opened the door for us to get more involved with local communities), we had the good fortune to receive a request for a proposal from the Kellogg Foundation for an initiative called "Community Based Public Health." This initiative was very much in the concept phase, and the more we talked to the Kellogg folks, the more we realized they were looking for us to create the flesh and substance for the work. That encouraged us to begin to think about relationships among local health departments, community-based organizations and schools of public health.

The foundation's focus, we later learned, was to try and change work underway in schools of public health, but as we began to consider how to work together as a community, we realized how important it is for us to be more in touch with people in the local community.

That's when I began to work with Yvonne and her predecessor, the Reverend A.C. Lee. I remember approaching Reverend Lee saying, "African American babies are dying at twice the rate of white babies in Genesee County. I don't know what to do. Can you help?"

After a year or two of working together, I realized there was something different about this organization and the relationships that were being built. We were building a partnership as we sought joint leadership and began to understand whom we each were and what we each had to bring and to build on.

Yvonne Lewis: When F.A.C.E.D. was formed, the group was like a lot of others–they had an idea, but no money. They wanted to address economic development, but didn't have any resources. Within the first year, however, Bobby and the health department presented the organization with an opportunity. Women and children needed transportation to and from medical appointments for early periodic and diagnostic testing and screening services. The idea was that churches might be able to transport families to and from medical appointments, because on weekdays church vans aren't in use. A contract was given to F.A.C.E.D. to provide transportation to and from medical appointments. That was F.A.C.E.D.'s initial contract with the health department. I came on staff about that same time and met Bobby. That's when our collaboration began.

The Reverend A. C. Lee, who was our director back then and a close friend of mine, understood the importance of relationships: that it is through relationships that work and development are really defined. Since that project, F.A.C.E.D. has entered into nearly $400,000 worth of contracts in various forms of collaboration with the health department. I was sharing with an individual the other day that our collaboration today is not an afterthought. Because of the relationship we have built, and the mutual recognition of challenges in the community, we see our collaboration as important and integral to each other.

Fred Smith: *It can't have been easy in the beginning to learn to work together. What were some of the issues you faced?*

Bobby Pestronk: I have to say that early in the process, I feared I was going to jail with F.A.C.E.D. Remember,; I work for a governmental organization. I come from a family who has worked in public service for a long time, and has had numerous elected members come out of it. I feel very strongly about the separation of church and state and the use of public funds.

Yvonne Lewis: In line with what Bobby said about going to jail, I vividly remember a frank three-way conversation between Bobby, the Reverend Lee, and me, when we took our shields down and discussed whether or not we were doing the right thing. Could we justify the work we were doing?

I was just a program coordinator at the time, and still called Bobby "Mr. Pestronk," because he was a friend of my boss. But I saw a different side of him that day as those two men began to think through how we could make this work. There is always a challenge between health and faith in terms of its government dollars, and there we were, talking about how a faith-based organization could engage ministers and churches. "How do we keep it clean? Or how do we clean it up so that we can go forward?" And then we began to think through what the challenge really was.

Of course, the churches weren't really receiving direct compensation from the projects. F.A.C.E.D. was receiving funding to engage faith communities in specific projects. But we had to clearly separate the work of F.A.C.E.D. projects within faith-based communities from other work those communities do. When the health department asked us if we could develop three health teams within churches, groups of individuals who could help disseminate information, we were walking on eggshells, because people were actually going to be sitting in their congregations talking about health stuff.

Fred Smith: *Did you have trouble selling this to your department, Bobby?*

Bobby Pestronk: I did the first time. When I brought a faith contract before the board, they asked me what F.A.C.E.D. was. I explained that it was a 501C3 non-profit organization, and described who was on the board and the work they do. My department's concern was that we couldn't use funds for proselytizing a particular faith. I explained how a separation could be made between proselytizing and the work F.A.C.E.D. would do with us. I pointed out that the work of keeping people healthy requires different skills, strengths, and different people, and that there was overlap between some of the work faith-based communities were trying to do and the work our health department was trying to do. What ultimately came out of that conversation was a paragraph in our contract with F.A.C.E.D. stating that our resources are to be used only to promote health and not to proselytize faith. That satisfied our board.

That discussion later carried over into other works our department does. We have in the health department what many call "boiler plate" language–core language we put in all our contracts. As I got to thinking about why we were making a distinction in our language with faith-based organizations, I realized it applied to other organizations as well. We moved that language of non-proselytizing faith into the boilerplate language for all contracts. We want non-faith based organizations to also be clear that they can't be in the business of using public funds to proselytize for their own positions.

Yvonne Lewis: Another problem for us initially was that back then, our health department did not have a very good image in our community. Flint is a General Motors town, and GM was starting to pull out, so people were losing jobs. There were services in the community, but they weren't reaching the community. People knew that. But suddenly, when the health department wanted something to happen, they were going to ministers of black churches expecting them to endorse things. Our role was to change how people saw the health department, because they

had services that we needed. And so it was a matter of beginning to talk to each other, to translate between the faith community and the health community.

That was how we began: we had to sell the health department by having a relationship with the individual who was leading it. So our director said to Bobby, "In order to really help others believe you, you have to come to my street, walk down my street, and sit at my table and drink from my chipped china cup. If you want me to trust you, to believe that you have something to offer and are going to help me, then you have to come into my house and share with me." That's how we began to move toward collaboration.

Fred Smith: *How did that look from your side, Bobby?*

Bobby Pestronk: My epiphany was that while the health organization looked like a rather large organization to grassroots people, if our mission was to improve the health of Genesee County and its people, there was no way we could do that alone. Achieving our mission would require a large number of relationships with other people. That would take time, including my time. I felt that the director of a health department needs to spend time out in the community to show that the work of developing relationships is important to the mission of the organization.

Fred Smith: *Talk about the process of collaborating. Tell us about some of those relationships and collaborations. Who collaborates? What part does each of you play?*

Yvonne Lewis: Both F.A.C.E.D. and the health department are concerned with the whole community, not just the faith community. However, faith provides a way for F.A.C.E.D. to access the larger community. To identify and begin to address health needs, we need to hear the voices of the community and from the leaders of those communities. For us, pastors are an important voice, speaking both for and about their communities. When we listen to those voices, we can go back to the health department and suggest ways we can engage and interact with each other. I think that is a very important part of how we work together.

One of our major ongoing issues, therefore, is relating to pastors. Initially we would talk about an initiative and the pastor would say, "I don't know if we want to do that, because our mission is to meet the comprehensive needs of people from a spiritual, mental, and health perspective." We have had to help pastors understand that our projects aren't in conflict with their mission. Furthermore, we are a multi-denominational group representing sixty-five churches. All these ministers have a different mindset and a different way they do things. Some have boards, some have various levels of hierarchy, some you just go right to the preacher and if he says no, you forget it. We have learned how to work with all of them.

Early in our community public health days, we talked about differences in definition. We talked about community-based organizations and faith-based opportunities. Then we asked, "Are they faith *based* or are they faith *placed*?" As we started discussing our mission, it really became, "How do we integrate these health concerns into faith-based communities so they are sustained, so the projects and programs are not based on 12-month grants or a 3-year project, but become integral to what is going on in that faith community over time?" We looked at structures in the faith-based community that we can embrace and engage, so there is a sustained effort to change behavior which doesn't take place overnight. I believe in miracles but I also believe that God gives us hands and ideas that help miracles happen.

One part F.A.C.E.D. has played in this collaboration is to develop a health team network that now has 48 churches–all sizes, from many denominations, with various ethnic memberships. Our motto is "Pathway to better health," and everything we do moves us along that path. Churches work both individually and sometimes collectively, as in a diabetes health fair we hold that provides screenings, testing, and information to the community about this disease.

Through the health team network, training was provided to individuals identified by each congregation to help them understand major health issues in their community–issues like diabetes, cardiovascular disease, high blood pressure, mental health issues, and a number of others. They learned to identify and assess health conditions in their own congregations and were encouraged to ask in their congregations, "How can we develop programs to help with these issues?"

Another program we've sponsored is TGIF: Thank Goodness It's Friday. On Friday nights we hold special mental health educational sessions in congregations. Folks have dinner and music by a guest choir, and then a presenter speaks on depression, dementia, or other mental health issue that relates to our community.

The health department was initially our primary partner in this. They assisted us with connecting with other health agencies and organizations in our community, helped us identify resources in the community to deal with these health issues, and also were helpful as we wrote collaborative grants with various organizations.

Bobby Pestronk: What has become very clear over time are the ways in which the work going on in faith-based communities and health-based communities overlaps—yet often, no one in either of those organizations recognizes how much they overlap. For example, in many faith-based organizations there are both retired and active nurses and doctors who volunteer their time to meet health needs brought to their attention by their ministers or by their congregation. We have health teams with the same information to share and to whom people in the community turn. When we realized that these very similar reservoirs of information were available from churches and the health department, it made sense for us to figure out how to bring these two together.

Another thing this collaboration has created for both of us is enough shared experience with one another over time, so that we remain committed to the work as the pressures to go back to doing business the way we used to do it mounts, even when our staff, boards, and communities tell us, "Don't ask us to change or be different."

Earlier, I mentioned money. Money was an important key in our early relationship. One of the things I said to the health community, as a statement of our seriousness, was that we would bring the money in, but we wouldn't take the money. We wouldn't use it to make the health department larger. Instead, we would hire one person to serve as an interface between the funder and us, but the majority of the money would be contracted out to community-based organizations. We would give them the resources, because they already had the relationships and contacts with people in the community. In essence, the final resources are trust, built over a period of time, and the work we can do together.

Fred Smith: *What do you see as the greatest value of this collaboration?*

Yvonne Lewis: I come from a background of business administration. Walking into the health arena, I initially sat around a table with health professionals who dismissed any credibility I had because I didn't have a health background. Yet I heard in the community from some of the moms who were losing babies, and I began to realize that they had no voice. So how could we get that voice to the table?

I originally went to work for F.A.C.E.D. to help the Reverend A. C. Lee, who was my friend. As a preacher, he also came from outside the arena of public health. He told me, "I have the greatest agenda in the world. All that other stuff that people are talking about, that's good, but at the end of the day, I'm a preacher. My mission is to save souls and save lives."

I said to him one day, "But Reverend Lee, the mission of the preacher and the mission of public health are so similar. Both are talking about changing behavior. Why do people frequent a faith community? Because they want something different to happen in their lives. They're expecting something different, even if they don't intend to practice their religion daily. When they go to that place of worship, they want to feel different, even if it's only for an hour. Now what does public health say? It says, "We need to look at conditions from a population perspective and try and change the course of things." We're both really trying to do the same thing: change lives. We just need to translate the language so that we know how to talk to one another."

Bobby Pestronk: The history of public health, in this country and others, is really a history of faith, and that's not just a play on words. Public health has always had faith in the fact that people in a community can actually do things that will improve the health, welfare, and spirit of the lives of people living in that community. It is also a history, in this country, of regularly giving away what one has and distributing it to the community. Social justice and personal improvement are the roots of public health: the notion that people in a community can use the organizations, policies, and institutions of their culture to create an environment that leads to health.

The Presenters

FRED D. SMITH, JR., D. Min and Ph.D., is Associate Professor of Christian Education and Youth Ministry and Director of the Summer Youth Institute at Pittsburgh Theological Seminary, funded by the Lilly Endowment. He is also the pastor of Fellowship United Methodist Church in Ambridge, PA. He was formerly Associate Director of the Interfaith Health Program, where he served for seven years at The Carter Presidential Center in Atlanta, GA, and now serves Interfaith Health Program in the role of Special Scholar.

Dr. Smith received a BA from Harvard College, the M. Div. from Perkins School of Theology of Southern Methodist University, and the Ph. D. from Emory University. He has authored or co-authored many articles, reports, and curricula such as: *The Revival of Hope: Faith-based Substance Abuse Curriculum* (Cokesbury); *Not Even One: A Report on the Crisis of Children and Firearms* (The Carter Center); "Violence as Public Health Issue for African American Youth" (*The Caregiver Journal*); "The Role of the Faith Community" (*Community Links*); and "Black-on-Black Violence" (*Contagion: Journal of Violence, Mimesis and Culture*).

Dr. Smith has directed a number of national initiatives including: Pan Methodist Coalition on Alcohol and Drug Abuse; The Carnegie Foundation's Not Even One-Kids and Guns Initiative; National Volunteer Training Center's National Interfaith Alliance Against Substance Abuse; The Southern Christian Leadership Conference's Stop the Killing Campaign; and The Carter Center's Whole Communities Collaborative national program.

E. YVONNE LEWIS, M.S., is the Executive Director of Faith Access to Community Economic Development (F.A.C.E.D.), a faith-based community organization. F.A.C.E.D. provides services to meet the comprehensive needs–physical, mental, and spiritual–of low-income residents of Flint/Genesee County, Michigan.

Ms. Lewis has worked extensively to engage faith communities in work with community agencies and organizations. Currently she chairs the Community Based Organization Partners (CBOP) in Flint, a collection of community-based organizations working together to identify issues and refine collaborations with agencies and universities. She represents the CBOP on the Coordinating Committee of the Michigan Prevention Research Center. She also represents the PRC Community Advisory Boards on the National Prevention Research Centers (PRC) Steering Committee, assisting in developing a National Identity for the Centers, as well as co-chairs the PRC National Community Committee.

Ms. Lewis is Past-chair of the Caucus on Public Health and the Faith Community, (Caucus to American Public Health Association), past Chair of the Tobacco Free Michigan Action Coalition. She chairs the Racial and Ethnic Approaches to Community Health (REACH) Task Force of the Greater Flint Health Coalition, and the PRIDE Coalition (Programs to Reduce Infant Deaths Effectively). She addresses cultural sensitivity and how to work effectively with Faith Communities and has provided consult to the Institute of Medicine Roundtable and contributed to their report, *Health Communities New Partnerships for the Future of Public Health* (1996).

ROBERT MIGGS PESTRONK, M.P.H., is Health Officer/Director of the Genesee County Health Department in Flint, Michigan. His major interest as Health Officer is to enable Genesee's 430,000 citizens to protect, promote, and improve their quality of life in partnership with the Health Department and other community resources.

Mr. Pestronk received an M.P.H. from the University of Michigan School of Public Health in 1979 with concentrations in human nutrition and health planning and administration. He received an A.B. in politics from Princeton University.

He is a past board member of the National Association of County Health Officials, Michigan Health Officers Association (of which he is a past President), and the Michigan Association for Local Public Health. From 1989 to 1992, he was Chairman of the Board of Governors for the Public Health Alumni Association at the University of Michigan. He was selected in 1993 for the Primary Care Policy Fellowship by the United States Department of Health and Human Services and as a Scholar in the Public Health Leadership Institute by the Centers for Disease Control and the University of California. He is Past President of the Primary Care Fellowship Society and Past President of the Leadership Society's Council. He was a member of the Institute of Medicine's Public Health Roundtable.

Mr. Pestronk was recognized in 1993 by the University of Michigan School of Public Health Department of Public Health Policy and Administration as the first recipient of the John H. Romani Outstanding Alumni Award. The American Lung Association, Genesee Valley, honored him in 1993 as Professional of the Year, and in 1997 as Health Advocate of the Year. In 1997, he was presented the Distinguished Alumnus Award by the University of Michigan School of Public Health.

Guide Questions: Empowerment Challenges and Strategies

1. What were the initial power relationships between the health department and the interfaith community group? Did they change? If so, how? If not, why not?

2. What role did trust play in the development of this collaboration?

3. Do you consider this to be a successful collaboration? Why or why not?

4. Was there evidence of sharing power and influence? If so, what? How was it accomplished?

5. What qualities and skills did those involved possess that moved the collaborative process forward?

6. This collaboration was based on some funding available through the health department. What do you think would have happened to the collaboration if those resources dwindled?

7. Bolman and Deal assert that "in the face of enduring differences and scarce resources, conflict is inevitable and power is a key resource." Do you agree or disagree with this statement?

8. What power sharing challenges have you experienced as you have worked in collaborative environments? What were the strategies you used to overcome those challenges?

Readings and Resources

Fundamental Concepts

Collaborative Leadership and Health: A Review of the Literature. Turning Point National Office, University of Washington, January 2002. http://www.turningpointprogram.org/Pages/devlead_lit_review.pdf.

Collaboration and the Turning Point Initiative: Proceedings of a Conference on Leadership Development Held at the University of Denver, April 6, 2001. http://www.turningpointprogram.org/Pages/devlead_expert_panel_full.pdf.

Turning Point. www.turningpointprogram.org. Collaborative leadership readings, Web links, products, case studies, and more.

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Web Resources

eric.web.tc.columbia.edu/families/TWC

www.ncrel.org/cscd/pubs/lead21

www.collaborativeleaders.org

www.pew-partnership.org

www.kettering.org

Community Toolbox. http://ctb.ku.edu/. The Community Toolbox's goal is to support your work in promoting community health and development. It provides over 6,000 pages of practical skill-building information on over 250 different topics. Topic sections include step-by-step instruction, examples, checklists, and related resources.

Working Together for Healthier Communities: A Framework for Collaboration Among Community Partnerships, Support Organizations, and Funders. Community Toolbox. http://ctb.ku.edu/tools/en/section_1381.htm.

Center for the Advancement of Collaborative Leadership Strategies in Health. www.cacsh.org. The Center for the Advancement of Collaborative Strategies in Health at The New York Academy of Medicine helps partnerships, funders, and policy makers realize the full potential of collaboration to solve complex problems related to health or any other area.

Free Management Library. Management Assistance for Nonprofits. http://www.managementhelp.org. Complete, highly integrated library for nonprofits and for-profits.

Sharing Power and Influence

Bolman, L. and Deal, T. *Reframing Organizations: Artistry, Choice and Leadership* (Chapter 9: Power, Conflict, and Coalitions). 2nd Edition, San Francisco: Jossey-Bass, 1997.

Minkler, M. (ed.). *Community Organizing and Community Building for Health.* New Brunswick, NJ: Rutgers University Press, 1997.

Pearce, C and Conger, J. *Shared Leadership: Reframing the How's and Why's of Leadership.* Thousand Oaks, CA: Sage Publications, 2003.

Schell, J. *The Unconquerable World: Power, Nonviolence, and the Will of the People,* (Chapter 8, Cooperative Power). New York: Metropolitan Books, 2003.

Personal Learning Plan

Refer to your *Sharing Power and Influence: Self-Assessment Exercise*. Look at your *Behavior Frequency* ratings for each item. List the three to five items with the lowest scores.

1.

2.

3.

4.

5.

These are areas you may want to focus on in your learning goals.

My learning goal(s) for the next six months:

Resources I will use (fill in specifics, if possible)?

Reading

Peer Support

Journaling

Coaching

Training

Other?