FINAL COMPREHENSIVE REPORT

Evaluation Findings and Lessons Learned from the Annie E. Casey Foundation Mental Health Initiative for Urban Children: Final Comprehensive Report

EVALUATION FINDINGS AND LESSONS LEARNED

September 2001

Department of
Child and Family Studies
Louis de la Parte
Florida Mental Health Institute
University of South Florida

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About the Department of Child and Family Studies…

The Louis de la Parte Florida Mental Health Institute, a college of the University of South Florida, is the state's primary research and training center for mental health services and a nationally recognized source for its innovative research and training. The Institute was created over 25 years ago by the Florida Legislature to expand knowledge about how best to serve the mental health needs of the state's citizens.

The Institute's Department of Child and Family Studies is committed to the enhancement of the development, mental health and well-being of children and families through leadership in integrating research, theory and practice. It's mission is to:

1. Promote the development, mental health, and well-being of children and families in their communities in Florida and nationally.
2. Promote the development of new knowledge and innovative practices through research.
3. Promote the effective application of best practices in communities and agencies through education, training, dissemination, consultation, evaluation, advocacy, and collaboration.
4. Promote and demonstrate a sensitivity to and understanding of the cultural, economic, and social diversity of our society through the manner in which we conduct our work and the outcomes of that work.
5. Promote accountability and improvement of services through supporting and influencing local, state, and federal policy-making bodies, funding agencies, communities and neighborhoods, and other organizations that support individuals and families.

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Final Evaluation of the Annie E. Casey Foundation Mental Health Initiative for Urban Children:
Final Evaluation Report

This evaluation report could not have been produced and distributed without the help of numerous people.

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To receive additional copies of this report, contact Connie Dykstra, Publications Coordinator, The Annie E. Casey Foundation, 701 St. Paul Street, Baltimore, MD 21202, Voice: 410-223-2977; Fax: 410-223-2983; E-Mail: connied@aecf.org; On the Web: www.aecf.org. **For more information about the evaluation itself,** contact Ruby Joseph at the Louis de la Parte Florida Mental Health Institute, University of South Florida, 813-974-9339.

PREFACE

This summary report on the evaluation findings for the Mental Health Initiative for Urban Children (MHI), represents the final evaluation report that concludes a three-volume report series that respectively covers each of the implementation areas (i.e., systems reform, service delivery and governance). The final summary provides a global perspective on the evaluation findings and spans the five-year implementation period (1993–1998). In addition, the report covers major highlights of the post-implementation phase.

The report comprises four sections and a set of appendices which are organized as follows:

- Section One—Background and Context For MHI Implementation: This section provides detailed historical and background information on the context in which the MHI was implemented. The discussion describes the three main components of the MHI and provides an overall framework for implementing the MHI in the four target sites.
- Section Two—Major Results and Findings of MHI Implementation: This portion of the report provides a detailed discussion of the major accomplishments and challenges experienced in Systems Reform, Governance and Service Delivery.
- Section Three—Lessons Learned From Implementation: Overall perspectives on lessons learned from implementation of the Initiative are summarized from different stakeholder perspectives.
- Section Four—Conclusions: Evaluators also offer a final commentary on the highlights, accomplishments and challenges of the MHI and discuss its implications on future national, multi-site, multi-faceted Initiatives.

Appendices

A. Methodology: provides a description of methods used to evaluate different implementation aspects of the MHI.

B. Site Profiles and Logic Models: provides a demographic description of each of the four sites and the corresponding Logic model for MHI implementation developed by each site.

C. References: provides complete citations for works cited in the text as well as resources used in preparing the report. Also provides a comprehensive listing of various evaluation reports on the MHI and other useful sources of information for the MHI.

For more comprehensive, in-depth discussions and analyses of each of the Implementation areas of the Mental Health Initiative For Urban Children, readers are encouraged to review either the comprehensive and/or abridged versions of the particular Implementation area of interest. This can be done by contacting Connie Dykstra, Publications Coordinator, The Annie E. Casey Foundation, 701 St. Paul Street, Baltimore, MD 21202, Voice: 410-223-2977; Fax: 410-223-2983; E-Mail: connied@aecf.org; On the Web: www.aecf.org.

To discuss the evaluation process itself, contact Ruby Joseph at the Louis de la Parte Florida Mental Health Institute, University of South Florida, 813-974-9339.

SECTION

ONE

Background and Context for Mental Health Initiative Implementation

Background and Context for Mental Health Initiative Implementation

In 1993, the Annie E. Casey Foundation launched the Mental Health Initiative for Urban Children (MHI). The overall goal of this five-year, neighborhood-scale program was to improve community mental health services to achieve positive outcomes for children, and, in the long run, avoid significant public expenditures. Specifically, the MHI sought to demonstrate new ways of delivering culturally appropriate, family-focused mental health services to children in high poverty, urban communities, and to work with states to improve the policies and practices supporting these services. Six sites submitted proposals and four sites were selected for implementation:

- East Little Havana in Miami, Florida
- Mission Hill, Highland Park and Lower Roxbury in Boston, Massachusetts
- Third Ward in Houston, Texas
- East End in Richmond, Virginia

A key aspect of the design of the MHI was its focus on very poor inner-city neighborhoods. This choice grew out of a recognition that while the needs of children and families were great all over the country, there were particularly severe needs that were inadequately met in our country's inner cities. According to the 2000 Kids Count Report,[1] families in impoverished urban and rural communities are still being overwhelmed by a number of factors such as lack of education and employment, single parenthood and welfare dependency and these factors continue to put these families at risk of poor life outcomes (p.7). Approximately 9.2 million children nationally are growing up with some combination of these risk factors. A demographic look at these children reveals they are mostly from minority groups (i.e., 30% of all Black and 25% of all Hispanic children are considered at high risk) and they live in poor central city neighborhoods. Since children of color are also the fastest growing population group[2], the implications of these statistics for their future health and well-being are sobering.

As individual demographics presented in the four site profiles indicate, these were impoverished, predominantly minority communities with many of the same socio-economic factors as identified in the 2000 Kids Count (See Appendix B–Site Profiles).

In addition to environmental stressors, in the United States today, a large number of children are experiencing some type of emotional, behavioral or developmental problem. A recent report from the Center for Mental Health Services estimates that approximately 20% of all children have a diagnosable mental disorder (Friedman, Katz-Leavy, Manderscheid, & Sondheimer, 1996, 1998). For children living in low income communities, the combination of more acute mental health problems and inadequate services results in disproportionate numbers of them spending time in foster care, special education, psychiatric hospitals and juvenile justice facilities–all at public expense.

For the reasons mentioned above, a key element in the MHI's design was to target a broad population of children at-risk, and incorporate unique features from other systems reform initiatives that specifically targeted

[1] The Kids Count Report, provides a status report of the Nation's children and is produced by the Annie E. Casey Foundation.

[2] The 1997 Kids Count report projects a growth between 1996 and 2005 in the number of African-American children by eight per cent, in the number of Latino children by 30%, in the number of Asian and Pacific Islander children by 39%, and in the number of Native American children by six per cent (Annie E. Casey Foundation, 1997). For the same time period, a decrease of three per cent is projected in the number of Caucasian children.

children with serious emotional disturbances and their families.[3] The MHI therefore embraced the philosophy of providing community-based, individualized, strength-based, culturally-competent services in a comprehensive way. In addition, there was a strong emphasis on collaboration among public service providers to implement systemic funding and policy reforms in support of services.

A final feature that made the MHI unique was its emphasis on the importance of delivering services that were responsive to the cultures of the target communities and their residents, and the strategic development of partnerships between neighborhood residents and public sector officials at the state and local levels. This was done in an effort to increase the potential impact of the neighborhood-level demonstration and also improve the chances for statewide adoption of the model.

For implementation purposes, the MHI involved a three-pronged approach: service design and delivery, neighborhood governance, and systems reform. Each of these components was further operationalized into strategies created by partnerships of state, local and neighborhood stakeholders based on broad guidelines provided by the Foundation. A national team of consultants was made available to the sites to provide necessary ongoing technical assistance and support in each of the implementation areas.

The Foundation also contracted with the Louis de la Parte Florida Mental Health Institute (FMHI), University of South Florida to conduct the national evaluation of the MHI. Overall, the general evaluation strategy was a process oriented, formative evaluation designed to answer a series of significant questions regarding implementation. In addition to documenting outcomes, the evaluation focused on understanding and describing the changes that took place during the implementation process.

The evaluation process generated reports on implementation findings in each of the three major areas of the Initiative, i.e., systems reform, governance and service delivery. Each implementation report consists of a volume providing detailed discussion and analysis of that area, as well as an abridged report highlighting accomplishments, challenges and major lessons learned.

Mental Health Initiative Framework

As previously stated, the Initiative was organized under a framework that included three critical components, Systems Reform, Governance and Service Delivery. With the assistance of technical assistants and evaluation staff, key stakeholders from each of the four sites developed and designed a logic model that organized implementation strategies that would allow them to work on each of these areas simultaneously. (See Logic Models–Appendix B).

The main goals and features of these areas are briefly outlined below.

Systems Reform[4]

Ultimately, the major responsibility of the state-local-neighborhood partnerships in the MHI sites was to plan, initiate and manage change–change in the way services and supports were provided, which, in turn, required change in the way traditional services operate.

Evidence of successful systems reform in the four MHI cities would include:

- Increased local leadership and control, and shared authority between neighborhood, local and state levels for the purpose of engaging community residents and families in the design and implementation of a neighborhood-based service system.
- Implementation of a high quality, prevention-focused, family centered service array to meet identified community needs.

[3] From the National Institute of Mental Health's Child and Adolescent Service System Program (CASSP), the MHI drew its emphasis on community-based service models partnering with the various systems that worked with children. It also adopted its philosophy of providing individualized, strength-based, culturally competent services that addressed family needs in a comprehensive manner. From the Robert Wood Johnson's "Mental Health Services Program for Youth," the MHI adopted a strong belief in collaboration among public sectors to implement systemic funding and policy reforms in support of the service piece. The Ventura Project in California further modeled the benefits of financing reforms to promote community-based services over institutionalization.

[4] For information on Systems Reform, see Systems Reform: Final Evaluation Report, May 2000; and Systems Reform: Summary of Findings and Lessons Learned, May 2000.

- Changes in policies, regulations and funding mechanisms to help sustain the Initiative and facilitate the application of models developed at the neighborhood level to other systems serving children and their families.
- Changes in the way information was used to support systems changes.

Neighborhood Governance[5]

The main vision of the governance process was to develop and strengthen partnerships between state, local and community level stakeholders involved in the Mental Health Initiative.

The neighborhood governance structures would include the following characteristics:

- Include leaders and key stakeholders from every part of the community, including government officials, community leaders, professionals and decision-makers from all major child-serving agencies, residents, and consumers of services.
- Ensure that community residents had input and ownership in all major aspects of implementation of the MHI.
- Have administrative oversight for the project.

Service Design and Delivery[6]

Instead of expanding traditional mental health services that emphasize office-based therapies and institutional care, the MHI was interested in fostering community-based service approaches. This emphasis was rooted in the conviction that interventions which focus only on children do little to change factors that give rise to or increase the incidence of mental health problems. Thus, the MHI was designed to:

- Broaden the traditional population of children served (i.e., those with severe emotional disturbances) to include children and adolescents who are "at risk"—not just those who have already been identified as having mental health problems;
- Focus on prevention and early intervention to keep problems from becoming so severe that out-of-home, out-of-community placements are the only remaining alternatives;
- Deliver mental health services in nontraditional settings, such as community settings that are less stigmatizing to the child and family.
- Emphasize parent education, support, and involvement.

[5] For information on Neighborhood Governance see Neighborhood Governance: Final Evaluation Report, December 2000; and Neighborhood Governance: Summary of Findings and Lessons Learned, December 2000.

[6] For information on Service Design and Delivery see Service Design and Delivery: Final Evaluation Report, December 2000; and Service Design and Delivery: Summary of Findings and Lessons Learned, December 2000.

SECTION

T W O

Major Results and Findings of MHI Implementation

- **Systems Reforms**
- **Neighborhood Governance**
- **Service Delivery and Design**

Major Results and Findings of MHI Implementation: Systems Reform

Systems Reform was perhaps the most ambitious of the three areas of implementation. This component of the Initiative called for initiating and managing reforms in service delivery philosophy, processes and procedures of major human service agencies, while allowing the newly created governance structures to play a critical role in initiating and managing these reforms. The successes and challenges in implementing these reforms are discussed in the four major areas below:

- Increased Local Leadership, Control and Shared Authority with Local Residents
- Implementation of a High Quality, Prevention-Focused, Family Centered Service Array
- Changes in Policies, Regulations, and Funding Mechanisms to Support the Service Strategy
- Management Information Systems and Effective Use of Data

Increased Local Leadership, Control and Shared Authority with the Neighborhood Residents

There is strong evidence from the MHI implementation that new and productive partnerships were established among neighborhoods and state and local stakeholders. There was an initial lack of trust among partners, and differing visions for the Initiative which slowed down progress and service implementation. Eventually however, the various governing configurations in the four sites led to increased levels of local control and shared authority with neighborhood residents.

The final governing structure of all boards was faithful to the MHI original design, involving a majority of residents along with a mix of stakeholders representing public and private sectors. All boards were led by an elected community resident. Despite high levels of turnover early on in the Initiative, a core group of residents, state, local and agency leaders remained committed to the goals of the MHI, and worked hard to develop trust and relate as equal partners. Resident and nonresident board members agreed that these relationships were a welcomed departure from the way in which neighborhoods and state and local representatives had worked in the past. Furthermore, they agreed that the experience would influence the way in which they approached future joint endeavors on behalf of neighborhoods.

Additional evidence of the shift to local control fostered by the MHI is the fact that three of the sites' neighborhood governing boards—People in Partnership in Texas, Abriendo Puertas in Florida, and Roxbury Unites for Children and Families in Massachusetts—incorporated and/or obtained nonprofit status. PIP and Abriendo Puertas are still active and operating as autonomous entities, managing their own budgets and successfully pursuing additional funds to support program expansion and ensure sustainability. Both boards achieved a level of development and maturity that eventually led the Foundation and other state and local agencies to fund them directly, bypassing the fiscal agents that had been used at the beginning of the MHI.

The negative side of this devolution of authority and control to the local boards is that the state eventually disengaged itself from the reform process pursued by the Foundation in design of the MHI. Without the state's involvement, the local MHIs are now func-

tioning as community-based organizations with strong resident leadership, but whose ability to impact major policy decisions at the state level is limited.

The MHI's philosophy of resident-driven service design embedded in a governance structure, however, has become a model adopted in arenas outside mental health. The Florida MHI, for instance, became a model for consumer-led governance adopted in Neighborhood Service Centers funded by federal Family Preservation/Family Support grants around the state. Similarly, the governing model employed for the East End's Family Resource Center in Virginia's MHI was used to pattern the board of a community-based health clinic which was at risk of closing for failing to address the neighborhood's needs. In Houston, the Mayor invited the Executive Director of PIP to be a part of a task force to promote the role of neighborhood organizations in addressing the needs of underserved areas in the city.

Finally, the increase in grass-root leadership capacity is an unquestionable outcome of the MHI in all four communities. Besides the mixed governing bodies established to guide implementation, the sites independently developed or strengthened other groups made up exclusively of residents (e.g., Family Council in Miami, the Family Advocacy Network in Houston, the Parent Resource Network in Richmond). These "informal" organizations took on community causes beyond the mandate of the MHI, becoming effective advocacy and organizing vehicles to give residents a voice in the decisions impacting their everyday lives. Groups of community residents have traveled to their respective state capitals and to Washington, DC to meet with their state delegates and lobby for various causes impacting their neighborhoods. Some of the residents more actively involved with the MHI have gone on to serve on boards of national organizations, attended national conferences, and advised other resident groups. Their work has also begun to fill service needs that have not been previously addressed by other established providers working in these communities.

The development of grass-root leadership was tied to a combination of two main factors: the natural yet untapped leadership abilities of residents involved with the MHI; and the knowledge gained through extensive technical support provided by Foundation consultants, exposure to family-centered service models from around the country, and involvement in the Initiative's governance and implementation process. Armed with these new skills and knowledge, neighborhood representatives were able to develop their own ideas of what systems reform was, and what it took to accomplish it, as evidenced by the various examples provided in the case study section of this report.

Implementation of a High Quality, Prevention-Focused, Family Centered Service Array

The status of services at the end of the MHI's five-year implementation suggests that some sites were better able to achieve systemic reforms than others. Three sites (i.e., Florida, Texas, and Virginia) are delivering services one year after the official end of the Initiative; one site has stopped serving families and dismantled its original service strategy (i.e., Boston). The common denominator among the active sites appears to be their emphasis on combining universal and prevention oriented services, a strong resident involvement in the design and delivery of those services, and effective sustainability strategies. The latter variable will be discussed in the following section.

Although the MHI was designed as a reform strategy to address the mental health needs of children with severe emotional or behavioral problems, mental health was also viewed in broad terms to include the healthy development of all children in the neighborhood, and the supports for families to help nurture and care for them. This broader understanding of mental health appears to have had more resonance with community members than the narrower focus on at-risk children. As a result, the service array designed and implemented by the MHI sites with significant involvement from community residents had a heavier emphasis on prevention rather than intervention, and on family as opposed to child-focused approaches.

The combination of broad support services provided at community-based Family Resource Centers (FRCs), and family-centered case management strategies to serve

needier families represents a new concept in the field of children's mental health, and is directly tied to community residents' view of mental health as a family well-being issue. All sites employed variations of this combination as a service strategy.

In addition to clinical services, programs offered at the FRCs included educational and vocational training for adults, parenting and child development classes, tutoring and after school programs for children, youth groups for teenagers, and food and clothing assistance, among others. The location of the FRCs in the heart of the MHI neighborhoods helped overcome the barriers of accessibility and convenience which afflicted programs run outside the community.

Another reform accomplishment for the MHI communities involved replacing the traditional service delivery approach relying exclusively on professionals with mixed teams of professionals and trained community residents. Richmond's Parent Resource Network (PRN), Boston's Family Resource Specialists, Houston's Friends of the Family, and Miami's Madrinas and Padrinos are all examples of resident groups that partnered with professionals as family advocates, information and referral sources, mentors, educators, and "24/7" (i.e., 24 hours a day, 7 days a week) support systems. Miami has developed an innovative training curriculum called "Equipo Training" to bridge the gaps between professionals and nonprofessionals, enhance their skills, and maximize each other's strengths.

Although evaluation findings derived from families served by these types of teams point to a greater emphasis on family strengths, family involvement, reciprocity (i.e., participants supporting each other) and sensitivity to family cultural values, state and local agencies have been reluctant to embrace them. The main concerns expressed have been over the preparation and credentials of nonprofessionals to work with families presenting serious problems. This lack of credentials affected the credibility of some of the local neighborhood systems. This was seen in Boston where more traditional human service systems were reluctant to refer their clients to the Family Resource Centers because they did not feel that staff at these centers had the expertise to serve some of families with more serious emotional and behavioral problems.

Another service systems reform accomplishment comes from the example set by Houston's pioneering effort to involve a grass-root minority community organization in the managed care scene. People in Partnership (PIP)—Houston's governing board and a nonprofit organization—applied with the state to become a Medicaid provider of mental health and addiction treatment for low income people. PIP proposed to use its community-based provider network as a base for a Medicaid provider pool. This brokering role, along with the support PIP provided its network members to fulfill accreditation requirements, and meet Medicaid's strict record-keeping demands, has enabled a small, mostly minority group of agencies based in the Third Ward to survive and succeed in the managed care world. This model is still new and significant barriers have been encountered, particularly around accreditation, where the site faced barriers in getting a qualified pool of minority community-based agencies certified. Nonetheless, the PIP model does provide an example of an innovative reform strategy which other community-based agencies can study and possibly adapt to suit their own unique situation.

Changes in Policies, Regulations, and Funding Mechanisms to Support the Service Strategy

A major goal of the MHI was to restructure policies and financial practices to provide for the development and sustainability of the service strategy at the neighborhood level. Examples of plausible reforms included: maximization and reinvestment of federal revenue so that services are more cost-efficient and have a preventive focus; changing standards and regulations, such as Medicaid rules and licensing requirements to support the service goals; promotion of integration and coordination across systems in their planning, budgeting and program development; and changing personnel and training policies and procedures to increase the fit with front-line practice.

Overview of Fiscal Reform

No established trend was noted in this aspect of systems reform, and individual sites varied greatly in what they were able to accomplish. What is clear, though, is that policy reforms seemed to have been limited to the local rather than state level. The fiscal reforms that were undertaken, although promising, were insufficient, at the end of the MHI, to fully replace the Foundation's investment.

Successful fiscal approaches took various forms in the MHI sites. A shared strategy involved reliance on new grants to replace or expand the MHI funding that was ending. Houston and Miami obtained federal and foundation grants to support service delivery and operational expenses. Richmond opted for local foundations to support new activities in its FRC.

Cost-sharing was another mechanism used. In Miami, the school district paid for half the salary of two MHI employees, with MHI funds covering the other half. Miami Dade County also provided the space for the FCR location at a nominal rate, and paid for utilities. In Richmond, various city agencies pooled their resources and paid the salaries of case managers who were part of a team assigned to work with families identified through the MHI, in addition to handling cases from other parts of the city. The City also contributed funds to operate and staff the FRC.

Houston provides the only example in the MHI of a refinancing strategy where Medicaid dollars were drawn through a managed care strategy, as noted in the previous section. The success of this effort remains to be established. However, it is already clear that for those community-based organizations which made it through the demanding accreditation process, the alternative would have been closing their doors to the public. PIP hopes that revenues generated by Medicaid reimbursements will eventually be used to pay for more flexible services for children and families. Following Houston's example, Richmond's MHI is presently exploring the possibility of having two local HMOs contract with them for the provision of integrated case management services in the East End.

Boston was able to raise new revenues from a special allocation assigned to the governing board by the state legislature early on in the MHI. Three million dollars were allocated for three years to support the service strategy in the three targeted neighborhoods. This significant achievement was the result of intensive lobbying of their representatives by resident members of the MHI's governing entity, Roxbury Unites for Children and Families (RUFC). Although the allocation was eventually suspended due to poor service implementation, the fact that state lawmakers chose to concentrate significant resources in a narrowly defined neighborhood to support a community-based preventive mental health model sets an important precedent for other communities to follow.

The Miami MHI took advantage of an opportunity offered by the Casey Foundation to implement a creative strategy to expand programmatic goals and ensure sustainability without additional funds. The Time Dollar Bank is an approach which relies on community residents volunteering their time to help others in exchange for goods and services for themselves when they need them. This reciprocity system provides a pool of support and services that no community agency can match, and at no cost to the program other than hiring a project coordinator. The Abriendo Puertas Time Dollar Bank has over 9,000 volunteer hours logged in by neighborhood residents working in various community settings and organizations, and with individual families.

Overview of Policy Reform

In the area of policy, accomplishments were fewer, but they set important precedents. Miami and Richmond were the only sites that achieved significant reforms tied to the MHI implementation and with implications beyond this initiative. In Miami, two important precedents were set in state contracting procedures. After Abriendo Puertas incorporated and obtained nonprofit status, the state decided to bypass the county as the MHI's fiscal agent and contract directly with Abriendo Puertas. This represented the first instance in which a state agency in South Florida had established a contractual relationship with an organization whose board largely consisted of residents from a minority, low income community. The state made another contractual exception to accommodate Abriendo Puertas when it allowed one of its employees with a long history of involvement with the local MHI to act as interim Executive Director during

recruitment for the position. As a rule, state employees are not allowed to serve on boards of organizations with which the state contracts.

Overview of Personnel Policy Reform

Personnel policies were also re-examined by the state and local providers involved with the MHI. In the case of Florida, the state requirement that Abriendo Puertas use existing county job descriptions to fill the Executive Director's position was waved to allow the grass roots organization to develop its own criteria and set of qualifications. The provider, a community mental health center located in the target community, changed the job description of one of its case managers assigned to work with Abriendo Puerta's families to give her more flexibility and allow her to focus more on the entire family rather than on a single member.

Richmond implemented similar personnel reforms. In their case, the city agreed to change job descriptions and salary ranges to accommodate the extended role that case managers working as part of a multi-agency integrated team (e.g., East District Families First or EDFF) had to play in working with entire families as opposed to targeted individuals within a family.

Richmond's commitment to practice the MHI philosophy of family/resident involvement in all aspects of community-based service delivery was also visible with regard to the staffing of the FRC, which the city partially funded. Job descriptions for all staff working at the FRC were created from scratch using examples from FRCs from all over the country. To ensure resident input in this process, neighborhood representatives sat on all hiring panels. Finally, a staff position on the EDFF was reserved for a representative of the Parent Resource Network (PRN) to serve as a source of advocacy and support to families from the East End.

Finally, Houston's struggles with the accreditation of community-based organizations as managed care providers need not be viewed as failure. Rather, they need to be studied in terms of a potential opportunity for reform that can change the way managed care providers operate in poor urban communities.

Management Information Systems and Effective Use of Information

Systematic data collection and analysis was an important element in the Foundation's overall vision for systems reform. The data was intended to guide the provision of services, identify gaps or weaknesses in the system, and evaluate the Initiative's success. Indicators to be tracked included out-of-home placements, available preventive and intervention services, and costs associated with the provision of services.

The four sites were able to enjoy only modest success in Management Information Systems reform. Site accomplishments were related more specifically to their ability to collect baseline information from larger agencies, and impact policies of a few state/local agencies.

One major accomplishment was that MHI secured the first baseline statistics at a neighborhood level for the target communities with sites collecting data on service, placements, and the cost of out-of-home placements for children. Traditionally, statistics are obtained for much larger geographical areas, making it difficult to deliver interventions that are community-based. In Massachusetts, for example, the MHI inspired the Executive Office of Health and Human Services to adopt the practice of looking at city-wide statistics by zip code in order to better target social and other types of programs to areas with the most need.

However, sites faced many challenges related to data collection such as time constraints and the labor intensity of this task. In some instances, sites also had to combat problems of philosophical 'buy-in' where traditional state agencies failed to see the benefit of committing large resources to retrieving retrospective data. This became an issue because many agency data collection systems were on paper and not computerized.

Although these problems were difficult to resolve, an unexpected benefit was identification of many important structural barriers to effective data collection. These barriers included: lack of residential zip codes

on client data bases, the difficulty in tying funding streams to specific programs and services, agency dependency on paper rather than electronic files, and a lack of agency staff dedicated to data collection tasks. Resolving some of these barriers is a critical first step towards improving information utilization in any systems reform endeavor.

A more fundamental accomplishment related to data collection and utilization is the increased awareness and understanding among many MHI stakeholders of complex MIS and data issues. In particular, resident stakeholders in the four MHI sites have now been left with a better grasp of the different aspects of service delivery, especially costs associated with providing services to neighborhood families and children. This knowledge is due, in large measure, to their involvement with MHI data collection activities (e.g., MIS board committees, technical assistance sessions, conferences, and individual mentoring). The capacity of neighborhood residents to interpret quantitative indicators of quality of life issues in their communities, and ask pertinent questions about funding and resource allocation will increase their long-term efficacy as advocates of systems reform.

A second major aspect of MIS reform in the MHI was the development of local client tracking systems to monitor and support the service delivery at each of the four sites. The Foundation expected each site to develop a complete description of their service systems, and to base their client tracking systems on this information. There was also an expectation that, ultimately, these client tracking systems would be connected or linked to existing state information systems, creating a more competent history of utilization patterns, and facilitating an efficient service delivery system.

In general, the MHI fell short of its stated goals in this area. There has been no significant long term impact on integration between federal, state, and local management information systems. There is also no evidence that the MHI substantially improved access to state cross-agency service data by local providers. In addition duplication of state level intake processes still remains problematic.

Although disappointing, these results are not surprising because sites were heavily focused on the other two areas of MIS reform—data collection and the development of local tracking systems. These efforts have been time consuming and labor intensive. During the official implementation phase of the Mental Health Initiative only Boston and Miami's tracking systems became fully operational toward the middle and latter phases of service implementation. Houston was able to install its information system, but that system had yet to become fully operational at the time of this report. Richmond was still in the process of developing its client tracking system when the formal implementation of the Initiative ended.

Major Results and Findings of MHI Implementation: Neighborhood Governance

The Annie E. Casey Foundation's Mental Health Initiative Planning Grant Guidebook provides the framework for neighborhood governance (Casey Foundation, 1992). One part of the Foundation's selection criteria for the sites was that there be "a neighborhood governance structure that has legitimacy, authority, capacity to manage and accountability for administering the resources" (Planning Grant Guidebook 1992:102). Other components stressed in the Guidebook include:

(1) an overall family centered approach,

(2) the involvement of every level of government,

(3) delegation of authority and decision making from local government to neighborhood,

(4) ensuring the active participation of neighborhood residents, and

(5) the development of a system of care at the neighborhood level: Ultimately, the neighborhood governing board (structure) will be the single point of accountability for the development, implementation and management of a system of care (Planning Grant Guidebook 1992:75).

This section highlights trends and commonalities in the form of successes and challenges related to implementing governance strategies across the four MHI sites. The discussion is based on the main attributes of the NGB Framework developed by the national evaluators (See Appendix A for a detailed description of attributes). Only the most salient findings across sites are included in this discussion however, more in-depth site specific findings can be reviewed in the final evaluation report on Governance (May 2001).

Site accomplishments and challenges occurred in the following areas:

- Development of Partnerships among Stakeholders
- Stakeholders' Visions of the MHI
- Stakeholders' Perceptions of the Role of the Neighborhood Governance Boards (NGBs)
- Leadership Development and Resident Empowerment
- Representatives and Accountability
- Resource Management and Sustainability

Development of Partnerships Among Stakeholders

The MHI envisioned the governing entities connecting neighborhood residents with local and state government representatives to work in collaboration around a common vision to benefit children and families in the target communities. A critical element in the development of any partnership is trust. This is especially important in relationships where the partners hold differential power and control over resources, decision-making and information. Findings from the evaluation of NGB development revealed that sites struggled with the establishment and maintenance of trust among stakeholders throughout the life of the Initiative.

Early on, the level of trust was impacted by experiences that pre-dated the MHI. Neighborhood residents in the four communities talked about their mistrust of the state based on a history of what they saw as "broken promises." The reported on community projects of the past that would start with high hopes and expectations on the part of residents, and end when funding was over with few successes and increased resentment. The words of a Boston resident interviewed in 1994 illustrate the feelings of residents in the other three communities: "*There is a lot of mistrust and misgiving because these communities have been abused and misused by the city and state agencies all the time…A lot*

of the opposition to this project [MHI] came because of those things…" (NGB report 1994). Similar issues were expressed by residents regarding the provider agencies in their communities, with whom they were to partner in the development and implementation of the service strategy of the MHI. Agencies were seen as self-centered and unwilling to involve residents in programmatic decision-making. A Houston resident expressed her early frustration as follows:

"*I have very little optimism about the potential for it [MHI] to be any real reform or changes for families…It's too involved with those local agency representatives…*" (NGB report 1994).

With time, personal relationships grew closer among the partners involved in the governing boards and trust began to emerge, albeit tenuous and continuously shifting among the different levels of stakeholders. In Boston, for instance, relationships between residents and the state were initially mediated by a strong State Coordinator. When she left the project, however, relations deteriorated and eventually crumbled. Miami related to the state through a local District Office of the Department of Children and Families. This arrangement was highly successful, and led to a long-term relationship between the community and the state. Neither Boston nor Miami, however, developed strong links to the city. Miami substituted the city with the county and built a very strong and lasting partnership.

Richmond and Houston never succeeded in establishing strong ties to the state. Most stakeholders attributed this to the fact that the original governors who supported the implementation of the MHI in their states were replaced in both sites during early implementation. The new state leadership was not as invested, and thus, never fully engaged. To compensate for the lack of state involvement, Richmond turned to the city, and Houston to the provider community.

A common element in all sites tied to the ups and downs of trust development was the uncertainty regarding the NGB's chances of influencing the systems change process called for by the MHI. Respondents at the state and local levels showed varying degrees of optimism about the capacity of the local governing boards to demonstrate and inspire system reforms in their states. Their skepticism was mostly based on the perception that residents serving as board members did not have the background necessary to engage in discussions about how to reform complex state policies, regulations and funding mechanisms. As a local level representative from Boston stated in 1996: *"It was certainly premature to ask them [residents] to stand as peers in the face of the professional expertise that was brought into the process by the state and the city. They [residents] didn't have a chance."* (NGB, Boston 1996).

Time, and the perseverance of a committed core of residents who served on the NGBs from the beginning of the MHI, changed this perception. An important factor in leveling the learning curve for residents and fostering equity with professionals from state, local and community agencies, was the work done by teams of residents and professionals in the various committees of the boards, especially around service and fiscal issues. A Miami resident and long-time board member described her participation: *"I am in the Finance committee because I am the treasurer. There are three people in the committee… always together the professionals and the parents. It's a very effective participation, [it's] open so people can express their opinion."* Another factor that contributed to narrowing the knowledge gap between residents and professionals was the technical assistance provided by consultants hired by the Foundation to support the implementation of the MHI. Leadership training, combined with technical sessions with residents on various service and financing topics helped break communication barriers and encouraged more open debates among stakeholders.

Finally, although residents agreed that at the end of the MHI they had more confidence and a better sense of partnership with representatives of state, local and provider levels, some never totally abandoned their initial lack of trust. According to the consultants who worked closely with residents throughout the MHI implementation "*underlying, unresolved issues of race, class and culture got in the way of the development of effective governance in the sites.*"

Stakeholders' Visions of the MHI

One important developmental attribute tracked in the evaluation of governance was the presence and nature of a vision for the MHI. The governance study sought to understand how the different levels represented in the governing boards understood and prioritized the goals of the project, and how they used this vision to guide implementation.

The evaluation found that all sites had similar overall visions for the MHI relating to the improvement of the quality of life for children and families in their respective communities. The analysis further revealed the existence of several "secondary visions" within the boards, which varied depending on whether the source were neighborhood residents, the local level (e.g., city, county, providers), or state level representatives. The neighborhood's vision focused on short-term expectations in the area of service delivery and program development. Neighborhood residents saw this Initiative as an opportunity to bring much needed services to the community, and upgrade existing programs to better serve children and families. A resident board member from Houston stated, "…*we have to be able to address those needs, be it socially, economically, educationally, culturally, so that the neighborhood can thrive.*" (NGB Houston 1998).

The state level, on the other hand, envisioned the MHI as an opportunity to accomplish long-term system reform in the area of children's mental health. This level saw programmatic development more as a means to an end, rather than as the end result of reform itself. The local level (e.g., county, city, and providers) combined a short and long-term vision of the Initiative. Like the state, it recognized systems reform as the ultimate goal; like the neighborhood, however, it considered the MHI an opportunity to supplement services by adding funds to existing pools of money already invested in the targeted communities (e.g., empowerment zones, Medicaid, full service schools, etc.). Additionally, the local level vision treated the Initiative as a chance to test the viability of new approaches to service delivery at the neighborhood level.

Stakeholders' Perceptions of the Role of the NGBs

The expectation that the NGBs would become the vehicle to transfer authority and control from the state and local levels to the neighborhood resulted in unexpected challenges to the MHI's implementation. To examine this issue, the evaluation collected longitudinal data on the various stakeholders' understandings of the role of the neighborhood, represented by residents, vis-á-vis the state, local, and provider levels on the NGB.

Organizationally, all boards included a majority of residents (i.e., 50% plus 1). All resident members in all boards were allowed to vote, and only residents could hold the chair's position. This organizational structure was designed to ensure that neighborhood residents would have the strongest voice on the board, and therefore, that they carried the weight in the decision making process.

The USF evaluation found that in principle, all parties at the beginning of the MHI saw the project as a community-driven effort, with neighborhood residents playing a key role in shaping and guiding it. In practice, however, there were conflicting views among stakeholders as to whether a resident-driven governing entity could assume this type of control.

Residents perceived that their involvement had to be at "all levels" of the decision-making process in the MHI, from planning and designing services, to approving the budget, and selecting and monitoring providers. Across the four sites, however, residents on the NGB felt they had to fight to be heard, to have their opinions respected and considered on an equal basis with non-resident, professional and government representatives. As a resident board member from Miami explained:

"*They [i.e., non-residents] don't vote against the parents. If the parents make mistakes, let them make them…that's why we are here, to learn. I make a mistake, I fall down, I get up and I learn from the fall. But we cannot learn through someone else's experiences.*"

A resident from Richmond expressed a similar feeling: "*Council and City administration are beginning to acknowledge that the community or the citizens in the East District do have a say…. I guess that means when we say to the city: 'OK, we've been part of this*

process, we've gone through all this training, we've been to all these conferences, we gather all this information, now, what will the city do to let us put our skills and knowledge to work?'"

State and local level representatives on the board, for their part, were concerned that the community did not have the necessary expertise, and were reluctant to delegate control. At the state level, representatives of state agencies designated as grantees by the Foundation, and the MHI's state coordinators who responded to those grantees mostly experienced this reluctance. All of these stakeholders saw themselves as ultimately accountable to the Foundation for the success of the Initiative at each site, and felt they needed ultimate approval power to guarantee the MHI's proposed outcomes.

For representatives of the local level, including city, county, and providers, the issue was less one of accountability and more one of quality of implementation. Providers, in particular, feared the board's interference with their traditional service delivery approaches. In Boston, for instance, Children Services of Roxbury (CSR), the lead agency for service delivery, was reluctant to provide detailed monthly updates and reports on their progress to the NGB, which they saw as an advisory rather than a policy-making entity. At times, the agency's actions were questioned or halted all together by the Board. In the words of a resident board member, "*…We have not been a quiet entity…DMH, DYS, DSS, DPH, Boston School Department sit there and they listen to what the community has to say about what is going on.*"

With the strengthening of trust among stakeholders discussed earlier on, some of these control issues were eventually overcome. Miami and Houston's Boards incorporated as non-profits, and eventually became the recipients of the Foundation's grant, bypassing the state and local levels. Abriendo Puertas in Miami, and People in Partnership (PIP) in Houston, now have their own executive directors who respond directly to the Board. The Boards develop and approve the budget they submit to the Foundation. Although residents and non-residents' viewpoints regarding board decisions often differ, the stakeholders have learned to negotiate their differences and come to consensus on the most important issues. Both Boards sought and obtained new sources of funding at the end of the MHI.

The role of the NGB in Richmond played out differently from the other sites, with the splitting of decision-making levels among three different entities: the East Team Board (ETB), the Strategic Partnership Team (SPT), and the Family Resource Center (FRC). The ETB in Richmond served as the MHI's governing entity, although it was not exclusive to it, as it had oversight of other East End initiatives. With the achievement of non-profit status, the ETB gained independence from the city, which had originally dominated it, and expanded its role from policy-making to service implementation in a broad spectrum of areas. The ETB is presently seeking independent sources of funding to add and expand services in the East District.

The Strategic Partnership Team was created after the ETB was established to ensure coordination across different stakeholders involved with the MHI. The SPT was seen as an advisory and planning group. Lastly, the Family Resource Center, Richmond's service delivery arm, created its own board, concerned mainly with the activities of the center and the services it provided to community residents. Residents who had been involved with the MHI since the beginning insisted that the FRC board should only include parents. Their insistence came from a lingering perception that the non-resident stakeholders would eventually "take over" the decision-making process and the residents' voice would be lost. The FRC board now oversees the expenditure of its own funds coming from the larger MHI budget for service delivery.

In Boston, Roxbury Unites for Children and Families, (RUFC), the initiative's board, never fully played the role of sole decision-maker vis-á-vis the state level represented first by the Department of Mental Health and later by the Executive Office of Health and Human Services. RUFC struggled to become the ultimate decision-making body for the MHI, and obtained some significant concessions in terms of what services should be offered and how. However, the state never gained enough confidence in the capacity of

the resident-led board to delegate full accountability to the group. By the end of the MHI, the state and provider stakeholders were no longer actively involved with the board. Presently, the board's Parent Committee, which involves only residents, is the only one active, and there are plans for it to administer some of the remaining MHI funds in the future.

Leadership Development and Resident Empowerment

The longitudinal evaluation of governance revealed a gradual evolution of leadership skills among resident board members in all the MHI sites. The Boston, Houston, and Richmond Boards involved many experienced community leaders with an extensive history of activism, advocacy, and organizing around various issues impacting their neighborhoods. These individuals were also involved with community civic organizations, boards, PTAs, tenant councils, churches, and clubs. The Miami board did not include residents with that kind of background because a majority of them did not have their U.S. resident legal status. Without it, the visibility brought by involvement in community organizations could result in deportation to their native countries. Several of the residents on the four boards also had knowledge of children's mental health issues because they had children with emotional and behavioral problems.

Participation in the MHI, however, required additional skills and knowledge in the areas of mental health policy and systems reform, financing, management information systems (MIS), and working in partnership with state and local governments. To fill this gap, the Foundation supplemented the existing leadership abilities of residents involved with the MHI through extensive technical support provided by consultants, exposure to family-centered service models from around the country, training on various financing mechanisms, and connections with national consumer organizations.

The combination of hands-on involvement in governance, and targeted training to level out differences in knowledge and experience of residents and professionals serving on the boards resulted in an unquestionable increase in grass-roots leadership capacity in all four communities. Besides the mixed governing bodies established to guide implementation, the sites independently developed or strengthened other groups made up exclusively of residents (e.g., Family Council in Miami, the Family Advocacy Network in Houston, the Parent Resource Network in Richmond). These "informal" organizations took on community causes beyond the mandate of the MHI, becoming effective advocacy and organizing vehicles to give residents a voice in the decisions impacting their every day lives. Groups of community residents have traveled to their respective state capitals and to Washington D.C. to meet with their state delegates and lobby for various causes impacting their neighborhoods. Some of the residents more actively involved with the MHI went on to serve on boards of national organizations, present at national conferences, and advise other resident groups. They also began to fill service needs that had not been addressed by the established agency providers working in their communities.

Finally, the MHI's philosophy of resident-driven service design embedded in its governance structure set an important precedent for reform in arenas outside mental health. The governance structure in Florida, for instance, became a model for consumer-led governance adopted in Neighborhood Service Centers funded by federal Family Preservation/Family Support grants around the state. Similarly, the governing model employed for the East End's Family Resource Center in Virginia's MHI was used to pattern the board of a community-based health clinic which was at risk of closing for failing to address the neighborhood's needs. In Houston, the Mayor invited the Executive Director of PIP to be a part of a task force to promote the role of neighborhood organizations in addressing the needs of underserved areas in the city.

Representativeness and Accountability

One of the Foundation's Benchmarks of progress for the governance strategy was that it be representative of the many stakeholders affected by the decisions made through the Initiative. These included state and local government agencies, community-based organi-

zations, service providers, neighborhood residents, parents of children with emotional and behavioral problems and youth. Along with representativeness, accountability to the community-at-large for the actions taken by the NGBs was another fundamental assumption.

During the early stages of governance, Boston and Richmond required that the resident slots on the NGB be filled by persons from the community who served on civic associations, community-based organizations, or represented community institutions (e.g., church). This was designed to ensure accountability. Miami drew its initial resident board members from the community at-large, and later from a leadership training program for neighborhood residents sponsored by a local university. Non-resident members in the four boards included representatives from various local provider agencies, in addition to county, city, and/or state stakeholders. Houston had a large number of residents with experience in community organizations and service provision. This cadre of local leaders functioned as the first provisional Board with no special criteria attached to people's participation.

As the Initiative progressed, the resident composition and selection criteria began to change. Houston and Boston moved to a community-wide election process whereby anyone interested, regardless of whether they were affiliated with an organization or not, could become a candidate and be elected to the NGB. Richmond continued with its original membership model. Miami moved from unrestricted membership to creating additional categories of "community representatives," with the requirement that they live in the neighborhood. In addition, Miami created the "Family Council," a resident-only organization with representation on the NGB.

Both approaches (i.e., unaffiliated vs. affiliated residents) raised issues regarding representativeness and accountability. Those that used residents belonging to pre-existing organizations reportedly inherited their shortcomings. In Boston for example, the perceived under-representation of Latinos, other non-African American minorities, and parents of at-risk children by the Healthy Boston Coalitions, was seen as a challenge to true representativeness. In Houston and Richmond, concerns related to differences between professional and non-professional community residents who sat on the board. The latter group of residents felt that professional community residents were more accountable to their employers than to their community. Similar concerns have been brought up in Miami since the board broadened the definition of "community resident" to include professionals and business representatives.

When the Boston and Houston boards moved to open community elections to fill resident positions on the NGB, the debate over representativeness switched to issues of ethnicity, gender, age, immigration status, and parental status (e.g., parents of at-risk children). In the absence of an effective community outreach process to keep the neighborhood residents informed of the decisions the NGB was making on their behalf, the question of accountability became even more pressing to non-resident stakeholders.

The non-resident composition of the boards also changed over time, but for different reasons. At the beginning, local providers eager to access the funds the MHI would bring, had a strong presence on the NGBs, and at times, overwhelmed resident representatives. The slow transition from planning to implementation caused by the need to build consensus around the MHI vision for services, however, prompted many providers to leave. Many state level stakeholders that were very involved during the planning and initial implementation phases were replaced later due to leadership changes within their agencies tied to larger political events (e.g., changes in governors).

Of all non-resident stakeholders, the local level had the most stable representation on all NGBs except Houston. In Richmond, the city has been a continuous partner and blended some of its own programs with those of the MHI. In Miami, the local District Office of the state's Department of Children and Families and Miami Dade County have had the same high ranking administrators serving on the NGB for the last five years. Boston's local partner was the city. Representatives from the Mayor's Office of Community Relations held a permanent seat on the NGB and followed the MHI implementation from the beginning. The city's level of

engagement, however, wavered and waned throughout the life of the Initiative.

In Houston, the initial NGB was heavily controlled by local providers from "The Cloth" group which had been instrumental in securing the MHI grant for the Third Ward. Eventually though, this top-down model came into question, and the site designed a new NGB structure under which providers and state agency representatives still had a place on the board, but could not vote.

The reorganization helped create a new dynamic within the board, which contrary to what some expected, strengthened the relationships between residents and local providers in Houston. In addition, the NGB developed relationships with various city commissioners, local legislative delegates and other city representatives which were mutually beneficial for the MHI implementation.

Resource Management and Sustainability

The evaluation tracked the capacity of the NGBs to administer and manage the Initiative funds as a sign of maturation and trust in the relationship among the partners. In general, all sites moved away from the original state control over the MHI resources to more board authority over how the grant's funds would be allocated. The transition from state, and in some cases, local administrative and fiscal functions occurred towards the end of the MHI. At that time, the Casey Foundation was emphasizing the need for all sites to develop sustainability plans to ensure programs started under the Initiative would continue after its official ending.

All sites had initiated procedures to become non-profit entities and incorporate to prepare themselves for the eventual transfer of resource management responsibilities to the local NGBs. The Foundation negotiated different arrangements with each of the sites. In 1998, Miami's Abriendo Puertas, Inc. was the first board to become fully autonomous and receive funds directly from the Foundation, bypassing the state and county. Houston and Richmond followed a similar path. Miami and Houston also filled an Executive Director position to replace the old Local Coordinator and be accountable to the Board. Richmond's Family Resource Center's Board, created under the MHI, also receives funds from the Foundation through a fiscal intermediary, but is solely responsible for their administration.

Although Boston's NGB incorporated, it never achieved total control over the MHI resources. The state legislature gave the Department of Mental Health (DMH) a three million dollar allocation for three years to supplement the MHI grant.[1] Those funds were subcontracted to a local community based organization, Children's Services of Roxbury (CSR), to provide direct services in the three target neighbors.

The state also subcontracted with the Latino Health Institute, a local non-profit consulting group, to administer Casey funds earmarked for board development and strengthening of the local provider network. RUFC was responsible for drafting a budget, but final approval remained with the state.

With the end of the MHI, the state withdrew its commitment to the project and to RUFC. The Board has been reduced to an active Parent Committee which has developed a proposal to the Foundation for spending the balance of MHI funds to support advocacy efforts on behalf of school children with mental health problems.

[1] Focus group participants identified long waiting lists, poor collaboration among agencies, disrespectful staff, services that were not culturally competent and an absence of adequate number of recreational activities for children and youth as major service issues. See focus group reports conducted prior to service implementation in four sites- Appendix C-Sources, References and List of Evaluation Reports.

Major Results and Findings of MHI Implementation: Service Design and Delivery

Instead of expanding traditional mental health services that emphasize office-based therapies and institutional care, the MHI was interested in fostering community-based service approaches. This emphasis was rooted in the conviction that interventions, which focus only on children, do little to change factors that give rise to or increase the incidence of mental health problems. Thus, the MHI was designed to:

- Broaden the traditional population of children served to include children and adolescents who are "at risk"—not just those who have already been identified as having mental health problems such as severe emotional disturbances;
- Focus on prevention and early intervention to keep problems from becoming so severe that out-of-home, out-of-community placements are the only remaining alternatives;
- Deliver mental health services in nontraditional settings, such as community settings that are less stigmatizing to the child and family.
- Emphasize parent education support and involvement.

Sites accomplishments and challenges are discussed in five main areas:

- Common Service Development Strategies in the MHI sites.
- Accomplishments of Sites' Direct Frontline Services.
- Challenges and Barriers of Direct Frontline Services.
- Further Successes and Achievements of MHI Service Implementation.
- Issues and Challenges Affecting Overall Service Implementation.

Common Service Development Strategies

The Foundation developed a benchmarking document to help sites monitor implementation of the three major areas of systems reform, governance and service delivery. This document addressed the two major service issues of service availability and accessibility and outlined seven guidelines to assist in the development of sites' service delivery designs. These were:

1. Identification of children at risk of emotional or behavioral problems and early intervention.
2. Development of an array of services that is integrated across agencies and programs and is capable of meeting the needs of children with serious emotional or behavioral problems.
3. Development of highly individualized services and supports for children with emotional or behavioral problems.
4. Availability of a continuum of services within a less restrictive environment.
5. Availability of case management services to ensure coordinated assessment and planning, service delivery and supports for transitions within the continuum of care.
6. Effective methods of engaging families as full partners in planning and providing services for their children.
7. Capacity to be sensitive and responsive to cultural and ethnic differences (Benchmarks Document: 1995, pg. 3, 4).

The four sites developed their service strategies based on the identified service needs of their target residents and the seven previously mentioned guiding principles. With the help of technical assistance providers, each of the sites carefully researched various service model options that might meet their site's service needs. The four sites independently arrived at service strategies that included three major service components:

- Family Resource Centers
- Community Outreach
- Intensive Case Management

It is important to note that although common service strategies were identified in all four sites, each site devised its own service delivery system incorporating unique features. These service differences represent innovative strategies that are discussed in depth as case studies in the Services Evaluation Report.[2] These site-specific service design features include Houston's Juvenile Probation Program. This program focused on youths in the probation system, provided an innovative way of diverting and supporting troubled youths within a peer setting. Another noteworthy service feature was Boston's 'tracking' service which supported at-risk youths by matching them with a tracker—i.e., an adult mentor who was culturally-competent and could identify with that youth's situation. Other examples include Miami's 'Equipo' training program, which teamed professionals with natural helpers from the community; and Richmond's 'Men of Vision' program, that focused on promoting a stronger presence of males in families.

Family Resource Centers

The Family Resource Center (FRC) concept was widely embraced by all four sites as a service strategy that could address some of the most immediate needs of families in their target population. The Early Childhood Digest (October 1998), describes family resource centers as follows:

- a place that will make families feel welcome,
- a place to get information
- a place to take classes
- a place to meet other parents
- a place that supports families by making services easier to get
- a place that offers family supports for a long time

In MHI, sites chose family resource centers as a service strategy because this approach incorporated characteristics that made it possible to address service accessibility and convenience. The FRC concept also addressed cultural competence issues and provided an opportunity for families to tackle some of their mental health needs in a comfortable and welcoming environment. The MHI Family Resource Center models comprised the following common features:

- A convenient location within the target communities;
- A place that was less stigmatizing where they could address their mental health concerns;
- A mixed and varied array of universal, targeted prevention and intervention support services;
- Staff and services that are culturally competent; and
- Family and resident input in the service design and implementation.

The convenient locations of the sites' family resource centers were considered essential to effective service delivery. In the Boston site, where three distinct neighborhoods comprised the MHI target area, one family resource center was initially located in each community, providing neighborhood residents easier access to services. Prior to implementation, residents had complained of having to go outside their neighborhood in order to obtain mental health and other social services. By establishing family resource centers in each of these three neighborhoods, the Boston site was able to significantly address the issue of service inaccessibility.

In addition to being conveniently located, the family resource centers also represented a place where residents felt welcome and comfortable. Residents in initial focus groups held by evaluators during early MHI implementation (and prior to service implementation),

[2] See individual case studies for detailed discussions on comprehensive site specific service strategies—in Service Development in the Mental Health Initiative for Urban Children Final Evaluation Report.

had often complained of feeling unwelcome and disrespected by staff at many service agencies. In contrast, family members from all four sites noted that the family resource centers that were created as a result of the MHI, made them feel welcome. Family resource centers developed at the MHI sites provided a place where families could receive mental health services which was less stigmatizing than traditional mental health facilities. Residents reported they were now able to obtain mental health services without feeling 'degraded' or 'ashamed'.

Another consistent feature of the family resource centers was that each center provided a broad mix of universal and targeted prevention services and intervention services. In Houston, this range of supports included services such as housing, employment, and transportation, literacy training for adults and parenting skills training. In Boston, services provided as part of the universal and targeted prevention services included daycare, job training and employment, summer camps, parenting education classes, after school programs, parent advocacy and tutoring. Some non-traditional services such as purchase of household equipment for families and providing food baskets and turkeys at Thanksgiving were also part of the rich mix of services provided through this site's resource centers. In Miami, the array of services included the Time Dollar Volunteer program, seminars and educational training for parents, hospital and recreational services for families, immigration services and a youth support group. Richmond's family resource center provided behavior modification training for parents and parenting enrichment, family support and advocacy for accessing other social service programs, and educational and vocational support for families.[3] Within these broad arrays of services and programs, services dedicated to facilitating parent and family development were consistently provided in all four sites.

A fourth consistent feature involved the way centers responded to racial and cultural service issues. Each site hired family resource center staff who represented the culture and ethnicity of the families in their respective neighborhoods. Many of the para-professional staff were also long-time residents who had a deep understanding about families and life in these target communities. This focus on para-professional staff who could identify and relate better to families represented a change from more traditional staffing patterns of human service agencies that tended to include more professional clinical staff. Residents generally agreed that the para-professional staff at the family resource centers were culturally-competent.[4]

The fifth feature consistently found in all centers was the significant involvement of family members and residents in the overall implementation of their site's service strategy. In Boston, Houston, and Miami for instance, family members played a role through their governing board structures and were able to have some influence on the types of services that were ultimately provided through their site's FRC. In Richmond, family input was also provided through the Parent Resource Network, a group of family advocates who were an instrumental part of the team that designed the East District Family Resource Center (EDFRC). Family input in service delivery resulted in proactive attempts to ensure that services were culturally-competent and sensitive to the issues and needs of the families seeking services. Residents also were instrumental in raising issues of family privacy and confidentiality as critical factors of service delivery in all family resource centers.

The family resource centers therefore emerged as a service strategy that provided residents in the target neighborhoods a variety of culturally competent, accessible services. These centers also reduced the stigma that is often associated with receiving mental health services. Consequently, family resource centers emerged as one of the strongest components of the sites' overall service delivery strategy.

Community Outreach

Sites recognized that if they were to be truly successful they needed to connect their services to families in their communities. To this end, four goals became the cornerstone of their outreach services:

[3] For more detailed service information see individual case studies—in Service Development in the Mental Health Initiative for Urban Children Final Evaluation Reports.

[4] See focus group reports conducted after implementation of site service strategies—Appendix C- Sources, References and List of Evaluation Reports.

- Information and referral.
- Connecting service delivery to the community at large.
- Connecting to other Community-Based Organizations (CBOs).
- Engaging and involving families in service delivery.

MHI sites focused on providing information and referral services as well as connecting their service strategy to the target community at large. To meet these two objectives, each site developed its own form of information and awareness campaign. These strategies included newsletters, word of mouth and/or testimonials from residents who had actually used some of the services. Staff employed at the family resource centers also provided information and referral services as they interacted with family members and local residents.

More formal outreach strategies were also employed to connect to the community at large. In Houston, for example, trained residents provided outreach and information services to families in their target neighborhoods through the federal Volunteers In Service To America (VISTA) program.[5] The Family Advocacy Network (FAN) was also closely connected to the Initiative in Houston and performed a family advocacy role.

In Richmond, the Parent Resource Network (PRN), was comprised of a small group of residents representing the public housing developments and other neighborhoods in the East District and provided outreach and information services. Since the PRN group consisted of community residents, they had an automatic connection to the East End; this was central to ensuring that its services were connected to the community itself. PRN activities were often described as "*…a Volunteer group that engages the pulse of the community by soliciting community feedback.*"[6]

The Madrinas/Padrinas[7] provided more informal outreach services to families at the Miami site. Again, being from the community made it easier for them to do outreach work informally linking residents to services. Some of these Madrinas/Padrinas also became a part of the Equipo[8] teams at the site. This site also had recreational and hospitality activities aimed at promoting closer ties among families participating in services at the family resource center.[9]

In Boston, para-professional family resource specialists, who were usually residents from the target neighborhoods, were responsible for most of the site's outreach work. These workers, through parent advocacy and the provision of home-based services, were able to do outreach to families and keep residents informed about services offered through the family resource centers.

In some sites, like Boston and Miami, communication and outreach activities were also conducted through the governance boards, as parent and youth committees performed outreach services informally in their target neighborhoods.

Throughout implementation sites continued to work on developing strategies that would ensure that outreach regarding available services was effectively maintained. Reviews about the effectiveness of some strategies remained mixed. In Boston and Miami family resource specialists were extremely successful at providing in-depth, comprehensive information to a relatively small number of residents. In contrast, other more formal outreach strategies performed by the VISTAs in Houston were more successful in reaching a larger number of residents.

The third outreach objective for the sites was connecting local service delivery systems with other community-based agencies. However, only two of the

[5] VISTA, Volunteers In Service To America places individuals with community-based agencies to help find long-term solutions to the problems caused by urban and rural poverty.

[6] East District News: April 1994: Vol.1, No. 3, p.7—Appendix C-Sources, References and List of Evaluation Reports.

[7] Madrinas/Padrinas, translated to mean "Godmother and Godfather," are natural helpers in the community who assist families.

[8] Equipo is based on a partnership between natural helpers and formal service providers to support and strengthen families. See Miami case study.

[9] See Miami site case study—in Service Development in the Mental Health Initiative for Urban Children Final Evaluation Report.

sites were successful in actually creating meaningful partnerships with other community-based mental health centers. In Richmond, a working relationship was formed with Memorial Child Guidance Clinic and Miami developed a partnership with the Miami Mental Health Center.

A final outreach objective, involving engaging families in service delivery, was effected through the governing boards. Site local governance boards provided a vehicle for keeping families connected with the Initiative and site service strategies.[10]

In summary, the community outreach aspect of service delivery had mixed results with sites being most successful in their information and referral and outreach to residents. Sites were also reasonably successful in involving family members in the design of their service strategy. However, less success was achieved with regard to being able to connect local MHI service systems with other community mental health centers and/or other community-based agencies.

Intensive Case Management

The third and final service feature consistently found in all four sites was the Intensive Case Management services component. These services included the organization and management of services for children and families in three main categories:

- Children with emotional and mental health problems.
- Children who were in some type of out-of-home placement.
- Children who were at-risk of being placed out of the home.

Intensive case management services included wraparound support services for target children and their families and involved the management of a variety of services geared towards prevention and intervention supports.[11] Such intensive services included but were not limited to the following:

- Individual and family therapy
- Counseling
- Psychiatric evaluations and assessments
- Consultations
- Medication management
- Transitional support services
- Crisis services

Although all four sites provided some type of intensive case management services, for three of the four sites this was not a major emphasis. Case management services in Houston, Miami and Richmond primarily focused on supports for at-risk children. The Boston site was the only one that specifically targeted case management to children with severe emotional and mental health problems and their families. For children in out-of-home placement, Boston implemented the Roxbury Return Project, which used case management and wraparound supports to help children transition back to their families and communities.

Staff who were part of the intensive case management or family resource center teams played a major role in managing, organizing and coordinating services for families. Some of these staff were also involved in providing additional supports such as advocacy and parent empowerment. Although labeled differently, all four sites used a combination of para-professional and professional staff to provide case management services. For example, in Boston, the family 'reunification team' and family resource specialists provided intensive case management support for target families. In Richmond, the East District Families First case management model comprised both para-professional and professional staff who functioned as managers. In Miami, the 'Equipo training' one of the innovative aspects of the Miami service strategy, was responsible for training case managers (professionals) and natural helpers as partners to help support and strengthen families. Houston's team of clinical and para-professional staff provided clinical support and case management for families in need.

[10] To see various ways in which family members were connected to the service development and implementation review Neighborhood Governance Reports—Appendix C-Sources, References and List of Evaluation Reports.

[11] See individual case studies in Service Development in the Annie E. Casey Mental Health Initiative for Urban Children for specific case management services provided at each site.

Service Delivery Accomplishments and Challenges in the Mental Health Initiative

Many accomplishments and challenges were related specifically to sites' *direct frontline* services and others were related to *overall implementation* of the MHI service delivery component.

Accomplishments of Sites' Direct Frontline Services

Findings from the national evaluation provide information on accomplishments and challenges of sites' frontline services and service delivery strategies. Due to the formative nature of the evaluation, results did not focus on individual family outcomes but rather on the effectiveness of each site's service delivery model. This assessment was made based on information provided through the focus groups and Family Experience Studies (FES).[12]

The national evaluation found that the MHI sites were successful in developing services that were *community-based, culturally competent, family-friendly* and to a limited extent *family-centered*.

Across the board, a key accomplishment of sites' service delivery strategies was that services were ***community-based***. In Richmond site, the family resource center was referred to as a 'community spot'; in Boston during the early implementation stage, each of the three neighborhoods (i.e. Mission Hill, Highland/Washington Park and Lower Roxbury) had their own neighborhood-based center; Houston's family resource center was housed within an elementary school in the Third Ward; and Miami's Abriendo Puertas, 'opening doors' family resource center became a fixture in the heart of the East Little Havana community. Overall, with the exception of Boston, the long-term success and viability of these community-based centers has been very positive.

The family experience study findings at baseline and follow-up suggest that the provision of support services for the MHI through community-based FRCs had a positive effect on service accessibility. In addition, case managers were willing to visit families at home and keep flexible schedules, contributing to families' satisfaction with the accessibility and convenience of services.

Sites were also successful in providing services that were ***culturally competent*** and sited this as another service delivery accomplishment. Services were adapted to meet the cultural and ethnic diversity of each of the target communities. Sites' service models were generally sensitive to the race and culture of the communities as demonstrated by staffing patterns and types of support services provided. FES findings confirmed that sites provided services that were culturally competent and most families involved in the case studies appeared to be satisfied with this aspect of their site's service delivery system.

Sites implemented cultural competence in different ways. First, in all four sites, there were deliberate considerations to ensure that workers reflected the racial and cultural diversity of the communities being served. Sites took steps to ensure that their staff were 'professional' and 'culturally-competent' and each site responded by hiring both para-professional and professional/clinical staff. In Boston, staff teams comprised both licensed clinical staff as well as para-professional workers who were from the target communities and who reflected the racial composition of the families in the three neighborhoods. In Miami, the 'Equipo' training helped formally train professionals and natural helpers to work together as partners and this pairing helped improve cultural competence of service providers and other professional staff. Houston's pairing of para-professional and professional staff was done through VISTAs, who were para-professionals that provided outreach services to the community, and other staff with Doctorate degrees and/or licensed clinical workers, who provided clinical service support. The para-professional/professional teaming in Richmond was through both the Parent Resource Network (PRN) and East District Families First Case Management model (EDFF). These para-professional staff comple-

[12] Review Methodology Section for more information on these two methodologies—Appendix A.

mented other case management staff who had more clinical expertise and extensive human service system experience.

In two sites, Boston and Miami, where language was a critical issue, bi-lingual staff were assigned to work with the Spanish families. This was an important step because some of the families in these two communities were mono-lingual Spanish speakers. Others who were bi-lingual still preferred to speak Spanish, their first language. Therefore, having staff that could accommodate them helped in the provision of services that were more culturally-competent.

Second, services offered through the sites delivery system also responded to family background and culture and were more sensitive to the families' needs. For instance, case managers/family resource specialists and other critical staff were generally willing to meet families in their familiar home settings, as opposed to having families come to the centers. Staff showed flexibility scheduling meeting times to accommodate family work schedules, other meeting families at times outside of traditional hours of 8:00 a.m. to 5:00 p.m. In addition, many staff gave parents and caretakers their personal cell phone numbers and pager/beeper numbers to ensure that they could be reached in the event of an emergency. These strategies made sites more responsive to the needs of their target families than traditional service systems.

Third, FES revealed that the sites were also willing to consider factors such as religion, family structure, values and beliefs as important factors in service planning and delivery. For example, case managers from each site reported they had voluntarily learned more about their clients' family background and values in order to better serve them. Family members served by these same case managers confirmed that they felt understood and respected.

Cultural competence in service delivery was also evident in the diverse and multiple roles assumed by many of the staff in order to effectively serve families. While some of these activities fell outside their professional case management obligations, these workers realized that this type of support was often very important to family functioning. In addition, this support responded more readily to the family needs, cultural background and circumstances surrounding the target families. As such, many case managers served as advocates and supportive friend, performing a wide range of formal and informal services. These services included:

- reviewing and interpreting documents such as letters from schools, eviction notices etc.,
- writing letters of recommendations for parents,
- attending meetings with caregivers to provide moral support, and
- calling caregivers to just check on them or remind them about an appointment or prior engagement.

Another accomplishment of site service models was that family members generally felt that services were being provided in ***family-friendly***, nurturing environments which were more conducive to interaction between family and providers. This finding was particularly true for the family resource centers where it appeared that the friendly atmosphere was created in part by staff with whom families could identify. For instance, in Boston families described the atmosphere in one of the family resource centers as 'welcoming' and 'friendly'. In Richmond, a stakeholder described this friendly atmosphere in terms of the center being a 'community spot.'

Findings of the FES suggest that by follow-up the sites' case managers had made modest progress in developing a ***family-centered*** approach to service delivery. At both baseline and follow-up, evidence of family centeredness was seen primarily in the staffs' advocacy role. However, although the integration of the principle was far from complete, progress was evident across sites.

At baseline, the FES found that most services were more child than family-focused. However, at follow-up, three sites (Boston, Richmond, and Miami) had begun to place much more emphasis on working with other members of the child's family and were taking a more comprehensive approach to solving problems. Clearly, these sites were taking a more family approach to service delivery, looking not only at the needs of the target child but also at the needs of other family members.

In addition, at follow-up some of the sites had taken additional steps to ensure a comprehensive approach to service delivery. In Boston for instance, the site initiated a multi-agency approach to work with children who were returning home from out-of-home placement. Through the site's Roxbury Return Project, families were able to draw from the collective insight and input of experienced agency staff from major service agencies, such as the Department of Mental Health (DMH), Department of Youth Services (DYS), and the Department of Social Services (DSS).

At follow-up Richmond also had started a more comprehensive approach to its family assessment process. This assessment process included the Family Assessment Planning Team (FAPT). Family members were permitted to invite whomever they chose to be part of the FAPT, allowing other individuals that supported the family to be included in the service assessment process.

Miami's identification and use of natural helpers was another example of sites' willingness to embrace the notion that the family centered approach should incorporate a broader, more comprehensive, support system. Miami's approach illustrates that in order to create plans that build on a family's strengths, it is often critical to appreciate and include extended family members.

Throughout implementation sites continued to make progress in this particular area of service delivery. Therefore, it seems reasonable to expect that future services will continue to embrace the notion of being family-centered as a core service feature.

Challenges and Barriers of Direct Frontline Services

Despite successes in the areas mentioned above, sites often struggled to accomplish other objectives outlined in the benchmarks. The FES found that sites were generally weak in two principle areas of *individualization* and *integration and coordination*.

Sites generated less impressive results regarding the *Individualization* of services, defined as designing services in accordance to the unique needs and potentials of each child and family. At baseline, all four site service systems were weak in designing service plans that reflected this focus. There was also little or no connection between the identified goals and the utilization of any child and/or family strengths.

At baseline, another consistent finding across the four sites was that case documentation (i.e., service/treatment plan) was incomplete and mostly child-focused. Written plans did not adequately reflect the extent of existing family needs, and service goals rarely addressed life domains.

Evaluation findings at baseline also supported the need for sites to spend more time responding to each family as a 'unique' entity. Evaluation results at that time highlighted the need for sites to put more consideration into being more flexible and responsive to the special circumstances and backgrounds of each individual family rather than responding to families with a "one size fits all" approach to service delivery.

However, some progress with respect to individualization of services was noted at follow-up. For instance, during the second round, FES evaluators found that case managers had made more attempts to identify and address life domains and individual needs of families in the service plans. Evaluators also found that sites had improved their ability to connect service goals identified in individual family case plans with the different life domains. In addition, these service plans included more complete and detailed documentation.

It should be noted however, that even at baseline when documentation in service plans was generally poor, evaluation findings indicated that services provided for the families were in reality more comprehensive than the documentation suggested. The commitment of most case managers and para-professionals involved in site service delivery was unquestionable. Families consistently rated their case management staff much more favorably than their counterparts in other larger human service systems.

Integration and coordination of services between service providers was also found to be weak during the initial and follow-up FES. In both studies case managers were the only ones who consistently communicated with the other providers within a child's local service support system. Although many families in the FES had multiple service providers, these individuals had often never spoken to or met one another. Providers for the most part were offering services to families independently with minimal consideration for other services

that the target child may have been receiving from other agencies. At both baseline and follow-up, evaluators suggested that there was a need to improve communication and coordination between various service providers involved with a particular child or family.

Integration and coordination between sites' service systems and other agency staff was difficult primarily because many larger agencies responded to different agency-specific guidelines and criteria. Because these guidelines and criteria had to be met they were often unwilling and unable to accommodate some of the more innovative approaches presented by the local site service plans. Others had large case loads and time constraints which made it difficult to meet with other community-based providers who were involved in providing supports for their clients. Therefore, in most instances, case managers employed by site service systems were left with the responsibility of ensuring that the communication channels between their service support systems and other service agencies remained open.

Further Successes and Achievements of MHI Service Implementation

Other successes were noted in the overall implementation of the service delivery component of the MHI. These accomplishments were identified during focus groups with representatives from all major stakeholder levels, i.e., technical assistants, foundation staff, providers, and neighborhood, local and state representatives. In addition, document reviews and individual stakeholder interviews provided critical information for this analysis.[13]

A major accomplishment of the overall service implementation was related to the ***resident inclusion*** in the service design, as well as the implementation and delivery of those services. Other impressive results were accomplished through sites' inclusion of families in the overall implementation of the service component of the MHI. The four sites deserve recognition for incorporating resident and family perspectives. This integration was made possible in part because of Neighborhood Governing Boards (NGB), a critical part of the MHI design. Sites integrated family and resident perspectives primarily through their governing boards and other working committees, which played a role in service design and implementation. Many residents were in favor of establishing a service system where services were consistent with the identified principles outlined in the previous section (e.g., family centered, culturally competent, etc.).

In addition to resident participation in service implementation through the NGBs, evaluators found other innovative examples of parent and family inclusion. In Richmond for instance, through the Parent Resource Network (PRN), residents were able to actively participate in planning the design of the East District Family Resource Center. This site made the PRN, which had preceded the Initiative, an integral part of services at the site, and used the group to help develop the Family Resource Center. The site also recognized the value of having para-professional residents working with families in the community, and in at least one instance hired an individual from the PRN to join the team implementing the East District Families First (EDFF) case management model. In addition, Richmond should be recognized for utilizing residents to accomplish meaningful goals, such as the pivotal role they played in preventing the closure of a local health center.

Houston's Friends of the Family training curriculum also included family and resident input in its design.[14] Miami's use of community residents in its outreach program and development of a resident advisory group are other examples of how residents played a critical role in service development. In Boston, for the first time residents were a part of the Request for Proposal Process (RFP) and took an active role in deciding which agency would be awarded the lead service contract for their communities. In addition, the Boston site can be recognized for the impressive way it included residents in service delivery design. Family members were actively engaged in lobbying and securing millions of dollars from the legislature for services for the target neighborhoods. Residents were also instrumental in en-

[13] See Methodology-Appendix A.

[14] The Friends of the Family training curriculum is a program that trains local residents to become paraprofessionals.

suring that affirmative action language was subsequently included in RFP's. The significance of this contribution is that minority agencies now stand a much better chance of receiving government contracts.

Resident inclusion in service design helped ensure that family and resident values remained central to service delivery. With families and residents at the core of the conceptualization and design of the service model, direct services were geared more towards being culturally competent and family-centered.

Other accomplishments have come from individual sites and reflect special ways in which the sites have pioneered philosophies or service strategies that are on the cutting edge of human service delivery. Some of these successes resulted in part because each site designed its service strategy to address its own site-specific needs.[15] Some noteworthy examples include Miami broadening its definition of mental-health to include other family needs that affect general well-being. With many families being undocumented, employment was a big problem in the area. The site responded to this need and used some of its MHI funds to contract with the Florida Immigration Advocacy Center (FIAC).

Another unique accomplishment of this site was the development of the 'Equipo' training which was designed to assist the local service system to respond to some of the shortcomings and challenges its case management model. This training was extremely successful in training professionals and natural helpers to partner with each other and with families. It was anticipated that 'Equipo' would bring about a shared sense of responsibility towards outcomes which would in turn, improve families' chances of meeting these outcomes.

Other pioneering approaches occurred in Houston, where as was the case in Miami, the site responded to its unique circumstances by capitalizing on the managed care environment that existed in Texas in 1997. The site modified its overall service strategy during the mid to latter phase of MHI implementation to become a Medicaid managed care coordinator. This was the site's bold attempt to acknowledge its external environment and at the same time secure financial sustainability for the Initiative. The site's strategic posturing of PIP enabled the organization to receive its Medicare and Medicaid provider number. The Houston site is a leader in showing how the role of a community-based organization can be expanded to administrative broker in a managed care service environment. Houston provides a noteworthy example of how communities can reshape their organizations to support fiscal strategies that contribute significantly to sustainability and survival.

Issues and Challenges Affecting Overall Service Implementation

Several broad issues were identified as significant challenges to implementation of the MHI services component. These issues were present in the general context of service delivery across all four sites, and elucidate the difficulty of implementing the notion of neighborhood based services—even when substantial amounts of funding are allocated. Some of the implementation obstacles encountered by the MHI sites reflect similar challenges that other mental health service systems across the nation face.

The major challenges to service implementation experienced by MHI sites included:

- Flawed MHI design
- Broad work scope of the Initiative
- Poor collaboration between Initiative stakeholders
- Difficulty in collecting Management Information Systems data

Flaw in MHI Design

A consistent barrier to effective service delivery related to a flaw in the overall design of the Initiative. The MHI did not have a clear strategy for shaping the role of community mental health centers (CMHC) or other central providers of services to children with Severe Emotional Disturbances (SED) within the site's service strategies.[16]

[15] See individual case studies in Service Development in the Mental Health Initiative for Urban Children Final Evaluation Report for detailed discussion of unique site accomplishments.

[16] See Lessons Learned—Benefits of Utilizing Local Community Assets and Resources Versus Benefits of Developing New Entity to Support MHI Implementation.

With no specific strategy in place, it was extremely difficult to ensure that the sites utilized and mobilized the resources and support of CMHCs. Consequently, the impact of MHI reform efforts on these community mental health centers was at best, minimal. Even in Richmond and Miami, where community mental health centers were actively involved, MHI still had limited impact in reforming services provided through either the Memorial Child Guidance Clinic or the Miami Mental Health Clinic.

Broad Work Scope of the Initiative

(Also see Lessons Learned—Adequate Time is Critical for Effective Implementation.)

Another consistent implementation problem was related to the work load demands on site staff and stakeholders. The stress of implementing service delivery was often compounded by competing assignments and responsibilities related specifically to systems reform and governance. In these circumstances, service delivery was sometimes put on hold as sites dealt with other reform components.

The challenge of implementing multiple components of the Initiative was exacerbated by the fact that sites did not have a clear vision of the correct sequence for implementation of the three areas. Most sites attempted to juggle implementation assignments between the areas, and not surprisingly, often faced challenges trying to prioritize assignments and responsibilities.

Poor Collaboration Between Initiative Stakeholders

(Also see lessons learned—Difficulty Changing Traditional State Agency Philosophy and Culture.)

A number of barriers contributed to the collaboration problems that existed among stakeholders, site neighborhood service systems and other 'traditional' state and local agencies. These barriers include the following:

- Difficulty in establishing working relationships between the various site stakeholders.
- Different work philosophies and hiring practices of site 'neighborhood service systems' and 'traditional' state, and local human service agencies and other Community Mental Health Centers.

As already described in discussion on governance, the Mental Health Initiative brought together state, local and community residents and prescribed that these three entities cultivate and maintain a working relationship in order to implement the Initiative. However, true collaboration and partnership was generally an uphill task. Establishing working relationships between stakeholders was difficult because of the following factors:

- Historically these groups of people, i.e., community residents, local service providers and state and local agencies, did not work together.[17]
- Stakeholder groups and entities had different views and perspectives and did not trust each other.
- Lack of clarity in the roles that each partner felt they were supposed to play and different objectives and perspectives had about service design and delivery.[18]
- Different 'learning curves' of stakeholder which some at state, local and provider representatives felt slowed down the service process.

Another factor contributing to poor collaboration between the site service systems and the state or local agencies was their incompatible service philosophies. These philosophical differences manifested themselves in the way each entity delivered services and whom they hired to provide these services. Traditional service delivery systems were more inclined to respond to federal mandates, while site neighborhood systems were more family focused and strength-based in their approach. Traditional systems also tended to hire clinical professional staff to provide services while site service systems were more open to staffing their family resource centers and case management models with para-professionals.

[17] See Neighborhood Governance in the Annie E. Casey Mental Health Initiative for Urban Children Final Evaluation Report for detailed analysis of governance strategies developed by sites.

[18] There were disagreements among stakeholders regarding which entities in the Initiative had decision-making power and which entities had more of a monitoring or advisory role. With these different visions, developing relationships was difficult and often very slow. For example, the resident governing board members in general felt that they had a decision-making role in service design and implementation. Their state and local counterparts perceived the residents' role as being advisory and geared towards monitoring service implementation.

These fundamental differences negatively affected collaboration between these organizations.

Boston's experience provides an excellent example of how philosophical differences hampered collaboration. At this site, the Department of Mental Health, the Department of Social Services and the Department of Youth Services refused to refer their clients to the local neighborhood-based service system. These agencies felt that staff employed by the local neighborhood service system lacked the professional expertise and ability to adequately serve children with significant mental health service needs.

It is important to note that sites have been most effective in addressing the collaboration issue by working through the philosophical differences between their neighborhood-based service systems and traditional service agencies. For instance, sites are taking a more balanced approach to accommodating state and federal mandates while hiring a combination of para-professional and professional staff. This has helped earn the respect of traditional agencies who are now more open to collaborating with them than they had been during the initial phases of implementation. Some sites like Houston have spent time and resources to ensure that some of their local community agencies are accredited and this has put them in a better position to obtain Medicaid privileges and become more competitive.

Difficulty in Collecting Management Information Systems Data

(Also see Lessons Learned—Strategic Management Information Systems Plan is Crucial for Implementation of an Effective Management Information System.)

Collecting comprehensive data on service utilization was one of the major goals of MHI service component. However, because this was an extremely difficult task, sites were not very successful in accomplishing this goal. The sites failed to accomplish this particular goal because they depended on the staff of larger human service systems to retrieve this information for them. Staff from these human service agencies found it difficult to provide the neighborhood-specific data which the local neighborhood systems requested. These neighborhood specific data were generally inaccessible because many of the agencies did not maintain neighborhood-specific databases. During the initial phase of data collection some agencies did not have computerized systems and found it extremely difficult and time consuming to retrieve this information. In addition, many agencies did not have the personnel to devote to this task.

Furthermore, in some instances where data were available, many agencies were reluctant to release this information to sites because of confidentiality issues and a lack of trust in these neighborhood systems. In addition, because these agencies generally had a different service philosophy than the site systems, they were somewhat skeptical about sharing this type of sensitive information.

As such, the data collection efforts to secure neighborhood-specific information on placements and service utilization were undermined, and although sites made efforts to report and collect this information, these efforts were not as successful as originally anticipated. However, sites were moderately successful in tracking service utilization of their own local neighborhood systems through their established local client tracking and management information systems.

Although all four sites during one phase or another encountered several of these challenges, most of the sites were able to successfully work through them and provide services in their communities. For example, Houston, Miami and Richmond established family resource centers that continue to provide services to residents to this day. These sites are operating today, in part because they have worked through many of these challenges. They also continue to explore sustainability options, including additional funding and grants from state government and private foundations such as the Casey Foundation and the Hogg Foundation.

SECTION

THREE

Stakeholders' Views on Lessons Learned from the Mental Health Initiative

Stakeholders' Views on Lessons Learned from the Mental Health Initiative

Many lessons were learned from the implementation of this five-year initiative. The lessons discussed in this section of the report span across the three areas of implementation. The information provided highlights useful insight into how a multi-faceted Initiative like MHI should or should not be approached in the future. Lessons related to specific areas of implementation can be found in individual evaluation reports on governance, services, and systems reform.

Adequate Time is Critical For Effective Implementation

> LESSON
>
> The general consensus was that more time should have been allocated to MHI implementation. The five-year period was insufficient to adequately meet the goals of the Initiative and this affected all areas of implementation. More time should have been allowed at the beginning of the Initiative for stakeholders to develop a common understanding of the type of changes and reforms called for by the MHI, and what it would take from each of the partners to achieve them. In addition, both the development of governance strategies and the establishment of service delivery strategies and outcomes required more time than the implementation period allowed.

When one considers all the goals of the MHI, it becomes clear that five years was not enough to successfully achieve the MHI goals. Insufficient time was an issue in all three areas of implementation. For *systems reform*, political and agency changes had a critical effect on implementation. Stakeholders agreed that a critical barrier to the state's involvement was the constant turnover of individuals in key agency positions, as illustrated by the following comments from a participant: "*…the politicians turned over at the City level, and they turned over at the state level. And the commitments were lost, the memories were lost, the understanding was lost, it became a constant source of difficulty.*" As a result, unanticipated amounts of time had to be devoted to orienting and training replacements of key stakeholders at the sites. Others, who in some cases did not have the same level of personal investment, replaced the original players who had been instrumental in bringing the project to their respective states. All four sites experienced leadership changes in critical state positions from Governors to Mental Health Commissioners, and department heads. These changes meant that time had to be devoted to more orientation and training time for successors and this in turn slowed the progress of systems reform. In retrospect, the designers of the Initiative should have anticipated political changes in state administrations, and should have procured the support of institutions outside the state realm. Some stakeholders suggested that involving the business community could have provided continuity, networks and connections, and more leverage in demanding accountability from politicians.

With respect to implementation of *governance strategies*, stakeholders recognized that more time should have been allocated to study and help bridge philosophical, racial and other differences that existed within the MHI's communities. Many stakeholders felt that time constraints prevented the MHI from openly exploring and addressing issues of race, class and culture as part of its agenda. Technical consultants believed that the Initiative did not recognize and address underlying and unresolved issues of race, class and culture that resulted in conflicts within the NGBs, between the boards and state and local stakeholders, and between members of the boards and other community residents. These consultants felt that a more deliberate attempt to openly discuss these issues should have been part of the MHI's agenda from the beginning. In addition, they believe that an adequate amount of time should have been scheduled to help sites discuss and possibly resolve these issues.

Providers and MHI staff echoed similar sentiments and suggested that perhaps Boston could have benefited the most from devoting more time to dealing with racial and ethnic issues, because three distinctive neighborhoods had been grouped together to form one target MHI community. In their opinion, it was unrealistic to expect that these very different communities would be able to work together in the timeframe of the Initiative when they had a much longer history of being separate.

The length of time of this initiative also affected *service implementation*. Stakeholders felt that new services were often delayed because sites had to deal with multiple tasks related to the different components of the initiative. In addition, one of the major site service strategies–the establishment of Family Resource Centers–was very complex to implement and stakeholders had to devote considerable time to conducting research and gathering information about this model. Even after sites had decided on family resource centers as a service strategy, putting their service plans into action was also very challenging. There were inevitable delays which resulted in actual service delivery beginning in most sites during the third year of implementation. Consequently, sites were unable to accomplish any significant or widespread service outcomes that were attributable to their local service strategies during the five-year implementation period.

Technical Assistance is a Priority

The need to provide on-going site-specific, technical assistance was rated a top priority by stakeholders. Technical training and assistance was especially significant when individuals who worked in different capacities came together to implement systems change. Differences in educational backgrounds and expertise affected implementation progress; for example, use of different terminology among stakeholder partners impacted implementation. The very notion of "systems reform" itself posed special challenges. According to some stakeholders, the fact that individuals were able to speak the jargon of 'systems reform', did not necessarily mean they understood what the concept meant or how to translate this concept into practice. Providers were perhaps most affected by this lack of clarity because they were in charge of implementing a service delivery strategy at the neighborhood level that would support goals of systems reform at higher levels. There was confusion about what services should be delivered to accomplish whatever systems reform was going to be implemented.

LESSON

Training and technical assistance support to meet the needs of resident board members, stakeholders and staff of local service support systems has to be an ongoing part of the implementation process. More attempts should have been made to ensure that the timing of technical assistance was appropriate and more tailored to specific needs of the sites at different stages of the MHI implementation. In addition, more concerted effort should have been made to find local trainers who were knowledgeable about grass-roots governing boards and low income, minority communities so that a core pool of local technical assistants could have been developed.

Consequently, some stakeholders agreed that in hind sight, more technical assistance should have been provided to help sites work through and clarify some of these issues. These individuals believed that information should have been provided on a more individual or case-by-case basis to ensure that the respective partners had clarity on the relevant implementation aspects.

Technical assistance was also considered essential for effectively implementing governance and service delivery strategies. In the former, many stakeholders emphasized the need for training to strengthen leadership skills among resident board members. In their opinion, the technical assistance offered by the Foundation was not enough to close the perceived gap in knowledge and experience between community residents and other "professionals" on the board. Furthermore, when local technical assistance providers were contracted to assist residents in their governing duties, the matches were not always successful.

The technical consultants themselves elaborated on the importance of technical assistance for implementing governance strategies, reflecting that, " The assumption that a state bureaucracy, such as the Department of Mental Health, could bridge the gap with the neighborhood and effectively work with it may have been wrong. The amount of technical assistance

and Foundation advocacy around this issue suggests that the state-neighborhood relationship was a forced one rather than a natural one."

Members of the state and local representatives agreed that residents needed on-going support to understand the role they were expected to play on the NGBs, vis-á-vis the other partners in the MHI. In the words of a participant: "We were not clear about really what was the expectation of the parents, what should the parents do in the Initiative…I think we have done a tremendous disservice to the members of these communities in not being clear."

Consultant stakeholders further suggested that the proper timing of technical assistance was also critical to implementation and reported that there had been times when technical support had been offered at inappropriate times. These stakeholders stated that in some of the sites technical assistance came too late, and on these occasions instead of helping stakeholders at the sites with the service design, consultants were often engaged in trying to 'undo' or 'fix' some of the wrong decisions that sites had already made. They suggested that allowing the sites to decide when they needed technical assistance sometimes resulted in sites formally requesting assistance when they were already in crisis. In other instances, they claimed technical assistance had been offered prematurely when sites were trying to form and establish relationships and were not yet at the stage when service-related technical assistance was needed or could be fully appreciated. As such, stakeholders recognized that the timing of technical support should not only respond to sites' demands, but more importantly, must suit the site's stage of implementation development or progress.

The technical consultants for the Foundation also noted that one of the major challenges they faced was getting professionals to share knowledge with residents. Consultants admitted that in most sites the MHI had not developed an accessible pool of local technical assistants who would have been in a better position to provide the necessary follow-up. Unfortunately, for the most part, the MHI failed to utilize local experts and relied almost exclusively on a pool of national consultants. The flaws in this strategy were apparent. For instance, one provider reported that his site had needed more technical assistance around service delivery and implied that technical assistance had been somewhat piece meal.

Other stakeholders reported that MHI had also failed to utilize the full potential of a core group of parents who had developed valuable leadership skills through their hands-on involvement with the governance process. Consultants suggested that because residents generally did not attach as much value to learning through practice as they did to formal training events, the MHI should have made more effort to distill and reinforce the value of the skills to residents by using more peer-to-peer training as a means of providing technical support.

With regard to service delivery, stakeholders noted that staff should have been more adequately trained and local community-based agencies needed to improve their accreditation standing. In all four sites, paraprofessionals such as the Family Resource Specialists in Boston, the Parent Resource Network in Richmond, the Friends of the Family Training Curriculum in Houston, and the Madrinas/Padrinas in Miami were important components of service delivery. However, it was clear that para-professional supports could not replace clinical or psychological expertise and other social work experience and training. As such, stakeholders at the state level identified the need to ensure that local systems maintain their trained clinical staff.

"If you are going to participate in this new change over (i.e., managed care), you have to forget about being able to be run strictly by para-professionals, you've got to have an upgraded image or nobody is going to talk to you."

This type of sentiment was seen in Boston, where although residents praised paraprofessional staff stating that, "…Para-professionals are aware of the true needs and they are undervalued," while state agencies refused to refer their families to the case management team at the FRCs. These agencies felt that the paraprofessional family resource managers were simply not qualified to serve some of families that required more intensive case management.

In addition, technical assistance was seen as an important issue particularly as it related to licensing and training in the managed care environment. In Houston for instance, many of the providers within that site's provider networks initially failed to meet Medicaid eligibility standards and the site had to work diligently to get some of these providers certified. As one state representative reported, "No managed care company is going to do business with you as a representative of service providers if nobody has a degree and nobody has a license."

Another stakeholder concurred, reflecting on the importance on getting the proper training and credentials:

"It (service delivery) is a serious business and we were naive not to train the community and community providers in this industry. It is a serious industry, it is being taken over by the managed care world and we have not prepared folks to be able to enter and participate in that world...So a lot of small providers simply could not respond (to the RFP) because they could not qualify."

Multiple Benefits Related to Including Residents in the MHI

First, from the systems reform and governance perspectives, MHI was successful in removing state and local bureaucrats from their "ivory tower" offices to work directly with families in the communities they theoretically served, but rarely visited. By participating with area residents on local governing boards and attending various neighborhood functions, these officials gained a renewed understanding of community issues.

As a resident from Boston commented: *"I also see real system reform in having the Commissioner of DMH coming out of town to answer questions for us. And also Assistant Commissioner of DYS, DSS sitting at the table and really providing substantial information… participating with us on committees, helping us strategize."*

LESSON

Resident participation and inclusion in the design and implementation of various aspects of the MHI had many benefits. First, while there were challenges involved with working with the governing boards, these boards provided an excellent opportunity for state and local entities to develop a better understanding of resident and family service issues. Second, residents helped to ensure that services were more culturally-competent and family-centered and broadened the definition of mental health to encompass a more holistic perspective of "mental well-being." Third, the governance strategy created an opportunity for residents to rally and unite around a 'common cause' such as service delivery. A final benefit of resident inclusion was that it improved consumer knowledge and confidence and expanded residents' roles in local and national advisory boards. Some of these individuals have become more empowered and are involved in outreach efforts to improve mental health awareness and education in their various communities.

Another resident commented that, *"It's (i.e., the MHI) opened the eyes of state folks around what community is…and I think that has had some impact on what's been happening…"*

State and local stakeholders themselves confirmed that their exposure to the MHI philosophy of neighborhood inclusion had changed the way they approached new projects. They credited this involvement with a heightened sensitivity to the opinion of neighborhood residents in planning and implementation. Representatives from the four sites shared examples of new initiatives and programs which included service consumers.

Resident inclusion also had a positive effect on service delivery. Among other things, residents involved in service design and delivery helped to make services more family-centered and culturally-competent and redefined what mental health meant to residents in the target neighborhoods. These residents helped highlight the distinction between residents' definition of mental health and the state, provider and other non-community stakeholder definitions of mental health. This distinction was reflected in the residents' emphasis on more preventive and supportive services, as opposed to the provider/state emphasis on more intervention and intensive type services. In general, providers' definition of mental health was narrower, and more clinically-based while residents described their mental health in terms of overall mental well-being. Residents also tended to focus on more supportive and prevention-type resources such as food baskets at Thanksgiving, camp and recreational activities for their children. While families appeared to recognize the importance of traditional services such as counseling and therapy, such services appeared to be less of a priority than more universal and prevention types of services and supports.

Residents were also more likely to define mental health as a general sense of 'well-being' for the *entire* family, not just the target child. By the end of the Initiative the gap between the two definitions was getting smaller. The state and provider agencies had begun to appreciate and understand a broader more flexible view of mental health and accommodated and modified some of their service strategies in response to this broader definition.

Resident inclusion in MHI also provided opportunity for residents to unite around a common cause. A resident stakeholder described how neighborhood unity made a positive difference: "*The MHI helped us speak more in a united voice around certain issues. As a result, we claimed the power and we have moved more and more faster than what they ever even imagined in regard to the community piece. We are more together across the board.*"

A final benefit of resident involvement in the Initiative was experienced on a more personal level; residents who were involved in the design and implementation of their site's service delivery model became generally more knowledgeable, informed and confident. They became more aware of their rights as consumers and developed a stronger consumer voice. Some have gone on to serve on local and national boards related to child and family issues, and due to their experience with the MHI are consequently more willing to advocate for prevention and support services in lieu of institutionalization.

The inclusion of residents in the MHI's framework of implementation has had implications for the broader field of children's mental health, as well, and has helped to diversify the national family movement in terms of racial and ethnic representation. For instance, the Initiative's focus on families of color has contributed to diversification in the Federation of Families for Children's Mental Health. There is a general consensus that the Casey Foundation has strengthened the Federation by giving it an important and meaningful function in the MHI. Resident stakeholders from all sites have attended Federation conferences and training workshops, received individualized support through the MHI's technical assistance consultants, and some of them have become members of committees and advisory groups to the Federation.

Also, as a result of the MHI, some resident stakeholders began to participate in peer-to-peer training. In addition, some stakeholders suggested that the contributions and efforts of these residents have had some impact on attitudes regarding mental health among families in the four target communities. These stakeholders reported that many residents now have a clearer under-

standing of issues around children's mental health and remarked that this has helped lessen the stigma normally associated with it.

LESSON

MHI was successful in providing mental health services in a unique, family-friendly environment. The MHI was innovative in terms of how sites implemented their service delivery strategies. It also used evaluators and technical assistants to support overall implementation in a unique non-traditional way.

Innovative Implementation Strategies Pay Off

Stakeholders representing the technical assistance team believed that one of the contributions of the MHI to the children's mental health field was its support and encouragement of service delivery models and approaches not typically associated with mental health. The most striking example of this was the establishment of neighborhood-based family resource centers that were responsive to the needs of the local residents. These centers offered a range of services from universal supports, to promotion and prevention activities, to more intense interventions for families and children in need. Rather than focusing on a "target child," these centers were family-centered. They were also more focused on family strengths rather than deficits, and were attentive and responsive to the cultural diversity of their participants.

MHI was innovative also in its use of evaluators and technical assistants. Stakeholders representing the Foundation, technical assistance teams, and various individuals who closely followed the implementation of the MHI, specifically endorsed the Initiative's evaluation approach as an example of change for the field. The evaluation emphasized gathering practical information to be used to support implementation rather than focusing almost exclusively on outcomes as many evaluations do. The evaluation's approach to gathering information from individuals representing different perspectives had strong roots in the discipline of anthropology and qualitative field methods. Some stakeholders, however, indicated that the information provided by the evaluator would have been even more beneficial if these data had been made available in a more timely manner.

Some of the methods of information gathering and summarizing were not only useful to the MHI but have already been used in other projects. This includes family-centered interviews in which numerous individuals describe their needs and services that were received; the creation of a developmental model of neighborhood governance with information obtained through multiple interviews of key stakeholders; and rapid ethnographies to describe the strengths, values, beliefs, attitudes towards help-seeking, and supports within neighborhoods.

Another novel way the Foundation used its technical assistants and evaluators was to allow some of them to participate in a dual role in MHI design as well as its implementation. This approach diverts from the norm, where technical services and evaluation tasks and assignments are usually provided after a project has been designed and is in full operation. In contrast, some MHI consultants were a part of both processes, and consultants believed that the Casey Foundation's approach of incorporating them as part of the decision-making process for the design of the MHI had a positive impact on implementation. For example, consultants reported that involvement in the decision-making process increased their commitment to the successful implementation of the Initiative.

As previously reported, stakeholders generally felt that technical assistance was a top priority. Stakeholders also commended the technical assistants for being flexible in their approach to helping sites. Although the proper timing of technical assistance was noted as a challenge, their flexibility in responding to site needs was impressive. At times technical assistants were very proactive in their approach while at other times they responded specifically to sites' requests and this approach represented a change from the common practice of providing technical support systematically at scheduled intervals.

Another interesting feature of MHI technical assistance and evaluation was the diverse cultural backgrounds of team members. Technical assistants and evaluation staff were culturally matched to the communities they worked in and this made it easier to work in and with community residents. As one technical assistant put it: "*When we went into Hispanic neighborhoods, …we tried to get Hispanic people in those neighborhoods.*" By being responsive to the racial and cultural background of the four sites, evaluators and consultants were able to evaluate, monitor and support MHI implementation more effectively.

Difficulty in Changing Traditional State Agency Philosophy and Culture

LESSON

It was difficult to implement this type of systems reform initiative because agency beliefs and philosophies sometimes ran contrary to many of the goals of the MHI. There were some instances where agency culture and procedures adversely impacted the implementation of various systems reform, governance and service delivery strategies.

In governance, working relationships were difficult to establish because of preconceived views that stakeholders from each level of the Initiative had about each other. Some stakeholders felt that the design of MHI, which made the state the sole conduit for the grant, worked against any real attempts at building partnerships in the beginning. Service providers and MHI staff also reflected on the state's lack of experience working with neighborhoods as a drawback to their participation on the governing boards.

As one participant described it, "*…the states did not have the vote (on the NGB), but they had all the power, all the money…and that in and of itself meant that from the beginning of the Initiative things pretty much had to happen the way the state needed them to happen, and wanted them to happen.*" This was particularly relevant because some stakeholders believed that the traditional views and objectives of many state agencies were counter-productive to those of the Initiative. For instance, as previously mentioned, states had certain philosophies when it came to sharing agency data and were not initially invested in the concept of sharing information and making data readily available to local community-based agencies.

Some stakeholders voiced concern over the inherent contradiction between the state's political interest in maintaining the status-quo, and the MHI's call to reform systems run by the state. One participant explained this contradiction in these terms:

"*You are talking about a neighborhood-focused initiative that is going to engage people who work and live in those neighborhoods. And that is where the focus is. But you made a key partner in all of this to be a State entity which was essentially a political operation that didn't have the personal commitment to that neighborhood. They don't live there, they don't work there.*"

Governance strategies were also adversely affected because stakeholders at the state, local and community levels often disagreed on the role of the neighborhood governance boards.

Traditional philosophical beliefs helped influence perceptions and attitudes about the role of the Board and the disagreement and confusion cost the Initiative in terms of time, relationship building and service development.

State and local representatives appeared to represent more traditional agency views, for the most part perceiving the board's role to be one of advocacy and advisory in nature. In contrast, across all sites, residents did not view themselves as limited to an advocacy role, and many residents felt that at least in theory, the governing board had a decision-making role. However, in reality, many of these same residents had different views about how successful their boards had been in influencing service delivery at their site. For instance, some residents felt that their resident Board members had been responsible for making service design decisions while others claimed that, *"(only) a few of the recommendations made by parents were listened to!"*

Consultants and representatives from the state and local levels speculated that lack of clarity about the goal of the governance strategy with regard to service delivery and implementation added to the confusion felt by stakeholders at the target sites. Many of these stakeholder were of the opinion that there were different visions and expectations about what the Board's function should be. As one consultant reported, *"…we were not clear about what was really the expectation of the parents, what should the parents do?…"*

Even when working relationships between stakeholder entities appeared to be strengthening, reform in service delivery was slow and in many instances absent. Many of the state and local providers provided services with limited or no family involvement. In contrast, the newer service models designed through the Initiative emphasized the family's role in service design and implementation. During MHI implementation, it was clear that a number of traditional agencies with whom many of the family resource centers and case management staff collaborated were not prepared to change the way they delivered services to families in these four communities. This attitude significantly affected systems reform and as one resident complained. *"we (community) were never able to get the state agencies to follow through."*

The state and local agencies' unwillingness to change the way in which they offered supports and services for families had two main origins. First, it was difficult for these agencies to identify the benefits of these newer, more culturally-competent service models. For the most part, the sites were not able to demonstrate that there were concrete advantages and outcomes associated with providing more culturally-competent and family-centered services. There was also no evidence shown, at least during MHI implementation, that these newer approaches were truly more cost-effective than more traditional service models. In these circumstances, it was difficult for agencies to justify the need for doing things differently. Second, some state and local service providers were unconvinced that these MHI models were capable of providing certain services effectively and were more comfortable providing services themselves. As

such, some more traditional human service agencies were reluctant to refer their clients to the sites' local service support systems for services.

Benefits of Utilizing Local Community Assets and Resources Versus Benefits of Developing New Entities to Support MHI Implementation

LESSON

Although sites made some use of existing local resources, some stakeholders argued that a more concerted effort should have been made to consistently utilize existing community assets. These stakeholders felt that the benefits that could have been gleaned from utilizing community resources would have multiplied, if more community-based organization (CBOs) with a strong record of success and high visibility in the MHI communities had been used. However, others suggest that establishing new governance structures that wiped the 'slate clean' also had certain benefits. Stakeholders in favor of this strategy reported that preconceptions and biases normally found in traditional CBOs had been minimized.

Some state and local representatives believed that the MHI broke one of its cardinal rules in terms of building on existing community assets. In terms of governance, this meant creating a new structure, the NGBs, rather than relying on existing institutions within the target communities. In the words of one participant: "The *major thing was looking at these assets in the community around governance and build capacity within existing institutions…there was never an effort to do that!*" These stakeholders felt that incorporating existing community-based organizations (CBO's) more effectively could also have saved stakeholders valuable time during the initial implementation phase of MHI when sites were working on developing their new governance structures. It also was believed that existing organizations offered connections with government sectors outside the neighborhood, and could have helped expedite relationship-building across stakeholder levels. Stakeholders who supported this strategy felt that these CBOs could have been offered technical support to strengthen their organizations and expand on effective practices that had already been established. They contended that eventually, other CBOs could have been invited to participate in the Initiative with a positive multiplying effect.

Other stakeholders argued that while complying with the Foundation mandate to establish a new governance strategy, sites had, in fact, made reasonable attempts to integrate existing local resources into the Initiative. These stakeholders suggested that the benefits of even these modest uses of community-based resources had impacted overall implementation. Technical consultants reported that some sites had incorporated existing community resources into the site's service strategy as well in their overall implementation of governance. For example, in Houston, the Provider Network became part of the site's local community network of human and social services. In Richmond, the Parent Resource Network (in existence prior to the MHI) was incorporated as part of the service delivery strategy. This created an immediate connection to East End residents. In Miami, the "Time Dollar Bank" integrated local expertise and resources as part of a pool of new resources. Stakeholders noted that these examples demonstrate how incorporating CBOs into reform strategies can serve as an effective catalyst for connecting known community resources with existing needs, as well as matching existing service gaps with newer service models introduced by the MHI.

In addition, some technical assistants, and state and local level agency representatives suggested that the process of creating new governing boards fostered important accomplishments.

First, formation of the NGBs provided opportunities for state and local stakeholders to hear directly from residents about the main issues and concerns impacting their communities. Second, NGBs also brought service providers and community consumers closer together, and allowed them to develop some level of mutual respect and understanding that perhaps would not have occurred through their traditional interactions. In this sense, the NGBs afforded a "powerful learning tool" to all involved. These stakeholders concluded that working with existing well-established community-based agencies might not have afforded these same benefits.

Therefore, while utilizing existing resources and entities in lieu of establishing new governance structures definitely had its benefits, one cannot discount the value of the MHI approach because the governing boards made it possible to connect different levels of government with residents around the needs of a community. This type of approach is unique and stakeholders believed that this makes it a model that is worth considering for future systems reform projects.

LESSON

Careful attention must be paid to identifying the "most appropriate grantee" for multi-faceted projects such as the MHI. There were obvious arguments to be made for choosing a Mental Health agency as the grantee for a Mental Health Initiative. However, the choice of which agency should be the grantee can be a difficult one. The following agency-related factors adversely affected implementation of the Initiative: traditional agency procedures, philosophies and attitudes; historically low service provision to minority children; the single-agency focus; absence of a matching funding requirement; and lukewarm agency commitment and "buy-in."

The Difficult Challenge of Finding the "Most Appropriate" Grantee

MHI has brought to the light importance of choosing the most appropriate organization as the grantee for implementation funds. Stakeholders at the neighborhood, state and local levels agreed that the Foundation's choice of the state as grantee created considerable obstacles in meeting MHI objectives. Stakeholders identified several factors that presented challenges to overall implementation.

One of the first challenges was related to the traditional agency procedures of the grantee agency which stakeholders characterized as the state's inflexible bureaucratic requirements and slow pace. These stakeholders contended that these procedures made it difficult for the local initiatives to access funds in a timely manner and use them in ways other than those consistent with standard budget categories of state agencies. Many stakeholders felt that a bigger but related challenge resulted from state agency philosophies and attitudes towards working with low-income residents. Many of these attitudes held by the state grantees stemmed in part from their inexperience in working in partnership with community residents. As such, the governance strategies encouraged by the Foundation were unfamiliar and State level stakeholders admitted that they felt accountable to the Foundation for the administration of the initiative's funds. State grantees, at least initially, were reluctant to delegate responsibilities or base their actions on local community input. This type of attitude created a rift between the state and the neighborhood governing boards who saw their role as guiding the decision-making process around how to use funds to meet local needs.

The fact that the monies were given directly to the state also affected the way partnerships with residents played out. Stakeholders at the provider level generally stated that decision-making power was in the hands of the grantees—i.e., the state—and therefore, since the governing board was not in control of money, the residents had less leverage and less decision-

making power. Some residents seemed to agree with this notion that money translated into decision-making power and these residents also reported that they had not had many opportunities to make service decisions. The implication here is that without access to the resources, residents' ability to make service decisions will be limited and the development of true partnerships severely hampered.

Some resident stakeholders, however, believed that this unequal partnership started long before the Initiative was actually implemented and that the attitudes towards residents by the grantees were already preconceived. These residents claimed that representatives from the target communities had not been involved in Request for Proposals process in a meaningful way. Resident participation in community forums and focus groups held when states were preparing a response to the Foundation's Request for Proposals were viewed as being only informational in nature. In the absence of an organized group of residents, these resident stakeholders claimed that state stakeholders did not see people who had attended these events as their future partners in governance. This paternalistic attitude reportedly continued even after the Initiative was implemented.

The imbalance of power between the state and community residents was further described by residents serving on the NGBs; many of these residents felt that the Boards did not have enough backing from state and local government to influence policy changes needed to enact the MHI's system reform agenda. For example, in some cases, state and local representatives on the NGBs were unable to secure their respective agency leaders' continued commitment and support. Furthermore, from the residents' perspective, the state and local partners could chose to disregard decisions made by the NGBs if they did not agree with them. In the words of a resident:

"The Board can be 100% in agreement with what we want to do, and it can be stopped in any level along the way because we are gonna have to go from that board to the city system, the county system, and the state systems, and if we are not in those systems, we are stopped."

A second challenge was that in three of the four sites, MHI was affiliated with the Department of Mental Health, a state agency which historically had a low level of service provision to minority children. This was significant since the Initiative specifically targeted low-income minority communities. Some stakeholders felt that while the decision made logical sense given that the focus of the Initiative was on Mental Health, the Foundation had overlooked the fact that state Departments of Mental Health often have very little clout and power to involve other key partners. These stakeholders suggested that this may have adversely affected the MHI's capacity to produce the kind of meaningful change that the project had envisioned.

A third challenge was related to the Foundation's decision to use a single agency grantee. Some state level stakeholders criticized this decision because they felt that using a single grantee narrowed the focus of the MHI, and may have possibly alienated other state agencies (e.g., Juvenile Justice, Child Welfare). These stakeholders believed that the support of these other child serving agency was necessary in order to address the significant cross-system issues impacting the MHI target population.

Stakeholders suggested a better approach may have been to funnel resources through either Juvenile Justice, Child Welfare, Special Education, or a combination of these agencies, because it would have integrated systems that have overlapping issues that were important to MHI. This approach would also have made it easier to identify minority children and fami-

lies in need of mental health services and supports, and provided an opportunity to increase the focus on cultural competence in these systems, an area of the MHI which stakeholders consistently rated as weak.

A fourth challenge identified by some stakeholders was that MHI had failed to require matching funds by the state grantee agencies. These stakeholders felt that government agencies tend to respond better when financial responsibility is shared. Stakeholders representing the state surmised that state and local governments did not have sufficient incentives to become heavily involved with the MHI because they were not mandated or required to commit any financial resources. In their opinion, this lack of financial responsibility diminished motivation to invest time and human resources in implementing a complex initiative such as the MHI. In fact, even in sites like Boston, where the state legislature consistently committed $3 million towards MHI, in general, agency administrators felt that compared to their own administrative budgets, the Foundation's investment in addressing important social problems was minimal.

A final challenge noted by some state and local level representatives who shared the perception of many residents, was that a lack of state 'buy-in' negatively affected implementation. In their opinion, the MHI had failed to concentrate on the right individuals within the state agencies, and had placed too much responsibility on high level state leaders (e.g., commissioners, other heads of large state agencies). These stakeholders stressed that these positions were the most vulnerable to political change, and least able to dedicate the time and attention that the MHI demanded. One participant explained the situation in this way:

"The local managers who are responsible for doing the work are the ones who are empowered at the state side, and by extension, on the Foundation side as well. They are the ones who are in the position of working most consistently, most diligently, with communities, not the commissioners."

These factors represent only some of the challenges that the MHI sites faced in working with their grantee agencies. However, these issues provide useful information that may be worth considering when choosing a grantee agency for a multi-faceted initiative of this kind.

LESSON

Broad community outreach was limited during the Initiative. The establishment of a governing entity for the MHI should not have been substituted for ongoing dialogue with other community residents not closely affiliated with the project. A parallel effort to inform and organize the target community around the issues embraced by the Initiative should have been part of the design. This effort should also have been supported through the life of the project using separate funds.

Community Organizing Should Have Had Separate Funding

One of the major challenges noted with respect to governance was the issue of keeping outreach to the broader community central to the Initiative. Stakeholders felt that the multiple tasks of the Initiative related to governance, service delivery and systems reform created time and resource management conflicts which resulted in less time being allotted to broad community outreach and on-going dialogue with the larger target communities.

The service provider and MHI staff also concluded that the work of developing and refining consensus between the state and local partners and the community-at-large was not accomplished. In the words of a participant from this group:

"A lot of things were assumed, and a lot of community work wasn't really done…After selection of the neighborhoods there had to be another process, and that process had to be to work with the community, the city and the state to reach a common understanding."

State and local representatives made a similar point. In their opinion, the MHI gave some residents an opportunity to influence the delivery of specified services (e.g., family support, counseling, case management) to a narrow group of children and families from the neighborhood. However, it failed to give residents a voice and the power to resolve other larger issues impacting their lives in the community. As explained by one stakeholder:

"It would be important at some future point to draw some distinction between a community organizing effort within a local community that is directed at increasing resident power and control over what is going on in their community, and about having a say in service delivery design or in a community center within their neighborhood. I think those are two separate things, and I think we neglected the more important one because of the demands that we have this participation and this involvement from these residents."

This participant contended that while residents' input on a variety of things was necessary to implement the Initiative, their agenda about gaining a greater voice within the greater community was always secondary. A local representative's solution to this problem was as follows:

"I think that the community organization needs to be funded separately from service delivery…there needs to be a linkage between the two, but if we are going to change power relationships within the neighborhoods then that has to be a separately funded and targeted…"

A Strategic Management Information Systems Plan Is Crucial for Implementation of an Effective Management Information System

LESSON

More time and attention should have been dedicated to determining the parameters and scope of the developing Management Information Systems. Sites should have been encouraged to establish a more realistic, shared vision for MIS with measurable and agreed upon goals and objectives. Clear steps on how these goals were to be accomplished should have been articulated and more local training and technical assistance should have been provided to stakeholders across all levels of the Initiative on an on-going basis.

Another lesson affecting all three areas of implementation was related to the Management Information Systems implementation. On reflection, the MHI vision on MIS was too ambitious, and while overall, MHI was relatively successful in collecting data on out-of-home placements, it fell far short of establishing the comprehensive picture of services it was intended to provide. Stakeholders agreed that the MHI scope of MIS was too wide and there was general dissatisfaction with the type of data that had been collected. Stakeholders from the different levels had different perspectives on exactly what and how data should have been collected. Local and state level stakeholders felt that each site should have had more autonomy in deciding what types of information they would collect rather than being told exactly what to collect. They suggested that if sites had been allowed to choose what information to retrieve, they would have chosen to focus on acquiring information on what they were actually doing—i.e., Family Resource Centers services and activities, and more prevention and intervention type services.

Focus group discussions highlighted the importance of establishing a shared and agreed upon vision for MIS among stakeholders at all levels of the Initiative. Stakeholders suggested

that this shared vision was missing from the MHI and made MIS implementation more difficult. For instance, a common experience across sites was that state agencies did not 'buy into' the concept of making data readily available to local community-based agencies. Historically, confidentiality and other factors made many state agencies reluctant to share data with other agencies and community-based providers. Therefore, even though some success was achieved in convincing state agencies to provide data to site stakeholders who were part of the overall data collection process, in many instances, this activity was contrary to agency philosophy and attitudes about sharing information. Some stakeholders speculated that better results would have been achieved if state agencies had been actively involved in designing the overall MIS vision.

Another significant factor across all sites was that stakeholders at all levels had limited knowledge and expertise in this area. Inexperience and a lack of true understanding about management information systems was a common challenge among stakeholders.

A state representative admitted that, *"…in an effort to spend the money, we bought the hardware, we got the contracts with the folks that were going to help us through this process, without the kind of results, without knowing what we were necessarily doing."*

A provider also acknowledged the lack of preparedness among MHI stakeholders stating, *"I think that the intent of MIS is good…this was something new that nobody had done, so we were trying…"* Residents echoed similar sentiments and like state and local level stakeholders, they openly admitted their inexperience. One resident acknowledged being largely unprepared for implementing this particular aspect of the Initiative stating, *"I was asked by my board president to chair the MIS committee. I had no knowledge, none whatsoever, about what I was doing."*

Although national technical assistance was readily available to the sites at their request, there was sufficiently widespread inadequacy and lack of knowledge regarding MIS and MIS-related issues to warrant the need for more intensive technical support. It appears that what was needed was on-going (almost daily), local technical assistance which would have provided sites with the type of 'hands-on' support, education and guidance most of the stakeholders appeared to have needed.

SECTION

FOUR

Conclusions

Conclusions

From the beginning of the Mental Health Initiative for Urban Children in 1992, it was obvious that this was a bold initiative that was going to differ in important ways from other major child mental health reform efforts. It was not, for example, going to be restricted to only serving children with serious emotional disturbances and their families, as had efforts such as the Child and Adolescent Service System Program, the Robert Wood Johnson Foundation Mental Health Initiative for Children, and the Ventura County demonstration project. Rather, it was going to focus on all children within the communities that were selected to participate, and to define "mental health" in a broad way.

Nor was it going to assess its effectiveness by measuring change at the child and family level, as had the demonstration project at Fort Bragg, North Carolina, and as is the norm in the child mental health field. While the Initiative was based on the belief that neighborhood development and systems reform in support of families would ultimately improve outcomes for children and families, and would in fact be the most powerful way to achieve such improvement, the evaluation focus was on the process of groups coming together to work towards that end rather than child and family outcomes.

Nor did the Annie E. Casey Foundation choose to focus on any single level of government. Rather it chose to give grants to states, and to promote partnerships between state government, local government, and neighborhood leaders. The emphasis on neighborhoods as the communities of concern was based on the Foundation's belief that there are a number of disinvested neighborhoods in this country in which a disproportionately large number of children and families encounter difficulties, and that this situation requires a targeted focus on neighborhood strengthening. Further, the Foundation, in its belief that governmental policies at the local and state level need to be changed to reflect the needs of neighborhoods, and that public officials at the local and state level need to better understand the needs and conditions of neighborhoods, chose to involve state government, local government, and neighborhoods in the effort. The Foundation also hoped that by requiring involvement at all levels, it would facilitate the successful transfer of knowledge gained through work done in a particular neighborhood to other neighborhoods in the same city and state.

Out of such beliefs grew an initiative that was described as "one of the boldest efforts to improve outcomes for children and their families through systems reform that the child mental health field has ever undertaken" by the evaluation team at the outset of the initiative (Friedman & Hernandez, 1993).

In July, 1992, at the first meeting of the sites selected to be grantees in the Mental Health Initiative for Urban Children, Doug Nelson, Executive Director of the Annie E. Casey Foundation, told the assembled group that this initiative was about learning – learning about such things as neighborhood governance, about building positive relationships between neighborhoods, local government, and state government, and about the provision of culturally competent services. It was clear then, and remains clear now, that the Foundation was committed to the development and support of neighborhoods, particularly neighborhoods with a high percentage of children and families in poverty, as a major part of its overall strategy for improving outcomes for children and families throughout the country, and that this program was just one part of a long-term effort in that direction by the Foundation.

Given this background, a concluding section of this final evaluation report must look broadly at lessons learned, and overall impact for the sites involved, for the children's mental health field, and for broader efforts at neighborhood development and systems reform.

As a postscript to its New Futures initiative, which was started in 1988, the Annie E. Casey Foundation published in 1995 a brief but very thoughtful monograph called, "The Path of Most Resistance: Reflections on Lessons Learned from New Futures." *New Futures* was the first of the Casey Foundation's "long-term, multi-site initiatives that was aimed at reforming public policies and improving the effectiveness of major institutions serving children" (The Annie E. Casey Foundation, 1995, p. ix). The first lesson learned from New Futures by the Foundation is that, "comprehensive system reform is the path of most resistance" (The Annie E. Casey Foundation, 1995, p. 1).

The Mental Health Initiative for Urban Children clearly validated this lesson – achieving significant and meaningful reform in those systems responsible for serving and supporting children and families, and in those neighborhoods with the greatest need is clearly a complex, challenging, and difficult undertaking. These challenges identified in the Lessons Learned section illustrate that the implementation of a multi-site initiative is slow and gradual and requires persistence, determination, and endurance.

This has perhaps been particularly the case with the Mental Health Initiative for Urban Children, given its broad focus, and its effort to get people of different races, cultures, and social class, and from several levels of government to work collaboratively. There was no shortage of committed and talented people with great leadership ability at all levels of the Initiative. The challenge was finding new types of leaders who could cross boundaries and transform long-standing practices. Traditionally, a leader is viewed as someone who is able to get a group of individuals to go beyond their individual goals to work together for a group goal. More recently, as organizations and systems strive for productive change, an increased focus is on individuals who are able to change the course of an entire organization – typically called "transformational" leaders (Friedman, 1996). In this new model of community development and system reform, the challenge is to change practices not only within a single organization or neighborhood, but to carry partnerships and collaborations to a new level. This calls for the development of transformational leadership teams, composed of individuals who can transcend an individual organization, system, level of government, or community. Such teams require a mutual trust and respect that can only be built gradually, or rebuilt at an even slower pace since in many cases the starting point is a history of distrust.

The evaluation of the Mental Health Initiative For Urban Children was able to describe and document progress in the development of governance structures at the neighborhood level, and partnerships between the different levels and systems involved. Through these partnerships, positive changes were achieved at the neighborhood level, although the gains always seemed tenuous particularly given the not infrequent changes in people involved, particularly representatives from the formal systems. The experience of the Mental Health Initiative is not discouraging, therefore, in terms of the feasibility of achieving the types of partnerships that are needed to bring about change. The experience does reinforce the finding of New Futures, however, that this is an extremely complex undertaking, and that individuals who are faint of heart, or impatient, are not well suited for these types of initiatives. It also emphasizes the need to devote considerable time to developing, maintaining and re-establishing these working relationships and partnerships.

Part of the challenge is that "systems reform" is a difficult vision for people to understand. It is much easier to understand the need for a new service, or even several new services. It is a constant challenge to maintain the broader vision, and to develop a practical theory of change that strategically points the way to improved outcomes for children and families in the long run. In the Mental Health Initiative for Urban Children, logic models were used as one tool to help as participants in each site came together to express their aspirations for their community, and to develop a set of strategies to help achieve the aspirations. These logic models (Appendix B), which were by no means static but rather evolving models, were helpful to the

sites. Still, the challenge of keeping one's eye on the big picture when there are so many pressing immediate needs is a very difficult one.

The support of enhanced direct service in the sites helped community participants, in particular, who lived day in and day out with the needs of the community, to see some benefit from the Initiative. This was helpful in keeping community leaders engaged in the process but the challenge was to keep faithful to the overall vision, and not become consumed with operational issues involved in implementing the direct services. This issue of the relationship between service provision and systems reform is a difficult one, especially in communities with great need, and requires a clear road map (or theory of change) so that service provision can be used not only for the direct benefit it provides to the recipients but as part of a strategy to achieve the broader vision.

The challenge of developing and maintaining a broad vision was perhaps increased in this initiative by the absence of a focus on clear outcomes. A focus on outcomes helps to provide direction to complex efforts. It is difficult to determine what the impact was in this initiative in the absence of a strong outcome focus. It did seem to contribute to a lack of clarity about purpose in the program. However, after the Foundation developed a set of benchmarks for the sites during the course of the program, this helped provide direction and clarity.

The focus on process rather than outcome did seem to contribute to the richness of the lessons learned. Often times in the mental health field, there is such a strong and premature emphasis on determining whether specific outcomes were achieved that the process of trying to achieve the outcomes receives little attention. Given the complexity of bringing about large scale systems reform, and developing effective partnerships, there is a strong need to focus on the developmental process that takes place at all levels of an initiative like this. Weiss (l996) talks about the need to reinvent evaluation, and particularly to move the evaluation field to more of a co-learning and participatory model rather than an emphasis on the evaluator as the outside onlooker and judge. The evaluation team felt fortunate to be able to utilize a participatory model, and very much felt like co-learners in the process. The team was pleased to be able to provide feedback to the sites as part of an ongoing formative process, and to gather information from multiple perspectives, using a variety of qualitative and quantitative methodologies. Such an approach seems much more appropriate at this early stage of the community development and systems reform effort than do more traditional evaluation approaches. Hopefully, it has provided valuable information that can be used to guide future initiatives of this foundation and others, as well as government agencies.

With regard to a theory of change, part of the theory that served as the basis for the Initiative was a belief that within neighborhoods there are many strengths and natural supports, and much shared culture, values, and beliefs, and that these can be used to create improved conditions for children and families. The experience of the Initiative would only serve to support and confirm this part of the theory of change. However, defining what constitutes a "neighborhood" is not an easy process, and the site selection process in several instances resulted in multiple neighborhoods coming together as one site. In such instances there was not the same level of shared culture, values, and beliefs that was anticipated, and instead there was competitiveness and sometimes conflict between residents of adjacent geographic areas that really constituted different neighborhoods. In this regard, the Initiative was not able to fully test its theory about strategies for achieving change at the neighborhood level. This is unfortunate and calls for great care in selecting sites in future initiatives.

It was also clear that the Initiative was not very successful in collecting comprehensive neighborhood level service data for the four target sites. In particular, data about use of services within different systems, and the cost of those services was rarely kept by neighborhoods and it was not possible to accurately map the formal services and supports that residents of each site were receiving. This impeded the evaluation effort but more important it resulted in the absence of information that would have been very helpful in planning within each site, and in making a case for the savings that could be achieved through the Initiative.

A strong part of the Initiative was the commitment to family involvement at all stages of development. The Federation of Families for Children's Mental Health, a very new organization at the time this initiative started, worked very conscientiously to generate a strong voice in the communities of parents with children in need of mental health services. The work of the Federation clearly reflected a co-learning model – parents in the communities benefited from the work of the Federation team, while the Federation team benefited from the experiences of the families in these neighborhoods. In fact, this entire effort has helped propel the Federation into becoming more focused on being responsive to the needs of families from different racial, cultural and social class backgrounds than virtually any other large family advocacy organization.

Another important part of the Initiative was the provision of technical assistance and consultation by outside experts. In addition to these consultants coming into the sites to assist, there were also staff from the Foundation, from the Federation of Families for Children's Mental Health, consultants on information systems, and members of the evaluation team. This proved to be a mixed blessing. While the infusion of outsiders into the sites helped bring important knowledge, it also brought a level of confusion. Perhaps more important, in an initiative that sought to promote empowerment of the sites to make change, it sometimes seemed to create an effort at the site to figure out how to provide the outsiders with what they wanted, rather than how to figure out what was most needed. This is somewhat of an inevitable conflict and calls for prudent planning between the Foundation and the sites, and between all of the outside individuals with legitimate need to have access to the sites. As the Initiative progressed, this seemed to work itself out but remains an issue to be considered in subsequent initiatives.

As noted earlier, large scale initiatives such as this one not only have impact upon the sites that are directly involved but also upon the broader field of which they are a part, and the overall effort both to promote improved mental health services, and broader system reform. Within the children's mental health field, this bold initiative has clearly generated increased attention on urban issues, and on the need to better understand how to serve children and families within inner-city communities. The Federation of Families for Children's Mental Health grew from the support of the Foundation, and from its involvement in this effort, and has become a powerful voice for improved mental health services nationally and in many states and communities. The Federation has clearly become a positive voice for culturally responsive services, and its advocacy for this is partly a reflection of its involvement in this program. Specific evaluation methods have been developed and tested during this initiative and, perhaps more important, a broader model of evaluation than is typically used in the mental health field was developed and is impacting other evaluation efforts.

Most important, however, while the results of this initiative will likely disappoint those who are looking for the "silver bullet," the powerful, convincing intervention to dramatically improve the outcomes for children and families, there has been much that has been learned about the process of change and the needs of communities. This knowledge will continue to be incorporated into new and improved efforts at community development and system reform. As one part of a continuous learning and changing process, this initiative has made important contributions. The challenge is to continue the effort, with each new undertaking being a little bit stronger and more effective because of the lessons learned from prior efforts.

APPENDICES

- **Appendix A – Methodology**
- **Appendix B – Site Profiles and Logic Models**
- **Appendix C – Sources, References and List of Evaluation Reports**

APPENDIX A
Methodology

The evaluation of the Mental Health Initiative For Urban Children was a formative evaluation that was mainly qualitative in nature and designed to answer a series of significant questions regarding the implementation. For the most part, the evaluation focused on documenting and understanding changes that took place while implementing the MHI, and focused less on the documentation of outcomes. An important aspect of the evaluation approach emphasized the process of providing practical information that sites could use to assist them during implementation. The evaluation was geared towards assessing the three major areas of implementation namely, Systems Reform, Governance and Services. In addition, evaluators documented the major overall Lessons Learned from implementing the Initiative. Each of these four areas was evaluated using different methods. These methods and data analyses are discussed below.

Systems Reform

Systems reform efforts of the target sites were evaluated using the following methods:

- In-person interviews with stakeholders from the State, Local, Provider and Resident levels conducted during the implementation period.
- Telephone interviews with key site stakeholder or policy representatives conducted in 1999.
- Review of major state legislation on web sites developed by state agencies, policy analysts and advocacy groups.
- Document Review (site reports, foundation reports, evaluation reports and other relevant documents).

In-Person Interviews

Interviews related to reforms that had been implemented as a result of the MHI. Stakeholders associated with the MHI implementation (e.g., state and local coordinators, board members, agency representatives, residents) were also asked to comment on MHI accomplishments and challenges.

Telephone Interviews

The evaluation team in consultation with the Foundation and technical assistance staff identified informants for the telephone interviews. Informants were typically middle-level to high-level government agency staff. Information covered both MHI related reforms as well other state and local reform efforts that had occurred over a five-year period (1993-1998). Some informants also provided copies of agency documents (e.g., strategic plans, program descriptions) and legislation which were subsequently reviewed.

Review of State Legislature on Web Sites

This involved locating specific web sites for State agencies (e.g., Florida Department of Children and Families; Virginia's Department of Mental Health and Mental Retardation) to obtain information on State programs, initiatives, plans and policies that reflected the tenets of the MHI. Web sites for children's advocacy groups (e.g., Child Welfare League of America; Children's Defense Fund) and groups which analyze public policy (e.g., National Conference of State Legislatures) were also accessed to document the status of state implementation of federal laws (e.g., IDEA 97; ASFA).

Document Review

Over the life of MHI, the sites, the Evaluation team, the Foundation, site consultants and others have written many pertinent documents in the children's mental health field. These documents were reviewed to pro-

vide both background information and reform information. Some of these documents provided references to other potential data sources.

Data Analysis

The process of collecting, analyzing and summarizing information on system reform was iterative. Evaluation team members had to obtain, verify and clarify information several times before an accurate and thorough description of the changes that had occurred could be developed.

For the purpose of the Systems Reform Implementation Report, evaluators organized their individual site analysis in three separate sections:

1. State reforms that preceded the MHI, and which provided an environment the Foundation judged to be a prerequisite for implementation.
2. Reforms that occurred during the MHI implementation and which were consistent with its vision and philosophy. These reforms would have occurred regardless of whether the MHI was implemented in the state or not. However, their existence strengthened the Casey Foundation's reform agenda in broader circles.
3. MHI initiated reforms occurring between 1993-1998. These reforms involved at least one of the focal MHI human service systems: Juvenile Justice, Mental Health, Child Welfare, and Special Education.

Challenges to the Study of Reform

- Difficulty in verifying information, as well as in identifying individuals with the right expertise.
- Different perspectives—Descriptions of MHI related reforms were obtained from informants from all levels of the Initiative. Informants sometimes had different opinions about what constituted a reform and the extent to which the reform had an impact.

Although much effort was placed into tapping all reasonable sources of information, evaluators are not totally confident they exhausted all avenues. It is therefore possible that some reforms were omitted in this analysis.

Governance

The evaluation was faced with the task of describing the development of grass-roots governing boards in four low-income urban communities. The goal behind the creation of these organizations was to have a structure that had legitimacy in the eyes of the community, the authority and capacity to administer the project's resources, and the necessary accountability to audiences inside and outside the neighborhood.

The national evaluation developed a comprehensive framework to document the evolution of the governing boards in each of the target sites, assess relationships, collaboration and partnerships among various stakeholders at all levels of the Initiative and evaluate the developmental growth and success of governance across all sites.

The task of creating a developmental framework that could be applied to neighborhood governance involved several steps: a) Review of relevant literature; b) Open-ended, key informant interviews on neighborhood governance; c) Data reduction and theme identification; d) Application of key concepts to the development of the framework; and e) Data collection.

The final stage of framework development entailed the combination of the key concepts derived from the literature review and the preliminary themes identified during data reduction from the open ended interviews. The Neighborhood Governance Development Framework describes NGB development as moving along several paths or attributes to effective administration and planning for the neighborhood. Each of the seven attributes of NGB development is in turn divided into two or more aspects which serve to define the attribute in more detail (see Table 1).

Based on the literature review, the attributes were defined as follows:

- **Consciousness/Knowledge:** Addresses the building of confidence and trust among NGB members and other key stakeholders, as well as an understanding of the long-term goals of the project;
- **Community Information:** The NGB's ability to gather, analyze, and use a wide array of need- and strength-related information relating to the community;

Table 1.
Seven Attributes of NGB Development and Corresponding Aspects

	Attributes						
	Consciousness/ Knowledge	Community Information	Organization	Community Involvement	Resource Management Capacity	Linkages	Programmatic Involvement
Aspects	Belief in Capacity to Change Overall Vision of the Initiative Knowledge of Human Service Systems Awareness of Political Process	Gathering and Sharing Information Content Information Utilization: Neighborhood Level	Role of NGB Structure Roles of Officers and Members of the Board Distribution of Labor Turnover Training	Recruitment Board Representativeness Communication	Control over External Resources Management of Internal Resources Allocation of Resources	State Local Providers	Program Development Collaboration and Coordination

- **Organization:** Involves the structure and role of the NGB as well as the development of NGB leadership, distribution of labor within the NGB, turnover, and training issues;
- **Community Involvement:** Refers to the NGB's ability to communicate with and involve community members in neighborhood governance activities;
- **Resource Management Capacity:** Involves the NGB's ability to secure, manage, and distribute resources;
- **Linkages:** Describes the connections of the NGB to state and local levels of government and the provider community;
- **Programmatic Involvement:** Refers to the NGB's role in the development and implementation of programs and the collaboration and coordination between the NGB and service providers who will deliver specific services.

The aspects within each attribute were defined using a nine-stage continuum. For instance, the attribute Consciousness/Knowledge is divided into four aspects: Belief in the Capacity to Change, Overall Vision of the Initiative, Knowledge of Human Service Systems, and Awareness of Political Process. Stages 1, 3, 5, 7, and 9 have been defined with anchors to assist evaluators in deciding how developed an NGB is. The intermediate stages 2, 4, 6, and 8 are not defined, but are included to allow for variance in the assignment of stages of development. For the "Overall Vision of the Initiative" aspect, for example, the anchors are as follows:

Stage 1: No sense of vision. The process is dominated by the personal agendas of the participants.

Stage 3: There are several competing visions of the Initiative, often imposed on the community from external sources.

Stage 5: There are the beginnings of an internally developed vision, shared by all participants.

Stage 7: Participants share a common vision. However, the vision has a limited neighborhood focus.

Stage 9: There is a shared vision consonant with the Initiative's goals and focusing beyond the neighborhood to the reform of the overall system.

It should be noted that developmental stages were not originally assigned to all aspects in the framework. This was due to the Evaluation Team's ongoing learning about the evolution of governance and our reluctance to develop anchors that were not based on the emerging characteristics of the NGBs as they moved further along the developmental continuum. As these features emerged, the gaps were closed.

Data Collection and Analysis

Once the framework was constructed, the Evaluation Team developed fourteen questions that touched on each of the attributes and their different aspects. The questions included probes for the interviewer to ensure that the main concepts were captured.

Since our approach to describing neighborhood governance was developmental, the evaluators used the questioning route each year to go back and determine if there had been changes, and what direction those changes had taken. NGB interviews were conducted in each of the four project sites on four consecutive years. Interviews were conducted with members of the NGB and other stakeholders close to the project and the board. Typically, ten to twelve individuals were interviewed face-to-face. Because the Board's composition changed every year, the interviewees also changed from year to year. To maintain the emphasis on grass roots involvement, the majority of the interviewees were community residents who were members of the NGB. The evaluation team interviewed people who had left the board for various reasons to balance the accounts of current board members. Interviews were taped and transcribed for the content analysis.

In addition to the questioning route, a questionnaire on issues related to the NGB's membership composition, committee structure and role, turnover rates, board training, and development of Board operating guidelines was developed. The NGB president completed this questionnaire.

For reliability purposes, two evaluators who read the same interviews and coded them separately conducted the content analysis. The reviewers first coded the text using the attributes from the framework and then decided on the appropriate developmental stage to assign. After this process was completed, the two evaluators came together and discussed the stage assignment for each attribute. If they disagreed, the decisions were reviewed and discussed until consensus was reached. The final report covered each NGB attribute and its aspects, and provided a discussion of the developmental stage assigned supplemented with direct quotes from the interview material.

Challenges

- It was difficult to ensure that the right people were interviewed since at any given assessment the evaluation could only interview a selected number of individuals.
- Analyzing and coding transcripts of the interviews with stakeholders was time consuming and entailed several hours of work.

Service Delivery

Evaluation of the service delivery component of the Mental Health Initiative for Urban Children was done at the direct frontline service level and at the macro or overall service implementation level. The Evaluation of Direct Frontline Services looked specifically at direct services that the sites were providing. The primary strategies used to evaluate the development and provision of direct services at the four sites were *Focus Groups* and the *Family Experience Studies* (FES). Supplemental information for this evaluation was obtained through *Document Reviews* of different site implementation reports and other reports developed by the Annie E. Casey Foundation. Service utilization information was also gathered using the *Matrices*, which were a set of service surveys.

For the Evaluation of Service Implementation at the Macro Level, evaluators described the overall implementation of the Service Delivery Component of the MHI. This level of evaluation was broader and included a variety of perspectives. Analyses involved *Document Reviews*, *Focus Groups* with stakeholders from the state, local, provider and neighborhood levels and a limited number of *stakeholder interviews*.

Evaluation of Direct Frontline Services

Focus groups and the FES were the major evaluation tools used to evaluate universal services, targeted prevention, and intervention services.

Focus groups

Focus groups were used to evaluate the universal, targeted prevention type services that had been mainly provided through site Family Resource Centers. The

national evaluation conducted two sets of focus groups in all four sites. The primary goals of the initial focus groups were to gather information on the quality of life, and existing services and supports, and assess residents' level of satisfaction with these services. In addition, these first sets of focus groups attempted to obtain information on the service needs of residents. The second round of focus groups were conducted after service delivery systems were initially implemented in all four sites. These findings were used to assess consumer satisfaction with services provided by and through the family resource centers which were developed in each of the sites. The data gathered through both sets of focus groups represent global impressions and trends identified by participants.

Focus groups were grouped into the following categories during the early implementation phase of the Initiative (1993 & 1994).

- Resident caregivers with children from birth to five.
- Resident caregivers with children aged 6-11.
- Resident caregivers with children from 12-17.
- Resident caregivers with children who were or had been in out-of-home placement.
- Resident teenage mothers who were under 18 years of age.

All participants had resided in one of the four target neighborhoods for at least one year and efforts were made to recruit residents who had used services from one of the following service systems: Mental Health, Child Welfare, Juvenile Justice and Special Education.

All participants were subjected to the same questioning guide which addressed challenges of everyday living in these communities and the experiences of residents with services and supports provided within and outside the target communities.

The second round of focus groups were conducted with four or five groups of service users. These groups were conducted very soon after sites had implemented their newly designed service systems during the middle phase of implementation (1995 & 1996). These groups looked at the quality of services and residents' satisfaction with the services provided through the sites' family resource centers and outreach programs. These groups were organized according to specific criteria primarily relating to service use and residence in the target neighborhood. Questions centered on service availability, service effectiveness, service environment, and family relationship with caseworkers or care coordinators.

Family Experience Study

The Family Experience Study (FES) was used to evaluate intensive intervention services provided through the sites' case management models. The family experience studies (FES) studied the interface between service systems and consumers. This research methodology focused on how the existing services system addressed the needs of individual children and families in the Mental Health Initiative's target neighborhoods.

Two sets of FES were conducted in each of the sites except Houston. The initial groups were completed early on in implementation with a second study conducted during the later phase of implementation. The second study was conducted only after sites had sufficient time to respond to the findings of the initial FES and had implemented changes resulting from that study. A second round of FES was not conducted at the Houston site because the site had not fully implemented its case management model that could meet the FES study criteria.

The goal of these studies was to take a critical look at the effectiveness of the intensive, universal, targeted/prevention services and assess their impact on individual family's mental health problems and family situations.

The FES operationalized the concept of "a well developed system of care" following the six service principles in the field of children's mental health identified and defined by Stroul and Friedman in 1986 and included in the Planning Guide for the Casey Children's Mental Health Initiative:

Early Intervention/Prevention: Services aimed at reducing the prevalence and severity of problems faced by families through effective early identification and intervention.

Family Centered/Focused: Services are dictated by the needs of the child and family, are based on the family's strengths, and are provided in a manner which

maximizes opportunities for involvement and self-determination in planning and delivery.

Individualized: Services are designed in accordance to the unique needs and potentials of each child and family, and are guided by an individualized plan.

Community-Based: Services are provided in the community, in the least restrictive environment possible, and are accessible and available to residents.

Integrated and Coordinated: Services respond to an inter-related array of problems, are delivered through linkages between public and private providers.

Culturally Competent: Services which value diversity, acknowledge and work with the underlying cultural dynamics of the community and family, and adapt to meet the needs of culturally and ethnically diverse groups within the community.

Case Sampling

A total of twelve families typically participated in each round of FES. For the purpose of this study, the following individuals represented a case:

- the target child receiving services from one or more service systems (e.g., mental health, juvenile justice, special education, and child welfare),
- his or her primary caregiver,
- persons who provide informal support to the child and family, and
- representatives of the different systems serving them, including case managers and direct service providers.

The approach included interviews with the target child, primary caregivers, service providers, case managers and other informal sources of support. This methodology also included an extensive review of records and documents relating to the target child's care and support.

All primary caregivers were asked to sign an Informed Consent and Release of Information form prior to being interviewed to authorize the FES reviewers to examine their records. Each primary caregiver interviewed was paid $50 in cash for participation in the study.

The review team conducting the FES generally comprised an interdisciplinary team of researchers with backgrounds in anthropology, public administration and other social science backgrounds. This team of reviewers had extensive interviewing and research experience in the field of children's mental health, and repeated experience in the use of the FES protocol in various sites around the country.

Document Review

Site reports, logic models, activity reports and work plans, Foundation documents and other supporting materials were used to outline the critical components of each site's overall service strategy and framework.

Matrices - Data Collection Surveys

The evaluation with key Foundation staff and site stakeholders and staff, developed the "matrices" which were a set of surveys that captured service information. These surveys focused on out-of-home placements and service utilization and costs associated the major human service systems such as Education, Child Welfare, Juvenile Justice and Mental Health and Recreation. The main purpose of these surveys was to collect information on service utilization by residents from the target neighborhoods, and to assess the various costs and expenditures related to placements of children from the four neighborhoods in major state human service systems.

Evaluation of Service Implementation at the Macro Level

In addition to knowledge of service delivery obtained during the five-year implementation period, the evaluation's assessment of services at the macro level was based on the following:

- focus groups (see discussion on Lessons Learned below)
- document reviews, and
- a limited number of stakeholder interviews.

Document Review

The evaluators reviewed site reports, logic models, activity reports and work plans, Foundation documents and other supporting materials to obtain information about site successes and challenges and overall service implementation.

Stakeholder Interview

A limited number of phone and/or in-person interviews conducted with key stakeholders to help clarify certain aspects of service implementation and provide supplemental information.

Lessons Learned

Information and data on the numerous lessons learned from the implementation of the Mental Health Initiative were derived from four focus groups conducted during a closing conference held in May 1999. These lessons were related to specific areas of implementation i.e., systems reform, governance and services, as well as overall implementation of the Mental Health Initiative.

Three of the focus groups were organized according to stakeholder type, and mixed representatives from all four sites. These groups were conformed as follows: 1) Resident and Parents involved with the MHI; 2) MHI staff (i.e., state and local coordinators) and service providers; and 3) State and local government representatives involved with the MHI. The fourth stakeholder group included representatives from the Foundation, the national technical assistance team, and other individuals who worked closely with the Foundation or the sites throughout the life of the Initiative.

The same questioning route was used for the four groups. The discussion, led by evaluation team members, centered around the significant events and lessons related to systems reform, governance and service delivery in the MHI, as well as on the Initiative's broader contributions to the field of children's mental health. Participants were also asked for suggestions as to how some of the barriers encountered in implementing the Initiative could have been overcome or prevented.

APPENDIX B
Site Profiles and Logic Models

- **East Little Havana Site Profile**
- **Boston Site Profile**
- **Houston Site Profile**
- **Richmond Site Profile**
- **Logic Model for East Little Havana**
- **Logic Model for Boston**
- **Logic Model for Houston**
- **Logic Model for Richmond**

East Little Havana SITE PROFILE

General Characteristics and Socio Demographics

East Little Havana is a vibrant neighborhood with a population of forty-five thousand inhabitants located West of Downtown Miami, Florida. The neighborhood boundaries are: N.W. 7th Street and the Miami River to the North; I-95 Expressway to the East; S.W. 8th Street to the South; and S.W. 17th Avenue to the West. East Little Havana has become a transitional neighborhood and gateway for incoming immigrants. The population is largely comprised of Hispanics (95%) with Spanish being the predominant language. Of the Hispanic population, the majority are of Cuban and Nicaraguan origin (49% and 25% respectively).

The population under 18 years of age is evenly distributed into three categories: birth to 5 (38%), 6 to 11 (31%), and 12 to 17 (32%). According to the City of Miami Planning Department, the Census significantly under-counts the Little Havana community. The under-count results from the high number of undocumented residents. An estimate of the under-count of total persons alone ranges from 16% to 20%. Therefore, the figures presented here underestimate the actual population of East Little Havana.

The neighborhood's yearly per capita income is $6,099 a year compared to $13, 686 in the surrounding county. This pervasive low income translates into 49% of children living below the poverty level. One third of the families living in poverty are headed by single females. Another reflection of the socioeconomic status of residents is the fact that 88% of the housing units are occupied by renters, not owners.

The traditional Hispanic emphasis on maintaining the family unit is evidenced by the fact that 47% of children in the community live with both parents. Furthermore, 13% of the persons in the typical Little Havana household are members of the householder's extended family.

Quality of Life and Neighborhood Resources

East Little Havana represents a contrast between the benefits of a good location relative to the city, including availability of services and commercial activity within the boundaries of the neighborhood, and important problems relative to issues such as safety, unemployment, and immigration status of residents.

Residents interviewed in 1996[1] said that safety represented their major concern, including juvenile delinquency and gang activity, drugs, prostitution, violence in the streets and schools, and lack of adequate police protection. Youth delinquency was perceived at the time as the main source of safety problems, and according to residents, it resulted from chronic unemployment, and lack of recreational and educational opportunities. The immigration status of residents is another issue seen by residents as a major source of stress in the community. The illegal status of many residents impacts their capacity to find employment and to obtain certain services, which in turn negatively impacts their quality of life. Lack of English language skills, in particular among recent immigrants represents an added barrier to employment opportunities.

Despite the hardships, East Little Havana remains an area rich in resources. Fifteen churches of multiple denominations serve Spanish speaking residents and provide social services to their members. There

[1] Gutierrez-Mayka, M. & Hernandez, M. 1996. A Report on Parents' Perceptions of Life and Services: A Focus on East Little Havana in Miami, Florida. Tampa: Louis de la Parte Florida Mental Health Institute.

are 9 child-care centers and 12 community centers covering diverse social needs of children and adults. Two banks offer financial services. Two public elementary schools are located within the boundaries of East Little Havana, serving the majority of children in the community. Health services are provided in 4 private medical offices, 13 dental offices and 20 pharmacies. Mental health services are delivered at five local clinics and private offices.

East Little Havana residents do not need to go far to purchase food and home supplies: 28 grocery stores and supermarkets offer a gamut of food options from Latin America and the Caribbean. Over 67 coffee shops and restaurants are spread throughout the community and range from informal sandwich shops to elegant facilities with international cuisine. There are four public parks in the area and even a soccer stadium, which is home to the city's professional team, and constitutes a source of affordable and accessible recreation for the neighborhood families. Located minutes from the downtown area, East Little Havana is connected to the rest of the city by six bus lines that pass by the neighborhood's main streets and avenues. Some of these bus lines also connect residents to the city's Metrorail system.

Mission Hill, Highland/ Washington Park and Lower Roxbury Communities SITE PROFILE

General Characteristics and Socio Demographics

The geographic area comprised by the Annie E. Casey Initiative for Urban Children (Initiative) in Boston is made up of three neighborhoods: Mission Hill, Highland/Washington Park, and Lower Roxbury. According to the 1990 Census, the total population of these neighborhoods is 38,677. This area is racially and ethnically diverse: 18,657 individuals (48%) are Black; 10,134 individuals (26%) are White; 8,079 individuals (20.9%) are Hispanic; and 1,449 individuals (3.7%) are Asian. Native Americans and other ethnic groups account for approximately 1% of the population. Of the total population, 15.25% is foreign born.

Mission Hill, the largest of the three neighborhoods, comprises 39.5% of the target area's population. It is bounded by Ruggles Street to the north, the Southwest Corridor to the northeast, Heath Street to the south, Riverway to the west and Francis Street and Huntington Avenue to the northwest. Highland/ Washington Park represents 35.2% of the target population and has a boundary that includes Dudley Street to the north, Warren Street to the west, Townsend Street to the south, Ritchie Street to the southwest and the Southwest Corridor to the west. The Lower Roxbury neighborhood accounts for 25.3% of the population. This area is bounded by Massachusetts Avenue to the North, Melnea Cass Boulevard and Hampden Street to the northeast and east, Dudley Street to the southeast, New Dudley Street to the southwest, the Southwest Corridor to the west and Columbus Avenue to the northeast.

According to the 1990 census[1], residents in the three neighborhoods have a lower median monthly income than residents in the county ($318 vs. $333). The per capita income in these three neighborhoods is $9,910, which is $5,504 less than the per capita income in the county. Single females head approximately 50% of the families in this target area, and 78.7% of these families live below the poverty line. The unemployment rate among males in the area is 11% and 6% among females. With respect to educational attainment, the aggregate of persons older than 17 years of age who have not completed 9th grade is higher for the three neighborhoods than in the county (13% vs. 9%). Children in these three communities are enrolled in the public school system (90.7%).

Quality of Life and Neighborhood Resources

These communities face their share of problems related to crime and safety. The presence of guns, drugs, and gangs in many parts of the target community makes safety a major issue, and parents are often afraid for themselves and their children. Consequently, many residents have become more isolated and community involvement has diminished over the years.

Although these problems do exist many residents still characterize their neighbors as having good qualities[2]. These residents also believe that the essential values that make community involvement

[1] Data obtained from the document "Census Report: Demographic Characteristics of the Neighborhoods of the Mental Health Initiative for Urban Children," prepared by the Louis de la Parte Florida Mental Health Institute, March 1994.

[2] Residents' points of view were obtained in interviews conducted with two residents in August 1999 and in a focus group conducted in 1995 (Department of Child and Family Studies, FMHI/USF (1995). A Report on Parents' Perceptions of Life and Services: A Focus on Mission Hill, Washington/Highland Park and Lower Roxbury Communities in Boston, Massachusetts. Tampa: Louis de la Parte Florida Mental Health Institute).

possible still exist today. One resident explained that, "there are a lot of really good people in our community, because we look out for one another." Many residents value this concept of neighbors 'looking out for one another' and supporting each other and think that this can be a useful defense strategy against some crime, guns, and drug problems.

This sense of community appears to be very strong among some Latino residents who identified a sense of "compañerismo," i.e., comradeship, which unites Latino neighbors. Some other residents credit implementation of the Mental Health Initiative for helping to improve and expand comradeship not only within ethnic groups but also between different ethnic groups.

The presence of numerous public service organizations within or in close proximity to the target neighborhoods[3] provides resources for community residents. In Mission Hill, there is one police station, a community center, a public library, seven public health facilities, and five churches of different denominations. Lower Roxbury houses two fire stations, a police station, three community centers, two public libraries, three public health facilities, and fifteen churches. Washington/Highland Park also has two public libraries, two community centers, two health care facilities, a police station, and eighteen churches. There are three public and three private schools in Mission Hill; two public and seven private schools in Lower Roxbury; and four public and seven private schools in Washington/Highland Park. The three neighborhoods collectively house approximately 25 group child care centers, and approximately 50 family child care centers.

Churches, hospitals, colleges, and community centers in the neighborhood represent important resources that help improve life for residents in these areas. Local churches play a vital role through outreach and community assistance. Universities and colleges also provide some resources through various community projects and initiatives. Local civic organizations contribute by engaging and bringing residents together for community activities. Youth development organizations also play an important role through their after school and recreational programs. Some residents believe that the contributions of hospitals to various local initiatives also provide resources that help support these communities.

[3] See web-site City of Boston. Address: www.boston.ma.us/neighborhoods.

Third Ward SITE PROFILE

General Characteristics and Socio Demographics

The Third Ward community is an area located approximately 2.5 miles southeast of the Central Business District in the city of Houston and is home to 25,394 people[1]. The area is bounded by the Gulf Freeway (IH-45) to the north, Cullen Boulevard to the east, US Highway 59 to the west, and Brays Bayou to the south. The population of the neighborhood are categorized as 85% Black, 3% Hispanic, and 9% as White. A small percentage of the residents is foreign born (5%). Over five thousand children reside in the Third Ward. Of these, 39% are younger than 6, 33% are between the ages of 6 and 11, and the remaining 28% are between the ages of 12 and 17.

The 1990 census found 10% of eligible adults to be unemployed and 47% of the adult population not to be in the workforce. Recent events have changed that situation markedly. The yearly per capita income in the neighborhood was $7,477, which is half the per capita income of the rest of the county. At that time, 22% of the households received public assistance. Seventy percent of children in the Third Ward lived in poverty. Of the families whose income fell below the poverty line, 76% were headed by single women. Statistics on the living arrangements of children reveal that 48% resided in female-headed households and 8% children living in family households live with a grandparent.

The Third Ward contains a number of neighborhoods[2] known historically as: Riverside/Washington Terrace, Southwood/North MacGregor, Oaks/Timbercrest, the "original" Third Ward, Tierwester/Canfield/College Oaks, Binz, and Oak Manor/University Oaks. In Houston, the term "Ward" has traditionally been applied to communities with predominantly African American populations. Third Ward roughly doubled in size during the 1950's as African American residents replaced Whites in the relatively affluent southern half of the present day community. Consequently there is considerable variety in housing in the Third Ward. Single-family detached units outnumber duplexes, triplexes, fourplexes, and apartments. Multi-unit dwellings include some public housing complexes. In the northern half of the community, single-family residences are markedly smaller and less well cared for. Many of these houses have been abandoned and either boarded up or removed, leaving behind a great many vacant lots. Few new units have been constructed since 1985.

Quality of Life and Neighborhood Resources

Many service providers and community organizations and are located in or near the Third Ward[2]. These include elementary, secondary, and post-secondary educational institutions (including two universities), service providers, recreational facilities, civic organizations, and religious institutions. Of the six public schools in the Third Ward, four are elementary level, one is a middle school, and one is a high school. Together, they have an annual enrollment of 5,189 children and youth. Additionally, there are four "Magnet" programs including one Vanguard program.

[1] All socio-demographic data is taken from the 1990 Census of Population and Housing. The area includes eight full or partial census tracts: 300.24, 304.01, 305.02, 307.02, 306, 307.01, and 308.10

[2] Information on neighborhoods and resources has been extracted from the application document of The Annie E. Casey Foundation Mental Health Initiative for Urban Children in Texas, 1993. The specific sections consulted are: "Third Ward Community Needs Assessment Report," Appendix #9 "Community Services and Resource Profile," and Appendix #10 "Community Resource Maps."

In 1992, 13 percent (compared to 10 percent district-wide) of the Third Ward student population were enrolled in Exceptional Education classes. These classes are for students identified as mentally/emotionally disabled. Three "pocket" and four neighborhood parks are located in or near the Third Ward.

In 1992, eighteen agencies provided mental health services to the area's population, and thirty-nine provided general health services. While there are a number of not-for-profit organizations providing substance abuse prevention services, much of the treatment service is expensive and available only to clients with insurance. Sixty-nine agencies offer some kind of social services and twenty-seven agencies provide vocational services.

In the Third Ward, there are several civic organizations and neighborhood associations, as well as offices of the Houston Area Urban League and of the National Association for the Advancement of Colored People (NAACP). Additionally, there are organizations that provide recreational services to youth, including an amateur boxing association, a community artists' collective, a community music center, the YMCA and the YWCA.

Activities for children and youth are also provided by some of the 45 churches located in or near the Third Ward. Some of these churches also offer services such as alcohol treatment programs, emergency aid programs, and educational and tutorial programs for youth. Twenty-seven of the area churches are Baptist, three are Methodist, one is Presbyterian, one is Evangelical, and the remaining thirteen are affiliated with minority Christian and non-Christian churches.

The Third Ward has a long tradition of leadership in the African American community. Texas Southern University, with a predominantly African American faculty and student body, has provided a central role in political, cultural, and intellectual affairs. The main business artery, Dowling Street, running along the western boundary of the community, was home to some of the city's most prosperous and influential African American businesses, churches, and professional institutions. A predominantly African American hospital in the community has served as a national center in training of African American doctors and nurses. Much of this leadership and wealth was dispersed after the modest successes of the civil rights movement, but the Third Ward remains a proud and vibrant community, even in the face of poverty and its attendant problems.

East End SITE PROFILE[1]

General Characteristics and Socio Demographics

Nine different neighborhoods comprise the East End District of Richmond: Eastview, Shockoe Bottom, Fairmount, Church Hill, Oakwood-Chimborazo, St. John's Church, Montrose Heights, Fulton, and Fulton Hill. According to the 1990 census, the population of the area was 27,650 and 90% are African American. Twenty eight percent of residents are children below the age of 18 (7,702).

Although well established in its history, the East End is an economically deprived area. The per capita income of the neighborhood residents averaged $8,326 in 1989 compared to $12,993 for the County in the same year. Twenty-three percent of the households in the area receive public assistance. Unemployment rates average 6%. Forty-seven percent of the area's residents are reportedly not in the labor force. Single parent families, most of whom are female, head 82% of the households living below poverty level. Sixty percent of the area's children live below federal poverty level standards. Hope for economic revitalization and growth of the area is afforded by the opening of the White Oak Semiconductor Plant of Motorola-Siemens on the Elko tract, and the expansion of the Richmond International Airport. A number of commercial warehouses and light industrial parks also have developed here recently which will provide greatly needed jobs for area residents.

In terms of the health of its residents, the East End is ranked as a high-risk environment, a ranking that partly paved the way for its selection as a Casey Foundation site for its five-year urban mental health initiative. For example, 21% of the infant mortality figures recorded in the city in 1990, occurred in the East District, while 27% of teen mothers lived in the East End, primarily in the Creighton and Fairfield Housing developments, and 15% of babies born had low birth weights.

Quality of Life and Neighborhood Resources

The quality of life in the East End is affected to a large degree by issues related to the prevalence of drug consumption and dealing and the lack of adequate public transportation for residents. In 1995,[2] drug activity was perceived by residents to be a major cause of the violence that regularly affected the population of some of the East End's neighborhoods, and which regularly killed youngsters. According to residents, violence had a strong effect on children's capacity to express themselves through collective activities. A parent reportedly expressed fear about letting her child go out to play with friends, because according to her "*…the minute you let them out you are always in the door watching, and don't let it get dark. You will go crazy if you don't know where they are.*" This fear of violence and resulting concern for the safety of children, is a major stress on families especially, mothers/primary caregivers who live in the East End. As a mother said, this stress sometimes results in the use of drugs as a means of stress relief among many families.

Despite these challenges however, residents of the East End boast of tremendous community strengths found mainly in local leadership capacity, and dedi-

[1]The descriptive information about the East End included in this profile has been extracted from the following documents: Rodwell, Mary and Barbara Conklin, 1995. The Casey Initiative Ethnographic Study: The East End, Richmond, Virginia. Volume I and Volume 2. Richmond: School of Social Work, Virginia Commonwealth University.

[2]Kay, P., 1995. The East End Focus Groups: A Report on Parents' Perceptions of Life and Services. Tampa: Louis de la Parte Florida Mental Health Institute.

cation among families and residents young and old, to contribute meaningfully, toward the development of the area through collaboration with businesses and local government. The East End is served by seven elementary schools, one middle school, two high schools, and one exceptional education school, in addition to one Catholic K-12 school. Still, many students are bused to schools in other areas of the city, including North Richmond. Nineteen percent of the adult population reportedly did not complete 9th grade, while 36% finished 9th grade but did not complete high school.

Several investment projects were also being funded or undertaken at the same time as the implementation of the MHI, some of which were mainly geared toward environmental revitalization, neighborhood redevelopment and transformation, etc. Targeted especially for neighborhood transformation were the Mosby Street, Fairmount Avenue, 25th Street and Jefferson Avenue areas, representing the worst of the East End neighborhoods with predominantly vacant and boarded homes. Local leaders tried hard to sell the new investment initiatives to residents and families, inviting their inclusion every length of the way:

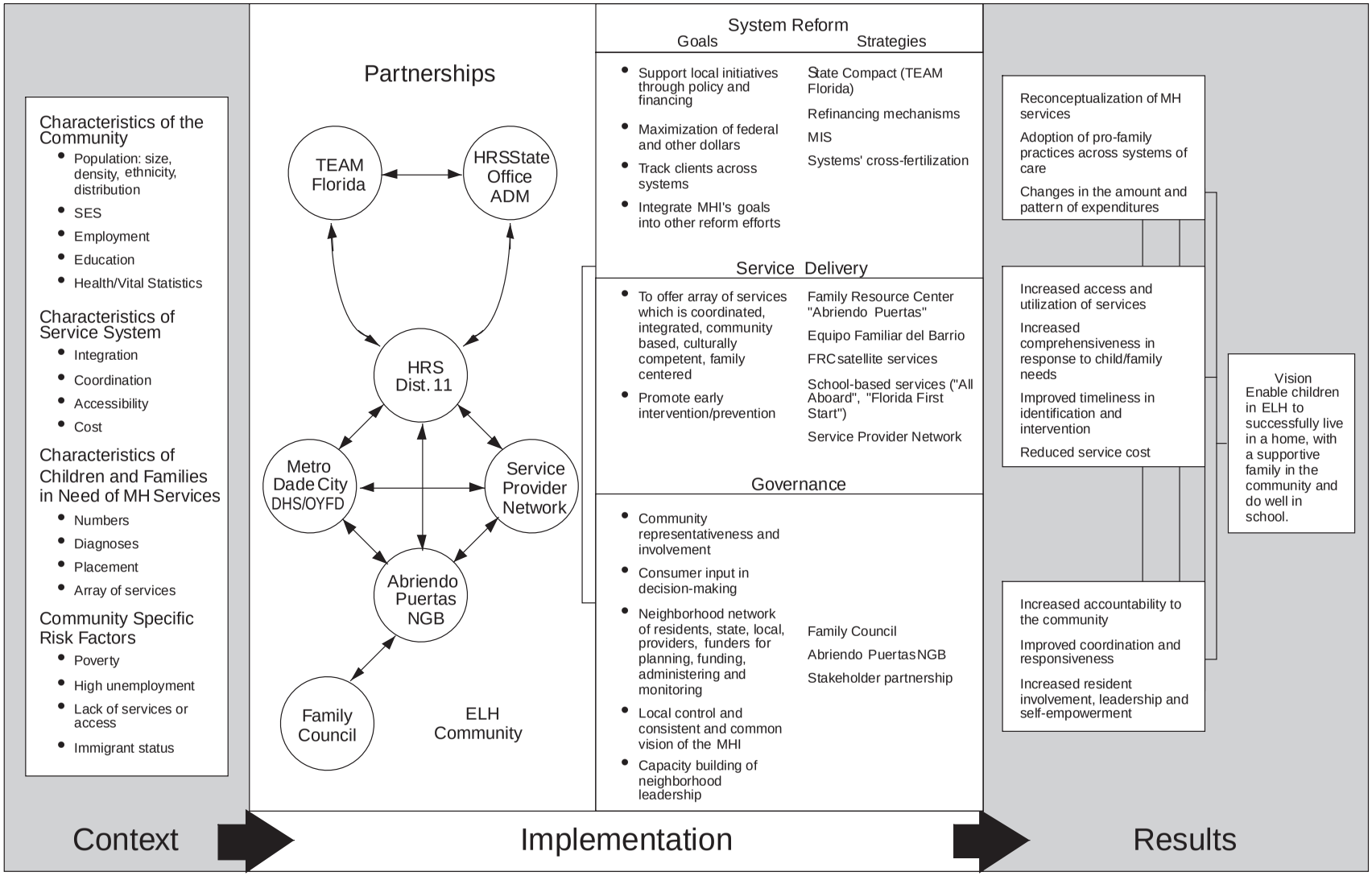
"The revival and the reawakening of Richmond's East District depends upon the 'investment' of time, money, energy, hope, etc. by anybody and everybody who works, plays, or lives here."

Although most of the East End neighborhoods are primarily residential, some commercial activity is found along the main arteries of the area. These include small shopping centers, beauty salons, convenience stores, restaurants, Laundromats, and auto repair shops, and a bank, among others. A common trait of commercial activity in East End is the absence of professional offices. This is explained by residents as being a consequence of crime and drug-related activity: *"Because of the crime and drugs you can't blame the professionals for not being here…they just can't make any money in this area."*

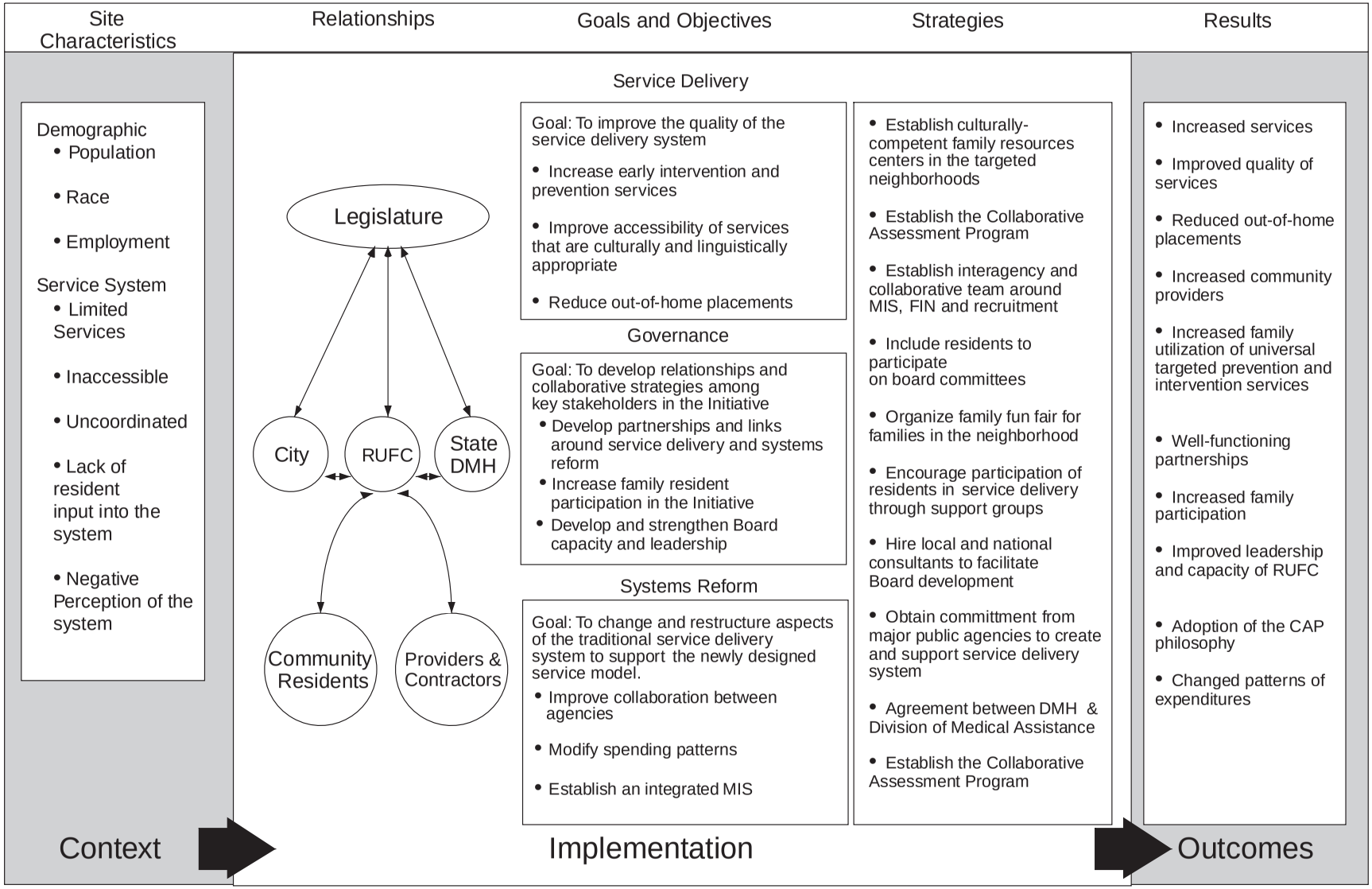
For recreation, East End children use neighborhood playgrounds and parks, which include swimming pools, tennis courts, softball fields, and walking paths. The largest playground is the Bill Robinson Playground, which is run by the city of Richmond. In terms of religion, the East End houses a large number of churches of several denominations, some of which are actively involved in community work. This is the case of the Masjid Bilal Muslim Mosque, whose members were once involved in patrolling the Oakwood-Chimborazo neighborhood identifying drug dealers and buyers for the police. Other churches provide a variety of social services, including day care, bible classes, summer camp, and after-school mentoring.

Social services are provided to the community of the East End District from the East District Center, a multiservice center located within the district's boundaries. The Center houses several agencies and programs, including Richmond's East District Urban Mental Health Initiative. Other services provided at the Center include: child support services, a career development center; a community education and volunteer development agency, a community revitalization/business opportunities program administered by the state Department of Health, focusing on the revitalization of the 25th Street corridor in Richmond's East District; and an annual community events collaborative.

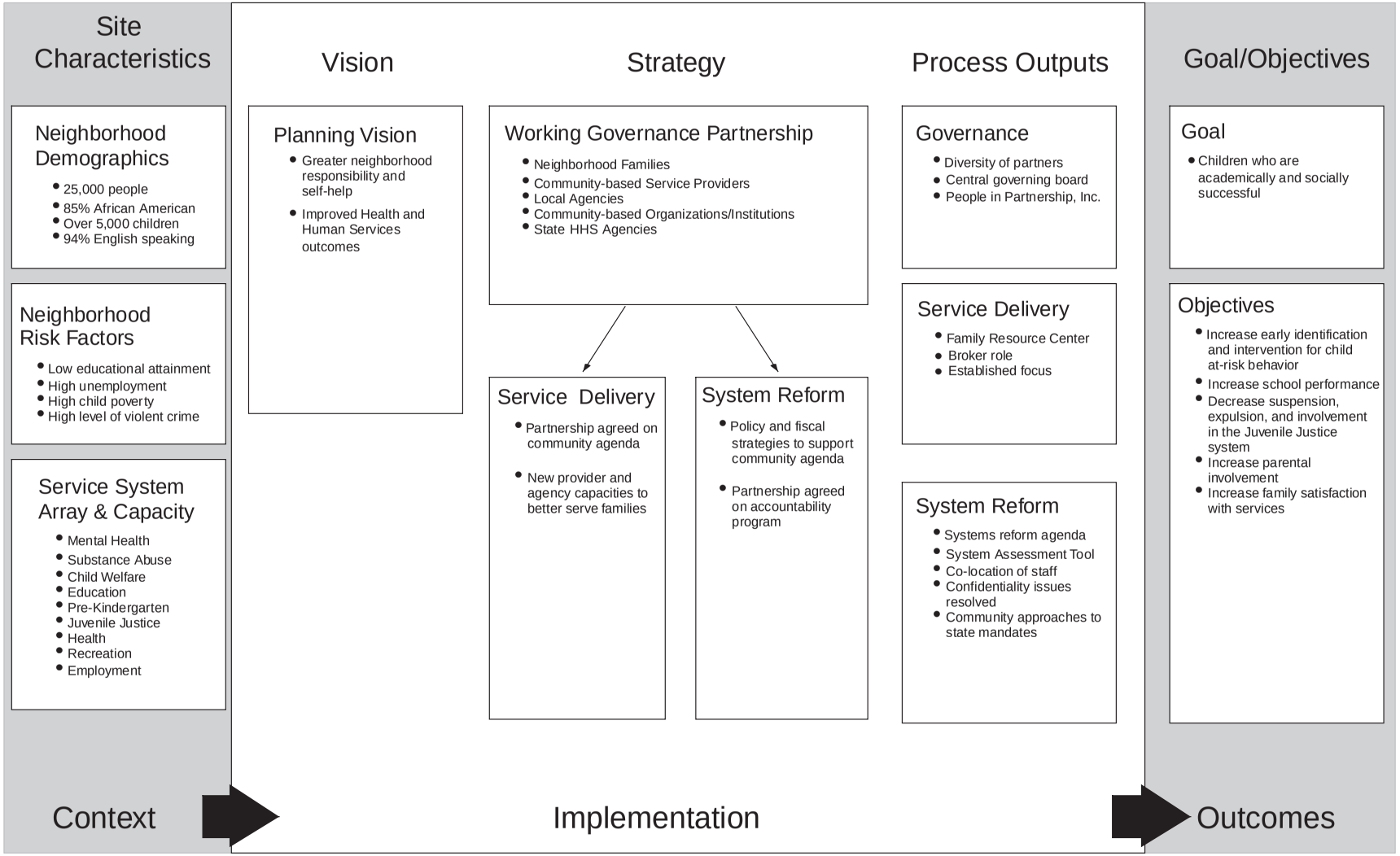
Logic Model of the Annie E.Casey Foundation's Mental Health Initiative for Urban Children in East Little Havana



Logic Model of the Annie E. Casey Foundation's Mental Health Initiative for Urban Children in Boston

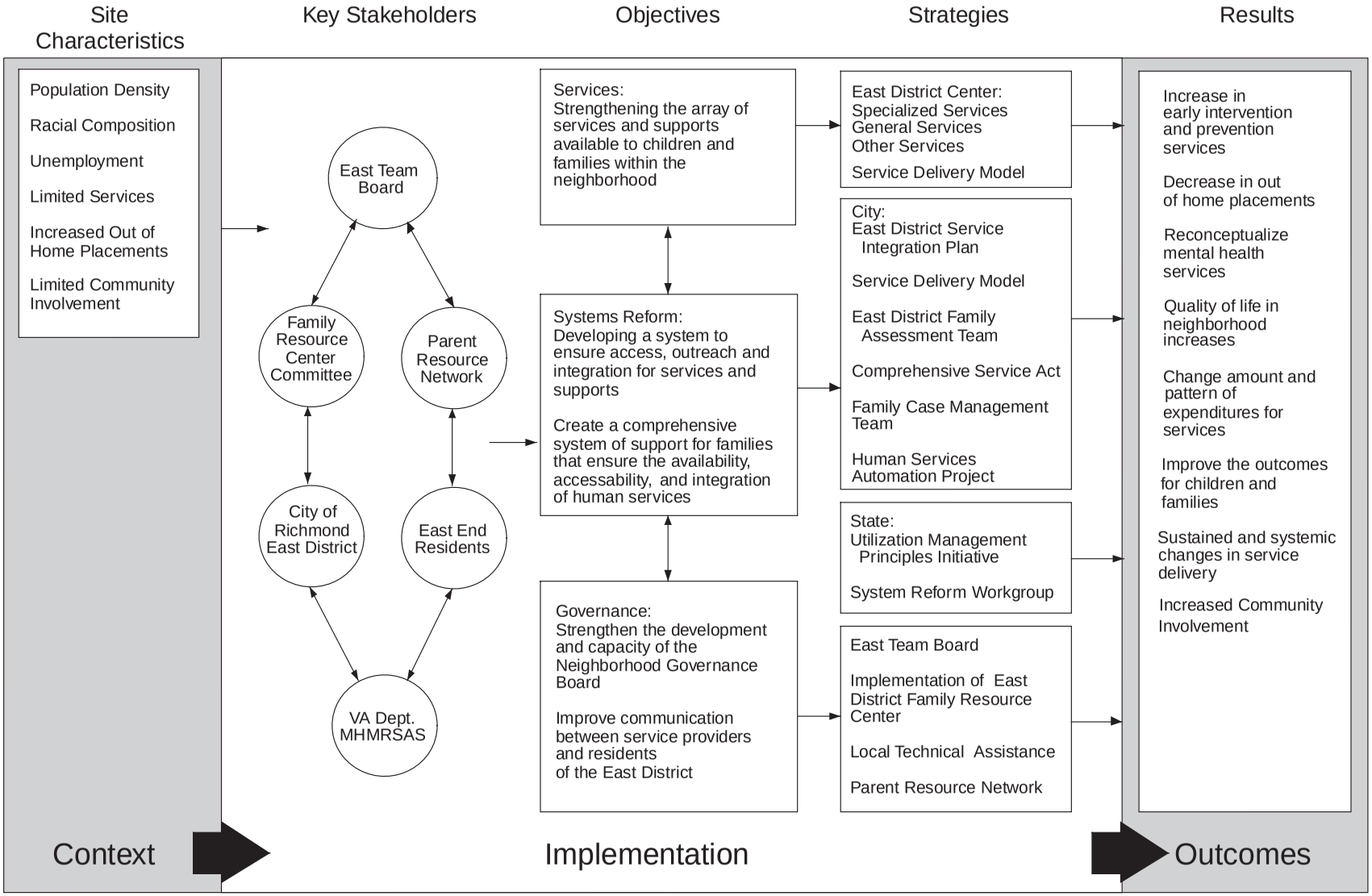


Logic Model of the Annie E. Casey Foundation's Mental Health Initiative for Urban Children in Houston



Virginia/City of Richmond Urban Mental Health Initiative

Mission Statement: To create an environment in the East End of Richmond that will positively effect the lives of youth and their families in reaching their full potential, through community involvement in the development of coordinated social, emotional, cultural, spiritual, recreational and educational programming



APPENDIX C
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